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.

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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 Communication and Education department of First Coast Service Options, Inc. (FCSO), to provide timely and useful information to Medicare Part B providers in Connecticut and Florida.

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

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

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 2005 are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2005	Mid-November 2004	January 1, 2005
Second Quarter 2005	**Mid-February 2005**	**April 1, 2005**
Third Quarter 2005	Mid-May 2005	July 1, 2005
Fourth Quarter 2005	Mid-August 2005	October 1, 2005

Important notifications that require communication in between these dates will be posted to the FCSO Medicare provider education websites, *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 117 of the First Quarter 2005 *Update!*).

Distribution of the *Update!* in hardcopy or CD-ROM format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to either Connecticut or Florida Medicare for processing during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us*.

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

We use the same mailing address for *all* correspondence, and cannot designate that the *Update!* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Registration department. Please remember that address changes must be done using the appropriate Form CMS-855.

Clear Identification of State-Specific Content

A blue header bar preceding articles clearly indicates whether the topic is applicable to both Connecticut and Florida, Connecticut only, or Florida only. Articles common to both states appear at the beginning of the publication. Within common articles, references to phone numbers, addresses, reimbursement amounts, past publications, etc., are state-specific as appropriate. Content specific to Connecticut is next, followed by content specific to Florida. Connecticut and Florida local medical review policy (LMRP/LCD) summaries are maintained in separate sections.

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.

Medical review and **comprehensive data analysis** will *always* be in state-specific sections, as will **educational resources**. Important **addresses, phone numbers**, and **websites** are also listed 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 website 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 website 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 website 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.

Modifier "GA" and Appeals

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 the modifier **GA** (wavier of liability statement on file).

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.

Claims containing modifier GA in which the patient has been found liable **must** have the patient's ***written consent*** for an appeal. Written appeal requests should be sent to the Attention of Medical Review at:

Connecticut
Medicare Part B CT
PO Box 45010
Jacksonville, FL 32232-5010

Florida
Medicare Part B FL
PO Box 2360
Jacksonville, FL
32231-0018

CLAIMS

Billing Issue with HPSA/PSA Bonus Payments

Prior to January 1, 2005, a claim for a global procedure billed in a HPSA was only denied if the provider submitted the modifier QB/QU and the modifier 26 was not billed.

Effective January 1, 2005, all claims for global procedures rendered in HPSA/PSA areas are denying if the provider fails to bill modifier 26 on the global procedure. HPSA/PSA bonus payments are generated based on the ZIP code reported. When billing for a global procedure, the technical/professional components must be billed separately. If not, the global service will be returned as unprocessable.

EXAMPLES (zip code in a designated HPSA):

010105 93000 50.00
The above global service will be returned unprocessable

010105 93010 25.00
010105 93005 25.00
The above services will be processed

You can access HPSA/PSA zip code information at CMS website *http://www.cms.hhs/gov/providers/bonuspayment*.

Additional information is available via Medlearn Matters article SE0449 at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0449.pdf.*

Implementation of the Medicare Physician Fee Schedule National Abstract File for Purchased Diagnostic Tests and Interpretations

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

Provider Types Affected

Physicians, laboratories, and independent diagnostic testing facilities.

Provider Action Needed

This instruction implements a national abstract file of the Medicare Physician Fee Schedule (MPFS) containing Healthcare Common Procedural Coding System (HCPCS) codes billable as purchased diagnostic tests and interpretations, for every locality throughout the country.

Effective April 1, 2005, suppliers, including laboratories, physicians, and independent diagnostic testing facilities, must bill their local carrier for purchased diagnostics tests and interpretations, regardless of the location where the service was furnished. The Centers for Medicare & Medicaid Services (CMS) recognizes that the abstract file for purchased diagnostic tests/interpretations may not include all diagnostic services that may be purchased. Suppliers may request to add other HCPCS codes that are billable as purchased services to this file by sending a note to CMS at the following address:

Centers for Medicare & Medicaid Services
Centers for Medicare Management/Provider Billing Group/Division of Supplier Claims Processing
7500 Security Blvd.
Baltimore, MD 21244

CMS will review these requests periodically to determine whether code additions or deletions are needed, and will make updates to the abstract file in conjunction with the MPFS quarterly releases.

The billing physicians/suppliers should be aware that they are responsible for ensuring that the physician or supplier that furnished the purchased test/interpretation is enrolled with Medicare and is in good standing (i.e., the physician/supplier is not sanctioned, barred, or otherwise excluded from participating in the Medicare program).

The Office of Inspector General (OIG) maintains a database of information concerning parties that are excluded from participation in the Medicare, Medicaid, or other federal health programs. The OIG exclusions database is available to the public on the OIG website at the following address: *http://www.oig.hhs.gov/fraud/exclusions.html*

Suppliers may access this database, or use another available source, to determine whether a physician/supplier is eligible to participate with Medicare prior to billing for a purchased diagnostic test or interpretation.

Background

CR 3481 implements a national abstract file of the MPFS containing HCPCS codes billable as a purchased diagnostic test/interpretation, for every locality throughout the country. Effective with the implementation of the abstract file on April 4, 2005, carrier jurisdiction rules for purchased diagnostic tests/interpretations will be changed to allow suppliers to bill

their local carriers for these services and receive the correct payment amount, regardless of the location where the service was performed. Carrier jurisdictional pricing rules for all other services payable under the MPFS will remain in effect.

Implementation

The implementation date for this instruction is April 4, 2005.

Additional Information

The revised portions of the Medicare Claims Processing Manual related to this change are attached to the official instruction issued to your carrier. That instruction may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

Once at that site, look for CR 3481 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: 3481
Medlearn Matters Number: MM3481
Related CR Release Date: October 29, 2004
Related CR Transmittal #: 341
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

"Incident to" Services

This information was previously published in the First Quarter 2005 Medicare B Update! pages 9-10.
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: This article was revised on November 1, 2004, to correct the spelling of physician assistants in the background section.

Provider Types Affected

All Medicare providers of professional services

Provider Action Needed

None. This article is for your information only. It clarifies when and how to bill for services "incident to" professional services.

Background

The intent of this article is to clarify "incident to" services billed by physicians and non physician practitioners to carriers. "Incident to" services are defined as those services that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home.

These services are billed as Part B services to your carrier as if you personally provided them, and are paid under the physician fee schedule.

Note: "Incident to" services are also relevant to services supervised by certain non physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. These services are subject to the same requirements as physician-supervised services. Remember that "incident services" supervised by non physician practitioners are reimbursed at 85% of the physician fee schedule. For clarity's sake, this article will refer to "physician" services as inclusive of nonphysician practitioners.

To qualify as "incident to," services must be part of your patient's normal course of treatment, during which a physician **personally performed an initial service** and remains **actively involved** in the course of treatment.

You do not have to be physically present in the patient's treatment room while these services are provided, but you must provide **direct supervision**, that is, you must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for incident to service.

More specifically, these services must be all of the following:

- An integral part of the patient's treatment course;
- Commonly rendered without charge (included in your physician's bills);
- Of a type commonly furnished in a physician's office or clinic (not in an institutional setting); and
- An expense to you.

Examples of qualifying "incident to" services include cardiac rehabilitation, providing non-self-administrable drugs and other biologicals, and supplies usually furnished by the physician in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen.

The following paragraphs discuss the various care settings, which are important to note because the processes for billing vary somewhat depending on the care site.

Your Office

In your office, qualifying "incident to" services must be provided by a caregiver whom you directly supervise, and who represents a direct financial expense to you (such as a "W-2" or leased employee, or an independent contractor).

You do not have to be physically present in the treatment room while the service is being provided, but you must be present in the immediate office suite to render assistance if needed. If you are a solo practitioner, **you** must directly supervise the care. If you are in a group, any physician member of the group may be present in the office to supervise.

Hospital or SNF

For inpatient or outpatient hospital services and services to residents in a Part A covered stay in a SNF the unbundling provision (1862 (a)(14) provides that payment for all services are made to the hospital or SNF by a Medicare intermediary (except for certain professional services personally performed by physicians and other allied health professionals). Therefore, incident to services are not separately billable to the carrier or payable under the physician fee schedule.

Offices in Institutions

In institutions including SNF, your office must be confined to a separately identifiable part of the facility and cannot be construed to extend throughout the entire facility. Your staff may provide service incident to your service in the office to outpatients, to patients who are not in a Medicare covered stay or in a Medicare certified part of a SNF.

If your employee (or contractor) provides services outside of your "office" area, these services would not qualify as "incident to" unless you are physically present where the service is being provided. One exception is that certain chemotherapy "incident to" services are excluded from the bundled SNF payments and may be separately billable to the carrier.

In Patients' Homes

In general, you must be present in the patient's home for the service to qualify as an "incident to" service. There are some exceptions to this direct supervision requirement that apply to homebound patients in medically underserved areas where there are no available home health services only for certain limited services found in Pub 100-02, Chapter 15 Section 60.4 (B).

In this instance, you need not be physically present in the home when the service is performed, although general supervision of the service is required. You must order the services, maintain contact with the nurse or other employee, and retain professional responsibility for the service. All other incident to requirements must be met. A second exception applies when the service at home is an individual or intermittent service performed by personnel meeting pertinent state requirements (e.g., nurse, technician, or physician extender), and is an integral part of the physician's services to the patient.

Ambulance Service

Neither ambulance services nor EMT services performed under your telephone supervision are billable as "incident to" services.

Additional Information

To provide additional clarity, we present the following scenarios:

Must a supervising physician be physically present when flu shots, EKGs, Laboratory tests, or Xrays are performed in an office setting in order to be billed as "incident to" services?

These services have their own statutory benefit categories and are subject to the rules applicable to their specific category. They are not "incident to" services and the "incident to" rules do not apply.

Can anti-coagulation monitoring be provided "incident to" a physician's services in an office?

Yes, if the requirements are met, i.e., the services are part of a course of treatment during which the physician personally performs the initial service and is actively involved in the course of treatment, is physically present in the immediate office when services are rendered by the employee, and the service represents an expense to the physician or other legal entity that bills for the service.

If the treating physician (Doctor X) refers a patient to an anti-coagulation monitoring clinic, can Doctor X bill these services as "incident to?"

No, because the services are not being provided by an employee under supervision of Doctor X.

Can the supervising physician (Doctor Y) at the anti-coagulation monitoring clinic (a physician group) bill the services as "incident to" if Doctor Y directly supervises those services at the clinic?

No, because Doctor Y is not treating the patient for the underlying condition. However, If Doctor Y receives a referral from Dr. X, and Dr. Y performs an initial evaluation of the patient and then orders and supervises the services, they may be billed by Doctor Y incident to her initial service.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request #: N/A
Medlearn Matters Number: SE0441
Effective Date: N/A Revised

The information contained in this article was current at the time of its development. We encourage users of this article to review statutes, regulations and other interpretive materials for the most current information.

Invalid Diagnosis Code Editing – Second Phase

Provider Types Affected

All physicians, providers, and suppliers who bill Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

STOP – Impact to You

New edits will be added to the Medicare claims processing systems to prevent acceptance of inbound claims with invalid diagnosis codes.

CAUTION – What You Need to Know

Diagnosis codes must always be valid on the date that the service was provided. Medicare systems will reject claims with diagnosis codes that were not valid on the date of service.

GO – What You Need to Do

As Medicare strengthens its edit processes to detect and reject claims with invalid diagnosis codes, ensure that your billing staff know the rules for diagnosis codes and that they submit diagnosis codes that are in compliance with HIPAA.

Background

To edit diagnosis accurately codes for validity, Medicare systems will apply date range edits to ensure that diagnosis codes are valid for the period of time for which they are reported on claims sent to Medicare. These edits will apply whether or not Medicare actually uses the reported diagnosis code in its claims processing.

HIPAA rules require that Medicare make sure that such codes are HIPAA-compliant, especially because these codes are passed on to other payers under Medicare's Coordination of Benefits processes. To be compliant, the diagnosis code must be valid on the date for which it is reported. These policy changes include validation of diagnosis codes on the National Council for Prescription Drug Program (NCPDP) claims and on 837 professional claims.

Additional Information

Additional information regarding this topic can be found in Transmittal 86 (CR 3050). The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR 3260 in the CR NUM column on the right, and click on the file for that CR.

Related Change Request (CR) #: 3260
Medlearn Matters Number: MM3260
Related CR Release Date: October 22, 2004
Related CR Transmittal #: 326
Effective Date: April1, 2005
Implementation Date: April 4, 2005

Medlearn Matters articles are prepared as a service to the public and are not intended to grant rights or impose obligations. Medlearn Matters articles may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Manualization of POS Code Set Program Memorandum; Revision to Group Home Code Description

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare carriers.

Provider Action Needed

Physicians, suppliers, and providers should note that this article addresses only a new definition for the Place of Service (POS) Code for Group Homes. Other POS code set information was issued on May 16, 2003 in CMS Program Memorandum/Transmittal B-03-040 and change request 2730, "Update of the Place of Service (POS) Code Set." That other information remains unchanged.

Background

Effective April 1, 2004, the description of POS code 14 (Group Home) will be as follows: "A residence, with shared living areas, where clients receive supervision and other services, such as social and/or behavioral services, custodial services, and minimal services (e.g. medical administration)."

Once again, the remainder of the updated POS code set remains as presented in program memorandum B-03-040, which may be found at*:* *http://www.cms.hhs.gov/manuals/pm_trans/B03040.pdf*.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R121CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3087
Medlearn Matters Number: MM3087
Related CR Release Date: March 19, 2004
Related CR Transmittal #: 121
Effective Date: April 1, 2004
Implementation Date: N/A- This is informational only.

Unprocessable Unassigned Form CMS-1500 Claims

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

No provider action is needed. This instruction makes necessary changes to assure consistency in the handling of Medicare Part B claims and that HIPAA noncompliant data is not transmitted to Coordination of Benefits (COB) trading partners.

Provider Impact

Formerly, unassigned claims were denied with appeal rights. However, this instruction notifies physicians, providers and suppliers that unassigned Centers for Medicare & Medicaid Services (CMS) Form 1500 claims and electronic interface equivalents that are incomplete or contain invalid information will be returned as unprocessable to the submitters for correction or resubmission. It is important to note that as an unprocessable, when the claim is returned, there are no appeal rights.

When the claims are corrected and then processed, electronic crossover claims can be sent to COB trading partners that are HIPAA compliant and the COB secondary payer claims can be processed for Medicare beneficiaries.

Background

The Medicare Claims Processing Manual (Pub. 100-04) provides instructions for handling Medicare claims, including Part B Form CMS-1500 claims that have incomplete or invalid information. Such claims are to be returned without appeal rights. See Pub. 100-04, Chapter 1 (General Billing Requirements), Section 80.3.1 (Incomplete or Invalid Claims Processing Terminology) at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf.*

Currently, the instructions for Form CMS-1500 claims are:

- Specified to apply only to assigned Part B claims, and
- Silent as to unassigned CMS-1500 claims.

As a result, many Part B carriers and DMERCs have been denying unassigned CMS-1500 claims with appeal rights and not returning these claims as unprocessable without appeal rights.

In addition, when denying these claims, the carriers/DMERCs have been sending to COB secondary payers electronic crossover claims containing Health Insurance Portability and Accountability Act of 1996 (HIPAA) noncompliant claims data (such as diagnosis codes and procedure codes that are not part of the standard code sets).

Under HIPAA rules, COB trading partners are not required to process claims that are not HIPAA compliant, and in claims with multiple service lines, the entire claim might be rejected. The inclusion of HIPAA noncompliant data has resulted in some COB trading partners refusing to process such crossover claims for Medicare beneficiaries.

Implementation

The implementation date for this instruction is July 5, 2005.

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 1 has been revised and is included as an attachment to the official instruction released to your carrier. You may view that instruction at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page, look for CR 3500 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: 3500
Medlearn Matters Number: MM3500
Related CR Release Date: January 21, 2005
Related CR Transmittal #: 443
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Update of Healthcare Common Procedure Coding System (HCPCS) Codes and File Names, Descriptions, and Instruction for Retrieving the 2005 Ambulatory Surgical/Surgery Center (ASC) HCPCS Deletions and Master Listing

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

Provider Types Affected

Ambulatory Surgical Centers

Provider Action Needed

Be aware that HCPCS codes 50559, 50959, and 50978 are being deleted from the ASC list effective for services performed on or after January 1, 2005.

Background

The Centers for Medicare & Medicaid Services (CMS) is updating the ASC HCPCS codes list as a result of changes in the American Medical Association (AMA) Physician's Current Procedural Terminology (CPT). The deletions of the HCPCS codes described in this notification are the results of changes in the CPT for 2005. There are no additions or replacement codes.

Additional Information

The link to your carrier's website may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp.*

Should you have any additional questions, please feel free to call your carrier/intermediary at their toll free number, which may also be found at that same website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0463
Related CR Release Date: N/A
Effective Date: January 1, 2005
Implementation Date: January 5, 2005

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COVERAGE/REIMBURSEMENT

CHIROPRACTIC

Electrocardiographic Services

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

Provider Types Affected

Physicians and providers billing Medicare carriers and fiscal intermediaries (FIs) for electrocardiographic (ECG or EKG) services.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) nationally covers the use of electrocardiographic (ECG or EKG) services under specific criteria described in §20.15, Pub. 100-03, National Coverage Determinations (NCD) Manual. EKG technologies are now organized into an updated framework to aid in making reasonable and necessary coverage determinations as they pertain to EKG technology. Effective August 26, 2004, electrocardiographic (EKG) services performed with a marketed, Food and Drug Administration (FDA)-approved device, are eligible for coverage if they can be categorized according to the EKG Services Framework described in the NCD Manual.

CAUTION – What You Need to Know

Ambulatory cardiac monitoring performed with a marketed, FDA-approved device is eligible for coverage if it can be categorized according to the EKG framework. Unless there is a specific NCD for that device or service, determination as to whether a device or service that fits into the framework is reasonable and necessary is at the discretion of your local carrier or FI.

GO – What You Need to Do

To ensure accurate claims processing for EKG services, review the information included here and stay current with instructions for electrocardiographic services.

Background

EKG technologies are now organized into an updated framework to aid in making reasonable and necessary coverage determinations as they pertain to EKG technology. Ambulatory cardiac monitoring performed with a marketed, FDA-approved device is eligible for coverage if it can be categorized according to that framework.

The framework is detailed and described in a revised portion of the NCD manual and that revised portion is attached to CR 3590. The following table summarizes the nationally covered indications and nationally noncovered indications for EKG technologies:

Nationally Covered Indications	Nationally Non-Covered Indications
1. Computer analysis of EKGs when furnished in a setting and under the circumstances required for coverage of other EKG services.	1. The time-sampling mode of operation of ambulatory EKG cardiac event monitoring/recording.
2. EKG services rendered by an independent diagnostic testing facility (IDTF), including physician review and interpretation. Separate physician services are not covered unless he/she is the patient's attending or consulting physician.	2. Separate physician services other than those rendered by an IDTF unless rendered by the patient's attending or consulting physician.
3. Emergency EKGs performed as a laboratory or diagnostic service by a portable x-ray supplier only when a physician is in attendance at the time the service is performed or immediately thereafter.	3. Emergency EKG services by a portable x-ray supplier without a physician in attendance at the time of service or immediately thereafter.
4. Home EKG services with documentation of medical necessity.	4. Home EKG services without documentation of medical necessity.

Electrocardiographic Services, continued

Nationally Covered Indications	Nationally Noncovered Indications
5. Ambulatory cardiac monitoring performed with a marketed, FDA-approved device is eligible for coverage if it can be categorized according to the electrocardiographic services framework of Chapter 1, Section 20.15 of the NCD Manual. Unless there is a specific NCD for that device or service, determination as to whether a device or service that fits into the framework is reasonable and necessary is according to local contractor discretion.	5. Any marketed Food and Drug Administration (FDA)-approved ambulatory cardiac monitoring device or service that cannot be categorized according to the electrocardiographic services framework discussed in Chapter 1, Section 20.15 of the NCD manual.
6. Trans-telephonic EKG transmissions used for the specific indications, when performed with specific equipment and subject to the specific limitations and conditions detailed in Chapter 1, Section 20.15 of the NCD manual.	6. Twenty-four-hour attended coverage used as early post-hospital monitoring of patients discharged after myocardial infarction unless provided according to specific criteria as mentioned in Chapter 1, Section 20.15 of the NCD manual.

Additional Information

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

On the above page, scroll down the CR NUM column on the right to find the link for CR 3590. Click on the link to open and view the file for the CR.

The revised §20.15, Pub. 100-03, National Coverage Determinations Manual, is attached to CR 3590.

If you have questions regarding this issue, you may also contact your carrier or FI at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp.*

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3590
Related CR Release Date: December 10, 2004
Effective Date: August 26, 2004
Medlearn Matters Number: MM3590
Related CR Transmittal #: 26
Implementation Date: December 10, 2004

CHIROPRACTIC

Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR 3063

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

Previously published in the First Quarter 2005 Medicare Part B Update! (page 22)

Note: This article is a full replacement for the article released on September 8 to clarify certain language regarding denials.

Provider Types Affected

Chiropractors.

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

This article completely replaces MM3063 on the same subject. on or after October 1, 2004, when you provide acute or chronic active/corrective treatment to Medicare patients, you must add the AT modifier to every claim that uses HCPCS

codes 98940, 98941, or 98942. If you don't add this modifier, your care will be considered maintenance therapy and will be denied because maintenance chiropractic therapy is not considered medically reasonable or necessary under Medicare.

GO – What You Need to Do

Ensure that your billing staff is aware that they must apply the AT modifier to HCPCS codes 98940, 98941, or 98942 when your clinical documentation reflects that the care you provided to a Medicare patient consists of active/corrective treatment. Additionally, your billing staff should be aware of any LCDs for these services in your area that might limit circumstances under which active/corrective chiropractic can be paid.

Background

The 2003 Improper Medicare FFS Payment report indicates that chiropractors have the highest provider compliance error rate in Medicare, filing claims incorrectly almost one-third of the time. Chapter 15, Section 30.5 of the Medicare Benefits Policy Manual states that the Medicare program does not consider chiropractic maintenance therapy as medically reasonable or necessary, and is not payable under the Medicare program. So, for you to bill Medicare correctly, you need to indicate which of your claims are for active/corrective therapy and which are for maintenance therapy. Modifier AT already exists that can be used for this purpose.

Therefore, you **must** place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. For services rendered on or after October 1, 2004, all of your claims for active/corrective therapy (HCPCS codes 98940, 98941, 98942) that do not contain the AT modifier will be denied. This is because, as mentioned above, services without this modifier will be considered maintenance therapy (services that seek to prevent disease, promote health, and prolong and enhance the quality of life; or maintain or prevent deterioration of a chronic condition) and are not considered medically reasonable or necessary under Medicare.

As always, your Medicare contractor may deny your claim, if appropriate, after medical review.

For services that are maintenance therapy, you may wish to obtain an advance beneficiary notice (ABN) from the beneficiary and also apply the GA modifier (to be used when you want to indicate that you expect that Medicare will deny a service as not reasonable and necessary and that you do have on file an ABN signed by the beneficiary) or the GZ modifier (to be used when you want to indicate that you expect that Medicare will deny an item or service as not reasonable and necessary and that you have not had an ABN signed by the beneficiary), as appropriate.

Important Dates to Know

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

Related Instruction

The revisions to Chapter 15 of the Medicare Benefits Policy Manual are attached to the official instruction released to your carrier. That instruction may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

Once at that web page, scroll down the CR NUM column on the right to locate CR3449 and click on that file.

Also, you may check any LMRP/LCDs that may apply to you at: *http://www.cms.hhs.gov/mcd.*

For more information about the use of the ABN, consult the Internet-Only Manual (IOM), Pub. 100-04, Chapter 23, Section 20.9.1.1. You can access this information at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf.*

Additional Information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Release (CR) #: 3449
Related CR Release Date: October 8, 2004 Revised
Effective Date: October 1, 2004
Medlearn Matters Number: MM3449
Related CR Transmittal #: 23
Implementation Date: October 4, 2004

DRUGS AND BIOLOGICALS

Minimum Number of Drug Pricing Files That Must Be Maintained Online for Medicare

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

Provider Types Affected

All providers billing Medicare carriers for drugs.

Provider Action Needed

None. This change request is for your information only.

Background

Medicare is creating a new minimum standard for the number of online drug price determination files that your Medicare carrier will maintain. The new minimum standard is eight fee screens/pricing files (the current period and seven prior files) for Part B (payment on a fee-for-service) drugs that you bill.

Since January 1, 2003, Medicare carriers have paid drug claims based on the prices shown on the single drug pricer (SDP) files. The Centers for Medicare & Medicaid Services (CMS) is creating a new minimum standard for the number of online pricing files maintained by carriers for determining drug prices. The new minimum standard is raised from five to eight fee screens/pricing files for Part B drugs billed to carriers for payment on a fee-for-service basis.

This will allow Medicare to be more precise in paying the rate in effect at the time services are provided.

Additional Information

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

From that web page, look for CR 3231 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3231	Medlearn Matters Number: MM3231
Related CR Release Date: August 3, 2004	Related CR Transmittal #: 269
Effective Date: January 1, 2005	Implementation Date: January 3, 2005

Revisions to January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File

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

Provider Types Affected

Providers who bill fiscal intermediaries and carriers (including DMERCs) for the affected drugs.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is replacing payment limits for the first quarter of 2005 for certain Medicare Part B drugs, effective January 1, 2005.

CAUTION – What You Need to Know

The revised payment limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. Please note that the related CR 3695 makes revisions to the earlier CR 3539 and that the revised payment limits in this notification supercede the payment limits for these codes in any publication published prior to this document.

GO – What You Need to Do

To ensure accurate claims processing, please review the information included here and stay current with guidelines on Medicare Part B drugs and biologicals.

Background

Section 303(c) of the Medicare Modernization Act (MMA) of 2003 revises the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Effective January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the new Average Sale Price (ASP) drug payment methodology.

The ASP payment methodology is based on data submitted to CMS by manufacturers at the 11-digit National Drug Code (NDC) level. CMS uses published drug pricing compendia and other sources to identify the number of billable units per NDC.

Through receipt of additional data, CMS has determined that certain payment limits included in the first quarter of calendar year 2005 (1Q05) Medicare Part B drug pricing file require revision. The revised payment limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. The revised payment limits in this notification supercede the payment limits for these codes in any publication published prior to this document.

The affected drugs and the associated revised payment limits are contained in the following table.

Revisions to January 2005 Quarterly ASP Medicare Part B Drug Pricing File, continued

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit
90747*	ENGERIX-B	40 MCG	$113.91	$113.91
J0835	Inj cosyntropin per 0.25 MG	0.25 MG	$64.60	$64.60
J1563	IV immune globulin	1 GRAM	$56.72	$56.72
J1564	Immune globulin 10 mg	10 MG	$0.57	$0.57
J1655	Tinzaparin sodium injection	1000 IU	$2.60	$2.60
J2324	Nesiritide	0.25 MG (revised)	$73.33	$73.33
J3315	Triptorelin pamoate	3.75 MG	$180.93	$180.93
J3470	Inj hyaluronidase	up to 150 units	$20.00	$20.00
J7030	Sodium Chloride	1000 CC	$0.10	$0.10
J7350	Injectable human tissue	10 MG	$4.53	$4.53
J7611	Albuterol concentrated form	1 MG	$0.07	$0.07
J8501	Oral aprepitant	5 MG	$4.62	$4.62
J9185	Fludarabine phosphate inj	50 MG	$272.09	$272.09
J9214	Intron-A	1 UNIT	$13.12	$13.12
Q0179	Zofran	8 MG	$30.86	$30.86
Q2014	Geref	0.5 MG	$8.77	$8.77

*The revised payment limit for 90747 is based on the pricing methodology for vaccines (95% AWP).

Note: **The absence or presence of a HCPCS code and its associated payment limit in the ASP files does not indicate Medicare coverage of the drug or biological.**

Additional Information

The official instruction issued regarding this change can be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

On the above page, scroll down the CR NUM column on the right to find the link for CR 3695. Click on the link to open and view the file for the CR.

You may also refer to the earlier CR 3539 for additional background information – CR 3695 makes revisions to information provided in CR 3539.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3695
Related CR Release Date: January 13, 2005
Effective Date: January 1, 2005
Medlearn Matters Number: MM3695
Related CR Transmittal #: 134
Implementation Date: January 18, 2005

MMA Drug Pricing Update—Payment Limit for J0207 (Amifostine)

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

Provider Types Affected

Physicians and providers billing Medicare carriers for amifostine.

Provider Action Needed

This article informs affected providers that Medicare will implement the Medicare Modernization Act of 2003 (MMA) payment limit for amifostine (HCPCS drug code J0207) with the new rate listed in this article for dates of service starting April 1, 2004 through December 31, 2004.

Please note that this payment limit for amifostine supercedes the payment limit published in change request (CR) 3161, Transmittal 119, dated March 15, 2004, and any other publication published prior to this document.

Background

The MMA (Section 303[b][2]) specifies that the Centers for Medicare & Medicaid Services (CMS) may adjust the percentage used in the calculation for pricing Medicare Part B drugs effective January 1, 2004 (based on data and information submitted by the manufacturer after October 15, 2003 and before January 1, 2004).

Therefore, based on information received by CMS, the payment limit for amifostine has been revised. From April 1, 2004 through December 31, 2004, the Medicare payment limit for the Healthcare Common Procedure Coding System (HCPCS) drug code J0207 applies when it is not paid on a cost or prospective payment basis. The old and revised payment limits are as follows:

Status	HCPCS	Short Description	Average Wholesale Price (AWP) %	2004 Payment Limit for Drugs (other than End Stage Renal Disease (ESRD) drugs separately billed by independent ESRD Facilities and drugs infused through Durable Medical Equipment (DME))
OLD	J0207	Amifostine	85	$405.29
NEW	J0207	Amifostine	89	$422.21

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

Implementation

The implementation date for the instruction is December 6, 2004.

Additional Information

To view the official instruction issued to your carrier regarding this change, go to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR3552 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3552
Related CR Release Date: November 5, 2004
Effective Date: April 1, 2004
Medlearn Matters Number: MM3552
Related CR Transmittal #: 361
Implementation Date: December 6, 2004

Influenza Treatment Demonstration

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

Provider Types Affected

Physicians, providers, and suppliers.

Provider Action Needed

Physicians, providers, and suppliers should note that Medicare will cover four new flu medications, including—where applicable—their generic equivalents. These medications are Amantadine Hydrocloride; Zanamivir, Inhalation Power Administered through Inhaler; Oseltamivir Phosphate, Oral; and Rimantadine Hydrochloide, Oral.

These drugs will be paid under a demonstration from the Centers for Medicare & Medicaid Services (CMS) for dates of service through May 31, 2005. In addition, physicians, providers and suppliers that enroll in Medicare before May 31, 2005 may also file claims for drugs furnished under this demonstration for dates of service beginning when the provider or supplier completes such enrollment.

Background

The Centers for Disease Control and Prevention (CDC) recommends that individuals in the following groups should be vaccinated against influenza annually:

- Adults aged 65 years and older
- Residents of nursing homes and long term care facilities
- Those with underlying chronic medical conditions.

Early in the flu vaccination season it was reported that there would be a shortage of vaccine due to manufacturing problems. Although it appears that there will be ample flu vaccine, many Medicare beneficiaries may not have been vaccinated and remain at risk. Vaccination against flu is still the best protection; however, for those Medicare beneficiaries who have been unable to receive a flu vaccination, the next best approach to protect them is to provide coverage for antiviral medicines that can prevent the complications of influenza infection by reducing the duration and severity of the infection. The shorter the duration of the infection, the less time the individual is contagious to others. In some cases, the antiviral medicine can also act as a primary preventive agent.

Influenza Treatment Demonstration

CMS is undertaking a demonstration project to measure the impact of providing coverage for certain antiviral drugs to treat and/or prevent influenza.

The Influenza Treatment Demonstration will provide coverage to Medicare beneficiaries for Food and Drug Administration (FDA)-approved drugs for the treatment and targeted prevention of influenza. Specifically, under this demonstration, Medicare will cover certain anti-viral drugs when furnished:

- To a beneficiary with symptoms of influenza;
- As a prophylaxis for a beneficiary exposed to a person with a diagnosis of influenza; or
- To a beneficiary in an institution where there has been an outbreak of influenza.

Note: **However, the demonstration does** not **cover these anti-viral drugs for general prophylactic use.**

The following drugs (including, when applicable, bioequivalents or generic equivalents) are included in the demonstration:

- Amantadine hydrocloride, oral
- Zanamivir, inhalation power administered through inhaler
- Oseltamivir phosphate, oral
- Rimantadine hydrochloide, oral.

The drugs under this demonstration must be furnished incident to a physician service or must be prescribed by a physician (or other practitioner authorized by sate law to prescribe such drugs). Except as noted below, all ancillary Medicare rules apply to the furnishing of these drugs to Medicare beneficiaries under this demonstration. Also, information regarding treatment and drug dosage of these influenza antiviral medications is included in the Additional Information Section of this special edition.

The demonstration will include dates of service through May 31, 2005. Also, note that **a**ll claims for drugs furnished under this demonstration **must be filed no later than December 31, 2005.**

Physicians, providers, and suppliers that enroll in Medicare before May 31, 2005 may also file claims for drugs furnished under this demonstration for dates of service beginning when the provider or supplier completes such enrollment.

Payment Amounts

Both the Medicare copayment and deductible apply to all claims under this demonstration, including claims for Medicare Advantage (MA) beneficiaries. The exception is in the calculations of co-payments for beneficiaries participating in the Drug Discount Card program. These beneficiaries will pay the lesser of 20 percent Medicare allowable amount or 20 percent negotiated drug discount sponsor's price for antiviral medicines, plus $.20 (20 percent of a $1.00 administrative charge). A chart explaining how to do the calculations for determining copayment amount for Drug Discount Card participants is attached. CMS will also make this chart available on its website at *http://www.cms.hhs.gov/researchers/demos/flu* and will update cost information monthly. Finally, no deductible will apply to claims from federally qualified health centers (FQHCs).

Except as noted below, the Medicare allowed amount for these demonstration drugs will be based on 95 percent of the average wholesale price (AWP) for the brand name of each drug (Zanamivir and Oseltamivir phosphate) covered under this demonstration, determined in accordance with customary Medicare payment policy. For drugs marketed as bioequivalent or generics (Amantadine and Rimantadine), the allowed amount will be based on 90 percent of AWP.

For the duration of the demonstration, the allowed HCPCS codes/charges are as follows:

G9017 Amantadine Hydrocloride, Oral, per 100 mg, (for use in a Medicare-approved demonstration project), $0.76.

G9018 Zanamivir, Inhalation Powder Administered Through Inhaler, per 10 mg, (for use in a Medicareapproved demonstration project), $5.43.

G9019 Oseltamivir Phosphate, Oral, per 75 mg, (for use in a Medicare-approved demonstration project), $6.99.

G9020 Rimantadine Hydrochloride, Oral, per 100 mg, (for use in a Medicare-approved demonstration project),$1.65.

G9033 Amandatine Hydrocloride, oral, brand, per 100 mg (for use in a Medicare-approved demonstration project), $1.32

G9034 Zanamivir, inhalation powder administered through Inhaler, brand, per 10 mg, (for use in a Medicare-approved demonstration project), $5.43

G9035 Oseltamivir phosphate, oral brand, per 75 mg, (for use in a Medicare-approved demonstration project), $6.99.

G9036 Rimantadine hydrochloride, oral brand, per 100 mg, (for use in a Medicare-approved demonstration project), $2.17.

Those entities that are to be paid on a basis other than of 90 percent or 95 percent of AWP are as follows:

- Indian health service (IHS) hospitals will be reimbursed on the basis of the outpatient all-inclusive rate.
- IHS critical access hospitals (CAHs) will be reimbursed on the basis of a facility-specific visit rate.
- Rural health clinics (RHCs) and federally qualified health centers (FQHCs) will be reimbursed on the basis of the all-inclusive rate when one of the drugs is furnished as part of a billable encounter under revenue code 052x. An encounter cannot be billed if furnishing the drug is the only service the RHC/FQHC provides. (Although the provision of these drugs in and by themselves does not constitute a billable encounter in the RHC/FQHC setting, the cost of the drugs can be claimed on the RHC/FQHC cost report and bundled into the all-inclusive payment rate calculation.)
- Maryland hospitals that are under the jurisdiction of the Health Services Cost Review Commission (HSCRC) are paid under the Maryland waiver.

Billing Instructions

Claims for drugs furnished under this demonstration may be submitted by enrolled Medicare providers as follows: hospitals including CAHs, skilled nursing facilities (SNFs), renal dialysis facilities (RDFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs) and by enrolled physicians, other practitioners, or other suppliers that are authorized under state law to dispense these drugs.

Except as noted below, providers, physicians, and other suppliers must follow customary Medicare billing and claims processing rules.

- An entity possessing a supplier number issued by the National Supplier Clearinghouse (NSC) must bill the DMERC having jurisdiction for the location of the beneficiary's permanent residence.
- All hospitals (other than Indian Health Service (IHS) hospitals, IHS-CAHs, Maryland hospitals as noted above, and hospitals which do not have a supplier number issued by the NSC) must bill the appropriate DMERC using the CMS-1500 or electronic equivalent. Otherwise, billing by the hospital is to the fiscal intermediary on the CMS-1450/UB-92 or electronic equivalent.
- All other institutional providers, not possessing an NSC-issued supplier number, must bill the fiscal intermediary on the CMS-1450/ UB-92 or electronic equivalent.
- All physicians, practitioners, and other suppliers, not possessing an NSC-issued supplier number, must submit claims to their local area carrier using the CMS-1500 or electronic equivalent.
- HHAs should follow billing requirements already in place for vaccines when billing for these drugs as specified in Pub. 100-4, Chapter 18, Section 10.2.3, which may be accessed at *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.
- All institutional providers billing their fiscal intermediary must submit a separate claim for these drugs.
- Roster billers submit claims in accordance with the instructions specified in Pub.100-4, Chapter 18, Section 10.3, except:
  - " HCPCS codes G0008, G0009, 90657, 90658, 90659, and 90732 should not be reported on the same roster bill under this demonstration.
  - " An administration fee will not be paid for drugs administered under this demonstration.
  - " Roster billers must bill different dates of service, dosages, codes, and quantities on different roster or claims forms.
  - " Payment may be made for MA beneficiaries under this demonstration and such claims should be reported to the provider's regular carrier or intermediary.
  - " Medicare Advantage (MA) plans, if enrolled in-fee-for service billing, must bill for these items using their normal procedures for billing for Medicare fee-for-service items and services. Providers and suppliers may submit claims for MA beneficiaries to their normal FI or carrier.

Acceptance of assignment is mandatory for all claims submitted under this demonstration and Medicare secondary payer (MSP) rules apply to claims under this demonstration.

Implementation

The implementation date for this instruction is January 17, 2005.

Additional Information

Treatment and Drug Dosage of Influenza Antiviral Medications[1]

You are referred to the Centers for Disease Control and Prevention website (Antiviral Agents for Influenza: Background Information for Clinicians) at: *http://www.cdc.gov/flu/professionals/antiviralback.htm*.

Treatment

For the treatment of influenza, controlled studies have found that neuraminidase inhibitor drugs (Zanamivir, Oseltamivir) and adamantane derivative drugs (Amantadine, Rimantadine) administered within 48 hours of illness onset, decrease viral shedding and reduce the duration of influenza A illness by approximately one day compared with placebo. The usual recommended duration of treatment is five days.

Chemoprophylaxis

Known exposure: For chemoprophylaxis of known exposure, treatment should begin within two days of contact with an infected individual and continue for two weeks.

In lieu of vaccination: To be maximally effective as prophylaxis in lieu of vaccination, influenza antiviral medications must be taken each day for the duration of influenza activity in the community. However, one study of amantadine or rimantadine prophylaxis reported that the drugs could be taken only during the period of peak influenza activity in a community.[2]

Outbreak in an institution: For residents of an institution, chemoprophylaxis is recommended during an outbreak, and should be continued for at least two weeks. If surveillance indicates that new cases continue to occur, chemoprophylaxis should be continued until approximately one week after the end of the outbreak.

[1] Source: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5306a1.htm.

[2] Patriarca PA, Arden NH, Koplan JP, Goodman RA. Prevention and control of type A influenza infections in nursing homes: benefits and costs of four approaches using vaccination and amantadine. Ann Intern Med 1987; 107:732—40.

Dosage:

Recommended Daily Dosage of Influenza Antiviral Medications for Treatment and Prophylaxis[3]

Antiviral Agent	Age Groups (yrs) 64-64	> 65
Amantadine* (Symmetrel®)		
Treatment, influenza A	100mg twice daily §	< 100 mg/day
Prophylaxis, influenza A	100mg twice daily §	< 100 mg/day
Rimantadine (Flumadine®)		
Treatment, ** influenza A	100mg twice daily §§	100 mg/day
Prophylaxis, influenza A	100mg twice daily §	100 mg/day
Zanamivir*†† (Relenza®)**		
Treatment, influenza A and B	10mg twice daily	10mg twice daily
Oseltamivir (Tamiflu®)		
Treatment, §§§ influenza A and B	75mg twice daily	75mg twice daily
Prophylaxis, influenza A and B	75mg/day	75mg/day

***** The drug package insert should be consulted for dosage recommendations for administering amantadine to persons with creatinine clearance < 50 ml/min/1.73m 2.

† 5 mg/kg of amantadine or rimantadine syrup = 1 tsp/22 lbs.

§ Children > 10 years who weigh <40 kg should be administered amantadine or rimantadine at a dosage of 5 mg/kg/day.

A reduction in dosage to 100 mg/day of rimantadine is recommended for persons who have severe hepatic dysfunction or those with creatinine clearance < 10 mL/min. Other persons with less severe hepatic or renal dysfunction taking 100 mg/day of rimantadine should be observed closely, and the dosage should be reduced or the drug discontinued, if necessary.

** Only approved by FDA for treatment among adults.

§§ Rimantadine is approved by FDA for treatment among adults. However, certain experts in the management of influenza consider it appropriate also for treatment among children. (See American Academy of Pediatrics, 2000 Red Book.)

Older nursing-home residents should be administered only 100 mg/day of rimantadine. A reduction in dosage to 100 mg/day should be considered for all persons aged > 65 years if they experience possible side effects when taking 200 mg/day.

******* Zanamivir administered via inhalation using a plastic device included in the medication package. Patients will benefit from instruction and demonstration of the correct use of the device.

†† Zanamivir is not approved for prophylaxis.

§§§ A reduction in the dose of oseltamivir is recommended for persons with creatinine clearance <30 ml/min.

[3] *http://www.cdc.gov/flu/professionals/antiviralback.htm*

Further Claims Preparation Instructions

Because Medicare carriers will hold claims received until Medicare systems changes are made on January 17, 2005, interest will be paid to providers, where applicable, when the held claims are processed on or after January 17, 2005. In addition, physicians, providers, and suppliers should note the following:

- The type of service code for these claims is "1".
- An appropriate diagnosis code must be included on the claim in order to be HIPAA compliant.
- Carriers will apply the 5 percent reduction in payment on claims from non-participating physicians.
- Assignment is mandatory for all claims filed under this demonstration.
- Providers billing for services under this demonstration for hospice patients should include condition code 07 on the claim.
- Hospitals, SNFs, CORFs, renal dialysis facilities, CAHs, IHS hospitals, and IHS CAHs should use revenue code 0636 along with the appropriate HCPCS code.
- Billing for codes G9017, G9018, G9019, G9020, G9033, G9034, G9035, or G9036 must be done on separate claims and **no other codes may be present on such claims.**
- For claims submitted to intermediaries, providers should use types of bill (TOB) 12x, 13x, 22x, 23x, 34x, 72x, 75x, or 85x. **Claims submitted with any other TOB for services under this demonstration will be returned to the provider.**
- Drugs covered under this demonstration will be payable even if the beneficiary has already received a flu vaccine.
- Beneficiaries may receive no more than two of the drugs permitted under this demonstration (e.g., the same drug twice or a combination of two different drugs).
- Medicare will not pay for HCPCS code G0008 (administration fee) under this demonstration.

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***.**

From that Web page, look for CR 3696 in the CR NUM column on the right, and click on the file for that CR.
If you have any questions, please contact your intermediary/carrier at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

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

ATTACHMENT: LOOK-UP TABLE FOR CALCULATING BENEFICIARY CO-PAYMENT FOR ANTIVIRAL INFLUENZA TREATMENT

INSTRUCTIONS FOR USING THIS TABLE

Note: **This table is only used to calculate the beneficiary co-payment amount for those participating in the Medicare Drug Discount Card Program.**

1. Locate the name of the Medicare Drug Discount Card Sponsor in column A, or the Sponsor's plan number in column B.
2. Locate the prescribed medicine in column C through I.
3. Find the cost per unit for the prescribed medicine for the specific Card Sponsor.
4. Multiply the unit cost of the medicine by the number of units in the prescription, PLUS $1.00, to calculate the total Drug Card Sponsor's cost.
5. Multiply the Medicare Allowed Payment Amount by the number of units in the prescription to calculate the Medicare allowed cost.
6. Compare the total cost of the Drug Card Sponsor with the total cost of the Medicare allowed cost.
7. If the total Medicare allowed cost is less than the total Drug Card Sponsor's cost the co-payment will be 20 percent of the Medicare Allowed cost.
8. If the total Drug Card Sponsor's cost is less than the Medicare allowed cost the co-payment will be 20 percent of the Drug Card Sponsor's costs.

** In either case Medicare will reimburse the pharmacy 80 percent of the Medicare allowed cost.

Related Change Request (CR) Number: 3696
Related CR Release Date: January 21, 2005
Related CR Transmittal Number: N/A
Effective Date: December 1, 2004
Implementation Date: January 17, 2005.

Source: CMS Pub. 100-20, Transmittal 136, CR 3696, PCM #0502422

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
Anthem Drug Discount Card	D7000	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
MedCare USA, Powered by MedImpact	D7001	0.0864	0.2113	0.4195	0.4901	0.3227	0.2451	1.2622
aClaim RxSavings Club	D7002	0.0871	0.1680	0.4147	0.4689	0.2567	0.2545	1.3328
AmeriHealth RxSavings	D7005	0.1082	0.2089		0.4954		0.2545	1.2831
InStil Health Solutions	D7007	0.0864	0.2113	0.4195	0.4901	0.3227	0.2451	1.2622
HealthSpring of Alabama Prescription Advantage	D7008	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
HealthSpring of Illinois Prescription Advantage	D7009	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
HealthSpring Prescription Advantage	D7010	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
Texas HealthSpring Prescription Advantage	D7011	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
Horizon RxSavings	D7013	0.1082	0.2089		0.4954		0.2545	1.2831
Priority Plus	D7015	0.0871	0.1680	0.4290	0.4932	0.2567	0.2633	1.2685
PBM Plus Senior Care	D7016	0.1181	0.2401	0.4767	0.5561	0.3024	0.2925	1.5320
The Pharmacy SmartCard	D7017	0.0560	0.1300	0.4147	0.5182	0.2750	0.2423	1.3328
myPharmaCare	D7019	0.1028	0.2089	0.4147	0.4787	0.3187	0.2423	1.3328
Liberty Prescription Discount Card	D7020	0.0933	0.1800	0.4147	0.4787	0.2750	0.2423	1.2348
ScriptSave Premier	D7021	0.1119	0.2161	0.4290	0.5063	0.3300	0.2507	1.3137
Blue Cross Blue Shield of Alabama's BlueRx	D7027	0.0889	0.2089	0.4147	0.4787	0.2794	0.2545	1.2348
Aetna Rx savings Card (SM)	D7028	0.1119	0.2161	0.4290	0.5063	0.3300	0.2507	1.3137
RxSavings distributed by Reader's Digest	D7029	0.1119	0.2161		0.5483		0.2779	1.4171
RxSavings distributed by Reader's Digest	D7029	0.1121	0.2401		0.5956		0.2925	1.4937
RxSavings distributed by MCS Life Insurance Company	D7030	0.1121	0.2401		0.5956		0.2925	1.4937
Anthem Drug Discount Card VA	D7031	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card NH	D7032	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card CO	D7033	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card IN	D7034	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
Anthem Drug Discount Card ME	D7035	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card KY	D7036	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card OH	D7037	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card CT	D7038	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Preferred Prescription Discount Card	D7041	0.0965	0.2089	0.4147	0.4703	0.3190	0.2545	1.2140
Prescription Discount Card	D7042	0.0965	0.2089	0.4147	0.4799	0.3190	0.2545	1.2377
BlueSaver Premier	D7043	0.1095	0.2113	0.4195	0.4944	0.3227	0.2451	1.2831
First Health Services Medicare Drug Discount Card	D7046	0.1119	0.1920	0.4290	0.5360	0.2934	0.2633	1.3788
First Health Services Medicare Drug Discount Card	D7046	0.1119	0.2161	0.4290	0.5360	0.3300	0.2633	1.3788
ArgusRx	D7047	0.0933	0.1800	0.4147	0.4753	0.2750	0.2545	1.2225
RxSavings	D7049	0.1119	0.2161		0.5483		0.2779	1.4171
RxSavings	D7049	0.1121	0.2401		0.5956		0.2925	1.4937
RxSavings distributed by BlueCross BlueShield of Tennessee	D7057	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by BlueCross BlueShield of South Carolina	D7058	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Wellmark BlueCross BlueShield	D7060	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Fidelis Care New York	D7062	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by OSF HealthPlans	D7063	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Premier Plus	D7064	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Texan Plus	D7066	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Mennonite Mutual Aid Association	D7068	0.1119	0.2161		0.5483		0.2779	1.4171
RxSavings distributed by UCare Minnesota	D7069	0.1082	0.2089		0.4954		0.2545	1.2831
EnvisionRx Plus	D7070	0.1057	0.2041	0.4290	0.4867	0.3117	0.2507	1.3788

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
Rx Savings Access Card	D7071	0.1082	0.2089	0.4147	0.4786	0.3190	0.2423	1.2348
Pharmacy Care Alliance (Option A)	D7072	0.1011	0.2160	0.4290	0.4884	0.3297	0.2632	1.2869
Pharmacy Care Alliance (Option B)	D7073	0.1011	0.2160	0.4290	0.4884	0.3297	0.2632	1.2869
AARP Prescription Discount Card	D7074	0.1011	0.2280	0.4529	0.5182	0.3480	0.2779	1.3635
SHL RxCard	D7075	0.1028						1.3328
ScripSolutions Freedom	D7076	0.1095	0.2113	0.5638	0.5144	0.3224	0.2574	1.2501
ScripSolutions Choice	D7077	0.1095	0.2113	0.5638	0.5144	0.3224	0.2574	1.2501
American Advantage-Med	D7079	0.1004	0.2089	0.4243	0.4924	0.3190	0.2479	1.2885
American Prescription Plan	D7080	0.1119	0.2161		0.5483		0.2779	1.4171
PrimeScript	D7081	0.1082	0.2089	0.4290	0.5182	0.3190	0.2633	1.3328
SXC Health Solutions, Inc.	D7082	0.0933	0.1800	0.4147	0.4787	0.2750	0.2423	1.2348
Walgreens Health Initiatives Prescription Discount Drug Card	D7083	0.0995	0.1920	0.4147	0.4742	0.2934	0.2545	1.2228
Walgreens Health Initiatives Prescription Discount Drug Card	D7083	0.1244	0.2401	0.4767	0.5956	0.3748	0.2925	1.5320
PrecisionDiscounts (Option A)	D7084	0.0746	0.1755	0.4290	0.4966	0.2748	0.2633	1.2808
Public Sector Partners Prescription Drug Discount Card	D7086	0.0933	0.1800	0.4147	0.5182	0.2750	0.2423	1.2103
Rx for Less delivered through UPMC for Life	D7087	0.1095	0.2113	0.4195	0.4872	0.3227	0.2574	1.3482
Sav-Rx Med-Advantage Prescription Discount Card	D7088	0.1004	0.2089	0.4243	0.4882	0.3190	0.2479	1.2801
U Share Prescription Drug Discount Card	D7089	0.0965	0.2089	0.4147	0.4703	0.3190	0.2545	1.2140
Community Care Rx	D7090	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Community Care Rx	D7090	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Criterion Advantage	D7091	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Criterion Advantage	D7091	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Golden Buckeye	D7092	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
Advantra X-tra Drug Discount Card Program	D7095	0.1082	0.2089		0.4954		0.2545	1.2831
BD Advantage Drug Discount Card	D7096	0.1119	0.2161				0.2779	1.4171

CONSOLIDATED BILLING

Change to the Common Working File Skilled Nursing Facility Consolidated Billing Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site

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

Provider Types Affected

Skilled nursing facilities (SNFs), suppliers of ambulance services, and therapists.

Provider Action Needed

STOP – Impact to You

Effective on or after April 1, 2005, you must not separately bill your fiscal intermediary (FI) for transporting, by ambulance, a Medicare beneficiary in a covered Part A SNF stay, to or from an independent diagnostic testing facility (IDTF). If you do submit this ambulance transport as a Part B bill, it will be denied. Also, the SNF must submit Medicare claims for all physical and occupational therapies, and speech-language pathology services its residents received under inpatient Part B.

CAUTION – What You Need to Know

Medicare considers the ambulance transport of a beneficiary in a covered Part A SNF stay, to or from an IDTF, to be part of SNF consolidated billing (CB). Therefore, this transport is to be paid in the SNF prospective payment system (PPS) rate and may **not** be paid separately as Part B services. Therefore, on or after April 1, 2005, any such Part B ambulance claims that you bill to your FI will be denied.

GO – What You Need to Do

Make sure that your billing staffs are aware that the ambulance transport of any beneficiary in a Part A covered SNF stay to or from an IDTF cannot be separately billed under Part B. Also, be sure they are aware of the requirements to bill for the therapies mentioned in the STOP section above.

Background

Section 4432(b) of the Balanced Budget Act (BBA) requires CB for SNFs. Under CB requirements, the SNF must submit under Part A, except for certain excluded services, all Medicare claims for all the services its residents receive. Also, the SNF must submit Medicare claims for all physical and occupational therapies and speech-language pathology services its residents received under inpatient Part B. In addition, all Medicare-covered Part A services that are deemed to be within a SNF's scope or capability are considered paid in the SNF PPS rate.

Except for specific exclusions, SNF CB includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay, including those to and from IDTFs.

This instruction clarifies the current SNF CB rules for ambulance transports to or from IDTFs, and implements a change to the processing of institutional provider claims for ambulance transports of a SNF Part A stay beneficiary to or from an IDTF, when billed separately as a Part B service to the FI.

Specifically, change request (CR) 3196, which was released earlier this year, included new edits to be installed in the Common Working File (CWF) to deny ambulance suppliers' Part B claims to their carriers (on or after October 4, 2004) for ambulance transports of SNF Part A stay beneficiaries to or from an IDTF. This instruction requires the CWF to apply the same edits to these ambulance services when billed to the FI by institutional providers.

This means that ambulance transports to or from IDTFs are considered paid in the SNF PPS rate and may **not** be billed as Part B services. More specifically, ambulance transports are included in the SNF PPS rate if:

- The first or second character (origin or destination) of any healthcare common procedure coding system (HCPCS) code ambulance modifier is "D" (diagnostic or therapeutic site other than P or H); and
- The other modifier (origin or destination) is "N" (SNF).

The "D" origin/destination modifier includes cancer treatment centers, wound care centers, radiation therapy centers, and all other diagnostic or therapeutic sites.

Ambulance transports to or from renal dialysis facilities for the purpose of receiving dialysis and related services are excluded from SNF CB. In this case, the first or second character (origin or destination) of any HCPCS code ambulance modifier is a "G" (hospital-based ESRD facility) or "J" (freestanding ESRD facility), and the other modifier (origin or destination) is "N" (SNF).

SNFs are not responsible for the costs of these transports.

Under this instruction, when Medicare denies a claim for services that are covered under SNF CB, your intermediary will reflect reason code 97, "Payment is included in the allowance for another service/procedure" on the remittance advice.

Implementation

The implementation date for this instruction is April 4, 2005.

Related Instructions

Updated manual instructions are attached to the official instruction released to your intermediary. You may view that instruction by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR3427 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3427
Medlearn Matters Number: MM3427
Related CR Release Date: October 29, 2004
Related CR Transmittal #: 342
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

The information contained in this article was current at the time of its development. We encourage users of this article to review statutes, regulations and other interpretive materials for the most current information.

April Quarterly Update to 2005 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

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

Provider Types Affected

Institutional providers billing claims to Medicare fiscal intermediaries and physicians, practitioners, and suppliers billing Medicare carriers for services.

Provider Action Needed

STOP – Impact to You

HCPCS codes are being added to or removed from the SNF consolidated billing enforcement list.

CAUTION – What You Need to Know

Services included on the SNF consolidated billing enforcement list will be paid to SNF Medicare providers only. Services excluded from the SNF consolidated billing enforcement list may be paid to Medicare providers other than SNFs. See *Background* and *Additional Information* sections for further explanation.

GO – What You Need to Do

Be aware of the requirements explained below and how they can impact your Medicare payment.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (SNF PPS).

Quarterly updates now apply to both fiscal intermediaries (FIs) and carriers/durable medical equipment regional carriers (DMERCs)

This is the first joint FI/Carrier/DMERCs quarterly update published subsequent to the 2005 Annual Updates. These updates affect claims with dates of service on or after the effective date of the instructions printed below unless otherwise indicated. **Services appearing on this HCPCS list** (that are submitted on claims to both Medicare FIs and Carriers, including DMERCs), **will not be paid by Medicare to providers, other than a SNF, when included in SNF CB.**

For the annual notice on SNF CB each January, separate instructions are published for FI and carriers/DMERCs. The 2005 Annual Update for FIs can be found on the CMS website at: *http://www.cms.hhs.gov/manuals/pm_trans/R360CP.pdf.*

Information on the 2005 annual update for Carriers can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp.*

Please take note of the following important points:

- For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay.
- For physical, occupational, or speech-language therapy services, SNF CB applies whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.
- Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay.
- Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB to assure proper payment in all settings.

This notification provides a list of the exclusions, and some inclusions, to SNF CB, and the codes below are being

added or removed from the annual update. Note the following:

Major Category I additions noted below means these codes:

- May only be billed by hospitals and critical access hospitals (CAHs) for beneficiaries in SNF Part A stays, and
- Will only be paid when billed by these providers.

Major Category III additions noted below means these services:

- May be provided by any Medicare provider licensed to provide them, except a SNF, and
- Are excluded from SNF PPS and CB.

Major Category IV additions noted below means these services:

- Are covered as Part B benefits and not included in SNF PPS, however
- Must be billed by the SNF for beneficiaries in a Part A stay with Part B eligibility on type of bill (TOB) 22x.

Major Category V additions to therapy inclusions noted below means:

- SNFs alone can bill and be paid for these services when delivered to beneficiaries in a SNF, whereastypes of providers for beneficiaries **NOT** in a Part A stay or in a SNF bed receiving ancillary services billed on TOB 22x.

Computerized Axial Tomography (CT) Scans
(Major Category I, FI Annual Update, EXCLUSION)

- **Remove G0131** - computerized tomography, bone mineral density study, one or more sites; axial skeleton
- **Remove G0132** - computerized tomography, bone mineral density study, one or more sites; appendicular skeleton
- **Add 76070*** - computed tomography, bone mineral density study, one or more sites; axial skeleton
- **Add 76071*** - computed tomography, bone mineral density study, one or more sites; appendicular skeleton

Note on Codes above:
* Codes replaced HCPCS codes G0131 and G0132. The professional components of these codes were already added with the 2005 annual update as separately payable by the carrier for claims with dates of service on or after January 1, 2005.

Radiation Therapy
(Major Category I, FI Annual Update, EXCLUSION)

- **Remove C9714^** - Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; concurrent/immediate
- **Remove C9715^** - Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; delayed
- **Remove G0256?** - prostate brachytherapy
- **Add 19296^^** - placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance
- **Add 19297 ^^**- placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent
- **Add C1715** - brachytherapy needle
- **Add C1717** - brachytx seed, HDR Ir-192
- **Add C1728** - Cath, brachytx seed adm
- **Add C2633**- brachytx source, Cesium-131
- **Add C2634** - Brachytx source, HA, I-125
- **Add C2635** - Brachytx source, HA, P-103
- **Add C2636** - Brachytx linear source, P-103
- **Add C9722** - KV imaging w/IR tracking

Note on Codes above:
^ These codes were discontinued December 31, 2004.
? HCPCS code G0256 was discontinued December 31, 2003
^^ These codes are effective January 1, 2005 and replaced codes C9714 and C9715 and these codes were already added with the 2005 annual update as separately payable by the carrier for claims with dates of service on or after January 1, 2005.

Dialysis Supplies
(Major Category II, FI Annual Update, EXCLUSION)

- **Remove A4712** - water, sterile, for injection

Note: *HCPCS code A4712 was discontinued December 31, 2003.*

Chemotherapy Administration
(Major Category III, FI Annual Update, EXCLUSION)

- **Add G0357+** - Intravenous, push technique, single or initial substance/drug
- **Add G0358+** - Intravenous, push technique, each additional substance/drug
- **Add G0359+** - chemotherapy administration, intravenous infusion technique, up to one hour, single or initial

substance/drug
- **Add G0360+** - Each additional hour, 1 to 8 hours
- **Add G0361+** - initiation of prolonged chemotherapy infusion (more than 8 hours)
- **Add G0362+** - Each additional sequential infusion (different substance/drug), up to 1 hour
- **Add G0363+** - Irrigation of implanted venous access device for drug delivery systems

Note on Codes above:
+ These codes were effective January 1, 2005. These codes were already added with the 2005 annual update as separately payable by the Medicare carrier for claims with dates of service on or after January 1, 2005.

Mammography
(Major Category IV, FI Annual Update, EXCLUSIONS)

- Remove G0203 - screening mammography

Note**: HCPCS code G0203 was discontinued December 31, 2001.**

Diabetic Screening
(Major Category IV, FI Annual Update, EXCLUSIONS)

- Add 82950 - Glucose; post glucose dose

Note**: This is not a physician service and will not be added as separately payable by the Medicare carrier.**

New Preventive Benefit (Per section 611 of the Medicare Modernization Act (MMA)– Initial Preventive Physical Exam
(Major Category IV, FI Annual Update, EXCLUSIONS)

- **Add G0344** – Initial prev exam
- **Add G0367•** - EKG tracing for initial prev

Note on Code above:
• HCPCS code G0367 was effective January 1, 2005. Only the corresponding professional component of this code, G0368, will be separately payable by the carrier. It was already added with the 2005 annual update. G0367 is the technical component only and will be subject to consolidated billing.

Therapies
(Major Category V, FI Annual Update, INCLUSIONS)

- Update for HCPCS 92605 and 92606 already included in the 2005 annual update. Payment for these codes is bundled with other rehabilitation services. They may be bundled with any therapy code. No payment can be made for these codes.
- Remove 92601 - Cochlear implant w/ programming
- Remove 92602 - Cochlear implant, subsequent programming
- Remove 92603 - Diagnostic analysis, cochlear implant w/ programming
- Remove 92604 - Diagnostic analysis, cochlear implant, subsequent programming
- Remove 92525 - Evaluation of swallowing
- Remove 97014 - E stim unattended (not payable by Medicare)(this was replaced by G0283)
- Remove 97545 - Work hardening, initial 2 hrs
- Remove 97546 - Work hardening, each add'l hr
- Add 96110 - Development testing, limited
- Add 96111 - Developmental testing, extended
- Add 96115 - Neurobehavioral status exam

Note: HCPCS code 92525 was discontinued December 31, 2002.

Note: **Section 1888 of the Social Security Act codifies SNF PPS and CB. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.**

Implementation

The implementation date for this instruction is April 4, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR 3683 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3683
Related CR Release Date: January 21, 2005
Effective Date: April 1, 2005
Medlearn Matters Number: MM3683
Related CR Transmittal #:449
Implementation Date: April 4, 2005

Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp)

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

Provider Types Affected

Skilled Nursing Facilities (SNF), physicians, suppliers, end-stage renal disease (ESRD) facilities and hospitals.

Provider Action Needed

This Special Edition is informational only and describes SNF Consolidated Billing (CB) as it applies to Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) and related services.

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These excluded services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of services (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier [DMERC]).

Background

The original Balanced Budget Act of 1997 list of exclusions from the PPS and CB for SNF Part A residents specified the services described in section 1861(s)(2)(O) of the Social Security Act—the Part B erythropoietin (EPO) benefit. This benefit covers EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secretary for its safe and effective use (see 42 CFR 405.2163(g) and (h)). See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB.

This article can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*

Regulations at 42 CFR 414.335 describe payment for EPO and require that EPO be furnished by either a Medicare approved end stage renal eisease (ESRD) facility or a supplier of home dialysis equipment and supplies. The amount that Medicare pays is established by law. Thus, the law and implementing regulations permit a SNF to unbundle the cost of the Epogen drug when it is furnished by an ESRD facility or an outside supplier, which can then bill their carrier/intermediary for it.

An SNF that elects to furnish EPO to its Part A resident itself cannot be separately reimbursed over and above the Part A SNF PPS per diem payment amount for the Epogen drug. As explained above, the exclusion of EPO from CB and the SNF PPS applies only to those services that meet the requirements for coverage under the separate Part B EPO benefit, i.e., those services that are furnished and billed by an approved ESRD facility or an outside dialysis supplier.

By contrast, if the SNF itself elects to furnish EPO services (including furnishing the Epogen drug) to a resident during a covered Part A stay (either directly with its own resources, or under an "arrangement" with an outside supplier in which the SNF itself does the billing), the services are no longer considered Part B EPO services, but rather, become Part A SNF services. Accordingly, they would no longer qualify for the exclusion of Part B EPO services from CB, and would instead be bundled into the PPS per diem payment that the SNF receives for its Part A services.

Note: The Part B coverage rules that apply to EPO are applied in the same manner to Aranesp. (See Medicare Claims Processing Manual, Pub.100-04, Chapter 8 – Outpatient ESRD Hospital, Independent Facility, and Physician/ Supplier Claims, §60.7.2; see also Medicare Benefit Policy Manual, Pub. 100-02, Chapter 11 – End Stage Renal Disease (ESRD), §90). Accordingly, Aranesp is now excluded on the same basis as EPO.

Note: EPO (Epoetin Alfa, trade name Epogen)/DPA (Darbepoetin Alfa, trade name Aranesp) are not separately billable when provided as treatment for any illness other than ESRD. In this case, the SNF is responsible for reimbursing the supplier. The SNF should include the charges on the Part A bill filed with its intermediary for that beneficiary.

Additional Information

Medlearn Matters SE0431, containing the list of services excluded from SNF CB, can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf.*

The Medicare Renal Dialysis Facility Manual, Chapter II, Coverage of Services can be found at the following CMS web site: *http://www.cms.hhs.gov/manuals/29_rdf/rd200.asp?#_1_17*

Also, you can find the Medicare Benefit Policy Manual Chapter 11 and Chapter 17 regarding billing and payment details for EPO and DPA at the following CMS web site: *http://www.cms.gov/manuals/102_policy/bp102c11.pdf* and: *http://www.cms.gov/manuals/102_policy/bp102c17.pdf*

The CMS Consolidated Billing web site can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The CMS Skilled Nursing Facility Prospective Payment System (SNF PPS) web site can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

Related Change Request (CR) #: N/A Medlearn Matters Number: SE0434
Effective Date: N/A Implementation Date: N/A

Skilled Nursing Facility Consolidated Billing

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article. The original article was published in the First Quarter 2005 Medicare B Update! (pages 65-66).

NOTE: This article was revised on January 20, 2005 to include clarifying language, but no substantive changes were made.

Provider Types Affected

All Medicare providers, suppliers, physicians, skilled nursing facilities (SNFs), and rural swing bed hospitals.

Provider Action Needed

This article is informational only and is intended to remind affected providers that SNFs must submit all Medicare claims for the services its residents receive, except for a short list of specifically excluded services as mentioned in the "Excluded Services" below. This requirement was established initially as specified in the Balanced Budget Act of 1997 (BBA, P.L. 105-33) and is known as SNF Consolidated Billing (CB).

Clarification: The SNF CB requirement make the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These included services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare DMERC.)

Background

Prior to the Balanced Budget Act of 1997 (BBA), a SNF could elect to furnish services to a resident in a covered Part A stay, either:

- Directly, using its own resources;
- Through the SNF's transfer agreement hospital; or
- Under arrangements with an independent therapist (for physical, occupational, and speech therapy services).

In each of these circumstances, the SNF billed the Medicare Part A intermediary for the services.

However, the SNF also had the further option of "unbundling" a service altogether; that is, the SNF could permit an outside supplier to furnish the service directly to the resident, and the outside supplier would submit a bill to its Medicare Part B carrier (or DMERC), without any involvement of the SNF itself. This practice created several problems, including the following:

- A potential for duplicate (Parts A/B) billing if both the SNF and outside supplier billed;

- An increased out-of-pocket liability incurred by the beneficiary for the Part B deductible and coinsurance even if only the supplier billed; and
- A dispersal of responsibility for resident care among various outside suppliers adversely affected quality (coordination of care) and program integrity, as documented in several reports by the Office of the Inspector General (OIG) and the General Accounting Office (GAO).

Based on the above-mentioned problems, Congress enacted the BBA, Public Law 105-33, Section 4432(b), and it contains a CB requirement for SNFs. Under the CB requirement, **an SNF itself must submit all Medicare claims for the services that its residents receive** (except for specifically excluded services listed below).

Conceptually, SNF CB resembles the bundling requirement for inpatient hospital services that's been in effect since the early 1980s—assigning to the facility itself the Medicare billing responsibility for virtually the entire package of services that a facility resident receives, except for certain services that are specifically excluded.

CB eliminates the potential for duplicative billings for the same service to the Part A fiscal intermediary by the SNF and the Part B carrier by an outside supplier. It also enhances the SNF's capacity to meet its existing responsibility to oversee and coordinate the total package of care that each of its residents receives.

Effective Dates

CB took effect as each SNF transitioned to the Prospective Payment System (PPS) at the start of the SNF's first cost reporting period that began on or after July 1, 1998.

The original CB legislation in the BBA applied this provision for services furnished to every resident of an SNF, regardless of whether Part A covered the resident's stay. However, due to systems modification delays that arose in connection with achieving Year 2000 (Y2K) compliance, the Centers for Medicare & Medicaid Services (CMS) initially postponed implementing the Part B aspect of CB, i.e., its application to services furnished during noncovered SNF stays.

The aspect of CB related to services furnished during noncovered SNF stays has now essentially been repealed altogether by Section 313 of the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554, Appendix F). Thus, with the exception of physical therapy, occupational therapy, and speechlanguage pathology services (which remain subject to CB regardless of whether the resident who receives them is in a covered Part A stay) this provision now applies only to those services that an SNF resident receives during the course of a covered Part A stay.

Excluded Services

There are a number of services that are excluded from SNF CB. These services are outside the PPS bundle, and they remain separately billable to Part B when furnished to an SNF resident by an outside supplier. However, Section 4432[b][4] of the BBA (as amended by Section 313[b][2] of the BIPA) requires that bills for these particular excluded services, when furnished to SNF residents, must contain the SNF's Medicare provider number. Services that are categorically excluded from SNF CB are the following:

- Physicians' services furnished to SNF residents. These services are not subject to CB and, thus, are still billed separately to the Part B carrier.
- Certain diagnostic services include both a professional component (representing the physician's interpretation of the test) and a technical component (representing the test itself), and the technical component is subject to SNF CB. **The technical component of these services must be billed to and reimbursed by the SNF**. (See Medlearn Matters Special Edition Article SE0440 for a more detailed discussion of billing for these diagnostic tests.)
- Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that **physical therapy, occupational therapy, and speech-language pathology services are subject to CB**, even when they are furnished by (or under the supervision of) a physician.
- Physician assistants working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists;
- Certified registered nurse anesthetists;
- Services described in Section 1861(s)(2)(F) of the Social Security Act (i.e., Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies);
- Services described in Section 1861(s)(2)(O) of the Social Security Act, i.e., Part B coverage of Epoetin Alfa (EPO, trade name Epogen) for certain dialysis patients. Note: Darbepoetin Alfa (DPA, trade name Aranesp) is now excluded on the same basis as EPO;
- Hospice care related to a resident's terminal condition;
- An ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge.

Physician "Incident To" Services

While CB excludes the types of services described above and applies to the professional services that the practitioner performs personally, ***the exclusion does not apply to physician "incident to"* services** furnished by someone else as an "incident to" the practitioner's professional service. These "incident to" services furnished by others to SNF residents are subject to CB and, accordingly, must be billed to Medicare by the SNF itself.

In Program Memorandum (PM) Transmittal # A-98-37 (November 1998, reissued as PM transmittal # A-00- 01, January 2000), CMS identified specific types of outpatient hospital services that are so exceptionally intensive or costly that they fall well outside the typical scope of SNF care plans. CMS has excluded these services from SNF CB as well (along with those medically necessary ambulance services that are furnished in conjunction with them). These excluded service categories include:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnetic resonance imaging (MRIs);
- Ambulatory surgery that involves the use of an operating room;

- Emergency services;
- Radiation therapy services;
- Angiography; and
- Certain lymphatic and venous procedures.

Effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) has identified certain additional exclusions from CB. The additional exclusions enacted in the BBRA apply only to certain specified, individual services ***within*** a number of broader service categories that otherwise remain subject to CB. Within the affected service categories the exclusion applies only to those individual services that are specifically identified by HCPCS code in the legislation itself, while all other services within those categories remain subject to CB. These service categories are:

- Chemotherapy items and their administration;
- Radioisotope services; and
- Customized prosthetic devices.

In addition, effective April 1, 2000, this section of the BBRA has unbundled those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services.

Finally, effective January 1, 2004, as provided in the August 4, 2003 final rule (68 Federal Register 46060), two radiopharmaceuticals, Zevalin and Bexxar, were added to the list of chemotherapy drugs that are excluded from CB (and, thus, are separately billable to Part B when furnished to a SNF resident during a covered Part A stay).

Effects of CB

SNFs can no longer "unbundle" services that are subject to CB to an outside supplier that can then submit a separate bill directly to the Part B carrier. Instead, the SNF itself must furnish the services, either directly, or under an "arrangement" with an outside supplier in which the SNF itself (rather than the supplier) bills Medicare. The outside supplier must look to the SNF (rather than to Medicare Part B) for payment.

In addition, SNF CB:

- Provides an essential foundation for the SNF PPS, by bundling into a single facility package all of the services that the PPS payment is intended to capture;
- Spares beneficiaries who are in covered Part A stays from incurring out-of-pocket financial liability for Part B deductibles and coinsurance;
- Eliminates potential for duplicative billings for the same service to the Part A fiscal intermediary (FI) by the SNF and to the Part B carrier by an outside supplier; and
- Enhances the SNF's capacity to meet its existing responsibility to oversee and coordinate each resident's overall package of care.

Additional Information

While this article presents an overview of the SNF CB process, CMS also has a number of articles that provide more specifics on how SNF CB applies to certain services and/or providers. These articles are as follows:

- Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0432.pdf*
- Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Service *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0433.pdf*
- Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0434.pdf*
- Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0435.pdf*
- Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0436.pdf*
- Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf*
- Medicare Prescription Drug, Improvement, and Modernization Act – Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0438.pdf*
- Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0439.pdf*
- Skilled Nursing Facility Consolidated Billing as It Relates to Certain Diagnostic Tests *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0440.pdf*
- Skilled Nursing Facility Consolidated Billing and "Incident To" Services (Services That Are Furnished as an Incident to the Professional Services of a Physician or Other Practitioner) (coming soon) In addition, the CMS SNF Consolidated Billing Website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb.*

It included the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0431
Effective Date: N/A Revised
Implementation Date: N/A

END STAGE RENAL DISEASE

Medicare Termination of Beneficiaries With End Stage Renal Disease

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

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

Physicians, suppliers, and providers should note that this instruction provides information to Medicare intermediaries, including regional home health intermediaries, on handling overpayment issues related to end-stage renal disease (ESRD) beneficiaries whose Medicare Part A coverage should have ended prior to December 1999.

It also tells contractors what to do if another third-party payer has voluntarily made or voluntarily makes a primary payment to the individual or entity when Medicare also paid for the services.

Background

Entitlement for individuals with ESRD is governed under the Social Security Act (Section 226A). In addition, under the Social Security Act (Section 226A[b][2]), Medicare Part A benefits based on ESRD will be terminated:

- Thirty-six (36) months after the month the individual receives a kidney transplant; or
- Twelve (12) months after the month in which the individual who has not received a kidney transplant no longer requires a regular course of dialysis.

However, when Part A entitlement is not terminated in a timely manner, the Social Security Act (Section 1837(h)) permits Part A entitlement to extend up through the month the individual is notified that Part A coverage has been terminated.

Generally, this means that no attempt will be made to recover any payments that Medicare previously made for Part A covered items and services. However, Medicare payments should be accepted in instances where another third-party payer has voluntarily made or voluntarily makes a primary payment for the items and services to the individual or other entity that Medicare paid, if the third party payer voluntarily repays Medicare its primary payment.

In November 2003 the Social Security Administration (SSA) terminated the Medicare coverage of approximately 8,000 individuals for Part A services and issued a notice to each beneficiary.

The notice provided the date(s) that Medicare coverage ends and gave the beneficiary the right to file an appeal. Also, neither beneficiaries nor providers are being held financially liable for items and services received prior to the formal notice of Medicare termination to the extent that another third party payer has not voluntarily made or does not voluntarily make a primary payment for any items and services.

Medicare intermediaries have been instructed not to issue demand letters or recoup Part A payments made to fee-for-service providers who have received payments on behalf of these individuals. The period for not issuing the demand letters or recouping Part A payments is the period on or after the date of Part A termination up to the final notice of termination of coverage from the Social Security Administration, which is November 2003.

In addition, Medicare intermediaries shall not reopen

any cost reports or claims paid for recouping these payments for services made to fee-for-service providers for these beneficiaries during the timeframes defined in the preceding paragraph.

This instruction relates to this subset of Medicare beneficiaries and does not revise Medicare policies.

Implementation

The implementation date for this instruction is April 4, 2005.

Additional Information

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

From that web page, look for CR2923 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 2923	Medlearn Matters Number: MM2923
Related CR Release Date: October 29, 2004	Related CR Transmittal #: 13
Effective Date: April 1, 2005	Implementation Date: April 4, 2005

The information contained in this article was current at the time of its development. We encourage users of this article to review statutes, regulations and other interpretive materials for the most current information.

End-Stage Renal Disease Reimbursement for Automated Multi-Channel Chemistry Tests

This information was previously published in the First Quarter 2005 Medicare B Update! pages 40-41
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

IMPORTANT NOTE: CR 2813 been revised by CR 3609, Emergency Change to Carrier Instructions for the End Stage Renal Disease (ESRD) 50/50 Rule Implementation. CR 3609 notifies carriers to discontinue the implementation of the business requirements associated with CR 2813 until further notice. To see MM3609, the Medlearn Matters article related to CR 3609, go to: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3609.pdf.*

Provider Types Affected

Physicians, suppliers, and ESRD facilities.

Provider Action Needed

Affected providers should note that this instruction begins the implementation of procedures to enforce compliance with the 50/50 payment policy for ESRD-related laboratory services. The Centers for Medicare & Medicaid Services (CMS) is staggering the programming for this payment policy over multiple releases. Independent labs are not to revise their billing procedures at this time. CMS will release additional provider education in the future to educate providers regarding the effective date of revised billing procedures. Medicare carriers will have front-end edits to reject any line items containing the "CD," "CE," or "CF" modifiers, as referenced in this article, until further notice.

Background

Medicare's composite rate payment to an ESRD facility or monthly capitation payment (MCP) to a physician includes reimbursement for certain routine clinical laboratory tests furnished to an ESRD beneficiary.

- Separate payment for automated multi-channel chemistry (AMCC) tests (for an ESRD beneficiary) **is** permitted when **more** than 50 percent of all Medicare-covered AMCC tests furnished on a particular date of service are tests that are not included in the composite payment rate paid to the ESRD facility or capitation payment made to the MCP physician. In this event, all of the AMCC tests (composite payment rate tests and non-composite payment rate tests) furnished on that date are separately payable.
- Separate payment for AMCC tests (for an ESRD beneficiary) **is not** permitted if **less** than 50 percent of all Medicare-covered AMCC tests furnished on a particular date of service are tests that are not included in the composite payment rate paid to the ESRD facility or capitation payment made to the MCP physician. In this event, no AMCC tests (including non-composite payment rate tests) furnished on that date are separately payable.

In other words, if 50 percent or more of the covered tests are included under composite payment rate tests, then all submitted claims are included within the composite payment. In this case, no separate payment in addition to the composite payment rate is made for any of the separately billable tests. However, if more than 50 percent of the covered tests are non-composite payment rate tests, then all AMCC tests submitted for that date of service are separately payable.

Defining Non-Composite Payment Rate Tests

A non-composite payment rate test is defined as any test separately reimbursable outside of the composite payment rate or beyond the normal frequency covered under the composite payment rate that is reasonable and necessary. Also, all chemistries ordered for beneficiaries with chronic dialysis for ESRD must be billed individually and must be rejected when billed as a panel.

The physician who orders the tests is responsible for identifying the appropriate modifier when ordering the test(s), and three pricing modifiers discretely identify the different payment situations for ESRD AMCC services as follows:

- **CD –** AMCC test that has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.
- **CE –** AMCC test that has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.
- **CF –** AMCC that is not part of the composite rate and is a separately billable test that has been ordered by an ESRD facility or MCP physician.

In addition, the ESRD clinical laboratory test identified with modifiers "CD", "CE," or "CF" may not be billed as organ or disease panels. Upon the effective date of this requirement, all ESRD clinical laboratory tests must be billed individually.

Carrier Standard System Calculation

The Medicare carrier's standard system will calculate the number of AMCC services provided for any given date of service. For a date of service, it should add all AMCC tests that have a CD modifier and divide by the sum of all line items with a CD, CE, or CF modifier for the same beneficiary and billing supplier/provider for any given date of service.

- If the result of the calculation for a date of service is 50 percent or greater, the carrier will not pay for the test.
- If the result of the calculation for a date of service is less than 50 percent, the carrier will pay for the entire test.

The carrier will adjust a previous claim when the incoming claim for a date of service is compared to a claim history and the action is to pay a previously denied claim. The Medicare carrier will spread the payment amount over each line item on both claims (the claim on history and the incoming claim).

ESRD Facilities

ESRD facilities must specify for each test, when ordering an ESRD-related AMCC tests, whether the test is:

- Part of the composite rate and not separately payable;
- A composite rate test but is, on the date of the order, beyond the frequency covered under the composite rate and thus separately payable; or
- Not part of the ESRD composite rate and thus separately payable.

Laboratories

Laboratories must identify the following:

- Tests not included within the ESRD facility composite rate payment.
- Tests ordered for chronic dialysis for ESRD as follows:
- Modifier CD: AMCC Test that is part of the composite rate and is not separately billable and has been ordered by an ESRD facility or MCP physician.
- Modifier CE: AMCC Test that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity and has been ordered by an ESRD facility or MCP physician.
- Modifier CF: AMCC Test that is not part of the composite rate and is separately billable and has been ordered by an ESRD facility or MCP physician.
- Bill all tests ordered for a chronic dialysis ESRD beneficiary individually and not as a panel.

The laboratory tests subject to this rule are those tests included within AMCC tests and then only when furnished to an ESRD beneficiary, based upon an order by:

- A doctor rendering care in the dialysis facility; or
- An MCP physician for the diagnosis and treatment of the beneficiary's ESRD.

Implementation

ON HOLD See Medlearn Matters article MM3609.

Related Instructions

The Medicare Claims Processing Manual, Chapter 16 (Laboratory Services from Independent Labs, Physicians, and Providers), Section 40 (Billing for Clinical Laboratory Tests), Subsection 6.1 (Billing for End Stage Renal Disease (ESRD) Related Laboratory Tests) was revised and can be found in Transmittal 79 of Pub 100-04, the original release of CR2813. This original CR may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R79CP.pdf*

The latest re-issuance, which includes tables listing the tests involved in this issue, may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R164CP.pdf*

This transmittal, which is Transmittal 164, also has some helpful examples of billing these tests as well as tables to show which tests are part of the composite rate and which are not.

Related Change Request (CR) #: 2813
Medlearn Matters Number: MM2813
Related CR Release Date: April 30, 2004 Revised
Related CR Transmittal #:198
Effective Date: October 4, 2004
Implementation Date: ON HOLD, based on Medlearn Matters article MM3609

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

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
Previously published in the Fourth Quarter 2004 Medicare Part B Update! (page 24)

NOTE: This article was revised on November 26, 2004 to delete an incorrect reference to organ and disease-oriented panels from the shaded box on page 2.

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

Physicians, suppliers, and providers should note that this instruction expands the implementation of certain processing rules to all bill types for automated multi-channel chemistry (AMCC) tests for end stage renal disease (ESRD) beneficiaries.

Background

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

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

This instruction expands the implementation of procedures for reimbursement of AMCC tests to all bill types for ESRD beneficiaries.

Implementation

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

Related Instructions

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

An extract of Section 40.6.1 is included as follows:

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

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

(Rev. 1, 10-01-03) A-03-033

Medicare will apply the following rules to AMCC tests for ESRD beneficiaries:

- Payment is at the lowest rate for services performed by the same provider, for the same beneficiary, for the same date of service.
- The facility must identify, for a particular date of service, the AMCC tests ordered that are included in the composite rate and those that are not included. See Chapter 8 for the composite rate tests for hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD), hemofiltration, and continuous ambulatory peritoneal dialysis (CAPD).
- If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.
- If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that date of

service (DOS) for that beneficiary are separately payable.

- A non-composite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary.

(See Section 100.6 for details regarding pricing modifiers.)

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

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

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

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

Additional Information

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

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

From that web page, look for CR 3239 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

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

New Case-Mix Adjusted End-Stage Renal Disease (ESRD) Composite Payment Rates and New Composite Rate Exceptions Window for Pediatric ESRD Facilities

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

Provider Types Affected

Physicians, providers, and suppliers.

Provider Action Needed

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that the Centers for Medicare & Medicaid Services (CMS) use a limited number of patient characteristics in establishing a basic case-mix adjusted prospective payment system for dialysis services furnished by providers and renal dialysis facilities to individuals in a facility or in their home. The current composite payment rates will be adjusted for individual patient characteristics and budget neutrality for services furnished on or after April 1, 2005.

Background

In accordance with the Social Security Act (Section 1881[b][12][A]), as added by the MMA (Section 623[d][1]), the CMS "shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to individuals at home. The case-mix under the system would be for a limited number of patient characteristics."

Use of a case-mix measure permits targeting of greater payments to facilities that treat more costly and more resource-intensive patients, and the methodology for applying patient characteristic adjusters applicable to each treatment will determine the case-mix adjustment that will vary for each patient. Thus, an ESRD facility's average composite payment rate per treatment will depend on the unique case mix of their patients. The patient characteristic variables that are utilized in determining an individual patient's case-mix adjusted composite payment rate include

- Five age groups;
- A low body mass index (BMI);
- A body surface area (BSA); and
- An adjustment for pediatric patients.

Note that pediatric ESRD patients (defined as under the age of 18) receive a specific case-mix adjustment factor. As a result, none of the other case-mix adjustors (i.e. the five age groups, low BMI and BSA) are applicable to pediatric ESRD patients.

Medicare has established software, known as the ESRD Pricer Program, to automatically calculate the composite payment rate for a particular patient for a particular month(s). As an example, the ESRD Pricer Program utilizes each patient's height and weight as reported on billing form CMS UB-92 to automatically calculate the low BMI and BSA case-mix adjustments to an ESRD facility's composite payment rate.

While payment formulas may change, Medicare is required to maintain overall budget neutrality and overall payments will not increase or decrease as a result of changes in the payment methodology. Therefore, the case-mix adjusted composite rate payments for 2004 must result in the same aggregate expenditures for 2005 (as if the adjustments are not made).

While the magnitude of some of the patient-specific case-mix adjustment factors appears to be significant, facility variation in the case-mix is limited. Regardless of the type of provider, the average case-mix adjustments for patient characteristics do not vary significantly. This is because of the overall similarity of the distribution of

patients among the eight case-mix classification categories across facility classification groups.

Since ESRD facilities can maintain their current exception rates, CMS expects ESRD facilities to compare their exception rate to their basic case-mix adjusted composite rate to determine the best payment rate for their facility.

Each dialysis facility has the option of continuing to be paid at its exception rate or at their basic case-mix adjusted composite rate (which includes all the MMA 623 payment adjustments).

If the facility retains its exception rate, it is not subject to any of the adjustments specified in Section 623 of the MMA. Determinations as to whether an ESRD facility's exception rate per treatment will exceed its average case-mix adjusted composite rate per treatment are left to the entities affected.

Each ESRD facility is allowed to notify its fiscal intermediary (in writing) at any time if it wishes to give up or withdraw its exception rate and be subject to the basic case-mix adjusted composite payment rate methodology. The case-mix adjusted composite payment rates will begin 30 days after the intermediary's receipt of the facility's notification letter. ESRD facilities electing to retain their exceptions do not need to notify their intermediaries.

Pediatric facilities should note that the MMA requires the opening of a new pediatric facility exception request window for such facilities that **did not have an approved exception rate** as of October 1, 2004. MMA defines a pediatric facility as a renal facility with at least 50 percent of whose patients are under 18 years of age. If a pediatric facility should project, on the basis of prior years cost and utilization trends that it will have an allowable cost per treatment higher than the prospective rate, the facility may request that CMS approve an exception to that rate and set a higher prospective payment rate. ***Pediatric facilities must submit request such requests from April 1, 2005 to September 27, 2005 in order for the request to be considered. The September 27, 2005 deadline will not be extended.***

CMS will adjudicate such exception requests in accordance with the procedure outlined in regulation at 42 CFR 413.180 and at Chapter 27 of Part I of the Provider Reimbursement Manual (PRM). Part I of the PRM can be accessed at: *http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp*. Please note that if the facility fails to adequately justify its pediatric exception request, such request would be denied.

Providers and facilities should note the following with regard to claims submissions:

- Be sure to populate Value Code A8 on Types of Bill (TOB) 72X with patient weight in kilograms or your claim will be returned.
- Be sure to populate Value Code A9 on TOBs 72X with patient height in centimeters or your claim will be returned.
- Because this new payment process is effective on April 1, 2005, renal dialysis facilities (RDFs) must split all ESRD claims that overlap April 1, 2005. I.e., the facility should split claims where the Through Date is on or after April 1, 2005, and the From Date is prior to April 1, 2005.
- RDFs should use Condition Code 80 when an ESRD beneficiary receives Home Dialysis in Nursing Facilities, including Skilled Nursing Facilities (SNFs).
- RDFs should also continue to use Condition Code 74 when an ESRD beneficiary receives Home Dialysis in Nursing Facilities, including SNFs.

Implementation

The implementation date for this instruction is April 4, 2005.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change.

That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR 3572 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: 3572
Medlearn Matters Number: MM3572
Related CR Release Date: November 19, 2004
Related CR Transmittal #: 370
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

EVALUATION AND MANAGEMENT

Nursing Facility Visits (Codes 99301 – 99313)—CR 3096 Rescinded

The Centers for Medicare & Medicaid Services (CMS) has rescinded Change Request 3096, Transmittal 302.

The Medlearn Matters article related to Change Request 3096 was published in the First Quarter 2005 *Medicare B Update!* (pages 42-43).

Source of Rescinded Change Request: CMS Pub 100-4 Transmittal 302, CR 3096

LABORATORY

Payment for Referred Laboratory Automated Multi-Channel Chemistry Tests

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

Provider Types Affected

Providers of laboratory services.

Provider Action Needed

This article summarizes the revised Medicare payment guidelines for automated multi-channel chemistry **(**AMCC) laboratory tests that a billing laboratory refers to other laboratories located outside of your carrier's processing jurisdiction.

Background

The Medicare Claims Processing Manual, Publication 100-04, Chapter 16, Section 90 (Automated Profile Tests and Organ/Disease Oriented Panels) provides that Medicare-covered laboratory tests may be billed either individually or as organ/disease panels.

In either case, your carrier must group the individual tests together, and consider the price of all of the related AMCC tests performed on the same day by the same physician/supplier, for a particular beneficiary.

The current guidelines for calculating the amounts payable for laboratory AMCC tests/panels do not require contractors to distinguish between:

- Those tests/panels that were performed by the billing laboratory; and
- Those that were referred to another laboratory and billed by the referring laboratory.

CR 3483 changes this policy for all AMCC tests. Effective April 1, 2005, if AMCC tests/panels are referred to another laboratory(s) for processing, your carrier must calculate the amount payable for each locality in which the particular test or panel is performed.

Carrier's Payment Process

The following are the general steps in your carrier's payment process (as outlined in Chapter 16, Section 90 of the Medicare Claims Processing Manual).

1. Deny Duplicates

Claims with the following characteristics will be considered as duplicates and will be denied:

- The service was performed by the same provider,
- For the same beneficiary, and
- For the same date of service.

2. Determine Medical Necessity

3. Process the claims using the following procedure to calculate the amounts payable for the individual AMCC tests and AMCC panels.

a. Unbundle all panels down to single lines representing individual AMCC tests, and identify duplicate tests within the claim. On concurrently processed claims, the carrier will determine the total amount payable based on the combination of all AMCC tests billed by the same laboratory, for the same beneficiary, and for the same date of service.
b. Check previously processed claims for AMCC services provided by the same provider for the same day to the same beneficiary; the carrier will unbundle any panels, identify duplicate services, and aggregate all nonduplicate services for pricing (include the submitted charge and paid amounts for both individually and paneled billed claims).

If a single organ disease panel or a single chemistry panel contains the only AMCC test claims for that date of service, the carrier will adjudicate as billed.

c. Compare each line's submitted charge to the fee schedule for that code including automated tests retrieved from previously processed claims.
d. Add the comparisons line by line.
e. Obtain the fee for all AMCC tests as a panel, including all services in the history. If organ disease panels are involved, this amount would include fees for no automated test included in the organ disease panel.
f. The carrier will carry forward the lesser of items d or e.
g. For steps (a-c) above, when one or more tests have been referred to another laboratory for processing, the carrier will calculate each claim price by locality, using the fee schedule amount for each locality. The carrier will use the total number of allowable AMCC tests (both referred and nonreferred) to calculate the amount payable for each test.

EXAMPLE: If three tests are performed within the local carrier's jurisdiction and two are referred to another laboratory for processing:

1. Determine the amount payable for the five tests in each payment jurisdiction.
2. Divide the total fee schedule amount for all tests being priced by the total number of allowable AMCC tests (in this example, five tests). The result is the unit price for each test.
3. Multiply this result by the total number of AMCC tests performed within each pricing jurisdiction. In this example, three tests were performed in jurisdiction 1 and two tests were performed in jurisdiction 2.
4. Repeat this process for each pricing jurisdiction. In this example, there are two pricing jurisdictions. In jurisdiction 1, the amount payable is calculated by dividing the total fee schedule amount for jurisdiction 1 by five, and multiplying the result by three. Similarly, the amount payable for jurisdiction 2 is calculated by dividing the total fee schedule amount for jurisdiction 2 by five, and multiplying the result

by two.
5. Add the two results (i.e., jurisdiction 1 amount + jurisdiction 2 amount).
6. Compare this calculated amount to the submitted charges for the AMCC tests to determine the amount payable. The amount payable is the lower of the fee schedule amount versus the submitted charges.

h. Your carrier will carry forward the lesser of either the fee schedule amount or the submitted charges, as determined in step g.
i. Your carrier will subtract from the amount in item (h) any previous automated laboratory test (individual or paneled) or organ disease panel containing automated tests payments. If nothing is payable on the claim, the carrier will accept the claim with no payment.
j. The amount payable is the total payable based on the combination of current and previously processed claims, less the total amount paid on the previous claim(s).

The above description is an example only. Your carrier has the flexibility to vary these procedures as long as they attain the same result.

Additional Information

You can find more information about these changes by viewing the official instruction issued to your carrier. That instruction is available at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR 3483 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3483
Medlearn Matters Number: MM3483
Related CR Release Date: November 19, 2004
Related CR Transmittal #: 372
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Routine Venipuncture – Clarification

This instruction clarifies the information published in the January 2005 Medicare B Update! Special Issue–2005 HCPCS and MPFSDB Update (page 75)

For 2005, the clinical laboratory fee schedule will not include code G0001 because it has been discontinued. However, code 36415 (*Collection of venous blood by venipuncture*) has now been activated to be payable by Medicare effective for services rendered on or after January 1, 2005.

Source: CMS Pub. 100-04 , Transmittal: 363 Date: November 1, 2004 Change Request 3526

PHYSICAL/OCCUPATIONAL THERAPY

2004 Changes to Outpatient Rehabilitation Services

The following changes have been made to the list of applicable outpatient rehabilitation therapy CPT/HCPCS codes effective for services furnished **on or after January 1, 2004.**

- *CPT* code *97755* has been added to the list.
- *CPT* code *97010* has been added to the list, however this code must be bundled with any therapy code. Regardless of whether it is billed alone or in conjunction with another therapy code, this code is not paid separately. If the code is billed alone, it will be denied.
- *CPT* codes *92601, 92602, 92603, 92604,* and HCPCS codes V5362, V5363, V5364 have been removed from the list. These codes are no longer applicable outpatient rehabilitation therapy codes for services furnished **on or after January 1, 2004.**

Billing Requirements

Billing requirements and guidelines for outpatient rehabilitation services were published in the Fourth Quarter 2003 *Medicare B Update!* (pages 34-36)

Source: CMS Pub 100-4 Transmittal 30, CR 2973

PSYCHIATRIC

Psychotherapy Notes

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

Provider Types Affected

Psychotherapists and providers billing Medicare carriers or Fiscal Intermediaries (FIs) for psychotherapy services.

Provider Action Needed

This article and related CR 3457 provide information about instructions to Medicare carriers/intermediaries not to deny claims for psychotherapy on the basis that providers failed to produce psychotherapy notes in response to a broad carrier/intermediary request for documentation. Providers are exempt from submitting psychotherapy notes without patient authorization when the notes in question fit the Final Privacy Rule, 45 CFR, Section 164.501. However, patient authorization is not required for the release of information excluded from the definition of psychotherapy notes, and the provider should release the nonpsychotherapy note material to demonstrate medical necessity. If the provider does not submit sufficient information to demonstrate that services were medically necessary, the claim will be denied.

Background

Psychotherapy notes are defined as notes recorded by a mental health professional that 1) document or analyze the contents of a counseling session and 2) are separated from the rest of a medical record (see Final Privacy Rule, 45 CFR, Part 164.501).

The definition of psychotherapy notes expressly excludes the following information:

- Medication prescription and monitoring,
- Counseling session start and stop times,
- Modalities and frequencies of treatment furnished, and
- Results of clinical tests, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.

The preceding class of information does not qualify as psychotherapy note materials, and physically integrating this information into protected psychotherapy notes does not automatically transform it into protected information.

It is important to note that if a provider has combined information excluded from the definition of psychotherapy notes with a psychotherapy note (e.g., symptoms), it is the responsibility of the provider to extract the information needed to support that a Medicare claim is reasonable and necessary.

Also, providers are exempt from submitting psychotherapy notes without patient authorization when the notes in question fit the Privacy Rule definition in, 45 CFR, Part 164.501.

Implementation

The implementation date for this instruction is February 22, 2005.

Related Instructions

The Medicare Program Integrity Manual (Pub. 100-08), Chapter 3, Subsection 3.4.1.2 (Additional Documentation Requests [ADR] During Prepayment or Postpayment MR) has been revised to reflect this change. The updated manual instructions are attached to the official instruction released to your carrier/intermediary. You may view that instruction by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR 3457 in the CR NUM column on the right, and click on the file for that CR.

Additional Information

The Code of Federal Regulations, Title 45 (Public Welfare and Human Services), Part 164 (Security and Privacy), Subpart E (Privacy of Individually Identifiable Health Information), Section 164.501 (Definitions) [45 CFR, Sec. 164.501] can be found at the following Health and Human Services (HHS) websites:
http://www.hhs.gov/ocr/hipaa/privrulepd.pdf
http://www.hhs.gov/ocr/regtext.html.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3457
Related CR Release Date: January 21, 2005
Effective Date: February 22, 2005
Medlearn Matters Number: MM3457
Related CR Transmittal #: 98
Implementation Date: February 22, 2005

RADIOLOGY

Clarification of Mammography Annual Screening Exam

This article clarifies the "annual" screening time frame for mammograms. Medicare will count eleven full months after the month the screening examination was performed.

Medicare Part B covers a screening mammogram, a radiological procedure for early detection of breast cancer. The Balanced Budget Act of 1997 provided for annual screening mammograms for women over age 39 and waived the Part B deductible.

Example: Mrs. Smith received a screening mammography examination in March 2002. Mrs. Smith starts counting in April 2002 and continues until 11 full months have elapsed, i.e., February 2003. The next annual screening mammography test may be done as early as March 1, 2003.

Source: CR 2932, dated November 28, 2003

Clarification: Modifiers for Transportation of Portable X-rays (R0075)

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

Provider Types Affected

Providers billing Medicare carriers for portable x-rays.

Provider Action Needed

STOP – Impact to You

This instruction provides further clarification on the use and processing of the five portable x-ray level II Healthcare Common Procedure Coding System (HCPCS) modifiers reportable with HCPCS code R0075 that were made effective April 1, 2005.

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

Previously, information on five new Level II HCPCS modifiers reportable with HCPCS code R0075 was provided by change request (CR) 2856, transmittal 14. Additional questions received by the Centers for Medicare & Medicaid Services (CMS) regional office indicated that there was confusion about the appropriate use of these new HCPCS modifiers.

This instruction is being issued to help answer these questions and provide further clarification on the processing of the five portable x-ray Level II HCPCS modifiers reportable with HCPCS R0075 that were made effective April 1, 2005.

Determining Single Payments

Medicare allows a single transportation payment for each trip that the portable x-ray supplier makes to a particular location. When more than one Medicare patient is x-rayed at the same location, the single fee schedule transportation payment is prorated among all the patients receiving the services.

Some contractors currently use the **units field** of the Medicare claim form to prorate the services to determine the appropriate single payment.

This results in inconsistencies in the reporting of these services among providers and carriers, and inflates the national frequency data based on the units field for these services.

Therefore, effective upon implementation of this instruction, the five (5) new modifiers (previously implemented for HCPCS Code R0075 in CR 2856, Transmittal 14) will be used to report the number of patients served during a single trip.

New Modifiers

HCPCS code R0075 must be billed in conjunction with the Current Procedural Terminology (CPT) radiology codes (70000 series) and only when the x-ray equipment used was actually transported to the location where the x-ray was taken. R0075 would **not** apply to the x-ray equipment stored in the location where the x-ray was done (e.g., a nursing home), for use as needed.

Below are the definitions for each modifier that must be reported, and only one of these five modifiers can be reported with HCPCS Code R0075:

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

Implementation

The implementation date for this instruction is April 4, 2005.

Related Instructions

The Medicare Claims Processing Manual, Pub. 100-04, Chapter 13 (Radiology Services and Other Diagnostic Procedures), Section 90.3, can be reviewed at the following CMS website: *http://www.cms.hhs.gov/manuals/104_claims/clm104c13.pdf*

CR 2856, Transmittal 14, October 24, 2003, can be

found at the following CMS website:
http://www.cms.hhs.gov/manuals/pm_trans/R14CP.pdf

Additional Information

For further information on prorating portable x-ray transportation services, please refer to Section 90.3 in Chapter 13 of the *Medicare Claims Processing Manual*. The revised section is attached to the CR that was issued by CMS to your carrier.

That official instruction may be found by going to:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR3280 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

In addition, a comprehensive overview of the HCPCS can be found at the following CMS website:
http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp

Related Change Request (CR) #: 3280
Medlearn Matters Number: MM3280
Related CR Release Date: October 29, 2004
Related CR Transmittal #: 343
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

The information contained in this article was current at the time of its development. We encourage users of this article to review statutes, regulations and other interpretive materials for the most current information.

Modification to Reporting of Diagnosis Codes for Screening Mammography Claims

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

Provider Types Affected

All providers billing Medicare carriers or fiscal intermediaries for screening mammography claims

Provider Action Needed

This article modifies instructions to allow reporting of either Diagnosis code V76.11 or V76.12. Providers should note that to ensure proper coding, one of the following diagnosis codes should be reported on screening mammography claims:

- · **V76.11** – "Special screening for malignant neoplasm, screening mammogram for high-risk patients" or;
- · **V76.12** – "Special screening for malignant neoplasm, other screening mammography"

Background

Effective January 1, 1998, providers only reported diagnosis code V76.12 on screening mammography claims. Effective July 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will now allow reporting of either V76.11 or V76.12 as appropriate.

Implementation

Implementation is July 5, 2005.

Additional Information

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

From that web page, look for CR 3562 in the CR NUM column on the right and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: 3562
Medlearn Matters Number: MM3562
Related CR Release Date: January 14, 2005
Related CR Transmittal #: 426
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

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Update for all PET Scan Services Performed in Critical Access Hospitals

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article explains updates to the Medicare Claims Processing Manual related to 2- deoxy-2- [F-18] fluoro-D-glucose Positron Emission Tomography (FDG-PET) Scans.

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

The Radiology Services and Other Diagnostic Procedures Chapter of the Medicare Claims Processing Manual has been updated in regard to billing requirements and coverage for 2-deoxy-2- [F-18] fluoro-dglucose positron emission tomography (FDG-PET) Scans for the differential diagnosis of front-temporal dementia (FTD) and alzheimer's disease (AD).

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

- The previous edit to allow HCPCS G0336 (PET imaging, brain imaging for the differential diagnosis of AD with aberrant features vs. FTD) to be billed no more than once in a beneficiary's lifetime has been removed.
- Medicare carriers and fiscal intermediaries must ensure that an appropriate diagnosis code accompanies the claim with HCPCS G0336. When submitting a claim for a FDG-PET Scan, one of the following diagnosis codes must accompany the HCPCS G0336 code: 290.0, 290.10 – 290.13, 290.20 – 290.21, 290.3, 331.0, 331.11, 331.19, 331.2, 331.9, 780.93. Line items with HCPCS code G0336 will be denied if one of the above diagnosis codes is not provided. Such denials will be reflected by claim adjustment reason code 11.
- The payment method for ALL PET Scan claims submitted for services provided in Critical Access Hospitals (CAHs) is as follows: CAHs under Method I have technical services paid at 101% of reasonable cost; CAHs under Method II have technical services paid at 101% of reasonable cost; and Professional services are paid at 115% of the Medicare Physician Fee Schedule Data Base.

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

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

Additional Information

The revised portion of Chapter 13, Section 60 of the Medicare Claims Processing Manual can be found as part of the official instruction issued to your carrier/intermediary regarding these changes. That instruction, CR 3640, may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that web page, look for CR 3640 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3640	Medlearn Matters Number: MM3640
Related CR Release Date: January 14, 2005	Related CR Transmittal #: 428
Effective Date: September 15, 2004	Implementation Date: April 4, 2005

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Valid Places of Service for Portable X-ray Suppliers

It has been brought to our attention that some portable x-ray suppliers are billing for incorrect places of service (POS). Utilize the POS code that corresponds with where the service was actually rendered. The following is a list of valid POS that should be used by portable x-ray suppliers:

12	Patients Home	33	Custodial Care Facility
13	Assisted Living Facility	54	Intermediate Care Facility/Mental Retarded
14	Group Home	55	Residential Substance Abuse Treatment Facility
31	Skilled Nursing Facility	57	Non-residential Substance Abuse Treatment Facility
32	Nursing Facility	99	Other Unlisted Facility

SURGERY

Addition of CLIA Edits to Certain Health Care Procedure Coding System (HCPCS) Codes for Mohs Surgery

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

Provider Types Affected

Physicians and clinical diagnostic laboratories billing Medicare carriers for Mohs Surgery.

Provider Action Needed

STOP – Impact to You

The Mohs micrographic surgical treatment for skin cancer requires the trained physician to serve as pathologist and surgeon. The applicable HCPCS codes (17304, 17305, 17306, 17307, and 17310) include the physician microscopic exam and interpretation, which are characterized as high complexity tests under the clinical laboratory improvement amendments (CLIA). Thus, these HCPCS codes will be subject to CLIA edits.

CAUTION – What You Need to Know

The CLIA of 1998 require a facility to be appropriately certified for each test performed.

The following types of facilities will not be permitted to bill for the above noted tests: those without a valid current CLIA certificate; those with a current CLIA certificate of waiver (certificate type code 2); OR those with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4).

GO – What You Need to Do

Please stay current with requirements for the Mohs micrographic surgical procedure to ensure accurate claims processing. The Mohs micrographic surgery HCPCS codes (17304, 17305, 17306, 17307, and 17310) will require either: a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), OR a CLIA certificate of accreditation (certificate type code 3).

Background

The CLIA of 1998 require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid pay only laboratory tests performed by certified facilities, each HCPCS code that includes a laboratory test is currently edited at the CLIA certificate level.

The Mohs surgery procedure usually includes the following steps:

- A physician generally removes the visible cancer, along with a thin layer of additional tissue;
- The removed tissue specimen is cut into sections, stained, and marked on a detailed diagram;
- The tissue is frozen on a cryostat, very thin slices are removed from the entire edge and undersurface and these slices are then placed on slides and stained for examination under the microscope;
- The physician examines the entire undersurface and complete edge of the tissue specimen, and all microscopic "roots" of the cancer are precisely identified and pinpointed on the Mohs map; and
- Upon microscopic examination, if residual cancer is found, the physician utilizes the Mohs map to direct the removal of additional tissue.

The process is repeated as many times as necessary to locate any remaining cancerous areas within the tissue specimen. When the microscopic examination reveals that there is no remaining tumor, the surgical defect is repaired.

The HCPCS codes for Mohs micrographic surgery [i.e., 17304, 17305, 17306, 17307, and 17310] require a physician to act as both a surgeon and a pathologist. These codes include the physician's microscopic examination and interpretation of tissue specimens. Both the microscopic examination and interpretation of tissue specimens are categorized as high complexity tests under CLIA in the specialty of histopathology.

At this time, all laboratory tests covered under CLIA are edited at the CLIA certificate level. The previously mentioned Mohs micrographic surgery HCPCS codes would require either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid current CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2), or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) will not be permitted to bill for these tests.

Medicare carriers will deny payment if a CLIA number is not submitted on claims by facilities for the HCPCS codes of 17304, 17305, 17306, 17307, and 17310.

Additional Information

The official instruction issued to your carrier regarding this change can be found online, referenced via CR 3458, at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

On the above online page, scroll down while referring to the CR NUM column on the right to find the link for CR 3458. Click on the link to open and view the file for the CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: 3458
Medlearn Matters Number: MM3458
Related CR Release Date: January 14, 2005
Related CR Transmittal #: 434
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

VISION

Ocular Photodynamic Therapy (OPT) with Verteporfin for Age-Related Macular Degeneration (AMD)

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

Note: **This article was revised on December 14, 2004 to show that HCPCS code J3396, instead of J3395, should be used for services rendered on or after January 1, 2005.**

Provider Types Affected

All Medicare providers.

Provider Action Needed

STOP – Impact to You

This National Coverage Determination (NCD) provides for a change in the Medicare coverage policy for the use of Ocular Photodynamic Therapy (OPT) with verteporfin for age-related macular degeneration (AMD). Under certain conditions (described below), OPT with verteporfin for AMD will now be covered for additional clinical indications.

CAUTION – What You Need to Know

CMS has determined that, provided certain criteria are met, OPT with verteporfin (CPT codes 67221 and 67225, as well as HCPCS code J3395) will now be covered for AMD in two additional clinical instances:

1) subfovial occult lesions with no classic choroidal neovascularization (CNV); and
2) subfoveal minimally classic CNV associated with AMD.

Note: **HCPCS code J3396 should be used instead of J3395 for services on or after January 1, 2005.**

GO – What You Need to Do

Make sure that your billing staffs are aware of these coverage changes.

Background

This NCD is documented in revisions to Chapters 80.2 and 80.3 of Pub. 100-03. Remember that NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. An NCD is also binding on Medicare + Choice Organizations. Administrative Law Judges may not review NCDs.

This NCD addresses coverage for the use of OPT with verteporfin in additional clinical instances. OPT with verteporfin continues to be approved for patients with a diagnosis of neovascular AMD with predominately *classic* subfoveal CNV lesions (where the area of classic CNV occupies = 50% of the area of the entire lesion).

Note: Remember that this diagnosis must be determined by a fluorescein angiogram at the initial visit. Also, there are no requirements regarding visual acuity, lesion size, and number of re-treatments when treating predominantly classic lesion patients; however, they do require a fluorescein angiogram in subsequent, follow-up visits prior to treatment.

In addition to this diagnosis, after thorough review and reconsideration of the August 20, 2002 noncoverage policy, CMS has determined that there is enough evidence to conclude that OPT with verteporfin, in certain instances, may be reasonable and necessary for treating subfoveal occult lesions with no classic CNV and subfoveal minimally-classic CNV lesions (where the area of classic CNV occupies <50% of the area of the entire lesion).

When Covered Indications are Reasonable and Necessary

These two new covered indications are considered reasonable and necessary only when:

- The lesions are small (four disk areas or less in size) at the time of initial treatment or within the 3 months prior to initial treatment; and
- They have shown evidence of progression within the three months prior to initial treatment. You must confirm this evidence of progression by documenting:
- The deterioration of visual acuity (at least five letters on a standard eye examination chart);
- Lesion growth (an increase in at least one disk area); **or**
- The appearance of blood associated with the lesion.

Be aware that the other AMD-related uses of OPT with verteporfin, not already addressed by CMS, will continue to be noncovered. These include, but are not limited to: juxtafoveal or extrafoveal CNV lesions (lesions outside the fovea); inability to obtain a fluorescein angiogram; or atrophic or "dry" AMD.

On the other hand, the use of OPT with verteporfin for other ocular indications, such as pathologic myopia or presumed ocular histoplasmosis syndrome, continue to be eligible for local coverage determinations through individual Medicare contractor discretion.

National Coverage Determination History

The following is a short history leading up to the current NCD:

1. Effective July 1, 2001, CMS approved the use of OPT with verteporfin in neovascular AMD patients having predominately classic subfoveal CNV lesions.
2. On October 17, 2001, CMS announced its "intent to cover" OPT with verteporfin for AMD patients with occult subfoveal CNV lesions; however, this decision was never implemented.
3. On March 28, 2002, CMS reviewed the October 17, 2001 intent-to-cover policy, and determined that the (then) current noncoverage policy for OPT for verteporfin for AMD patients with occult subfoveal CNV should remain in effect.
4. Effective August 20, 2002, CMS issued a noncovered instruction for OPT with verteporfin for AMD patients with occult subfoveal CNV lesions.
5. Now CMS, after through review and reconsideration of the August 2002 decision, has determined that there is enough evidence to conclude that OPT with verteporfin is also reasonable and necessary in these additional clinical instances. Therefore, this NCD, effective April 1, 2004, provides for covering the use of OPT with verteporfin in patients with subfoveal occult lesions with no classic CNV, and subfoveal minimally classic CNV lesions as described above.

Additional Information

Additional background information is available in Pub. 100-03, Chapters 80.2 and 80.3, which are included in the actual instruction issued to Medicare carriers and fiscal intermediaries on this NCD. This instruction can be found in CR 3191 at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

Once at that site, scroll down to find 3191 in the CR NUM column on the right and then click on the file for that number.

Related Change Request (CR) #: 3191
Medlearn Matters Number: MM3191
Related CR Release Date: April 1, 2004 Revised
Related CR Transmittal #: 9
Effective Date: April 1, 2004
Implementation Date: April 1, 2004

OTHER SERVICES

Editing and Adding New Low Risk Diagnosis Code (V72.31) for Pap Smear and Pelvic Examination

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

Provider Types Affected

Physicians billing Medicare carriers and providers billing Medicare fiscal intermediaries for screening Pap smears and pelvic examinations

Provider Action Needed

STOP – Impact to You

Medicare is modifying its claims processing edits for claims for screening Pap smears and pelvic examinations.

CAUTION – What You Need to Know

To ensure accurate Medicare processing of claims for these services, effective July 1, 2005, Medicare is establishing a separate edit for HCPCS code Q0091 – screening Papanicolaou (Pap) smear, obtaining, preparing and sending cervical or vaginal smear to laboratory, to prevent incorrectly paying for claims submitted outside of the frequency, one screening every two year for low risk beneficiaries and one screening every year for high risk beneficiaries. Also, Medicare will accommodate a new diagnosis code, V72.31, in Medicare system edits that are in place for Pap smear and pelvic examination for low risk beneficiaries.

GO – What You Need to Do

Be aware of the specifics in this article to assure accurate and timely processing of your Medicare claims for screening Pap smears and pelvic examination.

Background

Medicare pays for one screening Pap smear every two years for low-risk beneficiaries and one screening Pap smear every year for high-risk beneficiaries.

Currently, HCPCS code Q0091 is not part of the Medicare system editing for screening Pap smear claims. Since Medicare only pays for **one screening Pap smear every two years for low risk beneficiaries,** claims billed outside of this frequency have been processed incorrectly. This has happened on those occasions when physicians perform a screening Pap smear (Q0091) that should not be covered by Medicare because the low-risk patient has already received a covered screening Pap smear (Q0091) in the past two years but requests that the physician perform a screening Pap smear each year. Beginning for dates of service on and after July 1, 2005, these types of claims will deny appropriately. Medicare is establishing a separate edit for Q0091 to capture and reject claims submitted outside of this frequency. In instances where unsatisfactory screening Pap smear specimens have been collected and sent to the clinical laboratory and the clinical laboratory is unable to interpret the test results, another specimen is needed. When billing for sending another specimen to the clinical laboratory, the physicians should use HCPCS code Q0091 along with modifier 76, which will bypass the frequency editing and allow payment to be made for reconveyance of the specimen.

Effective for services rendered on and after July 1, 2005, where physicians must perform a screening Pap smear that they know will not be covered by Medicare because the low-risk beneficiary has already received a covered screening Pap smear in the past two years, the physicians can bill Q0091. The claim will be denied appropriately as being not reasonable and necessary. Thus, in these instances, the physician/provider should be aware that an advance beneficiary notice (ABN) is necessary, since the claim will be denied. The physician/provider should use **modifier GA** on the claim to indicate that an ABN has been obtained.

Finally, physicians/providers should note that a new diagnosis code V72.31 will be added to the edits in Medicare system for low-risk beneficiaries. The V72.31 diagnosis code is to be used on Pap smear and pelvic examination claims to indicate the beneficiary is a low risk patient, but only when a full gynecological examination is performed.

The following chart lists the diagnosis codes that Medicare recognizes for low-risk or high-risk patients for screening Pap smear services with V72.31 recognized as of July 1, 2005.

Low Risk Diagnosis Codes	**Definitions**
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites Note**: providers use this diagnosis for women without a cervix.**
V72.31	Routine gynecological examination Note**: This diagnosis should only be used when the provider performs a full gynecological examination.**

High Risk Diagnosis Code

V15.89 Other

Implementation Date

The implementation date for this instruction is July 5, 2005.

Additional Information

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

From that Web page, look for CR 3659 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3659
Related CR Release Date: January 21, 2005
Related CR Transmittal Number: 440
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 440, CR 3659, PCM #0502403

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HIPAA - The Health Insurance Portability and Accountability Act

Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims

Provider Types Affected

All Medicare providers.

Provider Action Needed

STOP – Impact to You

If you don't submit your Medicare claims electronically, your payments could be affected (unless you meet specific exception criteria mentioned below).

CAUTION – What You Need to Know

ASCA prohibits Medicare from making payments on or after October 16, 2003, for claims that are not submitted electronically. You must submit your claims electronically, unless you meet one of the exceptions listed below.

GO – What You Need to Do

Make sure that your billing staff submits your Medicare claims electronically. Or, if you believe that you meet one of the exception criteria, make sure that you appropriately complete the "Request for Documentation" letter from your carrier or fiscal intermediary to process your claims.

Background

Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires you, with limited exceptions, to submit all your initial claims for reimbursement under Medicare electronically, on or after October 16, 2003.

Further, ASCA amendment to Section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Consequently, unless you fit one of the exceptions listed below, any paper claims that you submit to Medicare will not be paid. In addition, if it is determined that you are in violation of the statute or rule, you may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

There are some exceptions to this electronic claim submission requirement. They include the following:

- You are a small provider - a provider billing a Medicare fiscal intermediary that has fewer than 25 full-time equivalent employees (FTEs), and a physician, practitioner, or supplier with fewer than 10 FTEs that bills a Medicare carrier;
- A dentist;
- A participant in a Medicare demonstration project in which paper claim filing is required due to the inability of the Applicable Implementation Guide, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to report data essential for the demonstration;
- A provider that conducts mass immunizations, such as flu injections, and may be permitted to submit paper roster bills;
- A provider that submits claims when more than one other payer is responsible for payment prior to Medicare payment;
- A provider that only furnishes services outside of the United States;
- A provider experiencing a disruption in electricity and communication connections that are beyond its control; and
- A provider that can establish an "unusual circumstance" exists that precludes submission of claims electronically.

The process for postpayment based enforcement is as follows:

- Your Medicare contractor will analyze reports displaying the number of paper claims that all providers submitted each quarter.
- By the end of the month following the quarter, selected providers who have submitted the highest numbers of paper claims will be reviewed.
- Medicare contractors will ask these providers to provide information that establishes the exception criteria listed above.

If you, as one such provider, do not respond to this initial "Request for Documentation" letter within 45 days of receipt, your contractor will notify you by mail that Medicare will deny and not pay any paper claims that you submit beginning ninety days after the date of the initial request letter. If you **do** respond to this initial letter, and your response does not establish eligibility to submit paper claims, the contractor will notify you by mail of your ineligibility to submit

paper claims. This Medicare decision is not subject to appeal.

In these letters, your Medicare contractor will also tell you how to obtain free and commercially available HIPAA-compliant billing software packages.

If you respond with information that does establish eligibility to submit paper claims, the contractor will notify you by mail that you meet one or more exception criteria to the requirements in Section 3 of the ASCA, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, and you will be permitted to submit paper claims.

However, you will be cautioned that if your situation changes to the point that you no longer meet the exception criteria, you will be required to begin electronic submission of your claims.

If you are permitted to submit paper claims, your carrier/intermediary will not review your eligibility to submit paper claims again for at least two years.

Additional Information

You can learn more about the instructions issued to your carrier/intermediary regarding ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims at: *http://www.cms.hhs.gov/manuals/transmittals/.comm_date_dsc.asp.*

Look for CR 3440 in the CR NUM column on the right, and click on the file for that CR. These instructions provide more detail on what constitutes an "unusual circumstance" that precludes submission of claims electronically.

You might also want to look at the online Manual 100.04, Chapter 24, Section 90, Subsection 5 (Enforcement). You can find this manual at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf.*

If you have any questions, please contact your contractor at his toll-free number: *http://www.cms.hhs.gov/medlearn/tollnums.asp.*

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #:3440
Medlearn Matters Number: MM3440
Related CR Release Date: January 14, 2005
Related CR Transmittal #: 435
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

April 2005 Update of Health Care Claims Status Codes and Health Care Claims Status Category Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

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

Provider Types Affected

Physicians, providers, and suppliers.

Provider Action Needed

Physicians, providers, and suppliers should note that this article and related CR 3566 provide information regarding updates to the Health Care Claims Status Codes and Health Care Claims Status Category Codes for use in requesting information about the status of claims with the Health Care Claim Status Request and Response ASC X12N 276/277 transactions. Effective April 1, 2005, Medicare carriers and intermediaries will use codes with the "new as of June 2004" designation and prior dates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) directs that all health care plans use national standards for the transfer of certain health care data. HIPAA requires all payers to use the applicable health care claims status category codes and health care claim status codes of the American National Standards Institute (ANSI) American Standards Committee (ASC) X12N. Medicare carriers and intermediaries must periodically update their claims system with the most current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277 transaction. These transactions are used by providers to inquire about the status of claims they have submitted and by health plans to reply to such inquiries.

Medicare contractors (carriers, durable medical equipment regional carriers, intermediaries, and Regional Home Health Intermediaries) must update their claims systems to ensure that the current version of these codes is used in their claim status responses. By April 4, 2005, Medicare contractors are to use the "new as of June 2004" or a prior date designation. These codes may be found at: *http://www.wpc-edi.com/codes/Codes.asp.*

Not all of the codes apply to Medicare. Thus, Medicare contractors are not required to accommodate codes that do not apply to Medicare in their 277 responses.

Note: Medicare contractors must comply with the requirements contained in the version 4010A1 ASC X12 276/277 IG and must use valid Health Care Claim Status Category Codes and Health Care Claim Status Codes when sending 277 responses.

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 31 (ANSI X12N Formats), Section 20 (ANSI X12N 276/277 Claims Status Request/Response Transaction Standard), Subsection 20.7, has been revised. The revised manual page(s) are attached to the official instruction released to your Medicare carrier/intermediary. You may view that instruction at: *http://www.cms.hhs.gov/manuals/pm_trans/R406CP.pdf.*

For additional information on claims status codes and claims status category codes, you may also refer to Medlearn Matters article MM3361, which is available at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3361.pdf.

The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes found at: *http://www.wpc-edi.com/codes/codes.asp.*

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: 3566
Related CR Release Date: December 17, 2004
Effective Date: April 1, 2005
Medlearn Matters Number: MM3566
Related CR Transmittal #: 408
Implementation Date: April 4, 2005

Guidance Regarding Elimination of Standard Paper Remittance (SPR) Advice Notices in the Old Format

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article. This was originally published in the First Quarter 2005 *Medicare Part B Update! (page 73)*

Note: This article was revised on December 7, 2004 to revise the implementation date for providers billing fiscal intermediaries (FIs) and clarifies expectations for carrier changes.

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

The Centers for Medicare & Medicaid Assistance (CMS) has issued a memorandum to all Medicare carriers and FIs, including Durable Medical Equipment Regional Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs) stating that, effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the Standard Paper Remittance (SPR) advice notices; no other format for SPRs will be used.

Background

CMS prohibits the inclusion of data in paper remittance advice notices that is not included in the Electronic Remittance Advice (ERA) transactions. The most recent version of the SPR advice and the ERA contain the same information in the comparable fields and data elements, including the same codes. The same flat file should be used to produce both the SPR and 835 version 4010A1 ERA.

Note: The effective date has been revised to April 4, 2005 for FIs.

Providers billing intermediaries are also advised that they may see new data elements in their SPRs, i.e.:

- An additional field for the new technology add-on payment;
- A "PRE PAY ADJ" (presumptive payment adjustment) field in the claim detail section; and
- A new field to report a provider-level adjustment used to balance an "out of balance" remittance on the SPR summary page.

Providers billing carriers should note that not all carriers and DMERCs will be able to create SPRs directly from an 835 flat file. In such cases, carriers and DMERCs may continue to follow current practices for SPR preparation, but they must ensure that each SPR issued contains the same data elements that would be reported in the equivalent segments and data elements of an 835 version 4010A1 if produced for the same claims and provider. This applies to SPRs produced both for providers that have already transitioned to the 835 version 4010A1, and to those that received earlier versions of the 835 or the National Standard Format ERA pending transition.

Also, providers billing carriers and DMERCs should know that carriers and DMERCs have been told that SPRs may not contain data, other than the contractor's name and address and some calculated totals (as permitted in the SPR format in Chapter 22 of the Medicare Claims Processing Manual), that is not reported in the ERA.

Additional Information

Refer to Chapter 22 of the Medicare Claims Processing Manual, Publication 100-4, which can be found online at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c22.pdf*

Additional information regarding the Fiscal Intermediary Part A 835 flat file, including a sample of the most recent SPR format, is available in CR 3344. You may view that CR at: *http://www.cms.hhs.gov/manuals/pm_trans/R252CP.pdf*

If you have any questions regarding receipt of or conversion to ERAs, please contact your carrier/intermediary. If you bill an intermediary, their number may be found at: *http://www.cms.hhs.gov/providers/edi/anum.asp*

If you bill a carrier, their number may be found at: *http://www.cms.hhs.gov/providers/edi/bnum.asp*

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0451
Effective Date: N/A Revised
Implementation Date: January 1, 2005 for providers billing carriers,
April 4, 2005 for providers billing fiscal intermediaries

Inappropriate Access to or Use of Electronic Data Interchange (EDI) Transaction Data by Third Party Entities

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

Provider Types Affected

All physicians, suppliers, and providers.

Provider Action Needed

STOP – Impact to You

Failure to abide by Medicare security requirements for EDI access could lead to suspension of EDI capabilities.

CAUTION – What You Need to Know

This article clarifies and reminds affected physicians, providers, and suppliers of existing Medicare requirements and prohibitions concerning use of EDI numbers and passwords.

GO – What You Need to Do

Be sure you and your third party partners are aware of and abide by these requirements to protect your EDI access and to maintain your ability to submit timely claims to Medicare.

Background

Medicare contractors (carriers and intermediaries) support electronic data interchange (EDI) to enable providers, either directly or through third party agents to:

- Verify patient eligibility to determine if a claim should be submitted to Medicare;
- Submit claims to Medicare electronically;
- Determine the status of a previously submitted claim; and
- Post adjudication decisions and payments to patient accounts.

It is important to note that these functions are the only functions for which a provider or a third party entity is entitled to send EDI transactions directly to Medicare contractors (carriers, DMERCs, or fiscal intermediaries) or receive EDI transactions directly from Medicare contractors.

Third-party entities that request permission to access Medicare EDI records directly generally fall into one of the following categories:

1. A clearinghouse as defined by the Health Insurance Portability and Accountability Act (HIPAA) that transfers and may translate claim, eligibility, claim status, and/or payment and remittance advice data for EDI transactions being transmitted between providers and one or more Medicare contractors;
2. An agent a provider has hired to prepare claims and possibly other EDI transactions for submission to one or more Medicare contractors, and possible posting to patient records/provider accounts of eligibility, claim status, and adjudication/payment data issued by one or more Medicare contractors;
3. A clearinghouse as in #1 above that also performs agent services as in #2 above; and
4. A third party that does not perform clearinghouse or agent services as described in #1-3, but that may want direct access to outbound Medicare EDI transactions for alternate functions. Entities included in this category include collection agents in pursuit of delinquent beneficiary payments to providers and vendors that market payment data analysis services to providers that serve Medicare patients.

Third parties in categories 1, 2, and 3 perform functions that qualify them for direct access to Medicare contractor EDI systems. If a provider elects to use the services of a third party to perform permitted Medicare EDI functions, the provider must complete an EDI Agreement and furnish the Medicare contractor with a signed authorization specifying the EDI services each third party may perform on their behalf. The third party must comply with existing requirements to obtain their own EDI number and password from the Medicare contractor that services each provider being represented.

Medicare contractors can issue EDI numbers and passwords to category 1, 2, and 3 entities and permit them to submit and/or obtain EDI data directly to/from the Medicare contractor EDI systems. Third parties in category 4 do not perform functions that qualify them for direct access to Medicare systems, and may not be issued EDI numbers or passwords.

Medicare requires that providers and third party entities to which EDI numbers and passwords are issued protect the security of those numbers and passwords to prevent use by unauthorized individuals.

Furthermore, providers and third party entities of any category are prohibited from accessing Medicare systems using an EDI number or password not directly issued to them by a Medicare contractor.

This instruction is being issued to clarify and remind affected parties of existing CMS requirements and prohibitions concerning access to and use of EDI numbers and passwords.

Issues

Although they may qualify for direct access to Medicare contractor EDI systems, the read, write and use rights vary for entities in categories 1, 2, and 3. Third parties in categories 2 or 3 are allowed to review data within transactions, whereas category 1 entities are limited to review of "electronic envelope" data that contains routing information for the transactions. Some category 1 entities may be confused regarding this limitation.

The Centers for Medicare & Medicaid Services (CMS) recently discovered that at least one third-party entity in category 4 has been using EDI numbers and passwords furnished them by providers to download electronic remittance advice (ERA) transactions for those providers. The data **was not being used** to post adjudication and payment data to patient accounts, but was being used solely for automated analysis to detect information such as payment patterns and to generate reports. The providers were using the paper remittance advice notices they received, and not the ERAs, to post their accounts. CMS has been advised that other companies may also be marketing similar services and may be using EDI numbers and passwords issued to providers to obtain outbound EDI transactions from Medicare contractor systems for use in ways other than intended by Medicare.

CMS Policy

The following manual instructions contain CMS requirements that apply to these issues:

- The Medicare Claims Processing Manual (Pub. 100-04, Chapter 24 (EDI Support Requirements) contains CMS requirements for EDI access. This can be accessed at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf*
- The Business Partners Systems Security Manual (BPSSM) (Appendix A, Section 2.9.10 of the Core Security Requirements (CSR)) contains further requirements applicable to use of passwords issued to permit system access. These can be found at: *http://www.cms.hhs.gov/manuals/117_systems_security/117_systems_security_atchA.pdf*
- These password requirements apply to entities to which Medicare contractors issue passwords, as well as to Medicare contractors themselves.
- The Medicare Claims Processing Manual (Pub. 100-04), Chapter 24 (EDI Support Requirements), Section 90 contains instructions concerning mandatory electronic submission of claims to Medicare as required by ASCA. This information is available at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf*
- The Medicare Claims Processing Manual (Pub.100-04), Chapter 1 (General Billing Requirements), Section 80 (Carrier and FI Claims Processing Timeliness) contains Medicare's payment floor requirements at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf*

In regard to access policies for entities in categories 1-4:

- Category 1 third parties that transfer EDI data to and/or from providers, but do not translate that data into or from a format that complies with the HIPAA requirements are **not permitted** to:
- Open the electronic envelope of the transmitted data; or
- Generate reports that include data from within those transmission envelopes.
- Category 2 and 3 agents **are permitted** to:
- Open the electronic envelopes of the transmitted data; and
- Use the data for analysis and generation of reports for the providers they serve, in addition to use of that data to prepare beneficiary claims, determine claim status or Medicare eligibility, and/or to post adjudication and payment data to patient accounts.
- Category 4 third parties may use data prepared by Medicare, but the following requirements must be met as conditions for use:
- The data must be forwarded to the entity by the provider;
- A signed agreement must be in effect between the provider and the entity in which the provider authorizes the entity to use the data and specifying how the data may and may not be used;

- The entity has furnished the provider with a signed confidentiality agreement that meets Medicare's and HIPAA's privacy and security requirements for protection of personally identifiable beneficiary health data;
- The provider has notified the patients that their personally identifiable health data will be shared with the entity and how it will be used; and
- The provider agrees not to furnish data to the entity for any patients who object.
- A category 4 entity:
- May **not** be given an EDI number or password for direct access to Medicare data; and
- Is never permitted to use a provider's EDI number or password for that or any other purpose.

As stated in the CSRs in BPSSM section 2.9.10, passwords (1) are "unique for specific individuals," (2) must be "controlled by the assigned user and [are] not subject to disclosure."

Contractor Actions if Improper Access is Identified

In the event a Medicare contractor becomes aware that improper access has been given, appropriate termination of EDI capabilities and notification must occur. For example:

- If an entity, previously issued an EDI number and password, falls under category 4, the Medicare contractor must immediately disable the EDI number and password of that entity, and then notify the entity and the provider why this has been done.
- If a third party entity is using a provider's EDI number and password to access Medicare systems, the Medicare contractor must immediately disable the EDI number and password, and then contact that provider by mail or phone to make them aware of Medicare's requirements and prohibitions.

During this contact, and while the EDI number and password are disabled, the Medicare contractor will remind the provider that:

- Loss of EDI privileges could result in termination of Medicare payment since the Administrative Simplification Compliance Act (ASCA) prohibits payment of claims submitted on paper that should have been submitted to Medicare electronically; and
- In those cases when ASCA permits claims to be submitted on paper, payment is delayed as result of the lengthier payment floor that applies to paper claims.

Additional Information

Providers can review appropriate requirements by checking the Web sites mentioned above.

Remember: The law requires most providers to bill Medicare electronically and EDI access is crucial to that process. Protect your access and protect your patients' confidentiality by abiding by Medicare's privacy and security requirements.

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

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0461
Related CR Release Date: N/A

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "eNews link" on the navigational bar and follow the prompts.

GENERAL INFORMATION

Manual Revision Regarding Waiver of Annual Deductible and Coinsurance for Both Ambulatory Surgery Centers (ASCs) and ASC/ Hospital Outpatient Department Physician Services

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

Provider Types Affected

Hospitals outpatient departments billing for physician services, ASCs, and physicians.

Provider Action Needed

STOP – Impact to You

The Omnibus Budget Reconciliation Act (OBRA) 1986 and OBRA 1987 rescinded the waiver of the Medicare Part B coinsurance and deductible requirements for ASC facility services and ASC/hospital outpatient department physician services.

CAUTION – What You Need to Know

Medicare is updating language in its manuals to ensure consistency with these legislative changes and this change.

GO – What You Need to Do

ASCs and hospital outpatient department billing staffs are reminded to be familiar with these policies.

Background

Effective April 1, 1988, section 4054 of OBRA 1987 (Public Law 100-203) imposed the Medicare Part B coinsurance and deductible requirements for physician services in connection with an ASC-covered procedure that is performed in an ambulatory setting.

For any physician services furnished on or after April 1, 1988, in connection with an ASC covered procedure, performed in an ASC or in a hospital on an outpatient basis, Medicare pays 80 percent of the physician fee schedule amount. After the beneficiary deductible is met, the beneficiary is responsible for 20 percent of the physician fee schedule amount.

Section 9343(e) of OBRA 1986 (Public Law 99-509) imposed that for any procedure on the ASC list furnished in an ASC, Medicare pays 80 percent of the applicable ASC fee schedule amount for such services furnished to Medicare patients. After the beneficiary's deductible is met, the beneficiary is responsible for 20 percent of the applicable facility fee schedule amount for that facility service. This provision was made for services furnished on or after July 1, 1987.

Additional Information

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

Related Change Request (CR) #: 3471
Medlearn Matters Number: MM3471
Related CR Release Date: October 22, 2004
Related CR Transmittal #: 11
Effective Date: November 22, 2004
Implementation Date: November 22, 2004

Coming Soon—The New Medicare Prescription Drug Program

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

The First in a Series of Medlearn Matters Articles for Providers On Medicare's New Prescription Drug Program

Provider Types Affected

All physicians, providers, suppliers, and their staff providing service to people with Medicare.

Provider Action Needed

STOP – Impact to You

On January 1, 2006, a very important new benefit will be available to your Medicare patients. These new Medicare Prescription Drug Plans will be of significant value to your patients by providing assistance with prescription drug expenses. This program is authorized under the Medicare Modernization Act of 2003 (MMA). Your patients may ask you about this new benefit.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is preparing an extensive campaign for both providers and beneficiaries, and will be disseminating information to these audiences. Over the next year, as materials are developed, you will be notified through a series of Medlearn Matters articles and other resources. Some providers will choose to be active in giving information to their Medicare patients, and we will help you do that. CMS encourages and appreciates the work providers are willing to do to help people with Medicare learn about this important new benefit.

GO – What You Need to Do

Stay informed. Go to the newly established website: *http://www.cms.hhs.gov/medicarereform/pdbma/* and check it often as new information is always being added. This easy-to-use website has a "General Information" link to the press releases, issue papers, fact sheets, and full copies and summaries of both regulations. Users can follow the menu and select the area that best matches their area of interest. Refer your Medicare patients to information resources – **1-800-MEDICARE** and *http://www.medicare.gov*.

Background

On December 8, 2003, the Medicare Modernization Act (MMA) was enacted, adding a very important new benefit to the Medicare program. This new benefit takes effect on January 1, 2006, and provides a much needed new drug benefit to help serve the 41 million Americans who rely on Medicare for their health care needs.

On January 21, 2005, Health and Human Services Secretary Tommy G. Thompson announced the final regulations establishing the new Medicare prescription drug benefit program. This is a very important step in making this great addition to the Medicare program a reality for your Medicare patients.

This is a very special time for your patients with Medicare, full of many exciting program improvements and enhancements. Great opportunities exist right now, through the MMA, to make the Medicare program more personalized and more up to date, and to keep it up to date. The Medicare Drug Benefit is a major step in that direction. A very important step toward fulfilling that opportunity is in the final regulation for the Medicare Drug Benefit program. Along with the new Medicare preventive benefits, this major program improvement brings Medicare's coverage up to date with 21st Century prevention-minded medicine.

WE NEED YOUR HELP

Because people with Medicare trust their physicians, other clinicians, pharmacists, and other health care providers, you are in a unique position to direct them to the resources available to help them learn about the new benefit. If any of your patients rely on caregivers, CMS appreciates your efforts to get this information into their hands as well.

CMS will be pursuing a number of activities to make sure the physician, provider, and supplier communities know about this new benefit, understand how it works, and will be highlighting the information that may be of most value to your Medicare patients. As educational materials are developed, you will be notified of their availability. These materials will help you and your staff to understand the new benefit. CMS will keep you up-to-date with education and outreach efforts on the new drug benefit. Here's how you can stay connected:

- Pay attention to correspondence from your Medicare carrier or fiscal intermediary or your national professional associations – they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listservs and read their newsletters.
- Register to receive listserv email messages to alert you when new Medlearn Matters articles have been released on the new drug benefit (and other Medicare information). Medlearn Matters articles provide succinct and timely messages on Medicare claims processing and other changes. These articles can be found on the web at: *http://www.cms.hhs.gov/medlearn/matters*.
- Participate in CMS open door forums to hear from and ask questions of CMS leadership on topics of interest to your particular provider-type. Information regarding these open door forums may be found on the web at: *http://www.cms.hhs.gov/opendoor*.

Related Change Request (CR) Number: N/A Medlearn Matters Number SE0501
Related CR Release Date: N/A

New Medicare-Approved Drug Discount Cards and Transitional Assistance Program: A Summary for Physicians and Other Health Care Professionals

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
The original article was published in the First Quarter 2005 Medicare B Update! (page 78).
***Note:** This article was revised on November 8 to correct the Web address for State Health Insurance Counseling and Assistance Programs.*

Provider Types Affected

Physicians and other health care professionals.

Provider Action Needed

Understand the Medicare-Approved Drug Discount Cards and Transitional Assistance Program that begins in 2004 to help Medicare beneficiaries save on prescription drugs.

Background

As part of the Medicare Modernization Act of 2003 (MMA), the Medicare-Approved Drug Discount Cards and Transitional Assistance Program begins in 2004 to help Medicare beneficiaries save on prescription drugs. Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare's seal of approval can help Medicare beneficiaries save on prescription drug costs.

This article is designed to give an overview of the new Medicare-Approved Drug Discount Cards and Transitional Assistance Program. It will also explain where you may refer Medicare patients for information on selecting and enrolling in the drug discount card that best suits their needs.

Medicare-Approved Drug Discount Cards

- Open enrollment started in May 2004;
- Available to qualified beneficiaries regardless of income;
- Represent a variety of discount and drug options from private companies;
- Available to beneficiaries eligible for or enrolled in Medicare Part A or enrolled in Medicare Part B, **unless** ;receiving outpatient prescription drug coverage through State Medicaid programs;
- May charge an annual enrollment fee of no more than $30, which may be paid by Medicare for some low-income beneficiaries;
- Do **not** require that beneficiaries purchase discount drugs through mail-order pharmacies; and
- Provide beneficiaries the ability to use their discount cards in pharmacies near their homes.

Transitional Assistance Program

Beneficiaries with the greatest need will have the greatest help available to them. Individuals with an annual income in 2004 of no more than $12,569 if single or $16,862 if married, and individuals receiving help from their state in paying their Medicare premiums or cost sharing, may qualify for a $600 credit on their discount card to help pay for prescription drugs. These income limits change every year. Residents of Puerto Rico or a U.S. territory are not eligible for the $600 credit from Medicare. However, they may be eligible for similar assistance provided by the territory in which they reside. Beneficiaries cannot qualify for the $600 if they already have outpatient prescription drug coverage from certain other sources.

Where Do I Refer Medicare Beneficiaries for Information on Prescription Drug Discount Programs?

In addition to the Medicare-approved drug discount cards, there are other programs available that provide assistance in paying for prescription drugs. Alternatives such as individual state pharmacy assistance programs and manufacturers' discount programs may be a better fit for certain individuals.

Medicare recognizes that physicians and other health care professionals have limited time available to counsel patients. The following resources are available to help individuals with questions about the Medicare-approved drug discount cards:

The 1-800-MEDICARE (1-800-633-4227) Toll-Free Call Center

This call center is available 24 hours per day and 7 days per week. It connects beneficiaries with customer service representatives who can answer questions and perform price comparisons for discount cards and other assistance programs. Beneficiaries should prepare a list of current prescription drugs and dosages prior to contacting the call center. Beneficiaries may request a copy of their individualized price comparison results. TTY users should call 1-877-486-2048.

The Prescription Drug and Other Assistance Programs Website at Medicare.gov

http://www.medicare.gov/AssistancePrograms/home.asp

For beneficiaries who use the Internet, this site features eligibility, enrollment, and price comparison information for each available discount card in a particular area, as well as their state pharmacy assistance programs. It also has a tool that helps beneficiaries determine the best savings program based on their prescription drug needs.

Medicare's Guide to Choosing a Medicare-Approved Drug Discount Card

http://www.medicare.gov

This resource provides beneficiaries with information on choosing a card, enrolling, and submitting complaints. This guide also features sample enrollment forms and worksheets to assist beneficiaries in selecting the discount card that is right for them.

State Health Insurance Counseling and Assistance Programs (SHIP)

Beneficiaries may also contact their SHIP counselor for information on prescription drug cost assistance programs. To find the telephone number for the nearest SHIP, call 1-800-MEDICARE (1-800-633-4227) or visit:
http://www.medicare.gov/contacts/Static/SHIPs.asp?dest=NAV

Information Resources for Physicians and Other Health Care Professionals

- Download a free patient-education brochure at *http://www.medicare.gov* (or call 1-800-MEDICARE to order a limited number of free copies).
- Read The Medicare-Approved Drug Discount Cards and Transitional Assistance Program - A Brochure for Physicians and Other Health Care Professionals at *http://www.cms.hhs.gov/medlearn*.
- Attend CMS Open Door Forums in person or by telephone (toll-free). These forums address concerns and issues of physicians, nurses, and allied health professionals. Visit *http://www.cms.hhs.gov/opendoor* for further details.
- Visit *http://www.cms.hhs.gov/medicarereform* for the latest information on MMA.

- Contact your carrier for information by using the toll-free provider lines. Visit *http://www.cms.hhs.gov/medlearn/tollnums.asp* for your carrier's toll-free number.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: N/A
Special Edition: SE0422 *Revised*

Medicare Prescription Drug, Improvement and Modernization Act of 2003 Information for Medicare Rural Health Providers, Suppliers, and Physicians

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

Provider Types Affected

Medicare rural providers, suppliers, and physicians.

Provider Action Needed

This Special Edition summarizes and explains rural health provisions included in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

Hospital Inpatient Prospective Payment System (PPS)

MMA Section 401 – As of April 1, 2004

The urban and rural standardized amounts under the Hospital Inpatient PPS will be permanently equalized by establishing a single base payment or standardized amount for hospitals in all areas of the 50 states, the District of Columbia, and Puerto Rico. The Centers for Medicare & Medicaid Services (CMS) has implemented the following:

- Equalized the standard amounts from April 1, 2003 to March 31, 2004;
- Increased the large urban and other area national adjusted amounts for Puerto Rico retroactive to
- October 1, 2003; and
- Equalized the Puerto Rico-specific urban and other area rates.

Although these changes were not effective in Medicare systems until April 1, 2004, CMS has calculated the payment necessary to make up for the six months that Puerto Rico and other areas did not receive payments equal to Puerto Rico urban rates.

MMA Section 401(d)(2) – From April 1, 2004 through September 30, 2004

Puerto Rico-specific other area rates will exceed the Puerto Rico urban rate so that the requirements of the provision can be implemented without reprocessing claims.

MMA Section 402 – For discharges on or after April 1, 2004

The Disproportionate Share Hospital (DSH) adjustment for rural hospitals, rural referral centers, Sole Community Hospitals (SCHs), and urban hospitals with fewer than 100 beds will be increased. The cap on the adjustment will be 12 percent, except for hospitals classified as rural referral centers. The formulas to establish a hospital's DSH payment adjustment are based on the following:

- Hospital's location
- Number of beds
- Status as a rural referral center or SCH.

Under §1886(d)(5)(F) of the Social Security Act (SSA), Medicare makes additional DSH payments to acute hospitals that serve a large number of low-income Medicare and Medicaid patients as part of its Inpatient PPS.

The new DSH adjustment is not applicable to Pickle Hospitals, as defined at §1886(d)(5)(F)(i)(II) of the SSA.

Effective April 1, 2001, as specified in §211 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000, all inpatient PPS hospitals that meet the number of beds requirement are eligible to receive DSH payments when their DSH patient percentage meets or exceeds 15 percent.

MMA Section 504 – For discharges occurring on April 1, 2004 through September 30, 2004

The current blend of input into Medicare payments will be changed from 50 percent for national and 50 percent for Puerto Rico to 62.5 percent for national and 37.5 percent for Puerto Rico.

On October 1, 2004, the blend will be further adjusted to 75 percent for national and 25 percent for Puerto Rico.

For discharges occurring on or after April 1, 2004 through September 30, 2004, the new fixed-loss amount used to determine the cost outlier threshold is $30,150.

This fixed-loss amount is part of the equation used to determine inpatient operating and capital-related costs in both

the operating PPS and the capital PPS. Because the fixed-loss amount is being changed for discharges during this period, the resultant new capital PPS rates are $413.48 for national and $202.96 for Puerto Rico.

These rates were determined by an updated national Geographic Adjustment Factor/Diagnosis-Related Group (GAF/DRG) adjustment factor of 1.0025 with an outlier adjustment of 0.9508 and a Puerto Rico GAF/DRG adjustment factor of 1.0011 with an outlier of 0.9922.

Hospital Inpatient PPS Wage Index

MMA Section 403(b) – For discharges occurring on or after October 1, 2004

The percentage of hospital inpatient PPS payment adjustment based on the area hospital wage index will be decreased from 71.1 percent to 62 percent. These payments are adjusted by the hospital wage index of the area where the hospital is located or the area in which the hospital is classified. The decrease in the percentage of Hospital Inpatient PPS payment adjustment is applicable only if the hospital would receive higher total payments.

Hospital Market Basket Weight Updates

MMA Section 404 – By October 1, 2005

The frequency with which CMS revises the category weights, re-evaluates the price priorities for the category weights, and rebases the hospital market basket will be determined. The hospital market basket weights are currently updated once every five years. Annual Hospital Inpatient PPS standardized amount increases are determined in part by the projected increase in the hospital market basket, which is the factor used to estimate the change in price of goods and services used to furnish inpatient hospital care.

Critical Access Hospitals (CAHs)

MMA Section 405(a)

CAHs will be paid under the *Standard Method Payment – Cost-Based Facility Services with Billing of Carrier for Professional Services*, unless they elect to be paid under the Optional (Elective) Payment Method.

For cost reporting periods beginning on or after January 1, 2004:

Outpatient CAH services payments have been increased to the lesser of the following:

- Eighty percent of the 101 percent of reasonable costs for CAH services, which is up from 100 percent of reasonable costs for CAH services; **or**
- One hundred and one percent of the reasonable cost of the CAH in furnishing CAH services minus the applicable Part B deductible and coinsurance amounts.

As of January 1, 2004:

The Optional Payment Method – Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for professional services for outpatient CAH services is based on the sum of the following:

- The lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services **or** 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts; **and**
- One hundred and fifteen percent of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule for physician professional services. Payment for non-physician practitioner professional services is 115 percent of 85 percent of the allowable amount under the MPFS.

MMA Section 405(a) – For cost reporting periods beginning on or after January 1, 2004

Reimbursement for services furnished will be based on 101 percent of the CAH's reasonable costs, up from 100 percent of reasonable costs.

MMA Section 405(b) – For services furnished on or after January 1, 2005

Cost-based reimbursement is extended to on-call emergency room physician's assistants, nurse practitioners, and clinical nurse specialists who are on-call emergency room providers.

MMA Section 405(c) – For services furnished on or after July 1, 2004

Periodic interim payments will be paid every two weeks to CAHs that provide inpatient services and meet certain requirements.

MMA Section 405(d) – *For cost reporting periods beginning on and after July 1, 2004*

Physicians or other practitioners providing professional services in the hospital are not required to reassign their Part B benefits to the CAH in order for the CAH to select the Optional Payment Method. The following applies:

- For CAHs that elected the Optional Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of this rule is retroactive to July 1, 2001.
- For CAHs that elected the Optional Payment Method on or after November 1, 2003, the rule will be effective for cost reporting periods beginning on or after July 1, 2004.

MMA Section 405(e) – Beginning on January 1, 2004

Prior to January 1, 2004, a CAH could not operate more than 15 acute care beds or more than 25 beds if it included up to 10 swing beds.

CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services.

MMA Section 405(f) – The Medicare Rural Hospital Flexibility Program (FLEX)

This program has been reauthorized to make grants to all states in the amount of $35 million in each of fiscal years (FY) 2005 through 2008. The FLEX program makes grants for specified purposes to states and eligible small rural hospitals.

MMA Section 405(g) – For cost reporting periods beginning on or after October 1, 2004

CAHs may establish psychiatric units and rehabilitation units that are distinct parts (DP) of the hospital. The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit. The psychiatric and rehabilitation DPs must meet the applicable requirements for such beds in short-term general hospitals, and Medicare payments will equal payments to units of short-term general hospitals for these services.

MMA Section 405(h) – Until January 1, 2006

States can continue to certify facilities as necessary providers in order for them to be designated as CAHs.

Low Volume Hospitals

MMA Section 406 – Effective October 1, 2004

Low volume hospitals can receive an additional percentage increase, capped at 25 percent, based on the relationship between the cost-per-case and the number of discharges for acute inpatient hospitals. A low volume hospital is a hospital that has fewer than 800 discharges during the fiscal year and is located more than 25 road miles from another acute care hospital.

Hospice

MMA Section 408 – Effective December 8, 2003

Nurse practitioners can serve as the attending physician for a patient who elects the hospice benefit. Nurse practitioners acting as the attending physician are prohibited from certifying the terminal diagnosis.

MMA Section 409 – Demonstration project

A demonstration project will be conducted for five years to test delivery of hospice care in rural areas, under which Medicare eligible individuals without a caregiver at home may receive care in a facility of 20 or fewer beds. This facility will not have to offer hospice services in the community or comply with the 20 percent limit on inpatient days.

MMA Section 512 – Effective on or after January 1, 2005

MMA provides for coverage of certain physician's services for certain terminally ill patients. Beneficiaries entitled to these services are those who have not yet elected the hospice benefit and have not previously received these services. The covered services include evaluating the patient's need for pain and symptom management, including the need for hospice care, counseling the beneficiary on end-of-life issues and care options, and advising the beneficiary regarding advanced care planning. The covered services are those furnished by a physician who is the medical director or employee of a hospice program.

Federally Qualified Health Centers (FQHCs)

MMA Section 410 – For services furnished on or after January 1, 2005

Professional services provided by physicians, physician's assistants, nurse practitioners, and clinical psychologists who are affiliated with FQHCs are excluded from the Skilled Nursing Facility (SNF) PPS in the same manner such services would be excluded if provided by individuals not affiliated with FQHCs.

MMA Section 431 – *Safe harbor*

A final rule will be published that contains standards for a new safe harbor to the anti-kickback statute. Under this safe harbor, prohibitions against kickbacks will not apply to remuneration under a contract, lease, grant, loan, or other agreement between certain FQHCs and any individual or entity that provides items, services, donations, or loans to the FQHC. The arrangement must contribute to the FQHC's ability to maintain or increase the availability or quality of services provided to a medically underserved population. These standards will determine whether the arrangement:

- Results in savings of federal grant funds or increased funds to the FQHC;
- Expands or limits a patient's freedom of choice; and
- Protects a health care professional's independent judgment regarding the provision of medically appropriate treatment.

Rural Health Clinics (RHCs)

MMA Section 410 – For services furnished on or after January 1, 2005

Professional services provided by physicians, physician's assistants, nurse practitioners, and clinical psychologists who are affiliated with RHCs are excluded from the SNF PPS, in the same manner as such services would be excluded if provided by individuals not affiliated with RHCs.

Rural Community Hospitals (RCHs)

MMA Section 410(A) – Not before October 1, 2004 or later than January 1, 2005

A five-year demonstration program will be conducted to test the advisability and feasibility of establishing RCHs to provide Medicare covered inpatient hospital services in rural areas. A RCH is a hospital located in a rural area, or reclassified as such, with fewer than 51 acute care beds that is not currently designated or eligible for designation as a CAH and makes 24-hour emergency care services available.

DP psychiatric and rehabilitation beds do not count toward the bed limit. Not more than 15 hospitals in states with low population densities will be selected to participate in the demonstration. Medicare payment to the hospitals will be on the basis of reasonable costs or a "target amount" of prior year reasonable costs plus the increase in the inpatient hospital update factor.

Hold Harmless Reimbursement Provisions

MMA Section 411 – Beginning with cost reporting periods on and after January 1, 2004

Hold harmless reimbursement provisions for hospital Outpatient Department (OPD) services performed at small rural hospitals and SCHs will be extended for two years. Under the hold harmless reimbursement provisions, small rural hospitals and SCHs with no more than 100 beds are paid no less under the Hospital OPD PPS than they would have been paid under the prior reimbursement system for covered OPD services provided before January 1, 2004.

Effective January 1, 2006, payments to small rural hospitals and SCHs may be increased if a study finds that rural costs of providing outpatient services is greater than urban costs of providing outpatient services.

Work Geographic Adjustment

MMA Section 412 – Work geographic index

The work geographic index will be raised to 1.0 in any physician payment locality where the index is less than 1.0 during 2004, 2005, and 2006. The work geographic index reflects the geographic variation in average professional compensation in one area compared to the national average.

Medicare Incentive Payment Programs for Physician Scarcity Areas (PSAs) and Health Professional Shortage Areas (HPSAs)

MMA Section 413 – For services furnished on or after January 1, 2005 and before January 1, 2008

For services furnished on or after January 1, 2005 and before January 1, 2008, a new PSA incentive payment of five percent will be available to primary care and specialty physicians in areas that have few physicians available. Counties will be identified based separately on the ratio of primary care physicians to Medicare eligible individuals residing in the county and on the ratio of specialist care physicians to Medicare eligible individuals residing in the county. To the extent that it is feasible, a rural census tract of a metropolitan statistical area, commonly known as the Goldsmith Modification area, will be counted as a scarcity area.

Effective January 1, 2005, the HPSA incentive payment will be paid automatically for services furnished in full county primary care geographic area HPSAs and mental health HPSAs rather than having the physician identify that the services are furnished in such areas. Services provided in areas other than full county

HPSAs will still require the submission of a modifier to receive the bonus payment.

CMS will develop a user-friendly web site that contains HPSA and PSA information, and before the beginning of the calendar year, a list of the HPSAs for which the incentive payments will automatically be made for the year.

Ambulance Services

MMA Section 414 – Effective July 1, 2004

An alternate fee schedule phase-in formula will be established for certain providers and suppliers based on a specified blend of the national fee schedule and a regional fee schedule based on census division. This provision is designed to ease the transition to the national fee schedule. If the alternate phase-in formula for a census division results in higher payment, all providers and suppliers in that region will be paid under that formula and their phase-in will last through 2010. Mileage payment increases are as follows:

- Through 2008, mileage payments for ground ambulance trips that are longer than 50 miles will be increased by one-quarter of the payment per mile otherwise applicable to the trip.
- Through 2009, the base payment rate for ambulance trips that originate in rural areas with a population density in the lowest quartile of all rural county populations will be increased by 22.6 percent. This increase is based on the estimated average cost per trip in the lowest quartile as compared to the average cost in the highest quartile of all rural county populations.
- Through 2006, payments will be increased by two percent for rural ground ambulance services and by one percent for non-rural ground ambulance services.

MMA Section 415 – Effective January 1, 2005

Rural air ambulance services will be reimbursed at the air ambulance rate if the services:

- Are reasonable and necessary based on the patient's condition at or immediately prior to transport; and
- Meet equipment and crew requirements.

Rural air ambulance services are deemed medically necessary when they are requested by:

- A physician or other qualified person who reasonably determines that land transport would threaten the patient's survival or health; or
- Recognized state or regional Emergency Medical Services personnel.

In most cases, the presumption of medical necessity does not apply if:

- There is a financial or employment relationship between the person requesting the air ambulance or his/her immediate family and the entity furnishing the service; or
- The entity requesting the service owns the entity furnishing the service.

Outpatient Hospital Clinical Diagnostic Laboratory Tests

MMA Section 416 – For cost reporting periods beginning July 1, 2004 through June 30, 2006

Part B-covered outpatient hospital clinical diagnostic laboratory tests furnished by rural hospitals with fewer than 50 beds located in rural areas with a population density in the lowest quartile of all rural county populations will be reimbursed on a reasonable cost basis.

Telemedicine

MMA Section 417 – Telemedicine demonstration

This section extends the telemedicine demonstration four additional years and authorizes an additional $30 million in funding. This demonstration uses high-capacity computer systems and medical informatics to improve primary care and prevent health complications in Medicare eligible individuals with diabetes mellitus who live in isolated rural and inner city areas.

Originating Telehealth Sites

MMA Section 418 – For Telehealth service beginning on January 1, 2006

The Health Resources & Services Administration (HRSA), in consultation with CMS, will evaluate the feasibility of including SNFs in the list of permissible originating sites for telehealth services beginning on January 1, 2006.

Home Health (HH) Agencies

MMA Section 421 – For Medicare Part A and Part B episodes and visits beginning on April 1, 2004 and before April 1, 2005

There will be a payment increase of five percent to HH agencies for services furnished in rural areas.

MMA Section 701(a) and 701(b) – *HH Payment Update*

These sections provide for holding the HH payment update at the current rate of the HH market basket percentage increase for the last calendar quarter of 2003 and the first calendar quarter of 2004.

Beginning with the last three calendar quarters of 2004 and continuing through calendar years 2005 and 2006, the HH update will be based on the HH market basket percentage increase minus 0.8 percent. Beginning in 2005, the annual HH PPS update will be effective in January of each year rather than in October.

Unused Resident Positions

MMA Section 422 – Effective July 1, 2005

Resident positions from hospitals that have not met their resident full-time equivalent (FTE) cap for the most recently settled or submitted (subject to audit) cost reporting period will be redistributed.

Redistribution of these positions is based on the difference between the hospital's otherwise applicable FTE cap or "otherwise applicable resident limit" and the number of resident slots filled in the most recently settled/submitted cost reporting period or the "reference resident level."

There are some exceptions regarding the expansion of existing programs or previously approved new residency programs that may apply to the calculation of the "reference resident level." Unused residency positions are limited to no more than 25 FTEs. They will be redistributed based on location, with priority given in the following order:

1) Rural hospitals;
2) Small urban hospitals; and
3) Hospitals that are the only ones with a particular residency program in the state. Whether the hospital will be likely to fill such positions within the first three cost periods after the determination is made will be taken into account.

Expanded Responsibilities of Office of Rural Health Policy

MMA Section 432 – Effective December 8, 2003

The HRSA Office of Health Policy's responsibilities will be expanded to include the administration of grants, cooperative agreements, contracts, and other activities that will improve health care in rural areas.

Medicare Payment Advisory Commission (MedPAC) Study

MMA Section 433

The MedPAC will analyze how certain rural sections in the MMA affect total payments, growth in costs, capital spending, and other payments.

Frontier Extended Stay Clinics (FESCs)

MMA Section 434(a) – Demonstration Project

A demonstration project will be conducted for three years under which FESCs located in isolated rural areas are treated as Medicare providers. The clinics must be located at least 75 miles from the nearest acute care hospital or be inaccessible by public road. The clinics also must be designed to address the needs of seriously ill, critically ill, or injured patients who, because of adverse weather conditions or for other reasons, need monitoring and observation for a limited period of time.

Indirect Medical Education (IME) Adjustment

MMA Section 502

For discharges occurring between April 1, 2004 and October 1, 2004, the IME add-on percentage will be 5.98 percent; during FY 2005, 5.79 percent; during FY 2006, 5.58 percent; during FY 2007, 5.38 percent; and during FY 2008 and future years, 5.5 percent.

Graduate Medical Education

MMA Section 711

For cost reporting periods beginning on or after October 1, 2004 through September 30, 2013, the freeze on updates to the hospital per resident amounts that exceed 140 percent of the geographically adjusted national average will be reinstated.

MMA Section 712

For cost reporting periods beginning on or after October 1, 2003, regardless of the reduction in the initial period of board eligibility by relevant medical boards, the geriatric exception to allow up to two years of additional training in a geriatrics program is considered part of the initial residency period.

MMA Section 713

For a one-year period beginning on January 1, 2004, hospitals will be allowed to count residents who are training at non-hospital sites in osteopathic and allopathic family programs that have been in existence as of January 1, 2002, regardless of the financial arrangement between the hospital and the supervisory teaching physician.

Additional Information

For detailed information about the MMA, please visit: *http://www.cms.hhs.gov/medicarereform.*
For the MMA update, please visit: *http://www.cms.hhs.gov/mmu.*

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0450
Effective Date: N/A
Implementation Date: N/A

Centers for Medicare & Medicaid Services (CMS) Working to Improve Provider Enrollment Process

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

Provider Types Affected

All Medicare physicians and providers.

Provider Action Needed

This article is primarily for informational purposes, but providers want to be sure they understand the processes available to assist them when enrolling for Medicare or when updating their information with Medicare. This article deals mostly with problems carriers are having in processing new provider enrollment applications, changes in provider enrollment information, and applications for reassignment of payments by providers.

Background

For some time, providers have expressed concerns about the length of time it takes to enroll in Medicare and about the processes they must go through to accomplish that enrollment. CMS also has been concerned about ways to improve the process, while assuring it has the information needed to process claims correctly and the data needed to safeguard Medicare trust funds.

As a way to improve the overall infrastructure for the systems supporting the provider enrollment function, CMS launched a new national enrollment system, the Provider Enrollment and Chain/Ownership System, also referred to as PECOS. This system was implemented in July 2002 for Medicare fiscal intermediaries (FIs) and the process began rather smoothly for providers who deal with FIs.

On November 3, 2003, CMS implemented PECOS for carriers, extending the new process to physicians and other providers who interact with carriers. Unfortunately, the extension of PECOS to the carriers was considerably more problematic than the implementation for FIs. Some of the problems with the carrier implementation phase included the following:

- Some carriers were already facing backlogs of work in the enrollment area and the introduction of PECOS initially increased that backlog.
- The PECOS system and its supporting infrastructure was not as stable on the carrier side as on the FI side, mostly due to the much larger provider population on the carrier side, and a correspondingly higher volume of data and transactions.
- The interaction between PECOS and carrier systems was more problematic than the interaction between PECOS and FI systems.
- CMS may have underestimated the amount of time that carrier staff needed to train on the system and the carrier staff actually needed more training on the enrollment process itself in order to use PECOS effectively.

To compound these problems, CMS was operating under a continuing budget resolution in November 2003, which meant it had no budgetary authority to enable the carriers to hire temporary staff or to work significant amounts of overtime to handle the increased and problematic workloads. The result was that many providers trying to enroll with carriers or change their enrollment information encountered undue delays in processing their requests and this caused a significant problem for many providers. CMS regrets these problems and has been working aggressively with the carrier community to eliminate the bottlenecks.

Additional Information

As soon as CMS became aware of the problems, it took measures to resolve the issues. CMS' actions included the following:

- An emergency team, led by a senior CMS manager, was formed to identify the specific problems, visit the carriers with the more significant backlogs, and to formulate solutions.
- In February 2004, CMS was able to provide fiscal year 2004 budget authority to the carriers and, more recently, CMS directed the carriers to identify funding needs and to hire temporary staff to reduce the backlogs and expedite processing of enrollment actions.
- Special work teams, consisting of CMS staff and staff from the CMS contractor that developed PECOS, have been formed to communicate with the carriers daily to resolve known problems and to surface new problems for resolution.
- CMS has directed the carriers to make some basic changes to their enrollment processes so initial screenings of enrollment actions are made early and missing information can be identified and obtained from providers more quickly than was previously done.
- CMS has directed the carriers to make other changes to streamline the overall enrollment process, while preserving the integrity and accuracy of those processes.

CMS and the carriers believe these initial steps will result in significant improvements, but CMS is also aware that it will take some time to reduce the backlogs and bring stability to these processes. If any provider is facing a severe problem as a result of this situation, CMS encourages them to contact their carrier at the toll-free enrollment help line. These toll-free numbers may be found at: *http://www.cms.hhs.gov/providers/enrollment/contacts.*

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

In addition, CMS outlines some steps that providers can take to speed up the processes for their own transactions, such as the following:

- Providers are encouraged to be sure to submit complete and correct applications, including all necessary information.
- If your carrier contacts you for additional information, be ready to provide it promptly.
- When the carrier contacts you by letter for more information, be sure to reply by letter to the specific address listed in the communication to you.
- When contacted by phone, ask the carrier how best to get the information back to them, i.e., by phone, mail, e-mail, or fax.
- Use the pdf version of the enrollment application. This pdf form has built-in edits that help eliminate basic errors. This form can also be found at: *http://www.cms.hhs.gov/providers/enrollment/forms.*
- Remember that you need not complete an entire form to change an address. Complete only the portions required to effect the change.

CMS regrets the inconvenience and burden these problems have caused providers. It is not unusual to experience growing pains when new and improved computer systems are installed. Nonetheless, CMS appreciates that providers should expect prompt and correct processing of their transactions. CMS and the carriers are working aggressively to make that happen.

Eventually, providers will benefit from PECOS because the new system will make it much easier for providers to

establish additional offices with Medicare or to enroll for multiple sites with Medicare.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0417
Effective Date: N/A

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The Centers for Medicare & Medicaid Services (CMS) Doctors' Office Quality Information Technology Demonstrations: Providing Leadership in the Adoption of Electronic Health Records

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

Provider Types Affected

All providers.

Impact on Providers

This article is informational only.

Background

Recent studies have highlighted the potential for Healthcare Information Technology (HIT) to improve the quality, safety, and efficiency of healthcare. Systems that enhance patient-clinician communication, access to patient information, as well as decision support and reference data hold the promise of improving the efficiency and effectiveness of healthcare delivery. Additionally, enhanced HIT infrastructure allows the implementation of improved tracking and surveillance applications, which are important in battling emerging public health threats. The Medicare Modernization Act of 2003 encourages the use of HIT to manage the clinical care of beneficiaries.

Furthermore, there is great interest in the integration of HIT in healthcare systems by patients, payers, and health policy leaders alike. A recent Institute of Medicine (IOM) report, *Fostering Rapid Advances in Health*, called for significant reforms in the practice and organization of medicine and recommended that the U.S. Department of Health & Human Services (DHHS) undertake a number of demonstration projects to stimulate innovation in the adoption of HIT systems in healthcare.

Despite this momentum, physician offices remain largely unengaged in terms of their adoption and use of e-health technologies. Given that the bulk of patient care is provided in ambulatory settings, the lack of HIT integration precludes potentially significant improvements in quality and efficiency in the delivery of healthcare. Through its role as a major payer of healthcare services and sponsor of both the largest national quality improvement program in the Nation, and innovative disease management demonstrations, CMS is actively engaged in fostering IT integration in the Nation's health care system.

The CMS Doctors' Office Quality Information Technology (DOQ-IT) is a major project created to promote Electronic Health Records (EHR) in ambulatory care. This two-year Special Study demonstration is designed to improve quality of care, patient safety, and efficiency for services provided to Medicare beneficiaries by promoting the adoption of Electronic Medical Records (EMR)/Electronic Health Records (EHR) and HIT in primary care physician offices. This demonstration involves 4 states: California, Arkansas, Massachusetts and Utah. Lumetra, the California Quality Improvement Organization (QIO), is the lead Medicare QIO and is coordinating the effort through the QIO program in the other three states.

The information gained from DOQ-IT will be used solely for the purposes of disseminating the use of HIT, and studying the role of HIT in improving healthcare delivery in the ambulatory setting. DOQ-IT will not be merged with any enforcement or program integrity efforts.

Additional Information

For additional information please see *http://www.doqit.org* or contact James Sorace MD at jsorace@cms.hhs.gov.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0505
Effective Date: N/A

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How to Locate Specific Transmittals/Change Requests (CRs) of Interest That Are Posted on Centers for Medicare & Medicaid Services (CMS) Web Sites

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

Provider Types Affected

All Medicare physicians, providers, suppliers, and others who use the Medlearn Matters Articles and Related Change Request Information.

Provider Action Needed

This Special Edition article has been written to assist physicians, providers, and suppliers in locating specific Change Requests of interest that CMS has issued and posted on its website.

Background

CMS Program Transmittals/Change Requests (CRs) are used to communicate new or changed policies, and/or procedures that are being incorporated into a specific CMS program manual, and Medlearn Matters articles are written about selected CMS Transmittals/Change Requests to assist providers in understanding these transmittals. Each Medlearn Matters article usually has a section included at the end of the article titled *Additional Information* that includes a variation of the following statement:

For complete details (regarding this Change Request XXXX), please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

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

Note: The above web site includes Transmittals/CRs issued for the current year. Therefore, starting in January 2005, the above website includes only those Transmittals/CRs with communication (comm.) release dates during calendar year 2005.

However, if you scroll down to the end of the above website page, you will find options for being redirected to websites for Transmittals/CRs issued in previous years (2000 through 2004).

An abbreviated copy/view of the above CMS website screen is shown below:

Medicare & Medicaid
2005 Program Transmittals/Program Memos
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SIZE	FILE	COMMUNICATION (COMM) DATE	MANUAL	SUBJECT	IMPLEMENTATION DATE	CR NUM
51 kb	R425CP	1/11/2005	PUB 100-04	Section 630 of the …	4/3/2005	3521
168 kb	R423CP	1/6/2005	PUB 100-04	January 2005 Update of the …	1/14/2005	3632

The files listed above are **PDF (Portable Document Format) files. In the past the transmittal cover page was all we were able to put on the Internet. PDF format enables us to put the entire transmittal on the Internet. You can view and print PDF files exactly as they were originally printed in paper form. To view these documents, you must have the Adobe Acrobat Reader, which can be downloaded at no cost at:

Adobe Reader - Download - *http://www.adobe.com/products/acrobat/readstep2.html.*
2004 Transmittals | 2003 Transmittals | 2002 Transmittals | 2001 Transmittals

Accessing CRs released prior to January 1, 2005

If you want to review a Transmittal/CR with a release date in a previous year, you can select the desired year, and you will be redirected to one of the following websites:

- 2004 - *http://www.cms.hhs.gov/manuals/pm_trans/2004/transmittals/comm_date_dsc.asp*
- 2003 - *http://www.cms.hhs.gov/manuals/pm_trans/2003/transmittals/comm_date_dsc.asp*
- 2002 - *http://www.cms.hhs.gov/manuals/pm_trans/2002/transmittals/comm_date_dsc.asp*
- 2001 - *http://www.cms.hhs.gov/manuals/pm_trans/2001/transmittals/comm_date_dsc.asp*
- 2000 - *http://www.cms.hhs.gov/manuals/pm_trans/2000/transmittals/comm_date_dsc.asp*

Once you have accessed the desired Transmittal/CR website, you can **sort** the Table of Contents (example shown above) by clicking your mouse on any column heading. To reverse the order of the sort for that column, click on the sort order icon.

For some users, once you have accessed the desired Transmittal/CR web site, type Ctrl F (i.e., hold down the Control (Ctrl) key first, then press the 'f' key), and a 'Find' box will appear. Type the desired CR number in the 'Find What?' box, press the enter key, and you will be taken directly to the CR of interest which will be highlighted.

Additional Information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Special Edition Article #: SE0506
Medlearn Matters Number: SE0506
Related Change Request (CR) #: NA
Implementation Date: January 14, 2005

The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contract (RAC) Initiative

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

Provider Types Affected

Physicians, providers, and suppliers, especially in California, Florida, and New York.

Provider Action Needed

Physicians, providers, and suppliers should note that this initiative is designed to determine whether the use of Recovery Audit Contracts (RACs) will be a cost-effective means of ensuring that you receive correct payments and to ensure that taxpayer funds are used for their intended purpose. As the states with the largest Medicare expenditure amounts, California, Florida, and New York have been selected for pilot RACs that will begin during the first part of 2005 and last for three years. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the Medicare affiliated contractors (MACs), which include carriers, fiscal intermediaries (FIs), and durable medical equipment regional carriers [DMERCs]).

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 306) directs the secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in 1) identifying underpayments and overpayments, and 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

A small percentage of claims (< 5 percent) are examined during medical review of claims performed by the MACs, and in annual studies of the Medicare program, claims payment error rates of between 6 percent and 10 percent have been identified. It is further estimated that in the last two fiscal years, billions of dollars have been inappropriately paid out by Medicare. There is growing concern that the Medicare Trust Funds may not be adequately protected against erroneous payment through current administrative procedures.

This pilot program is designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to providers. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the MACs. To accomplish this, the following is planned:

- There will be RACs for both medicare secondary payer (MSP) and non-MSP claims and activity.
- Compensation for RACs will be provided through retention of a percentage of the overpayment recoveries.

The following provides additional details about the RACs pilot program:

- Claims reviewed by RACs will have been submitted to the carriers/intermediaries at least a year before to ensure that the ordinary processing will have been completed.
- RACs will 1) perform data analysis to identify areas of investigation, and 2) request claims history information from the carriers/intermediaries.
- Non-MSP RACs will identify and recover claims overpayments only. They will not be permitted to establish cost report overpayments.
- RACs will apply national coverage policies and local coverage determinations (LCDs) that have been approved by the MACs.
- The collection policies to be applied by this pilot will be the same as those currently in effect for the carriers/

intermediaries, including assessment of interest on the portion of any debt that is unpaid 30 days after issuance of the demand letter.

- No new policy will be applied. In addition:
- Providers will be permitted to appeal any negative determinations to their MAC; and
- If underpayments are determined, the information will be forwarded to the MACs for processing and payment.

CMS selected the following three states with the largest Medicare benefit payment amounts as the pilot states for the Recovery Audit Contracts:

- California
- Florida
- New York

CMS released a request for proposal (RFP) to interested qualified bidders and expects the contractor selections to be made in the beginning of 2005. It is expected that RACs will start work in May of 2005, and the duration of the pilot contracts will be three years.

Each of the three pilot states will have 1) one contractor for non-MSP claims overpayment recovery and 2) another (or possibly the same) contractor for MSP recoveries. To avoid a conflict of interest, current Medicare contractors are not eligible to bid on these contracts.

A complete evaluation of the pilot program will be made before extending it in the three designated states or to additional states.

Additional Information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Find out more about the Medicare Prescription Drug and Modernization Act of 2003 (MMA) at the following CMS website: *http://www.cms.hhs.gov/medicarereform/.*

In addition, Section 306 was taken from the MMA and is provided below:

House Rpt.108-181 - PROVIDING FOR CONSIDERATION OF H.R. 1, THE MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AND H.R. 2596, HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

a) IN GENERAL- The Secretary shall conduct a demonstration project under this section (in this section referred to as the 'project') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project-

(1) Payment may be made to such a contractor on a contingent basis;
(2) Such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and
(3) The Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION -

(1) SCOPE- The project shall cover at least 2 states that are among the states with-

(A) The highest per capita utilization rates of Medicare services, and
(B) At least 3 contractors.

(2) DURATION - The project shall last for not longer than 3 years.

(c) WAIVER - The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS-

(1) IN GENERAL- The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS- The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42

U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY- In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program under Title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD- A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT- The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project information means information about a conviction for a relevant crime or a finding of patient or resident abuse.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0469
Related CR Release Date: N/A

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

All Medicare providers.

Provider Action Needed

STOP – Impact to You

The July 2004 through October 2004 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. Your Medicare carrier or fiscal intermediary must use the latest approved and valid codes in 835 transactions, corresponding standard paper remittance advice, and coordination of benefits transactions.

CAUTION – What You Need to Know

The most current and complete code list will be found online at: *http://wwwwpc-edi.com/codes.*

Please note that in case of a discrepancy, the code text included on this Washington Publishing Company (WPC) web site will supersede any corresponding text in a Medicare CR.

GO – What You Need to Do

The above noted codes are updated three times a year. Please advise your billing staff to stay current with the latest approved and valid codes, in accordance with effective and implementation dates, to ensure correct interpretation of the electronic or paper remittance advice notices sent by Medicare.

Background

The Remittance Advice Remark Code list is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). This list is maintained by The Centers for Medicare & Medicaid Services (CMS) and is updated three times a year.

The Health Care Claim Adjustment Codes are maintained by the Claim Adjustment Reason Code and Status Code Maintenance Committee. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and decides on any additions, modifications, or retirement of reason codes. This updated list is also posted three times a year.

The complete list of current codes is available online at the WPC website: *http://www.wpc-edi.com/codes.*

Here is a summary of the current updates.

Remark Codes

- **New**

New codes from N247 to N344 have been created to replace a number of generic remark codes, or to enable some existing codes to be split to better reflect their lowest component. This has been done to resolve some provider com-

plaints that it is difficult for them to correlate certain remark codes with segments and data elements submitted on their corresponding claims. Codes with multiple meanings have been split, and new code(s) added to report each of the multiple bits of information previously included in a single message. For example,

- M45 (Missing/incomplete/invalid occurrence codes or dates) has been modified to mean "Missing/incomplete/invalid occurrence code(s)," and N299 (Missing/incomplete/invalid occurrence date(s)) has been added to address the date portion of the prior message.
- MA29 has been deactivated entirely and codes N256, N258, N261, N264, N266, N269, N279, N281, N285, N289, N292, N294, and N296 have been added to convey distinct types of information previously conveyed in MA29.

The following is a list showing the new codes and the source code that has been modified/split to create the new code:

New Code	Split from Existing Code
N299	M45
N300	M46
N301	M51
N302	M74
N303	MA66
N304	N57

- **Modified Remark Codes**

The following table reflects modified remark codes:

Code	Current Modified Narrative	Modification Date
M67	Missing/incomplete/invalid other procedure code(s).	12/2/04
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.	12/2/04
M45	Missing/incomplete/invalid occurrence code(s).	12/2/04
M46	Missing/incomplete/invalid occurrence span code(s).	12/2/04
M51	Missing/incomplete/invalid procedure code(s).	12/2/04
MA66	Missing/incomplete/invalid principal procedure code.	12/2/04
MA121	Missing/incomplete/invalid x-ray date.	12/2/04
MA122	Missing/incomplete/invalid initial treatment date.	12/2/04
N31	Missing/incomplete/invalid prescribing provider identifier.	12/2/04
N57	Missing/incomplete/invalid prescribing date.	12/2/04

- **Deactivated Remark Codes**

Codes M57, M68, M108, M110, M120, M128, MA29, MA38, MA 52, MA82, MA105, MA127, and N145 have been deactivated.

Reason Codes

- **New**

Code 165 has been added as of October 2004 and its narrative is "Payment denied/reduced for absence of, or exceeded referral."

Additional Information

The most recent changes approved for the Remittance Advice Remark Codes and the Claim Adjustment Reason Codes can be found in the official instruction issued to your carrier or fiscal intermediary, including durable medical equipment regional carriers (DMERCs). That official instruction is found in CR 3636, which is available at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

Once at that page, scroll down the CR NUM column on the right to find the link for CR 3636. Click on the link to open and view the file for the CR. The CR attachments also include information on the process of the decision making process that updates the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. It also includes a table of changes; however, please note that the most current and complete list is online at the WPC website. This CR includes changes made only from July through October of 2004.

If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll free number at: *http://www.cms.hhs.gov/medlearn/tollnums.asp.*

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: 3636 Medlearn Matters Number: MM3636
Related CR Release Date: January 21, 2005 Related CR Transmittal #: 436
Effective Date: April 1, 2005 Implementation Date: April 4, 2005

Common Working File (CWF) Duplicate Claim Edit for Referred Clinical Diagnostic Services and Purchased Diagnostic Services

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

Provider Types Affected

Physicians, laboratories, clinical laboratories, and independent diagnostic testing facilities (IDTFs).

Provider Action Needed

STOP – Impact to You

Effective April 1, 2005, a new edit will be established in Medicare systems to check for duplicate claims for referred clinical diagnostic laboratory services and purchased diagnostic services submitted by physicians/suppliers to more than one carrier.

CAUTION – What You Need to Know

Claims submitted for referred clinical diagnostic/purchased diagnostic services will be identified as "duplicate claims" **when the involved claims contain different carrier numbers and all of the following data matches in the claim fields:** (a) Beneficiary Name; (b) Beneficiary Health Insurance Claim Number (HICN); (c) Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) code; (d) Date of Service; and (e) CPT/HCPCS Code Modifier.

GO – *What* You Need to Do

Affected providers should be aware that a claim for a referred clinical diagnostic/purchased diagnostic service that is identified as a duplicate claim under the above criteria would be rejected.

Background

The Center for Medicare & Medicare Services (CMS) recognizes that a clinical diagnostic laboratory may refer a specimen to another clinical diagnostic laboratory for testing. CMS generally requires the clinical diagnostic laboratory that furnishes the service to bill for the service. However, under certain conditions, §1833(h)(5)(A)(ii) of the Social Security Act permits a clinical diagnostic laboratory to bill for a clinical diagnostic laboratory fee-schedule service that was performed by another clinical diagnostic laboratory.

Prior to July 1, 2004, many carriers were unable to process a claim for a referred clinical diagnostic laboratory test when the test was performed outside of their jurisdiction because they did not possess that jurisdiction's fee schedule.

CMS had not previously required carriers to adjudicate a claim for a referred clinical diagnostic laboratory service furnished in another jurisdiction. Therefore, some carriers previously paid for referred clinical diagnostic services performed outside of their jurisdiction while others did not.

In addition, some carriers have permitted reference laboratories located outside of their jurisdiction to enroll by issuing "reference-use-only" provider identification numbers (PINs) for the reference laboratories to use when billing for a referred clinical diagnostic service that was performed within their jurisdiction.

Implementation of National Clinical Laboratory Fee Schedule

To resolve these issues, effective for claims with dates of service on or after July 1, 2004, CMS implemented a national clinical laboratory fee schedule and instructions to make fees for all localities within the United States available to their carriers for processing diagnostic laboratory claims, including claims for referred clinical diagnostic services performed outside of their jurisdiction.

Although CMS has issued billing guidelines for both referred clinical diagnostic laboratory services and for purchased diagnostic services, specifying that these services must be billed to the local carrier with the implementation of the respective fee schedules, either the physician/supplier performing the service, or the purchasing/referring physician/ supplier (as applicable) may bill for the service.

To address a potential program vulnerability, effective April 1, 2005, CMS is implementing a new Common Working File (CWF) edit for both referred clinical diagnostic laboratory services and purchased diagnostic services to identify as duplicate claims those claims that are submitted for the same service, provided to the same beneficiary, and provided on the same date, when these claims are submitted to more than one carrier.

NOTE: Referred clinical laboratory services are identified for processing purposes by the presence of a modifier "90." When performing the data matching, the CWF duplicate claim edit for referred clinical diagnostic/purchased diagnostic services will not include the modifier "90" on referred laboratory claims in the matching criteria, but will perform matching on all other criteria specified above.

The CWF duplicate claim edit will only apply to claims containing a CPT code that is included on the clinical laboratory fee schedule (available on the CMS clinical laboratory website at *http://www.cms.hhs.gov/suppliers/clinlab/default.asp*), or a HCPCS code that is included on the Abstract File for Purchased Diagnostic Tests/Interpretations to be implemented in April 2005.

Implementation Date

The implementation date for this instruction is April 4, 2005.

Additional Information

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

From that web page, look for CR 3551 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

Related Change Request (CR) #: 3551
Related CR Release Date: October 29, 2004
Effective Date: April 1, 2005
Medlearn Matters Number: MM3551
Related CR Transmittal #: 124
Implementation Date: April 4, 2005

Private Contracts Between Beneficiaries and Physicians or Practitioners

Section 1802 of the Social Security Act, as amended by section 4507 of the Balanced Budget Act (BBA) of 1997, permits a physician or practitioner to opt-out of Medicare and enter into private contracts with Medicare beneficiaries, if specific requirements of these instructions are met.

Effect Of Beneficiary Agreements Not To Use Medicare Coverage

Physicians and practitioners, as defined below, may be released from the obligations of the Act, with regard to submission of claims and limits on charges for Medicare covered services, only if they opt-out of Medicare in accordance with the following sections. Physicians and practitioners who do not meet the definition of these terms for the purposes of opting out of Medicare, and other suppliers of services covered by Medicare, are required to submit claims "on behalf of" beneficiaries for all items and services for which Medicare payment may be made on a reasonable charge or fee schedule basis and to abide by the limits on charges to beneficiaries that apply to the item or service being furnished.

- The *only* situation in which non-opt-out physicians or practitioners, or other suppliers, are not required to submit claims to Medicare for covered services is where a beneficiary or his/her legal representative refuses, of his/her own free will, to authorize the submission of a bill to Medicare. In this situation, the bill would not be submitted "on behalf of" the beneficiary. However, the limits on what the physician, practitioner or other supplier may collect from the beneficiary continue to apply to charges for the covered service, notwithstanding the absence of a claim to Medicare.
- If an item or service is one that Medicare may cover in some circumstances but not in others, a non-opt-out physician or practitioner, or other supplier, must still submit a claim to Medicare. However, he/she may choose to provide the beneficiary, prior to the rendering of the item or service, an Advance Beneficiary Notice (ABN). An ABN notifies the beneficiary that Medicare is likely to deny the claim and that if Medicare does deny the claim, the beneficiary will be liable for the full cost of the services. Where a valid ABN is given, subsequent denial of the claim *does* in fact relieve the non-opt-out physician or practitioner, or other supplier, of the limitations on charges that would apply if the services were covered.

NOTE: Opt-out physicians and practitioners should not use ABNs, because they should use private contracts for any item or service that is, or may be, covered by Medicare, except for emergency or urgent care services (see below).

Where a physician or practitioner, or other supplier, fails to submit a claim to Medicare "on behalf of" a beneficiary for a covered Part B service within one year of providing the service, or knowingly and willfully charges a beneficiary more than the applicable charge limits on a repeated basis, he/she may be subject to civil monetary penalties. Congress enacted these requirements for the protection of all Part B beneficiaries. Their application cannot be negotiated between a physician or practitioner, or other supplier, and the beneficiary unless the physician or practitioner is eligible to opt-out of Medicare and the remaining requirements described herein are met. Agreements with Medicare beneficiaries that are not authorized as described and that purport to waive the claims filing or charge limitation requirements, or other Medicare requirements, have no legal force and effect. For example, an agreement between a physician or practitioner, or other supplier, and a beneficiary to exclude services from Medicare coverage, or to excuse mandatory assignment requirements applicable to certain practitioners, is ineffective.

General Rules of Private Contracts

The following rules apply to physicians or practitioners who opt-out of Medicare:

- A physician or practitioner may enter into one or more private contracts with Medicare beneficiaries for the purpose of furnishing items or services that would otherwise be covered by Medicare.
- A physician or practitioner who enters into at least one private contract with a Medicare beneficiary and who submits one or more affidavits, opts out of Medicare for a two-year period unless the opt-out is terminated early or unless the physician or practitioner fails to maintain opt-out. The physician's or practitioner's opt-out may be renewed for subsequent two-year periods.

- Both the private contracts described in the first paragraph of this section and the physician's or practitioner's opt-out described in the second paragraph of this section are null and void if the physician or practitioner fails to properly opt-out in accordance with the conditions of these instructions.
- Both the private contracts described in the first paragraph of this section and the physician's or practitioner's opt-out described in the second paragraph of this section are null and void for the remainder of the opt-out period if the physician or practitioner fails to remain in compliance with the conditions of these instructions during the opt-out period.
- Services furnished under private contracts meeting the requirements of these instructions are not covered services under Medicare, and no Medicare payment will be made for such services either directly or indirectly.

Effective Date of the Opt-Out Provision

A physician or practitioner may enter into a private contract with a beneficiary for services furnished no earlier than January 1, 1998.

Definition of Physician or Practitioner

For purposes of this provision, the term "physician" is limited to doctors of medicine and doctors of osteopathy, optometrists, podiatrists, dentists, and doctors of oral surgery who are legally authorized to practice medicine and surgery by the State in which such function or action is performed; no other physicians may opt-out. Also, for purposes of this provision, the term "practitioner" means any of the following to the extent that they are legally authorized to practice by the State and otherwise meet Medicare requirements: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, or clinical social worker.

The opt-out law does not define "physician" to include chiropractors therefore, they may not opt-out of Medicare and provide services under private contract. Physical therapists in independent practice and occupational therapists in independent practice cannot opt-out because they are not within the opt-out law's definition of either a "physician" or "practitioner".

When a Physician or Practitioner Opts Out of Medicare

When a physician or practitioner opts of out of Medicare, no services provided by that individual are covered by Medicare and no Medicare payment can be made to that physician or practitioner directly or on a capitated basis. Additionally, no Medicare payment may be made to a beneficiary for items or services provided directly by a physician or practitioner who has opted out of the program.

> **EXCEPTION:** In an emergency or urgent care situation, a physician or practitioner who opts out may treat a Medicare beneficiary with whom he/she does not have a private contract and bill for such treatment. In such a situation, the physician or practitioner may not charge the beneficiary more than what a non-participating physician or practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with that physician or practitioner.

Under the statute, the physician or practitioner cannot choose to opt-out of Medicare for some Medicare beneficiaries but not others, or for some services but not others. The physician or practitioner who chooses to opt-out of Medicare may provide covered care to Medicare beneficiaries only through private agreements.

Medicare will make payment for covered, medically necessary services that are ordered by a physician or practitioner who has opted out of Medicare if the ordering physician or practitioner has acquired a unique provider identification number (UPIN) from Medicare, provided that the services are not furnished by another physician or practitioner who has also opted out. For example, if an opt-out physician or practitioner admits a beneficiary to a hospital, Medicare will reimburse the hospital for medically necessary care.

When Payment May be Made to a Beneficiary for Service of an Opt-Out Physician or practitioner

Payment may be made to a beneficiary for services of an opt-out in two cases:

- If the services are emergency or urgent care services furnished by an opt-out physician or practitioner to a beneficiary with whom he/she does not have a previously existing private contract, or
- If the opt-out physician or practitioner failed to privately contract with the beneficiary for services that he/she provided that were not emergency or urgent care services.

Definition of a Private Contract

A "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for 2 years for *all* covered items and services he/she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge. Pursuant to the statute, once a physician or practitioner files an affidavit notifying the Medicare carrier that he/she has opted out of Medicare, he/she is out of Medicare for 2 years from the date the affidavit is signed, unless the opt-out is terminated early, or unless the physician or practitioner fails to maintain opt-out. After those 2 years are over, a physician or practitioner could elect to return to Medicare or to opt-out again. Note that a beneficiary who signs a private contract with a physician or practitioner is not precluded from receiving services from

other physicians and practitioners who have not opted out of Medicare.

Physicians or practitioners who provide services to Medicare beneficiaries enrolled in the new Medical Savings Account (MSA) demonstration created by the BBA of 1997 are not required to enter into a private contract with those beneficiaries and to opt-out of Medicare under section 1802 of the Social Security Act.

Requirements of a Private Contract

A private contract under this section must:

- Be in writing and in print sufficiently large to ensure that the beneficiary is able to read the contract.
- Clearly state whether the physician or practitioner is excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act.
- State that the beneficiary or his/her legal representative accepts full responsibility for payment of the physician's or practitioner's charge for all services furnished by the physician or practitioner.
- State that the beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician or practitioner may charge for items or services furnished by the physician or practitioner.
- State that the beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician or practitioner to submit a claim to Medicare.
- State that the beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician or practitioner that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
- State that the beneficiary or his/her legal representative enters into the contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
- State the expected or known effective date and expected or known expiration date of the opt-out period.
- State that the beneficiary or his/her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- Be signed by the beneficiary or his/her legal representative and by the physician or practitioner.
- Not be entered into by the beneficiary or by the beneficiary's legal representative during a time when the beneficiary requires emergency care services or urgent care services. (However, a physician or practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with this provision.)
- Be provided (a photocopy is permissible) to the beneficiary or to his/her legal representative before items or services are furnished to the beneficiary under the terms of the contract.
- Be retained (original signatures of both parties required) by the physician or practitioner for the duration of the opt-out period.
- Be made available to HCFA upon request.
- Be entered into for each opt-out period.

In order for a private contract with a beneficiary to be effective, the physician or practitioner must file an affidavit with all Medicare carriers to which he/she would submit claims, advising that he/she has opted out of Medicare. The affidavit must be filed within 10 days of entering into the first private contract with a Medicare beneficiary. Once the physician or practitioner has opted out, such physician or practitioner must enter into a private contract with each Medicare beneficiary to whom he/she furnishes covered services (even where Medicare payment would be on a capitated basis or where Medicare would pay an organization for the physician's or practitioner's services to the Medicare beneficiary), except for a Medicare beneficiary needing emergency or urgent care.

If a physician or practitioner has opted out of Medicare, he/she must use a private contract for items and services that are, or may be, covered by Medicare (except for emergency or urgent care services). An opt-out physician or practitioner is not required to use a private contract for an item or service that is definitely excluded from coverage by Medicare.

A non-opt-out physician or practitioner, or other supplier, is required to submit a claim for any item or service that is, or may be, covered by Medicare. Where an item or service may be covered in some circumstances, but not in others, the physician or practitioner, or other supplier, may provide an Advance Beneficiary Notice to the beneficiary, which informs the beneficiary that Medicare may not pay for the item or service, and that if Medicare does not do so, the beneficiary is liable for the full charge.

Requirements of the Opt-Out Affidavit

Under section 1802 (3)(B) of the Social Security Act, a valid affidavit must:

- Be in writing and be signed by the physician or practitioner.
- Contain the physician's or practitioner's full name, address, telephone number, national provider identifier (NPI) or billing number (if one has been assigned), uniform provider identification number (UPIN) if one has been assigned, or, if neither an NPI nor a UPIN has been assigned, the physician's or practitioner's tax identification number (TIN).
- State that, except for emergency or urgent care services, during the opt-out period the physician or practitioner will provide services to Medicare beneficiaries only through private contracts that meet the criteria for services that, but for their provision under a private contract, would have been Medicare-covered services.

- State that the physician or practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the physician or practitioner permit any entity acting on his/her behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except for emergency or urgent care services.
- State that, during the opt-out period, the physician or practitioner understands that he/she may receive no direct or indirect Medicare payment for services that he/she furnishes to Medicare beneficiaries with whom he/she has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare+Choice plan.
- State that a physician or practitioner who opts out of Medicare acknowledges that, during the opt-out period, his/her services are not covered under Medicare and that no Medicare payment may be made to any entity for his/her services, directly or on a capitated basis.
- State on acknowledgment by the physician or practitioner to the effect that, during the opt-out period, the physician or practitioner agrees to be bound by the terms of both the affidavit and the private contracts that he/she has entered into.
- Acknowledge that the physician or practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the physician or practitioner during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom he/she has not previously privately contracted) without regard to any payment arrangements the physician or practitioner may make.
- With respect to a physician or practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit.
- Acknowledge that the physician or practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules specified below under "Emergency or Urgent Care Services" apply if the physician or practitioner furnishes such services.
- Identify the physician or practitioner sufficiently so that the carrier can ensure that no payment is made to the physician or practitioner during the opt-out period. If the physician has already enrolled in Medicare, this would include the physician or practitioner's Medicare uniform provider identification number (UPIN), if one has been assigned. If the physician or practitioner has not enrolled in Medicare, this would include the information necessary to be assigned a UPIN.
- Be filed with all carriers who have jurisdiction over claims the physician or practitioner would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into.

In addition, it is expected that the affidavit will include an effective (signature) date.

Failure to Properly Opt-Out

A. A physician or practitioner fails to properly opt-out for any of the following reasons:

- Any private contract between the physician or practitioner and a Medicare beneficiary, that was entered into before the affidavit was filed does not meet the requirements of a private contract under these rules or
- He/she fails to submit the affidavit(s) in accordance with these requirements.

B. If a physician or practitioner fails to properly opt-out in accordance with the above paragraphs of this section, the following will result:

- The physician's or practitioner's attempt to opt-out of Medicare is nullified, and all of the private contracts between the physician or practitioner and Medicare beneficiaries for the two-year period covered by the attempted opt-out are deemed null and void.
- The physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries, including the items and services furnished under the nullified contracts. A nonparticipating physician or practitioner is subject to the limiting charge provision. For items or services paid under the physician fee schedule, the limiting charge is 115 percent of the approved amount for non-participating physicians or practitioners. A participating physician or practitioner is subject to the limitations on charges of the participation agreement he/she signed.
- The practitioner may not reassign any claim except as provided in section 3060 of the Medicare Carrier's Manual.
- The practitioner may neither bill nor collect an amount from the beneficiary except for applicable deductible and coinsurance amounts, or for noncovered services.
- The physician or practitioner may make another attempt to properly opt-out at any time.

Failure to Maintain Opt-Out

A. A physician or practitioner fails to maintain opt-out under this section if during the opt-out period one of the following occurs:

- He/she has filed an affidavit and has signed private contracts in accordance with these requirements but,
- He/she knowingly and willfully submits a claim for Medicare payment (except emergency or urgent care services for non-contracted beneficiaries—see "Emergency or Urgent Care Services" section); or
- Receives Medicare payment directly or indirectly for Medicare-covered services furnished to a Medicare beneficiary (except emergency or urgent care services for non-contracted beneficiaries—see "Emergency or Urgent Care Services" section).
- He/she fails to enter into private contracts with Medicare beneficiaries for the purpose of furnishing items and services that would otherwise be covered by Medicare, or enters into private contracts that fail to meet the specifications of a private contract; or

- He/she fails to comply with the provisions of these requirements regarding billing for emergency care services or urgent care services; or
- He/she fails to retain a copy of each private contract that he/she has entered into for the duration of the opt-out period for which the contracts are applicable or fails to permit HCFA to inspect them upon request.

B. If a physician or practitioner fails to maintain opt-out in accordance with the above paragraphs of this section, and fails to demonstrate within 45 days of a notice from the carrier of a violation of the first paragraph of this section, that he/she has taken good faith efforts to maintain opt-out (including by refunding amounts in excess of the charge limits to the beneficiaries with whom he/she did not sign a private contract), the following will result effective 46 days after the date of the notice, **but only for the remainder of the opt-out period** (However, if the physician or practitioner did not privately contract and refunds coverage, he/she may still maintain the opt-out):

- All of the private contracts between the physician or practitioner and Medicare beneficiaries are deemed null and void.
- The physician's or practitioner's opt-out of Medicare is nullified.
- The physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries for the duration of the opt-out period.
- The physician or practitioner or beneficiary will not receive Medicare payment on Medicare claims for the remainder of the opt-out period, except as stated above.
- The physician or practitioner is subject to the limiting charge provisions as stated above.
- The practitioner may not reassign any claim except as provided in section 3060 of the Medicare Carrier's Manual.
- The practitioner may neither bill nor collect any amount from the beneficiary except for applicable deductible and coinsurance amounts, or for noncovered services.
- The physician or practitioner may not attempt to once more meet the criteria for properly opting out until the two-year opt-out period expires.

Actions to be Taken in Cases of Failure to Maintain Opt-Out

If Medicare becomes aware that a physician or practitioner has failed to maintain opt-out, he/she will be advised that a claim has been received and that he/she may have inadvertently failed to maintain opt-out. An explanation must be provided within 45 days of being contacted by Medicare of what happened and how the physician or practitioner will resolve it.

If a claim is received from an opt-out physician or practitioner, Medicare will ask if the received claim was:

a) an emergency or urgent situation, with missing documentation (modifier GJ - see below); or
b) filed in error.

When the reason for the letter is that the physician or practitioner filed a claim that he/she did not identify as an emergency or urgent care service, he/she should submit the following information in response:

- Emergency or urgent care documentation, if the claim was for a service furnished in an emergency or urgent situation but included no documentation to that effect; and/or
- If the claim was filed in error, explain whether the filing was an isolated incident or a systematic problem affecting a number of claims.

If the violation was due to a systems problem, he/she should respond with an explanation of the actions being taken to correct the problem and when he/she expects the systems error is expected to be fixed

If no response is received by the specified date Medicare will assume that there has been no correction of the failure to maintain opt-out and that this could result in a determination that he/she is once again subject to Medicare rules.

In the case of a wrongly filed claim, Medicare will hold the claim in suspense until the requested information is provided or the response date lapses. In this case, if the physician or practitioner responds that the claim was filed in error, Medicare will deny the claim and send the physician or practitioner the appropriate Remittance Advice. The beneficiary will be sent a Medicare Summary Notice (MSN) explaining that the claim was submitted erroneously and he/she is responsible for the physician's or practitioner's charge. In other words, the limiting charge provision does not apply and the beneficiary is responsible for all charges. This process will apply to all claims until the physician or practitioner is able to get his or her problem fixed.

If Medicare does not receive a response from the physician or practitioner by the due date, or if it is determined that the opt-out physician or practitioner knowingly and willfully failed to maintain opt-out, the physician or practitioner will be notified of the effects specified in the "Failure to Maintain Opt-out" section above apply. Upon formal notification of this determination, standard Medicare rules again apply (e.g., mandatory submission of claims, limiting charge, etc.)

The act of claims submission by the beneficiary for an item or service provided by a physician or practitioner who has opted out *is not* a violation by the physician or practitioner and does not nullify the contract with the beneficiary. However, if Medicare receives a substantial number of claims submissions by beneficiaries for items or services by an opt-out physician or practitioner, an investigation will be conducted to ensure that contracts between the physician or practitioner and the beneficiaries exist and that the terms of the contracts meet the Medicare statutory requirements outlined in this instruction.

Physician or Practitioner Who Has Never Enrolled in Medicare

A physician or practitioner who has never enrolled in the Medicare program and wishes to opt-out of Medicare must be provided with a Unique Physician Identification Number (UPIN). In order to refer or order services for a Medicare patient, the physician or practitioner must have a UPIN.

If an opt-out physician or practitioner provides emergency or urgent care service to a beneficiary who has not signed a private contact with the physician or practitioner and the physician or practitioner submits an assigned claim, the physician or practitioner must complete Form HCFA-855 and enroll in the Medicare program before receiving reimbursement.

Non-Participating Physicians or Practitioners Who Opt-Out of Medicare

A nonparticipating physician or practitioner may opt-out of Medicare at any time in accordance with the following:

- The two-year opt-out period begins the date the affidavit meeting the requirements is signed, provided the affidavit is filed within 10 days after he/she signs his/her first private contract with a Medicare beneficiary.
- If the physician or practitioner does not timely file any required affidavit, the two-year opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit and the furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subject to standard Medicare rules.

Excluded Physicians and Practitioners

An excluded physician or practitioner may opt-out of Medicare by submitting the required documentation. When determining effective dates of the exclusion versus the opt-out, the date of exclusion takes precedence over the date the physician or practitioner opts out of Medicare. A physician or practitioner who has been excluded must comply with section 1001.1901, title 42 of the Code of Federal Regulations (CFR), "Scope and Effect of Exclusion."

If an excluded or opt-out physician or practitioner submits a claim to Medicare, payment will not be made for services furnished, ordered or prescribed on or after the effective date of the exclusion.

The Relationship Between This Provision and Medicare Participation Agreements

Participating physicians and practitioners may opt-out by filing an affidavit that meets the above-described criteria and which is received by the carrier at least 30 days before the first day of the next calendar quarter showing *an effective date of the first day in that quarter (i.e., 1/1, 4/1, 7/1, 10/1).* The participation agreements will terminate at that time. Services may not be provided under private contracts with beneficiaries earlier than the effective date of the affidavit. Non-participating physicians and practitioners may opt-out at any time.

Because the participation agreement is terminated, services for emergency or urgent care services for beneficiaries with whom the opt-out provider has no contract will be paid at the nonparticipating rate.

Participating Physicians and Practitioners

Participating physicians and practitioners may opt-out if they file an affidavit that meets the criteria and which is received by the carrier at least 30 days before the first day of the next calendar quarter showing an effective date of the first day in that quarter (i.e., 1/1, 4/1, 7/1,10/1). They may not provide services under private contracts with beneficiaries earlier than the effective date of the affidavit.

Participating physicians or practitioners are paid at the full fee schedule for the services they furnish to Medicare beneficiaries. However, the law sets the payment amount for nonparticipating physicians or practitioners at 95 percent of the payment amount for participating physicians or practitioners. Therefore, it is necessary to treat nonparticipating physicians or practitioners differently from participating physicians or practitioners in order to assure that participating physicians or practitioners are paid properly for the services they furnish *before* the effective date of the affidavit. Participating physicians or practitioners must provide Medicare with 30 days notice that they intend to opt-out at the beginning of the next calendar quarter. Participating physicians or practitioners may sign private contracts only after the effective date of affidavits filed.

Physicians or Practitioners who Choose to Opt-Out of Medicare

If a physician or practitioner chooses to opt-out of Medicare, it means that he/she opts out for all covered items and services he/she furnishes. Physicians and practitioners may not have private contracts that apply to some covered services they furnish but not to others. For example, if a physician or practitioner provides laboratory tests or durable medical equipment incident to his/her professional services and chooses to opt-out of Medicare, then he/she has opted out of Medicare for payment of laboratory services and durable medical equipment, prosthetics or orthotics (DMEPOS), as well as for professional services. If a physician or practitioner who has opted out refers a beneficiary to a non-opt-out physician or practitioner for medically necessary services, such as laboratory, DMEPOS, or inpatient hospitalization, those services would be covered by Medicare. In addition, because suppliers of DMEPOS, independent diagnostic testing facilities, clinical laboratories, etc., may not opt-out, the physician or practitioner owner of such suppliers may not opt-out as such a supplier. Therefore, the participating physician or practitioner becomes a nonparticipating physician or practitioner for purposes of Medicare payment for emergency and urgent care services on the effective date of the opt-out.

Relationship to Noncovered Services

Because Medicare's rules do not apply to items or services that are categorically not covered by Medicare, a private contract is not needed to furnish such items or services to Medicare beneficiaries, and Medicare's claims filing rules and

limits on charges do not apply to such items or services. For example, because Medicare does not cover hearing aids, a physician or practitioner, or other supplier, may furnish a hearing aid to a Medicare beneficiary and would not be required to file a claim with Medicare; further, the physician, practitioner, or other supplier would not be subject to any Medicare limit on the amount he/she could collect for the hearing aid.

If the item or service is one that is not categorically excluded from coverage by Medicare, but may be noncovered in a given case (for example, it is covered only where certain clinical criteria are met and there is a question as to whether the criteria are met), a non-opt-out physician or practitioner, or other supplier is *not* relieved of his/her obligation to file a claim with Medicare. If the physician or practitioner, or other supplier, has given a proper advance beneficiary notice (ABN) he/she may collect from the beneficiary the full charge if Medicare does deny the claim.

Where a physician or practitioner has opted out of Medicare, he/she must provide covered services only through private contracts that meet the criteria specified (including items and services that are not categorically excluded from coverage but may be excluded in a given case). An opt-out physician or practitioner is prohibited from submitting claims to Medicare (except for emergency or urgent care services furnished to a beneficiary with whom the physician or practitioner did not have a private contract).

Organizations That Furnish Physician or Practitioner Services

The opt-out applies to all items or services the physician or practitioner furnishes to Medicare beneficiaries, regardless of the location where such items or services are furnished.

Where a physician or practitioner opts out and is a member of a group practice or otherwise reassigns his/her rights to Medicare payment to an organization, the organization may no longer bill Medicare or be paid by Medicare for services that the physician or practitioner furnishes to Medicare beneficiaries. However, if the physician or practitioner continues to grant the organization the right to bill and be paid for the services he/she furnishes to patients, the organization may bill and be paid by the beneficiary for the services that are provided under the private contract. The decision of a physician or practitioner to opt-out of Medicare does not affect the ability of the group practice or organization to bill Medicare for the services of physicians and practitioners who have not opted out of Medicare.

Corporations, partnerships, or other organizations that bill and are paid by Medicare for the services of physicians or practitioners who are employees, partners, or have other arrangements that meet the Medicare reassignment-of-payment rules cannot opt-out because they are neither physicians nor practitioners. However, if *every* physician and practitioner within a corporation, partnership, or other organization opts out, then such corporation, partnership, or other organization would have in effect, opted out.

The Difference Between Advance Beneficiary Notices (ABN) and Private Contracts

An Advance Beneficiary Notice (ABN) allows a beneficiary to make an informed consumer decision by knowing in advance that he/she may have to pay out-of-pocket. An ABN is not needed where the item or service is categorically excluded from Medicare coverage or outside the scope of the benefit.

An ABN is used when the physician or practitioner believes that Medicare will not make payment, while private contracts are used for services that are covered by Medicare and for which payment might be made *if the physician or practitioner had not opted out* and a claim were to be submitted.

Private Contracting Rules When Medicare is the Secondary Payer

The opt-out physician or practitioner must have a private contract with a Medicare beneficiary for all Medicare-covered services, notwithstanding that Medicare would be the secondary payer in a given situation. No Medicare primary *or* secondary payments will be made for items and services furnished by a physician or practitioner under the private contract.

Emergency and Urgent Care Situations

Payment may be made for services furnished by an opt-out physician or practitioner who has not signed a private contract with a Medicare beneficiary for emergency or urgent care items and services furnished to, or ordered or prescribed for, such beneficiary on or after the date the physician opted out.

Where a physician or a practitioner who has opted out of Medicare treats a beneficiary, with whom he does not have a private contract, in an emergency or urgent situation, the physician or practitioner may not charge the beneficiary more than the Medicare limiting charge for the service and must submit the claim to Medicare on behalf of the beneficiary for the emergency or urgent care. Medicare payment may be made to the beneficiary for the Medicare covered services furnished to the beneficiary.

In other words, where the physician or practitioner provides emergency or urgent services to the beneficiary, he/she must submit a claim to Medicare, may collect no more than the Medicare limiting charge in the case of a physician or the deductible and coinsurance in the case of a practitioner. This implements section 1802(b)(2)(A)(iii) of the Social Security Act, which specifies that the contract may not be entered into when the beneficiary is in need of emergency or urgent care. Because the services are excluded from coverage under section 1862(a)(19) of the Act *only* if they are furnished under private contract, HCFA concludes that they are not excluded in this case where there is no private contract, notwithstanding that they were furnished by an opt-out physician or practitioner. Hence, they are covered services furnished by a nonparticipating physician or practitioner, and the rules in effect absent the opt-out would apply in these cases. Specifically, a physician may choose to take assignment (thereby agreeing to collect no more than the Medicare deductible and coinsurance based on the allowed amount from the beneficiary) or not to take assignment (and to collect

no more than the Medicare limiting charge), but a practitioner must take assignment under section 1842(b)(18) of the Act.

Therefore, in this circumstance the physician or practitioner must submit a completed Medicare claim on behalf of the beneficiary with the appropriate procedure code and modifier (GJ) that indicates the services furnished to the Medicare beneficiary were emergency or urgent, and the beneficiary does not have a private agreement with him/her.

Definition of modifier **GJ**: Opt-out Physician or practitioner EMERGENCY OR URGENT SERVICES

The use of this modifier indicates that the service was furnished by an opt-out physician or practitioner who has not signed a private contract with a Medicare beneficiary for emergency or urgent care items and services furnished to, or ordered or prescribed for, such beneficiary on or after the date the physician or practitioner opted out.

Payment for emergency or urgent care items and services to both an opt-out physician or practitioner and the beneficiary will be denied if these parties have previously entered into a private contract (i.e., prior to the furnishing of the emergency or urgent care items or services but within the physician's or practitioner's opt-out period).

Under the emergency and urgent care situation where an opt-out physician or practitioner renders emergency or urgent service to a Medicare beneficiary (e.g., a fractured leg) who has not entered into a private agreement with him/her, as stated above the physician or practitioner is required to submit a claim to Medicare with the appropriate modifier (GJ and 54 as discussed below) and is subject to all the rules and regulations of Medicare including limiting charge. However, if the opt-out physician or practitioner asks the beneficiary, with whom he/she has no private contract, to return for a followup visit (e.g, return within 5 to 6 weeks to remove the cast and examine the leg) the physician or practitioner shall ask the beneficiary to sign a private contract. In other words, once a beneficiary no longer needs emergency or urgent care (i.e., nonurgent followup care), Medicare cannot pay for the followup care and the physician or practitioner can and must, under the opt-out affidavit agreement, ask the beneficiary to sign a private agreement as a condition of further treatment.

The way this would work in the fractured leg example, is that the physician or practitioner would bill Medicare for the setting of the fractured leg with the emergency opt-out HCFA modifier **(GJ)** and the surgical care only modifier (54) to ensure that HCFA does not pay the Evaluation and Management (E&M) that is in the global fee for the procedure. The physician or practitioner would then either have the beneficiary sign the private contract or refer the beneficiary to a Medicare physician or practitioner who has not opted out, who would bill Medicare using the post-operative-only modifier to be paid for the post operative care in the global period.

It would be different if the beneficiary continues to be in a condition that requires emergency or urgent care (e.g., unconscious or unstable after surgery for an aneurysm). In such a case, the followup care would continue to be paid under emergency or urgent care until such time as the beneficiary no longer needed such care.

Definition of Emergency and Urgent Care Situations

Emergency or urgent care services are defined as services furnished to an individual who has an emergency medical condition or who requires services to be furnished within twelve hours after the determination of need is made to avoid adverse health consequences.

An "emergency medical condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions:
- That there is inadequate time to effect a safe transfer to another provider before delivery; or
- That transfer may pose a threat to the health or safety of the woman or unborn child.

Medicare has adopted this definition of emergency medical condition since it has been a long-standing definition with respect to when a hospital must furnish emergency care to an individual who appears at their door. However, the term "emergency or urgent care services" is not limited to emergency services since it also includes "urgent care services." An urgent care service could be any service that needs to be furnished without significant delay to avoid adverse health consequences. For purposes of the "opt-out" provision, an urgent care service is one that needs to be furnished within twelve hours of the determination of need to avoid adverse consequences. For example, if a beneficiary has an ear infection with significant pain, Medicare would view that as requiring treatment to avoid the adverse consequences of continued pain and perforation of the ear drum. The patient's condition would not meet the definition of emergency medical condition since *immediate care* is not needed to avoid placing the health of the individual in serious jeopardy or to avoid serious impairment or dysfunction. However, although it does not meet the definition of emergency care, the beneficiary needs care within a relatively short period of time (which is defined as 12 hours) to avoid adverse consequences, and the beneficiary may not be able to find another physician or practitioner to provide treatment within 12 hours.

Denial of Payment to Employers of Opt-Out Physicians and Practitioners

If an opt-out physician or practitioner is employed in a hospital setting and submits bills for which payment is prohibited under the opt-out provision, Medicare will contact the hospital or clinic or group practice and inform it that payment will be reduced by the amount of Medicare money involved in paying the opt-out physician or practitioner.

Denial of Payment to Beneficiaries and Others

If a beneficiary submits a claim that includes items or services furnished by an opt-out physician or practitioner on dates on or after the effective date of opt-out by such physician or practitioner, Medicare will deny such items or services.

Payment for Medically Necessary Services Ordered or Prescribed By An Opt-out Physician or Practitioner

If claims are submitted for any items or services ordered or prescribed by an opt-out physician or practitioner under section 1802 of the Social Security Act, Medicare may pay for medically necessary services of the furnishing entity, provided the furnishing entity is not also a physician or practitioner that has opted out of the Medicare program.

Mandatory Claims Submission

Social Security Act section 1848(g)(4), Physician or Practitioner Submission of Claims, regarding mandatory claims submission, does not apply once a physician or practitioner signs and submits an affidavit to the Medicare carrier opting out of the Medicare program, for the duration of his/her opt-out period, unless he/she knowingly and willfully violates a term of the affidavit.

Renewal of Opt-Out

A physician or practitioner may renew an opt-out without interruption by filing an affidavit with each carrier to which an affidavit was submitted for the first opt-out period, and to each carrier to which a claim was submitted during the previous opt-out period, provided the affidavits are filed within 30 days after the current opt-out period expires.

Early Termination of Opt-Out

If a physician or practitioner changes his/her mind once the affidavit has been approved by the carrier, the opt-out may be terminated within 90 days of the effective date of the affidavit. To properly terminate an opt-out a physician or practitioner must:

- Not have previously opted out of Medicare.
- Notify all Medicare carriers, with which he/she filed an affidavit, of the termination of the opt-out no later than 90 days after the effective date of the opt-out period.
- Refund to each beneficiary with whom he/she has privately contracted all payment collected in excess of:
- The Medicare limiting charge (in the case of physicians or practitioners); or
- The deductible and coinsurance (in the case of practitioners).
- Notify all beneficiaries with whom the physician or practitioner entered into private contracts of the physician's or practitioner's decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period. In the event such claims are filed and have already been paid by the beneficiaries, the paid amount *must* be indicated on the claim.

When the physician or practitioner properly terminates opt-out in accordance with the second bullet above, he/she will be reinstated in Medicare as if there had been no opt-out.

For Florida providers requesting early termination of opt-out must be submitted in writing to:

Medicare Registration
P.O. Box 44021
Jacksonville, FL 32231-4021

For Connecticut providers reqesting requesting early terminations of opting-out must be submitted in writing to:
Medicare Part B Correspondence
Provider Enrollment Department
P. O. Box 45010
Jacksonville, FL. 32232-5010

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Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "eNews link" on the navigational bar and follow the prompts.

CONNECTICUT MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

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

Phone: 1-866-419-9455

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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.

NEW LCD IMPLEMENTATION

82043: Urinary Microalbumin

New Policy

A microalbumin test evaluates urine for the presence of a protein called albumin. Albumin is normally found in the blood and filtered by the kidneys. When the kidneys are working properly, albumin is not present in the urine. However, when the kidneys are damaged, small amounts of albumin leak into the urine, a condition known as microalbuminuria. In later stages of kidney disease, large amounts of protein leak into the urine, a condition called macroalbuminuria, also known as proteinuria.

Microalbuminia is most frequently associated with kidney damage from diabetes (diabetic nephropathy). However other conditions can lead to kidney damage, such as hypertension, heart failure, cirrhosis, some lipid abnormalities, and several immune disorders. Microalbuminuria is also a marker for increased risk of cardiovascular complications, including atherosclerotic coronary artery disease, stroke, peripheral vascular disease, and cardiovascular mortality.

An abnormal finding of microalbumia is demonstrated by any of the following results:

- A random spot urine sample measurement showing a microalbumin: creatinine ratio clearance ratio >30 mg/gCr
- A timed collection (e.g., 4 hour or overnight) showing > 20 mcg/minute microalbumin
- A 24 hour urine collection showing urinary albumin (30 - 300 mg)

Test results can be affected by conditions such as marked hyperglycemia, high blood pressure, heart failure, fever, blood in the urine, urinary tract infection, some drugs, dehydration and exercising within 24 hours of the test. These conditions may increase urinary albumin levels independently of diabetic nephropathy and may be a source of false positive results.

This LCD has been developed to define the indications and limitations of coverage and/or medical necessity for this service and will be effective for services rendered on or after April 11, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

51798: Post-Voiding Residual Ultrasound

New Policy

Post-voiding residual (PVR) urine volume is the volume in the bladder immediately after the completion of voiding. The standard method of determining PVR urine volumes is intermittent catheterization, which is associated with increased risk of urinary infection, urethral trauma and discomfort for the patient. Bladder ultrasound has been introduced as an alternative, noninvasive method, to avoid the potential complications of intermittent catheterization. CPT code *51798* is used to describe measurement of post-voiding residual urine and/or bladder capacity by ultrasound, *non-imaging*.

The Medicare Part B Extraction Summary System (BESS) statistical medical data obtained for CPT code *51798* revealed a Connecticut carrier to nation ratio of 1.65 for January –June 2003 dates of service.

Analysis of the data revealed that 169 unique diagnoses were billed for this service. Top diagnoses billed were ICD-9-CM 788.21 (incomplete bladder emptying); ICD-9-CM 600.00 (hypertrophy of prostate); and 788.20 (retention of urine, unspecified). The top performing providers were urology, nurse practitioners and physician assistants.

A local coverage determination (LCD) has been developed to define indications and limitations for the billing of post-voiding residual urine and/or bladder capacity by *non-imaging* ultrasound. The LCD will serve to differentiate the measurement of post voiding residual urine and/or bladder capacity by *non-imaging* ultrasound (CPT *51798*) from pelvic ultrasounds (non-obstetric), B-scan and/or real time *with image* documentation (CPT *76856*).

This policy is effective for services rendered on or after April 11, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

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New LMRPs/LCDs, continued

80051: Electrolyte Panel

New Policy

An electrolyte panel is a group of blood tests that measures electrolyte levels to assess the general functioning of the patient's organ systems and provides valuable information about chemical balances within the body. An electrolyte panel must include the following: carbon dioxide (*82374*), chloride (*82435*), potassium (*84132*), and sodium (*84295*).

According to the Medicare Part B statistical medical data obtained for dates of service from January 1, 2003 to June 30, 2003, CPT code *80051* (electrolyte panel) was found to be aberrant in Connecticut; therefore, a local coverage determination (LCD) has been developed. This LCD only defines the indications and limitations of coverage. It does not address ICD-9-CM codes, due to the extensive number of diagnoses and/or conditions that this test may be performed.

This LCD is effective for services rendered on or after April 11, 2005. The full text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

81000: Urinalysis

New Policy

A urinalysis is a physical, chemical, and/or microscopic analysis or examination of the urine used to detect renal or urinary tract disease or systemic disorders manifested by or through the urinary system. It has wide application in clinical practice and is one of the most useful indicators of health and disease.

The components of a urinalysis include the evaluation of physical characteristics including color, odor and clarity. Additionally, a urinalysis includes the evaluation of the urine and urinary sediment, using one or more chemical tests with or without a microscope. The physico-chemical tests are commercially available on a chemically impregnated reagent strip (dipstick). They allow for quick determination of pH, glucose, protein, ketones, bilirubin, hemoglobin, urobilinogen, nitrite, leukocyte estrase, specific gravity, and reducing substances. The tip of the dipstick is impregnated with chemicals that react with specific substances in the urine to produce colored end products. Color standards are provided against which the color can be compared. The reaction rates of the impregnated chemicals are standard for each dipstick, and color changes must be matched at the correct time after each stick is dipped into the urine specimen.

The microscopic examination detects formed elements in the urine. Approximately 10 milliliters of urine is spun in a centrifuge for several minutes, the supernatant decanted, and the sediment re-suspended and decanted onto a microscope slide. A cover slip is added and the slide is examined under low light using the low and high power lenses. The test reports crystals, casts and cells per low and high power field of view, respectively.

81000 Urinalysis, continued

Medicare provides coverage for services that are considered reasonable and medically necessary. Medicare cannot provide coverage for urinalysis performed without relationship to the evaluation or treatment of a sign, symptom, complaint, illness, or injury. Routine screening in the absence of signs, symptoms or illness is not a covered benefit.

This LCD has been developed to define the indications and limitations of coverage and/or medical necessity for urinalysis services as described by CPT codes *81000, 81001, 81002, 81003, 81005, 81007* and *81015*.

This LCD is effective for services rendered on or after April 11, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

82784: Gammaglobulin (Immunoglobulins); IgA, IgD, IgG, IgM, Each

New Policy

Protein with the blood is made up albumin and globulin. One type of globulin is gamma globulin protein. Antibodies are made up of gamma globulin protein. Immunoglobulin is a general term for antibody. Gammaglobulin, which consists of IgA, IgD, IgG, and IgM are helpful tests in the assessment and management of individuals with conditions such as, but not limited to: liver dysfunctions; acute or chronic infections; severe malnutrition; lymphoproliferative disorders, myeloma (polyclonal or monoclonal); autoimmune disorders/ collagen disorders; lyme disease; waldenstrom's macroglobulinemia; tissue necrosis; leukemia and other cancers; immune deficiency disorders (congenital and/or acquired).

Medicare provides coverage for services that are considered reasonable and medically necessary. Medicare cannot provide coverage for gammaglobulin tests performed with relationship to the evaluation or treatment of a sign, symptom, complaint, illness, or injury. Routine screening in the absence of signs, symptoms, or illness is not a covered a benefit.

According to the Medicare Part B statistical medical data obtained from January 1, 2003 to June 30, 2003, CPT code *82784* gammaglobulin was determined to be aberrant in Connecticut; therefore, a local coverage determination (LCD) has been developed to define the indication and limitations of coverage and/or medical necessity for this service.

This policy was presented to the Carriers Advisory Committee October 12, 2004. It will be effective for services rendered on or after April 11, 2005. The full-text LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

New LMRPs/LCDs, continued

82565: Creatinine and Urea Nitrogen

New Policy

Creatinine is the end product of creatine metabolism in muscle. Its formation and serum concentration are relatively constant. Urea is the end product of protein metabolism and its production and concentration vary with protein intake, enhanced tissue breakdown due to hemorrhage, trauma or use of corticosteroids and in liver disease. Serum creatinine and serum urea or blood urea nitrogen (BUN) are commonly ordered tests to assess renal function, however, these tests may be performed for a variety of other conditions.

Medicare provides coverage for services that are considered reasonable and medically necessary. Medicare provides coverage for Creatinine and Urea nitrogen; quantitative tests performed without relationship to the evaluation or treatment of a sign, symptom, complaint, illness, or injury. Routine screening in the absence of signs, symptoms, or illness is not a covered benefit.

According to the Medicare Part B statistical medical data obtained from January 1, 2003 to June 30, 2003, CPT code *82565* (creatinine; blood) and CPT code *84520* (urea nitrogen; quantitative) were both determined to be aberrant in Connecticut, therefore, a local coverage determination (LCD) has been developed to define the indication and limitations of coverage and/or medical necessity for this service.

This policy was presented to the Carriers Advisory Committee October 12, 2004. It will be effective for services rendered on or after April 11, 2005. The full-text LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

84155: Serum Protein

New Policy

A total serum protein test measures the total amount of protein in blood serum as well as the amounts of albumin and globulin. The reasons a total serum protein test may be done include the following:

- Evaluate liver and kidney function.
- Measure the total protein level in the bloodstream. This may be done to investigate symptoms of disease, or to estimate the risk of developing an infection.
- Evaluate nutritional status.
- Evaluate some rare diseases of the blood, such as multiple myeloma or Waldenstrom's macroglobulinemia.

The Medicare Part B Extraction Summary System (BESS) statistical medical data for CPT code *84155* obtained for dates of service from January through June 2003 showed Connecticut had a carrier to nation ratio of 4.45* for this time period.

Analysis of the data revealed that the majority of services were performed by clinical laboratories (99.53%). Further analysis revealed the top diagnoses billed were hematuria, unspecified disorder of the kidney and ureter, abnormal pap smear, other site, bladder disorder, diabetes type II without complication, chronic renal failure, hyperlipidemia, hypertension, and cystitis NOS. The majority of services (91.04%) were performed in an Independent Lab. Other places of services were office (6.20%), nursing facility (2.72%) and home (0.04%).

Based on the above data, a local coverage determination (LCD) is being developed for CPT code *84155* (Protein, total, except by refractometry; serum) to include indications and limitations of coverage and ICD-9-CM codes that support medical necessity.

This policy was presented to the Carriers Advisory Committee October 12, 2004. It will be effective for services rendered on or after April 11, 2005. The full-text LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

94010: Spirometry

New Policy

Spirometry, a component of pulmonary function tests (PFT's), is performed to detect abnormalities in respiratory function and to determine the extent of any pulmonary abnormalities.

According to the Medicare Part B statistical medical data obtained for dates of service from January 1, 2003 to June 30, 2003, CPT code *94010* (spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation) was found to be aberrant in Connecticut; therefore, a local coverage determination (LCD) has been developed to define indications and limitations of coverage, identify components of the test, and under what conditions one would expect repeat testing for spirometry (*94010*). In addition, CPT codes *94060, 94070, 94240,* and *94720* were added to this LCD to provide clinical guidance to a family of codes that one might see billed in addition to spirometry.

This LCD is effective for services rendered on or after April 11, 2005. The full text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

ADDITIONS/REVISIONS TO LMRPs/LCDs

J1440: G-CSF (Filgrastim, Neupogen®)

Revised Policy

The local medical review policy (LMRP) for G-CSF (Filgrastim, Neupogen®) was effective June 30, 2003. Since that time, the policy has been converted to the local coverage determination (LCD) format. Diagnosis code 995.2, unspecified adverse effects of drug, medicinal and biological substance, has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy. This policy revision is effective for claims processed on or after February 1, 2005.

The full-text LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

J9000: Antineoplastic Drugs

Revised Policy

This Local Coverage Determination (LCD) was last updated on September 3, 2004. A revision to the policy was made to update the following drugs with the addition of the ICD-9-CM codes and descriptors and/or off-labeled indications listed below, based on the Compendia-Based Drug Bulletin and/or the Antineoplastic Drugs Workgroup for diagnoses and/or indications and limitations of coverage.

- Carboplatin (J9045) – Added stomach carcinoma to off-labeled indications and changed diagnosis code 151.0 to include range 151.0 – 151.9 (malignant neoplasm of stomach).
- Irinotecan (J9206) – Added primary brain tumors to off-labeled indications and added ICD-9-CM codes 191.0 – 191.9 (malignant neoplasm of brain).
- Paclitaxel (J9265) Changed one off-labeled indication to read small cell and non-small cell lung carcinoma instead of small cell lung carcinoma
- The ICD-9-CM code range of 162.2 – 162.9 was changed to 162.0 – 162.9 (malignant neoplasm of trachea, bronchus, and lung) for the following drugs:

Carboplatin (J9045)	Paclitaxel (J9265)
Docetaxel (J9170)	Mitomycin (J9280, J9290, & J9291)
Epirubicin (J9178)	Topotecan (J9350)
Etoposide (J9181 & J9182)	Vinorelbine (J9390)
Gemcitabine (J9201)	Porfimer (J9600)

- Rituximab (J9310) – Changed the ICD-9-CM code ranges of 202.00 – 202.08 and 202.80 – 202.88 to 202.00 – 202.98 (other malignant neoplasms of lymphoid and histiocytic tissue).
- Gemcitabine (J9201) –Added the following note under the ICD-9-CM codes "*Note-Diagnosis code 189.0 only to be used for transitional cell cancer of the bladder residing in the kidney (renal transitional cell carcinoma)."
- Oxaliplatin (J9263) – Added additional off-labeled indication to allow adjuvant FOLFOX therapy for colon cancer.

This policy revision is effective for services rendered on or after January 24, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com*.

J9202: Luteinizing Hormone-Releasing Hormone Analogs for Treatment of Malignant Neoplasm of the Prostate

Revised Policy

The local medical review policy (LMRP) for Luteinizing Hormone-Releasing Hormone Analogs for Treatment of Malignant Neoplasm of the Prostate was last updated on June 2, 2003. The policy has now been converted to the local coverage determination (LCD) format and totally revised to incorporate all Leuprolide Acetate products for FDA approved indications (Zoladex removed from policy), and to focus the coverage solely on Leuprolide Acetate and the least costly alternative (LCA) requirements. As a result, the policy number and title have been changed to Leuprolide Acetate (J1950).

This policy revision was presented to the Carriers Advisory Committee October 12, 2004. These changes are effective for services rendered on or after April 11, 2005. The full-text of this LMRP may be found on the provider education website *www.connecticutmedicare.com*.

Additions/Revisions to LMRPs/LCDs, continued

J9212: Interferon

Revised Policy

The local medical review policy (LMRP) for Interferon was last updated on October 1, 2004. A review of this policy revealed HCPCS code J1825 was an invalid code; therefore it was removed from the policy. This policy revision is effective January 18, 2005 for services rendered on or after August 1, 2002. This policy has also been converted to a local coverage determination (LCD) format. Effective date of this policy revision is for claims processed on or after January 18, 2005.

The full-text LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

11055: Routine Foot Care

Revised Policy

This local coverage determination (LCD) was last updated in a Special Release article, which was posted on the web November 18, 2004. The following revisions were printed in this Special Release article as well as some additional revisions added to this publication.

Under the "Indications and Limitations of Coverage and/or Medical Necessity" the following paragraph was added:

Routine foot care may be available for patients with peripheral neuropathy involving the feet, but without the vascular impairment outlined in Class B findings. The neuropathy should be of such severity that care by a non-professional person would put the patient at risk. In such circumstances, claims for medically necessary services would be submitted without the Q7, Q8, or Q9 modifiers that indicate class findings. The medical record must document the patient has an absence of sensation at two or more sites out of five tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament to support the diagnosis of peripheral neuropathy with loss of protective sensation. This testing may be performed by the attending physician, non-physician practitioner, or the podiatrist.

Covered diagnoses codes are listed below showing those that require a Q modifier and those that do not:

The following diagnoses require a Q modifier:

250.70-250.73*	Diabetes with peripheral circulatory disorders
440.20	Atherosclerosis of the extremities, unspecified
440.21	Atherosclerosis of the extremities with intermittent claudication
440.22	Atherosclerosis of the extremities with rest pain
440.23	Atherosclerosis of the extremities with ulceration
440.24	Atherosclerosis of the extremities with gangrene
443.0	Raynaud's syndrome
443.1	Thromboangiitis obliterans (Buerger's disease)
444.22	Arterial embolism and thrombosis of arteries, lower extremity
446.0	Polyarteritis nodosa
446.7*	Takayasu's disease

The following diagnoses related to peripheral neuropathy do *not* require a Q modifier:

030.0-030.9	Leprosy
094.0	Neurosyphilis; tabes dorsalis
094.1	Neurosyphilis; general paresis
094.9	Neurosyphilis, unspecified
250.40	Diabetes with renal manifestations type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
250.50	Diabetes with ophthalmic manifestations type II [non-insulin dependent type] [NIDDM type] [adult on-set type] or unspecified type, not stated as uncontrolled
250.60-250.63*	Diabetes with neurological manifestations
263.9*	Unspecified protein-calorie malnutrition
265.0*	Beriberi
265.2*	Pellegra
266.1*	Vitamin B deficiency
266.2*	Other B-complex deficiencies (includes vitamin B12)

Additions/Revisions to LMRPs/LCDs, continued

272.7	Lipidoses (includes Fabry's)
277.3	Amyloidosis
281.0*	Pernicious anemia
281.3*	Other specified megaloblastic anemias not elsewhere classified
334.0	Friedreich's ataxia
340*	Multiple sclerosis
356.0-356.9	Hereditary and idiopathic peripheral neuropathy
357.0*-357.7*	Inflammatory and toxic neuropathy
358.1*	Myasthenic syndromes in diseases classified elsewhere
358.2*	Toxic myoneural disorders
451.0*	Phlebitis and thrombophlebitis of superficial vessels of lower extremities
451.11*	Phlebitis and thrombophlebitis of femoral vein (deep) (superficial)
451.19*	Phlebitis and thrombophlebitis of deep vessels of lower extremities, femeral vein (deep) (superficial)
579.0*	Celiac malabsorption
579.1*	Tropical sprue
579.2*	Blind loop syndrome
579.3*	Other and unspecified post surgical nonabsorption
579.4*	Pancreatic steatorrhea
585*	Chronic renal failure
586*	Renal failure, unspecified

The following diagnosis related to anticoagulation therapy does not require a Q modifier:

286.9*	Other and unspecified coagulation defects (Use for Long-term (current) use of anticoagulants)

Under the "Active Care Requirements" section of the policy, the name of the attending physician (MD or DO) who is actively treating the patient was expanded to include non-physician practitioner (PA or NP).

Under the "Documentation Requirements" the following paragraph was added:

For patients requiring anticoagulation therapy, the provider must document in the medical record the significant risk and danger posed by the non-professional rendering routine foot care services.

The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com*. This policy is effective for services rendered on or after January 1, 2005.

29540: Strapping

Revised Policy

This local medical review policy (LMRP) was last updated on January 12, 2004.

This policy has been converted into the new LCD format and the following additional ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the policy since they are appropriate for strapping:

- 733.93 – Stress fracture of tibia or fibula
- 733.94 – Stress fracture of the metatarsals
- 733.95 – Stress fracture of other bone

This policy revision is effective for services rendered on or after November 15, 2004. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com*.

82330: Ionized Calcium

Revised Policy

The local medical review policy (LMRP) for ionized calcium was last revised October 1, 2004. Since that time a revision to the policy has been made. Diagnosis 275.4 (Disorders of calcium metabolism, (hypo-, hyper-, pseudo-, parathyroidism) is not to the highest level of specificity, therefore, diagnosis 275.4 has been changed to diagnosis range 275.40-275.49 in the "ICD-9 Codes that Support Medical Necessity" section of the policy. This change is effective for claims processed on or after December 7, 2004. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com*.

98940: Chiropractic Services

Revised Policy

The latest revision for local coverage determination (LCD) Chiropractic Services was effective October 1, 2004. This LCD has been updated and revisions have been made to the following sections: Indications and Limitations of Coverage and/or Medical Necessity, Documentation Requirements and Coding Guidelines.

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

Connecticut Part B Policy Changes Related to the 2005 HCPCS Update

Policy Title	Changes
44388 Diagnostic Colonoscopy	Added procedure codes *45391* and *45392*
63650 Spinal Cord Stimulation	Descriptor change for procedure code *63685*
64555 Implanted Peripheral/Sacral Electrical Nerve Stimulation	Descriptor change for procedure codes *64590*, *95971*, *95972*, and *95973*
64561 Sacral Neuromodulation	Descriptor change for procedure codes *64590*, *95971*, *95972*, and *95973*
67221 Ocular Photodynamic Therapy (OPT) with Verteporfin	Deleted procedure code J3395 Added procedure code J3396
76070 Bone Mineral Density Studies	Descriptor change for procedure code *76075*
76514 Ocular Corneal Pachymetry	Descriptor change for procedure code *76514*
77301 Intensity Modulated Radiation Therapy (IMRT)	Descriptor change for procedure code *77418*
78460 Myocardial Perfusion Imaging	Descriptor change for procedure codes *78464* and *78465*
86294 Urinary Tumor Markers for Bladder Cancer	Added procedure codes *88367* and *88368*
88180 Flow Cytometry and Morphometric Analysis	Deleted procedure code *88180* and replaced it with procedure codes *88184*, *88185*, *88187*, *88188*, and *88189* Changed Policy Identification Number to *88182*
ALEFACEPT Alefacept (**Coding Guidelines only**)	Removed procedure code *90782* (Invalid for Medicare Purposes)
APBI Accelerated Partial Breast Irradiation (APBI)	Added procedure codes *19296* and *19297*
BEXXAR Tositumomab and Iodine I 131 Tositumomab (Bexxar®) Therapy (**Coding Guidelines only**)	Removed procedure code *90780* (Invalid for Medicare Purposes)
D0120 Dental Services	Added procedure codes D0416, D0421, D0431, D0475, D0476, D0477, D0478, D0479, D0481, D0482, D0483, D0484, D0485, D7283, D7288, D7321, D7511, D7521 Deleted procedure code D2970 Descriptor change for procedure codes D0480, D4273 and D4381 Deleted non-covered services under the "Other Comments" section of the policy (**not related to 2005 HCPCS**)
EATSV Endovenous Ablation Therapy of the Saphenous Vein	Removed procedure code *37799* and replaced it with procedure codes *36475*, *36476*, *36478*, and *36479* Changed Policy Identification Number to *36475*
J1563 Intravenous Immune Globulin	Descriptor change for procedure code *J1564*
J1745 Infliximab (Remicade™)	Removed procedure codes *90780* and *90781* (Invalid for Medicare purposes) from the "Coding Guidelines" section of the policy
J9293 Mitoxantrone Hydrochloride	Removed procedure codes *90780*, *90781*, *90782*, *90784*, *96400*, *96408*, *96410*, *96412*, and *96414* (Invalid for Medicare purposes) from the "Coding Guidelines" section of the policy
NCSVCS The List of Medicare Noncovered Services	Deleted procedure codes *78810*, *90473*, and *90474* from the National Noncoverage Decisions section of the policy Deleted procedure codes *97780* and *97781* from the National Noncoverage Decisions section of the policy and replaced them with procedure codes *97810*, *97811*, *97813*, and *97814* Added procedure codes *0066T*, *0074T*, A4520, J7304, and V2702 to National Noncoverage Decisions section of the policy Descriptor change for procedure code *89346* in the Local Noncoverage Decisions section of the policy
SKINSUB Skin Substitutes	Added procedure codes J7343 and J7344

Additions/Revisions to LMRPs/LCDs, continued

91110: Wireless Capsule Endoscopy

Revised Policy

This local medical review policy (LMRP) was last revised January 1, 2004. A request was made to expand indications of the policy to include the use of wireless capsule endoscopy for the initial diagnosis of suspected Crohn's disease when there is no evidence provided by conventional diagnostic tests. After reviewing recent literature, it was determined that this was a valid request.

Coverage has been expanded to include the use of wireless capsule endoscopy for the initial diagnosis of Crohn's disease. ICD-9-CM code 555.9 has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy. Furthermore, the LMRP has been converted into the LCD format.

This policy revision is effective for services rendered on or after January 1, 2005. The full-text of this LCD may be found on the provider education website *http://www.connecticutmedicare.com.*

RETIREMENT OF EXISTING LMRPs

Multiple Policies Being Retired

The following LMRPs were retired effective for services rendered on or after January 1, 2005. The decision to retire these policies was based on data analysis and standards of local practice.

Policy Number	Policy Name
94LMRP005 V1.0-90865	Narcosynthesis
22520	Percutaneous Vertebroplasty
53850	Prostate Treatments
55700	Ultrasound Guided Prostate Needle Biopsy
92568	Acoustic Reflex Testing
92569	Acoustic Reflex Decay Test
M0064	Brief Pharmacological Management of Psychiatric Illness

A0425: Coverage for Transportation by Ambulance

Retired Policy

In evaluating the Connecticut local medical review policy (LMRP) for Ambulance for conversion to a local coverage determination (LCD), it was determined that this LMRP did not fit the Centers for Medicare & Medicaid Services (CMS) criteria for an LCD.

The LMRP consisted of primarily national coverage information and the remaining local information did not meet the LCD requirements for "reasonable and necessary" information.

The national coverage and billing information that continues to be applicable for Ambulance providers can be located in the Medicare Benefit Policy Manual, Chapter 9 – Ambulance Services, which can be found on the CMS website at *http://www.cms.hhs.gov*.

Therefore, the local medical review policy for Coverage For Transportation by Ambulance is being retired effective for services rendered on or after December 1, 2004.The full-text of this LCD may be found on the provider education website *http://www.connecticutmedicare.com.*

J2916: Ferrlecit®

Retired Policy

The local coverage determination (LCD) for J2916 (Ferrlecit®) is being retired, effective for services rendered on or after January 1, 2005. Policy is being retired based on data analysis and local standard of medical practice.

The full-text of this LCD may be found on the provider education website *http://www.connecticutmedicare.com.*

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

Retired Policy

This policy was retired based on data analysis. The national coverage determination 20.8.1.1 (transtelephonic monitoring of cardiac pacemakers) defines national coverage and is available at *http://www.cms.gov*.

This policy retirement is effective for services rendered on or after January 1, 2005.The full-text of this LCD may be found on the provider education website *http://www.connecticutmedicare.com.*

ADDITIONAL INFORMATION ON LMRPs/LCDs

Diagnosis Not Subject to Psychiatric Reduction

The outpatient psychiatric services limitation, where 62.5 percent of the allowed amount is reimbursed to providers, is based on actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred. This limitation is called the outpatient mental health treatment limitation.

Due to changes published in the 2005 ICD-9-CM update, ICD-9-CM code 294.8 (other persistent mental disorders due to conditions classified elsewhere) has been added to the list of diagnosis codes that are not subject to the outpatient psychiatric services limitation.

This change is effective for claims processed on or after January 1, 2005.

79900: Provision of Therapeutic Radiopharmaceuticals – Billing Clarification for Radioactive Seeds

This article provides clarification for billing radioactive seeds in relation to brachytherapy. Previously, in the 3rd Quarter 2004 *Medicare B Update!* (pg. 59-60), Connecticut Medicare had instructed providers to bill procedure code *79900* (Provision of therapeutic radiopharmaceuticals). Through HCPCS 2005 procedure code *79900* has been deleted effective January 1, 2005. Therefore, effective January 1, 2005 the appropriate procedure code to utilize when billing for radioactive seeds (Iodine 125 (I-125), Palladium 103 (PD 103), Gold (198 Au), or Iridium (192 Ir) is procedure code Q3001 (Radioelements for brachytherapy, any type, each).

92700: CANALITH REPOSITIONING PROCEDURE

Connecticut Medicare will now cover the canalith repositioning procedure with reimbursement equivalent to an evaluation and management (E&M) visit at the CPT code level of *99212*. Claims submitted to Medicare for this service must bill CPT code *92700* (unlisted otorhinolaryngological service or procedure). In addition, the description "canalith repositioning maneuver" must be stated in Item 19 of the CMS-1500 claim form or on the free form line of electronic claims. An E&M service is allowed in addition to the above service when billed on the same day, by the same provider, if there is a significant, separately identifiable service. In those instances, modifier 25 should be applied to the E&M code.

Real time Outpatient Cardiac Telemetry Monitoring and Analysis

This article was posted December 3, 2004 as a Special Release Article on the Florida and Connecticut websites.

Real time Outpatient Cardiac Telemetry monitoring is one of the several long-term, external, mobile cardiac outpatient-monitoring modalities used to detect significant cardiac arrhythmias in patients with symptoms that might be attributable to cardiac arrhythmia.

This type of testing is useful for detection and diagnosis of arrhythmias that occur, which are infrequent and for which Holter monitoring, office or emergency room monitoring, or other shorter-term monitoring techniques are not useful. The monitoring device transmits cardiac rhythm data to a central processing center that analyzes the electronic data and provides a report to the physician who requested the test.

The technical component of this service includes supply of the equipment, hook-up of the patient and the set-up of the equipment, as well as the receipt of transmission, monitoring and notification of the referring provider and provision of the monitoring ECG rhythm strips and data. If the technical component is done in Connecticut it should be billed with the unlisted code *93799* (unlisted cardiovascular service) and the modifier TC.

The professional component consists of the review and interpretation of each 24-hour cardiac surveillance as well as 24-hour availability and response to monitoring events within a course of treatment that includes up to 30 consecutive days of cardiac monitoring and generation of a report. Since this is new technology and there is no unique code for this service, we would expect to see the physician interpretation of these services billed with unlisted code *93799* (unlisted cardiovascular service) with a modifier 26. Our claims processing department will request documentation for review of the claim. The documentation submitted should describe the service performed in its entirety and the physician should provide information to support medical necessity. In addition, the documentation must support the necessity for this modality in lieu of other outpatient or inpatient monitoring modalities.

This service should be billed one time as a single service in any 30-day period regardless of the number of transmissions or separate rhythm reports the physician interprets during that 30-day period.

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

Attention: Correspondence

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

Attention: Financial Services

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

Attention: Fraud and Abuse

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

Attention: Freedom of Information (FOIA)

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

Attention: Medical Review

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

Attention: MSP

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

Attention: Pricing/ Provider Maintenance

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

Attention: Resolutions

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

MAILING ADDRESS EXCEPTIONS

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

Reviews/Appeals

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

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

Hearings

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

Post Office Box for Appeals/Hearings:

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

Electronic Media Claims/EDI

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

Post Office Box for EDI:

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

Claims

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

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

CONNECTICUT MEDICARE PHONE NUMBERS

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

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

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

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

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

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

Electronic Funds Transfer Information
1-203-639-3219

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

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

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

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

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

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

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

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

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

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

WEB SITES

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

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

FLORIDA MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

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

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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.

LMRP/LCD (NEW)

51798 Post-Voiding Residual Ultrasound

New Policy

Post-voiding residual (PVR) urine volume is the volume in the bladder immediately after the completion of voiding. The standard method of determining PVR urine volumes is intermittent catheterization, which is associated with increased risk of urinary infection, urethral trauma and discomfort for the patient. Bladder ultrasound has been introduced as an alternative, noninvasive method, to avoid the potential complications of intermittent catheterization. CPT code *51798* is used to describe measurement of post-voiding residual urine and/or bladder capacity by ultrasound, *non-imaging*.

The Medicare Part B Extraction Summary System (BESS) statistical medical data obtained for CPT code *51798* revealed a Florida carrier to nation ratio of 2.15 for January –June 2003 dates of service.

Analysis of the data revealed that 318 unique diagnoses were billed for this service. Top diagnoses billed were ICD-9-CM 600.00 (hypertrophy of prostate); ICD-9-CM 788.21 (incomplete bladder emptying); and 788.20 (retention of urine, unspecified). The top performing providers were urology and general practice.

A local coverage determination (LCD) has been developed to define indications and limitations for the billing of post-voiding residual urine and/or bladder capacity by *non-imaging* ultrasound. The LCD will serve to differentiate the measurement of post-voiding residual urine and/or bladder capacity by *non-imaging* ultrasound (CPT *51798*) from pelvic ultrasounds (non-obstetric), B-scan and/or real time *with image* documentation (CPT *76856*).

This policy is effective for services rendered on or after April 11, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

92285: External Ocular Photography

New Policy

External ocular photography is a non-invasive procedure used to photo-document conditions of the external structures of the eye (e.g., eyelids, lashes, sclera, conjunctiva and cornea). External photography techniques may also be used to document conditions related to structures of the anterior segment of the eye. These would include the anterior chamber, iris, crystalline lens and filtration angle.

External ocular photography is accomplished by using a close-up hand-held camera, slit-lamp-integrated camera, photography through a goniophotography lens or with a close-up stereo camera. In any case, the resulting photographs may be prints, slides, videotapes or digitally stored.

This procedure may be indicated when photo-documentation is required to track the progression or lack of progression of an eye condition, or to document the progression of a particular course of treatment. While many conditions of the eye could be photographed, this procedure should not be used to simply document the existence of a condition in order to enhance the medical record.

Currently, LCD *92015* Ophthalmological Diagnostic Services includes the covered diagnosis codes for CPT code *92285* External ocular photography. However, this LCD is only a procedure to diagnosis billing guideline and medical necessity issues are not addressed. Therefore, a separate and distinct LCD has been developed to define the indications and limitations of coverage and/or medical necessity and provide coding guidelines and documentation requirements for external ocular photography. Accordingly, LCD *92015* has been revised to delete references to procedure code *92285*.

This LCD is effective for services rendered on or after April 11, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

LMRP/LCD (REVISED)

J1440 G-CSF (Filgrastim, Neupogen®)

Revised Policy

The local medical review policy (LMRP) for G-CSF (Filgrastim, Neupogen®) was last updated on April 7, 2003. Since that time, the policy has been converted to the local coverage determination (LCD) format. Diagnosis code 995.2, unspecified adverse effects of drug, medicinal and biological substance, has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy. This policy revision is effective for claims processed on or after February 1, 2005.

The full-text LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

Florida Part B Policy Changes Related to the 2005 HCPCS Update

Policy Title	Changes
11000 Debridement Services	Added procedure codes *11004*, *11005*, *11006*, *11008*, *97597*, and *97598*
43842 Surgical Management of Morbid Obesity	Added procedure codes *43644* and *43645* Removed procedure code *43999* (Biliopancreatic Bypass with Duodenal Switch) and replaced it with procedure code *43845* Descriptor change for procedure code *43846* Changed Policy Identification Number to *43644*
44388 Diagnostic Colonoscopy	Added procedure codes *45391* and *45392*
64561 Sacral Neuromodulation	Descriptor change for procedure codes *64590*, *95971*, *95972*, and *95973*
67221 Ocular Photodynamic Therapy (OPT) with Verteporfin	Deleted procedure code J3395 Added procedure code J3396
76070 Bone Mineral Density Studies	Descriptor change for procedure code *76075*
76512 B-Scan	Added procedure code *76510* Descriptor change for procedure code *76512* Changed Policy Identification Number to *76510*
76514 Ocular Corneal Pachymetry	Descriptor change for procedure code *76514*
77301 Intensity Modulated Radiation Therapy (IMRT)	Descriptor change for procedure code *77418*
77427 Weekly Radiation Therapy Management	Removed procedure codes *90780* and *90781* (Invalid for Medicare purposes) from the "Coding Guidelines" section of the policy
78460 Myocardial Perfusion Imaging	Descriptor change for procedure codes *78464* and *78465*
86294 Urinary Tumor Markers for Bladder Cancer	Added procedure codes *88367* and *88368*
86781 Fluorescent Treponemal Antibody Absorption (FTA-abs)	Deleted procedure code G0001 from the "Coding Guidelines" section of the policy Added procedure code *36415* to the "Coding Guidelines" section of the policy
90780 Therapeutic or Diagnostic Infusion/Injections	Retired policy as the majority of the codes (*90780*, *90781*, *90782*, and *90784*) are invalid for Medicare purposes
92506 Speech-Language Pathology Services	Descriptor change for procedure code *96111*
93886 Transcranial Doppler Studies	Added procedure codes *93890*, *93892*, and *93893*
A9600 Metastron C Strontium–89 Chloride	Deleted procedure code G0001 from the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy Added procedure code *36415* to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy Descriptor change for procedure code *77750*
ALEFACEPT Alefacept **(Coding Guidelines only)**	Removed procedure code *90782* (Invalid for Medicare Purposes)
APBI Accelerated Partial Breast Irradiation (APBI)	Added procedure codes *19296* and *19297*
BEXXAR Tositumomab and Iodine I 131 Tositumomab (Bexxar®) Therapy **(Coding Guidelines only)**	Removed procedure code *90780* (Invalid for Medicare Purposes)
D0110 Dental Services	Added procedure codes D0416, D0421, D0431, D0475, D0476, D0477, D0478, D0479, D0481, D0482, D0483, D0484, D0485, D7283, D7288, D7321, D7511, D7521 Descriptor change for procedure codes D4273 and D4381 Deleted non-covered services and codes not valid for Medicare purposes under the "Other Comments" section of the policy (not related to 2005 HCPCS) Changed Policy Identification Number to D0120

Florida Part B Policy Changes Related to the 2005 HCPCS Update, continued

Policy Title	Changes
EATSV Endovenous Ablation Therapy of the Saphenous Vein	Removed procedure code *37799* and replaced it with procedure codes *36475*, *36476*, *36478*, and *36479* Changed Policy Identification Number to *36475*
G0102 Prostate Cancer Screening	Deleted procedure code G0001 from the "Coding Guidelines" section of the policy Added procedure code *36415* to the "Coding Guidelines" section of the policy
J0470 Chelation Therapy	Removed procedure codes *90780, 90781, 90782, and 90784* (Invalid for Medicare purposes) from the "Reasons for Denials" and "Coding Guidelines" sections of the policy
J1563 Intravenous Immune Globulin	Descriptor change for procedure code J1564
J1745 Infliximab (Remicade™)	Removed procedure codes *90780* and *90781* (Invalid for Medicare purposes) from the "Coding Guidelines" section of the policy
J1950 Leuprolide Acetate	Removed procedure codes *90780*, *90781*, *90782*, *90784*, *96400*, *96408*, *96410*, *96412*, and *96414* (Invalid for Medicare purposes) from the "Coding Guidelines" section of the policy
J3487 Zoledronic Acid (Zometa®)	Removed procedure code *90780* (Invalid for Medicare purposes) from the "Coding Guidelines" section of the policy
J9293 Mitoxantrone Hydrochloride	Removed procedure codes *90780*, *90781*, *90782*, *90784*, *96400*, *96408*, *96410*, *96412*, and *96414* (Invalid for Medicare purposes) from the "Coding Guidelines" section of the policy
NCSVCS The List of Medicare Noncovered Services	Deleted procedure code *0014T* from the Local Noncoverage Decisions section of the policy and replaced it with procedure code 29868 Deleted procedure codes *78810*, *90473*, and *90474* from the National Noncoverage Decisions section of the policy Deleted procedure codes *97780* and *97781* from the National Noncoverage Decisions section of the policy and replaced them with procedure codes *97810*, *97811*, *97813*, and *97814* Added procedure codes *0066T*, *0074T*, A4520, J7304, and V2702 to National Noncoverage Decisions section of the policy Descriptor change for procedure codes *89346* in the Local Noncoverage Decisions section of the policy
PULMDIAGSVCS Pulmonary Diagnostic Services	Descriptor change for procedure codes *94060* and *94070*
SKINSUB Skin Substitutes	Added procedure codes J7343 and J7344

J1950: Leuprolide Acetate

Revised Policy

The local coverage determination (LCD) for Leuprolide Acetate was last updated on January 1, 2005. Since that time, diagnosis code range 174.0-174.9, malignant neoplasm of female breast has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy for procedure code J9217. This policy revision is effective for services rendered on or after January 14, 2005. Also, a revision was done to correct revision history #10 to indicate process date versus date of service for added diagnosis code range 218.0-218.9 for procedure code J1950. This policy revision is effective January 14, 2005 for claims processed on or after March 8, 2004.

The full-text of this LMRP may be found on the provider education website *http://www.floridamedicare.com*.

20550: Injection of Tendon Sheath, Ligament or Trigger Points

Revised Policy

This policy was last revised effective January 1, 2004. Since that time the policy was revised to add ICD-9-CM code range 727.00-727.09 (Other disorders of synovium, tendon, and bursa) to the "ICD-9-CM Codes that support Medical Necessity" section of the policy for procedure codes 20552 and 20553. In addition, the policy was converted to the local coverage determination format.

This revision is effective for services rendered on or after January 24, 2005.

The full-text of this LMRP may be found on the provider education website *http://www.floridamedicare.com*.

11055: Routine Foot Care

Revised Policy

This Local Coverage Determination (LCD) was last updated in a Special Release article, which was posted on the web November 18, 2004. The following revisions were printed in this Special Release article as well as some additional revisions added to this publication.

Under the "Indications and Limitations of Coverage and/or Medical Necessity" the following paragraph was added:

Routine foot care may be available for patients with peripheral neuropathy involving the feet, but without the vascular impairment outlined in Class B findings. The neuropathy should be of such severity that care by a non-professional person would put the patient at risk. In such circumstances, claims for medically necessary services would be submitted without the Q7, Q8, or Q9 modifiers that indicate class findings. The medical record must document the patient has an absence of sensation at two or more sites out of five tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament to support the diagnosis of peripheral neuropathy with loss of protective sensation. This testing may be performed by the attending physician, non-physician practitioner, or the podiatrist.

Covered diagnoses codes are listed below showing those that require a Q modifier and those that do not:

The following diagnoses require a Q modifier:

250.70-250.73*	Diabetes with peripheral circulatory disorders
440.20	Atherosclerosis of the extremities, unspecified
440.21	Atherosclerosis of the extremities with intermittent claudication
440.22	Atherosclerosis of the extremities with rest pain
440.23	Atherosclerosis of the extremities with ulceration
440.24	Atherosclerosis of the extremities with gangrene
443.0	Raynaud's syndrome
443.1	Thromboangiitis obliterans (Buerger's disease)
444.22	Arterial embolism and thrombosis of arteries, lower extremity
446.0	Polyarteritis nodosa
446.7*	Takayasu's disease

The following diagnoses related to peripheral neuropathy do *not* require a Q modifier:

030.0-030.9	Leprosy
094.0	Neurosyphilis; tabes dorsalis
094.1	Neurosyphilis; general paresis
094.9	Neurosyphilis, unspecified
250.40	Diabetes with renal manifestations type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
250.50	Diabetes with ophthalmic manifestations type II [non-insulin dependent type] [NIDDM type] [adult onset type] or unspecified type, not stated as uncontrolled
250.60-250.63*	Diabetes with neurological manifestations
263.9*	Unspecified protein-calorie malnutrition
265.0*	Beriberi
265.2*	Pellegra
266.1*	Vitamin B deficiency
266.2*	Other B-complex deficiencies (includes vitamin B_{12})
272.7	Lipidoses (includes Fabry's)
277.3	Amyloidosis
281.0*	Pernicious anemia
281.3*	Other specified megaloblastic anemias not elsewhere classified
334.0	Friedreich's ataxia
340*	Multiple sclerosis
356.0-356.9	Hereditary and idiopathic peripheral neuropathy
357.0*-357.7*	Inflammatory and toxic neuropathy
358.1*	Myasthenic syndromes in diseases classified elsewhere
358.2*	Toxic myoneural disorders
451.0*	Phlebitis and thrombophlebitis of superficial vessels of lower extremities
451.11*	Phlebitis and thrombophlebitis of femoral vein (deep) (superficial)
451.19*	Phlebitis and thrombophlebitis of deep vessels of lower extremities, femeral vein (deep) (superficial)
579.0*	Celiac malabsorption
579.1*	Tropical sprue

11055: Routine Foot Care, continued

579.2*	Blind loop syndrome
579.3*	Other and unspecified post surgical nonabsorption
579.4*	Pancreatic steatorrhea
585*	Chronic renal failure
586*	Renal failure, unspecified

The following diagnosis related to anticoagulation therapy does not require a Q modifier:

286.9*	Other and unspecified coagulation defects (Use for Long-term (current) use of anticoagulants)

Under the "Active Care Requirements" section of the policy, the name of the attending physician (MD or DO) who is actively treating the patient was expanded to include non-physician practitioner (PA or NP).

Under the "Documentation Requirements" the following paragraph was added:

For patients requiring anticoagulation therapy, the provider must document in the medical record the significant risk and danger posed by the non-professional rendering routine foot care services.

This policy revision is effective for services rendered on or after January 1, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com*.

J9000: Antineoplastic Drugs

Revised Policy

This local coverage determination (LCD) was last updated on September 3, 2004. A revision to the policy was made to update the following drugs with the addition of the ICD-9-CM codes and descriptors and/or off-labeled indications listed below, based on the Compendia-Based Drug Bulletin and/or the Antineoplastic Drugs Workgroup for diagnoses and/or indications and limitations of coverage.

- Carboplatin (J9045) – Added stomach carcinoma to off-labeled indications and changed diagnosis code 151.0 to include range 151.0 – 151.9 (malignant neoplasm of stomach).
- Irinotecan (J9206) – Added primary brain tumors to off-labeled indications and added ICD-9-CM codes 191.0 – 191.9 (malignant neoplasm of brain).
- Paclitaxel (J9265) Changed one off-labeled indication to read small cell and non-small cell lung carcinoma instead of small cell lung carcinoma
- The ICD-9-CM code range of 162.2 – 162.9 was changed to 162.0 – 162.9 (malignant neoplasm of trachea, bronchus, and lung) for the following drugs:

Carboplatin (J9045)	Paclitaxel (J9265)
Docetaxel (J9170)	Mitomycin (J9280, J9290, & J9291)
Epirubicin (J9178)	Topotecan (J9350)
Etoposide (J9181 & J9182)	Vinorelbine (J9390)
Gemcitabine (J9201)	Porfimer (J9600)

- Rituximab (J9310) – Changed the ICD-9-CM code ranges of 202.00 – 202.08 and 202.80 – 202.88 to 202.00 – 202.98 (other malignant neoplasms of lymphoid and histiocytic tissue).
- Gemcitabine (J9201) – Added the following note under the ICD-9-CM codes "*Note-Diagnosis code 189.0 only to be used for transitional cell cancer of the bladder residing in the kidney (renal transitional cell carcinoma)."
- Oxaliplatin (J9263) – Added additional off-labeled indication to allow adjuvant FOLFOX therapy for colon cancer.

This policy revision is effective for services rendered on or after January 24, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com*.

29540: Strapping

Revised Policy

This local medical review policy (LMRP) was last updated on January 12, 2004. This policy has been converted into the new LCD format and the following additional ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the policy since they are appropriate for strapping:

- 733.93 – Stress fracture of tibia or fibula
- 733.94 – Stress fracture of the metatarsals
- 733.95 – Stress fracture of other bone

This policy revision is effective for services rendered on or after November 15, 2004. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com*.

43842: Surgical Management of Morbid Obesity

Revised Policy

The local medical review policy (LMRP) for Surgical Management of Morbid Obesity was implemented on January 5, 2004.

Change request 3502, transmittal 23, dated October 1, 2004 removed language, which defined obesity from the national coverage determinations manual (NCDM). The remaining language was revised to address the coverage of specific care and services rather than the definition of an illness.

The LMRP is revised to comply with the NCDM language and coverage guidelines. The statement "obesity itself cannot be considered an illness" has been removed from the LMRP. Also the LMRP has been converted to a local coverage determination (LCD) format.

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

62310 Epidural

Revised Policy

This policy was last revised effective January 1, 2003. Since that time, the policy has been revised. Procedure codes *64479, 64480, 64483* and *64484* were added to the policy. The name of the policy was changed from Epidural/ Subarachnoid Injections to Epidural. The original policy was struck out in its entirety.

Using the Medicare Part B Extraction Summary system (BESS) statistical medical data obtained for the time period July 1, 2003 through December 31, 2003, the Florida to nation ratio for procedure code *62310* was 2.03

This policy has been converted to the local coverage determination (LCD) format and the revision is effective for services rendered on or after April 11, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com*.

64400: Peripheral Nerve Blocks

Revised Policy

This policy was implemented on September 29, 2003. Since that time, the policy has been revised. A major revision was done to add verbiage to indications, delete procedure code *64640* and add additional ICD-9-CM codes to the "ICD-9 Codes that Support Medical Necessity" section of the policy. The policy name and number was changed from 64405 Greater Occipital Nerve Blocks/Neurolysis to *64400* Peripheral Nerve Blocks. The original policy was struck out in its entirety.

Using the Medicare Part B Extraction Summary system (BESS) statistical medical data obtained for the time period July 1, 2003 through December 31, 2003, the Florida to nation ratio for procedure code *64400* was 2.51.

Based on the above information, local medical review policy *64405* was revised to define the indications and limitations of coverage and/or medical necessity for this service.

This policy has been converted to the local coverage determination (LCD) format and the revision is effective for services rendered on or after April 11, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com*.

64470: Paravertebral Facet Joint Blocks

Revised Policy

This policy was implemented on April 17, 2000. Since that time, the policy has been revised.

A major revision was done to further define the indications and limitations of coverage and/or medical necessity for this service. The policy name was changed from Paravertebral Facet Joint Nerve Injection to Paravertebral Facet Joint Blocks. The original policy was struck out in its entirety.

Using the Medicare Part B Extraction Summary system (BESS) statistical medical data obtained for the time period July 1, 2003 through December 31, 2003, the Florida to nation ratio for procedure code *64470* was 2.52.

Based on the above information, local medical review policy *64470* was revised to define the indications and limitations of coverage and/or medical necessity for this service.

This policy has been converted to the local coverage determination (LCD) format and the revision is effective for services rendered on or after April 11, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com*.

72192: Computed Tomography of the Pelvis

Revised Policy

This local medical review policy (LMRP) was last revised October 1, 2003. A request was made to add additional ICD-9-CM codes to the Computed Tomography of the Pelvis policy. The request for these additional ICD-9-CM codes was determined to be valid. Therefore, the following ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

72192: Computed Tomography of the Pelvis, continued

152.0-152.9	199.0-199.1	204.00-204.01	230.7
158.0-158.9	200.01-200. 04	204.10-204.11	235.5
159.0-159.9	200.07	211.2	236.3
170.6	200.11-200.14	213.6	236.4
171.3	200.17	215.3	236.6
172.9	200.21-200.24	221.1-221.2	236.91
176.0-176.9	200.27	221.8-221.9	239.0
184.1-184.4	200.80-200.88	222.0-222.9	239.2
187.1-187.7	202.00-202.68	223.0-223.9	592.1
195.8	202.81-202.84	230.3	592.9
196.8	202.87	230.5	V55.3
198.82	202.90-202.98	230.6	V55.5

ICD-9-CM codes identified, as secondary diagnoses cannot be billed as primary diagnoses.

The following V diagnosis codes identified as secondary diagnoses were found in this policy and therefore, they have been removed: V42.0, V42.84, V44.3, and V44.50-V44.59. Other ICD-9-CM codes already present in the policy were identified as replacements or additional codes were added to replace the deleted V codes. Diagnosis codes 996.81 and 996.87 can be used in place of V42.0 and V42.84, respectively. Diagnosis codes V55.3 and V55.5 have been added to the policy to replace V44.3 and V44.50-V44.59, respectively.

This LMRP has been converted to a local coverage determination (LCD).

This revision is effective for services rendered on or after January 1, 2005.

The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

73721: Magnetic Resonance Imaging of Any Joint of the Lower Extremity

Revised Policy

The local medical review policy (LMRP) for magnetic resonance imaging (MRI) of any joint of the lower extremity was last revised effective April 7, 2003. Since that time, it was determined the following ICD-9 codes should be added to the policy:

- 719.45 pain in joint, pelvic region and thigh
- 719.46 pain in joint, lower leg
- 719.47 pain in joint, ankle and foot

The Indications and Limitations of Coverage and/or Medical Necessity and Utilization Guidelines sections have been revised accordingly. This policy has been updated to local coverage determination (LCD) format. Italicized lettering has been used to identify national coverage information. This revision is effective for services rendered on or after February 1, 2005. The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

91110: Wireless Capsule Endoscopy

Revised Policy

This local medical review policy (LMRP) was last revised January 1, 2004. A request was made to expand indications of the policy to include the use of wireless capsule endoscopy for the initial diagnosis of suspected Crohn's disease when there is no evidence provided by conventional diagnostic tests. After reviewing recent literature, it was determined that this

91110: Wireless Capsule Endoscopy, continued

was a valid request.

Coverage has been expanded to include the use of wireless capsule endoscopy for the initial diagnosis of Crohn's disease. ICD-9-CM code 555.9 has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy. Furthermore, the LMRP has been converted into the LCD format.

This policy revision is effective for services rendered on or after January 1, 2005.

The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

92015: Ophthalmological Diagnostic Services

Revised Policy

The latest revision for local coverage determination (LCD) Ophthalmological Diagnostic Services was effective October 1, 2004. LCD *92015* Ophthalmological Diagnostic Services includes the covered diagnosis codes for CPT code *92285* External ocular photography. However, this LCD is only a procedure to diagnosis billing guideline and medical necessity issues are not addressed. Therefore, a separate and distinct local coverage determination (LCD) has been developed for external ocular photography to define the indications and limitations of coverage and/or medical necessity, and provide coding guidelines and documentation requirements for external ocular photography. LCD *92015* has been revised to delete references for procedure code *92285*.

This revision is effective for services rendered on or after April 11, 2005. The full-text of this local coverage determination may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

98940: Chiropractic Services

Revised Policy

The latest revision for local coverage determination (LCD) Chiropractic Services was effective October 1, 2004. This LCD has been updated and revisions have been made to the following sections: Indications and Limitations of Coverage and/or Medical Necessity, Documentation Requirements and Coding Guidelines.

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

92240 Indocyanine-Green Angiography

Revised Policy

Indocyanine-green (ICG) angiography is an infrared-based, dye imaging technique that is effective in the diagnosis and treatment of ill-defined choroidal neovascularization (e.g., associated with age-related macular degeneration). ICG dye is injected intravenously into the patient to highlight the vessels in the retina and those of a deeper tissue layer called the choroid. The green dye fluoresces with invisible infrared light and requires a special camera sensitive to these light rays. Photographs are then taken of the retina at intervals as increasing intensity of retinal and choroidal circulation is displayed.

Medicare will consider indocyanine-green (ICG) angiography to be medically necessary as an adjunct to fluorescein angiography (FA) in the evaluation of the following conditions:

- Serous detachment of retinal pigment epithelium
- Hemorrhagic detachment of retinal pigment epithelium
- Retinal hemorrhage
- Presence of subretinal hemorrhage or hemorrhagic retinal pigment epithelium (RPE). A fluorescein angiography need not be previously done if patient is allergic to fluorescein.
- Central serous retinopathy
- Focal and disseminated choroiditis

In the absence of pre-existing chronic disease, clinical signs or symptoms of disease, an ICG angiography is considered screening and is not a benefit of the Medicare program. Also, a bilateral study is not automatically appropriate, or covered, in every case. Therefore, evidence of medical necessity must be documented in the medical record for each eye.

This policy has been updated and revised to include: indications and limitations of coverage and/or medical necessity, additional ICD-9-CM codes (362.41, 363.00-363.08, 363.10-363.15 and 363.20), utilization guidelines, coding guidelines and documentation requirements. ICD-9-CM code 362.16 has been deleted as well. This policy has also been converted into the LCD format. Since this was a major revision, the original policy was struck through completely.

This LCD is effective for services rendered on or after April 11, 2005. The full-text of this local coverage determination may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

LMRP/LCD (RETIRED)

Multiple Policies Being Retired

The following LMRPs were retired effective for services rendered on or after January 1, 2005. The decision to retire these policies was based on data analysis and standards of local practice.

Policy Number	Policy Name
0012T	Autologous Cultured Chondrocyte Implantation
33282	Insertable Loop Recorder
36511	Therapeutic Apheresis (Plasma and/or Cell Exchange)
36522	Extracorporeal Photopheresis
52282	Urethral Stents
53850	Prostate Treatments
54240	Penile Plethysmography
54900	Epididymovasostomy Repair
55873	Cryosurgical Ablation of the Prostate
61720	Stereotactic Pallidotomy

Multiple Policies Being Retired, continued

64550	Application of Surface (Transcutaneous) Neurostimulator
76092	Screening Mammograms
76506	Diagnostic Ultrasound
78267	Breath Test for Helicobacter Pylori (H. PYLORI)
80100	Qualitative Drug Screen
80500	Clinical Pathology Consultations and Clinical Laboratory Interpretation Services
82607	Vitamin B-12 (Cyanocobalamin) Assay
82784	Gammaglobulin (Immunoglobulins); IgA, IgD, IgG, IgM, Each
84152	Complexed and Free Prostate Specific Antigen
84155	Serum Protein
84484	Troponin
85044	Reticulocyte Count
86003	Allergen Specific IGE
86235	Extractable Nuclear Antigen
86353	Lymphocyte Transformation
86592	Syphilis Testing
86812	Histocompatibility Testing
87101	Culture, Fungi
88348	Electron Microscope
90853	Group Psychotherapy
92973	Interventional Cardiology
92992	Atrial Septectomy
93278	Signal Averaged Electrocardiography (SAECG)
93600	Intracardiac Electrophysiological Procedures
93619	Intracardiac Electrophysiological Evaluation
93650	Intracardiac Catheter Ablation
93724	Electronic Analysis of Pacemaker System and Pacer Cardioverter –Defibrillator
93930	Duplex Scan of Upper Extremity Arteries or Arterial By-Pass Grafts
93990	Duplex Scan of Hemodialysis Access
94642	Aerosolized Pentamidine Isethionate
95800	Neurodiagnostic Services
95857	Tensilon Test
95937	Neuromuscular Junction Testing
95930	Visual Evoked Potential (VEP) Testing
96100	Psychological Testing
96910	Photochemotherapy
99221	Rehabilitative Medicine (Physiatrist) Visits
J0150	Adenosine (Adenocard®, Adenoscan®)
J0205	Ceradase/Cerezyme
J0256	Alpha 1 Peroteinase Inhibitor, Human
J0850	Cytomegalovirus Immune Globulin (Human), Intravenous (CMV-IGIV)
J1212	Dimethyl Sulfoxide
J1460	Gammaglobulin
J1955	Levocarnitine (Carnitor®, L-carnitine®)
J2916	Ferrlecit®
J3240	Thyrotropin Alfa (Thyrogen®)
J9031	BCG, Intravesical per Instillation

Independent Diagnostic Testing Facility (IDTF)

Retired Policy

A draft local medical review policy (LMRP) revision was published for notice and comment with the comment period ending on November 11, 2003. However, based on instructions received from CMS, all LMRPs are to be converted into the local coverage determination (LCD) format. LCDs are to contain only reasonable and necessary information. It has been determined that this policy does not conform to the LCD format. Therefore, this policy will be retired accordingly. However, the information within the policy will be converted into an IDTF Specialty Manual that will be available on the website at *http://www.floridamedicare.com* by November 30, 2004.

In evaluating the information to be contained in the Specialty Manual, the procedure codes contained in the LMRP were evaluated. It was determined that services that were not diagnostic in nature and that did not clearly identify the procedure performed should not be billed by an IDTF. A special release article was posted on November 17, 2004 to serve as a 45-day notice that the following procedure codes would no longer be allowed when billed by an IDTF:

Independent Diagnostic Testing Facility (IDTF), continued

51798	78199	78699	92130	92611
75556	78299	78799	92287	93799
76499	78399	78999	92516	94799
76999	78499	92100	92520	95999
78099	78599	92120	92610	

In addition, it has been determined that the following procedures can be performed by an IDTF and will be added to the final IDTF specialty manual

51725	74355	75807	76080	93313
51726	74360	75809	76082	93314
51736	74363	75810	76086	93316
51741	74425	75820	76088	93317
51772	74430	75822	76095	93508
51784	74440	75825	76096	93740
51785	74445	75827	76360	93784
51792	74450	75831	76362	93786
51795	74455	75833	76370	93788
51797	74470	75840	76390	94014
54250	74475	75842	76393	94015
59020	74480	75860	76394	94150
59025	74485	75870	76930	94772
70010	74740	75872	76932	95060
70015	74742	75880	76936	95065
70170	75600	75885	76941	95070
70332	75605	75887	76942	95071
70373	75625	75889	76945	95078
70390	75630	75891	76946	95806
71040	75650	75893	76948	95824
71060	75658	75894	76950	95829
71090	75660	75896	76965	95858
72240	75662	75898	76970	95860
72255	75665	75900	76975	95861
72265	75671	75940	76986	95863
72270	75676	75945	78459	95864
72275	75680	75946	78491	95867
72285	75685	75960	78492	95868
72295	75705	75961	78810	95869
73040	75710	75962	78890	95870
73085	75716	75964	78891	95872
73115	75722	75966	91000	95875
73525	75724	75968	91010	95920
73530	75726	75970	91011	95955
73580	75731	75978	91012	95961
73615	75733	75980	91020	95962
74190	75736	75982	91030	96100
74300	75741	75984	91032	96105
74301	75743	75989	91033	96110
74305	75746	75992	91052	96111
74320	75756	75993	91055	96115
74327	75774	75994	91060	96117
74328	75790	75995	91065	G0106
74329	75801	75996	91122	G0248-G0249
74330	75803	76000	92060	G0253
74340	75805	76001	92596	G0254
74350			93025	G0296

For additional information regarding IDTFs, please refer to the Medicare Program Integrity Manual, Chapter 10-5.

ADDITIONAL INFORMATION ON LMRPS/LCDS

Diagnosis Not Subject to Psychiatric Reduction

The outpatient psychiatric services limitation, where 62.5 percent of the allowed amount is reimbursed to providers, is based on actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred. This limitation is called the outpatient mental health treatment limitation.

Due to changes published in the 2005 ICD-9-CM update, ICD-9-CM code 294.8 (other persistent mental disorders due to conditions classified elsewhere) has been added to the list of diagnosis codes that are not subject to the outpatient psychiatric services limitation.

This change is effective for claims processed on or after January 1, 2005.

Impacted Cerumen Removal

Billing Article

The local medical review policy (LMRP) for Impacted Cerumen Removal – 69210 was retired on September 30, 2004 based on data analysis and local standards of practice. This article is being published in order to clarify the correct billing for impacted cerumen removal.

Removal of impacted cerumen usually entails one or more of three methods of removal. The first two methods of cerumen removal must be either personally performed by the physician, or performed by the physician's employees under the "incident to" provision. Simple cerumen removal which entails two methods, either through irrigation of the ear canal(s) or involves the use of chemical solvents, which are used to soften the cerumen in order to facilitate the removal of cerumen, and is considered part of the evaluation and management service (procedure codes *99201-99357*). Therefore, simple cerumen removal is not separately reimbursable with procedure code *69210* or G0268. The third method of cerumen removal is manual disimpaction. This method is performed by the physician under binocular magnification and generally entails grasping the cerumen plug with forceps, application of suction, and/or extraction with a right-angle hook. In cases of severely impacted ears, injections of local anesthesia may be required. Florida Medicare will consider only the manual disimpaction method of cerumen removal reimbursable as a separate procedure (*69210* or G0268).

Real time Outpatient Cardiac Telemetry Monitoring and Analysis

Real time Outpatient Cardiac Telemetry monitoring is one of the several long-term, external, mobile cardiac outpatient-monitoring modalities used to detect significant cardiac arrhythmias in patients with symptoms that might be attributable to cardiac arrhythmia.

This type of testing is useful for detection and diagnosis of arrhythmias that occur, which are infrequent and for which holter monitoring, office or emergency room monitoring, or other shorter-term monitoring techniques are not useful. The monitoring device transmits cardiac rhythm data to a central processing center that analyzes the electronic data and provides a report to the physician who requested the test.

The technical component of this service includes supply of the equipment, hook-up of the patient and the set-up of the equipment, as well as the receipt of transmission, monitoring and notification of the referring provider and provision of the monitoring ECG rhythm strips and data. If the technical component is done in Florida it should be billed with the unlisted code *93799* (unlisted cardiovascular service) and the modifier "TC".

The professional component consists of the review and interpretation of each 24- hour cardiac surveillance as well as 24- hour availability and response to monitoring events within a course of treatment that includes up to 30 consecutive days of cardiac monitoring and generation of a report. Since this is new technology and there is no unique code for this service, we would expect to see the physician interpretation of these services billed with unlisted code *93799* (unlisted cardiovascular service) with a modifier "26". Our claims processing department will request documentation for review of the claim. The documentation submitted should describe the service performed in its entirety and the physician should provide information to support medical necessity. In addition, the documentation must support the necessity for this modality in lieu of other outpatient or inpatient monitoring modalities.

This service should be billed one time as a single service in any 30-day period regardless of the number of transmissions or separate rhythm reports the physician interprets during that 30-day period.

92700 - CANALITH REPOSITIONING PROCEDURE

Florida Medicare will now cover the Canalith Repositioning Procedure, with reimbursement equivalent to an evaluation and management (E&M) visit at the CPT code level of *99212*. Claims submitted to Medicare for this service must bill CPT code *92700* (unlisted otorhinolaryngological service or procedure). In addition, the description "Canalith Repositioning Maneuver" must be stated in Item 19 of the CMS-1500 claim form or on the free form line of electronic claims. An E&M service is allowed in addition to the above service when billed on the same day, by the same provider, if there is a significant, separately identifiable service. In those instances, modifier 25 should be applied to the E&M code.

79900: Provision of Therapeutic Radiopharmaceuticals – Billing Clarification for Radioactive Seeds

This article provides clarification for billing radioactive seeds in relation to brachytherapy. Previously, in the 3rd Quarter 2004 Medicare B Update (pg. 73-74), Florida Medicare had instructed providers to bill procedure code 79900 (Provision of therapeutic radiopharmaceuticals). Through HCPCS 2005 procedure code 79900 has been deleted effective January 1, 2005. Therefore, effective January 1, 2005 the appropriate procedure code to utilize when billing for radioactive seeds (Iodine 125 (I-125), Palladium 103 (PD 103), Gold (198 Au), or Iridium (192 Ir) is procedure code Q3001 (Radioelements for brachytherapy, any type, each).

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EDUCATIONAL RESOURCES

First Coast Service Options

Presents….

Medifest 2005

The Medifest Symposium gives you an opportunity to attend various Medicare educational courses designed specifically for providers, billing/office managers and staff. You may select the courses that best meet the needs of your practice/office. New for 2005, we have added Medicare Specialty Seminars on day three (day two for Panama City). You have the following three options:

- Only attend our traditional Medifest sessions
- Attend our traditional Medifest session and a 3-hour Specialty Seminar
- Only attend a 3-hour Specialty Seminar

February 24-25, 2005
BayPoint Resort Marriott
4200 Marriott Drive, Panama City Beach, Florida 32408
Phone: (850) 236-6000

April 5-7, 2005
Coral Springs Marriott Hotel
11775 Heron Bay Blvd, Coral Springs, Florida 33076
Phone: (954) 753-5598

June 28-30, 2005
Omni Jacksonville Hotel
245 Water Street, Jacksonville, Florida 32202
Phone: (904) 355-6664

August 2-4, 2005
The Naples Beach Hotel
851 Gulf Shore Blvd North, Naples, Florida 34102
Phone: (239) 261-2222

November 1-3, 2005
Orlando Airport Marriott
7499 Augusta National Drive, Orlando, Florida 32822
Phone: (407) 851-9000

EDUCATIONAL RESOURCES

Medicare Specialty Seminars Coming to a City Near You

February 25, 2005, (8:00 am to 11:00 am)

BayPoint Marriott Resort, 4200 Marriott Drive, Panama City Beach, FL 32408

- Advanced Registered Nurse Practitioners/Physician Assistant (ARNP/PA) (B)
- Anesthesiology/Pain Management (B)
- ANSI 101 (HIPAA) (A/B)
- Evaluation and Management Documentation (B)
- Skilled Nursing Facility, Minimum Data Set Coding and Billing Efficiency (A)
- Rehabilitation Services (A/B)

April 7, 2005, (8:00 am to 11:00 am)

Coral Springs Marriott Hotel, 11775 Heron Bay Blvd, Coral Springs, FL 33076

- Oncology (B)
- Psychiatric Services (B)
- Cardiology (B)
- Evaluation and Management Documentation (B)
- Nephrology (B)
- Skilled Nursing Facilities (SNF) (A)

June 30, 2005, (8:00 am to 11:00 am)

Omni Jacksonville Hotel, 245 WaterStreet, Jacksonville, FL 32202

- End Stage Renal Disease (ESRD) (A)
- Psychiatric Services (B)
- Ambulatory Surgical Centers (B)
- Pathology/Clinical Lab (B)
- Skilled Nursing Facility, Minimum Data Set Coding and Billing Efficiency (A)
- Evaluation and Management Documentation (B)

August 4, 2005, (8:00 am to 11:00 am)

Naples Beach Hotel, 851 Gulf Shore Blvd North, Naples, FL 34102

- • Podiatry (B)
- • Urology (B)
- • Rehabilitation Services (A/B)
- • Chiropractic Services (B)
- • Evaluation and Management Documentation (B)
- • Skilled Nursing Facilities (SNF) (A)

November 3, 2005 (8:00 am to 11:00 am)

Orlando Airport Marriott, 7499 Augusta National Drive, Orlando, FL 32822

- • Oncology (B)
- • Ophthalmology Services (B)
- • Interventional Radiology (B)
- • Cardiology (B)
- • Skilled Nursing Facility, Minimum Data Set Coding and Billing Efficiency (A)
- • End Stage Renal Disease (ESRD) (A)

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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

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Medicare Part B Secondary Payer Dept.
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Jacksonville, FL 32231-4078

ESRD Claims
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DMERC Operations
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Jacksonville, FL 32231-0020

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P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
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Jacksonville, FL 32231-4021
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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
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Jacksonville, FL 32231-0048

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Jacksonville, FL 32232-5157

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P. O. Box 2360
Jacksonville, FL 32231-0048

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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

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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
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
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Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
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(Confirmation/Transmission):
1-904-905-8880 option 1

OCR

Printer Specifications/Test Claims:
1-904-791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
1-803-735-1034

MEDICARE PART A

Toll-Free:
1-877-602-8816

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PROVIDER

Florida
http://www.floridamedicare.com

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

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

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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!

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