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:

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

A PHYSICIAN'S FOCUS

The Changing Landscape of Medicare Medical Policy: NCDs, and LMRPs to LCDs

This issue's Medical Director column was written by John Montgomery, M.D., M.P.H., Carrier Medical Director for First Coast Service Options, Inc., in Florida.

A major aspect of the Medicare program is the making of policy concerning what procedures or services are covered by and, therefore, reimbursable by Medicare. First Coast Service Options, Inc. (FCSO) is projected to process over 90 million claims for the Medicare program in fiscal year 2004. In order for a procedure or service to be covered by Medicare it must: (1) fit into a statutory benefit category; (2) not be specifically excluded from coverage; and (3) be "reasonable and necessary" for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.

The decision as to which service or item will be covered by Medicare is generally made in two ways; either by the *Centers for Medicare & Medicaid Services* (CMS), through national coverage determinations (NCDs) and other coverage provisions in interpretive manuals, or by *local Medicare contractors* through local medical review policies (LMRPs), now called local coverage determinations (LCDs). An NCD is a determination that a specific device, procedure, treatment, or diagnostic service is or is not covered by Medicare. It may also state specific conditions or limitations on coverage. NCDs are national policies and are binding on all Medicare contractors. Once CMS issues an NCD for an item or service, it must be followed by all Medicare contractors and supersedes any LCD.

CMS published in the September 26, 2003, *Federal Register*, new policies and procedures for requesting NCDs, requesting reconsideration of an NCD, and steps for challenging an NCD under the Benefits Improvement and Protection Act (BIPA). NCDs cannot be appealed to an administrative law judge; however, a Medicare beneficiary may obtain review of an NCD by CMS, and any party may request reconsideration of an NCD.

For local contractor decisions, CMS has directed that LMRPs be converted to LCDs. The difference between LMRPs and LCDs is that LCDs consist only of "reasonable and necessary" information, while LMRPs address benefit categories, exclusive provisions, and coding provisions. The "reasonable and necessary" information from the LMRP will be converted to an LCD with the remaining information (benefit category, statutory exclusions, and billing and coding instructions) either converted to a supplemental instruction article, or deleted at the discretion of the contractor. Unlike NCDs, LCD provisions may be challenged to an Administrative Law Judge by an aggrieved party, regardless of whether the service has been received. A challenge to an LCD can result in the upholding of the LCD, a limited overturn, revision of an LCD, or deletion.

Over the next two years, all Medicare contractors will convert all existing local medical review policies into local coverage determinations. Until the conversion is complete the term LCD will refer to both (1) "reasonable and necessary" provisions of an LMRP and, (2) an LCD that contains only reasonable and necessary language by definition.

John Montgomery, MD, MPH

FCSO Office of the Medical Director
John.Montgomery@fcso.com

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

Elimination of the 90-day Grace Period for Billing Discontinued ICD-9-CM Codes

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

All physicians, practitioners, and suppliers who use ICD-9-CM codes in billing Medicare carriers and durable medical equipment regional carriers (DMERCs)

Provider Action Needed

STOP – Impact to You

Medicare systems will begin enforcing HIPAA standards on October 1, 2004, requiring that ICD-9-CM codes submitted on claims must be valid at the time the service is provided.

CAUTION – What You Need to Know

Physicians, practitioners, and suppliers should be aware that CMS is instructing carriers and DMERCs to eliminate the 90-day grace period for billing discontinued ICD-9-CM diagnosis codes effective October 1, 2004.

GO – What You Need to Do

Adopt the new codes in your billing processes effective October 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of your claim.

Background

Medicare has previously permitted a 90-day grace period after the annual October 1 implementation of an updated version of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes. This grace period gave physicians, practitioners, and suppliers time to become familiar with the new codes and learn about the discontinued codes.

During this 90-day grace period (October 1 through December 31 of each year), physicians, practitioners, and suppliers could use either the previous or the new ICD-9-CM diagnosis codes. For claims received on or after January 1, the updated ICD-9-CM codes were required to be used, and claims received with discontinued diagnosis codes were rejected as Returned Unprocessable Claims (RUCs).

However, the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Rule requires the use of national/medical code sets that are valid at the time that the service is provided, and ICD-9-CM is a national/medical code set.

Therefore, the Centers for Medicare & Medicaid Services (CMS) can no longer allow a 90-day grace period for physicians, practitioners, and suppliers to learn about the discontinued ICD-9 codes.

Providers can view the new, revised, and discontinued ICD-9-CM diagnosis codes at *http://www.cms.hhs.gov/medlearn/icd9code.asp*. CMS updates this site annually after the updated diagnosis codes are published in the *Federal Register*, which usually occurs by May 1 of each year.

Effective for dates of service on and after October 1, 2004, no further 90-day grace periods will apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers and DMERCs will no longer be able to accept discontinued codes for dates of service after the date on which the code is discontinued.

This is a HIPAA compliancy issue.

Implementation

October 1, 2004. This is the date on which Medicare's claims processing systems will be changed.

Related Instructions

The Medicare Claims Processing Manual, Chapter 23, Section 10, Subsection 10.2 (Relationship of ICD-9- CM Codes and Date of Service) has been revised. The relevant revisions to Subsection 10.2 are the following:

10-2 – Relationship of ICD-9-CM Codes and Date of Service
(Rev. 1, 10-01-03)
PM B-02-027 (CR-2108), B-03-063, B-02-064, B-03-002

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*.

For more information about the relationship of ICD-9-CM diagnosis codes and dates of service, go to Chapter 23, available at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf*

To view the actual instruction issued by CMS to your Medicare carrier, please go to: *http://www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf*

For more information on HIPAA's rules that relate to claims submission, other transactions, and code sets, please visit: *http://www.cms.hhs.gov/hipaa/hipaa2/default.asp*

Related Change Request (CR) #: 3094 Medlearn Matters Number: MM3094
Related CR Release Date: February 6, 2004
Effective Date: October 1, 2004
Implementation Date: October 1, 2004

MMA-Implementation of New Medicare Redetermination Notice

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Providers Affected

All Medicare physicians, providers, and suppliers.

Provider Action Needed

STOP – Impact to You

The first level of appeal for fee-for-service has a new name. Starting in October, first level appeals will be called "Redeterminations." You and your patients will receive a formal decision notification letter—the Medicare Redetermination Notice (MRN)—for any decision made on a request for redetermination made on or after October 1, 2004.

CAUTION – What You Need to Know

Contractors who judge these redetermination appeals must make their decisions within 60 days as a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and must then notify the providers and beneficiaries involved via the MRN (unless the decision is to pay the claim). The MRN describes the redetermination process, explains the results of the Medicare appeal, and provides information about how to file an appeal regarding Medicare's decision.

GO – What You Need to Do

The newly initiated redetermination appeals process provides information in a more concise and understandable manner and has been well received by Medicare beneficiaries and providers in consumer testing. The appeals process provides for timely notification of beneficiaries and providers via the (MRN). Be sure to understand how these new procedures affect your appeal rights.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, section 521). Section 1869 (a)(3)(C)(ii) required contractors to mail a written notification of the redetermination decision to the parties of an appeal. This section was then amended by MMA [Sections 1869 (a)(5) and 1869 (a)(4)(B)] to include specific requirements for the notices themselves. The requirements ensure that claim appellants receive complete, accurate, and understandable information about their redetermination decisions, as well as information explaining the process of further appeals.

CMS has provided a model cover letter and a Medicare Redetermination Notice to serve as guidelines for Medicare carriers and intermediaries who make the redeterminations. The MMA also ensures that redetermination decisions are made in a timely manner by requiring that 100% of redeterminations must be completed and mailed within 60 days of the receipt of the request [Section 940(a)(1)].

Additional Information

The MRN must be written in language that is clear and understandable to the beneficiary and must be printed legibly on white paper using black ink. The MRN must include specific required elements such as the sections outlined below:

- An Introductory section.
- A Summary Statement about the appeal decision.
- A Summary of the Facts section including information specific to the appeal and background information.

- A Decision section stating whether the claim is covered by Medicare and whether the beneficiary is responsible for payment.
- An Explanation of the Decision section outlining the logic and specific reasons that led to the redetermination. This must include relevant clinical or scientific evidence used in making the redetermination.
- A Who is Responsible for the Bill section with information on limitation of liability, waiver of recovery, and physician/supplier refund requirements.
- A What to Include in Your Request for Independent Appeal section to explain what policy was used to make the decision and identify specific documentation required to appeal at the Independent Appeal Level. It must also state that if this documentation is not introduced at the next level, it may not be introduced in subsequent appeals unless there is good cause that precluded inclusion of such evidence before.
- An Additional Relevant Information section to present any additional relevant information, not to include any sensitive medical information.
- A section on Important Information About Your Appeal Rights including contact information and an explanation of the next level of the appeal process.

The official instruction, including a copy of a model MRN, issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R97CP.pdf.*

Related Change Request (CR) #: 2620 Medlearn Matters Number: MM2620
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R97CP
Effective Date: October 1, 2004
Implementation Date: July 6, 2004

Medicare Incentive Payments for Physician Care in Underserved Areas

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Providers Affected

Psychiatrists

Provider Action Needed

Physicians, including psychiatrists, should note that if they furnish services in primary medical care health professional shortage areas (HPSAs), they are eligible to receive ten percent bonus payments. Psychiatrists furnishing services in mental health HPSAs are also eligible to receive ten percent bonus payments.

STOP – Impact to You

This instruction relates to the amount of payment psychiatrists receive if they provide services in a mental health HPSA.

CAUTION – What You Need to Know

Physicians, including psychiatrists, are eligible to receive ten percent bonus payments if they furnish services in primary medical care HPSAs. Psychiatrists furnishing services in mental health HPSAs are also eligible to receive ten percent bonus payments.

GO – What You Need to Do

Psychiatrists who qualify for these bonus payments are eligible to submit claims for services furnished in mental health HPSAs, effective for claims with dates of service on or after July 1, 2004.

Background

Under current law, Medicare pays a bonus to physicians for providing health care services in certain HPSAs. In light of recent physician inquiries, the Centers for Medicare & Medicaid Services (CMS) has issued instructions to clarify which types of geographic HPSA (primary medical care, dental and mental health) are applicable to the Medicare Bonus Payment program that provides a ten percent bonus payment.

Currently, the Health Resources and Services Administration (HRSA), part of the Department of Health and Human Services, is responsible for designating several types of HPSAs, including HPSA designations based on:

- Areas with shortages of primary care physicians, dentists, or psychiatrists, referred to as geographic-based HPSAs; and
- Underserved populations within an area, referred to as population-based HPSAs.

Federal law for Medicare bonus payments recognizes geographic-based, primary medical care, and mental health HPSAs as eligible areas for receiving bonus payments. Consequently, physicians, including psychiatrists, furnishing services in a primary medical care HPSA, are eligible to receive bonus payments. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. Dental HPSAs remain ineligible for the bonus payment program due to the fact that Medicare does not cover dental services for its beneficiaries.

This change would only affect psychiatrists furnishing services in mental health HPSAs that do not overlap with primary care HPSAs. In other words, these stand-alone mental health HPSAs are now eligible areas, as of July 1, 2004, for psychiatrists to receive bonus payments.

With respect to psychiatrist services in mental health HPSAs, CMS will furnish quarterly lists of mental health HPSAs to Medicare carriers so they can implement this change, which is effective for claims with dates of service on or after July 1, 2004. Should an area be both a mental health HPSA and a nonmental health HPSA, only one ten percent bonus payment will apply to a single service.

Also, it is important for physicians and psychiatrists to note that the bonus is paid for services in HPSA areas only if those services are actually provided in the HPSA area. For example, if the physician has an office in a HPSA area, but provides the service in the patient's home, which is outside the service area, the bonus is not payable.

Implementation

The implementation date is July 6, 2004 for the mental health HPSAs and the change for such services will apply effective for dates of service on or after July 1, 2004. For services provided in primary medical care HPSAs, this instruction is meant for clarification and informational purposes only.

Additional Information

The Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Section 90 (Physicians Practicing in Special Settings), Subsection 90.4 (Billing and Payment in a Health Professional Shortage Areas (HPSAs)) has been revised, and sections have been deleted. You can find this manual at:
http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Once at that site, scroll down to Chapter 12 and select the version of the file you would like to view.
Also, to see the specific instruction issued to your Medicare carrier, visit:
http://www.cms.hhs.gov/manuals/pm_trans/R78CP.pdf.

Related Change Request (CR) #: 3108 Medlearn Matters Number: MM3108
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R78CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Reminder—UPIN of Attending Physician and Date Last Seen Required for Podiatry and Physical/Occupational Therapy Claims

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).

Similarly, claims for outpatient services provided by a qualified, independent physical or occupational therapist require the UPIN of the attending physician and the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date the patient was last seen by the attending physician in item 19 on Form CMS-1500 (or electronic equivalent).

Claims for these services submitted without this information will be returned as unprocessable (RUC). For more information regarding claim completion requirements, including RUC, please refer to the *Medicare B Update!* Second Quarter 2004 issue (pages 9-15), and Fourth Quarter 2002 issue (pages 6-11).

Source: CMS Internet-only manual (IOM) - Medicare Claims Processing Manual, Chapter1, Section 80.3.2.1.3.e., g.

Filing Tips for Paper Claim Submissions

The Administrative Simplification Compliance Act (ASCA) and the Health Insurance Portability and Accountability Act (HIPAA) require electronic submission of Medicare claims, with few exceptions. Those exceptions may be found in the Second Quarter 2004 *Medicare B Update!* (pages 37-41).

Filing your claims electronically is both quicker and more cost effective. We understand, however, there are times when it is necessary to file paper claims. The Optical Character Recognition (OCR) department offers the following tips for more efficient processing of paper claims:

- Paper claims *must* be submitted on an approved 8 ½ inch wide red-and-white Form CMS-1500.
- Use 10 or 12 pitch characters, standard fonts in letter quality. `Courier is preferred.`
- Use UPPERCASE letters for all alpha characters.
- Align all information within the designated field.
- Print claims using black ink–dark and solid, but not **bold.** Do not use red ink.
- Send claims unfolded and in 10" x 13" envelopes.
- Ensure copies of documentation are clean and legible.
- Do not mix fonts on the same claim form.
- Do not use *italics*.
- Do not use special characters: dollar signs, decimals, dashes, and zeros or sevens with slashes.
- Do not space between dates of service (e.g., 10 15 2003 – enter date as 10152003).

SPECIAL SECTION

2004 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)/ HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) UPDATE

Annual Procedure Code Update

Effective for Services Rendered on or After January 1, 2004

The Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) is used to administer the Medicare Part B program for all carriers. The HCPCS is updated annually to reflect changes in the practice of medicine and provisions of healthcare. When filing claims for dates of service beginning January 1, 2004, refer to the coding changes in this publication. For services rendered in 2003, continue to use 2003 procedure codes.

The purpose of this section is to provide an overview of changes to the HCPCS coding structure for 2004. This publication only covers specific coding changes. Related billing and reimbursement changes will be posted to our provider education Web sites at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*, and in future issues of the *Medicare B Update!* This information is also shared with the Connecticut Medical Association, the Florida Medical Association, all county medical societies, and all active specialty associations. Stay in contact with these organizations and read their bulletins for additional HCPCS information.

Description of HCPCS Coding Levels

Procedure code additions, deletions and revisions have been made to all three levels of the HCPCS coding structure for 2004. The three levels of procedure codes are:

Level I–Numeric Codes (*CPT*)

Level I codes and modifiers include five-digit numeric codes (for example, procedure code *71010*). These codes describe various physician and laboratory procedures and are contained in the American Medical Association's *Current Procedural Terminology* (*CPT*).

> ***Note:*** CPT *codes, descriptors, and other data only are copyright 2003 American Medical Association (or such other date of publication of* CPT*). All Rights Reserved. Applicable FARS/DFARS apply. No fee schedules, basic units, relative values or related listings are included in* CPT*. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.*

Level II–Alphanumeric (CMS-Assigned)

Level II codes and modifiers include alphanumeric codes (for example, procedure code A6255) assigned by CMS. These codes describe various nonphysician and a relatively few number of physician services. These procedure codes begin with a letter in the A-V range and are used for durable medical equipment (DME), ambulance services, prosthetics, orthotics, ostomy supplies, etc.

Level III–Alphanumeric (Locally-Assigned)

Level III alphanumeric codes and modifiers assigned by local Medicare Part B carriers are discontinued effective for services rendered on or after January 1, 2004, as part of the standardization of the Medicare program.

The 2004 HCPCS Update

Additions

The procedure/modifier codes listed under "Modifiers/Procedure Codes Added for 2004" are newly identified codes and should be used only for services rendered on or after January 1, 2004.

Revisions

The procedure/modifier codes listed under "Modifiers/Procedure Codes Revised for 2004" include codes in which the descriptor or administrative instructions have changed from 2003. When using these codes, please be sure to refer to the 2004 HCPCS or *CPT* to ensure you are using the accurate procedure code for the service performed.

Reactivated Procedures

The procedure/modifier codes listed under "Modifiers/Procedure Codes Reactivated for 2004" include codes that, having been previously discontinued, are being reactivated for use for services rendered on or after January 1, 2004.

> ***Note:*** *all codes reactivated for 2004 are "C" codes used by Medicare Part A under the Outpatient Prospective Payment System (OPPS), and may not be billed to Medicare Part B carriers.*

Discontinued Procedures

The procedure/modifier codes listed under "Modifiers/Procedure Codes Discontinued for 2004" should not be used for service dates after December 31, 2003.

However, Medicare Part B continued to accept claims for certain discontinued procedure codes with 2004 service dates received prior to April 1, 2004.

Effective for claims received on or after April 1, 2004, services performed in 2004 billed using discontinued are denied payment when submitted to Medicare Part B. In these instances, providers are notified that a discontinued procedure code was submitted and a valid procedure code must be used.

When billing for services listed in the discontinued code section, the procedure code(s)indicated in the "Codes to Report" column must be used. If more than one replacement code or no replacement code exists, refer to the appropriate coding book for additional guidelines.

A Word About Coverage

Procedure codes that are noncovered by Medicare due to statute are not represented on these lists. However, inclusion of a code on the lists does not necessarily constitute Medicare coverage. For example, a code may be noncovered based on local medical review policy (LMRP). Diagnostic tests that are noncovered due to LMRP are noncovered whether purchased or personally performed.

Carrier Jurisdiction

The lists of procedures that are added, revised, or discontinued for 2004 are complete with no regard to carrier jurisdiction. The majority of procedure codes in HCPCS are processed by the local Medicare Part B carrier (FCSO). However, some procedure codes listed represent services that should be billed to the durable medical equipment regional carrier (DMERC), not the local carrier. The DMERC that serves Connecticut is HealthNow (*http://www.umd.nycpic.org*); for Florida, it is Palmetto Government Benefits Administrators (*http://www.palmettogba.com*). It is the responsibility of the billing provider to submit claims to the appropriate carrier.

Use of Unlisted Procedure Codes

If you are unable to find a procedure code which most closely relates to the service rendered, then an "unlisted or not otherwise classified" procedure code may be submitted with a complete narrative description of the service rendered and supporting documentation. To ensure accurate processing in these instances, the following documentation should be provided:

Type of Service Performed	Clarification/Documentation Needed
Surgery, surgical assistant	Operative report or office records (if anesthesia performed in an office setting)
Orthotic/prosthetic device	Physician's orders
Laboratory/pathology	Laboratory/pathology report
Radiology	Radiology report

Every effort should be made to locate a specific replacement code, since the use of unlisted procedure codes will result in delays in claims processing.

Reminder for Electronic Media Claim (EMC) Billers

- If the unlisted or not otherwise classified procedure code can be submitted with a brief descriptor, the required information may be indicated in the appropriate narrative record.
- Certain claims (e.g., claims that may require attachments in some cases) may continue to be submitted on paper. For such submissions, ***providers should continue to submit claims via their normal process in place prior to the October 16, 2003, HIPAA implementation date,*** *until further notification is provided.*

Questions or Concerns?

Providers are encouraged to refer to all available resource materials for specific procedure coding instructions and claims filing information. Medicare's reference materials include the *Medicare B Update!* and special bulletins.

If you have any questions about these coding changes, contact our provider customer service department toll-free at.

Connecticut: 1-(866)-419-9455
Florida: 1-(866)-454-9007

Acquiring the 2004 Coding Books

Because of the many changes to the HCPCS coding structure, providers are strongly encouraged to purchase the 2004 *CPT* (Level I) book and/or the 2004 HCPCS (Level II) coding book. The 2004 edition of *CPT* may be purchased from the American Medical Association online at *http://www.ama-assn.org*, by calling 1-(800)-621-8335, or by writing:

American Medical Association
P. O. Box 109050
Chicago, IL 60610-0946

The 2004 HCPCS Alpha-Numeric Hardcopy

In addition, the 2004 alpha-numeric hardcopy, titled *2004 Alpha-Numeric Healthcare Common Procedure Coding System*, may be secured from the AMA, or from:

Superintendent of Documents
U. S. Government Printing Office
Washington D. C. 20402
Telephone: 1-(202)-512-1800

Modifiers and Procedure Codes Added for 2004

MODIFIERS

UN
UP
UQ
UR
US

CMS ASSIGNED

A0800	A6452	E0247	E1634	E2506	J1335	P9054
A4216	A6453	E0248	E2120	E2508	J1595	P9055
A4217	A6454	E0300	E2201	E2510	J2001	P9056
A4248	A6455	E0301	E2202	E2511	J2185	P9057
A4366	A6456	E0302	E2203	E2512	J2280	P9058
A4416	A6550	E0303	E2204	E2599	J2353	P9059
A4417	A6551	E0304	E2300	G0302	J2354	P9060
A4418	A7046	E0470	E2301	G0303	J2505	Q0137
A4419	A7520	E0471	E2310	G0304	J2783	Q0182
A4420	A7521	E0472	E2311	G0305	J3411	Q4054
A4423	A7522	E0561	E2320	G0306	J3415	Q4055
A4424	A7523	E0562	E2321	G0307	J3465	S0107
A4425	A7524	E0637	E2322	G0308	J3486	S0115
A4426	A7525	E0638	E2323	G0309	J7303	S2085
A4427	A7526	E0675	E2324	G0310	J7621	S2095
A4428	A9280	E0955	E2325	G0311	J9098	S2113
A4429	A9525	E0956	E2326	G0312	J9178	S2135
A4430	A9526	E0957	E2327	G0313	J9263	S2225
A4431	A9528	E0960	E2328	G0314	J9395	S2362
A4432	A9529	E0981	E2329	G0315	L0112	S2363
A4433	A9530	E0982	E2330	G0316	L0861	S3853
A4434	A9531	E0983	E2331	G0317	L1831	S8075
A4638	A9532	E0984	E2340	G0318	L1907	S8948
A4671	A9533	E0985	E2341	G0319	L1951	T2101
A4672	A9534	E0986	E2342	G0320	L1971	T5001
A4673	A9999	E1002	E2343	G0321	L3031	T5999
A4674	C1080	E1003	E2351	G0322	L3917	V2121
A4728	C1081	E1004	E2360	G0323	L5673	V2221
A6407	C1082	E1005	E2361	G0324	L5679	V2321
A6441	C1083	E1006	E2362	G0325	L5681	V2745
A6442	C1819	E1007	E2363	G0326	L5683	V2756
A6443	C2633	E1008	E2364	G0327	L8511	V2761
A6444	C9210	E1009	E2365	G0328	L8512	V2762
A6445	C9211	E1010	E2366	G0338	L8513	V2782
A6446	C9212	E1019	E2367	G0339	L8514	V2783
A6447	C9704	E1021	E2399	G0340	L8631	V2784
A6448	E0118	E1028	E2402	J0152	L8659	V2786
A6449	E0140	E1029	E2500	J0215	P9051	V2797
A6450	E0190	E1030	E2502	J0583	P9052	
A6451	E0240	E1391	E2504	J0595	P9053	

CPT

0001F	*0009F*	*0050T*	*0057T*	*21685*	*35512*	*36560*
0002F	*0010F*	*0051T*	*0058T*	*22532*	*35522*	*36561*
0003F	*0011F*	*00529*	*0059T*	*22533*	*35525*	*36563*
0004F	*0045T*	*0052T*	*0060T*	*22534*	*35697*	*36565*
0005F	*0046T*	*0053T*	*0061T*	*31632*	*36555*	*36566*
0006F	*0047T*	*0054T*	*01173*	*31633*	*36556*	*36568*
0007F	*0048T*	*0055T*	*01958*	*34805*	*36557*	*36569*
0008F	*0049T*	*0056T*	*20982*	*35510*	*36558*	*36570*

Modifiers and Procedure Codes Added for 2004- Continued

36571	*36597*	*59076*	*64517*	*76937*	*89225*	*89346*
36575	*36838*	*59897*	*64681*	*76940*	*89230*	*89352*
36576	*37765*	*61537*	*65780*	*78804*	*89235*	*89353*
36578	*37766*	*61540*	*65781*	*79403*	*89240*	*89354*
36580	*43237*	*61566*	*65782*	*84156*	*89268*	*89356*
36581	*43238*	*61567*	*67912*	*84157*	*89272*	*90655*
36582	*47140*	*61863*	*68371*	*85055*	*89280*	*90698*
36583	*47141*	*61864*	*70557*	*85396*	*89281*	*90715*
36584	*47142*	*61867*	*70558*	*87269*	*89290*	*90734*
36585	*53500*	*61868*	*70559*	*87329*	*89291*	*91110*
36589	*57425*	*63101*	*75998*	*87660*	*89335*	*95991*
36590	*59070*	*63102*	*76082*	*88112*	*89342*	*97755*
36595	*59072*	*63103*	*76083*	*88361*	*89343*	*99601*
36596	*59074*	*64449*	*76514*	*89220*	*89344*	*99602*

Modifiers and Procedure Codes Revised for 2004

MODIFIERS

CB

CMS ASSIGNED

A4326	E0149	E0972	E1390	L1844	L5848	S2150
A4538	E0950	E0973	G0279	L1950	L5984	S9123
A4623	E0951	E0974	G0280	L2405	L6620	V5362
A6025	E0952	E0978	J0880	L3902	L6675	V5363
A9517	E0958	E0990	J1650	L4350	L6676	V5364
E0141	E0959	E0992	J7308	L4360	L8658	
E0143	E0961	E0995	J9130	L4386	M0100	
E0144	E0966	E1225	L0480	L5646	M0301	
E0147	E0967	E1226	L1843	L5648	P9017	

CPT

0001T	*0036T*	*20551*	*61538*	*72198*	*86300*	*90733*
0003T	*0037T*	*20552*	*61539*	*72270*	*86301*	*90871*
0005T	*0038T*	*22522*	*61543*	*74170*	*87040*	*90918*
0006T	*0039T*	*25025*	*63043*	*74175*	*87045*	*90919*
0007T	*0040T*	*26356*	*63044*	*74183*	*87070*	*90920*
0008T	*0041T*	*26357*	*63173*	*74185*	*87075*	*90921*
0009T	*0042T*	*31622*	*64680*	*75860*	*87271*	*90922*
0010T	*0043T*	*31625*	*64821*	*76355*	*87272*	*90923*
0012T	*0044T*	*31628*	*67221*	*76360*	*87328*	*90924*
0013T	*00220*	*31629*	*67916*	*76362*	*88045*	*90925*
0016T	*00320*	*33310*	*67917*	*76370*	*88312*	*92597*
0017T	*00528*	*34826*	*67923*	*76394*	*88342*	*93736*
0018T	*00580*	*36400*	*67924*	*76775*	*88358*	*93788*
0019T	*00942*	*36410*	*70250*	*76802*	*89055*	*95967*
0020T	*01214*	*37785*	*70260*	*76831*	*89250*	*96155*
0021T	*01382*	*38208*	*70470*	*76872*	*89251*	*97537*
0023T	*01402*	*38209*	*70543*	*78290*	*89258*	*99024*
0024T	*01464*	*43242*	*70552*	*78601*	*90657*	*99026*
0026T	*01622*	*43259*	*70553*	*78800*	*90658*	*99027*
0027T	*01732*	*43752*	*71270*	*78802*	*90693*	*99050*
0028T	*01916*	*44388*	*71552*	*80055*	*90703*	*99292*
0029T	*01995*	*44799*	*72127*	*83716*	*90704*	*99293*
0030T	*01996*	*45335*	*72130*	*84155*	*90705*	*99294*
0031T	*11100*	*45338*	*72133*	*84160*	*90706*	*99295*
0032T	*15852*	*45381*	*72156*	*84165*	*90707*	*99296*
0033T	*16036*	*45386*	*72157*	*84378*	*90708*	*99512*
0034T	*20240*	*50548*	*72158*	*86146*	*90718*	
0035T	*20550*	*58340*	*72194*	*86294*	*90727*	

Modifiers and Procedure Codes Reactivated for 2004

CMS ASSIGNED

C1713	C1731	C1760	C1777	C1815	C1885	C2619
C1714	C1732	C1762	C1778	C1816	C1887	C2620
C1715	C1733	C1763	C1779	C1817	C1891	C2621
C1717	C1750	C1764	C1780	C1874	C1892	C2622
C1721	C1751	C1766	C1781	C1875	C1893	C2625
C1722	C1752	C1767	C1782	C1876	C1894	C2626
C1724	C1753	C1768	C1784	C1877	C1895	C2627
C1725	C1754	C1769	C1785	C1878	C1896	C2628
C1726	C1755	C1770	C1786	C1879	C1897	C2629
C1727	C1756	C1771	C1787	C1880	C1898	C2630
C1728	C1757	C1772	C1788	C1881	C1899	C2631
C1729	C1758	C1773	C1789	C1882	C2615	
C1730	C1759	C1776	C1813	C1883	C2617	

Modifiers and Procedure Codes Discontinued for 2004

CMS ASSIGNED

A4214		C9503		K0029		K0542	
A4319		C9711		K0030	XREF E0992	K0543	XREF E2508
A4323		E0142		K0031		K0544	XREF E2510
A4621		E0145		K0032		K0545	XREF E2511
A4622		E0146		K0033		K0546	XREF E2512
A4631		E0943		K0035	XREF E0951	K0547	XREF E2599
A4644		E0975		K0036	XREF E0952	K0549	XREF E0303
A4645		E0976		K0048	XREF E0990	K0550	XREF E0304
A4646		E0979		K0049	XREF E0995	K0556	XREF L5673
A4712		E0991		K0054		K0557	XREF L5679
A6421		E0993		K0055		K0558	XREF L5681
A6422		E1065		K0057		K0559	XREF L5683
A6424		E1066		K0058		K0560	XREF L8631
A6426		E1069		K0062	XREF E0967	K0581	XREF A4416
A6428		G0110		K0063	XREF E0967	K0582	XREF A4417
A6430		G0111		K0079	XREF E0961	K0583	XREF A4418
A6432		G0112		K0080	XREF E0974	K0584	XREF A4419
A6434		G0113		K0082	XREF E2360	K0585	XREF A4420
A6436		G0114		K0083	XREF E2361	K0586	XREF A4423
A6438		G0115		K0084	XREF E2362	K0587	XREF A4424
A6440		G0116		K0085	XREF E2363	K0588	XREF A4425
A7019		G0167		K0086	XREF E2364	K0589	XREF A4426
A7020		G0236		K0087	XREF E2365	K0590	XREF A4427
A9518	XREF A9530	G0256		K0088	XREF E2366	K0591	XREF A4428
C1010		G0261		K0089	XREF E2367	K0592	XREF A4429
C1011		G0262		K0100	XREF E0959	K0593	XREF A4430
C1015		G0272		K0103	XREF E0972	K0594	XREF A4431
C1016		G0273		K0107	XREF E0950	K0595	XREF A4432
C1017		G0274		K0112		K0596	XREF A4433
C1018		J0151		K0113		K0597	XREF A4434
C1020		J1910		K0268	XREF E0561	K0610	XREF E1634
C1021		J2000		K0460	XREF E0983	K0611	XREF A4671
C1022		J2352		K0461	XREF E0984	K0612	XREF A4672
C1166		J7508		K0531	XREF E0562	K0613	XREF A4673
C1167		J9180		K0532	XREF E0470	K0614	XREF A4674
C1774		K0016	XREF E0973	K0533	XREF E0471	K0615	XREF E2502
C9010		K0022	XREF E0982	K0534	XREF E0472	K0616	XREF E2504
C9111		K0025	XREF E0966	K0538	XREF E2402	K0617	XREF E2506
C9116		K0026		K0539	XREF A6550	K0621	
C9120		K0027		K0540	XREF A6551	K0622	
C9204		K0028	XREF E1226	K0541	XREF E2500	K0623	

Modifiers and Procedure Codes Discontinued for 2004 - continued

K0624		Q9921	Q9935	S8470
K0625		Q9922	Q9936	S9806
K0626		Q9923	Q9937	V2116
L1885	XREF E1810	Q9924	Q9938	V2117
L2102		Q9925	Q9939	V2216
L2104		Q9926	Q9940	V2217
L2122		Q9927	S0009	V2316
L2124		Q9928	S0079	V2317
Q0086		Q9929	S0124	V2740
Q2010		Q9930	S0130	V2741
Q4052	XREF J2353	Q9931	S0135	V2742
Q4053	XREF J2505	Q9932	S0193	V2743
Q4078	XREF A9526	Q9933	S8180	
Q9920		Q9934	S8181	

CPT

0002T	*TO REPORT, USE 34805*	*89360*	*TO REPORT, USE 89230*
0025T	*TO REPORT, USE 76514*	*89365*	*TO REPORT, USE 89235*
00544	*TO REPORT, USE 00542*	*89399*	*TO REPORT, USE 89240*
47134	*TO REPORT, USE 47140*	*90659*	*TO REPORT INFLUENZA VIRUS VACCINE, SPLIT VIRUS, SEE 90657 OR 90658*
36493	*TO REPORT, USE 36597*		
36533	*TO REPORT, SEE 36557-36561, 36565-36566, 36570-36571*	*99025*	
		99551	*TO REPORT, SEE 99601-99602*
36530	*TO REPORT, USE 36563*	*99552*	*TO REPORT, SEE 99601-99602*
36531	*TO REPORT, SEE 36575-36576, 36578, 36581-36582, 36584-36585*	*99553*	*TO REPORT, SEE 99601-99602*
		99554	*TO REPORT, SEE 99601-99602*
36534	*TO REPORT, SEE 36575-36578, 36581-36583, 36585*	*99555*	*TO REPORT, SEE 99601-99602*
		99556	*TO REPORT, SEE 99601-99602*
36532	*TO REPORT, USE 36590*	*99557*	*TO REPORT, SEE 99601-99602*
36535	*TO REPORT, USE 36589*	*99558*	*TO REPORT, SEE 99601-99602*
36536	*TO REPORT, USE 36595*	*99559*	*TO REPORT, SEE 99601-99602*
36537	*TO REPORT, USE 36596*	*99560*	*TO REPORT, SEE 99601-99602*
47134	*TO REPORT, USE 47140*	*99561*	*TO REPORT, SEE 99601-99602*
61862	*TO REPORT, SEE 61867, 61868*	*99562*	*TO REPORT, SEE 99601-99602*
76085	*TO REPORT, SEE 76082, 76083*	*99563*	*TO REPORT, SEE 99601-99602*
76490	*TO REPORT, USE 76940*	*99564*	*TO REPORT, SEE 99601-99602*
89252	*TO REPORT, USE 89280-89281*	*99565*	*TO REPORT, SEE 99601-99602*
89256	*TO REPORT, USE 89352*	*99566*	*TO REPORT, SEE 99601-99602*
89256	*TO REPORT, USE 89352*	*99567*	*TO REPORT, SEE 99601-99602*
89350	*TO REPORT, USE 89220*	*99568*	*TO REPORT, SEE 99601-99602*
89355	*TO REPORT, USE 89225*	*99569*	*TO REPORT, SEE 99601-99602*

ANESTHESIA

Anesthesia Base Units

Listed below are the anesthesia base units (ABUs) for all anesthesia procedure codes in the 2004 Healthcare Common Procedure Coding System (HCPCS) file.

Procedures marked with a single asterisk (*) were added effective January 1, 2004; procedures marked with a double asterisk (**) were added effective January 1, 2003. All other procedures and relative values listed were effective January 1, 2002.

Code	ABU	Code	ABU	Code	ABU	Code	ABU	Code	ABU
00100	005	00537	007	00865	007	01250	004	01730	003
00102	006	00539*	018	00866	010	01260	003	01732	003
00103	005	00540	012	00868	010	01270	008	01740	004
00104	004	00541*	015	00870	005	01272	004	01742	005
00120	005	00542	015	00872	007	01274	006	01744	005
00124	004	00546	015	00873	005	01320	004	01756	006
00126	004	00548	017	00880	015	01340	004	01758	005
00140	005	00550	010	00882	010	01360	005	01760	007
00142	004	00560	015	00902	005	01380	003	01770	006
00144	006	00562	020	00904	007	01382	003	01772	006
00145	006	00563	025	00906	004	01390	003	01780	003
00147	004	00566	025	00908	006	01392	004	01782	004
00148	004	00580	020	00910	003	01400	004	01810	003
00160	005	00600	010	00912	005	01402	007	01820	003
00162	007	00604	013	00914	005	01404	005	01829*	003
00164	004	00620	010	00916	005	01420	003	01830	003
00170	005	00622	013	00918	005	01430	003	01832	006
00172	006	00630	008	00920	003	01432	006	01840	006
00174	006	00632	007	00921*	003	01440	008	01842	006
00176	007	00634	010	00922	006	01442	008	01844	006
00190	005	00635	004	00924	004	01444	008	01850	003
00192	007	00640	003	00926	004	01462	003	01852	004
00210	011	00670	013	00928	006	01464	003	01860	003
00212	005	00700	004	00930	004	01470	003	01905	005
00214	009	00702	004	00932	004	01472	005	01916	006
00215	009	00730	005	00934	006	01474	005	01920	007
00216	015	00740	005	00936	008	01480	003	01922	007
00218	013	00750	004	00938	004	01482	004	01924	005
00222	006	00752	006	00940	003	01484	004	01925	007
00300	005	00754	007	00942	004	01486	007	01926	008
00322	003	00756	007	00944	006	01490	003	01930	005
00326*	007	00770	015	00948	004	01500	008	01931	007
00350	010	00790	007	00950	005	01502	006	01932	006
00352	005	00792	013	00952	004	01520	003	01933	007
00400	003	00794	008	01112	005	01522	005	01951	003
00402	005	00796	030	01120	006	01610	005	01952	005
00404	005	00797	008	01130	003	01620	004	01953**	001
00406	013	00800	004	01140	015	01622	004	01958	005
00410	004	00802	005	01150	010	01630	005	01960	005
00450	005	00810	005	01160	004	01632	006	01961	007
00452	006	00820	005	01170**	008	01634	009	01962	008
00454	003	00830	004	01173	012	01636	015	01963	008
00470	006	00832	006	01180	003	01638	010	01964	004
00472	010	00834*	005	01190	004	01650	006	01967	005
00474	013	00836	006	01200	004	01652	010	01968	002
00500	015	00840	006	01202	004	01654	008	01969	005
00520	006	00842	004	01210	006	01656	010	01990	007
00522	004	00844	007	01212	010	01670	004	01991*	003
00524	004	00846	008	01214	008	01680	003	01992*	005
00528	008	00848	008	01215	010	01682	004	01995	005
00529*	011	00851	006	01220	004	01710	003	01996	003
00530	004	00860	006	01230	006	01712	005		
00532	004	00862	007	01232	005	01714	005		
00534	007	00864	008	01234	008	01716	005		

CARRIER-PRICED CODES

2004 Carrier-Priced Fee Schedule Services

Reimbursement for most procedures paid on the basis of the medicare physician fee schedule database (MPFSDB) is calculated by CMS and provided to carriers annually. These are listed on the MPFSDB with a code status of "A" (Active code). Reimbursement for other procedures, known as "C" status or carrier-priced codes, is calculated by each carrier. Per CMS, status "C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report."

In many instances, however, enough historical data has been collected to allow FCSO to develop a consistent allowance for some C status codes. These codes and allowances below, effective for services rendered on or after January 1, 2004, are listed separately for Connecticut and Florida.

Connecticut

CODE/MOD	PAR	NPAR	L CHG	NOTE
G0030	152.53	144.90	166.64	
G0030 TC	91.52	86.94	99.99	
G0031	205.87	195.58	224.91	
G0031 TC	123.53	117.35	134.96	
G0032	152.53	144.90	166.64	
G0032 TC	91.52	86.94	99.99	
G0033	205.87	195.58	224.91	
G0033 TC	123.53	117.35	134.96	
G0034	152.53	144.90	166.64	
G0034 TC	91.52	86.94	99.99	
G0035	205.87	195.58	224.91	
G0035 TC	123.53	117.35	134.96	
G0036	152.53	144.90	166.64	
G0036 TC	91.52	86.94	99.99	
G0037	205.87	195.58	224.91	
G0037 TC	123.53	117.35	134.96	
G0038	152.53	144.90	166.64	
G0038 TC	91.52	86.94	99.99	
G0039	205.87	195.58	224.91	
G0039 TC	123.53	117.35	134.96	
G0040	152.53	144.90	166.64	
G0040 TC	91.52	86.94	99.99	
G0041	205.87	195.58	224.91	
G0041 TC	123.53	117.35	134.96	
G0042	152.53	144.90	166.64	
G0042 TC	91.52	86.94	99.99	
G0043	205.87	195.58	224.91	
G0043 TC	123.53	117.35	134.96	
G0044	152.53	144.90	166.64	
G0044 TC	91.52	86.94	99.99	
G0045	205.87	195.58	224.91	
G0045 TC	123.53	117.35	134.96	
G0046	152.53	144.90	166.64	
G0046 TC	91.52	86.94	99.99	
G0047	205.87	195.58	224.91	
G0047 TC	123.53	117.35	134.96	
G0186	629.78	598.29	688.03	
G0186	609.93	579.43	666.35	*
G0125	2552.34	2424.72	2788.43	
G0125 TC	2469.27	2345.81	2697.68	
G0210	2176.73	2067.89	2378.08	
G0210 TC	2630.59	2499.06	2873.92	
G0211	2176.73	2067.89	2378.08	
G0211 TC	2630.59	2499.06	2873.92	
G0212	2176.73	2067.89	2378.08	
G0212 TC	2630.59	2499.06	2873.92	
G0213	2176.73	2067.89	2378.08	
G0213 TC	2630.59	2499.06	2873.92	
G0214	2176.73	2067.89	2378.08	
G0214 TC	2630.59	2499.06	2873.92	
G0215	2176.73	2067.89	2378.08	
G0215 TC	2630.59	2499.06	2873.92	
G0216	2176.73	2067.89	2378.08	
G0216 TC	2630.59	2499.06	2873.92	
G0217	2176.73	2067.89	2378.08	
G0217 TC	2630.59	2499.06	2873.92	
G0218	2176.73	2067.89	2378.08	
G0218 TC	2630.59	2499.06	2873.92	
G0220	2176.73	2067.89	2378.08	
G0220 TC	2630.59	2499.06	2873.92	
G0221	2176.73	2067.89	2378.08	
G0221 TC	2630.59	2499.06	2873.92	
G0222	2176.73	2067.89	2378.08	
G0222 TC	2630.59	2499.06	2873.92	
G0223	2176.73	2067.89	2378.08	
G0223 TC	2630.59	2499.06	2873.92	
G0224	2176.73	2067.89	2378.08	
G0224 TC	2630.59	2499.06	2873.92	
G0225	2176.73	2067.89	2378.08	
G0225 TC	2630.59	2499.06	2873.92	
G0226	2176.73	2067.89	2378.08	
G0226 TC	2630.59	2499.06	2873.92	
G0227	2176.73	2067.89	2378.08	
G0227 TC	2630.59	2499.06	2873.92	
G0228	2176.73	2067.89	2378.08	
G0228 TC	2630.59	2499.06	2873.92	
G0229	2176.73	2067.89	2378.08	
G0229 TC	2630.59	2499.06	2873.92	
G0230	2176.73	2067.89	2378.08	
G0230 TC	2630.59	2499.06	2873.92	
G0231	2176.73	2067.89	2378.08	
G0231 TC	2630.59	2499.06	2873.92	
G0232	2176.73	2067.89	2378.08	
G0232 TC	2630.59	2499.06	2873.92	
G0233	2176.73	2067.89	2378.08	
G0233 TC	2630.59	2499.06	2873.92	
G0234	2176.73	2067.89	2378.08	
G0234 TC	2630.59	2499.06	2873.92	
G0253	2176.73	2067.89	2378.08	
G0253 TC	2630.59	2499.06	2873.92	
G0254	2176.73	2067.89	2378.08	
G0254 TC	2630.59	2499.06	2873.92	
G0296	2737.93	2601.03	2991.19	
G0296 TC	2630.59	2499.06	2873.92	
0025T	30.35	28.83	33.16	
0025T	20.63	19.60	22.54	*
62367	63.77	60.58	69.67	
62367 TC	38.27	36.36	41.81	

* = THESE AMOUNTS APPLY WHEN SERVICE IS PERFORMED IN A FACILITY SETTING

D = 2004 DELETED CODE. PAYMENT FOR 2004 DATES OF SERVICE ALLOWED ONLY FOR CLAIMS RECEIVED DURING THE GRACE PERIOD, WHICH ENDS MARCH 31, 2004.

Connecticut - continued

CODE/MOD	PAR	NPAR	L CHG	NOTE
62368	92.65	88.02	101.22	
62368 TC	55.59	52.81	60.73	
70557	396.95	377.10	433.67	
70557 TC	238.17	226.26	260.20	
70558	438.88	416.94	479.48	
70558 TC	263.33	250.16	287.69	
70559	440.63	418.60	481.39	
70559 TC	264.38	251.16	288.84	
74300	50.04	47.54	54.67	
74300 TC	30.02	28.52	32.80	
74301	29.03	27.58	31.72	
74301 TC	17.42	16.55	19.03	
75952	691.19	656.63	755.13	
75952 TC	414.72	393.98	453.08	
75953	251.80	239.21	275.09	
75953 TC	151.08	143.53	165.05	
75954	616.05	585.25	673.03	
75954 TC	369.63	351.15	403.82	
76012	204.17	193.96	223.06	
76012 TC	122.50	116.38	133.83	
76013	236.80	224.96	258.70	
76013 TC	142.08	134.98	155.22	
76350	18.39	17.47	20.09	
78172	73.18	69.52	79.95	
78172 TC	43.91	41.71	47.97	
78282	54.15	51.44	59.16	
78282 TC	32.49	30.87	35.50	
78414	63.18	60.02	69.02	
78414 TC	37.91	36.01	41.42	
78459	214.30	203.59	234.12	
78459 TC	128.58	122.15	140.47	
79300	226.80	215.46	247.78	
79300 TC	136.08	129.28	148.67	
79420	209.53	199.05	228.91	
79420 TC	125.22	118.96	136.80	
91132	74.18	70.47	81.04	
91132 TC	44.51	42.28	48.63	
91133	93.28	88.62	101.91	
91133 TC	55.97	53.17	61.15	
93315	392.63	373.00	428.95	
93315 TC	235.58	223.80	257.37	
93317	259.23	246.27	283.21	
93317 TC	155.54	147.76	169.93	
93318	273.90	260.20	299.24	
93318 TC	164.34	156.12	179.54	
93620	1688.55	1604.12	1844.74	
93620 TC	1013.13	962.47	1106.84	
93621	309.98	294.48	338.65	
93621 TC	185.99	176.69	203.19	
93622	496.77	471.93	542.72	
93622 TC	298.19	283.28	325.77	
93623	414.78	394.04	453.15	
93623 TC	248.87	236.43	271.89	
93662	427.95	406.55	467.54	
93662 TC	256.77	243.93	280.52	
94642	30.94	29.39	33.80	
95824	111.58	106.00	121.90	
95824 TC	66.95	63.60	73.14	
95951	888.82	844.38	971.04	
95951 TC	533.29	506.63	582.62	
95965	1147.61	1090.23	1253.76	
95965 TC	688.57	654.14	752.26	
95966	572.82	544.18	625.81	
95966 TC	343.69	326.51	375.48	
95967	501.51	476.43	547.90	
95967 TC	300.91	285.86	328.74	

Florida

	PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04 NOTE
G0030	140.12	147.32	152.96	133.11	139.95	145.31	153.08	160.95	167.11
G0030 TC	84.07	88.40	91.78	79.87	83.98	87.19	91.85	96.58	100.27
G0031	188.24	197.71	205.10	178.83	187.82	194.85	205.65	216.00	224.07
G0031 TC	112.94	118.62	123.06	107.29	112.69	116.91	123.39	129.59	134.44
G0032	140.12	147.32	152.96	133.11	139.95	145.31	153.08	160.95	167.11
G0032 TC	84.07	88.40	91.78	79.87	83.98	87.19	91.85	96.58	100.27
G0033	188.24	197.71	205.10	178.83	187.82	194.85	205.65	216.00	224.07
G0033 TC	112.94	118.62	123.06	107.29	112.69	116.91	123.39	129.59	134.44
G0034	140.12	147.32	152.96	133.11	139.95	145.31	153.08	160.95	167.11
G0034 TC	84.07	88.40	91.78	79.87	83.98	87.19	91.85	96.58	100.27
G0035	188.24	197.71	205.10	178.83	187.82	194.85	205.65	216.00	224.07
G0035 TC	112.94	118.62	123.06	107.29	112.69	116.91	123.39	129.59	134.44
G0036	140.12	147.32	152.96	133.11	139.95	145.31	153.08	160.95	167.11
G0036 TC	84.07	88.40	91.78	79.87	83.98	87.19	91.85	96.58	100.27
G0037	188.24	197.71	205.10	178.83	187.82	194.85	205.65	216.00	224.07
G0037 TC	112.94	118.62	123.06	107.29	112.69	116.91	123.39	129.59	134.44
G0038	140.12	147.32	152.96	133.11	139.95	145.31	153.08	160.95	167.11
G0038 TC	84.07	88.40	91.78	79.87	83.98	87.19	91.85	96.58	100.27
G0039	188.24	197.71	205.10	178.83	187.82	194.85	205.65	216.00	224.07
G0039 TC	112.94	118.62	123.06	107.29	112.69	116.91	123.39	129.59	134.44
G0040	140.12	147.32	152.96	133.11	139.95	145.31	153.08	160.95	167.11
G0040 TC	84.07	88.40	91.78	79.87	83.98	87.19	91.85	96.58	100.27
G0041	188.24	197.71	205.10	178.83	187.82	194.85	205.65	216.00	224.07
G0041 TC	112.94	118.62	123.06	107.29	112.69	116.91	123.39	129.59	134.44
G0042	140.12	147.32	152.96	133.11	139.95	145.31	153.08	160.95	167.11
G0042 TC	84.07	88.40	91.78	79.87	83.98	87.19	91.85	96.58	100.27
G0043	188.24	197.71	205.10	178.83	187.82	194.85	205.65	216.00	224.07
G0043 TC	112.94	118.62	123.06	107.29	112.69	116.91	123.39	129.59	134.44
G0044	140.12	147.32	152.96	133.11	139.95	145.31	153.08	160.95	167.11
G0044 TC	84.07	88.40	91.78	79.87	83.98	87.19	91.85	96.58	100.27
G0045	188.24	197.71	205.10	178.83	187.82	194.85	205.65	216.00	224.07
G0045 TC	112.94	118.62	123.06	107.29	112.69	116.91	123.39	129.59	134.44

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Florida - continued

	PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE			
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	NOTE
G0046	140.12	147.32	152.96	133.11	139.95	145.31	153.08	160.95	167.11	
G0046 TC	84.07	88.40	91.78	79.87	83.98	87.19	91.85	96.58	100.27	
G0047	188.24	197.71	205.10	178.83	187.82	194.85	205.65	216.00	224.07	
G0047 TC	112.94	118.62	123.06	107.29	112.69	116.91	123.39	129.59	134.44	
G0125	2130.59	2433.21	2449.17	2024.06	2311.55	2326.71	2327.67	2658.28	2675.72	
G0125 TC	2055.25	2249.22	2367.18	1952.49	2136.76	2248.82	2245.36	2457.27	2586.14	
G0186	569.58	594.57	616.99	541.10	564.84	586.14	622.27	649.57	674.06	
G0186	553.34	577.09	598.92	525.67	548.24	568.97	604.52	630.47	654.32	*
G0210	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0210 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0211	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0211 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0212	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0212 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0213	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0213 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0214	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0214 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0215	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0215 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0216	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0216 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0217	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0217 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0218	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0218 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0220	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0220 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0221	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0221 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0222	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0222 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0223	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0223 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0224	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0224 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0225	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0225 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0226	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0226 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0227	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0227 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0228	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0228 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0229	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0229 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0230	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0230 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0231	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0231 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0232	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0232 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0233	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0233 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0234	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0234 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0253	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0253 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0254	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12	
G0254 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
G0296	2152.44	2351.42	2473.33	2044.82	2233.85	2349.66	2351.54	2568.93	2702.11	
G0296 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14	
0025T	27.42	28.86	29.80	26.05	27.42	28.31	29.96	31.53	32.56	
0025T	21.85	22.87	23.61	20.76	21.73	22.43	23.87	24.99	25.79	*
21088	6266.08	6266.08	6266.08	5952.78	5952.78	5952.78	6845.69	6845.69	6845.69	
21088	4010.30	4010.30	4010.30	3809.78	3809.78	3809.78	4381.25	4381.25	4381.25	*
62367	59.60	63.17	66.30	56.62	60.01	62.98	65.11	69.01	72.43	
62367 TC	35.76	37.91	39.78	33.97	36.01	37.79	39.07	41.42	43.46	

* = THESE AMOUNTS APPLY WHEN SERVICE IS PERFORMED IN A FACILITY SETTING

D = 2004 DELETED CODE. PAYMENT FOR 2004 DATES OF SERVICE ALLOWED ONLY FOR CLAIMS RECEIVED DURING THE GRACE PERIOD, WHICH ENDS MARCH 31, 2004.

Florida - continued

	PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04 NOTE
62368	91.83	97.50	102.50	87.24	92.63	97.38	100.32	106.52	111.98
62368 TC	55.10	58.50	61.51	52.34	55.58	58.43	60.20	63.91	67.20
70557	366.70	377.18	388.90	348.37	358.32	369.45	400.62	412.07	424.87
70557 TC	220.02	226.31	233.34	209.02	214.99	221.67	240.37	247.24	254.92
70558	405.90	418.03	431.63	385.61	397.13	410.05	443.45	456.70	471.56
70558 TC	243.54	250.82	258.98	231.36	238.28	246.03	266.07	274.02	282.94
70559	408.28	421.38	436.10	387.87	400.31	414.30	446.05	460.36	476.44
70559 TC	244.97	252.83	261.66	232.72	240.19	248.58	267.63	276.22	285.86
74300	46.60	49.33	51.60	44.27	46.86	49.02	50.91	53.89	56.37
74300 TC	27.96	29.60	30.97	26.56	28.12	29.42	30.55	32.34	33.83
74301	26.49	27.93	29.14	25.17	26.53	27.68	28.94	30.51	31.84
74301 TC	15.89	16.76	17.48	15.10	15.92	16.61	17.36	18.31	19.10
75952	648.78	708.55	763.55	616.34	673.12	725.37	708.79	774.09	834.18
75952 TC	389.26	425.13	458.14	369.80	403.87	435.23	425.27	464.45	500.52
75953	251.75	296.60	342.34	239.16	281.77	325.22	275.04	324.04	374.01
75953 TC	151.05	178.14	205.41	143.50	169.23	195.14	165.02	194.62	224.41
75954	616.11	727.96	841.13	585.30	691.56	799.07	673.10	795.30	918.93
75954 TC	369.66	436.77	504.68	351.18	414.93	479.45	403.85	477.17	551.36
76012	192.29	211.50	229.44	182.68	200.93	217.97	210.08	231.06	250.66
76012 TC	115.38	126.90	137.66	109.61	120.56	130.78	126.05	138.64	150.39
76013	230.84	264.47	298.01	219.30	251.25	283.11	252.19	288.93	325.58
76013 TC	138.51	158.80	178.81	131.58	150.86	169.87	151.32	173.49	195.35
76350	14.72	16.22	17.20	13.98	15.41	16.34	16.08	17.72	18.79
78172	68.26	71.79	74.57	64.85	68.20	70.84	74.57	78.43	81.47
78172 TC	40.96	43.08	44.74	38.91	40.93	42.50	44.75	47.06	48.88
78282	48.43	51.19	53.48	46.01	48.63	50.81	52.91	55.93	58.43
78282 TC	29.06	30.71	32.08	27.61	29.17	30.48	31.75	33.55	35.05
78414	57.45	60.54	63.07	54.58	57.51	59.92	62.76	66.14	68.90
78414 TC	34.47	36.33	37.84	32.75	34.51	35.95	37.66	39.69	41.34
78459	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12
78459 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14
79300	213.92	225.62	234.89	203.22	214.34	223.15	233.71	246.49	256.62
79300 TC	128.36	135.38	140.93	121.94	128.61	133.88	140.23	147.90	153.97
79420	192.19	202.22	210.26	182.58	192.11	199.75	209.97	220.93	229.71
79420 TC	115.31	121.33	126.15	109.54	115.26	119.84	125.98	132.55	137.82
86485	16.02	17.66	18.67	15.22	16.78	17.74	17.50	19.29	20.40
91132	66.24	70.20	73.45	62.93	66.69	69.78	72.37	76.69	80.24
91132 TC	39.74	41.12	44.14	37.75	39.06	41.93	43.42	44.92	48.22
91133	82.61	87.15	90.79	78.48	82.79	86.25	90.25	95.21	99.19
91133 TC	49.56	52.29	54.48	47.08	49.68	51.76	54.14	57.13	59.52
93315	355.76	373.85	388.14	337.97	355.16	368.73	388.67	408.43	424.04
93315 TC	213.45	224.32	232.88	202.78	213.10	221.24	233.19	245.07	254.42
93317	234.57	246.22	255.30	222.84	233.91	242.54	256.27	269.00	278.92
93317 TC	140.74	147.73	153.18	133.70	140.34	145.52	153.76	161.40	167.35
93318	285.02	298.68	309.02	270.77	283.75	293.57	311.38	326.31	337.60
93318 TC	171.02	179.21	185.41	162.47	170.25	176.14	186.84	195.79	202.56
93620	1533.61	1621.67	1693.32	1456.93	1540.59	1608.65	1675.47	1771.67	1849.95
93620 TC	920.17	973.00	1015.99	874.16	924.35	965.19	1005.29	1063.00	1109.97
93621	286.53	305.13	320.78	272.20	289.87	304.74	313.03	333.35	350.45
93621 TC	171.92	183.09	192.46	163.32	173.94	182.84	187.82	200.03	210.26
93622	476.05	529.13	579.46	452.25	502.67	550.49	520.08	578.07	633.06
93622 TC	285.63	317.48	347.68	271.35	301.61	330.30	312.05	346.85	379.84
93623	382.18	404.33	422.27	363.07	384.11	401.16	417.53	441.73	461.33
93623 TC	229.31	242.60	253.36	217.84	230.47	240.69	250.52	265.04	276.80
93662	402.14	438.57	472.02	382.03	416.64	448.42	439.34	479.14	515.68
93662 TC	241.29	263.14	283.22	229.23	249.98	269.06	263.61	287.48	309.42
94642	27.09	29.53	30.96	25.74	28.05	29.41	29.60	32.26	33.82
95824	90.25	101.21	106.27	85.74	96.15	100.96	98.60	110.57	116.10
95824 TC	54.15	60.72	63.76	51.44	57.68	60.57	59.16	66.34	69.66
95951	801.04	841.82	872.93	760.99	799.73	829.28	875.14	919.69	953.68
95951 TC	480.62	505.09	523.76	456.59	479.84	497.57	525.08	551.81	572.21
95965	1033.38	1081.93	1118.40	981.71	1027.83	1062.48	1128.97	1182.01	1221.85
95965 TC	620.03	649.16	671.04	589.03	616.70	637.49	677.38	709.21	733.11
95966	526.58	555.46	578.57	500.25	527.69	549.64	575.29	606.84	632.09
95966 TC	315.95	333.28	347.13	300.15	316.62	329.77	345.18	364.11	379.24
95967	462.24	488.22	509.21	439.13	463.81	483.75	505.00	533.38	556.31
95967 TC	277.35	292.93	305.53	263.48	278.28	290.25	303.00	320.03	333.79
99082	1.96	1.96	1.96	1.86	1.86	1.86	2.14	2.14	2.14

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D = 2004 DELETED CODE. PAYMENT FOR 2004 DATES OF SERVICE ALLOWED ONLY FOR CLAIMS RECEIVED DURING THE GRACE PERIOD, WHICH ENDS MARCH 31, 2004.

CLINICAL PSYCHOLOGISTS AND CLINICAL SOCIAL WORKERS

2004 Fee Schedule for Clinical Psychologist and Clinical Social Worker Services

The following are the 2004 Medicare physican fee schedule allowances for clinical psychologists and clinical social workers in Connecticut and Florida:

Connecticut

CODE	CP ALLOW	CSW ALLOW	FAC
90801	162.71	122.03	
	152.78	114.59	*
90802	172.59	129.44	
	163.09	122.32	*
90804	69.98	52.48	
	65.23	48.92	*
90805	76.68	57.51	
	73.23	54.92	*
90806	104.88	78.66	
	100.56	75.42	*
90808	156.62	117.47	
	151.44	113.58	*
90810	74.72	56.04	
	71.27	53.45	*
90812	113.42	85.06	
	106.95	80.21	*
90814	164.39	123.29	
	159.21	119.41	*
90816	70.25	52.69	
90818	105.62	79.22	
90821	156.98	117.73	
90823	75.43	56.57	
90826	112.05	84.04	
90828	164.23	123.17	
90829	167.05	125.29	
90846	101.54	76.16	
90847	124.12	93.09	
	121.53	91.15	*
90849	35.13	26.35	
	33.84	25.38	*
90853	34.27	25.70	
	33.41	25.06	*
90857	38.34	28.76	
	36.62	27.46	*
90880	132.84	99.63	
	117.73	88.30	*
90901	45.26	33.95	
	22.81	17.11	*
90911	106.12	79.59	
	50.01	37.51	*
96100	82.67	NC	
96105	82.67	NC	
96111	154.38	NC	
96115	82.67	NC	
96117	82.67	NC	
97532	26.66	NC	
97533	27.96	NC	

Florida

	CP ALLOW			CSW ALLOW			
CODE	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	FAC
90801	149.18	153.69	158.34	111.89	115.27	118.76	
	141.06	144.95	149.31	105.80	108.71	111.98	*
90802	158.56	163.34	168.37	118.92	122.51	126.28	
	150.79	154.98	159.73	113.09	116.23	119.80	*
90804	64.38	66.48	68.69	48.28	49.86	51.52	
	60.49	62.30	64.36	45.37	46.72	48.27	*
90805	70.71	72.83	75.14	53.03	54.62	56.36	
	67.88	69.79	72.00	50.91	52.34	54.00	*
90806	96.54	99.40	102.46	72.41	74.55	76.84	
	93.01	95.59	98.54	69.76	71.69	73.91	*
90808	144.34	148.67	153.36	108.26	111.50	115.02	
	140.10	144.11	148.64	105.07	108.08	111.48	*
90810	68.84	70.96	73.25	51.63	53.22	54.94	
	66.01	67.92	70.10	49.51	50.94	52.57	*
90812	104.30	107.59	111.06	78.22	80.69	83.30	
	99.00	101.89	105.17	74.25	76.42	78.88	*
90814	151.27	155.82	160.67	113.45	116.86	120.50	
	147.03	151.25	155.95	110.27	113.44	116.96	*
90816	64.81	66.83	69.02	48.61	50.12	51.77	
90819	102.34	105.26	108.60	76.75	78.95	81.45	
90821	144.65	148.73	153.19	108.49	111.55	114.89	
90823	69.63	71.70	73.98	52.22	53.78	55.48	
90826	103.20	106.14	109.33	77.40	79.61	82.00	
90828	151.35	155.79	160.61	113.51	116.84	120.46	
90829	154.50	158.72	163.53	115.88	119.04	122.65	
90846	93.65	96.38	99.36	70.24	72.28	74.52	
90847	114.32	117.69	121.34	85.74	88.27	91.00	
	112.20	115.41	118.98	84.15	86.56	89.23	*
90849	32.04	32.96	33.86	24.03	24.72	25.40	
	30.98	31.82	32.68	23.23	23.87	24.51	*
90853	31.33	32.20	33.07	23.50	24.15	24.80	
	30.63	31.44	32.29	22.97	23.58	24.22	*
90857	35.07	36.26	37.45	26.30	27.20	28.09	
	33.65	34.74	35.88	25.24	26.06	26.91	*
90880	121.34	125.31	129.22	91.00	93.98	96.91	
	108.98	112.01	115.47	81.73	84.01	86.60	*
90901	39.57	41.73	43.25	29.68	31.30	32.44	
	21.20	21.97	22.83	15.90	16.48	17.12	*
90911	92.46	97.77	101.45	69.34	73.33	76.09	
	46.55	48.35	50.38	34.91	36.26	37.79	*
96100	71.04	79.31	85.65	NC	NC	NC	
96105	71.04	79.31	85.65	NC	NC	NC	
96111	143.39	149.78	156.68	NC	NC	NC	
96115	71.04	79.31	85.65	NC	NC	NC	
96117	71.04	79.31	85.65	NC	NC	NC	
97532	24.32	25.08	25.82	NC	NC	NC	
97533	25.38	26.22	27.00	NC	NC	NC	

* these amounts apply when performed in a facility setting
NC = Noncovered for this type of provider

Elimination of the 90-day Grace Period for HCPCS Codes

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

All physicians, providers, and suppliers who use Healthcare Common Procedure Coding System (HCPCS) codes in billing Medicare carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs).

Provider Action Needed

STOP – Impact to You

Effective January 1, 2005, Medicare providers will no longer have a 90-day grace period to use discontinued HCPCS codes for services rendered in the first 90 days of the year. Use of such codes to bill services provided after the date on which the codes are discontinued will cause your claims to be returned and not paid. **In essence, HCPCS codes must be valid at the time the service is rendered.**

CAUTION – What You Need to Know

Providers should be aware that **effective January 1, 2005**, carriers, DMERCs, and FIs will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1.

GO – What You Need to Do

To ensure prompt and timely payment of claims, use the new HCPCS for 2005 beginning with services rendered on or after January 1, 2005, and stop using discontinued codes at that time. Each year thereafter, be sure to adopt the new codes.

Background

HCPCS consists of the following two levels of codes:

- Level I codes that are copyrighted by the American Medical Association's (AMA) *Current Procedural Terminology, Fourth Edition* (*CPT-4*); and
- Level II codes that are five-position alphanumeric codes approved and maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare & Medicaid Services [CMS], the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). The 'D' code series in Level II HCPCS is copyrighted by the American Dental Association.

Medicare has permitted a 90-day grace period after implementation of an updated HCPCS code set to familiarize providers with the new codes and to learn about the discontinued codes. For example, the 2004 HCPCS codes became effective for dates of service on or after January 1, 2004, and Medicare contractors were able to apply a three-month grace period for all applicable discontinued HCPCS codes. This means that the 2003 discontinued HCPCS codes and the new 2004 HCPCS codes will be accepted by carriers from physicians, suppliers, and providers during the January 2004-March 2004 grace period. This 90-day grace period applies to claims received by the carrier prior to April 1, 2004, which contain the 2003 discontinued codes for dates of service January 1, 2004 through March 31, 2004.

However, the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Rule requires providers to **use the medical code set that is valid at the time that the service is provided**.

Therefore, CMS will no longer be able to allow a 90-day grace period for providers to learn about the discontinued HCPCS codes. Providers should be aware that effective January 1, 2005, carriers, DMERCs, and fiscal intermediaries will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1. In addition, effective January 1, 2005, CMS will no longer allow a 90-day grace period for discontinued codes resulting from any mid-year HCPCS updates.

In order for providers to know about the new, revised, and discontinued numeric CPT-4 codes for the upcoming year, they should obtain the AMA's *CPT-4* coding book that is published each October. CMS posts on its Web site the annual alphanumeric HCPCS file for the upcoming year. The CMS Web site to view the annual HCPCS update is *http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp*

Physicians, providers, and suppliers should be aware that Medicare systems will begin to reject such discontinued codes, beginning on January 1, 2005, if the codes were not effective on the date of service. Such claims will be returned to the submitter for correction.

This is a HIPAA compliancy issue.

Implementation

July 6, 2004. While this is the date on which Medicare's claims processing systems will be changed to enforce these new rules, the systems will not apply these rules until January 1, 2005.

Related Instructions

The Medicare Claims Processing Manual, Chapter 23, Section 20 (Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)), Subsection 20.4 (Deleted HCPCS Codes/Modifiers) was revised and is included below (changes bolded and italicized). Also, **sentences that referred to the three-month HCPCS grace period** have been deleted from Subsections 40.1 (Access to Clinical Diagnostic Lab Fee Schedule Files) and 50 (Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries [RHHIs]).

20.4 – Deleted HCPCS Codes/Modifiers
(Rev.1, 10-01-03)
B3-4509.3, HO-442.2

Claims for services in a prior year are reported and processed using the HCPCS codes/modifiers in effect during that year. For example, a claim for a service furnished in November 2002 but received by a carrier/DMERC/intermediary in 2003 should contain codes/modifiers valid in 2002 and is processed using the prior year's pricing files.

HCPCS codes (Level I CPT-4 and Level II alpha-numeric) are updated on an annual basis. Each October, CMS releases the annual HCPCS file to carriers/DMERCs/FIs. The HCPCS file contains the CPT-4 and the alpha-numeric updates. Contractors are notified of the release date via a one-time notification instruction. The file contains new, deleted, and revised HCPCS codes which are effective on January 1 of each year. With each annual HCPCS update, CMS has permitted a 90-day grace period for billing discontinued HCPCS codes for dates of service January 1 through March 31 that were submitted to Medicare contractors by April 1 of the current year.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant. Since HCPCS is a medical code set, effective January 1, 2005, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued HCPCS codes. The elimination of the grace period applies to the annual HCPCS update and to any mid-year coding changes. Any codes discontinued mid-year will no longer have a 90-day grace period.

Contractors must eliminate the 90-day grace period from their system effective with the January 1, 2005, HCPCS update. Contractors will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31. Providers can purchase the American Medical Association's CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. In addition, CMS posts on its Web site the annual alphanumeric HCPCS file for the upcoming year at the end of each October. Providers are encouraged to access CMS' Web site to see the new, revised, and discontinued alpha-numeric codes for the upcoming year. The CMS Web site to view the annual HCPCS update is http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp

Carriers and DMERCs must continue to reject services submitted with discontinued HCPCS codes. FIs must continue to return to the provider (RTP) claims containing deleted codes.

See the Medicare Claims Processing Manual, Chapter 22, "Remittance Notices to Providers."

For more information on HCPCS, visit the CMS Web site at:
http://cms.hhs.gov/medicare/hcpcs

For more information on HIPAA and its impact on claims submission, please visit the CMS HIPAA Web site at:
http://www.cms.hhs.gov/hipaa/hipaa2/default.asp

Related Change Request (CR) #: 3093
Medlearn Matters Number: MM3093
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R89CP
Effective Date: January 1, 2005
Implementation Date for Medicare Systems: July 6, 2004

Deletion of HCPCS Level III Codes; New Level II Codes for Radiopharmaceutical Materials

The Consolidated Appropriations Act of 2001, Public Law 106-554 (enacted December 21, 2000), instructed carriers to maintain and continue the use of level III HCPCS codes (local codes) through December 31, 2003. Compliance with HIPAA requires deletion of any level III codes as of that date. CMS has developed level II HCPCS codes (national codes) for providers to use in place of many of these local codes.

Below are the level III HCPCS procedure codes and descriptors in effect **in Florida** prior to December 31, 2003 (these codes were not applicable in Connecticut). A one-to-one crosswalk from the deleted level III codes to the replacement level II codes is provided where appropriate. **Allowances for 2004 for Connecticut and Florida** for the new/replacement codes for radiopharmaceutical materials are furnished where available (IC = individual consideration. Please provide name, strength, and dosage when billing for IC procedures).

***Note**: Connecticut had one remaining level III code that was deleted December 31, 2003, code X1002, which was replaced with the new level II code A0800 (see related special release article posted to http://www.connecticutmedicare.com on January 14, 2004). Codes X1002 and A0800 were/are not applicable in Florida.*

Deleted Florida Level III Code/Descriptor	**Replacement Level II Code/Descriptor**	**2004 Allowance (CT *and* FL)**
W4125 99 technetium, 0 to 30 mci	A9512 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m pertechnetate, per mci	IC
W4126 99m technetium, each additional mci	N/A based on descriptor for A9512	IC
W4128 131 iodohippurate sodium, per uci	No replacement code available.	IC
W4130 Choletec, technetium 99; per mci	A9513 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m mebrofenin, per mci	IC
W4131 Mag 3, technetium 99m mertiatide, per mci	Q3005 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m mertiatide, per mci	IC
W4132 Red blood cells, technetium 99m, 1 to 30 mci	Q3010 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc99m - labeled red blood cells, per mci	IC
W4133 57 cobalt cyanocobalamin, per 0.5 uci	Q3012 Supply of oral radiopharmaceutical diagnostic imaging agent, cyanocobalamin cobalt Co57, per 0.5 mci	IC
W4134 99 m technetium pyrophosphate, per 20 mci	A9514 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m pyrophosphate, per mci	$23.92 (par and nonpar)
W4136 133 xenon gas, per mci	Q3004 Supply of radiopharmaceutical diagnostic imaging agent, xenon Xe 133, per 10 mci	$29.93 par; $28.43 nonpar
W4139 99m technetium pentetate injection, 0 to 50 mci	A9515 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m pentetate, per mci	IC
W4140 123 iodine (capsules), per 100 uci	A9516 Supply of radiopharmaceutical diagnostic imaging agent, I-123 sodium iodide capsule, per 100 uci	$62.97 (par and nonpar)
W4141 131 sodium iodide (diagnostic), per 100 uci	A9528 Supply of radiopharmaceutical diagnostic agent, I-131 capsule sodium iodide capsule, per millicurie	IC

W4142 131 sodium iodide (therapeutic), per initial mci	A9517 Supply of radiopharmaceutical therapeutic imaging agent, I-131 sodium iodide capsule, per MCI	IC
W4143 131 sodium iodide (therapeutic), each additional mci capsule	N/A based on descriptor for A9517	IC
W4144 67 gallium citrate, per mci diagnostic imaging agent, gallium Ga 67, per mci	Q3002 Supply of radiopharmaceutical	$29.62 par; $28.14 nonpar
W4147 131 sodium iodide oral solution, per mci	A9530 Supply of radiopharmaceutical therapeutic agent, I-131 sodium iodide solution, per millicurie	IC
W4149 99m technetium gluco-heptonate, 0 to 10 mci	Q3006 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m glucepatate, per 5 mci	IC
W4150 99m technetium albumin aggregated, 0 to 10 mci	A9519 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m macroaggregated albumin, per mci	IC
W4151 99m technetium medronate, up to 30 mci	A9503 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m, medronate, up to 30 MCI	$32.20 par; $30.59 nonpar
W4153 99m technetium sulfur colloid, 0 to 25 mci	A9520 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m sulfur colloid, per mci	$69.00 (par and nonpar)
W4156 99m technetium disofenin, 0 to 10 mci	A9510 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m isofenin, per vial	$55.20 par; $52.44 nonpar
W4158 Ceretec (technetium) per vial	A9521 Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m exametazine, per dose	$862.50 (par and nonpar)

COVERAGE/REIMBURSEMENT

AMBULANCE

MMA-Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Providers Affected

Ambulance suppliers.

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, the fee schedule will include certain temporary increases in payments.

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; the air ambulance base rates and mileage rates remain unchanged.

More details on these changes are as follows:

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:

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%

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.

Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate of the payment under the FS for ground ambulance transports furnished in certain rural areas is increased by an amount determined by the Centers for Medicare & Medicaid Services (CMS). 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.

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.

Important Dates

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

Additional Information

For further information, you may wish to view the actual instruction issued to your Medicare contractor. That instruction can be seen at: *http://www.cms.hhs.gov/manuals/pm_trans/R88CP.pdf*

Related Change Request (CR) #: 3099
Medlearn Matters Number: MM3099
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R88CP
Effective Date: July 1, 2004
Implementation Date: July 5, 2004

CARDIOLOGY

Cardiac Output Monitoring by Thoracic Electrical Bioimpedance

Thoracic electrical bioimpedance (TEB) devices, a form of plethysmography, monitor cardiac output by noninvasively measuring hemodynamic parameters, including: stroke volume, systemic vascular resistance, and thoracic fluid status. Under the previous coverage determination, effective July 1, 1999, use of TEB was covered for the "noninvasive diagnosis or monitoring of hemodynamics in patients with suspected or known cardiovascular disease." In reconsidering this policy, CMS concluded that this use was neither sufficiently defined nor supported by available clinical literature to offer the guidance necessary for practitioners to determine when TEB would be covered for patient management. Therefore, CMS revised its coverage policy language in response to a request for reconsideration to offer guidance that is more explicit and clarity for coverage of TEB, based on a complete and updated literature review.

Covered Indications

TEB is covered for the following uses:

- Differentiation of cardiogenic from pulmonary causes of acute dyspnea when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
- Optimization of atrioventricular (A/V) interval for patients with A/V sequential cardiac pacemakers when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
- Monitoring of continuous inotropic therapy for patients with terminal congestive heart failure, when those patients have chosen to die with comfort at home, or for patients waiting at home for a heart transplant.
- Evaluation for rejection in patients with a heart transplant as a predetermined alternative to a myocardial biopsy. Medical necessity must be documented should a biopsy be performed after TEB.
- Optimization of fluid management in patients with congestive heart failure when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.

In addition, use of TEB for the management of drug-resistant hypertension *may* be covered in cases where it is reasonable and necessary. Drug resistant hypertension

is defined as failure to achieve goal BP in patients who are adhering to full doses of an appropriate three-drug regimen that includes a diuretic.

(***FLORIDA PROVIDERS ONLY***: For more information, please refer to local medical review policy [LMRP] *93701*: Cardiac Output by Electrical Bioimpedance.)

Noncovered Indications

TEB is noncovered when used for patients:

- With proven or suspected disease involving severe regurgitation of the aorta;
- With minute ventilation (MV) sensor function pacemakers, since the device may adversely affect the functioning of that type of pacemaker;
- During cardiac bypass surgery; or
- In the management of all forms of hypertension (with the exception of drug-resistant hypertension as outlined above).

All other uses of TEB not otherwise specified remain noncovered. (This national coverage decision [NCD] was last reviewed January 2004.)

Source: CMS Pub. 100-03 Transmittal 6, CR 2689

DIAGNOSTIC TESTS

Updated Policy and Claims Processing Instructions for Ambulatory Blood Pressure Monitoring (ABPM)

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Physicians, hospitals, critical access hospitals (CAHs), comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs), federally qualified health centers (FQHCs), and rural health clinics (RHCs).

Provider Action Needed

STOP – Impact to You

Medicare has expanded payment for ABPM to include *CPT*/HCPCS code *93788* in addition to the three *CPT*/HCPCS codes already payable. (*CPT* code *93788* is defined as "*ABPM utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report*.") ABPM is only payable for patients with suspected "white coat hypertension" (WCH). **Note**: This is designated as an outpatient service; patients admitted to a hospital or residing in institutions (such as SNFs) who receive ABPM are not qualified for coverage. Additionally, if ABPM must be performed more than once for a particular beneficiary, the qualifying criteria (described in the *Background* section) must be met for each subsequent ABPM test.

CAUTION – What You Need to Know

ABPM involves the use of a non-invasive devise to measure blood pressure in 24-hour segments, the results of which are stored in the device and interpreted later by a physician. To be covered, ABPM must be performed for at least a 24-hour time period; the diagnosis code 796.2 (Elevated blood pressure reading without diagnosis of hypertension) must be used; and the results must be interpreted by a physician.

GO – What You Need to Do

Refer to the Additional Information section for *CPT*/HCPCS code information by provider type specific to ABPM for suspected WCH FI and for carrier billing instructions, which can be found in the Medicare Claims Processing Manual, Chapter 32, and in CR 2726, at: *http://www.cms.hhs.gov/manuals/pm_trans/R109CP.pdf*

Background

The qualifying criteria for white coat hypertension include:

1. Clinic/office blood pressure >140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit;
2. At least two documented separate blood pressure measurements taken outside the clinic/office which are <140/90 mm Hg; and
3. No evidence of end-organ damage.

Additional Information

When a claim for ABPM is made, the diagnosis code 796.2 (Elevated blood pressure reading without diagnosis of hypertension) must be used. Additionally, the effective dates for applicable HCPCS codes for ABPM for suspected WCH are as follows:

CPT/ HCPCS	Definition	Effective Date
93784	*ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer, including recording, scanning analysis, interpretation and report.*	04/01/2002
93786	*ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only.*	04/01/2002
93788	*ABPM, utilizing a system of magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.*	01/01/2004
93790	*ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report.*	04/01/2002

The above *CPT*/HCPCS codes can be billed by the following providers, for outpatients, as specified below:

- Hospitals (except CAHs) bill on a 13x or 14x type of bill with *CPT*/HCPCS *93786* and/or *93788*.
- CORFs bill on a 75x type of bill with *CPT*/HCPCS code *93786* and/or *93788*.
- CAHs bill on an 85x type of bill as follows: (1) for CAHs that elected the Standard Method, bill *CPT*/HCPCS code *93786* and/or *93788*; and (2) for CAHs that elected the Optional Method, bill any combination of *CPT*/HCPCS codes *93786*, *93788*, and *93790* as appropriate.
- SNFs bill on a 23x type of bill with *CPT*/HCPCS code *93786* and/or *93788*.
- RHCs bill for the professional component as a visit under the all-inclusive rate on a 71x type of bill with rev code 052x.
- FQHCs bill for the professional component as a visit under the all-inclusive rate on a 73x type of bill with rev code 052x.
- Provider-based RHCs/FQHCs bill for the technical component under their base provider's number using the above requirements for their particular base provider type.
- Independent and free-standing RHCs/FQHCs practitioners bill for the technical component to the carrier.

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R109CP.pdf*

You may also refer to Medicare National Coverage Determinations Manual, Chapter 1, Section 20.19, which may be found at: *http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp*

Related Change Request (CR) #: 2726
Medlearn Matters Number: MM2726
Related CR Release Date: February 27, 2004
Related CR Transmittal #: 109
Effective Date: April 1, 2004
Implementation Date: April 5, 2004

NCD: Current Perception Threshold/Sensory Nerve Conduction Threshold Test (sNCT)

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

Providers should be aware that the Centers for Medicare & Medicaid Services (CMS) has reviewed its policy on sNCT and reaffirms its original national noncoverage decision on sNCT.

Background

Based on a reconsideration of current Medicare policy for sNCT, CMS reaffirms its original national noncoverage policy regarding current perception threshold/sensory nerve conduction threshold test (sNCT). The National Coverage Determination Manual (Pub. 100-03; Chapter 1; Subsection 160.23) has been updated to reflect this most recent noncoverage determination as a result of the reconsideration review.

Please note that the revision to the National Coverage Determination Manual 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.

Also, under 42 Code of Federal Regulations (CFR) 422.256(b), an NCD that expands coverage is also binding on Medicare+Choice Organizations. In addition, an administrative law judge may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

Implementation

The effective and implementation dates of this instruction are April 1, 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*

On that web page, look for CR2988 in the CR NUM column on the right, and click on the file for that CR. The revised portions of the NCD Manual are included with that CR.

Related Change Request (CR) #: 2988
Medlearn Matters Number: MM2988
Related CR Release Date: March 19, 2004
Related CR Transmittal #: 8
Effective Date: April 1, 2004
Implementation Date: April 1, 2004

DRUGS AND BIOLOGICALS

MMA Pricing File Clarifications

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Providers Affected

All providers who bill Medicare carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries for Part B services.

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

Providers should be aware that this instruction provides corrections to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 pricing files that were provided with Pub.100-04, Revisions 54 and 55 issued on December 24, 2003.

GO – What You Need to Do

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

Background

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

- Corrections to the MMA pricing files that were provided with Pub.100-04, Revisions 54 issued on December 24, 2003; and
- Directions to replace the MMA pricing files provided with Pub.100-04, Revisions 54 and.55 with the new files available at *http://cms.hhs.gov/providers/drugs/default.asp* (MMA Drug Payment Limits Pricing Files For Dates of Service 1/1/2004 and After – Revised). These files are for claims for drugs and biologicals not paid on a cost or prospective payment basis with dates of service on or after January 1, 2004.

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

Exceptions

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

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

the published compendia as of the first of the month the payment limit for the drug or biological is determined.

For the purposes of this instruction, a new drug is an unlisted drug (not currently covered by a specific HCPCS code; i.e., a HCPCS code other than a NOC code such as J3490, J9999, etc.) that was approved by the Food and Drug Administration (FDA) subsequent to April 1, 2003. A drug is not considered to be a new drug if:

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

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

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

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

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

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

Implementation

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

Additional Information

As mentioned previously, this instruction provides corrections to and directs the replacement of MMA pricing files provided with Pub.100-04, Rev.54 and Rev.55 issued on December 24, 2003 with new files available at:
http://cms.hhs.gov/providers/drugs/default.asp (MMA Drug Payment Limits Pricing Files For Dates of Service 1/1/2004 and After – Revised).

The Centers for Medicare & Medicaid Services (CMS) Web page furnishes drug-related information to Medicare providers, physicians and other suppliers, Medicare beneficiaries, and to the public. Once at the Web site, the path to the MMA pricing files is:

Medicare Drugs Information Resource/Drug Pricing Files/Medicare Prescription Drug, Improvement, and Modernization Act (MMA)/ MMA Drug Payment Limits Pricing Files for Dates of Service 1/1/2004 and After – Revised 1/ 30/04.

The relevant files include the following:

- **HCPCS Drug Pricing File** - Microsoft Excel file (zip 31Kb)
- **FI Specific HCPCS Drug Pricing File** - Microsoft Excel file (zip 21Kb)
- **HCPCS Drug Pricing Background File for Other than ESRD-Related or DME Infusion Drugs** - Microsoft Excel file (zip 136Kb)
- **HCPCS Drug Pricing Background File for ESRD Drugs** - Microsoft Excel file (zip 135Kb)
- **HCPCS Drug Pricing Background File for DME Infusion Drugs** - Microsoft Excel file (zip 8Kb)
- **NOC Drug Pricing** - Microsoft Excel file (zip 16Kb)

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

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

Related Change Request (CR) #: 3105
Medlearn Matters Number: MM3105
Related CR Release Date: January 30, 2004
Related CR Transmittal #: R75CP
Effective Date: January 30, 2004
Implementation Date: January 30, 2004

MMA-Intravenous Immune Globulin

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Physicians, hospitals, pharmacies, DME suppliers, and home health agencies

Provider Action Needed

Please inform your staff and change your billing procedures as needed regarding reimbursement for the cost of the drug Intravenous (IV) Immune Globulin, when administered in the home.

STOP – Impact to You

This is a new policy. Beginning January 1, 2004, Medicare pays for IV Immune Globulin administered in the beneficiary's home.

CAUTION – What You Need to Know

Only the cost of the drug is paid for, once prescribed. Services and items related to drug administration are not paid for when the drug is administered in the home. The drug must be deemed medically appropriate as a treatment for primary immune deficiency diseases.

GO – What You Need to Do

Please implement this new policy and inform your staff about the new billing procedures.

Background

A new section has been added to the Medicare Claims Processing Manual describing this new policy. The claims processing instructions regarding intravenous immune globulin can be found in Chapter 17 – Drugs and Biologicals, Section 80.6. In addition, the coverage policy regarding IV immune globulin can be found in the Medicare Benefit Policy Manual (pub 100-02), Chapter 15, Section 50.6. Both of these manuals can be found at: *http://www.cms.hhs.gov/manuals/cmsindex.asp*

This CR implements Section 642 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). With this change, Medicare carriers, regional home health intermediaries (RHHIs), and DME carriers (DMERCs) will pay state licensed entities, which will receive the reimbursement. Beneficiaries may not be reimbursed for the cost of the drug. Further reimbursement information is provided in the following table:

Licensed Entity	Form of IV Immune Globulin (IVIG) Dispensed	Where To Bill
Pharmacies and Hospitals	IVIG	DMERC
Home Health Agencies	IVIG	RHHI
Physicians	IVIG for refilling implanted pump IVIG for refilling external pump for home infusion	Carriers DMERC

Additional Information

The official instruction issued to your carrier regarding this change may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R74CP.pdf*

To view the CR related to the coverage policy on this Medicare change, which was issued on January 23, 2004, as CR# 3059, please visit *http://www.cms.hhs.gov/manuals/pm_trans/R6BP.pdf*

Should you have further questions, please contact your local carrier or RHHI at their toll-free number. A list of these toll-free numbers may be found at: *http://www.cms.hhs.gov/medlearn/tollnums*

Related Change Request (CR) #: 3060 (and 3059)
Medlearn Matters Number: MM3060
Related CR Release Date: January 30, 2004
Related CR Transmittal #: R74CP for CR 3060 and R6BP for 3059
Effective Date: January 1, 2004
Implementation Date: April 5, 2004

MMA Drug Pricing Update—Drug Exceptions

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Physicians and suppliers.

Provider Action Needed

Physicians and suppliers should note that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), (Section 303(b)(2)), created a process for increasing the 2004 payment limits for some Medicare Part B drugs and biologicals provided from April 1, 2004, through December 31, 2004.

This instruction identifies those drugs and biologicals granted increases under this process and their new payment amounts.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), (Section 303(b)(2)), provides an opportunity for the manufacturer of a drug to submit data and information requesting a different percentage than the percentage the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* notice on January 7, 2004, or the 85 percent general rule.

Based on this data and information provided by the drug manufacturer, CMS may adjust the percentage beginning April 1, 2004, as appropriate for such granted exceptions.

These exceptions are described in the following table:

HCPCS	Short Description	AWP%	New 2004 Payment Limit
J2353	Octreotide acetate injection	92	$77.14
J3240	Thyrotropin injection	90	$585.65
J3395	Verteporfin injection	91	$1,404.26
J7320	Hylan G-F injection	83	$204.03
J7342	Metabolically active tissue	89	$14.42
J9045	Carboplatin injection	88	$137.54
J9201	Gemcitabine HCl	87	$111.33
J9206	Irinotecan injection	85	$130.24
Q3025	IM inj interferon beta 1-a	89	$80.22

Note that the absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug.

Implementation

The implementation date for this instruction is April 5, 2004.

Related Instructions

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

From that Web page, look for CR3161 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) #: 3161 Medlearn Matters Number: MM3161
Related CR Release Date: March 15, 2004
Related CR Transmittal #: 119
Effective Date: April 1, 2004
Implementation Date: April 5, 2004

Order Influenza Vaccine Now

In order to ensure the availability of influenza vaccine for administration early in the fall of 2004, physicians and providers should begin to order supplies of influenza vaccine immediately. Last year, large numbers of cases of influenza began to appear in October, and activity was widespread. Anticipation of increased demand for the vaccine in the fall of 2004 makes it imperative that physicians and providers who care for Medicare beneficiaries and others at high risk for complications from influenza begin to prepare for the 2004-2005 influenza season immediately.

While the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003 changed the Medicare payments for many covered drugs and biologicals, the basis for Medicare payment of influenza vaccine will continue to be 95% of the average wholesale price.

Source: CMS Joint Signature Memorandum (JSM) #188, March 29, 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.

2004 Jurisdiction List

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Durable Medical Equipment (DME) suppliers.

Provider Action Needed

DME suppliers should be aware of which Medicare contractor to bill for codes provided on the jurisdiction list of the Healthcare Common Procedure Coding System (HCPCS). This HCPCS list for DME regional carrier (DMERC) and local carrier jurisdictions is updated on annual basis to provide accurate billing information to providers. Ensure that your billing staffs know how to find the list and use the list in their billing processes for Medicare claims.

Background

The HCPCS is updated annually to reflect changes in medical practice and the provision of health care. The Centers for Medicare & Medicaid Services (CMS) provides a file containing updated HCPCS codes to Medicare carriers, DMERCs, and intermediaries and to Medicaid State Agencies 60 to 90 days before the implementation of the annual update.

A spreadsheet containing an updated list of the HCPCS for DMERC and Part B local carrier jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) during each year. CMS publishes a recurring update notification annually to notify the DMERCs and Part B carriers that the list has been updated and is available on the CMS Web site.

Both the DMERCs and the local carriers publish this list to educate providers as to which contractor—the DMERC or local Part B carrier—to bill for codes provided on that list.

Additional Information

Updates are available on an Excel spreadsheet on the CMS Web site at: *http://www.cms.hhs.gov/suppliers/dmepos*

The actual instruction issued to the DMERCs may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R127CP.pdf*

Related Change Request (CR) #: 3139
Medlearn Matters Number: MM3139
Related CR Release Date: March 26, 2004
Related CR Transmittal #: 127
Effective Date: May 26, 2004
Implementation Date: May 26, 2004

END-STAGE RENAL DISEASE (ESRD)

Frequency Limitations for Darbepoetin Alfa (trade name Aranesp®) for Treatment of Anemia in End Stage Renal Disease (ESRD) Patients on Dialysis

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Renal Dialysis Facilities.

Provider Action Needed

STOP – Impact to You

Medicare is instituting new frequency limitations for treatment of ESRD patients on dialysis with darbepoetin alfa (trade name Aranesp®).

CAUTION – What You Need to Know

Be aware of these frequency limitations to assure correct and timely payment for services supplied to Medicare patients.

GO – What You Need to Do

Make sure you understand the changes effective for services provided on and after April 1, 2004 for the frequency limitations on darbepoetin alfa for ESRD.

Background

Section 1881(b) (11) (B) of the Social Security Act states that payment will be provided for erythropoietin when a patient diagnosis is ESRD. Darbepoetin alfa, a new erythropoietin-like product, differs from epoetin alfa by the addition of two carbohydrate chains, which lengthens the biologic half-life. This change affects how often the biological can be administered and results in a decreased dosing schedule for darbepoetin alfa by comparison to epoetin alfa.

Additional Information

This notice establishes frequency limitations for darbepoetin alfa, and also reiterates the frequency limitations for epoetin alfa (trade name EPO) will remain the same. You can refer back to CR2963 for the payment guidelines on darbepoetin alfa (trade name Aranesp®).

That CR may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R39OTN.pdf*

Please note that this notice does not apply to physicians' payments for Aranesp® or EPO; those payments are established in the Drug Payment Limits Pricing File, set by the Medicare Prescription Drug, Modernization, and Improvement Act of 2003.

According to its FDA-approved labeling, darbepoetin alfa is to be given once a week, up to a maximum of five times for a calendar month (30/31 days). Coverage rules for darbepoetin alfa are the same as epoetin alfa for ESRD-related anemia.

To view the actual change request related to this article (CR2984), go to:
http://www.cms.hhs.gov/manuals/pm_trans/R8BP.pdf

Related Change Request (CR) #: 2984
Medlearn Matters Number: MM2984
Related CR Release Date: March 5, 2004
Related CR Transmittal #: 8
Effective Date: April 1, 2004
Implementation Date: April 5, 2004

LABORATORY/PATHOLOGY

Adjudication of Reference Laboratory Service Claims

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Independent clinical diagnostic laboratories.

Provider Action Needed

An independent laboratory may bill for services they refer to another laboratory no matter where the reference laboratory is located, as long as it is within any Medicare claims processing jurisdiction. When billing for reference laboratory services, independent clinical diagnostic laboratories must submit the ZIP code of the location where the laboratory service was actually performed. The carriers' standard billing systems will now price the payment of referred laboratory services based on the ZIP code where the service was performed.

Any independent laboratories that were assigned a provider identification number (PIN) for the purposes of reimbursement of reference laboratory services in a payment jurisdiction other than one they have a physical presence will have those PINs revoked. The independent laboratory will not need to take any action. Carriers will revoke the PIN and notify the appropriate independent laboratory. The following requirements apply when billing for reference laboratory services for dates of service, July 1, 2004, and later:

Electronic Claim Submission Requirements

ANSI format:

- Will require the presence of the performing and billing laboratory's CLIA number.
- If tests are referred to another laboratory, the CLIA number of the laboratory where the testing is rendered must also be on the claim.
- The clinical diagnostic laboratory will not have to submit separate claims for referred and performed services under the ANSI format.
- An independent clinical diagnostic laboratory submits modifier 90 on the line item when billing a reference laboratory service and the CLIA number assigned to the reference laboratory in X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4.

NSF:

- Suppliers may not combine services that they performed themselves and any that they referred to another laboratory on the same NSF claim form.
- If a billing laboratory performs some testing and refers the remaining tests to another (reference) laboratory to perform, the laboratory must segment the services and submit two separate claims.
- If services are referred to more than one laboratory, a separate claim must be submitted for each reference laboratory to which services were referred.
- The CLIA number assigned to the performing laboratory shall be reported in FA0 – 34.0.
- An NSF electronic claim for laboratory testing requires the presence of the performing and billing laboratory's name and address.
- The billing laboratory, for a service with a line item *CPT* modifier 90, requires the address information of the performing lab to be submitted in the following NSF record and fields:

EA0 Field 39 Facility/Lab Name	EA1 Field 08 Facility/Lab City
EA1 Field 06 Facility/Lab ADDR1	EA1 Field 09 Facility/Lab State
EA1 Field 07 Facility/Lab ADDR2	EA1 Field 10 Facility/Lab Zip Code

Paper Claim Submission Requirements

- Suppliers that submit claims in the paper format (Form CMS-1500) may not combine services that they performed themselves and any that they referred to another laboratory on the same Form CMS-1500.
- If a billing laboratory performs some testing and refers the remaining tests to another (reference) laboratory to perform, the laboratory must separate the services and submit two separate claims.
- If services are referred to more than one laboratory a separate claim must be submitted for each reference laboratory to which services were referred.
- Paper claims will be returned as unprocessable if billing providers combine clinical laboratory services performed themselves and any referred to another laboratory on the same Form CMS-1500.
- The line items submitted for referred laboratory test must contain modifier 90.
- The performing laboratory's name and address must be reported in item 32 on Form CMS-1500 to show where the service (test) was actually performed. A paper claim for laboratory testing requires the presence of the CLIA number of the laboratory actually performing the testing in item 23 of Form CMS-1500.

- An NSF electronic claim for laboratory testing requires the presence of the performing and billing laboratory's name and address.
- The performing laboratory, for a service with a line item *CPT* modifier 90, requires provider information to be submitted in the item 32 of Form CMS-1500.

Background

Sometimes a clinical diagnostic laboratory will refer a specimen to another laboratory for testing. In most cases the laboratory that furnishes the service will bill for the service. But it's also possible for one laboratory to bill for a service performed by *another* laboratory. Medicare uses certain terms of art in describing laboratories in this context. "Referring laboratory" is defined as the laboratory that refers a specimen to another laboratory for testing. "Reference laboratory" is defined as the laboratory that receives a specimen from another laboratory and performs one or more tests on such specimen.

Medicare's payment policy for laboratory services is generally based on fee schedules specific to each carrier jurisdiction. Previously, some carriers have been unable to process a claim for a laboratory test performed in another jurisdiction because they did not possess the fee schedule of that other jurisdiction. Thus, some carriers paid for referred services performed outside of their jurisdiction and based payment on the fee schedule for that jurisdiction.

Other carriers attempted to overcome the difficulty by enrolling the laboratory outside their jurisdiction as a reference laboratory. These carriers issued a provider identification number (PIN) for the reference laboratory as a "reference-use-only" PIN. However, not every carrier has been willing to issue "reference-use-only" PINs.

Implementation

This change resolves the issues by requiring that:

1. An independent clinical laboratory may bill only the carrier in which it is enrolled by location.
2. An independent clinical laboratory may not enroll with a carrier as a "reference-use-only" laboratory.
3. Every carrier must settle a claim for a referred service submitted by a laboratory located in its jurisdiction, regardless of where the service was performed.
4. Every carrier must pay for a referred service on the basis of the fee schedule in effect in the jurisdiction where the test was performed.
5. Every carrier must cancel all existing "reference-use-only" enrollments and "reference-use-only" PINs and refrain from making any further "reference-use-only" enrollments.
6. The referring laboratory must identify a referred service as such on the claim and identify reference laboratory performing that test and correctly entering the ZIP code of such laboratory.
7. Both the referring laboratory and the reference laboratory must be enrolled in Medicare.

When a billing laboratory is the referring laboratory it must identify the referred service as such by use of modifier 90 and must identify the reference laboratory by specifying its CLIA number and the address, including the correct ZIP code, where the service was actually performed. Also, the referring laboratory must meet one of the following conditions:

1. It must be located in, or be part of, a rural hospital;
2. It must be wholly-owned by the reference laboratory; or both it and the reference laboratory are wholly-owned subsidiaries of the same entity; or
3. It refers no more than thirty percent of the clinical laboratory tests annually to other laboratories (not including referrals made under the wholly-owned proviso stated above).

Important Dates

These changes will be implemented by Medicare on July 6, 2004, and will apply to services rendered on or after July 1, 2004.

Related Instructions

If you need further clarification, background, details, or just want to see the original change request implementing these changes, you can find it at: *http://www.cms.hhs.gov/manuals/pm_trans/R85CP.pdf*

Related Change Request (CR) #: 3090
Medlearn Matters Number: MM3090
Related CR Release Date: February 6, 2004
Effective Date: July 1, 2004
Implementation Date: July 6, 2004
Transmittal #: R85CP

2004 Reimbursement for Automated Multipanel Laboratory Tests

We posted the revised 2004 Clinical Diagnostic Laboratory Fee Schedule to our provider education Web sites on February 14, 2004. That article did not provide guidelines for automated multichannel chemistry tests billed on the same date as organ/disease panels.

When providers bill both automated multi-channel chemistry tests and organ/disease panels on the same date for the same patient, reimbursement is based on the allowance for the total number of tests performed. Medicare applies this pricing logic when providers bill an automated multichannel test or organ/disease panels on the same date of service as an individual automated laboratory service. The allowance for all covered tests is calculated, prorated, and distributed among all the detail lines billed. ***Note***: although the reimbursement allowance is the same when the same number of tests are paid, the distribution may vary on the detail line for each patient.

2004 Automated Multi-Channel Chemistry Tests

82040 Albumin, serum
82247 Bilirubin, total
82248 Bilirubin, direct
82310 Calcium
82374 Carbon Dioxide (bicarbonate)
82435 Chloride, blood
82465 Cholesterol, serum or whole blood, total
82550 Creatine kinase (CK), (CPK); total
82565 Creatinine, blood
82947 Glucose; quantitative, blood (except reagent strip)
82977 Glutamyltransferase, gamma (GGT)
83615 Lactate dehydrogenase (LD), (LDH)
84075 Phosphatase, alkaline
84100 Phosphorus inorganic (phosphate)
84132 Potassium, serum
84155 Protein, total, except by refractometry; serum
84295 Sodium, serum
84450 Transferase; aspartate amino (AST) (SGOT)
84460 Transferase; alanine amino (ALT) (SGPT)
84478 Triglycerides
84520 Urea nitrogen; quantitative
84550 Uric acid, blood

Claims for automated multichannel chemistry tests, organ/disease panels and individual automated laboratory services are reimbursed based on the total number of laboratory procedures allowed. To calculate the allowance, use the chart below. **The allowances are the same for Connecticut and Florida.**

# of Tests	2004 Allowance
1 or 2	7.28
3	9.29
4	9.80
5	10.93
6	10.96
7	11.42
8	11.83
9	12.13
10	12.13
11	12.34
12	12.62
16	14.77
18	14.87
19	15.45
20	15.95
21	16.45
22	16.95

RADIOLOGY

New Modifiers for Transportation of Portable X-Ray Equipment—Revised

This replaces information posted to our provider education Web site on February 20, 2004.

We published information in the First Quarter 2004 *Medicare B Update!* (page 27) concerning five new modifiers that became required for use effective January 1, 2004, when reporting HCPCS code R0075 (Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen). Subsequently, we posted information to our Web site on February 20, 2004, instructing portable X-ray suppliers to continue providing the number of patients seen in the days or units field (Form CMS-1500 item 24G, or electronic equivalent). Since we posted that information, we have received additional instruction from CMS:

> *…to ensure a supplier is paid appropriately the appropriate modifier must be used with HCPCS code R0075 to indicate the number of patients seen during a single trip. Carriers and providers must not use the days or units field on form CMS-1500 item 24G or the electronic equivalent to indicate the number of patients seen during a single trip.*

This means that effective for services rendered on or after January 1, 2004, processed on or after March 15, 2004, we will base the allowance for code R0075 from the **modifier**, not the number of patients in the days or units field. Therefore, if a portable X-ray supplier provides services to four residents in a nursing home, bill the claim for each beneficiary with code/modifier R0075 UQ and ***1*** (not 4) in the days or units field.

You *must* bill one of the five new modifiers with R0075 or your claim will be returned as unprocessable. As a reminder, the new modifiers are:

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

In addition, we are taking the necessary steps to identify all claims with dates of service on or after January 1, 2004, that may have been processed and paid incorrectly. Claims that were not properly reimbursed will be reopened immediately to make correct payments. **You do not need to submit an appeal**.

SURGERY

Skin Graft Coding/Billing Issues

The purpose of this article is to address recent billing issues that have been identified with procedure codes *15000* and *15400*. It has come to our attention that some providers are billing both the *15000* and *15400* procedure codes for each wound on both the initial xenograft application and each subsequent weekly treatments where the wound is debrided and the xenograft is reapplied.

Procedure code *15000* is intended for reporting the surgical preparation or creation of a graft recipient site by excision of open wounds, burn eschar, or scar, including subcutaneous tissue, for the first 100 sq. cm. or one percent of body area of infants and children. The American Medical Association's *Current Procedural Terminology* (*CPT*) clearly states "Use this code for initial wound preparation." It was intended that this code be reported for the "initial" creation/preparation of the graft site by excision, and not for reporting subsequent debridement procedures. Subsequent procedures should be billed with the appropriate level skin debridement code(s) (*11040-11042*). If multiple sites are debrided, codes *11040-11044* can be billed by appending the *59* modifier. In addition, *cpt Assistant* April 1999, pg. 10, and May 1999, pg. 10 clearly indicates code *15000* is for the first 100 sq. cm. (or for infants and children one percent of body area) and should be reported for the total body surface area involved not per wound site. Procedure code *15001* should be reported for each additional 100 sq. cm., if applicable. As these codes represent total body surface area, and, are therefore not dependent upon anatomical site, it would not be appropriate to use the RT and LT modifiers.

Procedure code *15400* is intended for reporting the application of xenograft, skin; 100 sq. cm. or less. Again, the *cpt Assistant* April 2001, pg. 10 clearly states code *15400* should be reported for the total body surface area involved, and not per wound site. In addition, for the purposes of billing Medicare, this procedure code has a 90-day global period. If the wound is being debrided and the xenograft is being reapplied weekly, the provision for payment of these services has been provided for in the Medicare physician fee schedule allowance. If the same treatment were being performed to the same wound, it would not be appropriate to bill the *59* or *79* modifiers in an attempt to circumvent the global period. As stated above, the appropriate level debridement code can be reported for these weekly debridements, if applicable. In addition, the xenograft may be billed if the physician is supplying the graft material. However, the xenograft material must not be billed by more than one entity (e.g., if the outpatient hospital is providing and billing for the graft material, the physician must not bill for the xenograft as a supply/drug/biological in addition to *15400*). The appropriate code for billing the xenograft prior to January 1, 2004, would be J3490 (unlisted drug/biological) and must be submitted with the invoice. On or after January 1, 2004, the xenograft should be reported with Q0182 for (xenograft) tissue of non-human origin, and must be submitted with the invoice.

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.

Modification of CMS' Medicare Contingency Plan for HIPAA Implementation

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Providers Affected

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

Provider Action Needed

STOP – Impact to You

Effective July 1, 2004, Medicare is modifying its Health Insurance Portability and Accountability Act (HIPAA) contingency plan. The modification continues to allow submission of non-compliant electronic claims. However, the payment of electronic claims that are not HIPAA compliant will take thirteen additional days.

CAUTION – What You Need to Know

While the contingency plan remains in place, the submission of non-HIPAA electronic claims to Medicare after July 6, 2004, means that Medicare will take longer to pay such claims.

GO – What You Need to Do

Submit HIPAA compliant claims. If you are already submitting HIPAA-compliant claims, or will do so on or before July 6, 2004, then this change does not apply to you.

Background

Currently, Medicare pays electronic media claims (EMC) no earlier than the 14th day after the date of receipt (13-day waiting period). Non-electronic claims cannot be paid earlier than the 27th day after the date of receipt (26-day waiting period).

HIPAA requires that claims submitted electronically, effective October 16, 2003, be in a format that complies with the appropriate standard adopted for national use.

The Administrative Simplification and Compliance Act (ASCA) requires claims to be submitted to Medicare electronically, with some exceptions, effective October 16, 2003.

Based on guidance issued by the Department of Health and Human Services to maintain cash flow in the healthcare industry beyond October 16, 2003, and the fact that only 33 percent of Medicare's electronic claims were in HIPAA formats as of that date, Medicare implemented a contingency plan to temporarily allow electronic claims to continue to be submitted in a pre-HIPAA format. This was done to provide those members of the healthcare community, who demonstrate a good faith effort to comply, additional time to become HIPAA compliant.

Under the subject modification to the October 16, 2003, contingency plan, those claims submitted electronically and in a HIPAA-compliant format will continue to be considered as eligible for Medicare payment on the 14th day after the date of receipt. Claims submitted electronically in a pre-HIPAA format under a Medicare contingency plan, will be considered as eligible for Medicare payment on the 27th day after the date of receipt. As an example, HIPAA compliant claims received on July 1, 2004, can be paid as early as July 15, while a claim that is not HIPAA compliant and is received electronically on July 1, 2004, can be paid no earlier than July 28.

Medicare is continuing to allow claims to be submitted in a pre-HIPAA format for a limited time to maintain provider payments, but this modification of the contingency plan should provide an incentive for moving to HIPAA formats quickly. This is a measured step toward ending the contingency plan for all incoming claims.

Important Dates

Medicare has instructed its carriers and intermediaries to begin enforcing these rules on July 6, 2004, and the rules will apply to claims received on or after July 1, 2004.

Additional Information

CMS has instructed its Medicare carriers and intermediaries to make available free/low cost software that will enable submission of HIPAA compliant claims electronically. Contact your carrier or intermediary in order to obtain this software at their special EDI number. For those billing Medicare Part A (including hospital outpatient services), the Florida number is 1-(904)-791-8767 (option 1). Or, you may find numbers listed by state at: *http://www.cms.hhs.gov/providers/edi/anum.asp*.

For those billing Medicare Part B, the Connecticut number is 1-(203)-639-3160 (option 1); the Florida number is 1-(904)-791-8767 (option 1). Or, you may find numbers listed by state at: *http://www.cms.hhs.gov/providers/edi/bnum.asp*.

For additional information on HIPAA, visit the CMS Web site at: *http://www.cms.hhs.gov/hipaa/hipaa2/default.asp*.

To view the revised manual chapter for the claims receipt rules, see Chapter 1, Section 80.2.1.2, which can be found in Pub 100-04, the Medicare Claims Processing Manual. This can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

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

Once at that site, scroll down the CR NUM column to 2981 and click on that file.

Related Change Request (CR) #: 2981 Medlearn Matters Number: MM2981
Related CR Release Date: February 27, 2004
Related CR Transmittal #: 114
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

GENERAL INFORMATION

FRAUD, WASTE, AND ABUSE

OIG Alerts Physicians About Added Charges For Covered Services

For Immediate Release, March 31, 2004

Extra Contractual Charges Beyond Medicare's Deductible, Coinsurance: A Potential Assignment Violation

Acting Principal Deputy IG Dara Corrigan today reminds Medicare participating physicians of the potential liabilities posed by billing Medicare patients for services that are already covered by Medicare.

Medicare participating providers can charge Medicare beneficiaries extra for items and services that are not covered by Medicare.

Participating providers may also, of course, charge beneficiaries for any Medicare deductibles and coinsurance without violating the terms of their assignment agreements. But when participating providers request any other payment for covered services from Medicare patients they are liable for substantial penalties and exclusion from Medicare and other Federal health care programs.

"We are hearing reports about physicians asking patients to pay additional fees, and we believe this is an ideal time to remind physicians and Medicare patients about this potential liability. Charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid for by Medicare," Corrigan said.

For example, the OIG recently alleged that a physician violated his assignment agreement when he presented to his patients – including Medicare beneficiaries – a "Personal Health Care Medical Care Contract" asking patients to pay an annual fee of $600.

While the physician characterized the services to be provided under the contract as "not covered" by Medicare, the OIG alleged that at least some of these contracted services were already covered and reimbursable by Medicare. Among other services offered under this contract were the "coordination of care with other providers," "a comprehensive assessment and plan for optimum health," and "extra time" spent on patient care. OIG alleged that based on the specific facts and circumstances of this case, at least some of these contracted services were already covered and reimbursable by Medicare.

Therefore, OIG alleged that each contract presented to this physician's Medicare patients constituted a request for payment for already covered services, other than the coinsurance and deductible, and was therefore a violation of the physician's assignment agreement.

In order to resolve these allegations, the physician agreed to pay a settlement amount to OIG, and to stop offering these contracts to his patients.

"If participating physicians decide they want to charge patients additional fees they should be mindful that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance," Corrigan said.

Note: A participating provider is a provider of Medicare covered items and services who agrees to accept the Medicare-approved charge for all covered services to Medicare patients. A participating provider "accepts assignment" for all Medicare-payable services. Non-participating providers may also be subject to penalties and exclusion for overcharging beneficiaries for covered services. This is true whether the provider accepts assignment for a given service or does not, in which case the provider's charge is limited to the "limiting charge."

Source: OIG ALERT
Office of Inspector General
330 Independence Ave., SW
Washington, D. C. 20201
Phone: (202) 619-1343

MEDICARE REGISTRATION/ENROLLMENT

Medicare Enrollment Questions and Answers

During the last few months, some questions regarding the Medicare provider enrollment process have been raised by members of the healthcare community. Therefore, CMS prepared the following questions and answers to clarify developments associated with provider enrollment.

Q: Why are providers and suppliers experiencing delays associated with processing their provider/supplier applications?

A: On November 3, 2003, CMS' Medicare carriers began using a new electronic database for recording and retaining enrollment data for providers/suppliers. This electronic database is known as the Provider Enrollment, Chain and Ownership System (PECOS). The PECOS system is the electronic implementation of a policy decision made by CMS in 1995, as a result of a CMS fraud and abuse initiative, "Operation Restore Trust," to create a national, uniform business process for provider/supplier enrollment.

The PECOS system was implemented for Medicare carriers on November 3, 2003; fiscal intermediaries began using the system in July 2002. As of this date, carriers were instructed to process any new enrollments and any changes in enrollment applications through PECOS. While some carriers have backlogs that must be reduced, other carriers have handled the transition to PECOS with less difficulty.

In addition to issues directly related to PECOS implementation, there have been unanticipated CMS data center infrastructure issues that have caused system outages. These unanticipated outages have made PECOS inaccessible to carrier staffs for certain periods of time.

Another factor is the learning curve staff is experiencing at our carriers. This is a new, uniform business process, most times different from the way carriers processed provider enrollment applications in the past. Ongoing training and support has been provided by CMS but, as with any change of this magnitude, it is anticipated that slowdowns in work processing will occur for a time. Another factor that has caused delays is the budget process. This fiscal year, CMS' appropriation was held up in Congress. As a result, CMS and its Medicare contractors were operating at a prior year continuing resolution levels until earlier this calendar year.

Q: What is CMS doing to resolve the delays associated with processing provider/supplier applications?

A: CMS recently assembled a senior leadership team with accountability for resolving these delays. This team is focusing on expeditiously resolving delays in processing provider enrollment applications. Steps are being taken to address the backlogs and all options are being considered. Teams of representatives from CMS headquarters and regional offices and the PECOS system developers have been assembled and began conducting site visits to each Medicare carrier beginning the week of March 1, 2004. These teams will have direct responsibility to provide on-site focused customer service to individual carriers to expeditiously resolve any issues related to PECOS and the provider enrollment business process so that delays in processing can be reduced or eliminated.

On the CMS infrastructure front, CMS is working diligently to resolve CMS data system infrastructure issues that are causing outages in access to PECOS. CMS is also in the process of addressing any current funding constraints so that carriers have the necessary resources to address the delays and reduce their inventories. The goal of CMS senior leadership is to have the backlog inventories reduced by the summer of 2004.

Source: CMS Joint Signature Memorandum-160, March 5, 2004

Change to Types of Providers Who May Enter Into Private Contracts with Beneficiaries

Section 1802 of the Social Security Act, as amended by section 4507 of the Balanced Budget Act (BBA) of 1997, permits a physician or practitioner to "opt-out" of Medicare and enter into private contracts with Medicare beneficiaries, if specific requirements are met. We previously provided instructions regarding the types of providers who may enter into such agreements (***Connecticut***: February 1998 *Medicare Provider News* No. 39 [page 16]; ***Florida***: September/October 1999 *Medicare B Update!* [pages 48-55]).

Since then, CMS has changed the definition of physician or practitioner who may opt-out to include **dentists**, **podiatrists**, and **optometrists**.

Source: CMS Pub. 100-02 Transmittal 4, CR 3016

MEDICARE SECONDARY PAYER

MMA-Medicare Secondary Payer (MSP) Policy for Hospital Reference Lab services and Independent Reference Lab Services

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Hospitals, including critical access hospitals, and independent reference laboratories

Provider Action Needed

STOP

Hospitals are no longer required to collect Medicare Secondary Payer (MSP) information because independent reference labs no longer need the information to bill Medicare for reference laboratory services.

CAUTION

This applies to all hospitals, including critical access hospitals.

GO

Please incorporate this policy change into your billing processes.

Background

Section 943 of the Medicare Prescription Drug, Improvement & 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. However, the Centers for Medicare & Medicaid Services (CMS) will not require independent reference laboratories to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) of Section 943 of MMA. Therefore, CMS will not require hospitals to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) of Section 943.

Effective Date

This change is effective for reference laboratory service claims with dates of service of December 8, 2003, or later.

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 3064 in the CR NUM column on the right, and click on the file for that CR.

Related Change Request (CR) #: 3064 .
Medlearn Matters Number: MM3064
Related CR Release Date: February 27, 2004
Related CR Transmittal #: 11
Effective Date: December 8, 2003
Implementation Date: March 29, 2004

SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)

April Quarterly Update to HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes subject to the consolidated billing (CB) provision of the skilled nursing facility (SNF) Prospective Payment System (PPS). The coding files for SNF CB will be updated effective for services rendered on or after April 1, 2004. Additional information is available on the CMS Web site at *http://www.cms.hhs.gov/medlearn/snfcode.asp*. In order to correctly bill services, physicians, non-physician practitioners, and suppliers should carefully review the revised code files.

Services appearing on the lists that are submitted on claims to Medicare fiscal intermediaries (FIs) and carriers (including durable medical equipment regional carriers [DMERCs]), will not be paid by Medicare to providers, other than a SNF, when included in SNF CB. For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical, occupational or speech-language therapy services when they are furnished to a SNF resident, regardless of whether Part A covers the stay.

Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

Source: CMS Pub. 100-04 Transmittal: 92, CR 3070

Implementation of Skilled Nursing Facility Claim Edits for Therapy Codes Considered Separately Payable Physician Services

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Physicians and other providers billing Medicare carriers for services provided at skilled nursing facilities (SNF).

Provider Action Needed

Providers billing for services rendered to Medicare beneficiaries in a SNF stay should note changes in the Medicare claims processing systems which will allow certain therapy services to be separately payable when provided by physicians. These same services will be considered therapy services when provided by therapists and will be subject to SNF consolidated billing.

Background

Physical, occupational, and speech therapy provided to beneficiaries in either 1) a Part A covered SNF stay, or 2) during a non-covered stay are considered bundled services and are paid through consolidated billing under the SNF Prospective Payment System.

A small number of these services are considered surgery when performed by a physician and may be separately paid by Medicare. When these services are performed by a physical or occupational therapist, they are considered therapy and continue to be subject to consolidated billing.

Effective for claims with dates of service on or after July 1, 2004, these changes to Medicare claims processing rules will prevent incorrect payment. Basically, the Medicare claims systems will allow separate payment to providers, other than physical and occupational therapists, for services provided to Medicare beneficiaries in a Part A covered SNF stay or a non-covered SNF stay for the Healthcare Common Procedure Coding System (HCPCS) codes in the following table:

29065	29075	29085	29086	29105	29125	29126
29130	29131	29200	29220	29240	29260	29280
29345	29365	29405	29445	29505	29515	29520
29540	29550	29580	29590	64550		

When physical and occupational therapists submit claims for these services for Medicare patients in a SNF stay, the claim will not be paid and the billing provider will receive a remittance message with remarks code N121, which states that there is "No coverage for items or services by this type of practitioner for patients in a covered skilled nursing facility (SNF) stay."

Implementation

The implementation date is July 6, 2004, and applies to claims with dates of service of July 1, 2004, or later.

Related Instructions

The following will be added to the Medicare Claims Processing Manual, Chapter 6, Section 110, Subsection 2.6, *Edit for Therapy Services Separately Payable When Furnished by a Physician:*

"A number of therapy services are considered separately payable when provided by a physician and shall be paid separately by the Medicare carrier. However, these services are considered therapy when provided by a physical or occupational therapist; will be subject to consolidated billing; and payment for them is included in the prospective payment rate provided to the SNF by the FI (Medicare fiscal intermediary).

Effective July 1, 2004, edits will be implemented in the claims processing system to correctly process claims for these services. A complete list of these services can be found on the CMS Web site at http://www.cms.hhs.gov/medlearn/snfcode.asp"

For additional information on SNF inpatient Part A billing, please see Chapter 6 of the Medicare Claims Processing Manual (Pub 100-04), which may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c06.pdf.*

To view the actual instructions issued to your carrier, please visit: *http://www.cms.hhs.gov/manuals/transmittals/pm_trans/R90CP.pdf.*

Related Change Request (CR) #: 2944
Medlearn Matters Number: MM2944
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R90CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Skilled Nursing Facility Consolidated Billing—Financial Arrangement Reminder

The skilled nursing facility (SNF) consolidated billing (CB) provision states that SNFs **must** submit Medicare claims to the fiscal intermediary (FI) for payment for all Part A and Part B services that its residents receive during the course of a covered Part A stay, except for a limited number of specifically excluded services.

Medicare B will not pay for services included in the SNF CB provision to providers for a beneficiary residing in a SNF. Providers are encouraged to enter into direct financial arrangement with the specific skilled nursing facility prior to the time of rendering the services.

If a provider received payment from the Medicare carrier for services rendered on or after April 1, 2001, to a beneficiary during a SNF Part A stay and the claim processed on or after July 1, 2002, a refund may be requested if applicable. Providers should contact the skilled nursing facility for reimbursement.

Additional guidelines on the SNF CB provision are available in the First Quarter 2004 *Medicare B Update!* (pages 37-38) and on CMS Web site at *http://www.cms.hhs.gov/medlearn/snfcode.asp.*

GENERAL INFORMATION

MMA-Clarifications to Certain Exceptions to Medicare Limits on Physician Referrals

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

Physicians and specialty hospitals.

Provider Action Needed

Be sure to understand these new rules surrounding physician self-referral ("Stark") prohibition as a result of changes in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

GENERAL INFORMATION

A. Background: Under section 1877 of the Social Security Act (42 U.S.C. §1395nn), a physician cannot refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship unless an exception applies. Section 1877 also prohibits the DHS entity from submitting claims to Medicare, the beneficiary, or any other entity for DHS that are furnished as a result of a prohibited referral.

The following services are DHS:

- Clinical laboratory services
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound)
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Orthotics, prosthetics, and prosthetic devices
- Parenteral and enteral nutrients, equipment and supplies
- Physical therapy, occupational therapy, and speech-language pathology services
- Outpatient prescription drugs
- Home health services and supplies
- Inpatient and outpatient hospital services.

A "financial relationship" includes both ownership/investment interests and compensation arrangements (e.g., contractual arrangements). The statute enumerates various exceptions, including exceptions for physician ownership or investment interests in hospitals and rural providers. Violations of the statute are punishable by the following: denial of payment for all DHS claims; refund of amounts collected for DHS claims; and civil money penalties for knowing violations of the prohibition. Applicable regulations are published at 42 C.F.R. Part 411, Subpart J.

B. Policy: The MMA, also known as Public Law 108-173, altered the hospital and rural provider ownership exceptions to the physician self-referral prohibition. Prior to MMA, the "whole hospital" exception allowed physicians to refer Medicare patients to a hospital in which they had ownership/investment interests, as long as the physicians were authorized to perform services at the hospital and their ownership or investment interests were in the hospital itself and not a subdivision of the hospital.

Section 507 of MMA added an additional criterion to the whole hospital exception, specifying that for the 18-month period beginning on December 8, 2003 and ending on June 8, 2005, physician ownership and investment interests in "specialty hospitals" would not qualify for the whole hospital exception. Section 507 further specified that, for the same 18-month period, the exception for physician ownership or investment interests in rural providers would not apply in the case of specialty hospitals located in a rural area. **In other words, for this 18-month period only, a physician may not refer a patient to a hospital in which he/she has an ownership or investment interest if the hospital is a specialty hospital, even if the specialty hospital is in a rural area.**

Definition of a Specialty Hospital

For the purposes of these modifications to the physician self-referral prohibition exceptions only, a "specialty hospital" is defined as a hospital in one of the 50 States or the District of Columbia that is primarily or exclusively engaged in the care and treatment of one of the following:

- Patients with a cardiac condition,
- Patients with an orthopedic condition,
- Patients receiving a surgical procedure, or
- Patients receiving any other specialized category of services that CMS designates.

CMS is not designating at this time any additional specialized services that would cause an institution to be considered a specialty hospital within the meaning of section 507 of MMA.

Certain hospitals that offer specialized services are not "specialty hospitals" for purposes of section 507 of MMA. Physician investment in and referrals to the following types of hospitals are **permitted**:

- Psychiatric hospitals
- Rehabilitation hospitals
- Children's hospitals
- Long-term care hospitals
- Certain cancer hospitals
- Existing specialty hospitals that satisfy the grandfathering provision in section 507 of MMA ("grandfathered specialty hospitals").

Grandfathered Specialty Hospitals

A grandfathered specialty hospital is one that the CMS central office determines was in operation or under development as of November 18, 2003 and for which:

i) the number of physician investors has not increased since that date;
ii) the specialized services furnished by the hospital have not changed since that date; and
iii) any increase in the number of beds has occurred only on the main campus of the hospital and does not exceed the greater of 5 beds or 50 percent of the beds in the hospital as of that date.

A physician may invest in and refer to a grandfathered hospital. However, an existing specialty hospital cannot continue to be grandfathered if, after November 18, 2003, the number of physician investors or the type of specialized services it offers has changed, or if the hospital's bed size has increased beyond the 5-bed/50 percent threshold. Consequently, its physician investors cannot refer to the hospital and the hospital cannot submit claims pursuant to any prohibited referrals for the remainder of 18-month period ending on June 8, 2005. In determining whether a specialty hospital was "under development" as of November 18, 2003, the MMA directs CMS to consider whether the following had occurred as of that date:

- Architectural plans were completed;
- Funding was received;
- Zoning requirements were met; and
- All necessary approvals from State agencies were received.

In addition, CMS may consider any other evidence that CMS believes would indicate whether a hospital is under development as of November 18, 2003. If CMS determines that an entity was not under development as of November 18, 2003, it is not a grandfathered specialty hospital. Consequently, physician investors in that hospital may not refer to the hospital until June 8, 2005, and the hospital may not submit any claims for items or services rendered pursuant to a prohibited referral.

Grandfathering Determinations

Interested parties may submit to the CMS central office written requests for a determination that their specialty hospital was under development as of November 18, 2003 (a "grandfathering determination"). Existing specialty hospitals that had a provider agreement in effect as of November 18, 2003 do not need to request a grandfathering determination; the provider agreement will constitute this determination. Grandfathering determination requests should include the following:

- A discussion establishing why the specialty hospital should be considered in operation before or under development as of November 18, 2003;
- Relevant supporting documentation;
- Contact information for an individual with whom CMS can discuss the request; and
- A certification that the information contained in the request and supporting documentation is true and correct and constitutes a complete description of the facts regarding the matter for which a determination is sought.

Upon receiving and reviewing the request, CMS may contact the requestor for additional information. Grandfathering determination requests may be mailed to:

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: Advisory Opinions
P.O. Box 26505
Baltimore, MD 21207

CMS contractors (for example, intermediaries and carriers) are not authorized to provide guidance on matters relating to the physician self-referral law or the application of the exclusion, civil monetary penalty, or criminal authorities under sections 1128, 1128A, or 1128B of the Social Security Act (including the antikickback statute).

Inquiries regarding the physician self-referral law should be directed to:

Joanne Sinsheimer
Division of Technical Payment Policy, CMS
(410) 786-4620

Inquiries concerning the application of the exclusion, civil monetary penalty, or criminal authorities under sections 1128, 1128A, or 1128B of the Social Security Act (including the anti-kickback statute) should be directed to the:

Office of Counsel to the Inspector General
Industry Guidance Branch
(202) 619-0335

Related Information

If you need further clarification, background, details, or just want to see the original change request implementing the 18-month additional criteria, please refer to the original Change Request # 3036. This may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Once at that page, scroll down the CR Number column to CR 3036 and click on the file for that CR.

Related Change Release (CR) #: 3036
Medlearn Matters Number: MM3036
Related CR Release Date: March 19, 2004
Related CR Transmittal #: 62
Effective Date: December 8, 2003
Implementation Date: April 2, 2004

Consolidation of the Claims Crossover Process: Additional Common Working File (CWF) Functionality

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

All Medicare providers.

Provider Action Needed

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

Background

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

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

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

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

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

These changes are the result of input from affected stakeholders in the health insurance industry and will result in a more effective implementation of the COBA process and more effective processes for Medicare providers to receive claim payments that are secondary to Medicare benefits. In addition, the revised COBA process will ensure that CMS fulfills the requirements imposed by the HIPAA ANSI-X12 835 (Electronic Remittance Advice [ERA]) Implementation Guide with respect to communication of crossover information to its Medicare providers and suppliers.

Eligibility-Based Crossover Process

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

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

Claim-Based Crossover Process

For those Medigap and Medicaid insurers that do not provide COB eligibility files identifying beneficiaries that are insured by their plans, a claim-based crossover process will be implemented by October 4, 2004. Unique five-digit COBA IDs will be assigned by the COBC to Medigap and Medicaid insurers that do not provide eligibility files to the COBC. Medicare providers and suppliers will receive a listing of all Medigap and Medicaid insurers that have been assigned unique claim-based COBA IDs and will be responsible for entering the unique claim-based COBA IDs on each claim submitted to Medicare to initiate the crossing over of claims to the Medigap or Medicaid insurer for supplemental payment to the provider or supplier.

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

- The beneficiary presents (or has presented) some evidence of his/her coverage under a Medigap plan or eligibility for Medicaid benefits and a corresponding COBA ID for the identified Medigap insurer or State Medicaid Agency can be located on CMS' COBA claim-based ID listing;
- The provider or supplier participates in the Medicare Program. Note that this condition applies both to Medigap and Medicaid claim-based crossover; and
- The beneficiary assigns (or has assigned) his/her Medigap benefits to the provider or supplier.

Implementation

July 6, 2004.

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

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

Additional Information

You can find the CMS Program Manuals Index at the following CMS Web site:
http://www.cms.hhs.gov/manuals/cmsindex.asp.

Also, the Medicare Claims Processing Manual (Pub 100-04) is located at the following CMS Web site:
http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Chapter 28 of that manual may be found at:
http://www.cms.hhs.gov/manuals/104_claims/clm104c28.pdf.

Additional Coordination of Benefits information may be found at:
http://www.cms.hhs.gov/manuals/105_msp/msp105c04.pdf.

Related Change Request (CR) #: 3109
Medlearn Matters Number: MM3109
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R98CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004. Carriers and durable medical equipment regional carriers (DMERCs) must complete the COBA claim-based crossover system changes described in this instruction by July 6, 2004. However, because of this instruction's impact on Part B providers and suppliers, the COBA claim-based crossover process will not be operational until October 4, 2004.

Consolidation of the Claims Crossover Process—Smaller-Scale Initial Implementation

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Providers Affected

All Medicare physicians, providers, and suppliers.

Provider Action Needed

In recent instructions to Medicare carriers, including durable medical equipment carriers (DMERCs) and fiscal intermediaries (FIs), the Centers for Medicare & Medicaid Services (CMS) presented the requirements for a redesigned process for coordination of benefits activities. (For an explanation of these requirements/instructions, see Medlearn Matters article MM3109.)

In Change Request (CR) 3218, CMS is advising the carriers, FIs, and DMERCs that the implementation schedule is being altered and some requirements have changed. Providers need to be aware of how these changes, as described below, may affect them.

The key message is that the impact of this change on providers is delayed from July 6, 2004 until further notice.

Background

CMS is starting the consolidation of the claims crossover process by beginning with a smaller-scale implementation on July 6, 2004. Through this instruction, CMS announces which portions of Transmittal R-98 (CR 3109) are:

- Still applicable;
- Which requirements have changed; and
- Which requirements are being moved to the October 4, 2004, systems release or to another future release.

Details regarding the requirements that have changed, and which are being moved to the October 4, 2004 systems release or to another future release, are listed in CR 3218, which can be found at the CMS Web site address that is included in the *Additional Information* section of this article.

A key change is that the entire process will not be implemented on July 6, 2004, as mentioned in CR 3109 and Medlearn Matters article MM3109.

Instead, a pilot test will be conducted from July 6, 2004, through October 1, 2004, when approximately eight coordination of benefits agreement (COBA) trading partners will participate as beta-testers in a parallel production crossover environment.

During the parallel production period, the eight COBA trading partners will continue to receive crossover claims from Medicare contractors and will also receive crossover claims as part of the COBA process.

In light of CMS' decision to implement the COBA crossover consolidation project on a smaller scale within a parallel environment, Medicare carriers/FIs/DMERCs will continue to follow their current processes for the printing of Medicare summary notice (MSN) and electronic remittance advice (ERA) crossover messages throughout the period from July 6, 2004, to October 1, 2004.

Medicare contractors will also continue to charge all trading partners to whom they cross Medicare claims.

During the parallel production period, CMS' Medicare coordination of benefits contractor (COBC) will **not** be charging the trading partners that participate in the COBA beta-site testing for claims that it crosses to them.

The eligibility-based crossover process will begin to be implemented on a larger scale on October 4, 2004.

Also on October 4, 2004, the initial eight COBA beta-site testers will be converted to full production and will begin to be charged for claims that the COBC crosses over to them.

CMS' claim-based COBA crossover process is being delayed until a future systems release**.**

This process previously had a major impact on the provider community as of October 2004 and that will not occur in October 2004 as previously planned.

Implementation

The implementation date for this instruction is July 6, 2004. This means that only those participating in the pilot phase are affected on that date. All other trading partners will not be affected until October 1, 2004, at the earliest. Additional instructions will be issued as new implementation dates are established for moving from the pilot phase to full implementation.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf.*

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***.**

Also, Transmittal R-98, CR 3109, Consolidation of the Claims Crossover Process: Additional Common Working File (CWF) Functionality, dated February 6, 2004, can be found at the following CMS Web site: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3109.pdf***.**

CR 3218 supercedes CR 3109 and deletes the impact on provider requirements listed in requirements 20 and 21 in CR 3109. Consolidated claim-based crossovers have been delayed until further notice. The claim-based crossover process remains unchanged at the Medicare contractors.

Related Change Request (CR) Number: 3218
Related CR Release Date: April 9, 2004
Related CR Transmittal Number: 138
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

MMA-Changes to Rules for Receiving Optional Payment Method for Outpatient Services

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Providers Affected

Physicians/Practitioners and Critical Access Hospitals (CAH).

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

CAHs need to understand the new rule and decide which payment method to select. (For more information on the optional payment method and the standard payment methods, please see the article MM3051, which can be retrieved at *http://www.cms.hhs.gov/medlearn/matters*. Once at that site, scroll down and select article MM3051.) Once the payment selection is made, the CAH must assure that physicians/practitioners are aware of the selection and act accordingly. In addition, CAHs must ensure that billing staffs are aware of any changes required as a result in any change of the selected payment methodology.

Background

MMA changed the provision that required CAHs to have all of their physician/professional practitioners, who rendered outpatient services at their hospitals, reassign their billing rights to the CAH. Specifically, the MMA prohibits CMS from requiring that all physician/professional practitioners in a CAH reassign their billing rights to the CAH as a condition for electing the optional payment option (Method 2).

This provision allows practitioners (all licensed professionals who otherwise would be entitled to bill the carrier under Part B) who render outpatient services in a CAH's outpatient department to choose whether they want to reassign their billing rights to the CAH, or file their own claims through their Medicare carrier.

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

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

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

Important Dates to Know

EFFECTIVE DATE: July 1, 2004, for CAHs selecting the optional payment method on or after November 1, 2003; for those CAHs who selected the optional method prior to November 1, the effective date is retroactive to July 1, 2001.
IMPLEMENTATION DATE: July 6, 2004

Related Instructions

For more detailed information on the two payment methods available, please refer to Chapter 4 of the Medicare Claims Processing Manual (Pub 100-04) sections 250.1 and 250.2. The table of contents for this manual may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*. Once at that site, scroll down to Chapter 4 and select the version you wish to receive.

The official instruction issued to your carrier or fiscal intermediary regarding this change may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*. Once at that page, scroll down to look for 3114 in the CR NUM column on the right and click on the file for that CR.

Related Change Request (CR) #: 3114
Medlearn Matters Number: MM3114
Related CR Release Date: February 20, 2004
Related CR Transmittal #: R103CP
Effective Date: July1, 2004
Implementation Date: July 6, 2004

MMA - New Part B Annual Deductible

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Providers Affected

Physicians, suppliers, and providers.

Provider Action Needed

Physicians, suppliers, and providers should note that, effective January 1, 2005, the supplementary medical insurance (SMI) or Medicare Part B deductible will be $110. These providers should assure that their billing processes are adjusted to handle this change in the Medicare Part B deductible.

Background

Medicare Part B helps beneficiaries pay for physician's services, diagnostic tests, ambulance services, durable medical equipment, and other health services, and the beneficiary is responsible for the first $100.00 deductible of Medicare Part B approved charges each calendar year, i.e. their annual deductible. For calendar years 1991 through 2004, the Medicare Part B annual deductible has been $100.
Beginning in 2005, the Medicare Part B deductible will be $110 (based on Section 629 of the Medicare Prescription Drug, Improvement, and Modernization Act [MMA]).

Implementation

This change is effective on January 1, 2005 and the implementation date in Medicare claims processing systems will be January 3, 2005.

Related Instructions

The Medicare General Information, Eligibility, and Entitlement Manual Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations), Section 20 (Supplementary Medical Insurance [SMI] [Part B]), Subsection 20.2 (Part B Annual Deductible) has been revised and is included below with changes bolded and italicized.

20.2 - Part B Annual Deductible - (Rev.)

In each calendar year, a cash deductible must be satisfied before payment can be made under SMI. (See 20.4 of this chapter for exceptions.)

- ***For 2005, and until further notice, the deductible is $110***.
- ***From 1991 through 2004***, the deductible is $100.
- From 1982 through 1990, the deductible was $75.
- From 1973 through 1981, the deductible was $60.
- From 1966 through 1972, the deductible was $50.

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on Medicare allowed amounts. ***Noncovered*** expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year (i.e., insurance coverage begins after the first month of a year or the individual dies before the last month of the year), he or she is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received. Services that are not subject to the deductible cannot be used to satisfy the deductible.

Additional Information

You can find the Centers for Medicare & Medicaid Services (CMS) Program Manuals Index at the following CMS Web site: *http://www.cms.hhs.gov/manuals/cmsindex.asp*

Also, the Medicare General Information, Eligibility, and Entitlement Manual is located at the following CMS Web site: *http://www.cms.hhs.gov/manuals/101_general/ge101index.asp*

Related Change Request (CR) #: 3121
Medlearn Matters Number: MM3121
Related CR Release Date: March 12, 2004
Related CR Transmittal #: 3
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Payment for Services Provided Under a Contractual Arrangement

The following is a "Medlearn Matters...Information for Medicare Providers" article issued by CMS.

Provider Types Affected

All providers who bill Medicare carriers for services rendered by a physician or other persons under a contractual arrangement.

Provider Action Needed

None, for information only. You can now submit claims for services that a physician or other persons provide for you, under a contractual arrangement, regardless of where they provide the service. You should make sure that your billing offices and contractors are aware of these changes.

Background

CMS has revised the instructions on reassignment. Specifically, Chapter 1, Section 30.2.7 of the Medicare Claims Processing Manual now enables a carrier to make payment to a Medicare program-enrolled entity (a person, group, or facility) that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. The service, therefore, may be furnished on or off the premises of the entity submitting the bill.

The contractual arrangement between the entity and the physician or other person should include the following program integrity safeguards:

- Joint and several liability is shared between the entity submitting the claim and the person actually furnishing the service, for any Medicare overpayment relating to such claim.
- The person furnishing the service has unrestricted access to claims submitted by the entity for the services provided by that person.

Additional Information

You can read these changes in the Medicare Claims Processing Manual, Chapter 1 Section 30.2.7, *Payment for Services Provided Under a Contractual Arrangement – Carrier Claims Only*. This manual may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*

Related Change Request (CR) #: 3083
Medlearn Matters Number: MM3083
Related CR Release Date: February 27, 2004
Related CR Transmittal #:111
Effective Date: December 8, 2003
Implementation Date: March 12, 2004

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

X12N 835 Health Care Remittance Advice Remark Codes

The CMS is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers, including Medicare, have to use reason and remark codes approved by X12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment. The CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities, and these additions and modifications may not impact Medicare. Traditionally, remark code changes that impact Medicare are requested by Medicare staff in conjunction with a policy change. Contractors are notified of those new/modified codes in the corresponding implementation instructions, which implement the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than Medicare for a code currently used by Medicare, contractors must use the modified code even though the modification was not initiated by Medicare. The complete list of remark codes is available at:

http://www.wpc-edi.com/codes/Codes.asp and *http://www.cms.hhs.gov/providers/edi/hipaadoc.asp*

The list is updated 3 times a year. The following list summarizes changes made from July 1, 2003 to October 31, 2003:

Code	Current Narrative	Medicare Initiated
N212	Changes processed under a Point of Service benefit.	No

Modified Remark Codes

Code	Current Modified Narrative	Modification Date
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	Modified 10/31/03
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.	Modified 2/28/03, 10/31/03
M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Modified 10/31/03
M81	You are required to code to the highest level of specificity.	Modified 10/31/03. See M76 for rest of the previous text
M84	Medical code sets used must be the codes in effect at the time of service	Modified 10/31/03
M116	Paid under the Competitive Bidding Demonstration project. Project is ending, and future services may not be paid under this project.	Modified 10/31/03
MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	Modified 2/28/03, 10/31/03
MA121	Missing/incomplete/invalid date the x-ray was performed.	Modified 2/28/03, 6/30/03, 10/31/03
N40	Missing/incomplete/invalid x-ray.	Modified 2/28/03, 6/30/03, 10/31/03
N157	Transportation to/from this destination is not covered.	New Code 2/28/03 Modified 10/31/03
N160	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.	New Code 2/28/03 Modified 10/31/03

Deactivated Remark Codes

Code	**Current Modified Narrative**	**Deactivation Date**
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	Modified 2/28/03 Deactivated eff. 8/1/04. Refer to M68
M34	Claim lacks the CLIA certification number.	Deactivated eff. 8/1/04. Refer to MA120
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.	Deactivated eff. 8/1/04. Refer to Reason Code B20
M92	Services subjected to review under the Home Health Medical Review Initiative.	Deactivated eff. 8/1/04.
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	Modified 2/28/03 Deactivated eff. 8/1/04. Refer to MA31
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.	Modified 2/28/03 Deactivated eff. 8/1/04. Refer to MA76
MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.	Deactivated eff. 8/1/04. Refer to MA92
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	Modified 2/28/03 Deactivated eff. 8/1/04. Refer to MA92
MA87	Missing/incomplete/invalid insured's name for the primary payer.	Modified 2/28/03 Deactivated eff. 8/1/04. Refer to MA92

Code	Current Modified Narrative	Deactivation Date
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.	Modified 2/28/03 Deactivated eff. 8/1/04. Refer to M68
N17	Per admission deductible.	Deactivated eff. 8/1/04. Refer to Reason code 1

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year after each X12 trimester meeting at *http://www.wpc-edi.com/codes/Codes.asp*. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in September 2003 are listed here. By April 1, 2004, you must have the most current reason code set installed for production to make sure that all carriers, intermediaries, and DMERCs are using the latest approved reason codes in 835 and standard paper remittance advice transactions.

The request for a reason code change may come from non-Medicare entities. If Medicare requests a change, it may be included in a Medicare instruction, in addition to this regular code update notification. The regular code update notification is issued on a periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update notification, and will establish the deadline for Medicare contractors to implement the reason and remark code changes that may not already have been implemented as part of a previous Medicare policy change instruction.

A reason code may be retired if it is no longer applicable or a similar code exists. Retirements are effective for a specified future and succeeding versions, but contractors can also discontinue use of retired codes in prior versions. The regular code update notification will establish the deadline for Medicare contractors to retire a reason code that could be earlier than the version specified in the WPC posting. The committee approved the following reason code changes in September 2003:

Reason Code Changes (as of 10/31/03)

Code	Current Narrative	Notes
156	Flexible spending account payments.	New as of 9/03
157	Payment denied/reduced because service/procedure was provided as a result of an act of war.	New as of 9/03
158	Payment denied/reduced because service/procedure was provided outside of the United States.	New as of 9/03
159	Payment denied/reduced because service/procedure was provided as a result of terrorism.	New as of 9/03
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.	New as of 9/03
113	Payment denied/reduced because service/procedure was provided outside the United States or as a result of war.	Inactive for version 4060. Use codes 15, 158 or 159
A2	Contractual Adjustment	Inactive for version 4060. Use code 45 with Group Code “CO” or use another appropriate specific adjustment code.

Source: CMS Pub. 100-04 Transmittal: 93, CR 3122

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.

Implementation of Local Coverage Determinations

The Benefit Improvement Protection Act (BIPA) section 522 created local coverage determinations (LCD) that consist only of reasonable and necessary information. LCDs will replace the local medical review policies (LMRP). First Coast Service Options, Inc. (FCSO) will be converting the existing LMRPs to LCDs over the next two years. The LCD format is similar

to the LMRP format. The format changes will consist of section title changes and the deletion of some sections. Where deleted sections contain significant information, this will be incorporated into the "Indications and Limitation of Coverage and/or Medical Necessity" section of the LCD.

If there are "Coding or Billing Instructions," these will appear in a companion article entitled with the policy name/ LCD title. At the end of the LCD under the section entitled "LCD Attachments," there will be a statement indicating whether or not there is a companion article for this LCD. If there is a companion article, the title will be given. On the Web site, you will be able to click on the title of the companion document to view the corresponding guidelines. Please note that you can only access the coding instructions from the policy with which the guidelines correspond.

Source: CMS Pub. 100-08, Transmittal 63, CR 3010

Outpatient Psychiatric Services Limitation

The outpatient psychiatric services limitation, where 62.5 percent of the allowed amount is reimbursed to providers, is based on actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders, while not an inpatient of a hospital at the time such expenses are incurred. This limitation is also called the outpatient mental health treatment limitation. It is applicable when the place of service is other than inpatient hospital (place of service code 21), inpatient psychiatric facility (POS 51), or comprehensive inpatient rehabilitation facility (POS 61).

Procedure Codes Subject to Psychiatric Limitation

The procedure codes listed below, by virtue of their description, are *always* subject to limitation when the POS is other than 21, 51, or 61:

G0071	G0072	G0073	G0074	G0075	G0076
G0077	G0078	G0079	G0080	G0081	G0082
G0083	G0084	G0085	G0086	G0087	G0088
G0089	G0090	G0091	G0092	G0093	G0094
G0115	G0116	H5010	H5020	H5025	00104
90804	90805	90806	90807	90808	90809
90810	90811	90812	90813	90814	90815
90816	90817	90818	90819	90821	90822
90823	90824	90826	90827	90828	90829
90835	90841	90842	90843	90844	90845
90846	90847	90849	90853	90853	90855
90857	90865	90870	90871	90875	90876
90880	90882	90885	90887	90889	90899

Procedures/Diagnoses Subject to Psychiatric Limitation

Certain procedures other than those listed above may be subject to limitation, depending on the patient's diagnosis. The ICD-9-CM codes subject to the limitation are:

291.0-294.0 294.8-319

The limitation is applicable to the following procedures when psychiatric diagnosis codes are billed:

90862	99212	99213	99214	99215	99291
99292	99301	99302	99303	99311	99312
99313	99315	99316	99321	99322	99323
99331	99332	99333	99341	99342	99343
99344	99345	99347	99348	99349	99350
99354	99355	99356	99357	99358	99359
99361	99362	99371	99372	99373	99374
99375	99377	99378	99379	99380	99381
99382	99383	99384	99385	99386	99387
99391	99392	99393	99394	99395	99396
99397	99401	99402	99403	99404	99411
99412	99420	99429	99431	99432	99433
99435	99436	99440	99450	99455	99456

Diagnoses *Not* Subject to Psychiatric Limitation

The limitation applies only to *therapeutic* services and to services performed to evaluate the progress of a course of treatment for a diagnosed condition. Expenses for *diagnostic* services (e.g., psychiatric testing and evaluation to diagnose the patient's illness) are *not* subject to this limitation.

In addition, effective for services *processed* on or after July 6, 2004, diagnoses of Alzheimer's disease or related disorders are not subject to the limitation and include the following ICD-9-CM codes:

290.0-290.9 294.10-294.11 331.0 331.11-331.19 331.2

Prostate Brachytherapy Performed in an Ambulatory Surgical Centers

Brachytherapy performed for the treatment of prostate cancer includes low dose rate (permanent seed) and high dose rate (HDR) brachytherapy. This article addresses the treatment of prostate cancer utilizing low dose rate (permanent seed) brachytherapy performed at an ASC- an entity approved by Medicare as a supplier of certain ambulatory surgery services that bills the Part B carrier and is licensed by the state. *CPT 55859* (*Transperineal placement of needles or catheters into prostate for interstitial radio element application, with or without cystoscopy*) was added to the list of Medicare-approved ASC procedures effective July 1, 2003.

Patients with prostate cancers that are eligible for seed implantation fall within a set of guidelines established by the treating radiation oncologist and urologist. These guidelines determine candidates for the procedure versus those patients who may be best suited for an alternative therapy. The physicians present the recommendations to the patient.

After the urology diagnostic work-up and low dose rate brachytherapy has been chosen by the patient, there are several aspects to the episode of care including preplan, implant, and post implant (post plan). Preplan tumor mapping and simulations done prior to the implant should not be billed again at the time of the implant. Conversely, simulations done on the day of implant (real time) should not be billed a second time on a day prior to the implant. The implant is generally done on an outpatient basis without an overnight hospital stay at an outpatient hospital facility or an ASC. The radiation oncologist and urologist are both present for the case, and work as a team along with other specialized staff. Fifty to 150 seeds are inserted using 20-40 needles. This varies with the size and shape of the prostate and other factors. There are two types of radioactive material (radioisotopes) that can be implanted into the prostate: iodine (I-125) and palladium (Pd-103). Post implant, a second dataset is done to produce an accurate and safe plan (post plan). The documentation should support the simulation done.

Providers

Facilities enrolled as an ASC that meet the requirements to perform the procedure would bill for the ASC group 9 payment and receive 80% of the prospectively determined rate. Facility payment for radiation oncology technical services performed may be obtained by arrangement from the performing providers for the services outlined below if performed at the ASC during the implant. All such arrangements are subject to applicable Federal Self Referral Regulations and Antitrust guidelines. Additionally, any use of radioactive material requires full compliance with NRC (Nuclear Regulatory Commission) guidelines.

Until there is further refinement of the payment methodology, the urologist and radiation oncologist performing the procedure should bill the services performed with their carrier-assigned Provider Identification Number (PIN) with place of service 24 (ASC) on the line item (item 24B of Form CMS-1500, or electronic equivalent). Any service with an associated technical component should be billed globally with the intent that the professional component is for the physician and the technical component is for the ASC per the physician-ASC arrangement. (A facility enrolled as an ASC and as an IDTF [Independent Diagnostic Testing Facility] may qualify to bill for certain technical components. In this case, the physicians would bill for the performed professional component only.) In all cases, the radioisotope is billed by the provider licensed and trained in nuclear materials use (usually radiation oncologist) with place of service 24 (ASC).

Billing and Coding

The following billing and coding guidelines should assist facilities and physicians in reporting and receiving payment for all medical necessary and reasonable services performed and documented on eligible Medicare beneficiaries.

Day of Implant at the ASC:

CPT code *55859: Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy*	
If the billing provider is:	**Then claims submission and payment is:**
Facility enrolled as ASC	Group 9 Payment. Modifier SG is required in the first modifier position (ASC facility services only). Facility Reimbursement-Multiple Procedures- special rules apply if other approved ASC procedures are billed.
Urologist	Physician service, no technical component

CPT code *79900: Provision of therapeutic radiopharmaceutical(s)*	
If the billing provider is:	Then claims submission and payment is:
Provider licensed and trained for nuclear materials use, usually Radiation Oncologist	For electronic billing in item 19 narrative, list I-125 or Pd-103, # of seeds ordered, invoice price, # seeds used in procedure. It is recognized that a small number of additional seeds is ordered and billed to cover plan changes or intra-operative loss. Until standard pricing can be established, the contractor will request by mail additional documentation (operative note and seed invoice) to confirm billed amount and seed # used.

Other possible procedures if medically necessary:

CPT code *52001: Cystourethroscopy with irrigation and evacuation of multiple obstructing clots*	
CPT code *52310: Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from the urethra or bladder (separate procedure); simple*	
If the billing provider is:	Then claims submission and payment is:
Urologist	Professional Component only

Ultrasonic Guidance Procedures

CPT code *76965: Ultrasonic guidance for interstitial radioelement application*	
If the billing provider is:	Then claims submission and payment is:
Radiation Oncologist or Urologist	Global if performed day of implant at ASC

Clinical Brachytherapy

CPT code *77778: Interstitial radiation source application; complex*	
CPT code *77790: Supervision, handling, loading of radiation source*	
Radiation Oncologist	Global if performed day of implant at ASC

Treatment Devices

CPT code *77332: Treatment devices, design and construction; simple*	
Radiation Oncologist	Global if performed day of implant at ASC

Dosimetry

CPT code *77331: Special Dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician*	
Radiation Oncologist	Global if performed day of implant at ASC

Radiology, other procedures

CPT code *76000: Fluoroscopy (separate procedure) up to one hour physician time*	
Radiation Oncologist	Global if performed day of implant at ASC

The following procedure code is appropriate if *real time dosimetry* is utilized for implant (it should be billed only one time in the preplan/implant episode of care).

CPT code *77295: Therapeutic radiology simulation-aided field testing; three-dimensional*	
If the billing provider is:	Then claims submission and payment is:
Radiation Oncologist	Global if performed day of implant at ASC

The following procedure codes are appropriate if *real time dosimetry* is utilized for implant and 3D (*77295*) is not utilized (they should be billed only one time in the preplan/implant episode of care).

CPT code *77290: Therapeutic radiology simulation-aided field testing; complex*	
CPT code *77328: Brachytherapy isodose plan; complex*	
If the billing provider is:	Then claims submission and payment is:
Radiation Oncologist	Global if performed day of implant at ASC

Billing for Internet Surveillance of an Implanted Cardioverter Defibrillator Without Face-to-Face Contact

Traditional follow-up of an implanted cardioverter defibrillator (ICD) is done by way of a compatible programmer in a face-to-face encounter. Intervening symptoms, event markers, and device responses are evaluated and if necessary reprogramming of the device is initiated.

The Internet now provides a medium through which a physician can acquire device information from a patient's ICD without face-to-face contact. The patient may use a manufacturer's specific transmitter to send data to a central server. The physician, in turn, retrieves the data with an office computer. This information is identical to a face-to-face ICD interrogation without reprogramming.

Unless otherwise instructed in the future and until a unique *CPT* code(s) is established and issued for this surveillance of an ICD without face-to-face contact, Connecticut Medicare will reimburse for the Internet-based ICD device evaluation using the one of the following *CPT* codes:

93741 *Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, without reprogramming*

or

93743 *Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, without reprogramming*

The date of the retrieval of the data from the central server by the physician will be considered the date of service for the Internet-based modality. When a physician practice purchases the Internet server-based service and performs the professional service, it is appropriate to bill a global charge as the practice is incurring a practice expense. All such purchasing arrangements are subject to applicable Federal Self Referral Regulations and Antitrust guidelines. In cases where a hospital purchases the Internet server-based service, the hospital would bill the technical component (TC) and the physician would bill the professional component (PC) by using modifier 26.

97003: Occupational Therapy Evaluation

We recently received correspondence asking why procedure code *97003* (*occupational therapy evaluation*) is not allowed in an assisted living facility (ALF). In researching this, it was determined that *CPT* codes, *97001*, *97002*, and *97004* (*physical therapy evaluation*, *physical therapy re-evaluation*, and *occupational therapy re-evaluation*) are allowed in an ALF, therefore it would be appropriate for code *97003* to be performed in an ALF. Code *97003* is allowable for claims processed on or after March 23, 2004.

Prolonged Evaluation and Management Services

This is to clarify correct companion codes for prolonged services (codes *99354-99357*) as outlined in the American Medical Association's (AMA) *Current Procedural Terminology* (*CPT*) book. Prolonged services (*CPT* codes *99354-99357*) are payable when they are billed on the same day by the same provider as the companion evaluation and management codes.

99354 *Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient evaluation and management service)*

The required evaluation and management companion codes for *99354* are *99201-99215*, *99241-99245*, and *99301-99350*. *CPT* code *99355* is used in conjunction with code *99354*.

99356 *Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service; first hour (List separately in addition to code for inpatient evaluation and management service)*

The required evaluation and management companion codes for *99356* are *99221-99233*, *99251-99255*, and *99261-99263*. *CPT* code *99357* is used in conjunction with code *99356*.

Prolonged services (*CPT* codes *99354-99357*) are not payable unless they are accompanied by one of these companion codes.

Physician Delegation of Tasks in Skilled Nursing Facilities

The following information comes from a memo from the Survey and Certification Group, based on 42 C.F.R. 424.20, 424.20(e)(2), 483.40(c)(4) and (e), to clarify "Physician and Other Medically Necessary Visits in SNFs / NFs":

The initial comprehensive visit for a beneficiary being admitted to a skilled nursing facility (SNF) is performed by the physician, to assess the beneficiary, develop a plan of care, and verify admitting orders. The physician must perform this initial visit no later than 30 days after admission. However, nonphysician practitioners may perform other medically necessary visits prior to and after the physician's initial comprehensive visit. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and a physician assistant, nurse practitioner, or clinical nurse specialist licensed as such by the state and performing within the scope of their practice.

At the option of the state, performance of any required physician task in a nursing facility (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

Certifications/recertifications in SNFs may be signed by:

- The physician responsible for the case, or with his or her authorization, by a physician on the SNF staff,
- A physician who is available in case of an emergency who has knowledge of the case, or
- A nurse practitioner or clinical nurse specialist who do not have a direct or indirect employment relationship with the facility, but who work in collaboration with a physician, when permitted under the scope of practice for the state.

CORRECTIONS

Local Medical Review Policy Implementation Correction—Process Date to Date of Service

The effective date for local medical review policies (LMRP) implemented by Connecticut Medicare since November 1, 2003, has been for services *rendered* (date of service) on or after the published effective date. However, the effective date for most LMRPs implemented prior to November 1, 2003, was published as "effective for claims *processed* on or after" the published effective date.

Beginning March 15, 2003, unless otherwise directed by CMS, the effective date for all LMRPs in effect for claims *processed* on or after that date will be changed to reflect that the effective date for these policies will be based on the date the service was *rendered*.

Providers can visit *http://www.connecticutmedicare.com* or the CMS Medical Coverage Database (MCD) at *http://www.cms.hhs.gov/mcd* to locate current and prior versions of LMRPs/local coverage determinations (LCDs). The carrier will apply the version of the medical policy/coverage determination that was in effect at the time the service was rendered.

Tips for using the CMS MCD site:

1. Select "Local Coverage."
2. Select "Policies" (LMRP/LCD), "Final Policies Only."
3. Select by "Contractor" - First Coast Service Options, Inc. (00591, carrier). Do *not* select by the "Geographic Area" (state).
4. Select "*CPT*/HCPCS" and then enter the *CPT* code you are researching.
5. Click on the "Search Now" button.
6. Click on the LMRP number underlined and in red, accept the *CPT* and CDT licensing agreement, and you will be viewing the most current version of the policy.
7. To find prior versions of the medical policy go to the end of the current LMRP and click on the version that was in effect at the time your service was rendered.

Please contact the Customer Service department at 1 (866) 419-9455 for help navigating this Web site, or if you have questions about how to obtain LMRP/LCD information.

70544: Magnetic Resonance Angiography (MRA)—Correction

An article was published in the First Quarter 2004 *Medicare B Update!* (page 57) for expanded coverage for MRA to include MRA of the pelvis (*CPT* code *72198*). However, some of the ICD-9-CM codes that support medical necessity for MRA of the abdomen were incorrectly listed for the pelvis as well.

The correct ICD-9-CM codes that support medical necessity for *CPT* code *72198 (Magnetic resonance angiography, pelvis with or without contrast material[s])* are:

233.9	Carcinoma in situ of other and unspecified urinary organs
236.90-236.99	Neoplasm of uncertain behavior of other and unspecified urinary organs
442.2	Other aneurysm of iliac artery
443.22	Dissection of iliac artery
444.81	Arterial embolism and thrombosis of iliac artery

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.*

LOCAL MEDICAL REVIEW POLICY (NEW)

33215: Implantation of Automatic Defibrillators

The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. This device consists of a pulse generator and electrodes for sensing and defibrillations.

This local coverage determination (LCD) was developed to communicate CMS guidelines and indications, and establish the ICD-9-CM codes that support medical necessity for this service. ICD-9-CM codes 412, 425.1, 425.4, 427.1, 427.5, 794.31, 996.01, 996.04, V53.31, and V53.32 have been identified locally as codes that support medical necessity.

This LCD was based on Transmittal 173, Change Request 2880, dated August 22, 2003, which expanded indications and limitations for coverage and/or medical necessity for services performed on or after October 1, 2003.

The full-text LCD is available on our provider education Web site at *http://www.connecticutmediare.com* and is effective for services rendered on or after July 6, 2004.

93501: Cardiac Catheterization

Cardiac catheterization is a technique in which a flexible catheter is passed along veins or arteries into the heart and associated vessels, for the measurement of physiological data and imaging of the heart and great vessels. This technique is utilized when there is a need to confirm the presence of a clinically suspected condition, define its anatomical and physiological severity, and determine the presence of associated conditions.

Policy was developed to define the indications and limitations of coverage and/or medical necessity, and documentation requirements for cardiac catheterization. Widespread probe results revealed medical record documentation did not support medical necessity for performing extracardiac angiography at the time of cardiac catheterization.

This policy is being published in the local coverage determination (LCD) format and is effective for services rendered on or after July 6, 2004. The full-text LCD is available on our provider education Web site at *http://www.connecticutmedicare.com*.

ALEFACEPT

Psoriasis is a chronic immune-mediated disease of the skin affecting an estimated 2% of the population. It has been treated with topical, photo, and systemic therapies. The topical therapies include tars, salicylic acid, corticosteroids, calcipotriene, tazarotene, and anthralin. Phototherapies include UVB, psoralens plus UVA (PUVA), and more recently laser therapy for localized lesions. Systemic therapies include drugs such as methotrexate, cyclosporine, retinoids, and an emerging class of biologic drugs including etanercept (Enbrel®) and now alefacept (manufactured by Biogen under the trade name Amevive®). Some of the therapies are used in combination to minimize toxicities while maximizing response, or as rotational therapy.

Alefacept is a human fusion protein directed at T-cells expressing the CD2 antigen, preventing lymphocyte activation. These lymphocytes are involved in the inflammatory process in psoriatic lesions. Alefacept is administered as an intramuscular injection of 15mg at weekly intervals, for a total of 12 consecutive weeks. Because **alefacept** may reduce circulating CD4+ and CD8+ T-lymphocytes, weekly CD4+ tests are required for monitoring while administering the drug. **Alefacept** has been approved by the FDA for treatment of adult

patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy.

Alefacept is billed using HCPCS code J0215 (Injection, Alefacept, 0.5 mg). This local coverage determination (LCD) is being developed to allow providers access to this new therapy and to provide indications and limitations for this service.

This LCD is effective for services rendered on or after July 6, 2004. The full-text LCD is available on our provider education Web site at *http://www.connecticutmedicare.com*.

BEXXAR: Tositumomab and Iodine I 131 Tositumomab (BEXXAR®) Therapy

The Bexxar® therapeutic regimen (Tositumomab and Iodine I 131 Tositumomab) is an anti-neoplastic radioimmunotherapeutic monoclonal antibody-based regimen composed of the monoclonal antibody, Tositumomab, and the radiolabeled monoclonal antibody, Iodine I 131 Tositumomab. The regimen is administered in two discrete steps: the dosimetric and therapeutic steps. Each step consists of a sequential infusion of Tositumomab followed by Iodine I 131 Tositumomab. The therapeutic step is administered 7-14 days after the dosimetric step.

The Bexxar® therapeutic regimen is indicated for the treatment of patients with CD20 positive, follicular, non-Hodgkin's lymphoma, with and without transformation, whose disease is refractory to Rituximab and has relapsed following chemotherapy. It is not indicated for the initial treatment of patients with CD20 positive non-Hodgkin's lymphoma.

The Bexxar® therapeutic regimen was FDA approved on June 27, 2003. Because this is a new treatment regimen, there is no utilization data available. This policy was developed to allow providers access to this new therapy, to define the indications and limitations of coverage for this therapy, and to provide appropriate coding guidelines for this therapy.

The following *CPT*/HCPCS codes are included in the LCD:

Dosimetric Step
A9533, G3001, *78804*, *77300*

Therapeutic Step
A9534, G3001, *79403*

The following are ICD-9-CM Codes that Support Medical Necessity:
200.00-200.88, 202.00-202.08, 202.80-202.88

This local coverage determination (LCD) is effective for services rendered on or after July 6, 2004. The full-text LCD is available on our provider education Web site at *http://www.connecticutmedicare.com*.

Botulinum Toxins

Botulinum toxins – botulinum toxin type A (Botox) and botulinum toxin type B (Myobloc) – are two of seven distinct immunologic serotypes produced by the anaerobic organism Clostridium botulinum. Botulinum toxin type A and Botulinum toxin type B injections are used to treat various focal muscle spastic disorders and excessive muscle contractions such as dystonias, spasms, twitches, etc. When administered intramuscularly or subcutaneously, these toxins produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. The resulting chemical-denervation of muscle produces local paresis or paralysis and allows individual muscles to be weakened selectively.

Policy has been developed to provide indications and limitations of coverage and clarify the appropriate use of botulinum toxins. The appropriate HCPCS codes used to report botulinum toxins are:

J0585 Botulinum toxin type, A per unit
J0587 Botulinum toxin type B, per 100 units

This policy is effective for services rendered on or after July 6, 2004. The full-text of this local coverage determination (LCD) is available on our provider education Web site at *http://www.connecticutmedicare.com*.

LOCAL MEDICAL REVIEW POLICY (REVISED)

15822: Upper Eyelid and Brow Procedures

The local medical review policy (LMRP) for upper eyelid and brow procedures was last revised December 5, 2002. This major revision of existing policy further defines the indications and limitations of coverage and clarifies documentation required to support medical necessity. The requirement to submit photographs with the upper eyelid and brow procedure claim has been eliminated. However, photographs are still required to be a part of the medical record and must be submitted when requested by the medical review staff.

This policy revision was presented to the November 2003 Carrier Advisory Committee.

This policy revision is being published in the local coverage determination (LCD) format for Connecticut and is effective for services rendered on or after July 6, 2004. The full text LCD is available on our provider education Web site at *http://www.connecticutmedicare.com*.

55700: Ultrasound Guided Prostate Needle Biopsy

The local medical review policy (LMRP) for ultrasound guided prostate needle biopsy was last updated October 1, 2003. Since that time, the descriptor for *CPT* code *76872 (Ultrasound, transrectal)* has changed. The "Coding Guidelines" section of this policy has been revised accordingly.

The full-text of this LMRP may be found on the provider education Web site at *http://www.connecticutmedicare.com*. These changes are effective for services rendered on or after January 1, 2004.

62263: Epidural

This local medical review policy (LMRP) was revised, along with numerous other pain management policies, with an effective date of September 29, 2003. Some of the policies contained duplicate procedure codes. Since then, this policy has been reviewed and duplicate codes have been identified. Therefore, the policy has been revised.

This revision includes the removal of procedure codes *62350*, *62351*, *62355*, *01996*, *62360*, *62365*, and *96520*. In addition, ICD-9-CM code range 789.00-789.05 (Abdominal pain) and V58.49 (Other specified aftercare following surgery) have been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

In addition, this policy has been changed from the LMRP to the local coverage determination (LCD) format.

The full-text LCD is available on our provider education Web site at *http://www.connecticutmedicare.com* and is effective for services rendered on or after September 29, 2003.

80100: Qualitative Drug Screen

It has come to our attention that an article informing providers of the implementation of a local medical review policy (LMRP) for qualitative drug screen was not published prior to implementation of the policy. This article serves as a 45-day notice for the implementation of the qualitative drug screen policy.

In addition, the LMRP has been changed to the local coverage determination (LCD) format and ICD-9-CM code 780.39 (other convulsions) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy. The addition of this diagnosis code appropriately reflects the condition "seizures with an undetermined history," which is currently listed under the "Indications and Limitations of Coverage and/or Medical Necessity" section.

The full-text LMRP/LCD is available on our provider education Web site at *http://www.connecticutmedicare.com* and is effective for services rendered on or after July 6, 2004.

83735: Serum Magnesium

The local medical review policy (LMRP) for serum magnesium was last updated October 1, 2002. Since that time, diagnosis codes 656.33 and 656.43 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure code *83735*.

The full-text LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*. These changes are effective for claims processed on or after March 8, 2004.

92499: Computerized Corneal Topography (formerly 95LMRP007 V1.2 Corneal Topography)

The last revision for local medical review policy (LMRP) for corneal topography was effective July 24, 1998. Revisions have since been made in the following sections of the policy:

- Number and Title of policy
- CMS National Coverage Policy
- LMRP Description
- Indications and Limitations
- Reasons for Denials
- Noncovered ICD-9 Codes
- Coding Guidelines
- Documentation Requirements
- Utilization Guidelines
- Other comments
- Sources of Information
- Additional ICD-9-CM codes have been added to the "ICD-9 Codes that Support Medical Necessity" section that include: 367.21, 367.22, 371.48, 371.52, 371.60, 371.71, 372.42, V45.61, and V45.69.

These revisions are effective for services rendered on or after May 3, 2004. The full-text LMRP is available on our provider education Web site *http://www.conecticutmedicare.com*.

93000: Electrocardiography

The local medical review policy (LMRP) for electrocardiography was last updated October 1, 2003. Since that time, diagnosis code 729.5 has been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure codes *93000*, *93005*, and *93010*.

These changes are effective for claims processed on or after March 8, 2004. The full-text LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*.

93724: Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator

This local medical review policy (LMRP) was last revised effective September 23, 2002. Since that time, the policy has been revised.

This policy was revised based on an inquiry from the manufacturer regarding proper billing for Web-based surveillance of the pacing cardioverter-defibrillator system. It was determined that this service is identical to the face-to-face ICD interrogation without reprogramming service. Therefore, this policy has been revised to add additional language and coding guidelines for the Web-based modality.

Procedure codes *93741* and *93743* are included in the policy and should be used rather than an unlisted code.

The full-text LMRP is available on our provider education Web site at *http://ww.connecticutmedicare.com*. This revision is effective for claims processed on or after March 23, 2004.

93925: Duplex Scan of Lower Extremity Arteries

This local medical review policy (LMRP) was last revised effective September 29, 2003. Since that time, the policy has been revised to include ICD-9-CM code 785.9 (other symptoms involving cardiovascular system) under the "ICD-9 Codes that Support Medical Necessity" section of the policy. This change is based on a request from a provider to add this ICD-9-CM code since it describes an indication already stated in the policy.

The full-text LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*. This revision is effective for claims processed on or after April 12, 2004.

97001: Physical Medicine and Rehabilitation

The local medical review policy (LMRP) for physical medicine and rehabilitation was last revised January 1, 2004. Since that time, language changes have been made to the policy to reflect clarifications per CMS Change Request 2859/2779. These changes clarify the time period when a physician must evaluate the patient and corrects omission of nonphysician practitioners. In addition, the policy has been converted to the local coverage decision (LCD) format.

The full-text LCD is available on our provider education Web site at *http://www.connecticutmedicare.com*. These changes are effective for claims processed on or after February 11, 2004.

98940: Chiropractic Services

The latest revision for local medical review policy (LMRP) Chiropractic Services was effective October 20, 2003. Revisions have since been made in the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the policy to clarify that the precise level of subluxation does not have to be on the claim form, but must be cited in the patient's medical record.

These revisions are effective for services rendered on or after April 12, 2004. The full-text LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*.

EATSV: Endovenous Ablation Therapy of the Saphenous Vein (formerly ERASV: Endoluminal Radiofrequency of the Saphenous Vein)

The local medical review policy (LMRP) for endoluminal radiofrequency of the saphenous vein became effective on January 1, 2004. The LMRP provides coverage for endoluminal *radiofrequency* ablation therapy of the saphenous vein. Since development of the policy, additional studies have been completed that support endovenous *laser* ablation therapy as treatment for varicose veins and viscosities associated with superficial reflux of the greater saphenous vein.

This revision expands coverage to include endovenous laser ablation treatment of varicose veins and viscosities associated with superficial reflux of the greater saphenous vein. The policy title and number have been changed accordingly.

This policy is being published in the local coverage determination (LCD) format for Connecticut and is effective for services rendered on or after April 20, 2004. The full-text LCD is available on our provider education Web site at *http://www.connecticutmedicare.com*.

EPO: Epoetin alfa

The local medical review policy (LMRP) for Epoetin alfa was last updated January 5, 2004. Since then, the LMRP has been converted to the local coverage determination (LCD) format.

The LCD for Epoetin alfa contains an indication for "reduction of allogeneic blood transfusion in surgery patients." Providers have previously been instructed to bill using ICD-9-CM codes E878.1 and E878.8 for this indication. It has come to our attention that these codes are not appropriate to bill as primary diagnosis codes; therefore, **effective July 6, 2004, providers are instructed to bill ICD-9-CM code V07.8 for this indication.** After this date, ICD-9-CM codes E878.1 and E878.8 will no longer be allowed for this indication.

The revised LCD is effective for services rendered on or after July 6, 2004. The full-text LCD is available on Web site at *http://www.connecticutmedicare.com*.

J0150: Adenosine (Adenocard®, Adenoscan®

The local medical review policy (LMRP) for Adenosine was last updated January 1, 2004. Since that time, code J0152 has been added to the "Coding Guidelines" section of the policy for clarification, effective for claims processed on or after March 8, 2004.

The full-text LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*.

J2430: Pamidronate (Aredia®, APD)

The local medical review policy (LMRP) for Pamidronate was last revised September 30, 2003. Pamidronate, a bisphosphonate which is administered intravenously, is used to inhibit bone resorption and to decrease serum calcium. In Paget's disease (osteitis deformans), Pamidronate reduces the rate of bone turnover by an initial blocking of bone resorption, resulting in a decrease in serum alkaline phosphatase and a decrease in urinary hydroxyproline excretion. Pamidronate is indicated for the treatment of the following FDA-approved indications:

- Hypercalcemia of malignancy, with or without bone metastases, that is inadequately controlled by hydration alone
- Symptomatic Paget's disease (osteitis deformans) characterized by abnormal and accelerated bone metabolism in one or more bones. Signs and symptoms may include bone pain, deformity, and/or fractures; neurologic disorders associated with skull lesions and spinal deformities
- Adjunct treatment of osteolytic lesions of breast cancer or myeloma

Statistical medical data obtained for dates of service from January 1, 2003, to June 30, 2003 for HCPCS code J2430 (Injection, pamidronate disodium, per 30 mg) found an aberrancy ratio of 2.09 (Connecticut to the Nation Ratio of Allowed Dollars Per 1,000 Enrollees). For the same timeframe, HCPCS code J2430 was billed 6,278 times, with 5,419 of the services allowed. Due to these findings, the policy was revised to further define the indications and limitations of coverage and clarify the appropriate use of Pamidronate.

HCPCS code J2430 may be billed with the following ICD-9-CM codes:

174.0-174.9*	Malignant neoplasm of female breast
175.0-175.9*	Malignant neoplasm of male breast
198.5*	Secondary malignant neoplasm of bone and bone marrow
203.00-203.01*	Multiple myeloma
275.42	Hypercalcemia (associated with malignancy)
731.0	Osteitis deformans without mention of bone tumor (Paget's disease of bone)
V10.3*	Personal history of malignant neoplasm; breast

*__Note__: The billing of Pamidronate for osteolytic lesions of breast cancer or myeloma requires a dual diagnosis. ICD-9-CM code 198.5 must be billed with the related neoplasm code (174.0-174.9, 175.0-175.9, 203.00-203.01, or V10.3). The starred (*) ICD-9-CM codes listed above may *not* be billed alone.

This policy was discussed at the Carrier Advisory Committee (CAC) meeting on November 18, 2003. The LMRP has been converted to the local coverage decisions (LCD) format. These revisions are effective for services rendered on or after July 6, 2004. The full-text LCD is available on our provider education Web site at *http://www.connecticutmedicare.com*.

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

The local medical review policy (LMRP) for Darbepoetin alfa was last updated January 1, 2004. Since then, the policy has been converted into the LCD format. In addition, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy has been updated to include the following:

- An indication for "anemia associated with malignancy." ICD-9-CM range 140.0-239.9 (Neoplasms) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD to support this indication, and
- To initiate therapy with Darbepoetin alfa, for indications other than ESRD on dialysis, the patient must have a documented anemia as evidenced by symptoms and a hematocrit (HCT) of less than 33% or a hemoglobin (HGB) less than 11 g/dL.

These revisions are effective for services rendered on or after February 2, 2004. The full-text LCD is available on our provider education Web site at *http://www.connecticutmedicare.com*.

92225: Ophthalmoscopy (formerly 95LMRP008V1.3 Extended Ophthalmoscopy/Indirect Ophthalmoscopy-Three mirror lens examination with slit lamp)

The latest revision to the local medical review policy (LMRP) for ophthalmoscopy was effective January 1, 1999. Since then, the policy has been revised as a result of a widespread probe performed for procedure codes *92225* and *92226*. Changes include revisions to the following sections of the policy:

- Name and Number of LMRP
- LMRP Description
- Reasons for Denials
- Coding Guidelines
- Documentation Requirements
- Utilization Guidelines and Other Comments
- Indications and Limitations
- ICD-9 Codes that Support Medical Necessity

These revisions are effective for services rendered on or after March 1, 2004. The full-text LMRP is available on our provider education Web site at *http://www.conecticutmedicare.com*.

92136: Optical Coherence Biometry

The latest revision to the local medical review policy (LMRP) for optical coherence biometry was effective March 1, 2003. This policy has been revised in accordance with the first update to the 2004 Medicare Physician Fee Schedule Database (CMS Change Request 3128, dated February 20, 2004), which indicates that the bilateral surgery indicator for this service has been changed to '3' (unilateral service).

This revision is effective for services rendered on or after January 1, 2004. The full-text LMRP is available on our provider education Web site *http://www.connecticutmedicare.com*.

LOCAL MEDICAL REVIEW POLICY (RETIRED)

61850: Implantation of Neurostimulator Electrodes

This local medical review policy (LMRP) has been retired effective September 29, 2003. It has been determined that this policy is no longer needed. This policy contains coding that is duplicative of policy 95LMRP010V1.0 (electrical neurostimulation). The electrical neurostimulation policy was retired, based on numerous policy revisions done in conjunction with the Connecticut pain management consultant, which was effective September 29, 2003. Therefore, LMRP *61850* is retired, effective for services rendered on or after September 29, 2003.

94LMRP005 V1.0-90887: Caregivers Education for Psychiatric Patients

The local medical review policy (LMRP) for caregivers education for psychiatric patients is being retired, effective for services rendered on or after March 23, 2004. This policy is being retired because *CPT* code *90887* is code status "B" on the Medicare Physician Fee Schedule Database (MPFSDB) and is therefore considered "always bundled into payment for other services not specified."

The full-text LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*.

94LMRP005 V1.0-90889: Report Preparation

The local medical review policy (LMRP) for report preparation is being retired effective for services rendered on or after March 23, 2004. This policy is being retired because *CPT* code *90889* is code status "B" on the Medicare Physician Fee Schedule Database (MPFSDB) and is therefore considered "always bundled into payment for other services not specified."

The full-text of this LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*.

92980: Interventional Cardiology in the Treatment of Ischemic Heart Disease

The local medical review policy (LMRP) for interventional cardiology in the treatment of ischemic heart disease is being retired, effective for services rendered on or after April 12, 2004. This policy is being retired based on local standards of care and data analysis.

The full-text of this LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*.

CONNECTICUT EDUCATIONAL RESOURCES

Event: **Basic Medicare Workshop Two-Part Series**

Free Event for Part B Providers
Continuing Education Units (CEUs) for members of the American Academy of Professional Coders (pending approval)

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

Designed for New Providers, Office Billing Staff and other Medicare professionals

Five Reasons Why You Should Attend:

1. Learn how to properly complete a Form CMS-1500
2. Identify and avoid the most common billing errors
3. Learn what is missing from your unprocessable claims
4. Enhance your office reimbursement efficiency
5. *AAPC Members only* receive CEUs (pending approval)

Registration: Don't delay—register today. Seating is limited to first 100 registrants. All sessions are free of charge!
Visit our Web site at *http://www.connecticutmedicare.com* and register online, or fax your registration to 1 (203) 634-5496
If you need further assistance, please call our Education and Outreach Department at 1 (203) 634-5430 or 1 (203) 634-5514

Location: ***Water's Edge Resort***
1525 Boston Post Road
Westbrook, Connecticut 06490

Call resort for driving directions: 1 (860) 399-8901
Lunch is on your own (call hotel for reservations if you plan to eat at the Water's Edge for lunch)
Free parking on premises

Agenda: ***Part 1 Wednesday, May 19, 2004***
Participant sign-in begins at 8:30 a.m.

AM Session 9:00 a.m. to 12:00 p.m.

- ❑ CMS 1500 Claims Processing, Reimbursement Office Efficiency, Interactive Session

Lunch Break

PM Session 1:00 p.m. to 4:00 p.m.

- ❑ Provider Enrollment, Inquiries, Appeals, Overpayments/ Refunds/Offsets, Interactive Session

Agenda: ***Part 2 Wednesday, June 23, 2004***
Participant sign-in begins at 8:30 a.m.

AM Session 9:00 a.m. to 12 p.m.

- ❑ Evaluation/Management Coding and Documentation, "Incident To" Guidelines, Non-Physician Practitioners, Interactive Session

Lunch Break

PM Session 1:00 p.m. to 4:00 p.m.

- ❑ Medical Review, Frequently Used Modifiers, Global Surgery Guidelines, Interactive Session

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)
First Coast Service Options, Inc.
Medicare Part B
P.O. Box 9000
Meriden, CT 06454-9000

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 Local Medical Review Policies 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.

Attention: 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.

MAILING ADDRESS EXCEPTIONS

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

Attention: Review

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

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.

Post Office Box for Reviews:

Attention: Appeals
First Coast Service Options, Inc.
P.O. Box C-1016
Meriden, CT 06450-1016

Attention: EDI

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

Post Office Box for EDI:

Attention: CT Medicare EDI
First Coast Service Options, Inc.
P.O. Box 44071
Jacksonville, FL 32231-4071

CONNECTICUT MEDICARE PHONE NUMBERS

Provider Services

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

Beneficiary Services

First Coast Service Options, Inc.
Medicare Part B
1-800-982-6819 ***(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

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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.

Implementation of Local Coverage Determinations

The Benefit Improvement Protection Act (BIPA) section 522 created local coverage determinations (LCD) that consist only of reasonable and necessary information. LCDs will replace the local medical review policies (LMRP). First Coast Service Options, Inc. (FCSO) will be converting the

existing LMRPs to LCDs over the next two years. The LCD format is similar to the LMRP format. The format changes will consist of section title changes and the deletion of some sections. Where deleted sections contain significant information, this will be incorporated into the "Indications and Limitation of Coverage and/or Medical Necessity" section of the LCD.

If there are "Coding or Billing Instructions," these will appear in a companion article entitled with the policy name/LCD title. At the end of the LCD under the section entitled "LCD Attachments," there will be a statement indicating whether or not there is a companion article for this LCD. If there is a companion article, the title will be given. On the Web site, you will be able to click on the title of the companion document to view the corresponding guidelines. Please note that you can only access the coding instructions from the policy with which the guidelines correspond.

Source: CMS Pub. 100-08, Transmittal 63, CR 3010

Outpatient Psychiatric Services Limitation

The outpatient psychiatric services limitation, where 62.5 percent of the allowed amount is reimbursed to providers, is based on actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders, while not an inpatient of a hospital at the time such expenses are incurred. This limitation is also called the outpatient mental health treatment limitation. It is applicable when the place of service is other than inpatient hospital (place of service code 21), inpatient psychiatric facility (POS 51), or comprehensive inpatient rehabilitation facility (POS 61).

Procedure Codes Subject to Psychiatric Limitation

The procedure codes listed below, by virtue of their description, are *always* subject to limitation when the POS is other than 21, 51, or 61:

G0071	G0072	G0073	G0074	G0075	G0076
G0077	G0078	G0079	G0080	G0081	G0082
G0083	G0084	G0085	G0086	G0087	G0088
G0089	G0090	G0091	G0092	G0093	G0094
G0115	G0116	H5010	H5020	H5025	00104
90804	90805	90806	90807	90808	90809
90810	90811	90812	90813	90814	90815
90816	90817	90818	90819	90821	90822
90823	90824	90826	90827	90828	90829
90835	90841	90842	90843	90844	90845
90846	90847	90849	90853	90853	90855
90857	90865	90870	90871	90875	90876
90880	90882	90885	90887	90889	90899

Procedures/Diagnoses Subject to Psychiatric Limitation

Certain procedures other than those listed above may be subject to limitation, depending on the patient's diagnosis. The ICD-9-CM codes subject to the limitation are:

291.0-294.0 294.8-319

The limitation is applicable to the following procedures when psychiatric diagnosis codes are billed:

90862	99212	99213	99214	99215	99291
99292	99301	99302	99303	99311	99312
99313	99315	99316	99321	99322	99323
99331	99332	99333	99341	99342	99343
99344	99345	99347	99348	99349	99350
99354	99355	99356	99357	99358	99359
99361	99362	99371	99372	99373	99374
99375	99377	99378	99379	99380	99381
99382	99383	99384	99385	99386	99387
99391	99392	99393	99394	99395	99396
99397	99401	99402	99403	99404	99411
99412	99420	99429	99431	99432	99433
99435	99436	99440	99450	99455	99456

Diagnoses *Not* Subject to Psychiatric Limitation

The limitation applies only to *therapeutic* services and to services performed to evaluate the progress of a course of treatment for a diagnosed condition. Expenses for *diagnostic* services (e.g., psychiatric testing and evaluation to diagnose the patient's illness) are *not* subject to this limitation.

In addition, effective for services *processed* on or after July 6, 2004, diagnoses of Alzheimer's disease or related disorders are not subject to the limitation and include the following ICD-9-CM codes:

290.0-290.9 294.10-294.11 331.0 331.11-331.19 331.2

Prostate Brachytherapy Performed in an Ambulatory Surgical Centers

Brachytherapy performed for the treatment of prostate cancer includes low dose rate (permanent seed) and high dose rate (HDR) brachytherapy. This article addresses the treatment of prostate cancer utilizing low dose rate (permanent seed) brachytherapy performed at an ASC- an entity approved by Medicare as a supplier of certain ambulatory surgery services that bills the Part B carrier and is licensed by the state. *CPT 55859* (*Transperineal placement of needles or catheters into prostate for interstitial radio element application, with or without cystoscopy*) was added to the list of Medicare-approved ASC procedures effective July 1, 2003.

Patients with prostate cancers that are eligible for seed implantation fall within a set of guidelines established by the treating radiation oncologist and urologist. These guidelines determine candidates for the procedure versus those patients who may be best suited for an alternative therapy. The physicians present the recommendations to the patient.

After the urology diagnostic work-up and low dose rate brachytherapy has been chosen by the patient, there are several aspects to the episode of care including preplan, implant, and post implant (post plan). Preplan tumor mapping and simulations done prior to the implant should not be billed again at the time of the implant. Conversely, simulations done on the day of implant (real time) should not be billed a second time on a day prior to the implant. The implant is generally done on an outpatient basis without an overnight hospital stay at an outpatient hospital facility or an ASC. The radiation oncologist and urologist are both present for the case, and work as a team along with other specialized staff. Fifty to 150 seeds are inserted using 20-40 needles. This varies with the size and shape of the prostate and other factors. There are two types of radioactive material (radioisotopes) that can be implanted into the prostate: iodine (I-125) and palladium (Pd-103). Post implant, a second dataset is done to produce an accurate and safe plan (post plan). The documentation should support the simulation done.

Providers

Facilities enrolled as an ASC that meet the requirements to perform the procedure would bill for the ASC group 9 payment and receive 80% of the prospectively determined rate. Facility payment for radiation oncology technical services performed may be obtained by arrangement from the performing providers for the services outlined below if performed at the ASC during the implant. All such arrangements are subject to applicable Federal Self Referral Regulations and Antitrust guidelines. Additionally, any use of radioactive material requires full compliance with NRC (Nuclear Regulatory Commission) guidelines.

Until there is further refinement of the payment methodology, the urologist and radiation oncologist performing the procedure should bill the services performed with their carrier-assigned Provider Identification Number (PIN) with place of service 24 (ASC) on the line item (item 24B of Form CMS-1500, or electronic equivalent). Any service with an associated technical component should be billed globally with the intent that the professional component is for the physician and the technical component is for the ASC per the physician-ASC arrangement. (A facility enrolled as an ASC and as an IDTF [Independent Diagnostic Testing Facility] may qualify to bill for certain technical components. In this case, the physicians would bill for the performed professional component only.) In all cases, the radioisotope is billed by the provider licensed and trained in nuclear materials use (usually radiation oncologist) with place of service 24 (ASC).

Billing and Coding

The following billing and coding guidelines should assist facilities and physicians in reporting and receiving payment for all medical necessary and reasonable services performed and documented on eligible Medicare beneficiaries.

Day of Implant at the ASC:

CPT code *55859: Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy*	
If the billing provider is:	**Then claims submission and payment is:**
Facility enrolled as ASC	Group 9 Payment. Modifier SG is required in the first modifier position (ASC facility services only). Facility Reimbursement-Multiple Procedures- special rules apply if other approved ASC procedures are billed.
Urologist	Physician service, no technical component

CPT code *79900: Provision of therapeutic radiopharmaceutical(s)*	
If the billing provider is:	Then claims submission and payment is:
Provider licensed and trained for nuclear materials use, usually Radiation Oncologist	For electronic billing in item 19 narrative, list I-125 or Pd-103, # of seeds ordered, invoice price, # seeds used in procedure. It is recognized that a small number of additional seeds is ordered and billed to cover plan changes or intra-operative loss. Until standard pricing can be established, the contractor will request by mail additional documentation (operative note and seed invoice) to confirm billed amount and seed # used.

Other possible procedures if medically necessary:

CPT code *52001: Cystourethroscopy with irrigation and evacuation of multiple obstructing clots*	
CPT code *52310: Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from the urethra or bladder (separate procedure); simple*	
If the billing provider is:	Then claims submission and payment is:
Urologist	Professional Component only

Ultrasonic Guidance Procedures

CPT code *76965: Ultrasonic guidance for interstitial radioelement application*	
If the billing provider is:	Then claims submission and payment is:
Radiation Oncologist or Urologist	Global if performed day of implant at ASC

Clinical Brachytherapy

CPT code *77778: Interstitial radiation source application; complex*	
CPT code *77790: Supervision, handling, loading of radiation source*	
Radiation Oncologist	Global if performed day of implant at ASC

Treatment Devices

CPT code *77332: Treatment devices, design and construction; simple*	
Radiation Oncologist	Global if performed day of implant at ASC

Dosimetry

CPT code *77331: Special Dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician*	
Radiation Oncologist	Global if performed day of implant at ASC

Radiology, other procedures

CPT code *76000: Fluoroscopy (separate procedure) up to one hour physician time*	
Radiation Oncologist	Global if performed day of implant at ASC

The following procedure code is appropriate if *real time dosimetry* is utilized for implant (it should be billed only one time in the preplan/implant episode of care).

CPT code *77295: Therapeutic radiology simulation-aided field testing; three-dimensional*	
If the billing provider is:	Then claims submission and payment is:
Radiation Oncologist	Global if performed day of implant at ASC

The following procedure codes are appropriate if *real time dosimetry* is utilized for implant and 3D (*77295*) is not utilized (they should be billed only one time in the preplan/implant episode of care).

CPT code *77290: Therapeutic radiology simulation-aided field testing; complex*	
CPT code *77328: Brachytherapy isodose plan; complex*	
If the billing provider is:	Then claims submission and payment is:
Radiation Oncologist	Global if performed day of implant at ASC

Billing for Internet Surveillance of an Implanted Cardioverter Defibrillator Without Face-to-Face Contact

Traditional follow-up of an implanted cardioverter defibrillator (ICD) is done by way of a compatible programmer in a face-to-face encounter. Intervening symptoms, event markers, and device responses are evaluated and if necessary reprogramming of the device is initiated.

The Internet now provides a medium through which a physician can acquire device information from a patient's ICD without face-to-face contact. The patient may use a manufacturer's specific transmitter to send data to a central server. The physician, in turn, retrieves the data with an office computer. This information is identical to a face-to-face ICD interrogation without reprogramming.

Unless otherwise instructed in the future and until a unique *CPT* code(s) is established and issued for this surveillance of an ICD without face-to-face contact, Florida Medicare will reimburse for the Internet-based ICD device evaluation using the one of the following *CPT* codes:

93741 *Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, without reprogramming*

or

93743 *Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, without reprogramming*

The date of the retrieval of the data from the central server by the physician will be considered the date of service for the Internet-based modality. When a physician practice purchases the Internet server-based service and performs the professional service, it is appropriate to bill a global charge as the practice is incurring a practice expense. All such purchasing arrangements are subject to applicable Federal Self Referral Regulations and Antitrust guidelines. In cases where a hospital purchases the Internet server-based service, the hospital would bill the technical component (TC) and the physician would bill the professional component (PC) by using modifier 26.

97003: Occupational Therapy Evaluation

We recently received correspondence asking why procedure code *97003* (*occupational therapy evaluation*) is not allowed in an assisted living facility (ALF). In researching this, it was determined that *CPT* codes, *97001*, *97002*, and *97004* (*physical therapy evaluation*, *physical therapy re-evaluation*, and *occupational therapy re-evaluation*) are allowed in an ALF, therefore it would be appropriate for code *97003* to be performed in an ALF. Code *97003* is allowable for claims processed on or after March 23, 2004.

Prolonged Evaluation and Management Services

This is to clarify correct companion codes for prolonged services (codes *99354-99357*) as outlined in the American Medical Association's (AMA) *Current Procedural Terminology* (*CPT*) book. Prolonged services (*CPT* codes *99354-99357*) are payable when they are billed on the same day by the same provider as the companion evaluation and management codes.

99354 *Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient evaluation and management service)*

The required evaluation and management companion codes for *99354* are *99201-99215*, *99241-99245*, and *99301-99350*. *CPT* code *99355* is used in conjunction with code *99354*.

99356 *Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service; first hour (List separately in addition to code for inpatient evaluation and management service)*

The required evaluation and management companion codes for *99356* are *99221-99233*, *99251-99255*, and *99261-99263*. *CPT* code *99357* is used in conjunction with code *99356*.

Prolonged services (*CPT* codes *99354-99357*) are not payable unless they are accompanied by one of these companion codes.

Physician Delegation of Tasks in Skilled Nursing Facilities

The following information comes from a memo from the Survey and Certification Group, based on 42 C.F.R. 424.20, 424.20(e)(2), 483.40(c)(4) and (e), to clarify "Physician and Other Medically Necessary Visits in SNFs / NFs":

The initial comprehensive visit for a beneficiary being admitted to a skilled nursing facility (SNF) is performed by the physician, to assess the beneficiary, develop a plan of care, and verify admitting orders. The physician must perform this initial visit no later than 30 days after admission. However, nonphysician practitioners may perform other medically necessary visits prior to and after the physician's initial comprehensive visit. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and a physician assistant, nurse practitioner, or clinical nurse specialist licensed as such by the state and performing within the scope of their practice.

At the option of the state, performance of any required physician task in a nursing facility (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

Certifications/recertifications in SNFs may be signed by:

- The physician responsible for the case, or with his or her authorization, by a physician on the SNF staff,
- A physician who is available in case of an emergency who has knowledge of the case, or
- A nurse practitioner or clinical nurse specialist who do not have a direct or indirect employment relationship with the facility, but who work in collaboration with a physician, when permitted under the scope of practice for the state.

Rho (D) Immune Globulin Intravenous

Rho (D) is an infusible biological used to address Rh incompatibilities in the perinatal period, along with other rare blood problems such as immune thrombocytopenic purpura (ITP). Rho (D) is billed using HCPCS code J2792 (Injection, rho D immune globulin, intravenous, human, solvent detergent, 100 I.U.). Recent data shows extraordinary utilization of IV rho (D) in Florida as 93% of the allowed dollars in the nation were paid to Florida providers. This article serves as a reminder of the "Indications and Limitations of Coverage and/or Medical Necessity" criteria identified in local medical review policy (LMRP) J2792 that was published in the July/August 2000 Florida *Medicare B Update!* In addition, the LMRP is available on our provider education Web site, *http://www.floridamedicare.com*.

Specifically of concern is utilization of rho (D) in treatment of immune thrombocytopenic purpura (ITP). As noted in the LMRP (based on FDA approved indications), use of rho (D) may be indicated for treatment of ITP for non-splenectomized rho (D) positive patients in clinical situations requiring an increase platelet count to prevent excessive hemorrhage in children with acute or chronic ITP, adults with chronic ITP, and children or adults with ITP secondary to HIV infection. For the purpose of the policy, ITP is defined based on the following criteria: signs and symptoms of bleeding, a platelet count of less than 30,000/mm3, rho (D) positive status and non-splenectomized status. The policy also stresses that all patients being treated with rho (D) for ITP should be monitored to determine the clinical response by assessing platelet counts, red blood cells, hemoglobin and reticulocyte counts. The FDA approved package insert was revised in 2000 to state that rho (D) positive ITP patients treated with rho (D) should be monitored for signs and symptoms of intravascular hemolysis, clinically compromising anemia and renal insufficiency based on higher rates of adverse effects in this patient population.

In addition, please note that the descriptor for procedure code J2792 is for 100 I.U. Therefore, if you are giving 300 I.U. of rho (D) then you would bill for three units of procedure code J2792. If you are giving 30,000 I.U. of rho (D) then you would bill for 300 units of procedure code J2792. Actual dosages should fall within the FDA recommended dosages.

Claims for IV rho (D) may be submitted electronically; it is not necessary to submit claims on the paper Form CMS-1500. We will develop for supporting documentation as needed for claims. However, documentation should be included with review requests.

CORRECTIONS

70544: Magnetic Resonance Angiography (MRA)—Correction

An article was published in the First Quarter 2004 *Medicare B Update!* (page 76) for expanded coverage for MRA to include MRA of the pelvis (*CPT* code *72198*). However, some of the ICD-9-CM codes that support medical necessity for MRA of the abdomen were incorrectly listed for the pelvis as well.

The correct ICD-9-CM codes that support medical necessity for *CPT* code *72198 (Magnetic resonance angiography, pelvis with or without contrast material[s])* are:

233.9	Carcinoma in situ of other and unspecified urinary organs
236.90-236.99	Neoplasm of uncertain behavior of other and unspecified urinary organs
442.2	Other aneurysm of iliac artery
443.22	Dissection of iliac artery
444.81	Arterial embolism and thrombosis of iliac artery

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.floridamedicare.com*.

LOCAL MEDICAL REVIEW POLICY (NEW)

ALEFACEPT

Psoriasis is a chronic immune-mediated disease of the skin affecting an estimated 2% of the population. It has been treated with topical, photo, and systemic therapies. The topical therapies include tars, salicylic acid, corticosteroids, calcipotriene, tazarotene, and anthralin. Phototherapies include UVB, psoralens plus UVA (PUVA), and more recently laser therapy for localized lesions. Systemic therapies include drugs such as methotrexate, cyclosporine, retinoids, and an emerging class of biologic drugs including etanercept (Enbrel®) and now alefacept (manufactured by Biogen under the trade name Amevive®). Some of the therapies are used in combination to minimize toxicities while maximizing response, or as rotational therapy.

Alefacept is a human fusion protein directed at T-cells expressing the CD2 antigen, preventing lymphocyte activation. These lymphocytes are involved in the inflammatory process in psoriatic lesions. Alefacept is administered as an intramuscular injection of 15mg at weekly intervals, for a total of 12 consecutive weeks. Because **alefacept** may reduce circulating CD4+ and CD8+ T-lymphocytes, weekly CD4+ tests are required for monitoring while administering the drug. **Alefacept** has been approved by the FDA for treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy.

Alefacept is billed using HCPCS code J0215 (Injection, Alefacept, 0.5 mg). This local coverage determination (LCD) is being developed to allow providers access to this new therapy and to provide indications and limitations for this service.

This LCD is effective for services rendered on or after July 6, 2004. The full-text LCD is available on our provider education Web site at *http://www.floridamedicare.com*.

BEXXAR: Tositumomab and Iodine I 131 Tositumomab (BEXXAR®) Therapy

The Bexxar® therapeutic regimen (Tositumomab and Iodine I 131 Tositumomab) is an anti-neoplastic radioimmunotherapeutic monoclonal antibody-based regimen composed of the monoclonal antibody, Tositumomab, and the radiolabeled monoclonal antibody, Iodine I 131 Tositumomab. The regimen is administered in two discrete steps: the dosimetric and therapeutic steps. Each step consists of a sequential infusion of Tositumomab followed by Iodine I 131 Tositumomab. The therapeutic step is administered 7-14 days after the dosimetric step.

The Bexxar® therapeutic regimen is indicated for the treatment of patients with CD20 positive, follicular, non-Hodgkin's lymphoma, with and without transformation, whose disease is refractory to Rituximab and has relapsed following chemotherapy. It is not indicated for the initial treatment of patients with CD20 positive non-Hodgkin's lymphoma.

The Bexxar® therapeutic regimen was FDA approved on June 27, 2003. Because this is a new treatment regimen, there is no utilization data available. This policy was developed to allow providers access to this new

therapy, to define the indications and limitations of coverage for this therapy, and to provide appropriate coding guidelines for this therapy.

The following *CPT*/HCPCS codes are included in the LCD:
Dosimetric Step
A9533, G3001, *78804*, *77300*

Therapeutic Step
A9534, G3001, *79403*

The following are ICD-9-CM Codes that Support Medical Necessity:
200.00-200.88, 202.00-202.08, 202.80-202.88

This local coverage determination (LCD) is effective for services rendered on or after July 6, 2004. The full-text LCD is available on our provider education Web site at *http://www.floridamedicare.com*.

G0179: Physician Certification and Recertification of Home Health Services

Physician's services involved in physician certification (and recertification) of Medicare-covered home health services may be separately coded and reimbursed. These services include creation and review of a plan of care, and verification that the home health agency initially complies with the physician's plan of care. The physician's work in reviewing data collected in the home health agency's patient assessment would be included in these services.

According to statistical medical data from July 1, 2002, through December 31, 2002, the use of HCPCS code G0180 was found to have an aberrancy ratio of 2.94. The use of HCPCS code G0179 was not found to be aberrant. Additional data for January 1, 2003 through June 30, 2003, revealed HCPCS code G0179 was billed for a total of 18,900 services, 17,291 of which were allowed. HCPCS code G0180 was billed for a total of 78,878 services, 68,705 of which were allowed.

Due to these findings, a policy was developed to define the indications and limitations of coverage and clarify the appropriate use of physician certification and recertification of home health services (HCPCS codes G0179 and G0180).

The following HCPCS codes are included in the local coverage determination (LCD):

G0179 Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period

G0180 Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period

The full-text LCD available on our provider education Web site at *http://www.floridamedicare.com* and is effective for services rendered on or after July 6, 2004. For more information regarding billing for physician certification and re-certification for home health services, please refer to the Fourth Quarter 2003 *Medicare B Update!* (page 31).

PULMDIAGSVCS: Pulmonary Diagnostic Services

Procedure codes *94240*, *94260*, *94360*, *94370*, *94620*, *94720*, *94725*, and *94750* were chosen for Comprehensive Data Analysis for fiscal year (FY) 2003 based on January through June 2001 data, revealing a carrier to nation ratio of allowed dollars varying from 1.83 (*94720 – monoxide diffusing capacity*) to 6.12 (*94725 – membrane diffusion capacity*) with a maximum potential savings of $2,734,265. Based on the conclusions of these findings, the performance of the services was considered a widespread problem; therefore, a recommendation to perform a widespread probe and possibly develop a local medical review policy (LMRP) was made. Two widespread probes were performed, encompassing a total of 201 claims from 37 providers for the period January 1, 2001 through June 30, 2001. The purpose of the reviews was to determine if the services billed to Medicare were documented as having been performed and to determine the medical conditions for which the services were being performed.

All of the submitted documentation for the reviews supported some type of pulmonary symptom and/or disease. The following recommendations were made as a result of the widespread probe reviews:

- Develop a comprehensive LMRP to define all pulmonary services, including indications and limitations, components of each test with the expected interpretive results, and the conditions that one would expect services to be repeated, and
- Revise and incorporate the current policies related to pulmonary services (*94240*, *94620*, and *94010*, which includes *94360*) in the comprehensive pulmonary policy referenced above.

The following *CPT*/HCPCS codes are included in the policy: *93720-93722*, *94010*, *94060*, *94070*, *94150*, *94200*, *94240*, *94250*, *94260*, *94350*, *94360*, *94370*, *94375*, *94620*, *94621*, *94720*, *94725*, *and 94750.*

This policy is provided in the local coverage determination (LCD) format. The full text-LCD is available on our provider education Web site at *http://www.floridamedicare.com* and is effective for services rendered on or after July 6, 2004.

LOCAL MEDICAL REVIEW POLICY (REVISED)

15822: Upper Eyelid and Brow Procedures

The local medical review policy (LMRP) for upper eyelid and brow procedures was last revised May 21, 1997. This major revision of existing policy further defines the indications and limitations of coverage and clarifies documentation required to support medical necessity. The requirement to submit photographs with the upper eyelid and brow procedure claim has been eliminated. However, photographs are still required to be a part of the medical record and must be submitted when requested by the medical review staff.

This policy revision was presented to the November 2003 Carriers Advisory Committee.

This policy revision is being published in the local coverage determination (LCD) format for Florida and is effective for services rendered on or after July 6, 2004. The full-text LCD is available on our provider education Web site at *http://www.floridamedicare.com*.

19318: Reduction Mammaplasty

The local medical review policy (LMRP) for reduction mammaplasty became effective on January 5, 2004. A revision has since been made to clarify documentation requirements when submitting claims for payment.

A photograph is not a requirement when submitting a claim for payment. However, it is expected that a photograph would be a part of the medical documentation maintained by the physician and that upon request it will be submitted for review.

This policy is being published in the local coverage determination (LCD) format for Florida and is effective for claims processed on or after April 6, 2004. The full-text LCD is available on our provider education Web site at *http://www.floridamedicare.com*.

43235: Diagnostic and Therapeutic Esophagogastroduodensocopy

This local medical review policy (LMRP) was revised January 1, 2004. Since that time, the policy has been revised to add an additional ICD-9-CM code.

This revision was based on a provider's request to consider adding ICD-9-CM code V12.71 (Personal history of peptic ulcer disease), as this indication was already stated in the policy. Therefore, this code has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy, effective for claims processed on or after April 19, 2004.

The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

80100: Qualitative Drug Screen

The local medical review policy (LMRP) for qualitative drug screen was last revised on February 17, 2003. Since then, a revision to the policy has been made due to an internal request, effective for services processed on or after March 15, 2004.

ICD-9-CM code 780.39 (other convulsions) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy. The addition of this code appropriately reflects the condition "seizures with an undetermined history," which is currently listed under the "Indications and Limitations of Coverage and/or Medical Necessity" section.

The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

92135: Scanning Computerized Ophthalmic Diagnostic Imaging

The latest revision for local medical review policy (LMRP) for scanning computerized ophthalmic diagnostic imaging was effective April 21, 2003. Since then, this policy has been revised. Changes include revisions to the LMRP Description, Indications and Limitations, Reasons for Denials, and Utilization Guidelines sections of the policy.

These revisions are effective for services rendered on or after March 16, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

92136: Optical Coherence Biometry

The latest revision to the local medical review policy (LMRP) for optical coherence biometry was effective March 1, 2003. This policy has been revised in accordance with the first update to the 2004 Medicare Physician Fee Schedule Database (CMS Change Request 3128, dated February 20, 2004), which indicates that the bilateral surgery indicator for this service has been changed to '3' (unilateral service).

This revision is effective for services rendered on or after January 1, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

92225: Ophthalmoscopy

The latest revision to the local medical review policy (LMRP) for ophthalmoscopy was effective July 30, 2001. Since then, the policy has been revised. Changes include revisions to the following sections of the policy:

- LMRP Description
- Coding Guidelines
- Documentation Requirements
- Utilization Guidelines
- Indications and Limitations
- ICD-9 Codes that Support Medical Necessity
  - ICD-9-CM codes added: 228.03, 360.55, 364.00-364.05, 377.42, 871.0-871.9, and 921.3

These revisions are effective for services rendered on or after February 20, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

93000: Electrocardiography

The local medical review policy (LMRP) for electrocardiography was last updated October 1, 2003. Since that time, diagnosis code 729.5 has been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure codes *93000, 93005*, and *93010*.

These changes are effective for services rendered on or after March 8, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

93501: Cardiac Catheterization

This local medical review policy (LMRP) was last revised effective October 1, 2002. Since that time, the policy has been revised to update the indications, limitations, and documentation requirements. In addition, language has been added regarding medical necessity for extracardiac angiography procedures (*75724*, *36245*) when performed during a cardiac catheterization.

This revision was based on results from a widespread probe, which revealed that medical necessity for the extracardiac angiography studies was not supported in the documentation.

The following ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the policy: 421.0, 423.8, 423.9, 427.1, 427.5, 446.0, 514, 518.81, 746.9, 785.2, and 785.51.

In addition, the LMRP has been updated to the local coverage determination (LCD) format. These revisions are effective for services rendered on or after July 6, 2004. The full-text LCD is available on our provider education Web site at *http://www.floridamedicare.com*.

93724: Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator

This local medical review policy (LMRP) was last revised effective April 1, 2002. Since that time, the policy has been revised.

This policy was revised based on an inquiry from the manufacturer regarding proper billing for Web-based surveillance of the pacing cardioverter-defibrillator system. It was determined that this service is identical to the face-to-face ICD interrogation without reprogramming service. Therefore, this policy has been revised to add additional language and coding guidelines for the Web-based modality.

Procedure codes *93741* and *93743* are included in the policy and should be used rather than an unlisted code.

The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*. This revision is effective for claims processed on or after March 9, 2004.

93925: Duplex Scan of Lower Extremities

This local medical review policy (LMRP) was revised effective October 1, 2002. Since that time, this policy has been revised to add ICD-9-CM code 785.9 (other symptoms involving cardiovascular system) to the "ICD-9 Codes that Support Medical Necessity" section of the policy. This change was based on a request from a provider to add this ICD-9-CM code, since the policy already contained the indication to support this.

This revision is effective for claims processed on or after April 19, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

95805: Sleep Testing

The local medical review policy (LMRP) for sleep testing was last updated on April 1, 2002. Since then, the policy has been revised. It is no longer necessary for providers of this service to submit documentation with the claim. However, the documentation maintained in the clinical record must support the medical necessity of this test, and support that the procedure billed was actually performed.

The "Documentation Requirements" section of the policy has been revised. The statement "documentation submitted with the claim" was removed, and replaced with "documentation maintained in the clinical record."

This revision is effective for claims processed on or after January 15, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

97001: Physical Medicine and Rehabilitation

The local medical review policy (LMRP) for physical medicine and rehabilitation was last revised January 1, 2004. Since that time, language changes have been made to the policy to reflect clarifications per CMS Change Request 2859/2779. These changes clarify the time period when a physician must evaluate the patient and corrects omission of nonphysician practitioners. In addition, the policy has been converted to the local coverage decision (LCD) format.

The full-text LCD is available on our provider education Web site at *http://www.floridamedicare.com*. These changes are effective for claims processed on or after February 11, 2004.

98940: Chiropractic Services

The latest revision for local medical review policy (LMRP) Chiropractic Services was effective October 20, 2003. Revisions have been made in the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the policy to clarify that the precise level of subluxation does not have to be on the claim form, but must be cited in the patient's medical record.

These revisions are effective for services rendered on or after April 12, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

Botulinum Toxins (Formerly J0585 Botulinum Toxin Type A [Botox] and J0587 Botulinum Toxin Type B [Myobloc])

Botulinum toxins – botulinum toxin type A (Botox) and botulinum toxin type B (Myobloc) – are two of seven distinct immunologic serotypes produced by the anaerobic organism Clostridium botulinum. Botulinum toxin type A and Botulinum toxin type B injections are used to treat various focal muscle spastic disorders and excessive muscle contractions such as dystonias, spasms, twitches, etc. When administered intramuscularly or subcutaneously, these toxins produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. The resulting chemical-denervation of muscle produces local paresis or paralysis and allows individual muscles to be weakened selectively.

Policy has been developed to provide indications and limitations of coverage and clarify the appropriate use of botulinum toxins. The appropriate HCPCS codes used to report botulinum toxins are:

J0585	Botulinum toxin type, A per unit
J0587	Botulinum toxin type B, per 100 units

This policy is effective for services rendered on or after July 6, 2004. The full-text of this local coverage determination (LCD) is available on our provider education Web site at *http://www.floridamedicare.com*

A4644: Low Osmolar Contrast Media (LOCM) (formerly A9525)

The local medical review policy (LMRP) for low osmolar contrast media (LOCM) was last revised on January 1, 2004. Since that time, CMS pub 100-20, Transmittal: 45, CR 3053, issued on January 23, 2004, instructed providers to continue using HCPCS codes A4644-A4646 rather than the new code A9525 when billing LOCM. The LMRP has been revised to reflect the correct coding of iso-osmolar material. The policy number has been changed from A9525 to A4644.

This revision is effective for service rendered on or after April 1, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

EPO: Epoetin alfa

The local medical review policy (LMRP) for Epoetin alfa was last updated January 5, 2004. Since then, the LMRP has been converted to the local coverage determination (LCD) format.

The LCD for Epoetin alfa contains an indication for "reduction of allogeneic blood transfusion in surgery patients." Providers have previously been instructed to bill using ICD-9-CM codes E878.1 and E878.8 for this indication. It has come to our attention that these codes are not appropriate to bill as primary diagnosis codes; therefore, **effective July 6, 2004, providers are instructed to bill ICD-9-CM code V07.8 for this indication.** After this date, ICD-9-CM codes E878.1 and E878.8 will no longer be allowed for this indication.

The revised LCD is effective for services rendered on or after July 6, 2004. The full-text LCD is available on Web site at *http://www.floridamedicare.com*.

EATSV: Endovenous Ablation Therapy of the Saphenous Vein (formerly ERASV: Endoluminal Radiofrequency of the Saphenous Vein)

The local medical review policy (LMRP) for endoluminal radiofrequency of the saphenous vein became effective on January 1, 2004. The LMRP provides coverage for endoluminal *radiofrequency* ablation therapy of the saphenous vein. Since development of the policy, additional studies have been completed that support endovenous *laser* ablation therapy as treatment for varicose veins and viscosities associated with superficial reflux of the greater saphenous vein.

This revision expands coverage to include endovenous laser ablation treatment of varicose veins and viscosities associated with superficial reflux of the greater saphenous vein. The policy title and number have been changed accordingly.

This policy is being published in the local coverage determination (LCD) format for Florida and is effective for services rendered on or after April 20, 2004. The full-text LCD is available on our provider education Web site at *http://www.floridamedicare.com*.

G0104: Colorectal Cancer Screening

The local medical review policy (LMRP) for colorectal cancer screening was last updated on January 1, 2004. A revision to the policy has been made as a result of CMS Transmittals 3, 5, and 52, Change Request 2996, dated December 19, 2003.

Effective for services furnished on or after January 1, 2004, payment may be made for an immunoassay-based fecal-occult blood test (FOBT, G0328) as an alternative to the guaiac-based FOBT, G0107. Medicare will pay for only one covered FOBT per year (either G0107 or G0328, but not both) for beneficiaries aged 50 and over. Code G0107 is for a guaiac-based test for peroxidase activity, in which the beneficiary takes samples from two different sites of three consecutive stools. Code G0328 is for an immunoassay test that includes the use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, as determined by the individual manufacturer's instructions. A written order from the beneficiary's attending physician is required for either of these screening tests.

A revision to the LMRP to reflect this additional coverage was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy. In addition, code G0328 was added under the "*CPT*/HCPCS Codes" section.

The full text of this LMRP is available on our provider education Web site at *http://www.floridamedicare.com*, and is effective for services rendered on or after January 1, 2004.

G0237: Respiratory Therapeutic Services

The local medical review policy (LMRP) for respiratory therapeutic services was effective April 12, 2004. Since that time, language changes have been made to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy for clarification of the physician who is treating the patient for the pulmonary disease.

The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*. These changes are also effective for services performed on or after April 12, 2004.

J0207: Amifostine (Ethyol®)

The local medical review policy (LMRP) for Amifostine was last revised October 20, 2003. The LMRP refers to ICD-9-CM code E933.1 to support nephrotoxicity, bone marrow toxicity, and/or neurotoxicity associated with Cisplatin and/or cyclophosphamide regimen. It has come to our attention that this code is not appropriate to bill as a primary code; therefore, **effective July 6, 2004, providers are instructed to bill ICD-9-CM code 995.2 for this indication.** After this date, ICD-9-CM code E933.1 will no longer be allowed for this indication.

This LMRP has been converted to the local coverage determination (LCD) format. The LCD revision is effective for services rendered on or after July 6, 2004; the full-text LCD is available on our provider education Web site at *http://www.floridamedicare.com*.

J1950: Leuprolide Acetate

The local medical review policy (LMRP) for leuprolide acetate was last updated on January 1, 2002. Since that time, the least costly alternative (LCA) method for administration and pricing of J9217 (Luteinizing hormone-releasing hormone analogs for diagnosed malignant neoplasm of the prostate) has been incorporated into this policy. Diagnosis codes 218.0-218.9 have been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy for procedure code J1950. In addition, ICD-9-CM codes that support medical necessity have been clarified for each *CPT*/HCPCS code. These changes are effective for services rendered on or after March 8, 2004.

The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

J3420: Vitamin B_{12} Injections

The local medical review policy (LMRP) for vitamin B_{12} injections was effective December 2, 1994. The LMRP has been converted to the local coverage determination (LCD) format. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy has been updated to allow vitamin B_{12} when given in conjunction with Alimta®. ICD-9-CM code 995.2 (Unspecified adverse effect of drug, medicinal and biological substance) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD to support this indication.

This revision is effective for services rendered on or after February 2, 2004, processed on or after April 19, 2004. The full-text LCD is available on our provider education Web site at *http://www.floridamedicare.com*.

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

The local medical review policy (LMRP) for Darbepoetin alfa was last updated February 2, 2004. Since then, the policy has been converted into the local coverage determination (LCD) format. In addition, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy has been updated to include the following:

- An indication for "anemia associated with malignancy." ICD-9-CM range 140.0-239.9 (Neoplasms) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD to support this indication, and
- To initiate therapy with Darbepoetin alfa, for indications other than ESRD on dialysis, the patient must have a documented anemia as evidenced by symptoms and a hematocrit (HCT) of less than 33% or a hemoglobin (HGB) less than 11 g/dL.

These revisions are also effective for services rendered on or after February 2, 2004. The full-text LCD is available on our provider education Web site at *http://wwwfloridamedicare.com*.

LOCAL MEDICAL REVIEW POLICY (RETIRED)

38230: Stem Cell Transplantation

National guidelines for stem cell transplantation are located in CMS Pub 100-3, section 10.8.1 and the Medicare Carriers Manual, Section 4183. Covered and noncovered *CPT* and ICD-9-CM codes are included in these CMS manual references.

The local medical review policy for stem cell transplantation is therefore retired effective for services rendered on or after March 8, 2004.

93784: Ambulatory Blood Pressure Monitoring (ABPM)

The local medical review policy (LMRP) for APBM has been retired, effective for services rendered on or after April 1, 2004. It is replaced with national coverage guidelines as specified in CMS Pub. 100-04, Transmittal 109, Change Request 2726, dated February 27, 2004.

APBM, billed under *CPT* codes *93784*, *93786*, *93788*, or *93780*, is payable only for ICD-9-CM diagnosis code 796.2 (Elevated blood pressure reading without diagnosis of hypertension).

For more information, please refer to Medlearn Matters article # MM2726, entitled "Updated Policy and Claims Processing Instructions for Ambulatory Blood Pressure Monitoring (ABPM)," available on CMS' Web site at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2726.pdf* (see article on page 28).

Multiple Policies Being Retired

The following local medical review policies (LMRPs) are being retired effective for services rendered on or after July 5, 2004. These LMRPs have been incorporated into the LMRP for pulmonary diagnostic services (PULMDIAGSVCS).

94010: Spirometry
94240: Functional Residual Capacity of Residual Volume
94620: Pulmonary Stress Testing

The full-text of the pulmonary diagnostic services LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

98925: Osteopathic Manipulative Treatment

The local medical review policy (LMRP) for osteopathic manipulative treatment is being retired, effective for services rendered on or after March 9, 2004. It has been determined that the information in the policy is informational only, and these codes are currently not aberrant in Florida. A policy may be developed in the future if services become aberrant.

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Jacksonville, FL 32231-4117

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Medicare Part B Chiropractic Unit
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Jacksonville, FL 32231-4067

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Jacksonville, FL 32231-4099

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Medicare Part B Secondary Payer Dept.
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Medicare Part B ESRD Claims
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Medicare Part B Fair Hearings
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Administrative Law Judge Hearing
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Columbia, SC 29202-3141

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Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
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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:
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Medicare Communication and Education
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1-904-791-8608
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OCR

Printer Specifications/Test Claims:
1-904-791-8132

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1-803-735-1034

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PROVIDER

Florida
http://www.floridamedicare.com

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The following is a comprehensive index covering all articles published the *FCSO Medicare B Update!* during fiscal year 2004 through March 5, 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 intended 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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