Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

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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.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FIRST COAST SERVICE OPTIONS, INC.
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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
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_____

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Medicare B Update!

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The *Medicare B Update!* is published quarterly by the Medicare Publications Department of First Coast Service Options, Inc., 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 Publications
P.O. Box 45270
Jacksonville, FL
32232-5270

A PHYSICIAN'S FOCUS

Humanitarian Use Device

Coverage and payment of medical devices for Medicare beneficiaries is governed by the interplay of two agencies, the *Food and Drug Administration* (Is device safe and effective? Is the device substantially equivalent to a predicate device?) and the *Centers for Medicare & Medicaid Services* (Does the device fit a benefit category? Is the use of the device reasonable and necessary to treat an illness or injury?). Each agency evolved from different statutory purposes and consequently employs different evaluation criteria per mandates. FDA decisions determine if a manufacturer can market a product in the United States. CMS and its contractor decisions establish if a provider can seek payment for a device from the Medicare program if used in the treatment of a Medicare beneficiary.

The FDA defines a **humanitarian use device** as one that is intended to benefit patients in the treatment and diagnosis of diseases or conditions that affect or is manifested in fewer than 4,000 individuals in the United States per year. A manufacturer must apply to the FDA for this designation and if so deemed must then apply for a **humanitarian device exemption** (HDE). An HDE is an application that is similar to a premarket approval application, but exempt from the effectiveness requirements. An approved HDE authorizes marketing of a humanitarian use device. See *http://www.fda.gov/cdrh/devadvice/pma/app_methods.html*

Is there Medicare Coverage for a Humanitarian Use Device?

Generally, the Medicare program covers devices approved for marketing by the FDA if:

- there exists a benefit category and the device is not statutorily excluded,
- there is not a national coverage determination of noncoverage
- or absent a national coverage determination, there is not local contractor noncoverage (or local medical review policy coverage limitation, – soon to be called local coverage decisions),
- and the device is used in an episode of care that is reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.

If there is a national or local coverage limitation, criteria have to be met for coverage.

As noted, the FDA must approve a humanitarian use device for marketing. Before using a humanitarian use device for traditional Medicare patients, please provide FCSO with the following information:

- Details about the specific device, including its humanitarian device exemption number and pertinent FDA approval data.
- A description of the clinical situations where you plan to use the device, *CPT*/HCPCS codes to be submitted with charges and invoice price if applicable.
- Institutional review board (IRB) approval document. Per the FDA, a humanitarian use device may only be used in facilities that have established a local IRB to supervise clinical testing of devices and, after an IRB has approved the use of the device, to treat or diagnose the specific disease. See *http://www.fda.gov/cdrh/ode/guidance/1381.html*.

Please submit the information to the Office of the Medical Director or *medical.policy@fcso.com*. FCSO will review your submission and respond as soon as possible. We may ask you to provide more information in some instances. Though there is no prior approval in traditional Medicare and all payment decisions are made when the claims are submitted, this process will help ensure Medicare beneficiaries are receiving covered services without unnecessary financial liability. Also, given the possible risk for the patient, the FDA IRB requirement establishes informed consent.

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FCSO Chief Medical Officer
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THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

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

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

Who Receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education Web site(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM (please see the hardcopy/CD-ROM registration form on page 6).

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 ot 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 separtely 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.

***Third party Web sites**. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites, and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

Distribution of the *Medicare B Update!*

Use of the Internet has become an accepted standard of communication throughout the world. Publications produced by First Coast Service Options, Inc. (FCSO) for our Connecticut Medicare Part B and Florida Part A and B customers are available on our provider education Web sites (*http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*). Our Medicare publications are posted to the Web sites in PDF (portable document format) and may be viewed, printed, or downloaded free of charge.

Hardcopy publications, by contrast, nationally cost Medicare a substantial amount of money for printing and postage. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better utilized elsewhere. In addition, enhancements to online publications can be made that are not possible in print.

Providers Must Qualify and Register to Receive the *Medicare B Update!* in Hardcopy or CD-ROM Format

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

If you believe you meet these criteria and wish to receive hardcopies or CD-ROMs, you must complete and return the registration form that follows. You will be required to re-register annually. If you registered previously and no longer need a hardcopy, please indicate this on the form.

If you are willing and able to receive the *Update!* electronically from the Internet, you do not need to reply to us. Providers and other entities that do not meet the criteria and desire a hardcopy or CD-ROM may purchase an annual subscription to the *Update!* (please see the "2004 Part B Materials" order form on the inside back cover of this issue).

Note: If you have a paid subscription, you will receive hardcopies or CD-ROMs of the *Medicare B Update!* through your subscription period.

Features of the Electronic Publication

There are advantages to accessing the *Update!* online: the electronic version is posted to the Web before print copies are distributed, and you can view, print, or download only those articles important to your practice.

In addition, we will be enhancing the format of electronic and CD-ROM newsletters to provide helpful features that do not appear in the current hardcopy format, including hyperlinks. A hyperlink is an element in an electronic document that links the user to another place in the same document, to an entirely different document, or to a Web site. This feature will provide users instant access to the following items:

- *Articles of Interest* – The table of contents will include hyperlinks to each article, therefore a provider can choose an article(s) of particular interest to his/her medical practice.
- *Third-Party Web sites* – All third-party Web sites referenced within articles will include hyperlinks to the applicable information on that Web site. (*Online publications only*.)
- *References within the Contractor Web sites* – All additional resources or reference materials mentioned in the newsletter will include hyperlinks to that information within the FCSO Medicare Web sites (e.g., full-text versions of local medical review policies, prior publications, forms, online registration, etc.). Additionally, links to unique Web pages will allow access to information applicable to the user's specialty classification. (*Online publications only*.)

The enhanced electronic publications are available at no charge through the FCSO Medicare Web sites and on CD-ROM at a minimal cost. In addition, you may sign up for the *FCSO eNews*, our free electronic mailing list. Subscribers receive an email notice when new publications are posted to our Web sites, plus frequent notification of other items of interest. Anyone with an email address may sign up for *eNews*; you don't have to be at the office.

Medicare B Update! Hardcopy/CD-ROM Registration Form

To receive the *Medicare B Update!* in hardcopy or CD-ROM format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. To receive a hardcopy or CD-ROM of the Third Quarter 2004 *Update!* your form must be faxed or postmarked on or before April 30, 2004.

Please note that you are not obligated to complete this form to obtain information published in the *Medicare B Update!* – issues published beginning in 1997 are available free of charge on our provider education Web sites *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com.*

Provider/Professional Association Name:

Medicare Provider Identification Number (PIN):

Address:

City, State, ZIP Code:

Contact Person/Title:

Telephone Number:

Rationale for needing a hardcopy:

Does your office have Internet access? YES ❑ NO ❑

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

Other technical barrier or reason for needing publications hardcopy or on CD-ROM:

Mail your completed form to:

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

or fax to 1 (904) 791-6292

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

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

Reader Survey—*Medicare B Update!*

We want readers of this publication to find it to be a helpful tool that is easy to use and understand. This survey is your opportunity to suggest ways we can better meet your needs. After the survey closes, we will publish the results on our Web sites and work to implement suggested enhancements as appropriate. Thank you for taking the time to complete this survey!

Please complete the questions below and return your reply to us by March 31, 2004.

Please Indicate Your Location: ❑ **Connecticut** ❑ **Florida**

Overall Satisfaction

On a scale of 5 to 1, with 5 being very satisfied and 1 being very dissatisfied, how satisfied are you with the publication overall? Please ***circle*** the number that best applies.

5 4 3 2 1

Accuracy

"When I read the *Medicare B Update!* I feel comfortable that the information presented is accurate."

5 4 3 2 1

"When I read the *Medicare B Update!* I am confident that the information is up-to-date."

5 4 3 2 1

Clarity

"Medicare rules and guidelines are complex; however, I generally find the articles in the *Medicare B Update!* clear."

5 4 3 2 1

"Medicare rules and guidelines are complex; however, I usually find the articles in the *Medicare B Update!* easy to read."

5 4 3 2 1

Value

"The *Medicare B Update!* assists me in performing my job."

5 4 3 2 1

Layout/Format

"The *Medicare B Update!* is arranged in a manner that makes it easy to find the information I need."

5 4 3 2 1

Comments/Feedback –

What else could we do to improve the publication for you?

_____

_____

_____

_____

Please remove this page and mail it to:

Attention: Robert Hannan
Medicare Part B
Medicare Communication and Education
P.O. Box 2078
Jacksonville, FL 32231-0048

or you may **fax** your survey to (904) 791-6292.

CLAIMS

Payment Jurisdiction and Claim Filing Requirements for Claims Received on or after April 1, 2004

Information concerning jurisdictional pricing was posted to our provider education Web sites on October 31, 2003, and January 16, 2004. Since then, CMS has provided the following additional information.

Provided below are separate instructions for processing electronic claims using the American National Standards Institute (ANSI) X12N 837 format and paper claims. **No changes are required in submission of claims for services subject to jurisdictional pricing for services paid under the Medicare physician fee schedule and anesthesia services submitted on the National Standard Format (NSF).** Additional information on purchased tests is also provided.

ANSI X12N 837 Electronic Claims

Note: the following instructions do not apply to services rendered in place of service (POS) home -12.

Per the implementation guide of the 4010/4010A1 version of the ANSI X12N 837, it is acceptable for claims to contain the code for POS home and any number of additional POS codes. If different POS codes are used for services on the claim, a corresponding service facility location and address must be entered for each service at the line level, if that location is different from the billing provider, pay-to-provider, or claim level service facility location. We will pay for covered services based on the ZIP code of the service facility location, billing provider address, or pay-to provider address depending upon which information is provided.

Refer to the current implementation guide of the ANSI X12N 837 to determine how information concerning where a service was rendered, the service facility location, must be entered on a claim. Per the documentation, though an address may not appear in the loop named "service facility address," the information may still be available on the claim in a related loop.

For example:

- On version 4010/4010A of the ANSI X12N 837 electronic claim format, the Billing Provider loop 2010AA is required and therefore must always be entered. If the Pay-To Provider Name and Address loop 2010AB is the same as the Billing Provider, only the Billing Provider will be entered. If no Pay-To Provider Name and Address is entered in loop 2010AB, and the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider, then only the Billing Provider will be entered. In this case, the service is priced based on the Billing Provider ZIP code.
- If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) will be entered. The service will be priced based on the ZIP code in Service Facility Location loop 2310D, unless the 2420C (line level) is also entered. In that case, the service is priced based on the ZIP code in the Service Facility Location loop 2420C (line level) for that line.

In the following situation, per the information in the 4010/4010A1 version of the ANSI X12N 837, the place where the service was rendered cannot be identified from the claim. In this situation, all services on the claim will be priced based on the ZIP code in the Billing Provider loop. We will continue to take this action until such time as the ANSI Accredited Standards Committee (ASC) documentation is revised to allow for identification of where the service was rendered to be identified from the claim.

If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider or the Pay-To Provider, no entry is required per version 4010/4010A1 for Service Facility Location loop 2310D (claim level) or 2420C (line level).

When the same POS code and same service location address is applicable to each service line on the claim, the service facility location name and address must be entered at the claim level loop 2310D.

In general, when the service facility location name and address is entered only at the claim level, we will use the ZIP code of that address to determine pricing locality for each of the services on the claim. When entered at the line level, the ZIP code for each line must be used.

If the POS code is the same for all services, but the services were provided at different addresses, each service must be submitted with line level information. This will provide a ZIP code to price each service on the claim.

Paper Claims Submitted on the Form CMS-1500

It is acceptable for claims to contain POS home and an additional POS code. No service address for POS home needs to be entered for the service rendered at POS home in this situation as the address will be drawn from our beneficiary file, and the information provided in Item 32 will apply to the other POS. ***Item 32 must be completed including the name, address, and ZIP code, for all POS other than 12 (home).***

Providers must submit separate claims for each POS. The specific location where the services were furnished must be entered on the claim. We use the ZIP code of the address entered in Item 32 to price the claim. If multiple POS codes are submitted on the same claim, the claim will be returned as unprocessable.

Payment to Physician for Purchased Diagnostic Tests - Claims Submitted to Carriers

A physician or a medical group may submit the claim and (if assignment is accepted) receive the Part B payment, for the technical component of diagnostic tests the physician or group purchases from an independent physician, medical group, or other supplier. (This claim and payment procedure does not extend to clinical diagnostic laboratory tests.) The purchasing physician or group may be the same physician or group that ordered the tests or may be a different physician or group. An example of the latter situation is when the attending physician orders radiology tests from a radiologist and the radiologist purchases the tests from an imaging center. The purchasing physician or group may not markup the charge for a test from the purchase price and must accept the lowest of the fee schedule amount if the supplier had billed directly; the physician's actual charge; or the supplier's net charge to the purchasing physician or group, as full payment for the test even if assignment is not accepted.

In order to purchase a diagnostic test, the purchaser must perform the interpretation. The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.

Effective for claims received on or after April 1, 2004:

- In order to have appropriate service facility location ZIP code and the purchase price of each test on the claim, when billing for purchased tests on Form CMS-1500 (paper claim form), each test must be submitted on a separate claim form. Paper claims submitted with more than one purchased test will be returned as unprocessable.
- More than one purchased test may be billed on the ANSI X12N 837 electronic format. When more than one test is billed, the total purchased service amount must be submitted for each service. Claims received with multiple purchased tests *without line level total purchased service amount information* will be returned as unprocessable.
- Paper claims submitted for purchased services with both the interpretation and the purchased test on one claim will be returned as unprocessable unless the services are submitted with the same date of service and same place of service codes.
- ANSI X12N 837 electronic claims submitted for purchased services with both the interpretation and purchased test on the same claim will be accepted.
- In order to price claims correctly and apply purchase price limitations, global billing is not acceptable for claims received on Form CMS-1500 or on the ANSI X12N 837 electronic format. Each component must be billed as a separate line item (or on a separate claim per the limitations described above). A claim will be returned as unprocessable when a global billing is received and there is information on the claim that indicates the test was purchased.
- No changes will be required in either submission or processing for claims for services paid under the Medicare physician fee schedule and anesthesia services subject to jurisdictional pricing submitted on the NSF.

As a reminder, when billing for purchased diagnostic tests, Item 32 must be completed including the name, address, and ZIP code, and PIN, regardless of POS.

Source: CMS Pub. 100-04 Transmittal: 67 Date: January 16, 2004 Change Request 3039

Revisions to Jurisdictional Pricing and Unprocessable Claim Guidelines Effective April 1, 2004

Effective for claims received on or after April 1, 2004, services paid on the physician fee schedule and anesthesia services will be reimbursed per payment locality (i.e., jurisdiction), based on the ZIP code of where the service is provided. To facilitate this, **item 32 of Form CMS-1500** (or electronic equivalent) **must be completed for all places of service other than the patient's home**.

A paper claim (submitted on Form CMS-1500) will be returned as unprocessable to a provider or supplier of service when **more than one place of service, other than home**, is submitted for services payable under the Medicare physician fee schedule and anesthesia services.

When billing for purchased tests on Form CMS-1500, each test must be submitted on a separate claim form. In this way, the appropriate service facility location ZIP code and the purchase price of each test will be submitted and the carrier will be able to pay the correct reimbursement rates. Multiple purchased tests may be submitted on electronic claims as long as appropriate service facility location information is submitted when services are rendered at different locations and the appropriate total purchased service amounts are submitted for each purchased test.

Item 32 on Form CMS-1500 is limited to one service facility location name and address. In most cases when a test is purchased, it has been rendered at a different service facility location from where the interpretation is performed. Therefore, **a physician may only bill for a purchased test and an interpretation on the same claim when the services are rendered on the same date of service and at the same service facility location, and are submitted with the same place of service codes**. However, if the purchased test and interpretation are billed on the same Form CMS-1500 claim and the above criteria are not met, the claim will be returned as unprocessable.

Electronic claims submitted for purchased services may be submitted with the interpretation and the test on the same claim. In order for the carrier to pay the correct locality based fee, appropriate service facility service location information must be submitted at the line level when services are rendered at different locations. If line item data is not submitted, it will be assumed by the carrier that the services were rendered at the same service facility location.

Providers may not submit a global billing code on paper or electronic claims when one component of the service has been purchased. In order for carriers to determine payment jurisdiction and price services correctly, the technical and professional components of the service must be submitted on separate lines of the claim.

In order for carriers to be able to correctly determine where services were provided and pay correct locality rates, **no more than one name, address, and ZIP code may be entered in Item 32 of Form CMS-1500**.

A reminder of rules currently in effect:

- In order to purchase a diagnostic test, the purchaser must perform the interpretation. The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.
- For all laboratory work performed outside a physician's office, a claim will be returned as unproccessable if the claim does not contain in item 32 the name, address, ZIP code, and PIN *where the laboratory services were performed*, if the services were performed at a location other than the patient's home

Source: CMS Pub. 100-04 Transmittal: 6 Date: October 17, 2003 CR 2912
CMS Transmittal 1813 Date: August 1, 2003 CR 2631

Form CMS-1500 Completion Requirements

Including Data Element Requirement Matrix for Electronic and Paper Claims

Form CMS-1500 is the basic claim form prescribed by the Centers for Medicare & Medicaid Services (CMS) for claims for Medicare Part B services. Section 3005 of the Medicare Carriers Manual (MCM), which provides instructions regarding unprocessable claims, is revised effective April 1, 2004. Specific information concerning how these revisions affect providers and suppliers is furnished below.

Overview of Revisions

Section 3005.4, Data Element Requirements, is revised as follows for claims received on or after April 1, 2004:

- **Section 3005.4.B.6** is revised to provide instructions for Form CMS-1500 paper claims when more than one place of service code is included on a claim.

  Effective for claims received on or after April 1, 2004, a claim received on the Form CMS-1500 will be returned as unprocessable if it contains more than one place of service (POS), other than home–12, for services paid under the physician fee schedule and anesthesia services.

- **Section 3005.4.C.1.c** is revised to add additional criteria that will cause the claim to be treated as unprocessable:
  - on a Form CMS-1500 paper claim, no more than one purchased test may be billed on one claim;
  - on a Form CMS-1500 paper claim, if both the interpretation and test are billed on the same claim and the dates of service and places of service do not match;
  - on an ASC X12 837 electronic claim, if more than one purchased test is billed, line level information must be provided for each total purchased service amount;
  - on a Form CMS-1500 paper claim and an ASC X12 837 electronic claim, a global code is billed when the test was purchased.
- **Sections 3005.4.C.1.e**, **3005.4.C.1.l**, **3005.4.C.2.d.2**, **3005.4.C.2.h**, and **3005.4.C.2.i.2** have been revised to require that services be treated as unprocessable should the name, address, and ZIP code of the service location not be entered for all services other than those furnished in place of service home–12.
- **Section 3005.4.C.2.o** is revised to clarify that "home" means place of service home–12.

Section 3060.4, Payment to Physician for Purchased Diagnostic Tests, is revised to add some additional requirements for the completion of claims as outlined above for section 3005.4.C.1. Effective for claims received on or after April 1, 2004:

- In order to have appropriate service facility location ZIP code and the purchase price of each test on the claim, when billing for purchased tests on the Form CMS-1500 paper claim form, per section 4020.2, Part 3 and section 2010.3, Part 4, Item 20, each test must be submitted on a separate claim form. Paper claims submitted with more than one purchased test will be returned as unprocessable per section 3005.
- More than one purchased test may be billed on the ASC X12 837 electronic format. When more than one test is billed, the total purchased service amount must be submitted for each service. Claims received with multiple purchased tests without line level total purchased service amount information will be returned as unprocessable per section 3005.
- Paper claims submitted for purchased services with both the interpretation and the purchased test on one claim will be returned as unprocessable per section 3005, unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and the date of service and place of service codes match, we will assume that the one address in Item 32 applies to both services.

- ASC X12 837 electronic claims submitted for purchased services with both the interpretation and purchased test on the same claim will be accepted. We will assume that the claim level service facility location information applies to both services if line level information is not provided.
- In order to price claims correctly and apply purchase price limitations, global billing is not acceptable for claims received on the paper Form CMS-1500 or the ASC X12 837 electronic format. Each component must be billed as a separate line item (or on a separate claim per the limitations described above). We will treat the claim as unprocessable per section 3005 when a global billing is received and there is information on the claim that indicates the test was purchased.

Sections 3101, Area Carrier – Physician's Services, is deleted and replaced with 3100.1–3100.6.

- **Section 3100.1**, Payment Jurisdiction for Services Paid Under the Physician Fee Schedule and Anesthesia Services, is a new section that mandates that jurisdiction will be determined by ZIP code and will apply to all services except those rendered at place of service home - 12.
- **Section 3100.2**, Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004, is a new section that mandates that the service facility location must be entered on every claim in a manner that will allow the carrier to be able to determine jurisdiction for every service on that claim. Carriers will no longer be able to use the addresses on their provider files for the service location when the place of service is office.
- **Section 3100.3**, Payment Jurisdiction for Purchased Services, is a new section that clarifies payment jurisdiction for purchased diagnostic tests and interpretations. It also clarifies that global billings will not be acceptable for purchased services.

  Diagnostic tests and their interpretations are paid on the Medicare physician fee schedule (MPFS); therefore, they are subject to the same jurisdictional payment rules as all other services paid on the MPFS. Additional explanation is provided here due to general confusion concerning these services when they are purchased and then billed, rather than rendered and billed by the billing entity. As for any other services, suppliers must also meet current enrollment criteria as stated in Chapter 10 of the Program Integrity Manual in order to be able to enroll and bill for purchased tests and interpretations. That these services are purchased does not negate the need for appropriate enrollment procedures with the carrier that has jurisdiction over the geographic area where the services were rendered.

  Effective for claims processed on or after April 1, 2004, in order to determine jurisdiction, price correctly, and apply purchase price limitations, global billing will not be accepted for purchased services on electronic or paper claims. Claims received with global billings in this situation will be treated as unprocessable per section 3005.
- **Section 3100.4**, Payment Jurisdiction for Reassigned Services, is a new section that clarifies payment jurisdiction for reassigned services.

  Though a supplier or provider may reassign payment for his services to another entity, that does not negate the necessity of billing the correct carrier for those services when they are services paid under the MPFS. The entity that bills for the services must still bill the carrier that has jurisdiction over the geographic area where the services were rendered. Suppliers and providers must also meet current enrollment criteria as stated in Chapter 10 of the Program Integrity Manual in order to be able to enroll and bill for reassigned services.
- **Section 3100.5**, Jurisdiction for Shipboard Services, is the former section 3101C. The content has not changed.
- **Section 3100.6**, Exceptions to Jurisdictional Payment, is the former section 3101D. The content has not changed.

Section 3999, Exhibit 10, is revised to change the information for certain data elements for electronic claims to be consistent with the requirements of the Accredited Standards Committee X12N 837 Version 4010 Health Care Claim: Professional implementation guide. (See "Data Element Requirements Matrix," below.)

Section 4020.2, Items 14-33–Physician or Supplier Information, is revised for claims received on or after April 1, 2004:

- to add language in Item 20 to allow for multiple purchased tests to be billed on the ASC X12 837 electronic format when certain criteria are met;
- to require that in Item 32 the address and ZIP code of where the service was rendered be entered on the claim for services furnished in all places of service other than the place of service home – 12; and
- to require in Item 32 that only one name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms must be submitted.

Terminology

Unprocessable Claim - Any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.
Incomplete Information - Missing, required or conditional information on a claim (e.g., no unique physician identification number [UPIN] / provider identification number [PIN] or national provider identifier [NPI] when effective).
Invalid Information - Complete required or conditional information on a claim which is illogical, incorrect (e.g., incorrect UPIN/PIN or NPI when effective), or no longer in effect (e.g., an expired number).
Required - Any data element that is needed in order to process a claim (e.g., date of service).
Conditional - Any data element that must be completed if other conditions(s) exist (e.g., if the insured is different from the patient, then the insured's name must be entered on a claim).

Not Required - Any data element that is not needed by Medicare to process a claim (e.g., patient status).
Return as Unprocessable - Returning a claim as unprocessable does not mean a claim received with incomplete or invalid information is physically returned. The term "return as unprocessable" is used to refer to the processes utilized for notifying the supplier or provider of service that their claim cannot be processed and must be corrected or resubmitted. A claim returned as unprocessable for incomplete or invalid information does not meet the criteria to be considered as a claim, is not denied, and, as such, is not afforded appeal rights.

Data Element Requirements Matrix

The matrix (MCM Section 3999, Exhibit 10) specifies data elements that are required and conditional. These standard data elements are minimal requirements for processing a Part B claim. A crosswalk is present to relate Form CMS-1500 items (hardcopy) to fields/records in the NSF 3.01 (electronic) and the ASC X12N 837 Professional Version 4010X098A1 implementation guide.

A copy of the matrix is provided below. Changes effective April 1, 2004, are shown in **bold** type.

Note: the matrix is not a comprehensive description of requirements that need to be met in order to submit a compliant transaction.

DATA ELEMENT REQUIREMENTS MATRIX

* R = Required - information which MUST always be on a claim.
* C = Conditional - information which is required on a claim if certain conditions exist.
NR = Not Required - information which is either optional or is not required in order to process a claim.
**Required prior to mandated use of PlanID. Not used after Plan ID is mandated.

CLAIMS WILLBE RETURNED AS UNPROCESSABLE IF THE FOLLOWING INFORMATION IS INCOMPLETE/INVALID

CMS 1500	NSF 3.01	ANSI 837 Version 4010	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	Medicare Status (Required or Conditional **for EDI**)*
1A	DA0 - 18.0	Loop 2010BA 2-015-NM109	Insured I.D. Number	Subscriber Primary Identifier	R
2	CA0 - 04.0	Loop 2010BA 2-015-NM103	Patient Name	Subscriber Last Name	R
	CA0 - 05.0	Loop 2010BA 2-015-NM104		Subscriber First Name	R
4	DA0 - 19.0	Loop 2330A 2-325-NM103	Insured Name	Other Insured Last Name	C
	DA0 - 20.0	Loop 2330A 2-325-NM104		Other Insured First Name	C
6	DA0 - 17.0	Loop 2000B 2-005-SBR02 Loop 2320 2-290-SBR02	Patient Relationship to Insured	Individual Relationship Code	C
7	DA2 – 04.0	Loop 2330A 2-332-N301	Insured's Address	Other Insured Address Line 1	C
	DA2 – 06.0	Loop 2330A 2-340-N401		Other Insured City	C
	DA2 - 07.0	Loop 2330A 2-340-N402		Other Insured State	C
	DA2 - 08.0	Loop 2330A 2-340-N403		Other Insured Zip Code	C
	DA2 - 09.0	Not Used	Insured Telephone Number		NR
8	CA0 - 17.0	Not Used	Patient Status		NR
	CA0 - 18.0	Not Used	Patient Student Status		NR
	CA0 - 19.0	Not Used	Patient Employment Status		NR
11	DA0 - 10.0	Loop 2320 2-290-SBR03	Insured's Policy Group Number	Insured Group or Policy Number	C
	DA0 - 05.0	Loop 2320 2-290-SBR09		Claim Filing Indicator Code	**C****
	DA0 - 06.0	Loop 2320 2-290-SBR05		Insurance Type Code	C
11C	DA0 - 11.0	Loop 2320 2-290-SBR04	Insurance Plan or Program Name	Other Insured Group Name	C
12	DA0 - 16.0	Loop 2300 2-130-CLM10	Patient Signature Source	Patient Signature Source Code	C
	EA0 - 13.0	Loop 2300 2-130-CLM09		Release of Information Indicator	R
14	EA0 - 07.0	Loop 2300 2-135-DTP03(439)	Date of Current Illness, etc.	Accident Date	C
	GC0 - 05.0	Loop 2300 2-135-DTP03(454) OR Loop 2400 2-455-DTP03(454)		Initial Treatment Date	C
15	EA0 - 15.0	Not Used	Patient Has Same/Similar Illness	Same/Similar Symptom Indicator	NR
	EA0 - 16.0	Loop 2300 2-135-DTP03(438) OR Loop 2400 2-455-DTP03(438)		Onset of Similar Symptoms or Illness	C
		Loop 2300 2-135-DTP03(431) OR Loop 2400 2-455-DTP03(431)	Date of current illness or injury	Onset of current illness or injury	C
17	EA0 - 24.0	Loop 2310A 2-250-NM103 OR Loop 2420F 2-500-NM103	Name of Referring Provider	Referring Provider Last Name	C
	EA0 – 25.0	Loop 2310A 2-250-NM104 OR Loop 2420F 2-500-NM104		Referring Provider First Name	C
			OR		
	FB1 - 06.0	Loop 2420E 2-500-NM103		Ordering Provider Last Name	C
	FB1 - 07.0	Loop 2420E 2-500-NM104		Ordering Provider First Name	C
			OR		
17A	FB1 - 09.0	Loop 2420E 2-525-REF02(1G)	I.D. Number of Referring Physician	Ordering Provider Secondary Identifier (UPIN)	C

			OR		
	FB0 - 09.0	Loop 2420E 2-**500**-NM109(**24 or 34)**		Order Provider Primary Identifier (**SSN or EIN**)	C
			OR		
	EA0 - 20.0	Loop 2310A 2-250-NM109(**24 or 34**)		Referring Provider Primary Identifier (**SSN or EIN**)	C
			OR		
		Loop 2420F 2-500-NM109(**24 or 34**)			
			OR		
	EA0 - 21.0	Loop 2310A 2-271-REF02(1G) OR		Referring Provider Secondary Identifier (UPIN)	C
	FB1 – 13.0	Loop 2420F 2-525-REF02(1G)			
19	EA1 - 16.0	Loop 2310E 2-250-NM109 OR Loop 2420D 2-500-NM109	Reserved for Local Use	Supervising Provider Primary Identifier (**UPIN**)	C
	FB1 - 21.0	Loop 2310E 2-**271**-REF02(1G) OR Loop 2420D-2-525-REF02(1G)		Supervising Provider Secondary Identifier (PIN)	C
	GC0 - 06.0	Loop 2300 2-135-DTP03(455) OR Loop 2400 2-455-DTP03(455)		X-Ray Date	C
	EA0 – 48.0	Loop 2300 2-135-DTP03(304) OR Loop 2400 2-455-DTP03(304)	Date Last Seen		C
	EA0 - 50.0	Loop 2300 2-220-CRC03(IH)		Homebound Indicator	C
	EA1 - 25.0	Loop 2300 2-135-DTP03(090/091)		Assumed and Relinquished Care Dates	C
	FA0 - 40.0	Loop 2400 2-450-CRC02(70)		Hospice Employed Provider Indicator	C
20	FB0 - 05.0	Loop 2400 2-488-PS102	Outside Lab	Purchased Service Charge	C
21	EA0 - 32.0	Loop 2300 2-231-HI01-02(BK)	Diagnosis	Principal Diagnosis Code	C
	EA0 - 33.0	Loop 2300 2-231-HI02-02(BF)		Diagnosis Code	C
	EA0 - 34.0	Loop 2300 2-231-HI03-02(BF)		Diagnosis Code	C
	EA0 - 35.0	Loop 2300 2-231-HI04-02(BF)		Diagnosis Code	C
22			Medicaid Resubmission Code		NR
23	DA0 - 14.0	Loop 2300 2-180-REF02(G1) OR Loop 2400 2-470-REF02(G1)	Prior Authorization Number	Prior Authorization or Referral Number	C
	FA0 - 34.0	Loop 2300 2-180-REF02(X4) OR Loop 2400 2-470-REF02(X4)	CLIA ID Number	CLIA Certification Number	C
	EA0 - 53.0	Loop 2310D 2-271-REF02(LU)	Care Plan Oversight (CPO) Number	CPO Number	C
	EA0 - 54.0	Loop 2300 2-180-REF02(LX)		Investigational Device Number	C
24A	FA0 - 05.0	Loop 2400 2-455-DTP03(472)	Dates of Service (s) (From date)	Service Date	R
	FA0 - 06.0	Loop 2400 2-455-DTP03(472)	Dates of Service (s) (To Date)	Service Date	C
24B	FA0 - 07.0	Loop 2300 2-130-CLM05-1 OR Loop 2400 2-370-SV105	Place of Service	Facility Type Code Place of Service Code	R
24C	FA0 - 08.0	Not Used	Type of Service	Type of Service Code	NR
24D	FA0 - 09.0	Loop 2400 2-370-SV101-2 (HC)	Procedures, Services, etc.	Procedure Code	R
	FA0 - 10.0	Loop 2400 2-370-SV101-3		Procedure Modifier 1	C
	FA0 - 11.0	Loop 2400 2-370-SV101-4		Procedure Modifier 2	C
	FA0 - 12.0	Loop 2400 2-370-SV101-5		Procedure Modifier 3	C
	FA0 - 36.0	Loop 2400 2-370-SV101-6		Procedure Modifier 4	C
24G	FA0 - 18.0	Loop 2400 2-370-SV104 (UN)	Days or Units of Service	Units of Service	R
			OR		
	FA0 - 19.0	Loop 2400 2-370-SV104 (MJ)		Anesthesia/Oxygen Minutes	R
24H	FB0 - 22.0	Loop 2400 2-370-SV112	EPSDT Family Plan	Family Planning Indicator	NR
24I	FA0 - 20.0	Loop 2400 2-370-SV109	EMG	Emergency Indicator	NR
24J	FB0 - 21.0	Loop 2400 2-370-SV115	COB	Co-pay Status Code	NR
24K	FA0 - 23.0	Loop 2310B 2-250-NM109(**24 or 34**)	Reserved for Local Use	Rendering Provider Primary Identifier (**SSN or EIN**)	C
			OR		
		Loop 2420A 2-500-NM109(**24 or 34**)			

	BA0 - 09.0	Loop 2310B 2-271-REF02(1C) OR Loop 2420A 2-525-REF02(1C)		Rendering Provider Secondary Identifier (PIN)	C
27	EA0 - 36.0	Loop 2300 2-130-CLM07	Accept Assignment	Medicare Assignment Code	R
31	EA0 - 37.0	Loop 2300 2-130-CLM06	Provider Signature Indicator	Provider or Supplier Signature Indicator	R
32	EA0 - 39.0	Loop 2310D 2-250-NM103	Facility Name and Address	Laboratory or Facility Name AND/OR	C
	EA1 - 04.0	Loop 2310D 2-250-NM109(**24or 32**) OR Loop 2420C 2-500-NM109(**24or 32**)		Laboratory or Facility Primary Identifier (**SSN or EIN**)	C
			OR		
		Loop 2310D 2-**271**-REF02(1C) OR Loop 2420C 2-525-REF02(1C)		Laboratory or Facility Secondary Identifier (**SSN or EIN**)	
	FB0 - 11.0	Loop 2310C 2-250-NM109(**24 or 34**) OR Loop 2400 2-488-PS101		Purchased Service Provider Primary Identifier (**SSN or EIN**)	C
		Loop 2310C 2-271-REF02(1C) **OR** Loop 2400 2-488-PS101 **OR** **Loop 2420B 2-525-REF02(1C)**		Purchased Service Provider Secondary Identifier (PIN)	
	FA0 - 31.0	Loop 2300 2-180-REF02(EW) OR Loop 2400 2-470-REF02(EW)		Mammography Certification Number	C
33	BA0 - 19.0	Loop 2010AA 2-015-NM103(85,1)	Provider's Billing Name & Address	Provider Last Name	R
	BA0 - 20.0	Loop 2010AA **or 2010AB** 2-015-NM104		Provider First Name	R
			OR	OR	
	BA0 - 18.0	Loop 2010AA **or 2010AB** 2-015-NM103(85,2)		Payer Organization Name	R
	BA1 - 13.0	Loop 2010AA **or 2010AB** 2-025-N301		Pay-To Provider Address 1	R
	BA1 - 15.0	Loop 2010AA **or 2010AB** 2-030-N401		Pay-To Provider City Name	R
	BA1 - 16.0	Loop 2010AA **or 2010AB** 2-030-N402		Pay-To Provider State Code	R
	BA1 - 17.0	Loop 2010AA **or 2010AB** 2-030-N403		Pay-To Provider Zip Code	R
	BA1 - 18.0	Loop 2010AA 2-040-PER04		Communication Number	C
			OR		
	BA0 - 09.0 BA0 - 02.0	Loop 2010AA **or 2010AB** 2-015-NM109(**24 or 34**)	Provider's Billing Name & Address	Billing Provider Primary Identifier (**SSN or EIN**)	R
	CA0 - 28.0	Loop 2010AA or 2010AB 2-035-REF02(1C)		Billing Provider Secondary Identifier (PIN)	C

Source: CMS Transmittal 1813 Date: August 1, 2003 Change Request 2631

COVERAGE/REIMBURSEMENT

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

2004 Medicare Physician Fee Schedule—Annual Changes

Effective January 1, 2004, new payment policies under the Medicare Physician Fee Schedule are established for billing services.

- The fee schedule update for 2004 is 1.5 percent. The conversion factor is $37.3374.
- The 2004 national average anesthesia conversion factor is $17.50.
- Section 1834(m) of the Social Security Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increased in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2004 is 2.9 percent. For calendar year 2004, the payment amount for HCPCS code "Q3014, telehealth originating site facility fee" is 80 percent of the lesser of the actual charge or $21.20.
- In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time he/she is present with resident. The anesthesiologist can bill base units if he/she is present with the resident throughout pre- and post-anesthesia care. The anesthesiologist should use the "AA" modifier to report such cases. The teaching anesthesiologist must document his/her involvement in cases with residents. The documentation must be sufficient to support the payment of the fee and available for review upon request.
- For Independent Laboratory Billing for the Technical Component of Physician Pathology Services to Hospital Patients, section 542 of the Benefits and Improvement Act of 2000 provides that the Medicare carrier can continue to pay for the technical component (TC) of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital. This provision had applied to TC services furnished during the 2-year period beginning on January 1, 2001. We will continue to make payments in accordance with Transmittal B-03-001 issued in January 2003 for 2004 and 2005.
- For skin lesions, benign, and malignant (*CPT* codes *11400* & *11600* series), CMS has withdrawn a proposal to make the work RVUs equivalent for removal of benign and malignant skin lesions in a budget neutral manner. A decision was made to maintain the current values and request that the specialty societies resurvey the services.
- The list of physicians who can enter into private contracts is expanded to include dentists, optometrists, and podiatrists. Previously, only physicians who were MDs and Doctors of Osteopathy could enter into private contracts with beneficiaries.
- For intensity modulated radiation therapy (IMRT), CMS will use the non-physician work pool methodology to establish final practice expense RVUs for 2004 that are approximately equal to the current ones.
- CMS will extend the deadline for submission of supplemental survey data for practice expense to March 1, 2004 to allow them to publish decisions regarding survey data in the proposed rule to provide an opportunity for public comments. The laboratory community has submitted survey data that will be addressed in next year's notice of proposed rulemaking (NPRM).
- There is a new definition of diabetes for diabetes self-management training (DSMT) at CFR 410.141 and medical nutritional therapy. In addition, the DSMT definition replaces the beneficiary's eligibility criteria in the old regulation.
- For dialysis patients seeing the doctor, CMS created separate temporary codes that describe procedures or services, known as G codes, for 1 physician visit per month, 2-3 visits per month, and 4 or more visits per month, with payment increasing with the number of visits. The aggregate payments for these services are approximately equal to current payments for *CPT* codes *90918* to *90921*.

CMS also created new G codes for the management of home dialysis patients in each of the age groups. In addition, four new G codes for home dialysis patients who are hospitalized during the month were also created. These codes are to be used to report daily management of home dialysis patients for the days the patient was not in the hospital. Provided on the folllwing page is a crosswalk from the current *CPT* codes to the G codes.

Patients Other than Home Dialysis

CPT Code	Age of Patient	New G Codes	Number of Visits
90918	<2	G0308	4+
		G0309	2 to 3
		G0310	One visit
90919	2 to 11	G0311	4+
		G0312	2 to 3
		G0313	One visit
90920	12 to 19	G0314	4+
		G0315	2 to 3
		G0316	One visit
90921	20 +	G0317	4+
		G0318	2 to 3
		G0319	One visit

Home Dialysis Patients (entire month)

No distinct *CPT* Codes	< 2	G0320
	2 – 11	G0321
	12 – 19	G0322
	20 +	G0323

Home Dialysis Patients (partial month only—perday)

90922	< 2	G0324
90923	2 – 11	G0325
90924	12-19	G0326
90925	20 +	G0327

- As in previous final rules, CMS has updated the list of certain services subject to the physician self-referral prohibition to address new and revised CPT and HCPCS codes.
- For chemotherapy administration, Section 303 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (DIMA) revises some of the Medicare physician payment policies for chemotherapy services.

1. For chemotherapy services furnished prior to January 1, 2004, Medicare allows CPT code 96408 (Chemotherapy administration, intravenous; push technique) to be reported only once per day even if the physician administers multiple drugs. For services furnished on or after January 1, 2004, we will allow code *96408* to be reported more than once per day for each drug administered.
2. Section 303 of DIMA requires the Secretary to establish work relative value units for drug administration services equal to the work relative values for a level 1 office medical visit for an established patient (*CPT* code *99211*). The law defines drug administration services as those services classified as of October 1, 2003, within any of the following groups: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections; for which there are no work relative values units assigned and for which national relative values are assigned. *CPT* code *99211* is a level 1 established patient office visit with physician work relative value units of .17. CMS is adding physician work relative value units of .17 to the following drug administration services: *CPT* codes *90780-90781, 90782-90788, 96400, 96408-96425, 96520,* and *96530*.
3. For services furnished on or after January 1, 2004, Medicare will not allow *CPT* code *99211* to be billed on the same day as a drug administration code that has a work relative value unit. We will continue to allow other office visits to be billed on the same day as a drug administration service with modifier 25 indicating that a separately identifiable evaluation and management service was provided.
4. CMS will revise the Internet-Only Manual in 2004 to incorporate these revisions.

Source: CMS Pub. 100-20 Transmittal: 34 Date: December 24, 2003 Change Request 3028

2004 Medicare Physician Fee Schedule Increase and Extension of the Annual Participation Enrollment Period

Physicians, limited licensed practitioners, and suppliers have until February 17, 2004, to consider the new fee schedule increase before making your 2004 participation decision. The new fee schedule incorporates increases passed by Congress and signed by the President into law on December 8, 2003.

Before making your 2004 Medicare participation decision, review the rate increase authorized by the Medicare Prescription Drug, Improvement, and Modernization Act. If you decide to maintain the same participation status in 2004 as you have now, ***you need take no further action***.

After reviewing the new rates, also understand the extended timeframes for making your decision and the rules involving your 2004 payments while your decision is being processed, especially if you change your participation status.

If you decide to change your participation status, be sure to complete the participation agreement that you received from your carrier and submit it to that carrier as soon as possible. Please know that we are extending the 2004 participation enrollment period and your carrier will accept the agreements postmarked as late as February 17, 2004.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, recently passed by Congress and signed into law by the President, establishes a 1.5 percent increase in the conversion factor to be effective on January 1, 2004. On average, Medicare Physician Fee Schedule (MPFS) rates will increase by approximately 1.5 percent. However, please remember that changes to relative value units and geographic practice cost indices (GPCIs) could result in an increase that is slightly more or less than 1.5 percent for any specific service in a given area.

Because this change has happened so late in the year, the Centers for Medicare & Medicaid Services (CMS) is extending the participation enrollment period for 2004. The enrollment period will continue beyond December 31, 2003, because we will accept enrollment forms that are postmarked as late as February 17, 2004. Thus, the complete enrollment period this year runs from November 14, 2003 through February 17, 2004.

Impact on Claims

Although the enrollment period runs until February 17, 2004, the effective date of the agreement will be January 1, 2004, and Medicare is ready to process your claims in a timely and accurate manner. If you change your participation status by submitting a form after December 31, 2003, you should begin submitting claims in accordance with the participation decision you convey as soon as you submit that form.

Enrollments and withdrawals for 2004 received after December 31, 2003, will be recorded in our system as soon as possible after receipt. Until your form is received and recorded in our system, your 2004 claims will be processed using your 2003 status. Such claims will not be reopened or reprocessed once your form and participation status are recorded unless you specifically notify us to do so.

Additional Information

The 2004 fee schedule is posted on our Web sites. If you subscribe to our "listserv," called *eNews*, you received notice that the 2004 fee schedule was been posted to our Web site on December 31, 2003. We will make hardcopies of the fee schedule available to you, upon request; however, there is a reasonable fee to cover the expense of providing a hardcopy.

If you have any questions, please contact us via the toll-free number or visit our Web site. In Connecticut, the number is 1-866-419-9455; the Web address is *http://www.connecticutmedicare.com*. In Florida, the number is 1-866-454-9007, and the Web address is *http://www.floridamedicare.com*.

Additionally, CMS makes information available on its Web site regarding the fee schedule. This information can be found at *http://www.cms.hhs.gov/physicians/pfs/*.

CMS also maintains a fee schedule lookup tool on its Web site to assist physicians. This tool can be found at *http://www.cms.hhs.gov/physicians/mpfsapp/default.asp*.

Also, the official instruction issued to your carrier regarding this fee schedule and enrollment period change may be found by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*. Once at that Web page, look for 3009 in the CR NUM column on the right and click on the file for that CR.

Please know that Medicare appreciates the valuable services you provide to Medicare beneficiaries and hopes this information encourages you to continue or elect participation status in this program.

Source: CMS Pub. 100-20 Transmittal: 38 Date: January 2, 2004 Change Request 3040 Medlearn Matters number MM3009

AMBULANCE

Reminder Notice of the Implementation of the Ambulance Fee Schedule Transition

On April 1, 2002, CMS implemented a new fee schedule that applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers (i.e., hospitals, critical access hospitals, and skilled nursing facilities). The fee schedule was effective for claims with dates of services on or after April 1, 2002. Under the fee schedule, ambulance services covered under Medicare will be paid based on the lower of the actual billed amount or the ambulance fee schedule amount.

The fee schedule is being phased in over a 5-year period. When fully implemented, the fee schedule will replace the retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers. January 1, 2004, began the third year of the 5-year transition period.

- For covered ambulance services, supplies furnished, and mileage incurred on or after January 1, 2004, through December 31, 2004, the Medicare allowed amount will be determined on the basis of 60 percent of the national fee schedule amount, plus 40 percent of the provider's reasonable cost or supplier's reasonable charge.

  The updated amounts for 2004 were provided to suppliers in early February 2004.
- For ambulance services, supplies furnished, and mileage incurred on or after January 1, 2005, through December 31, 2005, the Medicare allowed amount will be determined on the basis of 80 percent of the national fee schedule amount, plus 20 percent of the provider's reasonable cost or supplier's reasonable charge.
- For ambulance services, supplies furnished, and mileage incurred on or after January 1, 2006, and thereafter, the Medicare allowed amount will be determined solely on the basis of the national fee schedule amount.

Source: CMS Transmittal AB-03-146, CR 2834

2004 Ambulance Inflation Factor

Section 1834(l)(3)(A) of the Act provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2004 that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF).

During the transition period, the AIF is applied to both the fee schedule portion of the blended payment amount (incorporated in the ambulance fee schedule file), and to the reasonable charge portion of the blended payment amount separately for each ambulance provider/supplier. Then, these two amounts are added together to determine the total payment amount for each provider/supplier. The blending percentages used to combine these two components of the payment amounts for ambulance services for calendar year (CY) 2004 are 40 percent of the reasonable charge and 60 percent of the ambulance fee schedule.

The AIF for CY 2004 is **2.1 percent**. The blending percentages used to combine the two components of the payment amounts for ambulance services for CY 2004 are **40 percent** of the reasonable charge/ and **60 percent** of the ambulance fee schedule. Part B coinsurance and deductible requirements apply.

Source: CMS Pub 100-4 Transmittal 56, CR 3000

Payment for Ambulance Services Furnished by New Suppliers

Medicare-covered ambulance services are paid based on a fee schedule (FS) published in the February 27, 2002, issue of the *Federal Register* (Volume 67, Number 39) described originally in Program Memorandum (PM) AB-00-88 and further clarified in a series of subsequent PMs. This fee schedule is phased in over a transition period during which the Medicare payment allowance is based on a blend of the supplier's reasonable charge and the new fee schedule amount.

The information below addresses the amount to be used for a new supplier's reasonable charge for the period January 1, 2000, through March 31, 2002, and also for the reasonable charge portion of the blended rate applicable during the ambulance FS transition period. A new supplier is defined as:

1. An entity that established itself as an ambulance supplier after it could no longer establish a customary charge because carriers no longer profile charges;
2. An established supplier that had never billed Medicare and began furnishing and billing for Medicare ambulance services for the first time after it could no longer establish a customary charge because carriers no longer profile charges;
3. An established supplier that begins furnishing services in another geographic area; or
4. An established supplier that begins furnishing a service that it did not previously provide. For example, an ambulance supplier that formerly furnished only BLS services begins furnishing ALS services as well.

For a new supplier, the reasonable charge to be used for ambulance services furnished on or after January 1, 2000, including the reasonable charge portion of the blended transitional rate; is the lower of:

- The supplier's submitted charge,
- The 50th percentile prevailing charge*, or
- The prevailing IIC (inflation indexed charge)

** The 50th percentile prevailing is used as a new supplier's "default" customary charge for the purposes of calculating the supplier's reasonable charge.*

The 50th percentile amounts are subject to the IIC requirements applied to payment allowances for ambulance services. Per PM AB-00-88 (reissued as AB-01-185), carriers no longer construct customary and prevailing charge profiles from submitted claims. Instead, the ambulance inflation update factor is applied to the previous year's allowances to determine current reasonable charge amounts.

Following established program claims data requirements, the new supplier's customary charge is updated on January 1 of the year following the calendar year in which the new supplier has established with the Medicare carrier charge experience dating back at least to the month of April. Because carriers no longer profile charges, the updated customary charge is set at the prevailing IIC as indexed by inflation. Therefore, if a supplier establishes charge experience with its Medicare carrier that dates back to April, that supplier's customary charge for that service(s) may be updated to the prevailing IIC effective for services furnished on or after the following January 1 (i.e., after approximately 9 months). If a supplier establishes charge experience with its Medicare carrier that dates back to May, that supplier's customary charge for that service(s) may be updated to the prevailing IIC effective for services furnished on or after January 1 of the year following the subsequent January 1 (i.e., after approximately 20 months).

Example

Note: the dollar values below were selected for simplicity and are not actual amounts.

Supplier effective date February 1, 2003; supplier begin billing carrier for a procedure on February 1, 2003. Reimbursement for calendar year 2004 is based on:

60% of the ambulance fee schedule for that procedure and point-of-pickup ZIP code plus
40% of the reasonable charge (the *lower* of:
75th prev: example $10.00
75th prev IIC: ex. $8.00
50th prev: ex. $7.00)

In this example, the reasonable charge portion ($7.00 at 40% = $2.80) plus the ambulance fee schedule (AFS) portion (ex: AFS amount of $10.00 at 60% = $6.00) yields a reimbursement amount of $8.80.

If we are notified that a supplier is new, we will validate that the supplier began submitting Medicare claims for procedure A0425 prior to April 1, 2003, and we will install the 75th percentile prevailing IIC as the supplier's default customary charge. Reimbursement will then be based on

60% of the ambulance fee schedule for that procedure and point-of-pickup ZIP code plus
40% of the reasonable charge (the *lower* of:
75th prev: ex. $10.00
75th prev IIC: ex. $8.00)

The revised reasonable charge portion ($8.00 at 40% = $3.20) plus the ambulance fee schedule portion (ex. AFS amount of $10.00 at 60% = $6.00) yields a new reimbursement amount of $9.20.

Source: CMS Pub. 100-20 Transmittal: 23 Date: November 21, 2003 Change Request 2700

DENTAL SERVICES

Treatment of Certain Dental Claims as a Result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Providers who submit dental claims for services provided to Medicare beneficiaries need to be aware of the new law related to claims submissions to supplemental or other group health insurers of Medicare beneficiaries.

As of February 8, for outpatient dental services that are not covered by Medicare, you do not need to submit a claim to Medicare and receive a denial if the beneficiary has group secondary or supplemental coverage. Group health plans are prohibited from requiring such determinations as of February 8 for such services.

A group health plan may continue to require such determinations in cases involving or appearing to involve inpatient dental hospital services, or other dental services covered by Medicare.

Please amend your procedures regarding dental service claims for Medicare patients as reflected by the new legislation. See the "Additional Information" section for further illumination.

Background

Under present law, the Medicare benefit does not include coverage of most dental services. Some insurers have required dentists to receive a claim denial from Medicare before they will process a claim from the dentist for a Medicare beneficiary holding coverage from that group health insurer. Under section 950 of the Medicare Prescription Drug, Improvement, and Modernization act of 2003, a group health plan providing

supplemental or secondary coverage to Medicare beneficiaries cannot require dentists to obtain a claim denial from Medicare for dental services that are not covered by Medicare before paying the claim

However, a claims determination, i.e., a submission of a claim to Medicare, may be required for inpatient dental hospital services or dental services specifically covered by Medicare. (Payment may be made under part A for these services.)

This section of the new legislation is to be effective 60 days after enactment of the legislation, which was enacted on December 8, 2003. Thus, this provision is effective as of February 8, 2004.

Additional Information

For your convenience, the actual text of Section 950 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reads as follows:

> Sec. 950. Treatment of Certain Dental Claims
> (a) In General—Section 1862 (42 U.S.C. 1395y) is amended by adding at the end, after the subsection transferred and redesignated by section 948 (a), the following new subsection:
>
> (k) (1) Subject to paragraph (2), a group health plan (as defined in subsection (a) (1) (A) (v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a Medicare claims determination under this title for dental benefits specifically excluded under subsection (a) (12) as a condition of making a claims determination for such benefits under the group health plan.
>
> (2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.
>
> (b) Effective Date.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

Source: Medlearn Matters number SE0402

DRUGS AND BIOLOGICALS

New Basis for Medicare Drug Payment Amounts under Part B

This replaces information that was posted to our provider education Web site on January 30, 2004, based on CMS Pub.100-04, Rev.54, which was issued on December 24, 2003. Since then, CMS has issued revised pricing files. The new amounts are provided in this article.

Beginning January 1, 2004, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (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 Average Wholesale Price (AWP) reflected in the published compendia as of April 1, 2003, for those drugs and biologicals furnished on and after January 1, 2004. There are exceptions to this general rule as summarized below.

The 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 as 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 based on 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.) approved by the Food and Drugs Administration (FDA) subsequent to April 1, 2003. A drug is not considered to be new if: the brand or manufacturer of the drug changes; a new vial size is developed; the drug receives a new indication; or the drug is a combination of existing drugs.
- 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 section 20 of Chapter 17 of the Medicare Claims Processing Manual, Pub. 100-04.
- The payment limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2004 are 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted.
- The payment limits for drugs and biologicals furnished in connection with dialysis and billed by independent dialysis facilities are based on 95 percent of the AWP reflected in the published compendium as of September 1, 2003. The payment limits in the FI file are all based on 95 percent of the AWP reflected in the published compendium as of September 1, 2003.

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

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

The 2004 MMA drug payment limits effective January 1, 2004 are as follows:

Code	AWP %	2004 Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)	ESRD %	2004 Payment Limit for ESRD Drugs Separately Billed by Independent ESRD Facilities	DME Infusion %	2004 Payment Limit for Drugs when Infused through DME
90371	85	$581.40	95	$649.80		
90375	85	$65.18	95	$72.85		
90376	85	$69.89	95	$78.11		
90385	85	$32.13	95	$34.77		
90585	85	$143.28	95	$160.13		
90632	85	$62.94	95	$74.54		
90633	85	$26.66	95	$29.80		
90634	85	$26.66	95	$29.80		
90645	85	$21.76	95	$24.32		
90658	95	$9.95	95	$9.95		
90659	95	$9.95	95	$9.95		
90675	85	$121.83	95	$136.16		
90691	85	$37.58	95	$42.00		
90700	85	$20.05	95	$22.41		
90703	85	$12.86	95	$14.37		
90704	85	$17.38	95	$19.43		
90705	85	$13.45	95	$15.03		
90706	85	$14.97	95	$16.74		
90707	85	$34.93	95	$39.04		
90713	85	$23.00	95	$25.71		
90716	85	$57.86	95	$68.83		
90717	85	$52.93	95	$59.17		
90718	85	$10.31	95	$11.52		
90720	85	$33.63	95	$37.59		
90721	85	$43.70	95	$48.84		
90732	95	$18.62	95	$18.62		
90733	85	$58.66	95	$69.45		
90735	85	$71.37	95	$79.76		
90740	95	$110.92	95	$110.92		
90743	95	$27.05	95	$27.05		
90744	95	$27.05	95	$27.05		
90746	95	$55.46	95	$55.46		
90747	95	$110.92	95	$110.92		
J0130	85	$459.02	95	$513.02		
J0150	85	$34.80	95	$37.71		
J0151	85	$199.70	95	$229.26		
J0152	85	$66.56	95	$76.42		
J0170	85	$2.10	95	$2.34		
J0200	85	$17.03	95	$19.04		
J0205	94	$37.13	95	$37.52		
J0207	85	$405.29	95	$452.97		
J0210	85	$10.63	95	$11.88		
J0215	85	$28.19	95	$31.51		
J0256	85	$2.38	95	$2.66		
J0270	85	$0.31	95	$0.34		
J0275	85	$18.17				
J0280	85	$0.94	95	$1.04		
J0282	85	$5.51	95	$16.05		
J0285	85	$9.30	95	$10.39	95	$10.28
J0287	85	$19.55	95	$21.85	95	$21.85
J0288	85	$13.60	95	$15.20	95	$15.20
J0289	85	$32.03	95	$35.80	95	$35.80
J0290	85	$1.48	95	$1.65		
J0295	85	$6.64	95	$7.42		
J0300	85	$2.38	95	$2.66		
J0330	85	$0.17	95	$0.20		
J0360	85	$14.34	95	$16.04		
J0380	85	$1.14	95	$1.27		

Code	AWP %	2004 Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)	ESRD %	2004 Payment Limit for ESRD Drugs Separately Billed by Independent ESRD Facilities	DME Infusion %	2004 Payment Limit for Drugs when Infused through DME
J0390	85	$17.61	95	$19.68		
J0395	85	$163.20	95	$182.40		
J0456	85	$22.72	95	$25.38		
J0460	85	$0.74	95	$1.19		
J0470	85	$21.18	95	$23.67		
J0475	85	$192.53	95	$215.18	95	$215.18
J0476	85	$71.40	95	$79.80	95	$79.80
J0500	85	$15.27	95	$17.06		
J0515	85	$3.49	95	$3.90		
J0520	85	$4.78	95	$5.34		
J0530	85	$10.67	95	$11.92		
J0540	85	$20.94	95	$23.40		
J0550	85	$44.84	95	$50.12		
J0560	85	$8.85	95	$9.89		
J0570	85	$17.70	95	$19.78		
J0580	85	$35.39	95	$39.56		
J0583	85	$1.43	95	$1.74		
J0585	85	$4.43	95	$4.95		
J0587	85	$7.86	95	$8.79		
J0592	85	$0.92	95	$1.03		
J0595	85	$3.94	95	$4.40		
J0600	85	$39.46	95	$44.10		
J0610	85	$0.90	95	$1.44		
J0620	85	$5.55	95	$6.42		
J0630	85	$34.37	95	$38.41		
J0636	85	$1.24	95	$1.38		
J0637	85	$29.48	95	$32.95		
J0640	80	$3.00	95	$3.56		
J0670	85	$1.85	95	$2.07		
J0690	85	$2.01	95	$2.25		
J0692	85	$7.28	95	$8.13		
J0694	85	$9.56	95	$10.69		
J0696	85	$13.35	95	$14.92		
J0697	85	$5.75	95	$6.42		
J0698	85	$8.51	95	$9.51		
J0702	85	$4.45	95	$4.98		
J0704	85	$0.96	95	$1.07		
J0706	85	$3.07	95	$3.44		
J0713	85	$6.04	95	$6.75		
J0715	85	$4.44	95	$4.96		
J0720	85	$6.46	95	$7.22		
J0725	85	$2.39	95	$3.09		
J0735	85	$49.35	95	$55.16		
J0740	85	$754.80	95	$843.60		
J0743	85	$14.20	95	$15.87		
J0744	85	$12.25	95	$13.69		
J0745	85	$0.41	95	$0.87		
J0760	85	$6.32	95	$7.07		
J0770	85	$48.45	95	$54.15		
J0780	85	$3.74	95	$8.84		
J0800	85	$83.15	95	$92.94		
J0835	85	$75.06	95	$81.00		
J0850	85	$637.12	95	$712.07		
J0880	85	$21.20	95	$23.69		
J0895	85	$13.98	95	$15.63	95	$15.63
J0900	85	$1.46	95	$1.63		
J0945	85	$0.85	95	$0.95		
J0970	85	$1.44	95	$1.62		
J1000	85	$1.70	95	$1.90		
J1020	85	$2.40	95	$2.68		
J1030	85	$3.70	95	$4.13		
J1040	85	$7.40	95	$8.27		
J1051	85	$4.50	95	$5.04		

Code	AWP %	2004 Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)	ESRD %	2004 Payment Limit for ESRD Drugs Separately Billed by Independent ESRD Facilities	DME Infusion %	2004 Payment Limit for Drugs when Infused through DME
J1056	85	$22.02	95	$24.61		
J1060	85	$3.99	95	$4.46		
J1070	85	$4.43	95	$4.95		
J1080	85	$8.44	95	$9.43		
J1094	85	$0.64	95	$0.71		
J1100	86	$0.10	95	$0.10		
J1110	85	$36.04	95	$36.10		
J1120	85	$18.36	95	$20.52		
J1160	85	$1.59	95	$1.79		
J1165	85	$0.77	95	$0.86		
J1170	85	$1.38	95	$1.55	95	$1.49
J1180	85	$8.07	95	$9.02		
J1190	85	$209.34	95	$233.97		
J1200	85	$1.43	95	$1.61		
J1205	85	$9.38	95	$10.49		
J1212	85	$39.91	95	$44.60		
J1230	85	$0.68	95	$0.75		
J1240	85	$0.34	95	$0.38		
J1245	85	$5.10	95	$5.70		
J1250	85	$4.24	95	$4.74	95	$4.74
J1260	80	$13.85	95	$16.45		
J1270	85	$4.92	95	$5.50		
J1320	85	$2.15	95	$2.40		
J1325	85	$16.16	95	$18.06	95	$12.64
J1327	85	$11.48	95	$12.83		
J1335	85	$21.24	95	$23.74		
J1364	85	$3.14	95	$3.59		
J1380	85	$0.48	95	$0.53		
J1390	85	$1.02	95	$1.07		
J1410	85	$55.04	95	$61.51		
J1435	85	$0.51	95	$0.57		
J1436	85	$68.85	95	$76.95		
J1438	85	$138.83	95	$156.25		
J1440	81	$158.50	95	$185.90		
J1441	81	$267.79	95	$314.07		
J1450	85	$85.83	95	$97.61		
J1452	85	$850.00	95	$950.00		
J1455	85	$11.70	95	$13.07	95	$13.07
J1460	85	$10.20	95	$12.17		
J1470	85	$20.40	95	$24.35		
J1480	85	$30.63	95	$36.56		
J1490	85	$40.80	95	$48.69		
J1500	85	$51.00	95	$60.87		
J1510	85	$61.08	95	$72.88		
J1520	85	$71.33	95	$85.12		
J1530	85	$81.60	95	$97.38		
J1540	85	$91.89	95	$109.66		
J1550	85	$102.00	95	$121.72		
J1563	80	$66.00	95	$78.38		
J1564	80	$0.72	95	$0.85		
J1565	85	$14.81	95	$18.12		
J1570	85	$31.53	95	$35.24	95	$35.24
J1580	85	$1.70	95	$2.07		
J1590	85	$0.81	95	$0.90		
J1595	85	$30.13	95	$33.67		
J1600	85	$12.10	95	$13.52		
J1610	85	$40.80	95	$45.60		
J1620	85	$180.72	95	$201.98		
J1626	80	$15.62	95	$18.54		
J1630	85	$6.11	95	$6.83		
J1631	85	$8.16	95	$9.12		
J1642	80	$0.05	95	$0.06		
J1644	85	$0.35	95	$0.40		

Code	AWP %	2004 Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)	ESRD %	2004 Payment Limit for ESRD Drugs Separately Billed by Independent ESRD Facilities	DME Infusion %	2004 Payment Limit for Drugs when Infused through DME
J1645	85	$14.04	95	$15.69		
J1650	85	$5.46	95	$6.47		
J1652	85	$7.40	95	$8.27		
J1655	85	$3.43	95	$3.83		
J1670	85	$106.25	95	$119.70		
J1700	85	$0.30	95	$0.34		
J1710	85	$4.98	95	$5.57		
J1720	85	$1.55	95	$2.07		
J1730	85	$110.01	95	$122.95		
J1742	85	$224.89	95	$251.35		
J1745	85	$58.79	95	$65.70		
J1750	85	$16.03	95	$17.91		
J1756	85	$0.58	95	$0.66		
J1785	94	$3.71	95	$3.75		
J1790	85	$2.50	95	$2.80		
J1800	85	$8.45	95	$11.63		
J1810	85	$8.45	95	$9.44		
J1815	85	$0.09	95	$0.10		
J1817					95	$2.80
J1830	85	$60.14	95	$66.40		
J1835	85	$32.97	95	$38.65		
J1840	85	$2.94	95	$3.30		
J1850	85	$0.44	95	$0.49		
J1885	85	$3.19	95	$3.56		
J1890	85	$9.18	95	$10.26		
J1910	85	$13.88	95	$16.14		
J1940	85	$0.88	95	$0.93		
J1950	85	$453.79	95	$517.32		
J1955	85	$30.60	95	$34.20		
J1956	85	$18.62	95	$20.81		
J1960	85	$3.37	95	$3.76		
J1980	85	$7.66	95	$8.90		
J1990	85	$22.37	95	$24.99		
J2000	85	$3.57	95	$3.99		
J2001	85	$0.88	95	$0.98		
J2010	85	$2.84	95	$3.31		
J2020	85	$32.93	95	$38.98		
J2060	85	$2.81	95	$3.14		
J2150	85	$2.92	95	$3.27		
J2175	85	$0.48	95	$0.53	95	$0.56
J2180	85	$4.02	95	$4.50		
J2185	85	$4.40	95	$4.92		
J2210	85	$3.67	95	$4.10		
J2250	85	$1.14	95	$1.28		
J2260	85	$46.15	95	$51.58	95	$51.58
J2270	85	$0.60	95	$0.77	95	$0.71
J2271	85	$6.99	95	$11.07	95	$11.07
J2275	85	$1.70	95	$2.38	95	$4.39
J2280	85	$9.30	95	$10.39		
J2300	85	$1.35	95	$1.59		
J2310	85	$2.12	95	$2.49		
J2320	85	$3.43	95	$3.84		
J2321	85	$6.25	95	$7.67		
J2322	85	$14.08	95	$15.74		
J2324	85	$135.66	95	$151.62		
J2352	85	$71.11	95	$181.88		
J2353	85	$71.09	95	$92.68		
J2354	85	$3.81	95	$4.25		
J2355	85	$239.67	95	$267.86		
J2360	85	$4.84	95	$5.42		
J2370	85	$1.15	95	$1.28		
J2400	85	$5.72	95	$6.39		
J2405	87	$5.58	95	$6.09		

Code	AWP %	2004 Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)	ESRD %	2004 Payment Limit for ESRD Drugs Separately Billed by Independent ESRD Facilities	DME Infusion %	2004 Payment Limit for Drugs when Infused through DME
J2410	85	$2.64	95	$3.09		
J2430	85	$237.88	95	$265.87		
J2440	85	$2.98	95	$3.33		
J2460	85	$0.91	95	$1.01		
J2501	85	$4.49	95	$5.33		
J2505	85	$2,507.50	95	$2,802.50		
J2510	85	$8.59	95	$9.60		
J2515	85	$1.18	95	$1.46		
J2540	85	$0.26	95	$0.29		
J2543	85	$4.36	95	$4.90		
J2545	85	$40.12	95	$44.84		
J2550	85	$2.55	95	$2.85		
J2560	85	$1.44	95	$1.62		
J2590	85	$1.15	95	$1.28		
J2597	85	$3.09	95	$3.45		
J2650	85	$0.22	95	$0.31		
J2670	85	$3.51	95	$3.92		
J2675	85	$3.18	95	$3.62		
J2680	85	$8.02	95	$8.96		
J2690	85	$1.24	95	$1.43		
J2700	85	$0.71	95	$0.80		
J2710	85	$0.59	95	$0.67		
J2720	85	$0.68	95	$0.76		
J2725	85	$21.83	95	$24.40		
J2730	85	$92.12	95	$102.96		
J2760	85	$28.56	95	$31.92		
J2765	85	$1.67	95	$1.90		
J2770	85	$102.52	95	$114.58		
J2780	85	$1.29	95	$1.43		
J2783	85	$105.54	95	$117.96		
J2788	85	$45.81	95	$34.77		
J2790	85	$89.76	95	$100.32		
J2792	85	$18.39	95	$20.55		
J2795	85	$0.06	95	$0.07		
J2800	85	$3.40	95	$3.80		
J2820	80	$24.47	95	$29.06		
J2910	85	$15.49	95	$17.31		
J2912	85	$0.44	95	$0.49		
J2916	85	$7.31	95	$8.17		
J2920	85	$1.41	95	$2.11		
J2930	85	$1.72	95	$3.24		
J2940	85	$40.76	95	$45.56		
J2941	85	$41.09	95	$45.92		
J2950	85	$0.41	95	$0.46		
J2993	85	$1,168.75	95	$1,364.44		
J2995	85	$79.69	95	$89.06		
J2997	85	$32.83	95	$36.70		
J3000	85	$5.67	95	$6.35		
J3010	85	$0.83	95	$0.93	95	$0.70
J3030	85	$23.76	95	$26.56		
J3070	85	$4.67	95	$5.23		
J3100	85	$2,407.63	95	$2,690.88		
J3105	85	$26.30	95	$29.39		
J3120	85	$8.03	95	$8.98		
J3130	85	$16.07	95	$17.96		
J3140	85	$0.28	95	$0.40		
J3150	85	$0.84	95	$0.94		
J3230	85	$3.93	95	$4.40		
J3240	85	$552.50	95	$617.50		
J3245	85	$421.77	95	$471.39		
J3250	85	$1.25	95	$1.55		
J3260	85	$3.99	95	$4.46		
J3265	85	$1.39	95	$1.56		

Code	AWP %	2004 Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)	ESRD %	2004 Payment Limit for ESRD Drugs Separately Billed by Independent ESRD Facilities	DME Infusion %	2004 Payment Limit for Drugs when Infused through DME
J3280	85	$5.06	95	$5.65		
J3301	85	$1.43	95	$1.60		
J3302	85	$0.31	95	$0.33		
J3303	85	$0.90	95	$1.01		
J3305	85	$127.50	95	$142.50		
J3315	85	$356.66	95	$398.62		
J3320	85	$25.30	95	$28.27		
J3360	85	$0.77	95	$0.85		
J3364	85	$50.65	95	$10.23		
J3365	85	$457.66	95	$511.50		
J3370	85	$2.58	95	$7.03		
J3395	85	$1,304.75	95	$1,603.13		
J3410	85	$1.08	95	$1.21		
J3411	85	$0.81	95	$0.90		
J3415	85	$0.47	95	$0.52		
J3420	85	$0.15	95	$0.17		
J3430	85	$1.98	95	$2.21		
J3465	85	$4.51	95	$4.99		
J3475	85	$0.20	95	$0.23		
J3480	85	$0.07	95	$0.08		
J3485	85	$0.91	95	$1.02		
J3486	85	$18.60	95	$20.79		
J3487	85	$194.54	95	$227.86		
J7030	85	$8.89	95	$11.31		
J7040	85	$5.64	95	$4.68		
J7042	85	$8.45	95	$9.44		
J7050	85	$2.22	95	$2.83		
J7051	85	$0.68	95	$0.76		
J7060	85	$8.09	95	$7.50		
J7070	85	$9.78	95	$10.97		
J7100	85	$22.47	95	$25.11		
J7110	85	$12.72	95	$14.21		
J7120	85	$11.13	95	$12.45		
J7130	85	$0.44	95	$0.52		
J7190	95	$0.87	95	$0.87		
J7191	95	$2.04	95	$2.04		
J7192	95	$1.29	95	$1.29		
J7193	95	$1.12	95	$1.12		
J7194	95	$0.40	95	$0.40		
J7195	95	$0.95	95	$0.95		
J7197	95	$1.50	95	$1.50		
J7198	95	$1.43	95	$1.43		
J7308	85	$90.31	95	$100.94		
J7310	85	$4,250.00	95	$4,750.00		
J7317	85	$124.11	95	$138.71		
J7320	82	$201.24	95	$233.14		
J7330	85	$13,566.00	95	$15,920.10		
J7340	85	$26.21	95	$29.30		
J7342	85	$13.78	95	$16.16		
J7500	85	$1.11				
J7501	85	$53.54	95	$59.84		
J7502	85	$4.67				
J7504	85	$249.36	95	$289.85		
J7506	85	$0.03				
J7507	85	$3.13				
J7508	85	$15.64				
J7509	85	$0.44				
J7510	85	$0.03				
J7511	85	$319.94	95	$357.58		
J7513	85	$380.36	95	$425.11		
J7515	85	$1.17				
J7517	86	$2.55				
J7520	85	$6.38				

Code	AWP %	2004 Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)	ESRD %	2004 Payment Limit for ESRD Drugs Separately Billed by Independent ESRD Facilities	DME Infusion %	2004 Payment Limit for Drugs when Infused through DME
J7525	85	$106.29	95	$118.80		
J7608	80	$5.33				
J7618	80	$0.12				
J7619	80	$0.39	95	$0.41		
J7621	85	$3.40	95	$1.90		
J7622	85	$0.58				
J7626	85	$4.04				
J7631	80	$0.31				
J7633	85	$0.05				
J7635	85	$0.20				
J7636	85	$0.32				
J7637	85	$0.09				
J7638	85	$0.16				
J7639	85	$14.92				
J7641	85	$0.63				
J7642	85	$0.50				
J7643	85	$0.83				
J7644	80	$2.82				
J7658	85	$6.51				
J7659	85	$6.56				
J7681	85	$25.71				
J7682	85	$44.08				
J7683	85	$0.10				
J7684	85	$0.17				
J8510	85	$1.86				
J8520	90	$3.21				
J8521	90	$10.69				
J8530	85	$1.75				
J8560	85	$40.49				
J8600	85	$2.24				
J8610	85	$2.61				
J8700	85	$6.58				
J9000	80	$8.16	95	$12.54		
J9001	85	$352.06	95	$416.69	95	$393.48
J9010	85	$523.00	95	$584.53		
J9015	85	$657.15	95	$734.46		
J9017	85	$32.94	95	$36.81		
J9020	85	$56.02	95	$62.61		
J9031	85	$143.28	95	$160.13		
J9040	85	$150.61	95	$182.40	95	$289.37
J9045	81	$126.83	95	$155.65		
J9050	85	$121.84	95	$142.49		
J9060	85	$13.56	95	$15.15		
J9062	85	$67.79	95	$75.76		
J9065	85	$45.90	95	$51.30	95	$61.72
J9070	85	$5.13	95	$5.73		
J9080	85	$9.74	95	$10.89		
J9090	85	$20.45	95	$22.86		
J9091	85	$40.92	95	$45.73		
J9092	85	$81.82	95	$91.45		
J9093	85	$5.21	95	$4.88		
J9094	85	$10.41	95	$9.77		
J9095	85	$20.45	95	$24.42		
J9096	85	$40.92	95	$48.86		
J9097	85	$83.95	95	$97.75		
J9098	85	$332.35	95	$371.45		
J9100	85	$7.33	95	$8.19	95	$8.19
J9110	85	$7.65	95	$8.55	95	$8.55
J9120	85	$12.41	95	$13.87		
J9130	85	$10.04	95	$11.22		
J9140	85	$19.47	95	$22.06		
J9150	85	$66.42	95	$74.23		
J9151	85	$57.80	95	$64.60		

Code	AWP %	2004 Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)	ESRD %	2004 Payment Limit for ESRD Drugs Separately Billed by Independent ESRD Facilities	DME Infusion %	2004 Payment Limit for Drugs when Infused through DME
J9160	85	$1,190.85	95	$1,330.95		
J9165	85	$12.89	95	$14.41		
J9170	80	$301.40	95	$357.90		
J9178	85	$24.73	95	$27.64		
J9180	85	$618.26	95	$711.71		
J9181	85	$1.53	95	$1.71		
J9182	85	$15.30	95	$17.10		
J9185	85	$318.59	95	$348.67		
J9190	85	$1.85	95	$2.07	95	$2.07
J9200	85	$122.40	95	$136.80	95	$136.80
J9201	80	$101.90	95	$129.49		
J9202	80	$375.99	95	$446.49		
J9206	80	$122.73	95	$152.88		
J9208	85	$134.55	95	$150.38	95	$150.38
J9209	85	$31.45	95	$35.15		
J9211	85	$375.73	95	$419.94		
J9212	85	$3.67	95	$4.09		
J9213	85	$31.21	95	$34.88		
J9214	85	$13.31	95	$14.88		
J9215	85	$7.03	95	$7.86		
J9216	85	$187.19	95	$209.22		
J9217	81	$500.58	95	$622.33		
J9218	85	$23.26	95	$25.10		
J9219	85	$4,831.40	95	$5,399.80		
J9230	85	$10.74	95	$12.01		
J9245	85	$375.88	95	$420.10		
J9250	85	$0.35	95	$0.39		
J9260	85	$4.25	95	$4.75		
J9263	85	$8.45	95	$9.45		
J9265	81	$138.28	95	$162.16		
J9266	85	$1,277.13	95	$1,543.75		
J9268	85	$1,644.27	95	$1,837.72		
J9270	85	$83.93	95	$93.80		
J9280	85	$57.12	95	$63.84	95	$127.40
J9290	85	$185.64	95	$207.48		
J9291	85	$255.00	95	$285.00		
J9293	85	$321.52	95	$359.35		
J9300	85	$1,953.94	95	$2,183.81		
J9310	81	$427.28	95	$501.13		
J9320	85	$126.58	95	$141.47		
J9340	85	$83.73	95	$93.58		
J9350	84	$706.17	95	$798.65		
J9355	85	$52.01	95	$58.13	95	$58.13
J9357	85	$471.24	95	$526.68		
J9360	85	$2.81	95	$3.15	95	$4.10
J9370	85	$30.40	95	$33.98	95	$33.98
J9375	85	$60.81	95	$67.96	95	$67.96
J9380	85	$152.02	95	$160.36	95	$169.91
J9390	81	$76.19	95	$89.36		
J9395	85	$78.36	95	$87.58		
J9600	85	$2,329.60	95	$2,603.67		
P9041	85	$13.01	95	$14.54		
P9043	85	$13.01	95	$14.54		
P9045	85	$49.30	95	$55.10		
P9046	85	$13.01	95	$14.54		
P9047	85	$49.30	95	$55.10		
P9048	85	$26.04	95	$29.10		
Q0136	87	$11.62	95	$12.69		
Q0137	85	$4.24	95	$4.74		
Q0163	85	$0.08				
Q0164	85	$0.51				
Q0165	85	$0.77				
Q0166	85	$39.98				

Code	AWP %	2004 Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)	ESRD %	2004 Payment Limit for ESRD Drugs Separately Billed by Independent ESRD Facilities	DME Infusion %	2004 Payment Limit for Drugs when Infused through DME
Q0167	85	$2.93				
Q0168	85	$7.96				
Q0169	85	$0.28				
Q0170	85	$0.02				
Q0171	85	$0.06				
Q0172	85	$0.08				
Q0173	85	$0.40				
Q0174	85	$0.67				
Q0175	85	$0.51				
Q0176	85	$0.83				
Q0177	85	$0.38				
Q0178	85	$0.27				
Q0179	85	$27.22				
Q0180	85	$64.80				
Q0183	85	$13.78	95	$16.16		
Q0187	95	$1,681.50	95	$1,681.50		
Q2009	85	$5.44				
Q2011	85	$6.62				
Q2022	95	$0.95	95	$0.95		
Q3025	85	$76.23	95	$85.21		
Q4052	85	$79.36	95	$83.03		
Q4053	85	$417.92	95	$467.09		
Q4054	85	$4.24	95	$4.74		
Q4055	87	$11.62				
Q4075	85	$0.42	95	$0.47	95	$0.47
Q4076					95	$0.62
Q4077					95	$61.75
Q9920	87	$11.62				
Q9921	87	$11.62				
Q9922	87	$11.62				
Q9923	87	$11.62				
Q9924	87	$11.62				
Q9925	87	$11.62				
Q9926	87	$11.62				
Q9927	87	$11.62				
Q9928	87	$11.62				
Q9929	87	$11.62				
Q9930	87	$11.62				
Q9931	87	$11.62				
Q9932	87	$11.62				
Q9933	87	$11.62				
Q9934	87	$11.62				
Q9935	87	$11.62				
Q9936	87	$11.62				
Q9937	87	$11.62				
Q9938	87	$11.62				
Q9939	87	$11.62				
Q9940	87	$11.62				

***Note**: the absence or presence of a HCPCS code and its associated payment limit 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 shall be made by the local Medicare contractor processing the claim*

Source: CMS Pub. 100-04 Transmittal: 75 Date: January 30, 2004 Change Request 3105

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.

April Quarterly Update for 2004 DMEPOS Fee Schedule

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly updates process for the DMEPOS fee schedule is located in the CMS Manual System, Pub 100-4 Medicare Claims Processing Manual, Chapter 23, Section 60.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic and orthotic devices, and surgical dressings by sections 1834(a), (h), and (i) of the Social Security Act.

Effective for services furnished **on or after April 1, 2004,** the following new "K" codes have been established for billing spinal orthotics.

K0627 Traction equipment, cervical, free-standing, pneumatic, applying traction force to other than mandible

K0630 Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment

K0631 Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

K0632 Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment

K0633 Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

K0634 Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment

K0635 Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebrae, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0636 Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0637 Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0638 Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated

K0639 Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0640 Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0641 Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated

K0642 Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0643 Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated

K0644 Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0645 Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated

K0646 Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0647 Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated

K0648 Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid plastic and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0649 Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid plastic and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated.

Source: CMS Pub. 100-04 Transmittal: 58 Date: January 2, 2004 Change Request 3014
CMS Pub. 100-04 Transmittal: 50 Date: December 19, 2003 Change Request 2967

END-STAGE RENAL DISEASE (ESRD)

Change in Coding for Darbepoetin Alfa (Aranesp®) and Epoetin Alfa (Epogen®) for Patients on Dialysis

The Centers for Medicare & Medicaid Services (CMS) has established coding guidelines for billing for the administration of darbepoetin alfa (Aranesp®) and epoetin (EPO) alfa (Epoetin®) for treatment of anemia in end-stage renal disease patients on dialysis. Two new HCPCS codes have been assigned to report darbepoetin alfa and epoetin alfa effective for services furnished **on or after January 1, 2004:**

Q4054 Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)

Medicare jurisdiction: DME regional carrier when self-administered for Method II home patients; FI when self-administered for Method I or Method II home patients, when administered by the hospital outpatient department, when administered to infacility patients by the dialysis

facility; and **carrier when incident to a physician's service**. Use this code for darbepoetin alfa (Aranesp).

Q4055 Injection, epoetin alfa. 1,000 units (for ESRD on dialysis)

Medicare jurisdiction: DME regional carrier when self-administered for Method II home patients; FI when self-administered for Method I or Method II home patients, when administered by the hospital outpatient department, when administered to infacility patients by the dialysis facility; and **carrier when incident to a physician's service**. Use this code for Epoetin Alfa (Epogen, EPO).

Note: The multiple Q-codes for epoetin alfa (Q9920 through Q9940), representing a single hematocrit level, have been discontinued and are replaced with **Q4055**.

Since there is currently no payment rate for darbepoetin alfa, CMS has determined that HCPCS code Q4054 will be paid based on the single drug pricer payment amount. This payment rate will be in effect until CMS has determined an appropriate conversion factor and corresponding payment rate for darbepoetin alfa. Coverage guidelines for darbepoetin alfa are the same as for epoetin alfa for ESRD related anemia.

Source: CMS Pub. 100-20 Transmittal: 39 Date: January 6, 2004 Change Request: 2963

Additional Coding Changes for Darbepoetin Alfa and Epoetin Alfa

Effective **January 1, 2004**, Healthcare Common Procedure Coding System (HCPCS) code J0880 (injection, darbepoetin alfa 5 mcg) is billable only when administered in a physician's office to non-ESRD (end-stage renal disease) patients not on dialysis. HCPCS code Q0137 (injection, darbepoetin alfa, 1 mcg [non-ESRD use]) will remain covered in all non-ESRD settings. Physicians have the option of using either HCPCS codes J0880 or Q0137 to bill for darbepoetin alfa for non-ESRD patients not on dialysis.

For ESRD patients on dialysis treated in a physician's office, HCPCS code Q4054 (injection, darbepoetin alfa, 1 mcg [for ESRD patients]) should continue to be used with the hematocrit included on the claim. Claims without this information will be denied due to lack of documentation. Physicians who provide darbepoetin alfa for ESRD patients on dialysis must bill using HCPCS code Q4054.

Billing HCPCS codes J0880 and Q0137 for non-ESRD use on the same date of service is not allowable. Billing codes J0880 and Q4054 on the same date of service is also not allowable, as a patient cannot simultaneously be ESRD and non-ESRD.

Source: CMS Pub. 100-20 Transmittal 36 December 24, 2003 Change Request 3037

IMMUNOLOGY

Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

Beginning for dates of service on or after January 1, 2004, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases (ICD-9-CM diagnosis codes 279.04, 279.05, 279.06, 279.12, and 279.2) in the home. The corresponding HCPCS codes are J1563 and J1564. The Act defines "intravenous immune globulin" as an approved pooled plasma derivative for the treatment of primary immune deficiency disease. It is covered under this benefit when it is administered in the home of a patient with a diagnosed primary immune deficiency disease, and the physician determines that administration of the derivative in the patient's home is medically appropriate. The benefit does not include coverage for items or services related to the administration of the derivative. For coverage of IVIG under this benefit, it is not necessary for the derivative to be administered through durable medical equipment.

Source: CMS Pub. 100-02 Transmittal: 6 Date: January 23, 2004 Change Request 3059

LABORATORY/PATHOLOGY

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

In accordance with the decision memorandum published on the coverage Internet site on October 30, 2003, CMS is adding the following diagnosis codes to the list of "ICD-9-CM Codes Covered by Medicare" for the **serum iron studies NCD**:

403.01 Hypertensive renal disease, malignant, with renal failure
403.11 Hypertensive renal disease, benign, with renal failure
403.91 Hypertensive renal disease, unspecified, with renal failure
404.02 Hypertensive heart and renal disease, malignant, with renal failure
404.03 Hypertensive heart and renal disease, malignant, with heart and renal failure
404.12 Hypertensive heart and renal disease, benign, with renal failure
404.13 Hypertensive heart and renal disease, benign, with heart and renal failure
404.92 Hypertensive heart and renal disease, unspecified, with renal failure
404.93 Hypertensive heart and renal disease, unspecified, with heart and renal failure

These codes will be covered for services furnished on or after April 5, 2004.

Source: CMS Pub. 100-04 Transmittal: 71 Date: January 23, 2004 Change Request 3072

Independent Laboratory Billing Purchased Diagnostic Tests

CMS Publication 100-04 Chapter 1 section 30.2.9; Payment to Physician for Purchased Diagnostic Tests - Claims Submitted to Carriers, states:

> A physician or a medical group may submit the claim and (if assignment is accepted) receive the Part B payment, for the **technical component** of diagnostic tests which the physician or group purchases from an independent physician, medical group, or other supplier. (This claim and payment procedure does not extend to clinical diagnostic laboratory tests.) The purchasing physician or group may be the same physician or group as ordered the tests or may be a different physician or group. An example of the latter situation is when the attending physician orders radiology tests from a radiologist and the radiologist purchases the tests from an imaging center. The purchasing physician or group may not markup the charge for a test from the purchase price and must accept the lowest of the fee schedule amount if the supplier had billed directly; the physician's actual charge; or the supplier's net charge to the purchasing physician or group, as full payment for the test even if assignment is not accepted.

A new policy is being added to Publication 100-04 Chapter 16 section 40.2 that clarifies that when an independent laboratory bills for a laboratory test performed by an outside supplier, the payment amount for the purchased service is based on the lower of the submitted charge or the fee on the Medicare Physician Fee Schedule (MPFS). The independent laboratory must perform at least one of the services billed. If the service being billed is the professional component of a test, the independent laboratory must meet the rules of Publication 100-04 Chapter 1 section 30.2.6.

Purchased diagnostic tests are paid using the MPFS, thus, the jurisdiction rules for the MPFS apply.

Source: CMS Pub. 100-04 Chap. 16 section 40.2 Transmittal: 16 Date: October 31, 2003
Change Request 2919

PHYSICAL THERAPY/OCCUPATIONAL THERAPY

Renewed Moratorium on Outpatient Rehabilitation Therapy Caps

This affects providers of outpatient physical therapy, speech-language pathology, and occupational therapy services.

Impact to You

Beginning December 8, 2003, and continuing through December 31, 2005, there are no payment caps on claims received for the physical therapy, speech-language pathology, and occupational therapy services. The payment caps for these services remain in effect for claims received on September 1, 2003, through December 7, 2003, for services rendered during that timeframe.

What You Need to Know

The recently enacted Medicare Prescription Drug Modernization Act of 2003 renewed the moratorium on physical therapy, speech-language pathology, and occupational therapy services payment caps, effective on December 8, 2003, and continuing through calendar year 2005. The payment cap on services provided and for which claims were received from September 1, 2003 through December 7, 2003 for outpatient physical therapy and speech-language pathology services combined remains $1590 and for outpatient occupational therapy services remains $1590. These caps are based on the allowed incurred expenses, which are defined as the Medicare Physician Fee Schedule (MPFS) amount before the application of any beneficiary deductible and/or coinsurance. Caps apply to claims received during the time caps were in effect.

What You Need to Do

You need to know that the payment caps for these services will not be in effect on claims received from December 8, 2003, through December 31, 2005; therefore, you should not limit services or charge beneficiaries for these covered services based on therapy caps. Essentially, the Medicare payment policies with regard to the cap are the same as those prior to September 1, 2003. Note that the use of therapy modifiers is still required.

Background

The Balanced Budget Act (BBA) of 1997 required payment under a prospective payment system for outpatient rehabilitation services (physical therapy, speech-language pathology, and occupational therapy), and set financial limitations for these services.

The Balanced Budget Refinement Act (BBRA) of 1999 placed a two-year moratorium on these limitations effective January 1, 2000 through December 31, 2001. This moratorium was further extended through December 31, 2002 by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

In 2003, although there was not a moratorium on these payment limitations, their implementation was delayed until September 1, 2003. The financial limitations remain in effect for services provided and claims received for those services from September 1, 2003 through December 7, 2003, when the Medicare Prescription Drug Modernization Act of 2003 renewed the moratorium until the end of calendar year 2005.

Important Dates to Know

This Change Request is effective and implemented on December 8, 2003.

Related Instructions

To learn more about these issues, look for CR3005 on the CMS Web site page for 2003 transmittals. For example, that transmittal contains some specific examples of how the caps are computed for the period from September 1, 2003, through December 7, 2003. The transmittal page may be accessed at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

If you have any questions, please contact us via the toll-free number or visit our Web site. In Connecticut, the number is 1-866-419-9455; the Web address is *http://www.connecticutmedicare.com*. In Florida, the number is 1-866-454-9007, and the Web address is *http://www.floridamedicare.com*.

Source: CMS Pub. 100-20 Transmittal: 40
January 6, 2004 Change Request 3045
Medlearn Matters number MM3005

SCREENING SERVICES

Expanded Colorectal Cancer Screening Fecal-Occult Blood Tests

Effective for services furnished on or after January 1, 2004, Medicare covers the new colorectal cancer screening fecal-occult blood test (FOBT) – HCPCS code G0328. Screening FOBT (HCPCS code G0328) may be paid as an alternative to HCPCS code G0107 for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either G0107 or G0328, but not both) at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed).

HCPCS Codes

G0107 Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations; (effective for services furnished on or after January 1, 1998)

G0328 Colorectal cancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations (effective for services furnished on or after January 1, 2004)

Coverage Guidelines

Effective for services furnished on or after January 1, 2004, one screening FOBT (HCPCS code G0107 or G0328) is covered for beneficiaries who have attained age 50, at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed).

Screening FOBT means:

1) a guaiac-based test for peroxidase activity in which the beneficiary completes it by taking samples from two different sites of three consecutive stools or,
2) an immunoassay (or immunochemical) test for antibody activity in which the beneficiary completes the test by use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, determined by the individual manufacturer's instructions.

Both screenings require a written order from the beneficiary's attending physician. The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in section 1861(r)(10 of the Social Security Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

Billing Guidelines

Providers must bill the carrier for colorectal cancer screening FOBT on Form CMS-1500 or its electronic equivalent. HCPCS code G0328 is effective for services rendered on or after January 1, 2004.

Payment Methodology

HCPCS code G0328 or G0328QW is payable under the clinical laboratory fee schedule methodology. G0328QW identifies a laboratory registered with a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988.

Reference Resources:

CMS Manual System, Pub. 100-2 Benefit Policy Manual, chapter 15, section 280.2
CMS Manual System, Pub. 100-3, Medicare National Coverage manual, chapter 1, section 210.3
CMS Manual System, Pub. 100-4, Medicare Claim Processing manual, chapter 18, section 60.

Source: CMS Pub 100-2 Transmittal 2, Change Request 2996

OTHER SERVICES AND PROCEDURES

Correction to HCPCS Codes for Low Osmolar Contrast Material

Healthcare Common Procedure Coding System (HCPCS) codes A4644 thru A4646 have been used to bill for low osmolar contrast material since 1994. The HCPCS Alpha-Numeric Editorial Panel added a new single code A9525 for low or iso-osmolar contrast material and deleted codes A4644 thru A4646 effective January 1, 2004.

CMS has determined that this change may result in incorrect coding of low osmolar contrast material and that providers should continue to use codes A4644 thru A4646 rather than new code A9525. Therefore, effective April 1, 2004, we will continue to process claims for low osmolar contrast material coded under A4644 thru A4646. In addition, effective April 1, 2004, for claims received on or after April 1, 2004, code A9525 will be made invalid for Medicare claims processing purposes (coverage/status indicator = I). Iso-osmolar products should continue to be coded using the appropriate low osmolar code A6444, A4645, or A4646.

Source: CMS Pub 100-20 Transmittal: 45 January 23, 2004 Change Request 3053

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.

Mandatory Electronic Submission of Medicare Claims Based on the Administrative Simplification Compliance Act (ASCA)

Including Specific Conditions under Which a Waiver May Be Granted for Submission of Electronic Claims

The Administrative Simplification Compliance Act (ASCA) went into effect October 16, 2003, along with the HIPAA Transactions rule. We recently published information concerning CMS' contingency plan for HIPAA transactions and code sets. CMS did not implement a contingency plan for ASCA, although much discussion has taken place with regards to a "waiver" for certain providers in certain circumstances. The information that follows provides additional guidance regarding such waivers. All providers, even those meeting an exception, are encouraged to submit as many of their claims electronically as possible.

Providers that do not qualify as "small," and that do not meet any of the remaining exception or waiver criteria provided below, must submit their claims to Medicare electronically. Submission of paper claims constitutes an attestation by a provider that at least one of the paper claim exception or waiver criteria applies at the time of submission.

Definition of "Small Provider;" FTE Definition and Calculation Methodology

A "small provider" is defined at 42 CFR section 424.32(d)(1)(vii) to mean

a) A provider of services (as that term is defined in section 1861(u) of the Social Security Act) with fewer than 25 full-time equivalent (FTE) employees; or
b) A physician, practitioner, facility or supplier that is not otherwise a provider under section 1861(u) with fewer than 10 FTEs.

To simplify implementation, Medicare will consider all providers that have fewer than 25 FTEs and that are required to bill a Medicare intermediary to be small; and will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier or DMERC to be small.

The ASCA law and regulation do not modify pre-existing laws or employer policies defining full time employment. Each employer has an established policy, subject to certain non-Medicare state and federal regulations, that define the number of hours employees must work on average on a weekly, biweekly, monthly, or other basis to qualify for full-time benefits. Some employers do not grant full-time benefits until an employee works an average of 40 hours a week, whereas another employer might consider an employee who works an average of 32 hours a week to be eligible for fulltime benefits. An employee who works an average of 40 hours a week would always be considered full time, but employees who work a lesser number of hours weekly on average could also be considered full time according to the policy of a specific employer.

Everyone on staff for whom a health care provider withholds taxes and files reports with the Internal Revenue Service (IRS) using an employer identification number (EIN) is considered an employee, including if applicable, a physician(s) who owns a practice and provides hands on services and those support staff who do not furnish health care services but do retain records of, perform billing for, order supplies related to, provide personnel services for, and otherwise perform support services to enable the provider to function. Unpaid volunteers are not employees. Individuals that perform services for a provider under contract, such as individuals employed by a billing agency or medical placement service, for whom a provider does not withhold taxes, are not considered members of a provider's staff for FTE calculation purposes when determining whether a provider can be considered as "small" for electronic billing waiver purposes.

Medical staff sometimes work part time, or may work full time but their time is split among multiple providers. Part time employee hours must also be counted when determining the number of FTEs employed by a provider. For example, if a provider has a policy that anyone who works at least 35 hours per week on average qualifies for fulltime benefits, and has 5 full-time employees and 7 part-time employees, each of whom works 25 hours a week, that provider would have 10 FTEs (5+[7 x 25= 175 divided by 35= 5]).

In some cases, the EIN of a parent company may be used to file employee tax reports for multiple providers under multiple provider numbers. In that instance, it is acceptable to consider only those staff, or staff hours worked for a particular provider as identified by provider number, UPIN, or national provider identifier (NPI) when implemented to calculate the number of FTEs employed by that provider. For example, ABC Health Care Company owns hospital, home health agency (HHA), ambulatory surgical center (ASC), and durable medical equipment (DME) subsidiaries. Some of those providers bill intermediaries and some carriers. All have separate provider numbers but the tax records for all employees are reported under the same EIN to the IRS. There is a company policy that staff must work an average of 40 hours a week to qualify for full time benefits.

Some of the same staff split hours between the hospital and the ASC, or between the DME and HHA subsidiaries. To determine total FTEs by provider number, it is acceptable to base the calculation on the number of hours each staff member contributes to the support of each separate provider by provider number. First, each provider would need to determine the number of staff who work on a full time basis under a single provider number only; do not count more than 40 hours a week for these employees. Then each provider would need to determine the number of part time hours a week worked on average by all staff who furnished services for the provider on a less than full time basis. Divide that total by 40 hours to determine their full time equivalent total. If certain staff members regularly work an average of 60 hours per week, but their time is divided 50 hours to the hospital and 10 hours to the ASC, for FTE calculation purposes, it is acceptable to consider the person as 1 FTE for the hospital and .25 FTE for the ASC.

In some cases, a single provider number and EIN may be assigned, but the entity's primary mission is not as a health care provider. For instance, a grocery store's primary role is the retail sale of groceries and ancillary items including over the counter medications, but the grocery store has a small pharmacy section that provides prescription drugs and some DME to Medicare beneficiaries. A large drug store has a pharmacy department that supplies prescriptions and DME to Medicare beneficiaries but most of the store's revenue and most of their employees are not involved with prescription drugs or DME and concentrate on non-related departments of the store, such as film development, cosmetics, electronics, cleaning supplies, etc. A county government uses the same EIN for all county employees but their health care provider services are limited to furnishing of emergency medical care and ambulance transport to residents.

Legal issues regarding the definition of providers, particularly when multiple providers have data reported under the same EIN, will be addressed in the NPI regulation when published in the *Federal Register* in final. For FTE calculation purposes in the interim, it is acceptable to include only those staff of the grocery store, drug store, or county involved with or that support the provision of health care in the FTE count when assessing whether a small provider waiver may apply. This process will be modified if warranted by the definitions established in the NPI final rule.

Support staff who should be included in the FTE calculation in these instances include but are not necessarily limited to those that restock the pharmacy or ambulance, order supplies, maintain patient records, or provide billing and personnel services for the pharmacy or emergency medical services department if under the same EIN, according to the number of hours on average that each staff member contributes to the department that furnishes the services or supplies for which the Medicare provider number was issued.

Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically. The small provider exception for submission of paper claims does not apply to health care claim clearinghouses that are agents for electronic claim submission for small providers. HIPAA defines a clearinghouse as an entity that translates data to or from a standard format for electronic transmission. As such, HIPAA requires that clearinghouses submit claims electronically effective October 16, 2003 without exception.

Exception Criteria

In some cases, it has been determined that due to limitations in the claims transaction formats adopted for national use under HIPAA, it would not be reasonable or possible to submit certain claims to Medicare electronically. Providers are to self-assess to determine if they meet these exceptions. At the present time, only the following claim types are considered to meet this condition:

1. **Roster billing of vaccinations covered by Medicare**—Although flu shots and similar covered vaccines and their administration can be billed to Medicare electronically, one claim for one beneficiary at a time, in the past, some suppliers have been allowed to submit a single claim on paper with the basic provider and service data to which was attached a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. The claim implementation guides adopted under HIPAA can submit single claims to payer for single individuals, but cannot be used to submit a single claim for multiple individuals.

   Flu shots are often administered in senior citizen centers, grocery stores, malls, and other locations in the field. It is not always reasonable or hygienic to use a laptop computer to register all necessary data to enable generation of an electronic (HIPAA-compliant) claim in such field settings. In some cases, a single nurse who is not accompanied by support staff might conduct mass immunizations. Due to the low cost of these vaccinations, it is not always cost effective to obtain all of the data normally needed for preparation

of a HIPAA-compliant claim. Such suppliers rarely have a long-term health care relationship with their patients and do not have a need for the extensive medical and personal history routinely collected in most other health care situations.

It is in the interest of Medicare and public health to make it as simple as possible for mass immunization activities to continue. Although suppliers are encouraged to submit these claims to Medicare electronically, one claim for one beneficiary at a time, this is not required. In the absence of an electronic format that would allow a single claim for the same service to be submitted on behalf of multiple patients using abbreviated data, providers/suppliers currently allowed to submit paper roster bills may continue to submit paper roster bills for vaccinations. Providers or suppliers that furnish vaccinations and other medical services or supplies must bill those other medical services or supplies to Medicare electronically though unless the provider qualifies as "small" or meets other exception criteria.

This vaccinations waiver applies only to injections such as flu shots frequently furnished in non-traditional medical situations, and does not apply to injections furnished in a traditional medical setting such as a doctor's office or an outpatient clinic when supplied as a component of other medical care or examination. In traditional medical situations where the provider is required to bill the other services furnished to the patient electronically, the flu shot or other vaccination is also to be included in the electronic claim sent to Medicare for the patient.

2. **Claims for payment under a Medicare demonstration project that specifies paper submission**—By their nature, demonstration projects test something not previously done, such as coverage of a new service. As a result of the novelty, the code set that applies to the new service may not have been included as an accepted code set in the claim implementation guide(s) previously adopted as HIPAA standards. The HIPAA regulation itself makes provisions for demonstrations to occur that could involve use of alternate standards. In the event a Medicare demonstration project begins that requires some type of data not supported by the existing claim formats adopted under HIPAA, Medicare could mandate that the claims for that demonstration be submitted on paper. In the event demonstration data can be supported by an adopted HIPAA format, Medicare will not require use of paper claims for a demonstration project. Demonstrations typically involve a limited number of providers and limited geographic areas. Providers that submit both demonstration and regular claims to Medicare may be directed to submit demonstration claims on paper. Non-demonstration claims will continue to be submitted electronically, unless another exception or waiver condition applies.

3. **Medicare Secondary Payment Claims (MSP)**—MSP claims occur when one or more payers are primary to Medicare. The claim formats adopted for national use under HIPAA include segments for provider or payer use to submit secondary claims as well as initial claims. Since a patient rarely has more than two insurers in total, the formats were designed for a provider to bill a payer secondarily and include payment data from one primary in the claim. In actuality, there may have been more than one primary payer. The claim formats adopted under HIPAA do not currently contain the ability to report individual service level payments made by more than one primary payer.

The paper claim format has no fields for reporting of more than one primary payment data when Medicare is secondary. When paper claims are submitted, a copy of the primary plan's explanation of benefits (EOB) must always be attached if there is one or more payers that pay prior to Medicare. Since the HIPAA claim formats do allow service level data to be submitted electronically when there is only one payer primary to Medicare, those claims can be sent to Medicare electronically. When more than one payer is primary, the formats cannot accommodate this additional reporting and the only alternative is for providers to submit those claims to Medicare on paper with copies of the EOBs/remittance advices (RAs).

The payment segments of the claim formats adopted under HIPAA include fields for reporting of the identity of the primary payer, service procedure code, allowed amount, payment amount, and claim adjustment reason codes and amounts applied by the other payer when the billed amount of the service was not paid in full. These segments correspond to segments reported in the X12 835 remittance advice format. Since the HIPAA requirements apply only to electronic transactions, and not to paper transactions such as paper EOBs or RA notices, there is no requirement that payers use the same codes in their paper EOBs or RAs as in their electronic RAs. Medicare uses the same code set in both paper and electronic RAs, but other payers may not. Payers can elect to use different code sets in their paper transactions than their electronic transactions, or to use text messages in their paper transactions and not use codes at all. Payers that do not use the standard claim adjustment reason codes in their paper EOBs or RAs, generally use proprietary codes or messages for which there is no standard crosswalk to the 835 claim adjustment reason codes.

Providers that receive those paper EOBs/RAs cannot reasonably furnish standard claim adjustment reason codes for use in the HIPAA claim and COB formats. As a result, when there is only one payer primary to Medicare and those claims must be sent to Medicare electronically, those providers cannot complete the situational CAS segment for those claims. The coordination of benefits implementation guide adopted under HIPAA does not require that this segment be completed in this situation. This is acceptable, although this will prevent the primary payer data in the claim from balancing, akin to balancing when the data is reported in an 835 transaction. There is no requirement in the implementation guide that these payment segments balance in a claim transaction. Providers should not try to convert non-standard messages or codes to standard claim adjustment reason codes to submit

these claims to Medicare electronically. Medicare does not use the CAS segment data elements to calculate the Medicare payment in any case. However, providers must still report the primary's allowed, contract amount when Obligation to Accept in Full (OTAF) applies, and payment amounts for the individual services to enable Medicare to calculate payment.

4. **Claims submitted by Medicare beneficiaries**.

Unusual Circumstances

Congress granted the Secretary considerable discretion to decide what other circumstances should qualify as "unusual circumstances" for which a waiver of the electronic claim submission requirement would be appropriate. The Secretary delegated that authority to CMS. In the event it is determined that enforcement of the electronic claim submission requirement would be against equity and good conscience as result of an "unusual circumstance," CMS will waive the electronic claim submission requirement for temporary or extended periods. In those situations, providers are encouraged to file claims electronically where possible, but electronic filing is not required.

CMS has in turn delegated certain authority to the Medicare contractors (carrier, DMERC, or intermediary) to determine whether an "unusual circumstance" applies. Providers who feel they should qualify for a waiver as result of an "unusual circumstance" must submit their waiver requests to the Medicare carrier, DMERC or intermediary to whom they submit their claims. The Medicare contractor must issue a form letter in the event of receipt of a written waiver request that does not allege an "unusual circumstance."

In some cases, an "unusual circumstance" or the applicability of one of the other exception criteria may be temporary; in which case, the related waiver would also be temporary. Once the criteria no longer applied, that provider would again be subject to the requirement that claims be submitted to Medicare electronically. Likewise, some exception and waiver criteria apply to only a specific type of claim, such as secondary claims when more than one other payer is primary. Other claim types not covered by an exception or waiver must still be submitted to Medicare electronically, unless the provider is small or meets other unusual circumstance criteria.

Unusual Circumstance Waivers Subject to Provider Self-Assessment

The following circumstances *always* meet the criteria for waiver. Providers that experience one of the following "unusual circumstances" are automatically waived from the electronic claim submission requirement. A provider is expected to self-assess when one of these circumstances applies, rather than apply for contractor or CMS waiver approval. A provider may continue to submit claims to Medicare on paper when one of these circumstances applies. A provider is not expected to pre-notify their Medicare contractor(s) that one of the circumstances applies as a condition of paper submission.

1. **Dental claims**—Medicare does not provide dental benefits. Medicare does cover certain injuries of the mouth that may be treated by dentists, but those injury treatments are covered as medical benefits. Less than .01 percent of Medicare expenditures were for oral and maxillofacial surgery costs in 2002. The X12 837 professional implementation guide standard for submission of medical claims requires submission of certain data that not traditionally reported in a dental claim but which is needed by payers to adjudicate medical claims. As result, Medicare contractors have not implemented the dental claim standard adopted for national use under HIPAA. Due to the small number of claims they would ever send to Medicare, most dentists have not found it cost effective to invest in software they could use to submit medical claims to Medicare electronically. For these reasons, dentists will not be required to submit claims to Medicare electronically. They can continue to submit claims, when appropriate, to Medicare on paper.
2. **Disruption in electricity or phone/communication services**—In the event of a major storm or other disaster outside of a provider's control, a provider could lose the ability to use personal computers, or transmit data electronically. If such a disruption is expected to last more than two business days, all of the affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be two business days or less, providers should simply hold claims for submission when power and/or communication restored.
3. A provider is not small based on FTEs, but **submits fewer than 10 claims to Medicare per month on average** (not more than 120 claims per year). This would generally apply to a provider that rarely deals with Medicare beneficiaries.
4. **Non-Medicare Managed Care Organizations** that are able to bill Medicare for co-payments may continue to submit those claims on paper. These claims are not processable by the MSP Pay module and must be manually adjudicated by Medicare contractors.

Unusual Circumstance Waivers Subject to Medicare Contractor Approval

Medicare contractors may *at their discretion* approve a single waiver for up to 90 days after the date of the decision notice for a provider if the contractor considers there to be "good cause" that prevents a provider to submit claims electronically for a temporary period. "Good cause" would apply if a provider has made good faith efforts to submit claims electronically, but due to testing difficulties, or a similar short-term problem that the provider is making reasonable efforts to rectify, the provider is not initially able to submit all affected claims electronically effective October 16, 2003.

Unusual Circumstance Waivers Subject to Medicare Contractor Approval and CMS Decision

A provider may submit a waiver request to their Medicare contractor in the following "unusual circumstances." It is the responsibility of the provider to submit documentation appropriate to establish the validity of the waiver request in these situations. Requests received without documentation to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied.

If the Medicare contractor agrees that the waiver request has merit, CMS approval is required. The contractor will forward an explanation as to why contractor staff recommends CMS approval with the waiver request. If the contractor does not consider an "unusual circumstance" to be met, and does not recommend CMS approval, the contractor will issue a "denial of an unusual circumstance waiver request" letter.

1. Provider alleges that the claim transaction implementation guides adopted under HIPAA do not support electronic submission of all data required for claim adjudication may request a waiver. (If a waiver is approved in this case, it will apply only to the specific claim type(s) affected by the implementation guides deficiency.)

   ***Note**: Pending issuance of future instructions concerning submission of medical records for electronic claims, providers and Medicare contractors can continue current policies and practices regarding submission of attachments with claims (see "Paper Claims/Attachments," below).*

2. A provider is not small, but all those employed by the provider have documented disabilities that would prevent their use of a personal computer for electronic submission of claims.
3. Any other unusual situation that is documented by a provider to establish that enforcement of the electronic claim submission requirement would be against equity and good conscience.

Submission of a Request for an Unusual Circumstance Waiver

If a provider believes the above criteria are met, he/she should submit a request for an unusual circumstance waiver to:

Attention: ASCA Waiver
Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Be sure to include documentation appropriate to establish the validity of the waiver request. A waiver request should include the providers' name, address, contact person, the reason for the waiver, and why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience.

Enforcement

A separate enforcement instruction will be issued to Medicare contractors. Enforcement will be conducted on a post-payment basis and will entail targeted investigation of providers that appear to be submitting extraordinary numbers of paper claims. If an investigation establishes that a provider incorrectly submitted paper claims, the provider will be notified that any paper claims submitted after a certain date (a reasonable period will be allowed for implementation of necessary provider changes) will be denied by Medicare.

Paper Claims/Attachments

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.*

Source: CMS Pub. 100-04 Transmittal: 44
December 19, 2003 Change Request 2966

Additional Guidance Relating to Health Insurance Portability and Accountability Act (HIPAA) Contingency Plan

Under Medicare's HIPAA contingency plan, contractors may not add new users of legacy formats. The contingency plan applies only to those trading partners already exchanging electronic transactions prior to October 16, 2003.

Effective Immediately:

- New electronic submitters may only test on the HIPAA format (X12N 4010A1) for inbound claims;
- New electronic submitters may only go into production on the HIPAA format for inbound claims;
- Current electronic submitters may not begin testing or submitting inbound claims for any new providers in other than the HIPAA-compliant format.
- New electronic remittance receivers may only test and go into production on the HIPAA format; and
- Any entity (e.g., clearinghouse) currently receiving electronic remittance advice may not add a new provider receiving electronic remittance advice in a pre-HIPAA format.

In addition, submitters must move their entire workload into production within 30 days after successfully completing testing of the HIPAA 4010A1 claim format.

First Coast Service Options, Inc. (FCSO) offers PC-ACE Pro32® at-cost software to enable providers to become HIPAA compliant. You can learn more about the software at *http://www.fcso.com*. Select "Online Services"; there is a link to PC-ACE Pro32® under "Medicare Provider Services." If additional marketing information is needed, contact 1-904-791-8767, option 1.

Source: CMS Joint Signature Memorandum 20, 11-25-03

ANSI 4010A1 Claims Submission Issues

The following information is related to errors being encountered on claims submitted on the new HIPAA-compliant ANSI 4010A1 format. *Please provide this information to your vendor, IT programmer, or software representative.*

Issue #1: *Claims are being denied or overpaid when the minutes/units of service are billed incorrectly.*

Resolution: When completing the SV1 segment in the 2400 loop, Professional Service Line, please verify the values submitted in the SV103 (Unit or Basis for Measurement Code). UN (unit) is the correct qualifier for Medicare claims, unless you are submitting a service line for anesthesia minutes. If billing anesthesia minutes, the MJ (minutes) qualifier can be used. If your software does not automatically default to UN for the SV103, please make note to change the SV103 value back to the UN qualifier if you had entered a different qualifier on the previous claim. You should also check to make sure the SV104 reflects the correct number of units for the service line. Claims submitted incorrectly to Medicare will result in denial of payment.

Issue #2: *Group provider claims denying for invalid or missing rendering physician number.*

Resolution: If you bill for a group practice, ensure your group provider number appears in the 2010AA loop in the REF-03 segment, and the rendering provider number appears in the 2310B loop in the REF-03 segment.

Issue #3: *Provider claims denying when the referring name and UPIN are not provided.*

Resolution: **This information is required.** If you are billing for services that require the referring physician information, you must provide the complete name and UPIN in the 2310A loop of your file (the referring provider name in the NM1 segment, and the referring provider UPIN number in the REF segment of this loop).

HIPAA Issues Pertaining to Medigap

Effective October 16, 2003, under requirements of the Administration Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA-AS), providers must submit Medicare claims electronically using ANSI X12N 837 version 4010A1.

Prior to HIPAA-AS implementation, providers were allowed to submit either the Medigap ID number *or* (if using the national standard format [NSF]) the complete name and address of the Medigap insurer. Under 4010A1, if your program asks for the Medigap ID, this number *must* be submitted in the NM109 Identification Code element of the Other Payer Loop 2330B, or the claim will be rejected in pre-pass editing. Providing only the Medigap insurer's name and address is no longer sufficient.

You may obtain a Medigap ID list from our provider education Web site. If a provider has an insurer listed as a Medigap insurer but we have not yet assigned a Medigap ID, obtain the name and address of the Medigap insurer and policy number from the beneficiary's card. **Connecticut and Florida providers** may submit this information to:

Attention: Medigap Coordinator
Medicare Part B
P.O. Box 2078 10T
Jacksonville, FL 32231-0048

It is not necessary to include ID numbers for insurers on the Supplemental Insurer Listing (Automatic Crossovers) listing; these will cross over automatically.

GENERAL INFORMATION

FRAUD, WASTE, AND ABUSE

Medicare Discount Drug Program Scam

A Medicare beneficiary reported that supposed representatives from Medicare were going door-to-door discussing the Medicare Discount Drug Program. According to the information reported, these individuals were fraudulently impersonating or misrepresenting Medicare by telephone and by door-to-door visits to Medicare beneficiary homes. Attempts were made to secure personal identifying information from beneficiaries by discussing the Medicare Discount Drug Program. In one particular case, the impersonator had a beneficiary's personal identifying information and asked for "the color of her house" to make sure he/she went to the correct address. The impersonator did not leave a name, telephone number, or any business cards.

Medicare beneficiaries should not release their personal identifying information to individuals representing themselves as Medicare officials. The Medicare program has not yet begun its enrollment, marketing, or outreach efforts for the Prescription Discount Drug Program.

Medicare is asking for assistance from individuals who may be aware of this activity occurring in their areas by reporting it to the Medicare contractor. Please refer to "Important Addresses, Phone Numbers, and Web Sites" (for Connecticut, page 68; for Florida, page 79) for information on how to report suspected fraud or abuse.

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

HOME HEALTH CONSOLIDATED BILLING

Correction to the Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

An article addressing the 2004 annual update of HCPCS (Healthcare Common Procedure Coding System) codes used for home health consolidation billing was published in the First Quarter 2004 *Medicare B Update!* (page 34). Since then, the Centers for Medicare & Medicaid Services (CMS) has issued a correction to the master code list for calendar year 2004 and the following HCPCS codes will **not** be added to home health consolidated billing enforcement:

A7525	Tracheostomy mask, each
A7526	Tracheostomy tube collar/holder, each

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency. This requirement is found in Medicare regulations at 42 CFR 409.100. The corrected HH consolidated billing master code list is available at *http://www.cms.hhs.gov/providers/hhapps/#billing*.

Source: CMS Pub. 100-4 Transmittal 62, CR 3024

MANAGED CARE (MEDICARE+CHOICE)

New Enrollee Rights, New Provider Responsibilities in M+C Program

The following provider education article is provided by the Centers for Medicare & Medicaid Services (CMS)

Introduction

Beginning on January 1, 2004, enrollees of Medicare+Choice (M+C) plans will have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their M+C plan's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. This new right stems originally from the Grijalva lawsuit and was established in regulations in a final rule published on April 4, 2003 (68 FR 16652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

What is "Grijalva"?

"Grijalva" is Grijalva v. Shalala – a class action lawsuit that challenged the adequacy of the Medicare managed care appeals process. The plaintiffs claimed that beneficiaries in Medicare managed care plans were not given adequate notice and appeal rights when coverage of their health care services was denied, reduced or terminated. Following extended legal negotiations — and significant changes to appeals procedures that resolved many issues — CMS reached a settlement agreement with plaintiffs and published a proposed rule based on that agreement in January 2001, and the final rule in April 2003.

New Regulations

Based on the provisions of the April 2003 final rule, SNFs, HHAs, and CORFs must provide an advance notice of Medicare coverage termination to M+C enrollees no later than 2 days before coverage of their services will end. If the patient does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in that state and the enrollee's M+C plan must furnish a detailed notice explaining why services are no longer necessary or covered. The review process generally will be completed within less than 48 hours of the enrollee's request for a review.

The new SNF, HHA, and CORF notification and appeal requirements distribute responsibilities under the new procedures among four parties:

1) The *M+C organization* generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. (In some cases, M+C organizations may choose to delegate these responsibilities to their contracting providers.)
2) The *provider* is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to all enrollees no later than 2 days before their covered services end.
3) The *patient/M+C enrollee* (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.
4) The *QIO* is responsible for immediately contacting the M+C organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end. Again, these new notice and appeal procedures go into effect on January 1, 2004. You should be aware that the Medicare law (section 1869[b][1][F] of the Social Security Act) establishes a parallel right to an expedited review for "fee-for-service" Medicare beneficiaries, and we expect to implement similar procedures for these beneficiaries later in 2004.

What Do the New SNF, HHA, and CORF Notification Requirements Mean for Providers?

Notice of Medicare Non-Coverage (NOMNC)

The NOMNC (formerly referred to as the Important Medicare Message of Non-Coverage) is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS is developing a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider. The NOMNC essentially includes only two variable fields (i.e., patient name and last day of coverage) that the provider will have to fill in.

When to Deliver the NOMNC

Based on the M+C organization's determination of when services should end, the provider is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a 2-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. We encourage providers to work with M+C organizations so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

How to Deliver the NOMNC

The provider must carry out "valid delivery" of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

Expedited Review Process

If the enrollee decides to appeal the end of coverage, he or she must contact the QIO by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform the M+C organization and the provider of the request for a review and the M+C organization is responsible for providing the QIO and enrollee with a detailed explanation of why coverage is ending. The M+C organization may need to present additional information needed for the QIO to make a decision. Providers should cooperate with M+C organization requests for assistance in getting needed information. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

Importance of Timing/Need for Flexibility

Although the regulations and accompanying CMS instructions do not require action by any of the four responsible parties until 2 days before the planned termination of covered services, we want to emphasize that whenever possible, it's in everyone's best interest for an M+C organization and its providers to work together to make sure that the advance termination notice is given to enrollees as early as possible. Delivery of the NOMNC by the provider as soon as it knows when the M+C organization will terminate coverage will allow the patient more time to determine if they wish to appeal. The sooner a patient contacts the QIO to ask for a review, the more time the QIO has to decide the case, meaning that a provider or M+C organization may have more time to provide required information.

We understand the challenges presented by this new process and have tried to develop a process that can accommodate the practical realities associated with these appeals. With respect to weekends, for example, many QIOs are closed (except for purposes of receiving expedited review requests), as are the administrative offices of M+C organizations and providers. Thus, to the extent possible, providers should try to deliver termination notices early enough in the week to minimize the possibility of extended liability for weekend services for either M+C enrollees or M+C organizations, depending on the QIO's decision.

Similarly, SNF providers may want to consider how they can assist patients that wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to accumulate liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance and, thus, facilitate a faster and more simple discharge. We strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible.

We recognize that these new requirements will be a challenge – at least at first – and that there may be unforeseen complications that will need to be resolved as the process evolves. We intend to work together with all involved parties to identify problems, publicize best practices, and implement needed changes.

More Information

Further information on this process, including the NOMNC and related instructions can be found on the CMS Web site at *http://www.cms.hhs.gov/healthplans/appeals*. (Also, see regulations are at 42 CFR 422.624, 422.626, and 489.27 and Chapter 13 of the M+C Manual.)

Source: CMS Pub. 100-20 Transmittal: 41 Date: January 9, 2004 Change Request 3044

Billing Instructions for Claims for Ventricular Assist Devices for Beneficiaries in a Medicare+Choice Plan

Information based on CMS Change Request (CR) 2958 was posted to our provider education Web site on December 11, 2003. Since then, CMS has indicated the Current Procedural Terminology *(*CPT*) codes listed in CR 2958 are incorrect. This instruction provides the correct code. All other information, except the* CPT *coding, within CR 2958 remains the same.*

CMS recently expanded coverage for ventricular assist devices (VADs). Until Medicare capitation rates to Medicare+Choice (M+C) organizations are adjusted to account for this expanded VADs coverage, Medicare will pay providers on a fee-for-service basis for VADs that fall under the new indication for destination therapy (see National Coverage Determination [NCD] manual section 20.9). This notification provides billing instructions for claims for VADs for beneficiaries in a M+C Plan.

The fee-for-service claim processing system automatically excludes claims for services provided for risk M+C beneficiaries except in certain circumstances for which editing has been created (e.g. NETT claims, clinical trial claims).

Physicians/practitioners are instructed to use modifier **KZ (new coverage not implemented by managed care)** when billing for services for VADs for beneficiaries in an M+C plan when conditions fall under the new indications for destination therapy, which are effective for dates of service on or after October 1, 2003.

Claims for M+C organizations' beneficiaries with existing covered indications (NCD manual section 20.9) should *not* be billed with the condition code or modifier; such indications are currently included in the M+C plan's capitated rates.

CPT/HCPCS Codes

33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle*

Source: CMS Pub. 100-04 Transmittal: 64 Date: January 16 2004 Change Request 3068

CPT Code for Lung Volume Reduction Surgery and Instructions for Processing Claims for Beneficiaries in a Risk M+C Plan

Lung volume reduction surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for services rendered on and after January 1, 2004, Medicare covers LVRS under certain conditions described in section 240 of Pub. 100-03, National Coverage Determinations (NCD). Physicians, when submitting claims for LVRS that meet the coverage conditions noted, are to use *CPT* code *32491*.

In addition, Medicare will pay for professional services for *CPT* code *32491* according to fee-for-service methodology for beneficiaries in a risk Medicare+Choice (M+C) plan, including the application of coinsurance, but excluding the application of the Part B deductible. (Beneficiaries in a risk M+C plan are liable for the coinsurance for this service, but are considered to have already met their Part B deductible.)

Because Medicare's fee-for-service claims processing systems automatically exclude claims for services provided for risk M+C beneficiaries, except in certain circumstances for which editing has been created (e.g., claims for services performed in clinical trials), physicians are to add modifier KZ (new coverage not implemented by managed care) to *CPT* code *32491* on claims for LVRS performed on Medicare beneficiaries in a risk M+C plan.

Carriers will pay claims for LVRS *CPT* code *32491* furnished to beneficiaries enrolled in risk M+C plans as noted above until the capitation rates to M+C organizations are adjusted to include the cost of this expanded coverage and carriers receive additional instructions. In addition, because systems changes needed to create edits for modifier KZ will not be implemented until the April 2004 standard systems release, carriers will hold claims for *CPT* code *32491* with modifier KZ from January 1, 2004, through March 31, 2004, or until the systems changes are made.

Source: CMS Pub. 100-04 Transmittal: 27 Date: October 4, 2003 Change Request 2688

PROVIDER ENROLLMENT

The Provider Enrollment Chain and Ownership System (PECOS)

On November 3, 2003, the Centers for Medicare & Medicaid Services (CMS) implemented the latest stage of the Provider Enrollment Chain and Ownership System (PECOS), CMS' new national provider enrollment system. PECOS has been used by Medicare's fiscal intermediaries since July 2002 and is now being used by all carriers.

As a national system, PECOS standardizes the process used by carriers and will allow a one-time enrollment process for providers and suppliers. Once entered into PECOS, information will be available nationally for all carriers, and additional enrollment activity will require only an update to the initial enrollment data. Therefore, the need for individuals and entities practicing in multiple states or billing multiple contractors to completely reenroll will be eliminated. PECOS will also make updating existing information easier, and eliminate the need to send duplicate information to both the local carrier and the Railroad Medicare carrier. PECOS implementation will be completed in 2004, when the National Supplier Clearinghouse (NSC) is brought online. In the near future, PECOS will enable applicants to validate and submit their enrollment data via the Internet, and will facilitate between the Medicare and Medicaid programs.

PECOS will also assist Medicare as a tool to detect and fight fraud and abuse. It will improve the accuracy of enrollment data and help ensure that only qualified individuals and entities are enrolled with Medicare. When fraud or abuse is detected, PECOS will make it easier to identify other associated providers and suppliers.

CMS is working with carriers to ensure any delays that occur during implementation of PECOS are minimized. Ultimately, CMS expects that PECOS will greatly reduce the amount of time needed to process provider enrollment applications. In the short term, however, ***providers may experience longer than usual enrollment processing times,*** as carriers get accustomed to the new system.

Absent extenuating circumstances, Medicare carriers strive to process applications within 60 days. In the event that an application is returned or development is required for missing or incorrect information, the process will cause further delays and can take up to 120 days to complete. FCSO is aggressively working to minimize any impacts to the enrollment process.

> **Note**: If your application *has not been returned nor has there been any development requested* for missing or incorrect information and it has been processing for *more than 60 days*, you may contact our Customer Service Department for status at 1-866-419-9455 (Connecticut) or 1-866-454-9007 (Florida). If your application *has been returned or there has been development requested* for incorrect or missing information and your application has been processing for *longer than 120 days*, you may contact Customer Service for status.

FCSO has provided additional instructions/clarification on the enrollment process on our Web sites at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com.*

SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)

Criteria for Using Modifier CB

The purpose of this article is to address two specific areas of concern related to skilled nursing facility (SNF) consolidated billing (CB) editing and separately billed end stage renal disease (ESRD) laboratory tests furnished to patients of independent dialysis facilities (CR 2475 Transmittal AB-02-175).

Issue/Concern #1:

Transmittal AB-02-175 requires that with respect to modifier CB,

"the provider or supplier may use the modifier only when it has determined that:
(a) The beneficiary has ESRD entitlement,
(b) The test is related to the dialysis treatment for ESRD,
(c) The test is ordered by a dialysis facility,
(d) The test is not included in the dialysis facility's composite rate payment and
(e) The beneficiary is in a SNF Part A stay."

Providers/suppliers often times cannot ascertain from the dialysis facility or the laboratory order that the ESRD beneficiary is in a SNF Part A stay.

CMS Response

The guidance issued on submission of modifier CB is being modified to no longer require that the provider/supplier determine that the beneficiary is in a SNF Part A stay.

Issue/Concern #2:

Providers/suppliers need a listing of diagnostic tests that are considered ESRD-related in submitting claims for services with modifier CB. Transmittal AB-02-175 did not define specific diagnostic tests as ESRD-related.

CMS Response

CMS has identified certain diagnostic tests considered ESRD-related (see list of codes, below).

> ***Note**: this was not designed as an all-inclusive list of Medicare covered diagnostic services.* Additional diagnostic services related to the beneficiary's ESRD treatment/care may be considered ESRD-related. Any diagnostic services related to the beneficiary's ESRD treatment/care must be submitted using modifier CB; however, if these services are not listed, we may require supporting medical documentation. In addition, beneficiaries in a SNF Part A stay are eligible for a broad range of diagnostic services as part of the SNF Part A benefit. Physicians ordering medically necessary diagnostic test that are not directly related to the beneficiary's ESRD dialysis treatment are subject to the SNF consolidated billing requirements. Physicians may bill the carrier for the professional component of these diagnostic tests. In most cases, however, the technical component of diagnostic tests is included in the SNF PPS rate, and is not separately billable to the carrier. Physicians should coordinate with the SNF in ordering such tests since the SNF will be responsible for reimbursing for the technical component.

Codes Identified as Diagnostic Tests Considered ESRD-Related

71010	*71015*	*71020*	*71021*	*71022*	*71030*	*71035*	*73120*	*75710*	*75716*	*75774*	*75790*	*75820*
75822	*75893*	*75894*	*75896*	*75898*	*75901*	*75902*	*75961*	*75962*	*75964*	*76070*	*76075*	*76080*
76092	*76778*	*78070*	*78351*	*80048*	*80051*	*80053*	*80061*	*80069*	*80074*	*80076*	*80197*	*80410*
81000	*81001*	*81002*	*81003*	*81005*	*81007*	*81015*	*82009*	*82010*	*82017*	*82040*	*82042*	*82108*
82232	*82247*	*82248*	*82306*	*82307*	*82308*	*82310*	*82330*	*82374*	*82379*	*82435*	*82465*	*82550*
82565	*82570*	*82575*	*82607*	*82728*	*82746*	*82747*	*82800*	*82803*	*82805*	*82810*	*82945*	*82947*
82948	*83540*	*83550*	*83735*	*83937*	*83970*	*83986*	*84075*	*84100*	*84105*	*84132*	*84133*	*84134*
84155	*84160*	*84295*	*84315*	*84450*	*84460*	*84466*	*84520*	*84540*	*84545*	*84630*	*85002*	*85004*
85007	*85008*	*85009*	*85013*	*85014*	*85018*	*85025*	*85027*	*85032*	*85041*	*85044*	*85045*	*85046*
85048	*85049*	*85345*	*85347*	*85348*	*85520*	*85610*	*85611*	*85651*	*85652*	*85730*	*85732*	*86590*
86644	*86645*	*86687*	*86688*	*86689*	*86692*	*86701*	*86702*	*86703*	*86704*	*86705*	*86706*	*86707*
86709	*86803*	*86804*	*86812*	*86813*	*86816*	*86817*	*86900*	*86901*	*86903*	*86904*	*86905*	*86906*
87040	*87070*	*87071*	*87073*	*87075*	*87076*	*87077*	*87081*	*87084*	*87086*	*87088*	*87181*	*87184*
87185	*87186*	*87187*	*87188*	*87190*	*87197*	*87205*	*87271*	*87340*	*87341*	*87350*	*87380*	*87390*
87391	*87515*	*87516*	*87517*	*87520*	*87521*	*87522*	*87525*	*87526*	*87527*	*89050*	*89051*	*93000*

93005 93010 93040 93041 93042 93307 93308 93922 93923 93925 93926 93930 93931 93965 93970 93971 G0001 G0202

Source: CMS Pub. 100-04 Transmittal: 69 Date: January 23, 2004 Change Request 2906

GENERAL INFORMATION

Claims Crossover Consolidation Process—National Coordination of Benefits Agreement

The Centers for Medicare & Medicaid Services (CMS) has decided to streamline the claims crossover process to better serve our customers. Medicare complementary insurers (i.e., non- Medigap plans), Title XIX State Medicaid Agencies, and Medigap plans—collectively known as coordination of benefit (COB) trading partners—that 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 contractors. Each COB trading partner will now enter into one national Coordination of Benefits Agreement (COBA) with CMS' consolidated claims crossover contractor, the Coordination of Benefits Contractor (COBC).

Likewise, each COB trading partner will no longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers nor receive numerous crossover files. The COBC shall be designated to collect crossover fees from all COB trading partners (except for Title XIX State Medicaid Agencies which are exempt from such fees) on behalf of CMS. Sections of the Medicare Claims Processing Manual will be added or revised to capture the scope of the many changes that will result from the claims crossover consolidation process.

This will be accomplished via a phased-in approach. **Phase I** will include analysis, design and programmer coding for the January 2004 system release. **Phase II** will include testing and address any additional programmer coding or other specifications necessary as a result of testing, and will be completed with the April 2004 system release. **Phase III** (future instructions) will include the claim-based crossover and recovery of claims processes, and is the portion that will affect our customers. We will provide information concerning future instructions as soon as it is available.

Source: CMS Pub. 100-04 Transmittal: 29 Date: November 7, 2003 Change Request 2961
CMS Pub. 100-04 Transmittal: 28 Date: November 27, 2003 Change Request 2962

Medicare Deductible, Coinsurance, and Premium Rates for 2004

The Medicare Part B deductible, coinsurance, and premium amounts for calendar year 2004 are as follows:

Deductible	$100.00 per year
Coinsurance	20 percent
Premium	$66.60 per month

Source: CMS Pub. 100-04 Transmittal: 21 Date: October 31, 2003 Change Request 2969

Payment Denial for Medicare Services Furnished to Alien Beneficiaries Who Are Not Lawfully Present in the United States

Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) prohibited aliens who are not "qualified aliens" from receiving Federal public benefits including Medicare. The term "qualified alien" is defined to include six groups of aliens as follows:

1. Aliens who are lawfully admitted for permanent residence under the Immigration and Nationality Act (Act).
2. Aliens who are granted asylum under section 208 of the Act.
3. Refugees admitted into the United States under section 207 of the Act.
4. Aliens who are paroled into the United States under section 212(d)(5) of the Act for a period of at least one year.
5. Aliens whose deportation is being withheld under section 243(h) of the Act.
6. Aliens who are granted conditional entry pursuant to section 203(a)(7) of the Act as in effect prior to April 1, 1980.

Two groups of qualified aliens were added to the statute after the original enactment of the restriction in the 1996 Welfare Reform statute. These groups are:

1. Certain Cuban and Haitian entrants to the United States.
2. Certain "battered aliens."

Under the terms of the PRWORA, nonqualified aliens cannot receive Medicare benefits.

Section 5561 of the Balanced Budget Act of 1997 (BBA) amended section 401 of the PRWORA to create a Medicare exemption to the prohibition on eligibility for nonqualified alien beneficiaries, who are lawfully present in the United States and who meet certain other conditions.

Under the provisions of the final rule, payment may be made for services furnished to an alien who is lawfully present in the United States (and, provided that with respect to benefits payable under Part A of Title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for Medicare benefits). The definition for "lawfully present in the United States" is found at 8 CFR 103.12.

Payment for Medicare Benefits

No Medicare payment will be issued for services furnished to an alien beneficiary who is not lawfully present in the United States on the date the services are rendered. Providers may advise beneficiaries appealing the initial Medicare determination to provide the Social Security Administration with the appropriate documentation establishing that on the date the services were furnished he or she was lawfully present in the United States.

Source: CMS Transmittal AB-03-115, CR 2825

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 that 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 list posted on the two Web sites also have the following codes deactivated without any replacement codes: M16, MA116, and MA94. Research has revealed that these codes are still being used by Medicare contractors, and will be reactivated in the next update.

The complete list of remark codes is available at:
http://www.cms.hhs.gov/providers/edi/hipaadoc.asp and *http://www.wpc-edi.com/codes/Codes.asp*

The list is updated three times a year – in the months following X12 trimester meetings. The following list summarizes changes made from March 1, 2003 to June 30, 2003.

Code	Current Narrative	Medicare Initiated
N202	Additional information/explanation will be sent separately.	No
N203	Missing/incomplete/invalid anesthesia time/units.	No
N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.	No
N205	Information provided was illegible.	No
N206	The supporting documentation does not match the claim.	No
N207	Missing/incomplete/invalid birth weight.	No
N208	Missing/incomplete/invalid DRG code.	No
N209	Missing/invalid/incomplete taxpayer identification number (TIN).	No
N210	You may appeal this decision.	No
N211	You may not appeal this decision.	No

Modified Remark Codes

Code	Current Modified Narrative	Modification Date
M13	Only one initial visit is covered per specialty per medical group.	6/30/03
M18	Certain services may be approved for home use. Neither a hospital nor a skilled nursing facility (SNF) is considered to be a patient's home.	6/30/03
M25	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	6/30/03
M26	The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.	

	The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Contact this office if you have any questions about this notice.	
M60	Missing/incomplete/invalid Certificate of Medical Necessity.	6/30/03
M86	Service denied because payment already made for some/similar procedure within set time frame.	6/30/03
M117	Not covered unless submitted via electronic claim.	6/30/03
M129	Missing/incomplete/invalid indicator of x-ray availability for view.	6/30/03
M134	Performed by a facility/supplier in which the provider has a financial interest.	6/30/03
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal. If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.	6/30/03
MA02	If you do not agree with this determination, you have the right to appeal. You must file a written request for reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days. An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.	6/30/03
MA03	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.	6/30/03

MA20	Skilled nursing facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.	6/30/03
MA24	Christian science sanitarium/skilled nursing facility (SNF) bill in the same benefit period	. 6/30/03
MA93	Non-PIP (Periodic Interim Payment) Claim.	6/30/03
MA101	A skilled nursing facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	6/30/03
MA106	PIP (Periodic Interim Payment) claim.	6/30/03
MA121	Missing/incomplete/invalid date the x-ray was performed.	6/30/03
N30	Patient ineligible for this service.	6/30/03
N32	Claim must be submitted by the provider who rendered the service.	6/30/03
N40	Missing/incomplete/invalid x-ray.	6/30/03
N69	PPS (Prospective Payment System) code changed by claims processing system. Insufficient visits or therapies.	6/30/03
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.	6/30/03
N72	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.	6/30/03
N100	PPS (Prospect Payment System) code corrected during adjudication.	6/30/03
N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.	6/30/03
N106	Payment for services furnished to skilled nursing facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.	6/30/03
N107	Services furnished to skilled nursing facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.	6/30/03
N113	Only one initial visit is covered per physician, group practice or provider.	6/30/03
N115	This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd*, or if you do not have web access, you may contact the contractor to request a copy of the LMRP.	6/30/03
N117	This service is paid only once in a patient's lifetime.	6/30/03
N119	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or skilled nursing facility (SNF) within those 28 days.	6/30/03
N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.	6/30/03
N121	No coverage for items or services provided by this type of practitioner for patients in a covered skilled nursing facility (SNF) stay.	6/30/03
N177	We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.	6/30/03

Deactivated Remark Codes

Code	Current Modified Narrative	Deactivation Date
M43	Payment for this service previously issued to you or another provider by another carrier/intermediary.	Deactiv. eff. 1/31/04 Refer to Reason Code 23
M48	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.	Deactiv. eff. 1/31/04 Refer to M97
M63	We do not pay for more than one of these on the same day.	Deactiv. eff. 1/31/04 Refer to M86
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.	Deactiv. eff.1/31/04 Refer to M99
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.	Deactiv. eff. 1/31/04 Refer to M78
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.	Deactiv. eff. 1/31/04 Refer to MA31
M140	Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday.	Deactiv. eff. 1/31/04 Refer to M82
MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Contact us if the patient is covered by any of these sources.	Deactiv. eff. 1/31/04 Refer to M32
MA78	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.	Deactiv. eff. 1/31/04 Refer to MA59
MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.	Deactiv. eff. 1/31/04 Refer to M128 or M57
MA124	Processed for IME only.	Deactiv. eff. 1/31/04 Refer to reason code 74
MA129	This provider was not certified for this procedure on this date of service.	Deactiv. eff. 1/31/04 Refer to MA120 and reason code B7
N18	Payment based on the Medicare allowed amount.	Deactiv. eff. 1/31/04 Refer to N14
N60	A valid NDC is required for payment of drug claims effective October 02.	Deactiv. eff. 1/31/04 Refer to M119
N73	A skilled nursing facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.	Deactiv. eff. 1/31/04 Refer to MA101 or N200
N101	Additional information is needed in order to process this claim. Resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.	Deactiv. eff. 1/31/04 Refer to MA105
N164	Transportation to/from this destination is not covered.	Deactiv. eff. 1/31/04 Refer to N157
N165	Transportation in a vehicle other than an ambulance is not covered.	Deactiv. eff. 1/31/04 Refer to N158
N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	Deactiv. eff. 1/31/04 Refer to N159

N168	The patient must choose an option before a payment can be made for this procedure/ equipment/supply/service.	Deactiv. eff. 1/31/04 Refer to N160
N169	This drug/service/supply is covered only when the associated service is covered.	Deactiv. eff. 1/31/04 Refer to N161

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 three 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 June 2003 are listed here.

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 the regular code update notification. The regular code update notification will be 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 also can 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 June 2003.

Reason Code Changes (as of 6/30/03)

Code	Current Narrative	Notes
155	This claim is denied because the patient refused the service/procedure.	New as of 6/03
38	Services not provided or authorized by designated (network/primary care) providers.	Modified as of 6/03
107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	Modified as of 6/03

The following is a comprehensive list of retired reason codes. Codes that have been retired effective version 4010 must be deactivated by the implementation date of this instruction. Codes retired effective version 4010 or any previous version is bolded. System limitation prohibits using codes that are retired effective version 4010 for any pre-4010 formats/versions being generated during the HIPAA contingency period invoked by CMS.

Code	Current Narrative	Notes
28	Coverage not in effect at the time the service was provided.	Inactive for 004010, since 6/98. Redundant to codes 26 & 27.
36	Balance does not exceed co-payment amount.	Inactive for 003040
37	Balance does not exceed deductible.	Inactive for 003040
41	Discount agreed to in Preferred Provider contract.	Inactive for 003040
46	This (these) service(s) is (are) not covered.	Inactive for 004010, since 6/00. Use code 96.
48	This (these) procedure(s) is (are) not covered.	Inactive for 004010, since 6/00. Use code 96.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	Inactive for 004050. Split into codes 150, 151, 152, 153, and 154.
63	Correction to a prior claim.	Inactive for 003040
64	Denial reversed per medical review.	Inactive for 003040
65	Procedure code was incorrect. This payment reflects the correct code.	Inactive for 003040

67	Lifetime reserve days. (Handled in QTY, QTY01=LA)	Inactive for 003040
68	DRG weight. (Handled in CLP12)	Inactive for 003040
71	Primary payer amount.	Deleted as of 6/00. Use code 23.
72	Coinsurance day. (Handled in QTY, QTY01=CD)	Inactive for 003040
73	Administrative days.	Inactive for 003050
77	Covered days. (Handled in QTY, QTY01=CA)	Inactive for 003040
79	Cost Report days. (Handled in MIA15)	Inactive for 003050
80	Outlier days. (Handled in QTY, QTY01=OU)	Inactive for 003050
81	Discharges.	Inactive for 003040
82	PIP days.	Inactive for 003040
83	Total visits.	Inactive for 003040
84	Capital Adjustment. (Handled in MIA)	Inactive for 003050
86	Statutory Adjustment.	Inactive for 004010, since 6/98. Duplicative of code 45.
88	Adjustment amount represents collection against receivable created in prior overpayment.	Inactive for 004050.
92	Claim paid in full.	Inactive for 003040
93	No claim level adjustments.	Inactive for 004010, since 2/99. In 004010, CAS at the claim level is optional.
98	The hospital must file the Medicare claim for this inpatient non-physician service.	Inactive for 003040
99	Medicare Secondary Payer Adjustment Amount.	Inactive for 003040
120	Patient is covered by a managed care plan.	Inactive for 004030
123	Payer refund due to overpayment.	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
124	Payer refund amount - not our patient.	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
A3	Medicare Secondary Payer liability met.	Inactive for 004010, since 6/98.
B2	Covered visits.	Inactive for 003040
B3	Covered charges.	Inactive for 003040
B19	Claim/service adjusted because of the finding of a Review Organization.	Inactive for 003070
B21	The charges were reduced because the service/care was partially furnished by another physician.	Inactive for 003040
D1	Claim/service denied. Level of subluxation is missing or inadequate.	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D2	Claim lacks the name, strength, or dosage of the drug furnished.	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D3	Claim/service denied because information to indicate if the patient owns the	equipment that requires the part or supply was missing. Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D4	Claim/service does not indicate the period of time for which this will be needed.	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D5	Claim/service denied. Claim lacks individual lab codes included in the test.	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D6	Claim/service denied. Claim did not include patient's medical record for the service.	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review.	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D10	Claim/service denied. Completed physician financial relationship form not on file.	Inactive for 003070, since 8/97. Use code 17.
D11	Claim lacks completed pacemaker registration form.	Inactive for 003070, since 8/97. Use code 17.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.	Inactive for 003070, since 8/97. Use code 17.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/ referring physician has a financial interest.	Inactive for 003070, since 8/97. Use code 17.
D14	Claim lacks indication that plan of treatment is on file.	Inactive for 003070, since 8/97. Use code 17.
D15	Claim lacks indication that service was supervised or evaluated by a physician.	Inactive for 003070, since 8/97. Use code 17.

Source: CMS Pub. 100-04 Transmittal: 32 Date: November 21, 2003 Change Request 2975

MEDLEARN MATTERS...
INFORMATION FOR MEDICARE PROVIDERS

Announcing the New Medlearn Matters…
Information for Medicare Providers
Educational Resource for Medicare Providers

The Centers for Medicare & Medicaid Services and your Medicare Learning Network introduces *Medlearn Matters…Information for Medicare Providers*, a new educational resource for Medicare Providers. *Medlearn Matters…Information for Medicare Providers* is designed to inform you of important changes to the Medicare system in a user-friendly format that will accommodate your busy schedule.

Please let us know if these articles help you understand these changes more readily. Provide us with suggestions for improvements to articles. If there is a special topic of interest that you believe warrants an article, let us know and we will consider a special edition for that topic. To provide feedback, please go to:
http://www.cms.hhs.gov/medlearn/suggestform.asp

Bookmark this page, use it frequently, and let us know how best to continue providing good service to you.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to partnering with the Medicare physician, provider, and supplier communities so services to Medicare beneficiaries can be timely and of the highest quality. One way of providing the best services to Medicare patients is assuring that the providers of care have ready access to Medicare's latest coverage and reimbursement rules and policies in a brief, accurate, and easy-to-understand format.

CMS recognizes that the Medicare provider communities have been hampered by the number, frequency, and complexity of Medicare changes. CMS also appreciates the feedback from those same providers who indicate that Medicare rules and changes are not always relayed to them in an easy, timely, and consistent manner.

To address those issues, CMS has implemented a new initiative — "Consistency in Medicare Contractor Outreach Material" or CMCOM, designed to provide more timely information on Medicare changes. The product of this effort, *Medlearn Matters…Information for Medicare Providers*, is a series of articles prepared by actual clinicians and billing experts. *Medlearn Matters…Information for Medicare Providers* articles are tailored, in content and language, to the specific provider types who are affected by Medicare changes.

Previously, each Medicare carrier and intermediary was responsible for crafting educational articles within days of release of the related Medicare change. With this new effort, the Medicare carrier or intermediary will still be responsible for local provider education. However, they will benefit from the availability of *Medlearn Matters…Information for Medicare Providers* articles to support their efforts. These articles are easily accessible from the Medlearn Web site, which providers already access for other Medicare information.

Enlisting the expertise of medical professionals to develop these articles and providing them from a single location will result in more consistent, accurate, and timely information than in the past. This initiative supplements and should improve the ability of your carrier or intermediary to provide better service to you.

Those of you who have relied on Medicare Program Memorandums or Manual Transmittals on the Web, may be familiar with the Change Request (CR) documents and their accompanying CR numbers. Since you may have used the original CRs to get early information on upcoming changes, we think you will agree that those documents were not always clear as to provider impact and action needed.

One reason is that those CRs were written to provide instructions to Medicare carriers, intermediaries, and Medicare system maintainers. Thus, the focus of the message was quite different and probably contained more information than providers needed to know. The intent of *Medlearn Matters…Information for Medicare Providers* articles is to help focus the information more toward providers, to give you only the information you need and thus reduce the amount of time you need to spend on that information.

The articles will be placed on the Medlearn Web site on the new *Medlearn Matters…Information for Medicare Providers* page. Each article's number will usually correspond to the number of the Change Request (CR) that officially announced the change, but the number will be preceded by MM to show it is a related *Medlearn Matters…Information for Medicare Providers* article. There are exceptions, designated as Special Editions. These articles will be numbered in a distinctive manner, as "SEyynn" where "SE" stands for Special Edition, the "yy" is the two-digit year the article was released, and "nn" is the number of the special edition for that year. Thus, this first Special Edition article is numbered as SE0401.

To view all the articles available, please visit: *http://www.cms.hhs.gov/medlearn/matters/*

We hope you find this new vehicle of assistance to you and we invite your feedback.

CONNECTICUT MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and 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) to providers in the *Update!* Summaries of revised and new LMRPs are provided instead. Providers may obtain full-text LMRPs on our provider education Web site, *http://www.connecticutmedicare.com*. Final LMRPs, draft LMRPs available for comment, LMRP statuses, and LMRP 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; the date the LMRP is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs 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, 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

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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.

Medical Review Development Process Changes

Because only providers who meet exception criteria are allowed to submit paper claims under the new HIPAA requirements, we are requesting that you no longer submit paper claims in circumstances for which you know, or anticipate, medical record review will be necessary before payment can be made. In those cases where prepayment review is necessary, we will request the appropriate documentation via an additional development request (ADR). In addition, providers who meet the exception requirements and routinely submit paper claims need not submit medical record documentation unless requested through an ADR. We are currently evaluating all prepayment medical review edits, and documentation may or may not be required. Submitting medical records only in response to an ADR request will reduce the administrative burden on both the provider and Medicare.

While we are evaluating our prepayment medical review edits and associated claims processing guidelines, applicable local medical review policies (LMRP) that appear on our Web sites are still in effect. It is important for providers to understand that whether or not we have a prepayment edit in the system, all medical necessity requirements in an LMRP must be met. You must maintain medical record documentation that supports the service and make it available upon request, whether requested on a prepayment or postpayment basis.

If you have received a claim denial on a service denied due to medical necessity, you may file an appeal and provide the necessary medical documentation that supports the need for the service. If you do not provide the supporting medical documentation record with your appeal, the previous claims decision will be affirmed.

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.

Correct Billing of Ibritumomab Tiuxetan (Zevalin™) Therapy

A local medical review policy (LMRP) for ibritumomab tiuxetan (Zevalin™) therapy, which includes billing instructions, was implemented on June 30, 2003. It has since been noted that some providers are utilizing the incorrect codes when billing for Zevalin™ therapy.

In-111 Zevalin™ (the diagnostic component of the therapy)

For all dates of service:

A9522 Supply of radiopharmaceutical diagnostic imaging agent, Indium 111 ibritumumab tiuxetan, per mci

Note: A9522 should be submitted with "5" in the number billed field as the unit dose available for this radiopharmaceutical is only available in the 5 mci (millicurie) dosage and the code references a per-mci amount.

AND

For dates of service on or after January 1, 2004:

78804 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging

For dates of service March 1, 2003 – December 31, 2003:

G0273 Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)

Y-90 Zevalin™ (the therapeutic component of the therapy)

For all dates of service:

A9523 Supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxetan, per mci

Note: A9523 should be submitted with "40" in the number billed field as the unit dose available for this radiopharmaceutical is only available in the 40 mci dosage and the code references a per-mci amount.

AND

For dates of service on or after January 1, 2004:

79403 Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion

For dates of service March 1, 2003 – December 31, 2003:

G0274 Radiopharmaceutical therapy, non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)

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

Please reference the Web site for dates of service prior to March 1, 2003.

LOCAL MEDICAL REVIEW POLICY (REVISED)

Policy Changes Related to the 2004 HCPCS Update

The table that follows provides a list of local medical review policies (LMRPs) affected by the 2004 HCPCS update. The full-texts of these LMRPs are available on our provider education Web site at *http://www.connecticutmedicare.com*.

Policy Number & Title	Changes
20550: Trigger Point Injections	Descriptor change for procedure codes *20550*, *20551*, and *20552* Changed policy name to Injection of Tendon Sheath, Ligament or Trigger Points Added diagnoses 728.71 and 729.4 for procedure codes *20550* and *20551*
61862: Deep Brain Stimulation	Deleted procedure code *61862* Added procedure codes *61863*, *61864*, *61867*, and *61868* Deleted unlisted procedure code *64999* and replaced it with procedure code *61795* **(not related to 2004 HCPCS)** Changed language in the "Coding Guidelines" section Changed Policy Identification Number to *61863*
70551: Magnetic Resonance Imaging of the Brain	Added procedure codes *70557*, *70558*, and *70559* Added language in the "Coding Guidelines" section
76090: Mammography	Deleted procedure codes G0236 and 76085 Added procedure codes *76082* and *76083* Added/Deleted language in the "Coding Guidelines" section

77301: Intensity Modulated Radiation Therapy (IMRT)	Descriptor change for procedure code *76375* in the "Coding Guidelines" section
97001: Physical Medicine and Rehabilitation	Descriptor change for procedure code *97537*
99183: Hyperbaric Oxygen Therapy (HBO Therapy)	Deleted procedure code G0167 Removed language related to G0167 from the "Reasons for Denials" section
A0425: Coverage for Transportation by Ambulance	Added procedure code A0800 Added language in the "Indications and Limitations of Coverage and/or Medical Necessity" section
G0030: Positron Emission Tomography (PET) Scans	Deleted procedure code Q4078 Added procedure code A9526 Added language in the "Coding Guidelines" section
G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes	Descriptor change for procedure code G0247
G0262: Wireless Capsule Endoscopy	Deleted procedure code G0262 Added procedure code *91110* Changed Policy Identification Number to *91110*
J0150: Adenosine (Adenocard®, Adenoscan®)	Deleted procedure code J0151 Added procedure code J0152 Changed language in the "Coding Guidelines" section
J0880: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	Added procedure codes Q0137 and Q4054 Added language in the "Coding Guidelines" section Changed Policy Identification Number to NESP
J9999: Antineoplastic Drugs	Deleted procedure codes J9180 and J9999 Added procedure codes J9178, J9263, and J9395 Added language in the "Coding Guidelines" section Changed Policy Identification Number to J9000
NCSVCS: The List of Medicare Noncovered Services	Descriptor change for procedure codes M0100* and M0301* in National Noncoverage Decisions section Deleted procedure code *93788* from National Noncoverage Decisions section Added procedure codes *89268, 89272, 89280, 89281, 89290, 89291, 89335, 89342, 89343, 89344, 89346, 89352, 89353, 89354, 89356, 0058T,* and *0059T* to Local Noncoverage Decisions section Removed procedure code 33999* from the "Devices" section in the National Noncoverage Decisions section and replaced it with procedure codes *0051T*, 0052T**, and *0053T** Added procedure codes 96155, J7303, V5362, V5363, and V5364 to National Noncoverage Decisions section
Q4053: Pegfilgrastim (Neulasta™)	Deleted procedure code Q4053 Added procedure code J2505 Changed Policy Identification Number to J2505
994V11: Labeled and Off Labeled Uses of Erythropoietin	Deleted procedure codes Q9920-Q9940 Added procedure code Q4055 Added language in the "Coding Guidelines" section Changed Policy Identification Number to EPO Changed Policy Name to Epoetin alfa
ZEVALIN: Ibritumomab Tiuxetan (Zevalin™) Therapy	Deleted procedure codes G0273 and G0274 Added procedure codes *78804* and *79403* Changed language in the "Coding Guidelines" section

EPO: Epoetin alfa

The local medical review policy (LMRP) for epoetin alfa was last updated on January 5, 2004. Since then, dual diagnosis requirements for HCPCS code Q0136 have been removed from the LMRP. The ICD-9-CM code for the appropriate anemia diagnosis is no longer required. ICD-9-CM codes 285.22, 285.8, and 285.9 have been removed from the LMRP.

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

NCSVCS: The List of Medicare Noncovered Services

The local medical review policy (LMRP) for Noncovered Services was implemented on January 5, 2004. *CPT* codes *62281* and *64577* are covered through either an existing LMRP, and *CPT* code *86301* is covered under a laboratory services national coverage decision (NCD). Therefore, these codes should not be included in the list of noncovered services. A revision has been made to remove the codes from the Local Noncoverage Decisions section of this policy.

62281 *Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid*

64577 *Incision for implantation of neurostimulator electrodes; autonomic nerve*

86301 *Immunoassay for tumor antigen, quantitative; CA 19-9*

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

NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) (formerly J0880)

The local medical review policy (LMRP) for darbepoetin alfa was last updated on September 29, 2003. The following revisions have since been made to the LMRP.

Dual diagnosis requirements for darbepoetin alfa have been removed. The ICD-9-CM code for the appropriate anemia diagnosis is no longer required; and ICD-9-CM codes 285.21, 285.22, 285.8, and 285.9 have been removed from the LMRP.

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

Revised Local Medical Review Policies for Pain Management

Numerous local medical review policies (LMRP) for pain management services were finalized with an effective date of September 29, 2003; notification was published in the Fourth Quarter 2003 *Medicare B Update!* Some of these policies contained duplicate procedure codes. Since then, the policies have been reviewed, and duplicate codes have been identified. Each policy specifically identifies the *CPT* codes that have corresponding ICD-9-CM codes for medical necessity. The following policies have been revised:

27096: Sacroiliac Joint Injection

Procedure codes *20610*, *73542*, and *76005* have been removed from the *CPT*/HCPCS Codes section of the policy. This revision is effective for services rendered on or after September 29, 2003.

64470: Paravertebral Facet Joint Blocks

Procedure codes *20551* and *76005* have been removed from the *CPT*/HCPCS Codes section of the policy. This revision is effective for services rendered on or after September 29, 2003.

64622: Paravertebral Facet Joint, Nerve Destruction by a Neurolytic Agent

Procedure code *76005* has been removed from the *CPT*/HCPCS Codes section of the policy. This revision is effective for services rendered on or after September 29, 2003.

63650: Spinal Cord Stimulation

ICD-9-CM codes 053.12 (Post herpetic trigeminal neuralgia), ICD-9-CM code 348.8 (other conditions of the brain), and ICD-9-CM code range 952.00-952.09 (Spinal cord injury without evidence of spinal bone injury) have been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy. Additionally, procedure codes *63660*, *63688*, *95970*, *95971*, *95972*, and *95973* have been removed from the *CPT*/HCPCS Codes section. These revisions are effective for services rendered on or after September 29, 2003.

64555: Implanted Peripheral/Sacral Electrical Nerve Stimulation

Procedure codes *64561*, *64581*, and A4290 have been removed from the *CPT*/HCPCS section of the policy. These procedure codes are addressed in the LMRP *64561* (Sacral neuromodulation). In addition, the ICD-9-CM codes 595.1, 596.51, 596.54, 596.55, 596.59, 788.20, 788.21, 788.30, 788.31, 788.34, and 788.41 have been removed from the "ICD-9 Codes that Support Medical Necessity" section of the policy. Language has been removed related to sacral nerve stimulation and indication for bladder/voiding disorders throughout the policy. This revision is effective for services rendered on or after January 5, 2004.

The full-texts of these LMRPs are available on our provider education Web site at *http://www.connecticutmedicare.com*.

11055: Routine Foot Care (Formerly 94004A V1.2: Coverage for Services for Trimming, Reduction of Non-Dystrophic Toenails, Reduction of Corns and Calluses of the Feet)

The local medical review policy (LMRP) for coverage for services for trimming, reduction of non-dystrophic toenails, and reduction of corns and calluses of the feet was last updated on March 1, 2003. A revision to the entire policy has since been made for carrier consistency.

The policy number and title were changed to *11055*: Routine Foot Care

The following additional ICD-9-CM Codes or ranges of ICD-9-CM codes were added to "The ICD-9 Codes that Support Medical Necessity" section of the policy, effective for services rendered on or after January 12, 2004:

Diagnosis 030.1 was changed to diagnosis range 030.0 – 030.9
Diagnosis 356.2 was changed to diagnosis range 356.0 – 356.9
Added diagnosis codes 094.0, 094.1, 094.9, 334.0, 443.0, 444.22, & 446.0

The class findings were changed to national guidelines under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy.

Additional changes/revisions were made to these sections of the policy effective for claims processed on or after April 12, 2004:

- LMRP Description
- Indications and Limitations of Coverage and/or Medical Necessity
- Reasons for Denial
- Noncovered Diagnosis
- Coding Guidelines
- Documentation Requirements
- Utilization Guidelines.

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

11730: Surgical Treatment of Nails (Formerly 94004C V1.2: Treatment of Ingrown Nails)

The local medical review policy (LMRP) for treatment of ingrown toenails was last revised on January 1, 2003. A revision to the policy has been made to include coverage of fingernails in addition to toenails, and to add additional covered diagnoses.

The policy number and title were changed from 94004C V1.2: "Treatment of Ingrown Toenails" to *11730*: "Surgical Treatment of Nails." Modifiers for finger digits were added under "Coding Guidelines," and the word toenail was changed to nail throughout the policy. Verbiage was added under "Utilization Guidelines" concerning standards of practice. Additional ICD-9-CM codes were added under "ICD-9 Codes that Support Medical Necessity." The following is a complete list of diagnosis codes that are covered for procedure codes *11730*, *11732*, *11750*, and *11765*:

110.1	681.00	681.02	681.10	681.11	681.9
686.1	703.0	703.8	703.9	757.5	785.4
816.02	816.03	816.12	816.13	826.0	826.1
883.0	883.1	883.2	893.0	893.1	893.2
923.3	924.3	927.3	928.3	991.1	991.2

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

20974: Osteogenic Stimulation

The local medical review policy (LMRP) for osteogenic stimulation was established in March 2002. Since that time, diagnosis code 724.9 has been added to the ICD-9 Codes that Support Medical Necessity" section of the policy for procedure code ***20974***, and diagnosis codes 724.9, 738.4, 756.12, 909.3, 996.4, and V45.4 have been added to the "ICD-9 Codes that Support Medical Necessity" section for procedure code ***20975***.

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

29540: Strapping

The local medical review policy (LMRP) for strapping was published in the Second Quarter 2003 *Medicare B Update!* Since that time, diagnosis code 959.7 (injury of ankle and foot) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy for procedure codes *29540* and *29550*.

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 5, 2004.

44388: Diagnostic Colonoscopy (formerly Colonoscopy)

The local medical review policy (LMRP) for colonoscopy was last updated on May 9, 2003. A revision to the policy has been made as a result of CMS Change Request 2822, Transmittal AB-03-114, dated August 1, 2003, entitled "Claims Processing and Payment of Incomplete Screening Colonoscopies."

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy, as long as coverage conditions are met for the incomplete procedure. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to payment methodology for the procedure as long as coverage conditions are met. When submitting a claim for the interrupted colonoscopy, append the colonoscopy code with modifier *53* to indicate the procedure was interrupted. Medicare would expect the provider to maintain adequate documentation in the patient's medical record to support an incomplete procedure.

The LMRP title was changed from Colonoscopy to Diagnostic Colonoscopy. The full-text of this LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com* and is effective for services rendered on or after January 1, 2004.

70551: Magnetic Resonance Imaging of the Brain

The local medical review policy (LMRP) for magnetic resonance imaging (MRI) of the brain was last updated on September 22, 2003. This LMRP has since been revised to include ICD-9-CM code 676.60 (galactorrhea, unspecified as to episode of care or not applicable).

This revision is effective for services rendered on or after December 15, 2003. The full text LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*.

76090: Mammography

The local medical review policy (LMRP) for mammography was last updated on April 1, 2003. The LMRP has since been revised to reflect the 2004 HCPCS update. Procedure codes *76085* and G0236 were deleted from the LMRP, and codes *76082* and *76083* were added.

In addition, the "ICD-9 Codes that Support Medical Necessity" section of the LMRP has been revised to clarify the appropriate diagnosis code(s) for the specified procedure codes.

> **Note**: ICD-9-CM code V76.12 (other screening mammogram) must be on the claim when billing the following screening mammography procedure codes: *76083*, *76092*, and G0202.

These revisions are 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.connecticutmedicare.com*.

92235: Fluorescein Angiography

The local medical review policy (LMRP) for fluorescein angiography was effective January 1, 2003. This policy has been revised as a result of a widespread probe performed for procedure code *92235*. Changes include revisions to the "Coding Guidelines" and "Utilization Guidelines" sections of the policy. The "ICD-9 Codes that Support Medical Necessity" section of the policy has been expanded as well. ICD-9-CM codes added include: 115.02, 115.92, 130.2, 135, 250.52, 250.53, 361.2, and 368.11.

This revision will be effective for services rendered on or after January 20, 2004. The full-text of this local medical review policy is available on our provider education Web site at *http://www.conecticutmedicare.com*.

92552: Audiometric Testing

The local medical review policy (LMRP) for audiometric testing was last updated on January 1, 2003. A revision to the policy has been made to correct a typographical error in the previous revision.

It was determined that on the previous revision under the "ICD-9 Codes that Support Medical Necessity" section of the policy, ICD-9-CM code range 389.00 – 389.08 for Hearing Loss should have been 389.00 – 389.9.

The full text of this LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com.* and is effective for services rendered on or after October 1, 2002.

96105: Neuropsychological Exam (formerly 95LMRP005-V1.0-*96105*)—Policy Revision Initiative

Information concerning our local medical review policy (LMRP) revision initiative was published in the First Quarter 2004 *Medicare B Update!* Since then, an additional LMRP has been revised. In the process of updating the LMRP for neuropsychological exam, the diagnosis-to-procedure code edit was reviewed, and a change was identified that occurred due to conversion to the Multi-Carrier System (MCS). The system was updated under the direction of the Connecticut Carrier Medical Director (CMD) and medical staff to reflect diagnoses that were included in the edit prior to MCS conversion. A system update was done prior to the policy revision due to provider inquiries and a high volume of post-payment reviews. Therefore, the LMRP for neuropsychological exam has been revised by the addition of ICD-9-CM diagnosis criteria. In addition, the policy number has been changed to *96105*.

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

98940: Chiropractic Services

The most recent revision for the local medical review policy (LMRP) for chiropractic services was effective October 20, 2003. That revision deleted the requirement for billing of dual diagnoses. Therefore, the following ICD-9-CM codes (formerly referred to as the primary diagnoses) have been removed from the policy:

739.1 Cervical (C1-C7)
739.2 Dorsal (D1-D12) or Thoracic (T1-T12)
739.3 Lumbar (L1-L5)
739.4 Sacrococcygeal (S) (To be used to indicate pelvic/sacroiliac region)

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

99183: Hyperbaric Oxygen Therapy (HBO Therapy)

The latest revision for local medical review policy (LMRP) for HBO therapy was effective April 1, 2003. It has since been determined that ICD-9-CM code 909.2 (Late effect of radiation) should be added to the "ICD-9 Codes that Support Medical Necessity" and to the "Coding Guidelines" sections of the policy. Also, clarification has been provided in the "Indications and Limitations" and the "Coding Guidelines" sections regarding acute peripheral arterial insufficiency as follows: "...and acute peripheral arterial insufficiency associated with arterial embolism and thrombosis."

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

LOCAL MEDICAL REVIEW POLICY (RETIRED)

Multiple Policies Being Retired

The following LMRPs were retired effective for services rendered on or after January 1, 2004. There can be any number of rationales for policy retirement. Some of the rationales involve claims data and aberrancy rates; it can be a change or update in medical technology, or the mere fact of changes in medically prudent practice guidelines or clinical pathways. Other issues could have to do with CPT changes that effect certain codes and how they layout in policy format. The decision was made to retire these policies for any of the aforementioned reasons or for an issue with their efficacy and/or yield.

The following LMRPs are being retired because claims data indicates services are not aberrant compared to the nation. Therefore, these policies are no longer required.

Policy Number	Policy Name
95LMRP006 V1.1	Acid Phosphatase Testing
98044 V1.0 FINAL	Debridement of Tissues Around Open Fracture Wounds/Open Dislocation Wounds
76872	Echography Transrectal; for evaluation of male genital organs
99.6 V1.0 FINAL	Erectile Dysfunction
(No policy #)	Foot Care Services
99-3 V1.0	Frequency of Psychiatric Interventions; in the Management of Patients with Dementia in the Nursing Home Setting
99-12 V1.0	HER-2 Protein Tests
94004D V1.2	Incision and Drainage Services of Periungal and Other Abscesses of the Foot
96LMRP019D V1.0	Iridoplasty by Photocoagulation (one or more sessions)
96LMRP019F V1.0	Pan Retinal Photocoagulation
99.7 V1.0 FINAL	Preoperative Evaluation and Testing for Cataract Extraction
94LMRP001-V1.1	Pulmonary Function Testing
99.8 V1.0 FINAL	Surgery for Cataract Extraction
94004B V1.2	Treatment of Thickened Dystrophic Mycotic Toenails with Debridement
98040 V1.0 FINAL	Urethral Endoprosthesis

Retired Local Medical Review Policies for Pain Management

Numerous local medical review policies (LMRP) for pain management services were recently finalized with an effective date of September 29, 2003. Some of the policies contained duplicate procedure codes. Since then, the LMRPs have been reviewed and duplicate codes have been identified, and it has been determined that the following policies are being retired:

63660: Removal/Revision of Implanted Spinal Neurostimulator Electrode/Pulse Generator

This LMRP was last published in 1998. Since that time, it has been determined that the CPT codes are a duplicate of LMRP *63650* (Spinal Cord Stimulation). Therefore, LMRP *63660* is being retired effective for services rendered on or after September 29, 2003.

64405: Greater Occipital Nerve Block/ Neurolysis

This LMRP was last revised on September 29, 2003. Since that time, it has been determined that the procedure codes and ICD-9-CM codes contained in this policy are a duplicate of LMRP *64400* (Peripheral Nerve Blocks). Therefore, LMRP *64405* is being retired effective for services rendered on or after September 29, 2003.

63650: Dorsal Column Stimulators

This LMRP was last published in 1998. Since that time, it has been determined that the procedure codes and ICD-9-CM codes contained in this policy are a duplicate of LMRP *63650* (Spinal Cord Stimulation) with the exception of ICD-9-CM code 053.12 (Postherpetic trigeminal neuralgia). Therefore, this ICD-9-CM code was added to LMRP *63650* (Spinal Cord Stimulation) in the "ICD-9 Codes that Support Medical Necessity" section of the policy. Therefore, LMRP *63650* (Dorsal Column Stimulators) is being retired effective for services rendered on or after September 29, 2003.

64479: Nerve Blocks and Paravertebral Nerve Blocks

This LMRP was last published in 1998. Since that time, it has been determined that the procedure codes and ICD-9-CM codes contained in this policy are a duplicate of LMRP *62263* (Epidural 2003). Therefore, LMRP *64479* is being retired effective for services rendered on or after February 17, 2004.

95 LMRP010 V1.0 Electrical Neurostimulation

LMRP 95 LMRP010 V1.0 was last published in 1996. Since that time, it has been determined that the procedure codes and ICD-9-CM codes contained in this policy are a duplicate of LMRP *63650* (Spinal Cord Stimulation) with the exception of ICD-9-CM code 348.8 and ICD-9-CM code range 952.00-952.09. These ICD-9-CM codes were added to LMRP *63650* (Spinal Cord Stimulation). Therefore, LMRP 95 LMRP010 V1.0 is being retired effective for services rendered on or after September 29, 2003.

64418: Suprascapular Nerve Injection

This LMRP was last published in 1998. Since that time, it has been determined that the procedure codes contained in this policy are a duplicate of LMRP *64400* (Peripheral Nerve Blocks). Therefore, LMRP *64418* is being retired effective services rendered on or after September 29, 2003.

CORRECTIONS

Correction to Effective Dates for Multiple Local Medical Review Policies

Summary notices for the local medical review policies (LMRPs) listed below were published in the First Quarter 2004 *Medicare B Update!* The effective date that was published for these policies was claims *processed* on or after January 5, 2004. The correct effective date is for services *rendered* on or after January 5, 2004.

Policy Number	Title
D0120	Dental Services
ERASV	Endoluminal Radiofrequency Ablation of the Saphenous Vein
EPO	Epogen alfa
G0179	Physician Certification and Recertification of Home Health Service
J2792	Rho (D) Immune Globulin Intravenous
J2820	Sargramostim [GM-CSF, Leukine®]
NCSVCS	The List of Medicare Noncovered Services
31525	Laryngoscopy
64561	Sacral Neuromodulation
70544	Magnetic Resonance Angiography [MRA]
74150	Computed Tomography of the Abdomen
76514	Ocular Corneal Pachymetry
83880	B-Type Natriuretic Peptide [BNP]
84154	Free Prostate Specific Antigen
88180	Flow Cytometry and Morphometric Analysis
88271	Urinary FISH Test for Recurrent Bladder Cancer
90901	Biofeedback

The full-texts of these LMRPs are available on our provider education Web site at *http://www.connecticutmedicare.com*.

CONNECTICUT EDUCATIONAL RESOURCES

Connect with Medicare Teleconference

Teleconference Agenda

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

Claims Resolution Workshop

Don't miss this "free" educational session
Reduce your paperwork and give your claims a powerful boost!

No Pre-Registration Required—Open to First 100 lines!
Participants may begin to dial in 10 minutes prior to call at (1-800-860-2442) pass code Claims Resolution
Visit our Web site Education and Training page one-week prior to teleconference to download presentation materials.

Friday, February 27, 2004 (1:00 p.m. to 2:30 p.m.)

1:00 p.m. **PowerPoint Presentation**

- Troubleshoot Form CMS-1500 claim filing
- File paper claims correctly
- Identify "What's Wrong' or missing from your claim form
- Reduce unprocessable claims
- Reading the Medicare Remittance Advice
- Reconciling the Medicare Remittance Advice
- Navigate the appeal process effectively
- Where to learn more

2:00 p.m. **Questions and Answers: Limit two per caller**

For more information, call our Education and Outreach Department at 1-203-634-5430 or 1-203-634-5514.

Enhance your Medicare Billing Knowledge!
Visit our Web site at *http://www.connecticutmedicare.com*

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

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

FLORIDA MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies 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) to providers in the *Update!* Summaries of revised and new LMRPs are provided instead. Providers may obtain full-text LMRPs on our provider education Web site, *http://www.floridamedicare.com*. Final LMRPs, draft LMRPs available for comment, LMRP statuses, and LMRP 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; the date the LMRP is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs 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, contact Medical Policy at:

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

1-904-791-8465

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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.

Medical Review Development Process Changes

Because only providers who meet exception criteria are allowed to submit paper claims under the new HIPAA requirements, we are requesting that you no longer submit paper claims in circumstances for which you know, or anticipate, medical record review will be necessary before payment can be made. In those cases where prepayment review is necessary, we will request the appropriate documentation via an additional development request (ADR). In addition, providers who meet the exception requirements and routinely submit paper claims need not submit medical record documentation unless requested through an ADR. We are currently evaluating all prepayment medical review edits, and documentation may or may not be required. Submitting medical records only in response to an ADR request will reduce the administrative burden on both the provider and Medicare.

While we are evaluating our prepayment medical review edits and associated claims processing guidelines, applicable local medical review policies (LMRP) that appear on our Web sites are still in effect. It is important for providers to understand that whether or not we have a prepayment edit in the system, all medical necessity requirements in an LMRP must be met. You must maintain medical record documentation that supports the service and make it available upon request, whether requested on a prepayment or postpayment basis.

If you have received a claim denial on a service denied due to medical necessity, you may file an appeal and provide the necessary medical documentation that supports the need for the service. If you do not provide the supporting medical documentation record with your appeal, the previous claims decision will be affirmed.

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.

Correct Billing of Ibritumomab Tiuxetan (Zevalin™) Therapy

A local medical review policy (LMRP) for ibritumomab tiuxetan (Zevalin™) therapy, which includes billing instructions, was implemented on June 30, 2003. It has since been noted that some providers are utilizing the incorrect codes when billing for Zevalin™ therapy.

In-111 Zevalin™ (the diagnostic component of the therapy)

For all dates of service:

A9522 Supply of radiopharmaceutical diagnostic imaging agent, Indium 111 ibritumumab tiuxetan, per mci

Note: A9522 should be submitted with "5" in the number billed field as the unit dose available for this radiopharmaceutical is only available in the 5 mci (millicurie) dosage and the code references a per-mci amount.

AND

For dates of service on or after January 1, 2004:

78804 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging

For dates of service March 1, 2003 – December 31, 2003:

G0273 Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)

Y-90 Zevalin™ (the therapeutic component of the therapy)

For all dates of service:

A9523 Supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxetan, per mci

Note: A9523 should be submitted with "40" in the number billed field as the unit dose available for this radiopharmaceutical is only available in the 40 mci dosage and the code references a per-mci amount.

AND

For dates of service on or after January 1, 2004:

79403 Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion

For dates of service March 1, 2003 – December 31, 2003:

G0274 Radiopharmaceutical therapy, non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)

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

Please reference the Web site for dates of service prior to March 1, 2003.

LOCAL MEDICAL REVIEW POLICY (NEW)

G0237: Respiratory Therapeutic Services

Healthcare Common Procedure Coding System (HCPCS) Codes G0237, G0238, and G0239 are new codes for respiratory therapy services. Per the *Federal Register*, December 31, 2002 (Vol. 67, No. 251), pgs. 79965-80184, there is no Pulmonary Rehabilitation Benefit Category. HCPCS codes G0237, G0238, and G0239 were developed to provide more specificity about the services being delivered by respiratory therapists. A policy is being developed to define the indications and limitations of coverage, further define the HCPCS codes, identify a procedure to diagnosis relationship, and clarify coding guidelines, as well as the documentation requirements.

These changes 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*.

LOCAL MEDICAL REVIEW POLICY (REVISED)

Policy Changes Related to the 2004 HCPCS Update

The table that follows provides a list of local medical review policies (LMRPs) affected by the 2004 HCPCS update. The full-texts of these LMRPs are available on the provider education Web site at *http://www.floridamedicare.com.*

Policy Title/Name	Changes
20550: Injection of Tendon Sheath, Ligament or Trigger Points	Descriptor change for procedure codes *20550*, *20551*, and *20552* Added language in the "Coding Guidelines" section
43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy	Added procedure codes *43237* and *43238*
58340: Infertility	Descriptor change for procedure codes *58340*, *89250*, *89251* and *89258* Deleted procedure codes *89252* and *89256* Added procedure codes *89268*, *89272*, *89280*, *89281*, *89290*, *89291*, *89335*, *89342*, *89343*, *89344*, *89346*, *89352*, *89353*, *89354*, *89356*, *0058T*, *0059T* to the 'Reasons for Denials' section
61793: Stereotactic Radiosurgery	Descriptor change for procedure code *76375* in the "Coding Guidelines" section
61862: Deep Brain Stimulation	Deleted procedure code *61862* Added procedure codes *61863*, *61864*, *61867*, and *61868* Deleted unlisted procedure code *64999* and replaced it with procedure code *61795* (not related to 2004 HCPCS) Changed language in the "Coding Guidelines" section Changed Policy Identification Number to *61863*
70551: Magnetic Resonance Imaging of the Brain	Added procedure codes *70557*, *70558*, and *70559* Added language in the "Coding Guidelines" section
76090: Diagnostic Mammography	Deleted procedure code G0236 Added procedure code *76082* Added language in the "Coding Guidelines" section
76092: Screening Mammograms	Deleted procedure code *76085* Added procedure code *76083* Added/Deleted language in the "Coding Guidelines" section
77427: Weekly Radiation Therapy Management	Descriptor change for procedure code *99050* in the "Coding Guidelines" section
84155: Serum Protein	Descriptor change for procedure codes *84155* and *84160*
88300: Surgical Pathology	Descriptor change for procedure code *88312*
93784: Ambulatory Blood Pressure Monitoring (ABPM)	Deleted procedure code *93788* Deleted language related to procedure code *93788* from the "Reasons for Denials" section
97001: Physical Medicine and Rehabilitation	Descriptor change for procedure code *97537*
99183: Hyperbaric Oxygen Therapy (HBO Therapy)	Deleted procedure code G0167 Deleted language related to procedure code G0167 from the "Reasons for Denials" section
A4644: Low Osmolar Contrast Media (LOCM)	Deleted procedure codes A4644, A4645, and A4646 Added procedure code A9525 Changed Policy Identification Number to A9525
G0030: Positron Emission Tomography (PET) Scan	Deleted procedure code Q4078 Added procedure code A9526 Added language in the "Coding Guidelines" section
G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes	Descriptor change for procedure code G0247
G0262: Wireless Capsule Endoscopy	Deleted procedure code G0262 Added procedure code *91110* Changed Policy Identification Number to *91110*
J0150: Adenosine (Adenocard®, Adenoscan®)	Deleted procedure code J0151 Added procedure code J0152 Changed language in the "Coding Guidelines" section
J0880: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	Added procedure codes Q0137 and Q4054 Added language in the "Coding Guidelines" section Changed Policy Identification Number to NESP

J9999: Antineoplastic Drugs	Deleted procedure codes J9180 and J9999 Added procedure codes J9178, J9263, and J9395 Added language in the "Coding Guidelines" section Changed Policy Identification Number to J9000
NCSVCS: The List of Medicare Noncovered Services	Descriptor change for procedure codes *89250*, *89251*, *89258*, *90693*, M0100*, and M0301* Deleted procedure codes *89252*, *89256*, and G0167 from Local Noncoverage Decisions section Deleted procedure codes *93788* and J1910 from National Noncoverage Decisions section Removed procedure code *33999** from the "Devices" section in the National Noncoverage Decisions section and replaced it with procedure codes *0051T**, *0052T**, and *0053T** Deleted procedure code *96155* from Local Noncoverage Decisions section of the policy and added it to the National Noncoverage Decisions section Added procedure codes *0058T*, *0059T*, *89268*, *89272*, *89280*, 89281, *89290*, *89291*, *89335*, *89342*, *89343*, *89344*, *89346*, *89352*, *89353*, *89354*, *89356*, and A0800 to Local Noncoverage Decisions section Added procedure codes J7303, V5362, V5363 and V5364 to National Noncoverage Decisions section
Q4053: Pegfilgrastim (Neulasta™)	Deleted procedure code Q4053 Added procedure code J2505 Changed Policy Identification Number to J2505
Q9920: Chronic Renal Failure Erythropoietin (EPOGEN)/ Q0136 Non-ESRD Epoetin (Procrit)	Deleted procedure codes Q9920-Q9940 Added procedure code Q4055 Added language in the "Coding Guidelines" section Changed Policy Identification Number to EPO Changed Policy Name to Epoetin alfa
R0070: Portable X-Ray Supplier Services	Added Modifiers UN, UP, UQ, UR, and US with instructions in "Coding Guidelines" section for procedure code R0075
ZEVALIN: Ibritumomab Tiuxetan (Zevalin™) Therapy	Deleted procedure codes G0273 and G0274 Added procedure codes *78804* and *79403* Changed language in the "Coding Guidelines" section

EPO: Epoetin alfa

The local medical review policy (LMRP) for Epoetin alfa was last updated on January 5, 2004.

Dual diagnosis requirements for HCPCS code Q0136 have been removed from the LMRP. The ICD-9-CM code for the appropriate anemia diagnosis is no longer required. ICD-9-CM codes 285.22, 285.8, and 285.9 have been removed from the LMRP.

This revision is effective for services rendered on or after January 5, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) (formerly J0880)

The local medical review policy (LMRP) for Darbepoetin alfa was last updated on September 29, 2003.

Dual diagnosis requirements for Darbepoetin alfa have been removed from the LMRP. The ICD-9-CM code for the appropriate anemia diagnosis is no longer required; therefore, ICD-9-CM codes 285.21, 285.22, 285.8, and 285.9 have been removed from the LMRP.

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*.

NCSVCS: The List of Medicare Noncovered Services

CMS Transmittal 27, Change Request 2688, issued instructions for contractors to remove *CPT* code *32491 (Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous)*, for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure) from their list of noncovered services. Therefore, The List of Medicare Noncovered Services local medical review policy (LMRP) is revised to remove *CPT* code 32491 from the **National Noncoverage Decisions** section, effective for services rendered on or after January 1, 2004.

In addition, upon reconsideration of coverage, it has been determined that a local medical review policy (LMRP) should be developed to provide indications and limitations of coverage and/or medical necessity for procedure code *83880* (*Natriuretic Peptide*). Therefore, *CPT* code *83880* has been removed from the **Local Noncoverage Decisions** section of The List of Medicare Noncovered Services LMRP, effective for services rendered on or after January 5, 2004.

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

A0425: Ground Ambulance Services

The LMRP for Ground Ambulance Services was last updated on June 30, 2003. Effective for services processed on or after July 31, 2002 the ICD-9-CM codes were no longer used as examples to assume that the patient meets coverage requirements during routine claims processing. Therefore, the diagnoses have been removed from the "ICD-9 Codes that Support Medical Necessity" section of the policy.

The full-text LMRP 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, 2003. A revision to the policy has been made as a result of CMS Change Request #2822, Transmittal AB-03-114, dated August 1, 2003, for "Claims Processing and Payment of Incomplete Screening Colonoscopies."

Medicare covers colorectal cancer screening test/procedures for the early detection of colorectal cancer when coverage conditions are met. Among the screening procedures covered are screening colonoscopies (G0105 & G0121).

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies. When submitting a claim for the interrupted colonoscopy, suffix the colonoscopy code with a modifier of -53 to indicate that the procedure was interrupted. Medicare would expect the provider to maintain adequate documentation in the patient's medical record to support an incomplete procedure.

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

G0108: Diabetes Outpatient Self-Management Training

The local medical review policy (LMRP) for diabetes outpatient self-management training was last revised August 1, 2003.

CMS Transmittal 1895 (Change Request 2793, dated August 1, 2003) expands the payment for diabetic outpatient self-management training to include home health agencies, renal dialysis facilities, and durable medical equipment suppliers if certified by one of the appropriate accreditation organizations. The outpatient diabetes self-management training program must be accredited as meeting approved quality standards. In addition to the American Diabetes Association (ADA), CMS has approved the Indian Health Service as an accreditation organization. Providers are instructed to forward a copy of their Certificate of Recognition received from one of the accredited organizations to:

Medicare Registration
P. O. Box 2078
Jacksonville, FL 32231-2078

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.*

J0585: Botulinum Toxin Type A (Botox)

The local medical review policy (LMRP) for botulinum toxin type A (Botox) was last updated on February 12, 2003. A request was subsequently received to add ICD-9-CM code 478.79 (Other disease of larynx, not elsewhere classified [spasmodic dysphonia]) to the "ICD-9 Codes that Support Medical Necessity" section of the LMRP. Spasmodic dysphonia is included in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LMRP; however, there was no corresponding ICD-9-CM code in the LMRP. Therefore, the "ICD-9 Codes that Support Medical Necessity" section has been updated to include ICD-9-CM code 478.79 for HCPCS code J0585.

This revision is effective for claims processed on or after January 6, 2004. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

J1955: Levocarnitine (Carnitor®, L-carnitine®)

The local medical review policy (LMRP) for levocarnitine (Carnitor®, L-carnitine®) was effective September 29, 2003. Since that time, dual diagnosis requirements (for end-stage renal disease [ESRD] patients) for procedure code J1955 have been removed from the LMRP. Therefore, ICD-9-CM codes 280.0-280.9, 285.21, 458.2, and 791.3 have been removed from the LMRP for ESRD patients.

This revision is effective for claims processed on or after November 17, 2003. The full-text LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

11730: Surgical Treatment of Nails (formerly Surgical Treatment of Ingrown Nails)

The local medical review policy (LMRP) for treatment of ingrown nails was implemented on September 29, 2003. A revision to the policy has been made to include coverage of fingernails in addition to toenails, and to add additional covered diagnoses.

In addition, the policy title was changed from "Surgical Treatment of Ingrown Nails" to "Surgical Treatment of Nails." Modifiers for finger digits were added under "Coding Guidelines," and the verbiage under "Utilization Guidelines" referring to a timeframe of 16 weeks for repeat nail avulsion was deleted. Additional ICD-9-CM codes were added under "ICD-9 Codes that Support Medical Necessity." The following is a complete list of diagnosis codes that are covered for procedure codes *11730*, *11732*, *11750*, and *11765*:

110.1	681.00	681.02	681.10	681.11	681.9
686.1	703.0	703.8	703.9	757.5	785.4
816.02	816.03	816.12	816.13	826.0	826.1
883.0	883.1	883.2	893.0	893.1	893.2
923.3	924.3	927.3	928.3	991.1	991.2

The full text of this LMRP is available on our provider education Web site *http://www.floridamedicare.com* and is effective for services rendered on or after January 12, 2004.

20974: Osteogenic Stimulation

The local medical review policy (LMRP) for osteogenic stimulation was last updated on October 28, 2002. Since that time, diagnosis codes 738.4, 756.12, and 996.4 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure code ***20975***.

The full-text of this LMRP may be found on our provider education Web site at *http://www.floridamedicare.com*. These changes are effective for services rendered on or after January 12, 2004.

29540: Strapping

The local medical review policy (LMRP) for strapping was last updated January 27, 2003. Since that time, diagnosis code 959.7 (injury of ankle and foot) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy for procedure codes ***29540*** and ***29550***.

The full-text of this LMRP may be found on the provider education Web site *http://www.floridamedicare.com*. These changes are effective for services rendered on or after January 12, 2004.

44388: Colonoscopy

The local medical review policy (LMRP) for colonoscopy was last updated on January 1, 2003. A revision to the policy has been made as a result of CMS Change Request 2822, Transmittal AB-03-114, dated August 1, 2003, entitled "Claims Processing and Payment of Incomplete Screening Colonoscopies."

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to payment methodology for the procedure as long as coverage conditions are met. When submitting a claim for the interrupted colonoscopy, append the colonoscopy code with modifier *53* to indicate the procedure was interrupted. Medicare would expect the provider to maintain adequate documentation in the patient's medical record to support an incomplete procedure.

The LMRP title was changed from Colonoscopy to Diagnostic Colonoscopy. 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.

70551: Magnetic Resonance Imaging (MRI) of the Brain

The local medical review policy (LMRP) for MRI of the brain was last updated on September 22, 2003. Since then, the policy has been revised to include ICD-9-CM code 676.60 (galactorrhea, unspecified as to episode of care or not applicable).

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

76519: A-Scan

The latest revision for local medical review policy (LMRP) for A-Scan was effective October 28, 1997. It has been determined that a correction is needed in the 'Coding Guidelines' section of the policy. Therefore, the coding guidelines instructions for modifier usage have been changed from *76519 26 7**9*** (unrelated procedure or service by the same physician during the postoperative period) to *76519 26 7**6*** (Repeat procedure by same physician).

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

85651: Sedimentation Rate, Erythrocyte

The latest revision to the local medical review policy (LMRP) for sedimentation rate, erythrocyte, was effective October 28, 2002. It has since been determined that additional ICD-9-CM codes should be added. Therefore, ICD-9-CM codes 285.29 (Anemia of other chronic illness) and 285.9 (Anemia, unspecified) have been added to the 'ICD-9-CM Codes that Support Medical Necessity" of the policy.

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

92235: Fluorescein Angiography

The local medical review policy (LMRP) for fluorescein angiography was effective November 18, 1996. Since then, the policy has been updated and revised. Changes include revisions to the "Coding Guidelines" and "Utilization Guidelines" sections of the policy. The "ICD-9 Codes that Support Medical Necessity" section of the policy have been expanded as well. ICD-9-CM codes added include: 115.02, 115.92, 130.2, 135, 250.52, 250.53, 361.2, and 368.11.

This revision will be effective for services rendered on or after January 29, 2004. The full-text of this local medical review policy is available on our provider education Web site *http://www.floridamedicare.com*.

92973: Interventional Cardiology

The local medical review policy (LMRP) for interventional cardiology was published in the First Quarter 2004 *Medicare B Update!* Since that time, the paragraph pertaining to "hierarchical scheme" in the "Coding Guidelines" section of the policy has been removed.

These changes are effective for services rendered on or after January 12, 2004. The full-text LMRP may be found on our provider education Web site *http://www.floridamedicare.com*.

95805: Sleep Testing

The local medical review policy (LMRP) for sleep testing was last updated on January 1, 2003. The policy has been revised as a result of CMS Transmittal 150, CR 1949, effective for services furnished on or after April 1, 2002.

The following revisions were made to the LMRP under the "Indications and Limitations of Coverage and/or Medical Necessity" section for sleep apnea:

> The use of CPAP devices are covered under Medicare when ordered and prescribed by the licensed treating physician to be used in adult patients with OSA if either of the following criteria using the Apnea-Hypopnea Index (AHI) are met:
>
> - AHI greater than or equal to 15 events per hour, or
> - AHI greater than or equal to 5, and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease or history of stroke.
>
> The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected).
>
> The polysomnography must be performed in a facility-based sleep study laboratory, not in the home or in a mobile facility.

The following statement was added under "Documentation Requirements:"

> Initial claims for CPAP devices must be supported by information contained in the medical record indicating that the patient meets Medicare's stated coverage criteria.

Under "Other Comments" the definition of the following terms were revised as follows:

- Apnea is defined as a cessation of airflow for at least 10 seconds.
- Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 4% oxygen desaturation.

The full text of this LMRP is available on our provider education Web site *http://www.floridamedicare.com*, and is effective for services rendered on or after April 1, 2002.

99183: Hyperbaric Oxygen Therapy (HBO Therapy)

The latest revision for local medical review policy (LMRP) for HBO therapy was effective April 1, 2003. It has since been determined that ICD-9-CM code 909.2 (Late effect of radiation) should be added to the "ICD-9 Codes that Support Medical Necessity" and to the "Coding Guidelines" sections of the policy. Also, clarification has been provided in the "Indications and Limitations" and the "Coding Guidelines" sections regarding acute peripheral arterial insufficiency as follows: "...and acute peripheral arterial insufficiency associated with arterial embolism and thrombosis."

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

LOCAL MEDICAL REVIEW POLICY (RETIRED)

36430: Transfusion Medicine

The local medical review policy (LMRP) for transfusion medicine is being retired, effective for services rendered on or after January 1, 2004. It has been determined that the information in the policy is informational only. Please be aware, however, that Florida Medicare Part B pays for this service only when provided in a physician's office. All other places of service should be billed to the fiscal intermediary (Part A).

80048: Automated Multichannel Tests

The local medical review policy (LMRP) for automated multichannel tests has been retired, effective for services rendered on or after January 1, 2004. We determined the LMRP should be retired because:

- The policy is not inclusive of all multichannel codes
- There are overlaps with codes in other "stand-alone" policies
- Services in the LMRP are not being reviewed on either a pre- or post-pay basis

Stand-alone policies may be developed in the future, if services become aberrant.

40000: Digestive System

The local medical review policy (LMRP) for Digestive System is retired, effective for services rendered on or after January 1, 2004. The information in this LMRP is either no longer valid or can be found incorporated in LMRPs for other services.

94799: Pulmonary Rehabilitation

Per the *Federal Register*, December 31, 2002 (Vol. 67, No. 251), pgs. 79965-80184, there is no Pulmonary Rehabilitation Benefit Category. Therefore, the local medical review policy (LMRP) for pulmonary rehabilitation is being retired for services rendered on or after January 1, 2004.

Codes G0237, G0238, and G0239 were developed to provide more specificity concerning services delivered by respiratory therapists. A policy has been developed to define these services. The full-text of this LMRP is available on our provider education Web site at *http://www.floridamedicare.com*.

CORRECTIONS

Correction to Effective Dates for Multiple Local Medical Review Policies

Summary notices for the local medical review policies (LMRPs) listed below were published in the First Quarter 2004 Update. The effective date that was published for these policies was claims *processed* on or after January 5, 2004. The correct effective date is for services *rendered* on or after January 5, 2004.

83880	B-Type Natriuretic Peptide [BNP]
90901	Biofeedback
ERASV	Endoluminal Radiofrequency Ablation of the Saphenous Vein
EPO	Epogen alfa
31525	Laryngoscopy
70544	Magnetic Resonance Angiography [MRA]
76514	Ocular Corneal Pachymetry
OOS	Outpatient Observation
19318	Reduction Mammaplasty
43842	Surgical Management of Morbid Obesity
88271	Urinary FISH Test for Recurrent Bladder Cancer

The full-texts of these LMRPs are available on our provider education Web site at *http://www.floridamedicare.com.*

FLORIDA EDUCATIONAL RESOURCES

First Medifest of 2004 to be Held in Jacksonville in May

MEDIFEST Class Schedule and Registration Form

May 27-28, 2004
Omni Jacksonville Hotel
245 Water Street
Jacksonville, FL 32202
Please contact hotel for directions and/or reservations 1-(904)-355-6664

Select one class per session (time slot)

DAY 1
Thursday, May 27

9:00AM - 10:30AM SESSION 1/DAY 1
- ☐ Direct Data Exchange (DDE) (A)
- ☐ Fraud & Abuse (A/B)
- ☐ Global Surgery (B)
- ☐ HOPPS (A)
- ☐ Pathology (B)
- ☐ Preventive Services (B)

10:45 AM – 12:15 PM SESSION 2/DAY 1
- ☐ 57, 78, & 79 Modifier Workshop (B)
- ☐ MSP for Part A Providers (A)
- ☐ SNF (Consolidated Billing) (A/B)
- ☐ Understanding LMRPs (A/B)
- ☐ Urology (B)

1:30PM - 4:30PM SESSION 3/DAY 1/WORKSHOPS
- ☐ ANSI 101 (HIPAA) (A/B)
- ☐ Evaluation and Management Services (B)
- ☐ Life after a Claim Denial (B)
- ☐ MSP for Part B Providers (B)
- ☐ Provider Enrollment (B)
- ☐ Rehab Services (A/B)

6:30PM - 8:00PM SESSION 4/DAY 1
- ☐ E/M Documentation Guidelines (B)*

This session is designed for physicians only. There is no charge to attend this session.

DAY 2
Friday, May 28

9:00AM – 12:00PM SESSION 1/DAY 2/WORKSHOPS
- ☐ ANSI 101 (HIPAA) (A/B)
- ☐ Evaluation and Management Services (B)
- ☐ Life after a Claim Denial (B)
- ☐ MSP for Part B Providers (B)
- ☐ Provider Enrollment (B)
- ☐ Rehab Services (A/B)

1:30AM - 3:00PM SESSION 2/DAY 2
- ☐ Anesthesia (B)
- ☐ Appeals Process for Part A Providers (A)
- ☐ Global Surgery (B)
- ☐ Medicaid (B)
- ☐ Inquiries received by the Medical Director's Office (A)
- ☐ Preventive Services (B)

3:30PM - 5:00PM SESSION 3/DAY 2
- ☐ 24, 25, & 57 Modifier Workshop
- ☐ Diagnostic Radiology (B)
- ☐ Fraud & Abuse (A/B)
- ☐ Medicaid (A)
- ☐ Reason Code Resolution (A)
- ☐ Understanding LMRPs (A/B)

For seminar cost and complete class descriptors, please visit our Web site at http://www.floridamedicare.com

Registrant's Name	Telephone Number
Email Address	Fax Number
Provider's Name	
Street Address	
City, State, ZIP Code	

FAXED REGISTRATION

1. Fax both registration form and class schedule(s) to **1-(904)-791-6035.**
2. A confirmation and invoice will be faxed or emailed to you.
3. Make checks payable to: **FCSO Account #700390**
4. Mail the forms (after you have faxed them) and payment to:
   Medifest Registration
   P.O. Box 45157
   Jacksonville, FL 32231
5. Bring your Medifest confirmation notice to the event.

CONFIRMATION NOTICE

Faxed registration: A confirmation notice will be faxed or emailed to you within 14 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Training), please contact us at **1-(904)-791-8103.**

Online registration: When registering online for an education event, you will automatically receive your confirmation via email notification.

FLORIDA MEDICARE PART B MAIL DIRECTORY

CLAIMS SUBMISSIONS

Routine Paper Claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating Providers
Medicare Part B Participating Providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic Claims
Medicare Part B Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance Claims
Medicare Part B Ambulance Dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare Secondary Payer
Medicare Part B Secondary Payer Dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD Claims
Medicare Part B ESRD Claims
P. O. Box 45236
Jacksonville, FL 32232-5236

COMMUNICATIONS

Review Requests
Medicare Part B Claims Review
P. O. Box 2360
Jacksonville, FL 32231-0018

Fair Hearing Requests
Medicare Part B Fair Hearings
P. O. Box 45156
Jacksonville, FL 32232-5156

Administrative Law Judge Hearing
Administrative Law Judge Hearing
P. O. Box 45001
Jacksonville, FL 32232-5001

Status/General Inquiries
Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B Financial Services
P. O. Box 44141
Jacksonville, FL 32231-4141

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims
Palmetto GBA Medicare
DMERC Operations
P. O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request:
Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Communication and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and Abuse
First Coast Service Options, Inc.
P. O. Box 45087
Jacksonville, FL 32232-5087

FLORIDA MEDICARE PHONE NUMBERS

BENEFICIARY

Toll-Free:
1-800-333-7586
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

PROVIDERS

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992

For Seminar Registration Only (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
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Help Desk:
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OCR

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http://www.cms.hhs.gov

BENEFICIARY

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Centers for Medicare & Medicaid Services
http://www.medicare.gov

Index to Connecticut and Florida *Medicare B Update!* - Fiscal Year 2004

The following is a comprehensive index covering all articles published the *FCSO Medicare B Update!* during fiscal year 2004 (including special electronic-only issues).

Beginning in January 2003, the *Update!* is consolidated into one issue for both states. In this index, content published for both Connecticut and Florida is listed first, followed by content intented only for Connecticut, then content intended only for Florida.

> **Note**: Electronic issues denoted with an asterisk (*) are *not* produced in hard copy format, and are available only on FCSO's provider education Web sites, *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*.

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