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

Special Issue

2005 Healthcare Common Procedure Coding System and Medicare Physician Fee Schedule Database Update

In This Issue…

This *Medicare B Update! Special Issue* is published by the Medicare Communication & 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 Publications
P.O. Box 45270
Jacksonville, FL 32232-5270

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

Routing Suggestions:

- ❑ Physician/Provider
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Special Issue
January 2005

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Kimberly McCaw
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Betty Alix

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ANNUAL HCPCS UPDATE

Effective for Services Rendered on or After January 1, 2005

The Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) is used to administer the Medicare Part B program for all carriers. The HCPCS is updated annually to reflect changes in the practice of medicine and provisions of healthcare. When filing claims for dates of service beginning January 1, 2005, refer to the coding changes in this publication. For dates of service in 2004, continue to use 2004 procedure codes.

The purpose of this section is to provide an overview of changes to the HCPCS coding structure for 2005. This publication only covers specific coding changes. Related billing and reimbursement changes will be posted to our provider education Web sites at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*, and in future issues of the *Medicare B Update!* This information will also be shared with the Connecticut Medical Association, the Florida Medical Association, all county medical societies, and all active specialty associations. Stay in contact with these organizations and read their bulletins for additional HCPCS information.

Description of HCPCS Coding Levels

Procedure code additions, deletions and revisions are being made to all three levels of the HCPCS coding structure for 2005. The three levels of procedure codes are:

Level I -Numeric Codes (*CPT*)

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

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Level II -Alpha Numeric (CMS-Assigned)

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

The 2005 HCPCS Update

Additions

The procedure/modifier codes listed under "Modifiers/Procedure Codes Added for 2005 " (pages 4-5) are newly identified codes and should be used only for services rendered on or after January 1, 2005.

Revisions

The procedure/modifier codes listed under "Modifiers/Procedure Codes Revised for 2005 " (pages 5-6) include codes in which the descriptor or administrative instructions have changed from 2004. When using these codes, please be sure to refer to the 2005 HCPCS or *CPT* to ensure you are using the accurate procedure code for the service performed.

Discontinued Procedures

The procedure/modifier codes listed under "Modifiers/Procedure Codes Discontinued for 2005 " (page 7) should not be used for service dates after December 31, 2004. However, FCSO Medicare will continue to accept claims for certain discontinued procedure codes with 2005 service dates received prior to April 1, 2005.

Effective for claims received on or after April 1, 2005, services performed in 2005 that are billed using discontinued codes will be denied payment when submitted to Medicare Part B. In these instances, providers will be notified that a discontinued procedure code was submitted and a valid procedure code must be used.

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

A Word About Coverage

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

Carrier Jurisdiction

The lists of procedures that are added, revised, or discontinued for 2005 are complete with no regard to carrier jurisdiction. The majority of procedure codes in HCPCS are processed by the local Medicare Part B carrier, FCSO. However, some procedure codes listed represent services that should be billed to the Durable Medical Equipment Regional Carrier (DMERC), not the local carrier. The DMERC that serves Connecticut is HealthNow (*http://www.healthnow.org*); for Florida, it is Palmetto Government Benefits Administrators (*http://www.palmettogba.com*). It is the responsibility of the billing provider to submit claims to the appropriate carrier.

Use of Unlisted Procedure Codes

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

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

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

Reminder for Electronic Media Claim (EMC) Billers

Unlisted and not otherwise classified procedure codes may be submitted in two ways:

- If the unlisted or not otherwise classified procedure code can be submitted with a brief descriptor, the required information may be indicated in the appropriate narrative record. If you are unsure if your system has this capability, contact your vendor.
- If the unlisted or not otherwise classified procedure code requires documentation (e. g., pathology or operative reports), the service must be submitted on a paper Form CMS-1500.

Questions or Concerns?

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

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

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

Acquiring the 2005 Coding Books

Because of the many changes to the HCPCS coding structure, providers are strongly encouraged to purchase the 2005 *CPT* (Level I) book and/or the 2005 HCPCS (Level II) coding book. The 2005 edition of *CPT* may be purchased from the American Medical Association online at *http://www.ama-assn.org/catalog*, by calling 1-800-621-8335, or by writing:

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

The 2005 HCPCS Alpha-Numeric Hardcopy

Additionally the 2005 alpha-numeric hardcopy, titled *2005 Alpha-Numeric Healthcare Common Procedure Coding System*, may be secured from:

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

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Modifiers and Procedure Codes Added for 2005

MODIFIERS

AE
AF
AG
AK
AR
CD
CE
CF
CG
KC
KD
KF
RD
SW
SY

CMS ASSIGNED

A4223
A4349
A4520
A4605
A7040
A7041
A7045
A7527
A9152
A9153
A9180
B4102
B4103
B4104
B4149
B4157
B4158
B4159
B4160
B4161
B4162
D0416
D0421
D0431
D0475
D0476
D0477
D0478
D0479
D0481
D0482
D0483
D0484
D0485
D2712
D2794
D2915
D2934
D2971
D2975
D5225
D5226
D6094
D6190
D6194
D6205
D6214
D6624
D6634
D6710
D6794
D7283
D7288
D7311
D7321
D7511
D7521
D7953
D7963
D9942
E0463
E0464
E0639
E0640
E0769
E0849
E1039
E1229
E1239
E1841
E2205
E2206
E2291
E2292
E2293
E2294
E2368
E2369
E2370
E2601
E2602
E2603
E2604
E2605
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E2618
E2619
E2620
E2621
E8000
E8001
E8002
G0337
G0344
G0345
G0346
G0347
G0348
G0349
G0350
G0351
G0353
G0354
G0355
G0356
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G0358
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G0365 TC
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G9021
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G9023
G9024
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G9029
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G9031
G9032
J0128
J0135
J0180
J0878
J1457
J1931
J2357
J2469
J2794
J3110
J3246
J3396
J7304
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J7344
J7518
J7611
J7612
J7613
J7614
J7616
J7617
J7674
J8501
J8565
J9035
J9041
J9055
J9305
L1932
L2005
L2232
L4002
L5685
L5856
L5857
L6694
L6695
L6696
L6697
L6698
L7181
L8515
L8615
L8616
L8617
L8618
L8620
L8621
L8622
S0196
S0257
S2348
S4042
S9482
T4521
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V2702

CPT

0500F
0501F
0502F
0503F
1000F
1001F
1002F
2000F
4000F
4001F
4002F
4006F
4009F
4011F
0062T
0063T
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0065T
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76510 26
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79101
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79445
79445 TC
79445 26
82045
82656
83009
83630
84163
84166
84166 26
86064
86335
86335 26
86379
86587
87807
88184
88185
88187
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88360
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88367
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88368 TC
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90465
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97597
97598
97605
97606
97810
97811
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Modifiers and Procedure Codes Revised for 2005

MODIFIERS

FP

CMS ASSIGNED

A4222
A4332
A5119
A5500
A5501
A5503
A5504
A5505
A5506
A5507
A5508
A5509
A5510
A5511
A9517
A9525
A9530
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B4150
B4152
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C1716
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C8920
C9211
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D3332
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D7111
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D7955
E0118
E0221
E0450
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E0986
E1010
E1011
E1014
E1025
E1026
E1027
E1038
E1225
E1226
G0173
G0237
G0238
G0239
G0244
G0260
G0295
G0308
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G0318
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G0323
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J0152
J0880
J1564
J2324
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L2035
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L2330
L2755
L2800
L4040
L4045
L4050
L4055
L6890
L6895
L7180
Q3031
S2150
T2005
V2745

CPT

0040T
0055T
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70546
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70553
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77750

Modifiers and Procedure Codes Revised for 2005, continued

78267	83894	88313	90700	95971
78464	83896	88361	90780	95972
78465	83897	88365	90781	95973
79200	83898	89346	90782	96111
79300	83901	90471	90784	96150
79403	83902	90473	91065	97802
79440	83912	90474	91122	97803
83013	84165	90586	93741	97804
83014	85046	90655	93742	99293
83892	86334	90657	94060	99294
83893	87046	90658	94070	99295
				99296

Modifiers and Procedure Codes Reactivated for 2005

CMS ASSIGNED	
A4644	A4646
A4645	L0430

Modifiers and Procedure Codes Discontinued for 2005

CMS ASSIGNED					
A4324	XREF A4349	C9216	XREF J0128	K0061	
A4325	XREF A4349	C9217	XREF J2357	K0081	XREF E2206
A4347	XREF A4349	C9219	XREF J7518	K0114	
A4521		C9412	XREF J7310	K0115	
A4522		C9701		K0116	
A4523		C9703		K0627	XREF E0849
A4524		C9712	XREF 91035	K0650	XREF E2601
A4525		C9714	XREF 19297	K0651	XREF E2602
A4526		C9715	XREF 19296	K0652	XREF E2603
A4527		C9717	XREF 46947	K0653	XREF E2604
A4528		D2970		K0654	XREF E2605
A4529		D6020	XREF 21248	K0655	XREF E2606
A4530		D7281		K0656	XREF E2607
A4531		E0176		K0657	XREF E2608
A4532		E0177		K0658	XREF E2609
A4533		E0178		K0659	XREF E2610
A4535		E0179		K0660	XREF E2611
A4536		E0192		K0661	XREF E2612
A4537		E0454		K0662	XREF E2613
A4538		E0962		K0663	XREF E2614
A4609	XREF A4605	E0963		K0664	XREF E2615
A4610	XREF A4605	E0964		K0665	XREF E2616
B4151		E0965		K0666	XREF E2617
B4156		E1012		K0667	
C9109	XREF J3246	E1013		K0668	XREF E2619
C9124	XREF J0878	G0001		L0476	
C9125	XREF J2794	G0292		L0478	
C9207	XREF J9041	J3245		L0500	
C9208	XREF J0180	J3395		L0510	
C9209	XREF J1931	J7618		L0515	
C9210	XREF J2469	J7619		L0520	
C9213	XREF J9305	J7621		L0530	
C9214	XREF J9305	K0023		L0540	
C9215	XREF J9055	K0024		L0550	
		K0059		L0560	
		K0060		L0561	

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L0565	
L0600	
L0610	
L0620	
L2435	
L5674	XREF L5685
L5675	XREF L5685
L5846	
L5847	
L5989	
L8490	
Q0182	XREF J7343
Q0183	XREF J7344
S0115	
S0163	
S0165	
S0830	
S2085	
S2113	
S2130	
S2131	
S2211	
S2255	
S8182	
S8183	
T1500	

CPT

35161	TO REPORT, USE 37799
35162	TO REPORT, USE 37799
35582	
50559	
50578	
50959	
50978	
52347	
78810	TO REPORT, SEE 78811-78813
78990	
79000	TO REPORT, USE 79005
79001	TO REPORT, USE 79005
79020	TO REPORT, USE 79005
79030	TO REPORT, USE 79005
79035	TO REPORT, USE 79005
79100	TO REPORT, USE 79101
79400	TO REPORT, USE 79101
79420	TO REPORT, USE 79445
79900	
88180	TO REPORT, SEE 88182, 88189
91032	TO REPORT, SEE 91034, 91035
91033	TO REPORT, SEE 91034, 91035
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97601	TO REPORT, USE 97597, 97598
97780	TO REPORT, SEE 97810, 97811
97781	TO REPORT, SEE 97813, 97814
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0002F	TO REPORT, USE 1000F
0003F	TO REPORT, USE 1001F
0004F	TO REPORT, USE 4000F
0005F	TO REPORT, USE 4001F
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0010F	
0011F	TO REPORT, USE 4011F
0001T	TO REPORT, USE 34803
0005T	TO REPORT, SEE 0075T, 0076T
0006T	TO REPORT, SEE 0075T, 0076T
0007T	TO REPORT, SEE 0075T, 0076T
0009T	TO REPORT, USE 58356
0012T	TO REPORT, USE 29866
0013T	TO REPORT, SEE 29867, 27415
0014T	TO REPORT, USE 29868
0057T	TO REPORT, USE 43257

MEDICARE PHYSICIAN FEE SCHEDULE

Emergency Update to the 2005 Medicare Physician Fee Schedule Database (MPFSDB)

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

Provider Types Affected

Physicians and practitioners billing Medicare carriers

Provider Action Needed

Physicians and practitioners should note there are changes to the 2005 MPFSDB. The new fees are posted on the Medicare carriers' web site.

Background

MPFSDB files were issued to carriers based upon the November 15, 2004, Medicare Physician Fee Schedule Final Rule. These are the fees that are on the CDs that were recently mailed to all physicians as part of the annual participation enrollment process. However, the Centers for Medicare & Medicaid Services (CMS) has made a few changes to that database. These include changes to a few CPT codes with respect to status indicators, global periods, and the addition of 12 demonstration codes (G9021- G9032) for use with chemotherapy infusion. Anew MPFSDB file was released to carriers and this new MPFSDB file will be posted to your local carrier's web site. Physicians and practitioners should refer to their local carrier web site to view the new updated fees.

Implementation

The implementation date for the new fees is January 3, 2005. However, the new fees will be available on your Medicare carrier's web site before January 1.

Additional Information

The specific changes to the fee schedule are identified in an attachment to the instructions issued to your carrier. Those instructions are CR 3595 and they may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

Once at that page, scroll down the CR NUM column on the right looking for CR 3595, then 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://www.cms.hhs.gov/medlearn/tollnums.asp*

Related Change Request (CR) #: 3595
Medlearn Matters Number: MM3595
Related CR Release Date: December 23, 2004
Related CR Transmittal #: 414
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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2005 FEES FOR INJECTABLE 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.

January 2005 Quarterly Average Sale Price Medicare Part B Drug Pricing

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

Provider Types Affected

All providers

Provider Action Needed

No provider action is necessary. This article is informational only and explains how Medicare pays for certain drugs that are not paid on a cost or prospective payment basis, effective January 1, 2005.

Background

According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005 drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the average sales price (ASP) plus six percent. The Centers for Medicare & Medicaid Services (CMS) will supply its carriers/intermediaries with the ASP drug-pricing file for Medicare Part B drugs. The ASP is based on quarterly drug information supplied to CMS by drug manufacturers.

Thus, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions

There are exceptions to this general rule, as summarized below:

1. The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
2. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted.

The payment allowance limits will not be updated in 2005.

3. The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
4. The payment allowance limits for drugs not included in the ASP Medicare Part B Drug Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing.

Note that 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. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Implementation

The implementation date is January 3, 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 3539 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*.

Related Change Request (CR) Number: 3539
Related CR Release Date: October 29, 2004
Related CR Transmittal Number: 348
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 348, CR 3539

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Medicare Part B Drugs Average Sales Price Information Resource

The Centers for Medicare & Medicaid Services has announced the January 2005 Average Sales Price (ASP) Pricing File for Medicare Part B Drugs. For important information and the actual payment amounts, visit the CMS web site at *http://www.cms.hhs.gov/providers/drugs/asp.asp*.

CARRIER PRICED FEES

2005 Carrier-Priced Fee Schedule Services

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

In many instances, however, enough historical data has been collected to allow FCSO to develop a consistent allowance for some C status codes. These codes and allowances below, effective for services rendered on or after January 1, 2005, are listed separately for Connecticut and Florida.

Connecticut

CODE/MOD	PAR	NPAR	L CHG
G0030	154.82	147.08	169.14
G0030 TC	92.89	88.25	101.48
G0031	208.96	198.51	228.29
G0031 TC	125.38	119.11	136.98
G0032	154.82	147.08	169.14
G0032 TC	92.89	88.25	101.48
G0033	208.96	198.51	228.29
G0033 TC	125.38	119.11	136.98
G0034	154.82	147.08	169.14
G0034 TC	92.89	88.25	101.48
G0035	208.96	198.51	228.29
G0035 TC	125.38	119.11	136.98
G0036	154.82	147.08	169.14
G0036 TC	92.89	88.25	101.48
G0037	208.96	198.51	228.29
G0037 TC	125.38	119.11	136.98
G0038	154.82	147.08	169.14
G0038 TC	92.89	88.25	101.48
G0039	208.96	198.51	228.29
G0039 TC	125.38	119.11	136.98
G0040	154.82	147.08	169.14
G0040 TC	92.89	88.25	101.48
G0041	208.96	198.51	228.29
G0041 TC	125.38	119.11	136.98
G0042	154.82	147.08	169.14
G0042 TC	92.89	88.25	101.48
G0043	208.96	198.51	228.29
G0043 TC	125.38	119.11	136.98
G0044	154.82	147.08	169.14
G0044 TC	92.89	88.25	101.48
G0045	208.96	198.51	228.29
G0045 TC	125.38	119.11	136.98
G0046	154.82	147.08	169.14
G0046 TC	92.89	88.25	101.48

CODE/MOD	PAR	NPAR	L CHG	NOTE
G0047	208.96	198.51	228.29	
G0047 TC	125.38	119.11	136.98	
G0125	2,590.63	2461.10	2830.26	
G0125 TC	2,506.31	2380.99	2738.14	
G0186	639.23	607.27	698.36	
G0186	619.08	588.13	676.34	*
G0210	2,757.48	2619.61	3012.55	
G0210 TC	2,670.05	2536.55	2917.03	
G0211	2,757.95	2620.05	3013.06	
G0211 TC	2,670.50	2536.97	2917.52	
G0212	2,757.48	2619.61	3012.55	
G0212 TC	2,670.05	2536.55	2917.03	
G0213	2,757.48	2619.61	3012.55	
G0213 TC	2,670.05	2536.55	2917.03	
G0214	2,757.48	2619.61	3012.55	
G0214 TC	2,670.05	2536.55	2917.03	
G0215	2,757.48	2619.61	3012.55	
G0215 TC	2,670.05	2536.55	2917.03	
G0216	2,757.48	2619.61	3012.55	
G0216 TC	2,670.05	2536.55	2917.03	
G0217	2,757.48	2619.61	3012.55	
G0217 TC	2,670.05	2536.55	2917.03	
G0218	2,757.48	2619.61	3012.55	
G0218 TC	125.38	119.11	136.98	
G0220	2,757.48	2619.61	3012.55	
G0220 TC	2,670.05	2536.55	2917.03	
G0221	2,757.48	2619.61	3012.55	
G0221 TC	2,670.05	2536.55	2917.03	
G0222	2,757.48	2619.61	3012.55	
G0222 TC	2,670.05	2536.55	2917.03	
G0223	2,757.48	2619.61	3012.55	
G0223 TC	2,670.05	2536.55	2917.03	
G0224	2,757.48	2619.61	3012.55	
G0224 TC	92.89	88.25	101.48	

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

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Connecticut - continued

CODE/MOD		PAR	NPAR	L CHG
G0225		2,757.48	2619.61	3012.55
G0225	TC	2,670.05	2536.55	2917.03
G0226		2,757.48	2619.61	3012.55
G0226	TC	2,670.05	2536.55	2917.03
G0227		2,757.48	2619.61	3012.55
G0227	TC	2,670.05	2536.55	2917.03
G0228		2,757.48	2619.61	3012.55
G0228	TC	2,670.05	2536.55	2917.03
G0229		2,757.48	2619.61	3012.55
G0229	TC	2,670.05	2536.55	2917.03
G0230		2,757.48	2619.61	3012.55
G0230	TC	2,670.05	2536.55	2917.03
G0231		2,757.48	2619.61	3012.55
G0231	TC	2,670.05	2536.55	2917.03
G0232		2,757.48	2619.61	3012.55
G0232	TC	2,670.05	2536.55	2917.03
G0233		2,757.48	2619.61	3012.55
G0233	TC	2,670.05	2536.55	2917.03
G0234		2,757.48	2619.61	3012.55
G0234	TC	2,670.05	2536.55	2917.03
G0253		2,757.48	2619.61	3012.55
G0253	TC	2,670.05	2536.55	2917.03
G0254		2,757.48	2619.61	3012.55
G0254	TC	2,670.05	2536.55	2917.03
G0296		2,779.00	2640.05	3036.06
G0296	TC	2,670.05	2536.55	2917.03
G0336		2,757.48	2619.61	3012.55
G0336	TC	2,670.05	2536.55	2917.03
R0070		156.12	148.31	170.56
R0075		156.12	148.31	170.56
0017T		1,014.72	963.98	1108.58
70557		402.90	382.75	440.17
70557	TC	241.74	229.65	264.10
70558		445.46	423.19	486.67
70558	TC	267.28	253.92	292.00
70559		447.24	424.88	488.61
70559	TC	268.35	254.93	293.17
74300		50.79	48.25	55.49
74300	TC	30.47	28.95	33.29
74301		29.47	28.00	32.20
74301	TC	17.68	16.80	19.32
75952		701.56	666.48	766.45
75952	TC	420.94	399.89	459.88
75953		255.58	242.80	279.22
75953	TC	153.35	145.68	167.53
75954		625.29	594.03	683.13
75954	TC	375.17	356.41	409.87

CODE/MOD		PAR	NPAR	L CHG
76012		207.23	196.87	226.40
76012	TC	124.34	118.12	135.84
76013		240.35	228.33	262.58
76013	TC	144.21	137.00	157.55
76350		18.67	17.74	20.40
78172		74.28	70.57	81.15
78172	TC	44.57	42.34	48.69
78282		54.96	52.21	60.04
78282	TC	32.98	31.33	36.03
78414		64.13	60.92	70.06
78414	TC	38.48	36.56	42.04
78459		217.51	206.63	237.63
78459	TC	130.51	123.98	142.58
79300		230.20	218.69	251.49
79300	TC	138.12	131.21	150.90
91132		75.29	71.53	82.25
91132	TC	45.18	42.92	49.36
91133		94.68	89.95	103.44
91133	TC	56.81	53.97	62.06
93315		398.52	378.59	435.38
93315	TC	239.11	227.15	261.23
93317		263.12	249.96	287.46
93317	TC	157.87	149.98	172.47
93318		278.01	264.11	303.73
93318	TC	166.81	158.47	182.24
93620		1,713.88	1628.19	1872.41
93620	TC	1,028.33	976.91	1123.45
93621		314.63	298.90	343.73
93621	TC	188.78	179.34	206.24
93622		504.42	479.20	551.08
93622	TC	302.66	287.53	330.66
93623		421.00	399.95	459.94
93623	TC	252.60	239.97	275.97
93662		434.37	412.65	474.55
93662	TC	260.62	247.59	284.73
94642		31.40	29.83	34.30
95824		113.25	107.59	123.73
95824	TC	67.95	64.55	74.24
95951		902.15	857.04	985.60
95951	TC	541.29	514.23	591.36
95965		1,164.82	1106.58	1272.57
95965	TC	698.90	663.95	763.55
95966		581.41	552.34	635.19
95966	TC	348.85	331.41	381.12
95967		509.03	483.58	556.12
95967	TC	305.42	290.15	333.67

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Florida

	PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04 NOTE
G0030	142.22	149.53	155.25	135.11	142.05	147.49	155.38	163.36	169.61
G0030 TC	85.33	89.73	93.16	81.06	85.24	88.50	93.22	98.03	101.78
G0031	191.06	200.68	208.18	181.51	190.65	197.77	208.73	219.24	227.44
G0031 TC	114.63	120.40	124.91	108.90	114.38	118.66	125.23	131.54	136.46
G0032	142.22	149.53	155.25	135.11	142.05	147.49	155.38	163.36	169.61
G0032 TC	85.33	89.73	93.16	81.06	85.24	88.50	93.22	98.03	101.78
G0033	191.06	200.68	208.18	181.51	190.65	197.77	208.73	219.24	227.44
G0033 TC	114.63	120.40	124.91	108.90	114.38	118.66	125.23	131.54	136.46
G0034	142.22	149.53	155.25	135.11	142.05	147.49	155.38	163.36	169.61
G0034 TC	85.33	89.73	93.16	81.06	85.24	88.50	93.22	98.03	101.78
G0035	191.06	200.68	208.18	181.51	190.65	197.77	208.73	219.24	227.44
G0035 TC	114.63	120.40	124.91	108.90	114.38	118.66	125.23	131.54	136.46
G0036	142.22	149.53	155.25	135.11	142.05	147.49	155.38	163.36	169.61
G0036 TC	85.33	89.73	93.16	81.06	85.24	88.50	93.22	98.03	101.78
G0037	191.06	200.68	208.18	181.51	190.65	197.77	208.73	219.24	227.44
G0037 TC	114.63	120.40	124.91	108.90	114.38	118.66	125.23	131.54	136.46
G0038	142.22	149.53	155.25	135.11	142.05	147.49	155.38	163.36	169.61
G0038 TC	85.33	89.73	93.16	81.06	85.24	88.50	93.22	98.03	101.78
G0039	191.06	200.68	208.18	181.51	190.65	197.77	208.73	219.24	227.44
G0039 TC	114.63	120.40	124.91	108.90	114.38	118.66	125.23	131.54	136.46
G0040	142.22	149.53	155.25	135.11	142.05	147.49	155.38	163.36	169.61
G0040 TC	85.33	89.73	93.16	81.06	85.24	88.50	93.22	98.03	101.78
G0041	191.06	200.68	208.18	181.51	190.65	197.77	208.73	219.24	227.44
G0041 TC	114.63	120.40	124.91	108.90	114.38	118.66	125.23	131.54	136.46
G0042	142.22	149.53	155.25	135.11	142.05	147.49	155.38	163.36	169.61
G0042 TC	85.33	89.73	93.16	81.06	85.24	88.50	93.22	98.03	101.78
G0043	191.06	200.68	208.18	181.51	190.65	197.77	208.73	219.24	227.44
G0043 TC	114.63	120.40	124.91	108.90	114.38	118.66	125.23	131.54	136.46
G0044	142.22	149.53	155.25	135.11	142.05	147.49	155.38	163.36	169.61
G0044 TC	85.33	89.73	93.16	81.06	85.24	88.50	93.22	98.03	101.78
G0045	191.06	200.68	208.18	181.51	190.65	197.77	208.73	219.24	227.44
G0045 TC	114.63	120.40	124.91	108.90	114.38	118.66	125.23	131.54	136.46
G0046	142.22	149.53	155.25	135.11	142.05	147.49	155.38	163.36	169.61
G0046 TC	85.33	89.73	93.16	81.06	85.24	88.50	93.22	98.03	101.78
G0047	191.06	200.68	208.18	181.51	190.65	197.77	208.73	219.24	227.44
G0047 TC	114.63	120.40	124.91	108.90	114.38	118.66	125.23	131.54	136.46
G0125	2162.55	2469.71	2485.91	2054.42	2346.22	2361.61	2362.59	2698.16	2715.86
G0125 TC	2086.08	2282.96	2402.69	1981.78	2168.81	2282.56	2279.04	2494.13	2624.94
G0186	578.12	603.49	626.24	549.21	573.32	594.93	631.60	659.31	684.17
G0186	561.64	585.75	607.90	533.56	556.46	577.51	613.59	639.93	664.13*
G0210	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0210 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0211	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0211 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0212	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0212 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0213	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0213 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0214	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0214 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0215	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0215 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94

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

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Florida

	PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
G0216	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0216 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0217	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0217 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0218	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0218 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0220	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0220 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0221	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0221 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0222	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0222 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0223	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0223 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0224	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0224 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0225	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0225 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0226	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0226 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0227	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0227 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0228	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0228 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0229	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0229 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0230	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0230 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0231	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0231 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0232	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0232 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0233	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0233 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0234	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0234 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0253	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0253 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0254	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0254 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0296	2184.73	2386.69	2510.43	2075.49	2267.36	2384.91	2386.82	2607.46	2742.64
G0296 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
G0336	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
G0336 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
R0070	98.42	98.42	98.42	93.50	93.50	93.50	107.52	107.52	107.52
R0075	98.42	98.42	98.42	93.50	93.50	93.50	107.52	107.52	107.52
21088	6360.07	6360.07	6360.07	6042.07	6042.07	6042.07	6948.38	6948.38	6948.38
21088	4070.45	4070.45	4070.45	3866.93	3866.93	3866.93	4446.97	4446.97	4446.97*
70557	372.20	382.84	394.73	353.59	363.70	374.99	406.63	418.25	431.24
70557 TC	223.32	229.70	236.84	212.15	218.21	225.00	243.98	250.95	258.75
70558	411.99	424.30	438.10	391.39	403.08	416.19	450.10	463.55	478.62
70558 TC	247.19	254.58	262.86	234.83	241.85	249.72	270.06	278.13	287.17
70559	414.40	427.70	442.64	393.68	406.32	420.51	452.73	467.26	483.58

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Florida - continued

	PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
70559 TC	248.64	256.62	265.58	236.21	243.79	252.30	271.64	280.36	290.15
74300	47.30	50.07	52.37	44.93	47.57	49.75	51.68	54.70	57.21
74300 TC	28.38	30.04	31.43	26.96	28.54	29.86	31.01	32.82	34.34
74301	26.89	28.35	29.58	25.55	26.93	28.10	29.38	30.97	32.32
74301 TC	16.13	17.01	17.74	15.32	16.16	16.85	17.62	18.58	19.38
75952	658.51	719.18	775.00	625.58	683.22	736.25	719.42	785.70	846.69
75952 TC	395.10	431.51	465.01	375.35	409.93	441.76	431.65	471.42	508.02
75953	255.53	301.35	347.48	242.75	286.28	330.11	279.17	329.22	379.62
75953 TC	153.32	180.81	208.49	145.65	171.77	198.07	167.50	197.53	227.78
75954	625.35	738.88	853.75	594.08	701.94	811.06	683.19	807.23	932.72
75954 TC	375.20	443.32	512.25	356.44	421.15	486.64	409.91	484.33	559.63
76012	195.17	214.67	232.88	185.41	203.94	221.24	213.22	234.53	254.42
76012 TC	117.11	128.80	139.72	111.25	122.36	132.73	127.94	140.71	152.64
76013	234.30	268.64	302.48	222.59	255.21	287.36	255.97	293.49	330.46
76013 TC	140.59	161.18	181.49	133.56	153.12	172.42	153.59	176.09	198.28
76350	14.94	16.46	17.46	14.19	15.64	16.59	16.32	17.98	19.08
78172	69.28	72.87	75.69	65.82	69.23	71.91	75.69	79.61	82.69
78172 TC	41.57	43.73	45.41	39.49	41.54	43.14	45.42	47.78	49.61
78282	49.16	51.96	54.28	46.70	49.36	51.57	53.71	56.77	59.30
78282 TC	29.50	31.17	32.56	28.02	29.61	30.93	32.23	34.05	35.57
78414	58.31	61.45	64.02	55.39	58.38	60.82	63.70	67.13	69.94
78414 TC	34.99	36.87	38.41	33.24	35.03	36.49	38.23	40.28	41.96
78459	2164.93	2365.58	2488.14	2056.68	2247.30	2363.73	2365.19	2584.40	2718.29
78459 TC	2086.08	2282.97	2402.69	1981.78	2168.82	2282.56	2279.04	2494.14	2624.94
79300	217.13	229.00	238.41	206.27	217.55	226.49	237.21	250.18	260.46
79300 TC	130.29	137.41	143.04	123.78	130.54	135.89	142.34	150.12	156.27
86485	16.26	17.92	18.95	15.45	17.02	18.00	17.76	19.58	20.70
91132	67.23	71.25	74.55	63.87	67.69	70.82	73.45	77.84	81.45
91132 TC	40.34	42.75	44.80	38.32	40.61	42.56	44.07	46.70	48.94
91133	83.85	88.46	92.15	79.66	84.04	87.54	91.61	96.64	100.67
91133 TC	50.30	53.07	55.30	47.78	50.42	52.53	54.95	57.98	60.42
93315	361.10	379.46	393.96	343.05	360.49	374.26	394.50	414.56	430.40
93315 TC	216.65	227.68	236.37	205.82	216.30	224.55	236.69	248.74	258.23
93317	238.09	249.91	259.13	226.19	237.41	246.17	260.11	273.03	283.10
93317 TC	142.85	149.95	155.48	135.71	142.45	147.71	156.06	163.82	169.86
93318	289.30	303.16	313.66	274.83	288.00	297.98	316.06	331.20	342.67
93318 TC	173.59	181.90	188.19	164.91	172.81	178.78	189.65	198.73	205.60
93620	1556.61	1646.00	1718.72	1478.78	1563.70	1632.78	1700.60	1798.25	1877.70
93620 TC	933.97	987.60	1031.23	887.27	938.22	979.67	1020.36	1078.95	1126.62
93621	290.83	309.71	325.59	276.29	294.22	309.31	317.73	338.36	355.71
93621 TC	174.50	185.84	195.35	165.78	176.55	185.58	190.64	203.03	213.42
93622	483.19	537.07	588.15	459.03	510.22	558.74	527.89	586.75	642.55
93622 TC	289.91	322.24	352.90	275.41	306.13	335.25	316.73	352.05	385.54
93623	387.91	410.39	428.60	368.51	389.87	407.17	423.79	448.35	468.25
93623 TC	232.75	246.24	257.16	221.11	233.93	244.30	254.28	269.02	280.95
93662	408.17	445.15	479.10	387.76	422.89	455.14	445.93	486.33	523.42
93662 TC	244.91	267.09	287.47	232.66	253.74	273.10	267.56	291.80	314.06
94642	27.50	29.97	31.42	26.13	28.47	29.85	30.04	32.74	34.33
95824	91.60	102.73	107.86	87.02	97.59	102.47	100.07	112.23	117.84
95824 TC	54.96	61.63	64.72	52.21	58.55	61.48	60.04	67.33	70.71
95951	813.06	854.45	886.02	772.41	811.73	841.72	888.27	933.49	967.98
95951 TC	487.83	512.67	531.62	463.44	487.04	505.04	532.95	560.09	580.79
95965	1048.88	1098.16	1135.18	996.44	1043.25	1078.42	1145.90	1199.74	1240.18

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Florida - continued

CODE/MOD	PARTICIPATING FEE SCHEDULE LOC 01/02	LOC 03	LOC 04	NONPARTICIPATING FEE SCHEDULE LOC 01/02	LOC 03	LOC 04	LIMITING CHARGE LOC 01/02	LOC 03	LOC 04
95965 TC	629.33	658.90	681.11	597.86	625.95	647.05	687.54	719.85	744.11
95966	534.48	563.79	587.25	507.76	535.60	557.89	583.92	615.94	641.57
95966 TC	320.69	338.28	352.34	304.66	321.37	334.72	350.35	369.57	384.93
95967	469.17	495.54	516.85	445.71	470.76	491.01	512.57	541.38	564.66
95967 TC	281.51	297.32	310.11	267.43	282.45	294.60	307.55	324.82	338.80
99082	1.99	1.99	1.99	1.89	1.89	1.89	2.17	2.17	2.17

AMBULANCE FEE SCHEDULE

2005 Ambulance Fee Schedule and Inflation Factor

Section 1834(l)(3)(A) of the Act provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2005 that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF). The AIF for calendar year (CY) 2005 is 3.3 percent.

2005 Ambulance Fee Schedule Transition/Reasonable Cost Blend

During the transition period, the AIF is applied to both the fee schedule portion of the blended payment amount (incorporated in the ambulance fee schedule file), and to the reasonable cost portion of the blended payment amount separately for each ambulance provider. Then, these two amounts are added together to determine the total payment amount for each provider. The blending percentages used to combine these two components of the payment amounts for ambulance services for CY 2005 are **20 percent** of the reasonable cost and **80 percent** of the ambulance fee schedule (AFS).

The AFS rates for 2005 for Florida based on localities are provided below. Providers may calculate their payment by combining 80 percent of the appropriate fee schedule with 20 percent of their 2005 reasonable cost for the same service. Part B coinsurance and deductible requirements apply to these services.

2005 Ambulance Fee Schedule Rates

Florida

Procedure	Loc 01/02		Loc 03		Loc 04	
	Urban	Rural	Urban	Rural	Urban	Rural
A0425	5.90	5.96	5.90	5.96	5.90	5.96
A0426	211.15	213.24	220.87	223.05	227.96	230.22
A0427	334.31	337.62	349.70	353.17	360.94	364.51
A0428	175.95	177.70	184.05	185.88	189.97	191.85
A0429	281.53	284.31	294.49	297.40	303.95	306.96
A0430	2,393.91	3,590.87	2,471.65	3,707.48	2,528.41	3,792.62
A0431	2,783.27	4,174.90	2,873.65	4,310.48	2,939.65	4,409.47
A0432	307.92	310.97	322.09	325.28	332.44	335.74
A0433	483.87	488.67	506.15	511.16	522.41	527.59
A0434	571.85	577.51	598.18	604.10	617.40	623.51
Q3019	281.53	284.31	294.49	297.40	303.95	306.96
Q3020	175.95	177.70	184.05	185.88	189.97	191.85

Connecticut

Procedure	Urban	Rural
A0425	5.90	5.96
A0426	288.52	291.37
A0427	456.82	461.34
A0428	240.43	242.81
A0429	384.69	388.50
A0430	2,669.09	4,003.63
A0431	3,103.20	4,654.80
A0432	420.75	424.92
A0433	661.18	667.73
A0434	781.40	789.13
Q3019	384.69	388.50
Q3020	240.43	242.81

Source: CMS Pub. 100-04, Transmittal 411, CR 3599; CMS Pub. 100-04, Transmittal 320, CR 3473

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AMBULATORY SURGICAL CENTER

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

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.

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

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.

2005 CLINICAL LABORATORY FEES FOR CONNECTICUT

2005 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

Provider Types Affected

Clinical Laboratories

Provider Action Needed

This article and related CR3526 contains important information regarding the 2005 annual updates to the clinical laboratory fee schedule and for laboratory costs related to services subject to reasonable charge payments. It is important that affected laboratories understand these changes to assure correct and accurate payments from Medicare.

Background

Update to Clinical Laboratory Fees

In accordance with §1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2005 is zero (0) percent.

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the National Limitation Amount (NLA). For a cervical or vaginal smear test (pap smear), §1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), §1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The 2005 national minimum payment amount is $14.76 ($14.76 plus zero percent update for 2005). The affected codes for the national minimum payment amount include the following:

88142	88143	88147	88148	88150	88152	88153
88154	88164	88165	88166	88167	88174	88175
G0123	G0143	G0144	G0145	G0147	G0148	P3000

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with §1833(h)(4)(B)(viii) of the Act.

Access to 2005 Clinical Laboratory Fee Schedule

Internet access to the 2005 clinical laboratory fee schedule data file should be available after November 18, 2004, at: *http://www.cms.hhs.gov/paymentsystems*

Interested providers should use the Internet to retrieve the 2005 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 26, 2004, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on the payment relationship between 2004 codes and new 2005 Current Procedural Terminology (CPT) codes. The meeting announcement was published in the **Federal Register** on May 28, 2004, pages 30658-30659, and on the CMS web site.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on its web site at *http://www.cms.hhs.gov/paymentsystems*. Additional written comments from the public were accepted until September 24, 2004.

Comments after the release of the 2005 laboratory fee schedule can be submitted to the following address, so that CMS may consider them for the development of the 2006 laboratory fee schedule.

2005 Clinical Laboratory Fees for Connecticut, continued.

Centers for Medicare & Medicaid Services (CMS)
Center for Medicare Management
Division of Ambulatory Services
Mailstop: C4-07-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

A comment should be in written format and include clinical, coding, and costing information. To make it possible for CMS and its contractors to meet a January 3, 2006 implementation date, comments must be submitted before August 1, 2005.

Additional Pricing Information

The 2005 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). For dates of service January 1, 2005 through December 31, 2005, the personnel payment is $.45 per mile. For dates of service January 1, 2005 through December 31, 2005, the standard mileage rate for transportation costs is $.385. The 2005 payment for code P9603 is $.835 and for code P9604 it is $8.35.

The 2005 laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

CPT code 36415 for *Collection of venous blood by venipuncture* is now payable by Medicare, but code 36416 *Collection of capillary blood specimen (e.g., finger, heel, ear stick)* remains as not payable by Medicare as a separate service.

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2005 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping Information for New and Revised Codes

New Code:	Is Priced at the same rate as:
82045	83880
82656	83516
83009	83013
83630	83516
84163	84702
84166	the sum of 84165 and 87015
84450QW	84450
86064	86359
86335	the sum of 86334 and 87015
86379	86359
86587	86359
87807	87804

Laboratory Costs Subject to Reasonable Charge Payment in 2005

For outpatients, the codes in the following tables are paid under a reasonable charge basis. In accordance with §42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update.

The inflation-indexed update for year 2005 is 3.3 percent.

Manual instructions for determining the reasonable charge payment can be found in the Medicare Claims Processing Manual, Pub. 100-04, chapter 23, §80-80.8. (The Web address for this manual is provided in the "Additional Information" section below.) If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, Medicare Claims Processing Manual, Pub. 100-04, chapter 8, §60.3 instructs that the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis.

Also, when these services are performed for hospital outpatients, payment is made under the hospital Outpatient Prospective Payment System (OPPS).

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

Blood Products

P9010	P9011	P9012	P9016	P9017	P9019	P9020
P9021	P9022	P9023	P9031	P9032	P9033	P9034
P9035	P9036	P9037	P9038	P9039	P9040	P9044
P9050	P9051	P9052	P9053	P9054	P9055	P9056
P9057	P9058	P9059	P9060			

Also, the following codes should be applied to the blood deductible as instructed Pub. 100-01, Chapter 3, §20.5-20.54:

P9010	P9016	P9021	P9022	P9038	P9039	P9040
P9051	P9054	P9056	P9057	P9058		

Note: Biologic products not paid on a cost or prospective payment basis are paid based on §1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes P9041 P9043 P9045 P9046 P9047 P9048, should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine

86850	86860	86870	86880	86885	86886	86890
86891	86900	86901	86903	86904	86905	86906
86920	86921	86922	86927	86930	86931	86932
86945	86950	86965	86970	86971	86972	86975
86976	86977	86978	86985	G0267		

Reproductive Medicine Procedures

89250	89251	89253	89254	89255	89257	89258
89259	89260	89261	89264	89268	89272	89280
89281	89290	89291	89335	89342	89343	89344
89346	89352	89353	89354	89356		

Implementation

The changes for 2005 will be implemented on January 3, 2005.

Additional Information

Instructions for calculating reasonable charges are located in the Medicare Claims Processing Manual (Pub. 100-04) chapter 23, sections 80-80.8. at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*

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 CR3526 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please contact your carrier or intermediary on their toll free phone number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

Related Change Request (CR) #: 3526
Medlearn Matters Number: MM3526
Related CR Release Date: November 5, 2004
Related CR Transmittal #: 363
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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PROC	FEES	PROC	FEES	PROC	FEES	PROC	FEES	PROC	FEES
G0027	9.09	80188	23.18	82044	6.39	82370	17.51	82633	43.28
G0103	25.70	80190	23.41	82044QW	6.39	82373	25.23	82634	40.90
G0107	4.54	80192	23.41	82045	47.43	82374	6.83	82638	17.11
G0123	28.31	80194	20.39	82055	15.10	82375	17.22	82646	28.85
G0143	28.31	80196	9.92	82055QW	15.10	82376	8.37	82649	35.91
G0144	29.85	80197	19.17	82075	16.84	82378	26.51	82651	36.07
G0145	37.01	80198	19.77	82085	13.56	82379	23.57	82652	53.78
G0147	15.90	80200	22.52	82088	56.94	82380	12.89	82654	19.34
G0148	21.23	80201	16.66	82101	32.50	82382	24.02	82656	16.12
G0265	14.11	80202	18.93	82103	18.77	82383	35.01	82657	25.23
G0266	14.11	80299	19.13	82104	12.72	82384	35.28	82658	25.23
G0306	10.86	80400	45.56	82105	23.44	82387	29.07	82664	48.00
G0307	9.04	80402	121.46	82106	23.44	82390	15.01	82666	30.01
G0328	20.28	80406	109.34	82108	35.60	82397	19.74	82668	26.26
G0328QW	20.28	80408	175.34	82120	5.25	82415	17.70	82670	39.04
P2038	7.02	80410	112.23	82120QW	5.25	82435	6.42	82671	45.13
P3000	14.76	80412	460.50	82127	19.37	82436	7.02	82672	30.30
P9612	3.00	80414	72.16	82128	19.37	82438	6.63	82677	33.79
P9615	3.00	80415	78.08	82131	23.57	82441	8.12	82679	34.88
Q0111	5.96	80416	184.38	82135	16.89	82465	6.08	82679QW	34.88
Q0112	5.96	80417	61.46	82136	23.57	82465QW	6.08	82690	24.15
Q0113	7.56	80418	809.76	82139	23.57	82480	11.01	82693	20.82
Q0114	9.99	80420	100.64	82140	20.36	82482	10.74	82696	32.95
Q0115	13.83	80422	64.38	82143	9.61	82485	28.85	82705	7.11
36415	3.00	80424	70.56	82145	13.40	82486	25.23	82710	23.47
78267	10.98	80426	207.40	82150	9.06	82487	22.30	82715	24.05
78268	94.11	80428	93.16	82154	40.29	82488	29.85	82725	18.60
80048	11.83	80430	109.60	82157	40.90	82489	25.84	82726	25.23
80051	9.80	80432	188.73	82160	34.94	82491	25.23	82728	19.03
80053	14.77	80434	141.30	82163	28.68	82492	25.23	82731	89.99
80061	18.72	80435	143.85	82164	20.39	82495	28.34	82735	25.91
80061QW	18.72	80436	127.36	82172	21.65	82507	38.85	82742	27.66
80069	12.13	80438	70.41	82175	26.51	82520	21.17	82746	20.54
80074	66.54	80439	93.88	82180	13.81	82523	26.11	82747	24.20
80076	11.42	80440	81.24	82190	20.83	82523QW	26.11	82757	24.24
80100	14.65	81000	4.43	82205	16.01	82525	17.34	82759	30.01
80101	19.24	81001	4.43	82232	22.61	82528	31.45	82760	15.64
80101QW	19.24	81002	3.57	82239	23.94	82530	23.35	82775	29.43
80102	18.51	81003	3.14	82240	24.31	82533	22.78	82776	11.31
80150	21.06	81003QW	3.14	82247	7.02	82540	6.48	82784	12.99
80152	25.01	81005	3.03	82248	7.02	82541	25.23	82785	23.01
80154	25.84	81007	3.59	82252	2.84	82542	25.23	82787	11.20
80156	20.34	81007QW	3.59	82261	23.57	82543	25.23	82800	11.83
80157	18.52	81015	4.24	82270	4.54	82544	25.23	82803	27.04
80158	25.23	81020	5.15	82273	4.54	82550	9.10	82805	39.65
80160	24.05	81025	8.84	82273QW	4.54	82552	18.71	82810	12.20
80162	18.55	81050	4.19	82274	20.28	82553	16.13	82820	13.96
80164	18.93	82000	17.31	82274QW	20.28	82554	16.58	82926	7.61
80166	21.66	82003	28.28	82286	9.62	82565	7.16	82928	9.15
80168	22.83	82009	6.31	82300	32.33	82570	7.23	82938	24.72
80170	22.90	82010	11.42	82306	41.36	82570QW	7.23	82941	24.64
80172	22.76	82010QW	11.42	82307	45.02	82575	13.20	82943	19.97
80173	20.34	82013	15.61	82308	37.41	82585	11.98	82945	5.48
80174	24.05	82016	19.37	82310	7.20	82595	9.04	82946	21.06
80176	20.52	82017	23.57	82330	16.26	82600	27.11	82947	5.48
80178	9.24	82024	53.97	82331	7.23	82607	21.06	82947QW	5.48
80182	18.93	82030	36.05	82340	8.43	82608	20.01	82948	4.43
80184	16.01	82040	6.37	82355	16.17	82615	11.41	82950	6.64
80185	18.52	82042	7.23	82360	17.99	82626	35.31	82950QW	6.64
80186	19.23	82043	8.09	82365	18.01	82627	31.07	82951	17.99

PROC	FEES	PROC	FEES	PROC	FEES	PROC	FEES	PROC	FEES
82951QW	17.99	83520	18.09	83901	23.42	84165	15.01	84485	10.49
82952	5.48	83525	15.98	83902	19.83	84166	24.92	84488	5.47
82952QW	5.48	83527	18.09	83903	23.42	84181	23.80	84490	10.63
82953	21.16	83528	22.22	83904	23.42	84182	25.15	84510	14.53
82955	13.55	83540	9.05	83905	23.42	84202	20.05	84512	10.76
82960	8.47	83550	12.21	83906	23.42	84203	12.03	84520	5.51
82962	3.27	83570	12.36	83912	5.60	84206	23.53	84525	5.25
82963	30.01	83582	19.80	83915	15.58	84207	34.32	84540	6.64
82965	10.80	83586	17.89	83916	28.09	84210	15.17	84545	7.94
82975	22.13	83593	36.75	83918	23.00	84220	13.18	84550	6.31
82977	9.77	83605	14.92	83919	23.00	84228	12.22	84560	6.64
82978	19.91	83605QW	14.92	83921	23.00	84233	89.99	84577	4.88
82979	9.62	83615	8.44	83925	27.19	84234	90.64	84578	4.54
82980	25.60	83625	17.88	83930	9.24	84235	73.12	84580	9.92
82985	21.06	83630	16.12	83935	9.52	84238	51.09	84583	7.02
82985QW	21.06	83632	28.24	83937	41.71	84244	30.73	84585	21.66
83001	25.97	83633	7.69	83945	17.99	84252	16.26	84586	49.37
83001QW	25.97	83634	16.10	83950	89.99	84255	35.67	84588	47.43
83002	25.88	83655	16.91	83970	57.67	84260	24.31	84590	15.03
83002QW	25.88	83661	30.71	83986	5.00	84270	30.36	84591	15.03
83003	23.29	83662	26.43	83986QW	5.00	84275	18.77	84597	13.00
83008	23.45	83663	26.43	83992	20.54	84285	32.90	84600	22.45
83009	94.11	83664	26.43	84022	21.76	84295	6.72	84620	16.55
83010	17.58	83670	12.80	84030	7.69	84300	6.79	84630	15.91
83012	24.02	83690	9.62	84035	5.11	84302	6.79	84681	29.07
83013	94.11	83715	15.73	84060	10.32	84305	29.70	84702	16.29
83014	10.98	83716	34.68	84061	11.06	84307	25.54	84703	10.49
83015	26.31	83718	11.44	84066	13.50	84311	9.77	84703QW	10.49
83018	30.68	83718QW	11.44	84075	7.23	84315	3.50	84830	14.02
83020	17.99	83719	16.26	84078	10.20	84375	27.39	85002	6.29
83021	25.23	83721	13.33	84080	20.66	84376	7.69	85004	9.04
83026	3.30	83727	24.02	84081	23.09	84377	7.69	85007	4.81
83030	11.56	83735	9.36	84085	9.42	84378	16.10	85008	4.41
83033	8.33	83775	10.30	84087	14.42	84379	16.10	85009	4.88
83036	13.56	83785	34.36	84100	6.63	84392	6.64	85013	3.31
83036QW	13.56	83788	25.23	84105	7.23	84402	35.57	85014	3.31
83045	6.93	83789	25.23	84106	5.99	84403	36.08	85014QW	3.31
83050	7.73	83805	24.63	84110	11.80	84425	29.67	85018	3.31
83051	10.21	83825	22.72	84119	9.61	84430	16.26	85018QW	3.31
83055	6.87	83835	23.67	84120	20.55	84432	22.44	85025	10.86
83060	11.56	83840	22.81	84126	35.59	84436	9.61	85027	9.04
83065	9.62	83857	15.01	84127	16.28	84437	9.04	85032	6.01
83068	11.83	83858	20.71	84132	6.42	84439	12.60	85041	4.02
83069	5.51	83864	27.82	84133	6.01	84442	20.66	85044	6.01
83070	6.64	83866	13.76	84134	20.38	84443	23.47	85045	5.59
83071	8.70	83872	8.19	84135	26.73	84445	71.05	85046	7.80
83080	23.57	83873	24.04	84138	26.46	84446	19.81	85048	3.55
83088	41.26	83874	18.04	84140	28.89	84449	25.15	85049	5.47
83090	23.57	83880	47.43	84143	31.89	84450	7.22	85055	37.41
83150	27.04	83883	19.00	84144	29.15	84450QW	7.22	85130	6.06
83491	24.47	83885	34.23	84146	27.08	84460	7.40	85170	5.05
83497	15.09	83887	33.09	84150	34.88	84460QW	7.40	85175	5.47
83498	37.95	83890	5.60	84152	25.70	84466	17.84	85210	18.14
83499	35.22	83891	5.60	84153	25.70	84478	8.04	85220	24.66
83500	31.65	83892	5.60	84154	25.70	84478QW	8.04	85230	25.02
83505	33.96	83893	5.60	84155	5.12	84479	9.04	85240	25.02
83516	16.12	83894	5.60	84156	5.12	84480	19.81	85244	28.53
83518	11.85	83896	5.60	84157	5.12	84481	23.67	85245	32.06
83518QW	11.85	83897	5.60	84160	7.23	84482	22.02	85246	32.06
83519	16.46	83898	23.42	84163	16.29	84484	13.75	85247	32.06

PROC	FEES	PROC	FEES	PROC	FEES	PROC	FEES	PROC	FEES
85250	26.60	85670	8.07	86335	41.00	86684	22.14	86821	78.88
85260	25.02	85675	9.58	86336	21.77	86687	11.72	86822	51.07
85270	25.02	85705	13.45	86337	23.20	86688	19.57	86880	7.50
85280	27.04	85730	8.38	86340	21.06	86689	27.05	86885	7.99
85290	22.83	85732	9.04	86341	27.65	86692	23.98	86886	7.23
85291	12.42	85810	16.32	86343	17.41	86694	20.11	86900	4.17
85292	26.46	86000	9.75	86344	11.16	86695	18.43	86903	13.19
85293	26.46	86001	7.30	86353	68.49	86696	27.05	86904	13.28
85300	15.35	86003	7.30	86359	19.97	86698	17.46	86905	5.34
85301	15.11	86005	11.14	86360	65.65	86701	12.41	86906	10.83
85302	16.80	86021	21.03	86361	37.41	86701QW	12.41	86940	11.46
85303	19.32	86022	25.66	86376	17.54	86702	18.88	86941	16.92
85305	16.20	86023	17.40	86378	27.51	86703	19.17	87001	18.47
85306	21.41	86038	16.89	86379	19.97	86704	16.84	87003	23.52
85307	21.41	86039	15.60	86382	23.62	86705	16.44	87015	9.33
85335	17.99	86060	10.20	86384	15.91	86706	15.01	87040	13.00
85337	14.56	86063	8.07	86403	14.24	86707	16.16	87045	13.18
85345	6.01	86064	19.97	86406	14.87	86708	17.31	87046	13.18
85347	5.95	86140	7.23	86430	7.93	86709	15.73	87070	10.53
85348	5.20	86141	18.09	86431	7.93	86710	18.94	87071	13.18
85360	11.74	86146	35.54	86587	19.97	86713	21.39	87073	13.18
85362	9.62	86147	35.54	86590	12.22	86717	17.12	87075	13.22
85366	12.03	86148	22.44	86592	5.96	86720	18.43	87076	11.29
85370	15.87	86155	22.33	86593	6.16	86723	18.43	87077	11.29
85378	9.97	86156	9.36	86602	14.22	86727	17.98	87077QW	11.29
85379	14.22	86157	11.27	86603	17.98	86729	16.69	87081	9.26
85380	14.22	86160	16.78	86606	21.03	86732	18.43	87084	12.03
85384	11.87	86161	16.78	86609	18.00	86735	18.23	87086	11.28
85385	11.87	86162	28.39	86611	14.22	86738	18.51	87088	11.31
85390	7.22	86171	13.52	86612	18.03	86741	18.43	87101	10.77
85400	12.36	86185	12.50	86615	18.43	86744	18.43	87102	11.74
85410	10.77	86215	18.51	86617	21.64	86747	21.00	87103	12.60
85415	24.02	86225	19.20	86618	23.80	86750	18.43	87106	14.42
85420	9.13	86226	16.92	86618QW	23.80	86753	17.32	87107	14.42
85421	8.70	86235	25.06	86619	18.69	86756	18.01	87109	21.50
85441	5.88	86243	28.68	86622	12.48	86757	27.05	87110	27.37
85445	9.52	86255	16.84	86625	18.33	86759	18.43	87116	15.10
85460	10.81	86256	16.84	86628	16.78	86762	20.11	87118	15.29
85461	9.26	86277	21.99	86631	16.52	86765	18.00	87140	7.79
85475	12.40	86280	11.44	86632	17.74	86768	18.43	87143	17.51
85520	12.22	86294	27.41	86635	16.03	86771	18.43	87147	7.23
85525	16.55	86294QW	27.41	86638	16.94	86774	20.68	87149	28.02
85530	19.81	86300	29.07	86641	20.14	86777	20.11	87152	7.31
85536	9.04	86301	29.07	86644	20.11	86778	20.12	87158	7.31
85540	12.02	86304	29.07	86645	23.54	86781	18.50	87164	15.01
85547	12.02	86308	7.23	86648	21.25	86784	17.55	87166	15.78
85549	26.21	86308QW	7.23	86651	18.43	86787	18.00	87168	5.96
85555	9.34	86309	9.04	86652	18.43	86790	18.00	87169	5.96
85557	18.66	86310	10.30	86653	18.43	86793	18.43	87172	5.96
85576	30.01	86316	29.07	86654	18.43	86800	20.28	87176	8.22
85597	25.12	86317	20.95	86658	18.20	86803	19.94	87177	12.43
85610	5.49	86318	18.09	86663	18.33	86804	21.64	87181	1.27
85610QW	5.49	86318QW	18.09	86664	21.38	86805	73.05	87184	9.63
85611	5.51	86320	31.32	86665	25.35	86806	66.49	87185	1.27
85612	13.37	86325	31.24	86666	14.22	86807	55.29	87186	12.08
85613	13.37	86327	31.70	86668	14.53	86808	41.47	87187	14.48
85635	13.76	86329	19.62	86671	17.13	86812	36.06	87188	9.27
85651	4.96	86331	16.75	86674	20.56	86813	81.02	87190	7.90
85652	3.77	86332	34.05	86677	20.28	86816	38.92	87197	20.99
85660	7.26	86334	31.21	86682	18.17	86817	89.95	87205	5.96

PROC	FEES	PROC	FEES	PROC	FEES	PROC	FEES	PROC	FEES
87206	7.50	87338	20.10	87520	28.02	87652	58.33	88237	176.47
87207	5.73	87339	16.76	87521	49.04	87660	28.02	88239	206.12
87210	5.96	87340	14.43	87522	59.85	87797	28.02	88240	14.11
87210QW	5.96	87341	14.43	87525	28.02	87798	49.04	88241	14.11
87220	5.96	87350	16.10	87526	49.04	87799	59.85	88245	207.98
87230	27.59	87380	22.94	87527	58.33	87800	56.03	88248	241.96
87250	27.32	87385	16.76	87528	28.02	87801	98.07	88249	241.96
87252	36.42	87390	24.65	87529	49.04	87802	16.76	88261	246.93
87253	28.22	87391	24.65	87530	59.85	87803	16.76	88262	174.14
87254	27.32	87400	16.76	87531	28.02	87804	16.76	88263	209.97
87255	47.31	87420	16.76	87532	49.04	87804QW	16.76	88264	174.14
87260	16.76	87425	16.76	87533	58.33	87807	16.76	88267	251.17
87265	16.76	87427	16.76	87534	28.02	87810	16.76	88269	232.38
87267	16.76	87430	16.76	87535	49.04	87850	16.76	88271	29.93
87269	16.76	87449	16.76	87536	118.89	87880	16.76	88272	30.33
87270	16.76	87449QW	16.76	87537	28.02	87880QW	16.76	88273	30.33
87271	16.76	87450	13.39	87538	49.04	87899	16.76	88274	30.33
87272	16.76	87451	13.39	87539	59.85	87899QW	16.76	88275	30.33
87273	16.76	87470	28.02	87540	28.02	87901	359.69	88280	35.07
87274	16.76	87471	49.04	87541	49.04	87902	359.69	88283	95.84
87275	16.76	87472	59.85	87542	58.33	87903	682.72	88285	26.54
87276	16.76	87475	28.02	87550	28.02	87904	182.11	88289	48.11
87277	16.76	87476	49.04	87551	49.04	88130	21.02	88371	31.05
87278	16.76	87477	59.85	87552	59.85	88140	11.17	88372	31.79
87279	16.76	87480	28.02	87555	28.02	88142	28.31	88400	7.02
87280	16.76	87481	49.04	87556	49.04	88143	28.31	89050	6.61
87281	16.76	87482	58.33	87557	59.85	88147	15.90	89051	7.70
87283	16.76	87485	28.02	87560	28.02	88148	21.23	89055	5.96
87285	16.76	87486	49.04	87561	49.04	88150	14.76	89060	9.99
87290	16.76	87487	59.85	87562	59.85	88152	14.76	89125	6.03
87299	16.76	87490	28.02	87580	28.02	88153	14.76	89160	5.15
87300	16.76	87491	49.04	87581	49.04	88154	14.76	89190	6.64
87301	16.76	87492	22.93	87582	58.33	88155	7.78	89225	4.67
87320	16.76	87495	28.02	87590	28.02	88164	14.76	89235	6.74
87324	16.76	87496	49.04	87591	49.04	88165	14.76	89300	12.45
87327	16.76	87497	59.85	87592	59.85	88166	14.76	89300QW	12.45
87328	16.76	87510	28.02	87620	28.02	88167	14.76	89310	12.03
87329	16.76	87511	49.04	87621	49.04	88174	29.85	89320	16.84
87332	16.76	87512	58.33	87622	58.33	88175	37.01	89321	16.84
87335	16.76	87515	28.02	87650	28.02	88230	162.77	89325	14.91
87336	16.76	87516	49.04	87651	49.04	88233	196.63	89329	29.30
87337	16.76	87517	59.85			88235	205.74	89330	13.83

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

Fee Schedule Update for 2005 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction provides specific information regarding the 2005 annual update for the DMEPOS fee schedule.

Background

The DMEPOS fee schedules are updated on an annual basis in accordance with the statute and regulations, as described in the Medicare Claims Processing Manual (Pub 100-04, Section 60, Chapter 23). This notification provides details regarding the 2005 annual update for the DMEPOS fee schedule.

The Social Security Act (SSA) (Sections 1834(a), (h), and (i)) requires payment on a fee schedule basis for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. In addition, the Code of Federal Regulations (42 CFR 414.102) requires payment on a fee schedule basis for parenteral and enteral nutrition (PEN).

The 2005 DMEPOS fee schedule update factors for items furnished from January 1, 2005 through December 31, 2005 are as follows:

- DME other than items classified as class III devices by the Food and Drug Administration (FDA) – 0 percent
- DME classified as class III devices by the FDA – 3.3 percent
- Prosthetic devices, prosthetics, and orthotics – 0 percent
- PEN – 3.3 percent
- Surgical dressings – 0 percent

Please refer to the table below for comments and notes on several Healthcare Common Procedure Coding System (HCPCS) codes. The descriptions for the items falling under the HCPCS codes listed in the table can be obtained from the HCPCS file at *https://www.cms.hhs.gov/medicare/hcpcs/default.asp*

Healthcare Common Procedure Coding System Codes

HCPCS Codes	Notes
E2340 thru E2343, and K0108	Codes E2340 thru E2343 for nonstandard power wheelchair seat frame width and depth were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated using retail prices for some products for nonstandard seat dimensions (i.e., captain's chairs that sit on top of power wheelchair bases) as opposed to nonstandard seat frame dimensions. The base fee schedule amounts for codes E2340 thru E2343 will be adjusted to remove these products from the base fee calculations. Suppliers of nonstandard seat dimensions should bill HCPCS K0108 instead of codes E2340 thru E2343.
K0646, K0648, and L0565	The fee schedule amounts for codes K0646 and K0648 are being revised effective January 1, 2005, by cross walking the fee schedule amounts for previous code L0565 to both code K0646 and K0648. As a result of a court settlement, previously paid claims for K0646 and K0648 that were submitted between July 6, 2004 and January 1, 2005, shall be adjusted if such claims are resubmitted by suppliers on or after January 1, 2005, and on or before 18 months after the date the claim was originally submitted.

2005 DMEPOS Fee Schedule Update, (continued)

HCPCS Codes	Notes
E0617, E0691 thru E0694, K0606 thru K0609, and modifier KF	A one-time notification (Transmittal 35, Change Request 3020) was issued on December 24, 2003, and listed HCPCS codes for categories of DME items identified by the FDA as class III devices. As indicated above, the fee schedule amounts for class III DME will be increased by 3.3 percent effective January 1, 2005, whereas the fee schedule amounts for items that are not classified as class III devices by the FDA will not be increased on January 1, 2005. Transmittal 35 indicated that HCPCS codes E0617, E0691 thru E0694, and K0606 thru K0609 represented codes for categories of DME items identified by the FDA as class III devices. However, some products billed under these codes are not class III devices. Therefore, effective January 1, 2005, separate fee schedules will be provided in the DMEPOS fee schedule file: one for class III products within these codes that must be billed with HCPCS modifier KF and one for products within these codes that are not class III devices that may not be billed with HCPCS modifier KF.
A7040, A7041, L8615 thru L8618, L8620 thru L8622	Codes A7040, A7041, L8615 thru L8618, and L8620 thru L8622 describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPCS effective January 1, 2005. These codes fall under the jurisdiction of the local carriers rather than the DMERCs. CMS will be calculating the fee schedule amounts for these items using the standard gap-filling process. The description for these codes can be obtained from the 2005 HCPCS file as soon as it is available at: *http://www.cms.hhs.gov/medicare/hcpcs/default.asp*
A4324 thru A4325; A4347; A4609 thru A4610; B4151; B4156; E0176 thru E0179; E0192; E0454; E0962 thru E0965; E1012 thru E1013 K0023 thru K0024; K0059 thru K0061; K0081; K0114 thru K0116; K0627; L0476; L0478; L0500; L0510; L0515; L0520; L0530; L0540; L0550 L0560 thru L0561; L0565* L0600; L0610; L0620 L2435; L5674 thru L5675 L5846 thru L5847; L5989 L8490	These codes are being deleted from the HCPCS effective January 1, 2005, and are therefore being removed from the DMEPOS and PEN fee schedule files. *As indicated above, the fee schedule amounts for code L0565 are being cross-walked to codes K0646 and K0648.

2005 DMEPOS Fee Schedule Update, (continued)

HCPCS Codes	Notes
A4253, A4259, E0260, E0277, E0424, E0431, E0434, E0439, E0570, E1390, E1391, K0001, and K0011	These codes are affected by the provision in Section 302 (c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requiring reductions for certain DME equal to the percentage difference between 2002 Medicare fee schedule amounts and the median 2002 price paid under Federal Employee Health Benefit (FEHB) plans surveyed by the Office of the Inspector General. The reductions take effect January 1, 2005, and will be implemented as part of this annual update to the DMEPOS fee schedules.
A5500 (extra-depth shoe) A5501 (custom molded shoe) K0628 (direct formed insert) K0629 (custom molded insert)	Section 627 of the MMA requires the calculation and implementation of fee schedule amounts for therapeutic shoes and inserts effective January 1, 2005. Fee schedules for these HCPCS codes have been calculated by CMS using the methodology contained in section 1834(h) of the Social Security Act for prosthetic devices, prosthetics, and orthotics. These fee schedule amounts will be implemented as part of this annual update to the DMEPOS fee schedules.
A5503 thru A5507 (shoe modification codes) K0628 or K0629 (inserts)	In accordance with section 1833(o)(2)(C) of the Social Security Act, the payment amounts established for shoe modification codes (A5503 thru A5507) must be established in a way that prevents a net increase in expenditures when substituting these items for inserts (codes K0628 or K0629). Therefore, the 2005 fee schedule amounts for codes A5503 thru A5507 have been calculated based on the weighted average of the fee schedule amounts for insert codes K0628 and K0629. The fees for K0628 and K0629 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2006 and each subsequent year, the weighted average insert fee used to establish the fee schedule amounts for the shoe modification codes will be based on an updated weighted average (i.e., using more current allowed service data for each insert code).
E0675	Code E0675 was added to the HCPCS effective January 1, 2004. The fee schedule for code E0675 was calculated using retail prices for two products; however, the fee schedule is being revised effective January 1, 2005, to remove pricing for one product that was not yet an established product in the market at the time the code was added.
E1010	The description for code E1010 for "wheelchair accessory, addition to power seating system, including leg rest, …each" is changed effective January 1, 2005, to show "wheelchair accessory, addition to power seating system,……., including leg rest, pair" and the fee schedule for E1010 is revised to reflect this change. Suppliers should bill single leg rest power elevation systems under code K0108.
E2320 thru E2330, and Modifier KC	Codes E2320 thru E2330 for special power wheelchair interfaces were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated based on pricing for the differential cost of furnishing these special interfaces over a standard interface that is paid for as part of the payment for the wheelchair (e.g., K0011). However, when these items are furnished to replace existing interfaces on wheelchairs that have been in use by the patient for a period of time due to a change in the patient's medical condition or in cases where the existing interface is irreparably damaged or has exceeded its reasonable useful lifetime, the fee schedule payment should reflect payment for the full cost of the replacement special interface. Modifier KC is being added to the HCPCS effective January 1, 2005, to identify replacement of special power wheelchair interfaces in these cases. Fee schedule amounts for replacement of special power wheelchair interfaces will be established effective January 1, 2005, for use in paying claims for use Codes E2320 thru E2330 billed with the KC modifier.

2005 DMEPOS Fee Schedule Update, (continued)

Additional Information

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

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3574. 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, fiscal intermediary, or DMERC at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*

Related Change Request (CR) #: 3574
Medlearn Matters Number: MM3574
Related CR Release Date: November 19, 2004
Related CR Transmittal #: 369
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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CONNECTICUT DMEPOS FEES

PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE
A6010	30.96	A6214	10.29	A6244	39.28	A4562	46.38	L8612	575.41
A6011	2.28	A6216	0.05	A6245	7.27	A7040	36.86	L8613	250.55
A6021	21.02	A6219	0.95	A6246	9.92	A7041	69.26	L8614	15354.57
A6022	21.02	A6220	2.58	A6247	23.78	A7042	165.63	L8615	355.07
A6023	190.30	A6222	2.13	A6248	16.24	A7043	23.50	L8616	82.70
A6024	6.19	A6223	2.42	A6251	1.99	E0749	270.14	L8617	72.23
A6154	14.38	A6224	3.61	A6252	3.25	E0752	361.63	L8618	20.64
A6196	7.35	A6229	3.61	A6253	6.34	E0754	865.16	L8619	6591.62
A6197	16.44	A6231	4.66	A6254	1.21	E0756	6569.18	L8620	50.93
A6199	5.29	A6232	6.88	A6255	3.03	E0757	4693.57	L8621	0.49
A6200	9.50	A6233	19.19	A6257	1.53	E0758	4131.42	L8622	0.26
A6201	20.80	A6234	6.54	A6258	4.30	E0759	546.09	L8630	360.25
A6202	34.88	A6235	16.82	A6259	10.94	E0782	3466.79	L8631	1756.79
A6203	3.35	A6236	27.25	A6266	1.92	E0783	7777.24	L8641	374.30
A6204	6.23	A6237	7.91	A6402	0.12	E0785	381.53	L8642	227.70
A6207	7.34	A6238	22.79	A6403	0.43	E0786	7586.23	L8658	326.35
A6209	7.48	A6240	12.24	A6407	1.88	L8600	505.14	L8659	1519.23
A6210	19.92	A6241	2.57	A6410	0.39	L8603	351.17	L8670	446.41
A6211	29.37	A6242	6.07	E0781	264.87	L8606	172.59		
A6212	9.70	A6243	12.31	A4561	18.63	L8610	469.40		

2005 CLINICAL LABORATORY FEES FOR FLORIDA

2005 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

Provider Types Affected

Clinical Laboratories

Provider Action Needed

This article and related CR3526 contains important information regarding the 2005 annual updates to the clinical laboratory fee schedule and for laboratory costs related to services subject to reasonable charge payments. It is important that affected laboratories understand these changes to assure correct and accurate payments from Medicare.

Background

Update to Clinical Laboratory Fees

In accordance with section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2005 is zero (0) percent.

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). For a cervical or vaginal smear test (pap smear), section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), §1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The 2005 national minimum payment amount is $14.76 ($14.76 plus zero percent update for 2005). The affected codes for the national minimum payment amount include the following:

88142	88143	88147	88148	88150	88152	88153
88154	88164	88165	88166	88167	88174	88175
G0123	G0143	G0144	G0145	G0147	G0148	P3000

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with section 1833(h)(4)(B)(viii) of the Act.

Access to 2005 Clinical Laboratory Fee Schedule

Internet access to the 2005 clinical laboratory fee schedule data file should be available after November 18, 2004, at: *http://www.cms.hhs.gov/paymentsystems*

Interested providers should use the Internet to retrieve the 2005 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 26, 2004, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on the payment relationship between 2004 codes and new 2005 current procedural terminology (CPT) codes. The meeting announcement was published in the **federal register** on May 28, 2004, pages 30658-30659, and on the CMS web site.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on its web site at *http://www.cms.hhs.gov/paymentsystems*. Additional written comments from the public were accepted until September 24, 2004.

Comments after the release of the 2005 laboratory fee schedule can be submitted to the following address, so that CMS may consider them for the development of the 2006 laboratory fee schedule.

2005 Clinical Laboratory Fees for Connecticut, continued.

Centers for Medicare & Medicaid Services (CMS)
Center for Medicare Management
Division of Ambulatory Services
Mailstop: C4-07-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

A comment should be in written format and include clinical, coding, and costing information. To make it possible for CMS and its contractors to meet a January 3, 2006 implementation date, comments must be submitted before August 1, 2005.

Additional Pricing Information

The 2005 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). For dates of service January 1, 2005 through December 31, 2005, the personnel payment is $.45 per mile. For dates of service January 1, 2005 through December 31, 2005, the standard mileage rate for transportation costs is $.385. The 2005 payment for code P9603 is $.835 and for code P9604 it is $8.35.

The 2005 laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

CPT code 36415 for *Collection of venous blood by venipuncture* is now payable by Medicare, but code 36416 *Collection of capillary blood specimen (e.g., finger, heel, ear stick)* remains as not payable by Medicare as a separate service.

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2005 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping Information for New and Revised Codes

New Code:	Is Priced at the same rate as:
82045	83880
82656	83516
83009	83013
83630	83516
84163	84702
84166	the sum of 84165 and 87015
84450QW	84450
86064	86359
86335	the sum of 86334 and 87015
86379	86359
86587	86359
87807	87804

Laboratory Costs Subject to Reasonable Charge Payment in 2005

For outpatients, the codes in the following tables are paid under a reasonable charge basis. In accordance with section 42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update.

The inflation-indexed update for year 2005 is 3.3 percent.

Manual instructions for determining the reasonable charge payment can be found in the Medicare Claims Processing Manual, Pub. 100-04, chapter 23, section 80-80.8. (The Web address for this manual is provided in the "Additional Information" section below.) If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, Medicare Claims Processing Manual, Pub. 100-04, chapter 8, section 60.3 instructs that the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis.

Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

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Blood Products

P9010	P9011	P9012	P9016	P9017	P9019	P9020
P9021	P9022	P9023	P9031	P9032	P9033	P9034
P9035	P9036	P9037	P9038	P9039	P9040	P9044
P9050	P9051	P9052	P9053	P9054	P9055	P9056
P9057	P9058	P9059	P9060			

Also, the following codes should be applied to the blood deductible as instructed Pub. 100-01, chapter 3, section 20.5-20.54:

P9010	P9016	P9021	P9022	P9038	P9039	P9040
P9051	P9054	P9056	P9057	P9058		

Note: Biologic products not paid on a cost or prospective payment basis are paid based on section 1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes P9041 P9043 P9045 P9046 P9047 P9048, should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine

86850	86860	86870	86880	86885	86886	86890
86891	86900	86901	86903	86904	86905	86906
86920	86921	86922	86927	86930	86931	86932
86945	86950	86965	86970	86971	86972	86975
86976	86977	86978	86985	G0267		

89250	89251	89253	89254	89255	89257	89258
89259	89260	89261	89264	89268	89272	89280
89281	89290	89291	89335	89342	89343	89344
89346	89352	89353	89354	89356		

Implementation

The changes for 2005 will be implemented on January 3, 2005.

Additional Information

Instructions for calculating reasonable charges are located in the Medicare Claims Processing Manual (Pub. 100-04) chapter 23, sections 80-80.8. at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*

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 CR3526 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please contact your carrier or intermediary on their toll free phone number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

Related Change Request (CR) #: 3526
Medlearn Matters Number: MM3526
Related CR Release Date: November 5, 2004
Related CR Transmittal #: 363
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE
ATP02	7.28	80168	22.83	82016	19.37	82360	12.22	82638	17.11	82963	30.01
ATP03	9.29	80170	22.90	82017	23.57	82365	17.30	82646	27.81	82965	7.28
ATP04	9.80	80172	22.76	82024	53.97	82370	17.51	82649	35.91	82975	22.13
ATP05	10.93	80173	20.34	82030	18.08	82373	24.35	82651	36.07	82977	10.06
ATP06	10.96	80174	24.05	82040	5.73	82374	6.83	82652	53.78	82978	19.91
ATP07	11.42	80176	16.26	82042	2.46	82375	17.22	82654	19.11	82979	9.62
ATP08	11.83	80178	9.24	82043	2.46	82376	7.94	82657	24.35	82980	24.31
ATP09	12.13	80182	18.93	82044	6.39	82378	26.51	82658	24.35	82985	21.06
ATP10	12.13	80184	16.01	82044QW	6.39	82379	23.57	82664	48.00	82985QW	21.06
ATP11	12.34	80185	18.52	82055	15.10	82380	12.89	82666	30.01	83001	25.97
ATP12	12.62	80186	19.23	82055QW	15.10	82382	24.02	82668	26.26	83001QW	25.97
ATP16	14.77	80188	23.18	82075	16.84	82383	35.01	82670	39.04	83002	25.88
ATP18	14.87	80190	23.41	82085	13.56	82384	33.28	82671	45.13	83002QW	25.88
ATP19	15.45	80192	23.41	82088	56.94	82387	29.07	82672	30.30	83003	23.29
ATP20	15.95	80194	20.39	82101	41.94	82390	15.01	82677	33.79	83008	23.45
ATP21	16.45	80196	9.92	82103	18.77	82397	19.74	82679	34.88	83010	17.58
ATP22	16.95	80197	19.17	82104	20.20	82415	17.70	82679QW	34.88	83012	24.02
G0001	3.00	80198	19.77	82105	23.44	82435	6.42	82690	21.99	83013	94.11
G0026	5.96	80200	22.52	82106	23.44	82436	4.55	82693	13.75	83014	10.98
G0027	9.09	80201	16.66	82108	35.60	82438	6.83	82696	32.95	83015	26.31
G0103	25.70	80202	18.93	82120	4.02	82441	8.38	82705	7.11	83018	30.68
G0107	4.54	80299	19.13	82120QW	4.02	82465	6.08	82710	22.12	83020	17.99
G0123	28.21	80400	45.56	82127	19.37	82465QW	6.08	82715	24.05	83021	24.35
G0143	28.21	80402	121.46	82128	19.37	82480	9.93	82725	12.08	83026	3.30
G0144	29.39	80406	109.34	82131	23.57	82482	8.31	82726	24.35	83030	11.56
G0145	34.70	80408	175.34	82135	23.00	82485	20.02	82728	19.03	83033	6.50
G0147	14.76	80410	112.23	82136	23.57	82486	24.35	82731	89.99	83036	13.56
G0148	14.76	80412	460.50	82139	23.57	82487	20.02	82735	12.62	83036QW	13.56
G0265	14.11	80414	72.16	82140	20.36	82488	20.02	82742	27.66	83045	4.88
G0266	14.11	80415	78.08	82143	9.61	82489	20.02	82746	20.54	83050	5.86
P2038	7.02	80416	184.38	82145	21.72	82491	24.35	82747	4.30	83051	10.21
P3000	14.76	80417	61.46	82150	9.06	82492	24.35	82757	16.89	83055	6.87
P9612	3.00	80418	809.76	82154	40.29	82495	28.34	82759	30.01	83060	8.12
P9615	3.00	80420	100.64	82157	40.90	82507	38.85	82760	15.64	83065	6.00
Q0111	5.96	80422	64.38	82160	34.94	82520	21.17	82775	29.43	83068	11.83
Q0112	5.96	80424	66.56	82163	28.68	82523	26.11	82776	11.71	83069	5.51
Q0113	7.56	80426	207.40	82164	20.39	82523QW	26.11	82784	12.99	83070	6.64
Q0114	9.99	80428	93.16	82172	19.80	82525	17.34	82785	23.01	83071	9.61
Q0115	13.83	80430	109.60	82175	26.51	82528	31.45	82787	4.36	83080	23.57
78267	10.98	80432	177.43	82180	13.81	82530	23.35	82800	4.88	83088	41.26
78268	94.11	80434	141.30	82190	17.08	82533	22.78	82803	27.04	83090	23.57
80048	11.83	80435	143.85	82205	16.01	82540	6.48	82805	39.65	83150	17.30
80051	9.80	80436	127.36	82232	22.61	82541	24.35	82810	12.20	83491	24.47
80053	14.77	80438	70.41	82239	23.94	82542	24.35	82820	13.96	83497	18.01
80061	18.72	80439	93.88	82240	24.31	82543	24.35	82926	7.61	83498	37.95
80061QW	18.72	80440	81.24	82247	7.02	82544	24.35	82928	7.32	83499	35.22
80069	12.13	81000	4.43	82248	7.02	82550	9.10	82938	24.72	83500	31.65
80074	66.54	81001	4.43	82252	2.73	82552	18.71	82941	24.64	83505	33.96
80076	11.42	81002	3.57	82261	23.57	82553	13.00	82943	19.97	83516	16.12
80090	80.44	81003	3.14	82270	4.54	82554	13.00	82945	5.48	83518	11.85
80100	20.32	81003QW	3.14	82273	4.54	82565	7.16	82946	21.06	83518QW	11.85
80101	19.24	81005	3.03	82273QW	4.54	82570	7.23	82947	5.48	83519	18.88
80101QW	19.24	81007	3.59	82274	0.00	82570QW	7.23	82947QW	5.48	83520	18.09
80102	18.51	81007QW	3.59	82274QW	0.00	82575	13.20	82948	4.43	83525	15.98
80150	21.06	81015	4.02	82286	9.62	82585	11.98	82950	6.64	83527	18.09
80152	25.01	81020	5.15	82300	13.25	82595	9.04	82950QW	6.64	83528	22.22
80154	25.84	81025	8.84	82306	41.36	82600	27.11	82951	17.99	83540	9.05
80156	20.34	81050	4.19	82307	45.02	82607	21.06	82951QW	17.99	83550	12.21
80157	13.89	82000	17.31	82308	37.41	82608	20.01	82952	5.48	83570	12.36
80158	24.31	82003	28.28	82310	7.20	82615	11.41	82952QW	5.48	83582	19.80
80160	24.05	82009	6.31	82330	19.09	82626	35.31	82953	6.63	83586	17.89
80162	18.55	82010	9.99	82331	7.23	82627	31.07	82955	13.55	83593	36.75
80164	18.93	82010QW	9.99	82340	8.43	82633	43.28	82960	8.12	83605	14.92
80166	21.66	82013	15.61	82355	16.17	82634	40.90	82962	3.27	83605QW	14.92

PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE
83615	8.44	83950	89.99	84305	27.55	85004	9.04	85400	12.36	86225	19.20
83625	17.88	83970	57.67	84307	21.61	85007	4.81	85410	10.77	86226	16.92
83632	28.24	83986	5.00	84311	9.77	85008	4.81	85415	13.25	86235	25.06
83633	7.69	83986QW	5.00	84315	3.50	85009	5.19	85420	9.13	86243	28.68
83634	11.17	83992	20.54	84375	12.22	85013	3.31	85421	14.23	86255	16.84
83655	16.91	84022	21.76	84376	7.69	85014	3.31	85441	5.88	86256	16.84
83661	27.56	84030	7.69	84377	7.69	85014QW	3.31	85445	9.52	86277	21.99
83662	26.43	84035	5.11	84378	11.17	85018	3.31	85460	10.81	86280	11.44
83663	13.22	84060	10.32	84379	11.17	85018QW	3.31	85461	9.26	86294	27.41
83664	6.61	84061	11.06	84392	6.64	85021	7.80	85475	12.40	86294QW	27.41
83670	12.80	84066	13.50	84402	35.57	85022	7.67	85520	13.25	86300	28.50
83690	9.62	84075	7.23	84403	36.08	85023	11.84	85525	13.25	86301	28.50
83715	15.73	84078	10.20	84425	12.22	85024	11.83	85530	13.25	86304	28.50
83716	17.30	84080	20.66	84430	16.26	85025	10.86	85536	9.04	86308	7.23
83718	11.44	84081	23.09	84432	22.44	85027	9.04	85540	12.02	86308QW	7.23
83718QW	11.44	84085	9.42	84436	9.61	85031	8.27	85547	12.02	86309	9.04
83719	16.26	84087	11.31	84437	7.94	85032	6.01	85549	26.21	86310	10.30
83721	13.33	84100	6.63	84439	12.60	85041	4.20	85555	9.34	86316	28.50
83727	24.02	84105	6.50	84442	20.66	85044	6.01	85557	18.66	86317	20.95
83735	9.36	84106	5.99	84443	23.47	85045	5.59	85576	30.01	86318	18.09
83775	10.30	84110	11.80	84445	24.31	85046	7.80	85585	4.02	86318QW	18.09
83785	34.36	84119	12.03	84446	19.81	85048	3.55	85590	6.01	86320	31.32
83788	24.35	84120	20.55	84449	21.05	85049	6.25	85595	6.25	86325	31.24
83789	24.35	84126	35.59	84450	7.22	85130	16.62	85597	25.12	86327	31.70
83805	24.63	84127	16.28	84460	7.40	85170	5.05	85610	5.49	86329	19.62
83825	22.72	84132	6.42	84460QW	7.40	85175	6.35	85610QW	5.49	86331	16.75
83835	23.67	84133	6.01	84466	17.84	85210	8.12	85611	5.51	86332	34.05
83840	22.81	84134	20.38	84478	8.04	85220	24.66	85612	13.37	86334	31.21
83857	15.01	84135	26.73	84478QW	8.04	85230	25.02	85613	13.37	86336	21.77
83858	18.72	84138	26.46	84479	9.04	85240	25.02	85635	13.76	86337	29.92
83864	27.82	84140	23.53	84480	19.81	85244	28.53	85651	4.96	86340	21.06
83866	13.76	84143	31.89	84481	21.97	85245	32.06	85652	3.77	86341	27.65
83872	8.19	84144	29.15	84482	21.97	85246	32.06	85660	7.71	86343	17.41
83873	24.04	84146	27.08	84484	13.75	85247	32.06	85670	8.07	86344	11.16
83874	18.04	84150	34.88	84485	10.01	85250	26.60	85675	6.50	86353	68.49
83880	47.43	84152	25.70	84488	10.01	85260	25.02	85705	11.17	86359	4.47
83883	19.00	84153	25.70	84490	10.01	85270	25.02	85730	8.38	86360	9.77
83885	7.94	84154	25.70	84510	12.22	85280	27.04	85732	9.04	86361	5.86
83887	33.09	84155	5.12	84512	7.58	85290	22.83	85810	16.32	86376	20.33
83890	3.56	84160	7.23	84520	5.51	85291	12.42	86000	9.75	86378	27.51
83891	3.56	84165	15.01	84525	4.02	85292	7.28	86001	7.30	86382	23.62
83892	3.56	84181	23.80	84540	6.64	85293	7.28	86003	7.30	86384	15.91
83893	3.56	84182	25.15	84545	9.23	85300	8.12	86005	11.14	86403	14.24
83894	3.56	84202	10.67	84550	6.31	85301	15.11	86021	21.03	86406	14.87
83896	3.56	84203	10.67	84560	6.64	85302	16.80	86022	25.66	86430	7.93
83897	3.56	84206	18.72	84577	17.43	85303	19.32	86023	17.40	86431	7.93
83898	23.42	84207	26.00	84578	4.54	85305	16.20	86038	16.89	86590	12.22
83901	23.42	84210	15.17	84580	9.92	85306	21.41	86039	15.60	86592	5.96
83902	15.17	84220	7.28	84583	7.02	85307	21.41	86060	10.20	86593	6.16
83903	23.42	84228	7.94	84585	21.66	85335	17.99	86063	8.07	86602	8.11
83904	23.42	84233	89.99	84586	26.81	85337	14.56	86140	7.23	86603	17.98
83905	23.42	84234	90.64	84588	47.43	85345	6.01	86141	18.09	86606	21.03
83906	23.42	84235	73.12	84590	16.20	85347	5.95	86146	23.12	86609	18.00
83912	3.56	84238	51.09	84591	16.20	85348	5.20	86147	23.12	86611	8.11
83915	15.58	84244	30.73	84597	9.77	85360	11.17	86148	22.44	86612	18.03
83916	27.42	84252	17.81	84600	22.45	85362	9.62	86155	22.33	86615	18.43
83918	21.19	84255	35.67	84620	16.55	85366	12.03	86156	9.36	86617	21.64
83919	21.19	84260	21.19	84630	15.91	85370	14.83	86157	11.27	86618	21.05
83921	21.19	84270	11.17	84681	26.81	85378	9.97	86160	16.78	86618QW	21.05
83925	27.19	84275	10.28	84702	21.03	85379	14.22	86161	16.78	86619	18.69
83930	9.24	84285	32.90	84703	10.49	85380	14.22	86162	28.39	86622	12.48
83935	9.52	84295	6.72	84703QW	10.49	85384	11.87	86171	14.00	86625	18.33
83937	28.73	84300	6.79	84830	14.02	85385	11.87	86185	12.50	86628	11.31
83945	17.99	84302	6.79	85002	6.29	85390	6.63	86215	18.51	86631	16.52

PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE
86632	17.74	86765	18.00	87116	15.10	87320	16.76	87530	59.85	88147	14.76
86635	16.03	86768	16.26	87118	15.29	87324	16.76	87531	17.79	88148	14.76
86638	16.94	86771	18.33	87140	7.79	87327	16.76	87532	41.65	88150	14.76
86641	15.86	86774	20.68	87143	17.51	87328	16.76	87533	58.33	88152	14.76
86644	20.11	86777	20.11	87147	7.23	87332	16.76	87534	17.79	88153	14.76
86645	23.54	86778	20.12	87149	17.79	87335	16.76	87535	41.65	88154	14.76
86648	21.25	86781	18.50	87152	7.31	87336	16.76	87536	98.47	88155	8.37
86651	18.43	86784	11.31	87158	7.31	87337	16.76	87537	17.79	88164	14.76
86652	18.43	86787	18.00	87164	15.01	87338	17.19	87538	41.65	88165	14.76
86653	18.43	86790	18.00	87166	15.78	87339	16.76	87539	59.85	88166	14.76
86654	18.43	86793	18.33	87168	5.96	87340	14.43	87540	17.79	88167	14.76
86658	18.20	86800	22.22	87169	5.96	87341	14.43	87541	41.65	88174	29.39
86663	18.33	86803	19.94	87172	5.96	87350	16.10	87542	58.33	88175	34.70
86664	21.38	86804	21.64	87176	8.22	87380	22.94	87550	17.79	88230	162.77
86665	25.35	86805	73.05	87177	12.43	87385	16.76	87551	41.65	88233	196.63
86666	8.11	86806	66.49	87181	1.17	87390	15.61	87552	59.85	88235	205.74
86668	14.53	86807	55.29	87184	9.63	87391	15.61	87555	17.79	88237	176.47
86671	17.13	86808	41.47	87185	1.17	87400	16.76	87556	41.65	88239	206.12
86674	19.64	86812	36.06	87186	12.08	87420	16.76	87557	59.85	88240	14.11
86677	20.28	86813	81.02	87187	14.48	87425	16.76	87560	17.79	88241	14.11
86682	18.17	86816	38.92	87188	8.12	87427	16.76	87561	41.65	88245	190.23
86684	22.14	86817	89.95	87190	7.90	87430	16.76	87562	59.85	88248	241.96
86687	11.72	86821	78.88	87197	20.99	87449	16.76	87580	17.79	88249	241.96
86688	19.57	86822	51.07	87198	16.76	87449QW	16.76	87581	41.65	88261	246.93
86689	27.05	86880	7.50	87199	16.76	87450	13.39	87582	58.33	88262	174.14
86692	23.98	86885	7.99	87205	5.96	87451	13.39	87590	17.79	88263	190.23
86694	20.11	86886	7.23	87206	7.50	87470	17.79	87591	41.65	88264	174.14
86695	18.43	86900	4.17	87207	8.37	87471	41.65	87592	59.85	88267	251.17
86696	27.05	86903	8.46	87210	5.96	87472	59.85	87620	17.79	88269	190.23
86698	17.46	86904	13.28	87210QW	5.96	87475	17.79	87621	41.65	88271	20.22
86701	12.41	86905	5.34	87220	5.96	87476	41.65	87622	58.33	88272	35.39
86702	18.88	86906	10.83	87230	27.59	87477	59.85	87650	17.79	88273	44.89
86703	19.17	86940	11.46	87250	27.32	87480	17.79	87651	41.65	88274	48.63
86704	16.84	86941	13.27	87252	36.42	87481	41.65	87652	58.33	88275	56.11
86705	16.44	87001	18.47	87253	28.22	87482	58.33	87797	17.79	88280	35.07
86706	15.01	87003	23.52	87254	6.83	87485	17.79	87798	41.65	88283	95.84
86707	16.16	87015	9.33	87255	47.31	87486	41.65	87799	59.85	88285	26.54
86708	17.31	87040	14.42	87260	16.76	87487	59.85	87800	35.58	88289	40.56
86709	15.73	87045	13.18	87265	16.76	87490	17.79	87801	83.30	88371	31.05
86710	18.94	87046	3.30	87267	16.76	87491	41.65	87802	16.76	88372	31.79
86713	21.39	87070	12.03	87270	16.76	87492	48.84	87803	16.76	88400	3.51
86717	17.12	87071	6.59	87271	16.76	87495	17.79	87804	16.76	89050	6.61
86720	18.43	87073	6.59	87272	16.76	87496	41.65	87810	16.76	89051	7.70
86723	18.43	87075	13.22	87273	16.76	87497	59.85	87850	16.76	89055	5.96
86727	17.98	87076	11.29	87274	16.76	87510	17.79	87880	16.76	89060	9.99
86729	16.69	87077	11.29	87275	16.76	87511	41.65	87880QW	16.76	89125	6.03
86732	18.43	87077QW	11.29	87276	16.76	87512	58.33	87899	16.76	89160	5.15
86735	18.23	87081	9.26	87277	16.76	87515	17.79	87899QW	16.76	89190	6.64
86738	18.51	87084	12.03	87278	16.76	87516	41.65	87901	359.69	89300	12.45
86741	18.43	87086	11.28	87279	16.76	87517	59.85	87902	359.69	89300QW	12.45
86744	18.43	87088	11.31	87280	16.76	87520	17.79	87903	682.72	89310	12.03
86747	21.00	87101	10.77	87281	16.76	87521	41.65	87904	36.42	89320	16.84
86750	13.00	87102	11.74	87283	16.76	87522	59.85	88130	21.02	89321	16.84
86753	17.32	87103	12.60	87285	16.76	87525	17.79	88140	11.17	89325	14.91
86756	18.01	87106	14.42	87290	16.76	87526	41.65	88142	28.21	89329	29.30
86757	27.05	87107	14.42	87299	16.76	87527	58.33	88143	28.21	89330	13.83
86759	18.43	87109	21.50	87300	8.38	87528	17.79	88144	28.21	89355	4.67
86762	20.11	87110	23.73	87301	16.76	87529	41.65	88145	28.21	89365	7.69

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

Fee Schedule Update for 2005 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction provides specific information regarding the 2005 annual update for the DMEPOS fee schedule.

Background

The DMEPOS fee schedules are updated on an annual basis in accordance with the statute and regulations, as described in the Medicare Claims Processing Manual (Pub 100-04, Section 60, Chapter 23). This notification provides details regarding the 2005 annual update for the DMEPOS fee schedule.

The Social Security Act (SSA) (Sections 1834(a), (h), and (i)) requires payment on a fee schedule basis for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. In addition, the Code of Federal Regulations (42 CFR 414.102) requires payment on a fee schedule basis for parenteral and enteral nutrition (PEN).

The 2005 DMEPOS fee schedule update factors for items furnished from January 1, 2005 through December 31, 2005 are as follows:

- DME other than items classified as class III devices by the Food and Drug Administration (FDA) – 0 percent
- DME classified as class III devices by the FDA – 3.3 percent
- Prosthetic devices, prosthetics, and orthotics – 0 percent
- PEN – 3.3 percent
- Surgical dressings – 0 percent

Please refer to the table below for comments and notes on several Healthcare Common Procedure Coding System (HCPCS) codes. The descriptions for the items falling under the HCPCS codes listed in the table can be obtained from the HCPCS file at *https://www.cms.hhs.gov/medicare/hcpcs/default.asp*

Healthcare Common Procedure Coding System Codes

HCPCS Codes	Notes
E2340 thru E2343, and K0108	Codes E2340 thru E2343 for nonstandard power wheelchair seat frame width and depth were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated using retail prices for some products for nonstandard seat dimensions (i.e., captain's chairs that sit on top of power wheelchair bases) as opposed to nonstandard seat frame dimensions. The base fee schedule amounts for codes E2340 thru E2343 will be adjusted to remove these products from the base fee calculations. Suppliers of nonstandard seat dimensions should bill HCPCS K0108 instead of codes E2340 thru E2343.
K0646, K0648, and L0565	The fee schedule amounts for codes K0646 and K0648 are being revised effective January 1, 2005, by cross walking the fee schedule amounts for previous code L0565 to both code K0646 and K0648. As a result of a court settlement, previously paid claims for K0646 and K0648 that were submitted between July 6, 2004 and January 1, 2005, shall be adjusted if such claims are resubmitted by suppliers on or after January 1, 2005, and on or before 18 months after the date the claim was originally submitted.

2005 DMEPOS Fee Schedule Update, (continued)

HCPCS Codes	Notes
E0617, E0691 thru E0694, K0606 thru K0609, and modifier KF	A one-time notification (Transmittal 35, Change Request 3020) was issued on December 24, 2003, and listed HCPCS codes for categories of DME items identified by the FDA as class III devices. As indicated above, the fee schedule amounts for class III DME will be increased by 3.3 percent effective January 1, 2005, whereas the fee schedule amounts for items that are not classified as class III devices by the FDA will not be increased on January 1, 2005. Transmittal 35 indicated that HCPCS codes E0617, E0691 thru E0694, and K0606 thru K0609 represented codes for categories of DME items identified by the FDA as class III devices. However, some products billed under these codes are not class III devices. Therefore, effective January 1, 2005, separate fee schedules will be provided in the DMEPOS fee schedule file: one for class III products within these codes that must be billed with HCPCS modifier KF and one for products within these codes that are not class III devices that may not be billed with HCPCS modifier KF.
A7040, A7041, L8615 thru L8618, L8620 thru L8622	Codes A7040, A7041, L8615 thru L8618, and L8620 thru L8622 describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPCS effective January 1, 2005. These codes fall under the jurisdiction of the local carriers rather than the DMERCs. CMS will be calculating the fee schedule amounts for these items using the standard gap-filling process. The description for these codes can be obtained from the 2005 HCPCS file as soon as it is available at: *http://www.cms.hhs.gov/medicare/hcpcs/default.asp*
A4324 thru A4325; A4347; A4609 thru A4610; B4151; B4156; E0176 thru E0179; E0192; E0454; E0962 thru E0965; E1012 thru E1013 K0023 thru K0024; K0059 thru K0061; K0081; K0114 thru K0116; K0627; L0476; L0478; L0500; L0510; L0515; L0520; L0530; L0540; L0550 L0560 thru L0561; L0565* L0600; L0610; L0620 L2435; L5674 thru L5675 L5846 thru L5847; L5989 L8490	These codes are being deleted from the HCPCS effective January 1, 2005, and are therefore being removed from the DMEPOS and PEN fee schedule files. *As indicated above, the fee schedule amounts for code L0565 are being cross-walked to codes K0646 and K0648.

2005 DMEPOS Fee Schedule Update, (continued)

HCPCS Codes	Notes
A4253, A4259, E0260, E0277, E0424, E0431, E0434, E0439, E0570, E1390, E1391, K0001, and K0011	These codes are affected by the provision in Section 302 (c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requiring reductions for certain DME equal to the percentage difference between 2002 Medicare fee schedule amounts and the median 2002 price paid under Federal Employee Health Benefit (FEHB) plans surveyed by the Office of the Inspector General. The reductions take effect January 1, 2005, and will be implemented as part of this annual update to the DMEPOS fee schedules.
A5500 (extra-depth shoe) A5501 (custom molded shoe) K0628 (direct formed insert) K0629 (custom molded insert)	Section 627 of the MMA requires the calculation and implementation of fee schedule amounts for therapeutic shoes and inserts effective January 1, 2005. Fee schedules for these HCPCS codes have been calculated by CMS using the methodology contained in section 1834(h) of the Social Security Act for prosthetic devices, prosthetics, and orthotics. These fee schedule amounts will be implemented as part of this annual update to the DMEPOS fee schedules.
A5503 thru A5507 (shoe modification codes) K0628 or K0629 (inserts)	In accordance with section 1833(o)(2)(C) of the Social Security Act, the payment amounts established for shoe modification codes (A5503 thru A5507) must be established in a way that prevents a net increase in expenditures when substituting these items for inserts (codes K0628 or K0629). Therefore, the 2005 fee schedule amounts for codes A5503 thru A5507 have been calculated based on the weighted average of the fee schedule amounts for insert codes K0628 and K0629. The fees for K0628 and K0629 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2006 and each subsequent year, the weighted average insert fee used to establish the fee schedule amounts for the shoe modification codes will be based on an updated weighted average (i.e., using more current allowed service data for each insert code).
E0675	Code E0675 was added to the HCPCS effective January 1, 2004. The fee schedule for code E0675 was calculated using retail prices for two products; however, the fee schedule is being revised effective January 1, 2005, to remove pricing for one product that was not yet an established product in the market at the time the code was added.
E1010	The description for code E1010 for "wheelchair accessory, addition to power seating system, including leg rest, …each" is changed effective January 1, 2005, to show "wheelchair accessory, addition to power seating system,……., including leg rest, pair" and the fee schedule for E1010 is revised to reflect this change. Suppliers should bill single leg rest power elevation systems under code K0108.
E2320 thru E2330, and Modifier KC	Codes E2320 thru E2330 for special power wheelchair interfaces were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated based on pricing for the differential cost of furnishing these special interfaces over a standard interface that is paid for as part of the payment for the wheelchair (e.g., K0011). However, when these items are furnished to replace existing interfaces on wheelchairs that have been in use by the patient for a period of time due to a change in the patient's medical condition or in cases where the existing interface is irreparably damaged or has exceeded its reasonable useful lifetime, the fee schedule payment should reflect payment for the full cost of the replacement special interface. Modifier KC is being added to the HCPCS effective January 1, 2005, to identify replacement of special power wheelchair interfaces in these cases. Fee schedule amounts for replacement of special power wheelchair interfaces will be established effective January 1, 2005, for use in paying claims for use Codes E2320 thru E2330 billed with the KC modifier.

2005 DMEPOS Fee Schedule Update, (continued)

Additional Information

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

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3574. 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, fiscal intermediary, or DMERC at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*

Related Change Request (CR) #: 3574
Medlearn Matters Number: MM3574
Related CR Release Date: November 19, 2004
Related CR Transmittal #: 369
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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FLORIDA DMEPOS FEES

PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE	PROC	FEE
A6010	30.96	A6214	10.29	A6244	39.28	A4562	47.78	L8612	540.78
A6011	2.28	A6216	0.05	A6245	7.27	A7040	37.98	L8613	242.57
A6021	21.02	A6219	0.95	A6246	9.92	A7041	71.35	L8614	15353.47
A6022	21.02	A6220	2.58	A6247	23.78	A7042	169.52	L8615	365.77
A6023	190.30	A6222	2.13	A6248	16.24	A7043	23.31	L8616	85.20
A6024	6.19	A6223	2.42	A6251	1.99	E0749	229.62	L8617	74.41
A6154	13.93	A6224	3.61	A6252	3.25	E0752	372.52	L8618	21.25
A6196	7.35	A6229	3.61	A6253	6.34	E0754	916.00	L8619	6586.07
A6197	16.44	A6231	4.66	A6254	1.21	E0756	6767.01	L8620	52.46
A6199	5.29	A6232	6.88	A6255	3.03	E0757	4834.90	L8621	0.50
A6200	9.50	A6233	19.19	A6257	1.53	E0758	4255.80	L8622	0.27
A6201	20.80	A6234	6.54	A6258	4.30	E0759	558.88	L8630	270.19
A6202	34.88	A6235	16.82	A6259	10.94	E0782	4078.58	L8631	1813.25
A6203	3.35	A6236	27.25	A6266	1.92	E0783	7777.24	L8641	293.24
A6204	6.23	A6237	7.91	A6402	0.12	E0785	448.86	L8642	240.71
A6207	7.34	A6238	22.79	A6403	0.43	E0786	7586.23	L8658	251.57
A6209	7.48	A6240	12.24	A6407	1.88	L8600	500.79	L8659	1564.96
A6210	19.92	A6241	2.57	A6410	0.39	L8603	351.71	L8670	446.41
A6211	29.37	A6242	6.07	E0781	242.46	L8606	184.62		
A6212	9.70	A6243	12.31	A4561	19.22	L8610	513.68		

GENERAL INFORMATION

FRAUD, WASTE, AND ABUSE

Provider Enrollment Fraud Alert

This is to inform you that Medicare is aware of an organized group who is representing themselves as either a Medicare fraud investigator; or a Medicare employee from the enrollment, claim or audit units. These callers tell the physician, or office personnel, that the Medicare computer system has had a malfunction and they need to update lost information. The callers may also say they need to update the physician's provider record. They then request via telephone or fax the following information:

- Copy of physician's drivers license
- Copy of physician's social security number (SSN)
- Unique physician identification number (UPIN)
- Verification of education
- Verification of practice location
- Copy of physician's medical license
- Copy of patient's charts for a specific period of time.

Once the entity receives this information, they falsify enrollment data using the physician's name and request a change to their practice locations, telephone numbers, and pay-to-addresses.

The Centers for Medicare & Medicaid Services (CMS) has not suffered any computer system malfunction and are not calling providers requesting the above information be provided. If you should receive such a call, please try to verify the telephone number of the caller, and immediately notify your Medicare carrier that you suspect fraud.

CMS is committed to protect all Medicare providers/suppliers and to ensure that only those qualified make changes to enrollment data. CMS believes that with your help we can target those unscrupulous individuals that are looking to take advantage of you and the Medicare trust fund.

To report these calls please contact the toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center at 1-866-454-9007. ❖

Source: CMS JSM-05154, December 27, 2004, PCM #0436303

GENERAL INFORMATION

Implementation of Section 921 of the Medicare Modernization Act (MMA) – Provider Customer Service Program

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction implements Section 921 of the Medicare Modernization Act (MMA). It creates the Provider Customer Service Program (PCSP) at most Medicare contractors. Collectively, carriers and fiscal intermediaries (FIs) are referred to as contractors or Medicare contractors. Because of funding limitations, the Centers for Medicare & Medicaid Services (CMS) is implementing this instruction in phases. Currently, only carriers and some FIs will be implementing this program in January 2005. Check with your carrier/FI to see if they are participating in the first phase.

Background

Medicare contractors are required to implement a PCSP designed to meet provider informational and educational needs.

The PCSP flows from provisions in Section 921 of the MMA that strengthen and enhance Medicare's ongoing efforts associated with provider inquiries and education. The PCSP is designed to improve accuracy, completeness, consistency, and timeliness by ensuring that providers' issues are addressed by staff with the appropriate levels of expertise.

The PCSP includes the following three principal components:

- Provider self-service technology
- Provider contact center (PCC)
- Provider outreach and education

Provider Self-Service Technology

- Self-service technology will enable the contact centers to handle the increasing volume of provider calls by allowing providers access to certain information without direct personal assistance from Medicare contractor staff. Contractors will require providers to use the interactive voice response (IVR) systems to access information about claims status, beneficiary eligibility, and remittance advice code definitions.

Provider Contact Center

The PCC will respond to inquiries from the following:

- Telephone calls
- Letters
- Faxes
- E-mails

Contractors will use an inquiry triage process for telephone inquiries to ensure that inquiries are answered by the staff with the appropriate expertise. Each contractor will organize its customer service representatives (CSRs) into at least two levels.

Inquiries that require even more specialized expertise or research or that just require significant additional time to resolve will be referred to a new group, the Provider Relations Research Specialists (PRRSs).The PRRS will provide clear and accurate written answers within 10 business days for at least 75 percent of cases referred by telephone CSRs, 20 business days for 90 percent of the cases referred by telephone CSRs, and 45 business days for 100 percent of all cases (referred by CSRs or from the general inquiries area). All general inquiries (letter, fax, and e-mail) will be answered within 45 business days.

Provider Outreach and Education

This component of the PCSP includes all provider outreach, education, and training activities that your carrier/FI currently performs, plus some additional requirements and activities. These new areas include:

- Training tailored for small providers and tailored to reduce the claims error rate
- Enhanced use of the Internet
- Local "Ask-the-Contractor" teleconferences and other new methods of communication

Small providers are defined by law as providers with fewer than 25 full-time equivalents or suppliers with fewer than 10 full-time equivalent staff. Contractors are required to identify providers meeting the definition of small providers and, beginning April 1, 2005, offer to all providers at least two educational programs tailored to the needs of the small providers/suppliers within their jurisdiction. Thereafter, contractors shall offer at least one additional event tailored to small providers per quarter with a minimum of six such events per state per federal fiscal year. (Thus, there may be more than one event in certain quarters of the year.)

Additional Information

For complete details, please see the official instruction issued to your contractor 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 3376 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions or want to take advantage of any opportunities under this expanded PCSP, visit the web site of your carrier/intermediary or call them at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*

Related Change Request (CR) #: 3376
Medlearn Matters Number: MM3376
Related CR Release Date: September 10, 2004
Related CR Transmittal #: 113
Effective Date: January 1, 2005
Implementation Date: January 5, 2005, unless otherwise indicated

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Type of Service Changes

Effective for claims processed on or after January 1, 2005, the type of service (TOS) for some new procedure codes will require a UPIN. There are also some codes that will no longer require a UPIN. The following identifies the procedures codes and their respective UPIN requirement.

Procedure Codes added for 2005 requiring a UPIN

0064T	82045	88184 - 88185	D0416
0070T	82656	88187 - 88189	D0421
0073T	83009	88360	D0431
0085T	83630	88367 - 88368	D0475-D0479
0087T	84163	91000 - 91033	D0481-D0485
76077	84166	91052 - 91065	G0336
76820- 76821	86064	93701 - 93744	G0365
78812-78816	86335	93760 - 93888	G0366
79005	86379	93922 - 94450	G0367
79101	86587	94620 - 94621	G0368
79445	87807		

Reminder: Services will deny as return unprocessable (RUC) if a UPIN is required and not provided.

Procedure codes no longer requiring a UPIN:

Procedure Code	Old TOS	New TOS
76510	4	1
91034-91040	5	1
93890	5	1
93892	5	6
94452-94453	5	1

Source: CMS Pub. 100-04, Transmittal 359
Date: November 4, 2004 Change Request 3519

Interactive Voice Response Changes

On January 1, 2005, enhancements will be added to our Interactive Voice Response (IVR) unit for our provider community. Enhancements include:

- The IVR will let you know if the claim did or did not crossover with one of the following responses.
- Yes crossover message: The claim information was forwarded to the patient's supplemental insurer.
- No crossover message: The claim information was not forwarded to a supplemental insurer.
- To obtain pricing information, enter only the procedure code. The type of service is no longer required
- The IVR will provide the status of unlimited claims for the same date of service. Previously, status requests were limited to only ten claims.

The toll-free number for the IVR is (877) 847-4992 (Florida) or (866) 419-9455 (Connecticut).

Telephone Redetermination – Clarification

FCSO recently posted complete guidelines for telephone redeterminations on the Education section of the website.

The purpose of this article is to clarify that services requiring submission of additional documentation do not qualify for a telephone redetermination. Examples are:

- Modifier changes for 24, 25, 53, 58, 59, 62, 66, 78, and 79 (medical documentation must be submitted with the redetermination request)
- Procedure code changes when the code requires documentation on the initial submission or codes now being upcoded.

Timely Claim Filing Guidelines for All Medicare Providers

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

Dates of Service	*Last Filing Date*
October 1, 2002 – September 30, 2003	by December 31, 2004
October 1, 2003 – September 30, 2004	by December 31, 2005
October 1, 2004 – September 30, 2005	by December 31, 2006*
October 1, 2005 – September 30, 2006	by December 31, 2007*
October 1, 2006 – September 30, 2007	by December 31, 2008

*****If December 31 falls on a federal nonworking day, the last filing date is extended to the next succeeding workday. A federal nonworking day is considered a Saturday, Sunday, legal holiday, or a day declared by statute or executive order as a nonworking day for federal employees.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned unprocessable, is not protected from the timely filing guidelines. ❖

2005 Holiday Schedule

First Coast Services Options, Inc will observe the following holiday schedule in 2005:

January 3, (Monday) New Year's Day

January 17, (Monday) Martin Luther King Jr. Day

March 25, (Friday) Good Friday

May 30, (Monday) Memorial Day

July 4, (Monday) Independence Day

September 5, (Monday) Labor Day

November 24, (Thursday) Thanksgiving Holiday

November 25, (Friday) Thanksgiving Holiday

December 23, (Friday) Christmas Holiday

December 26, (Monday) Christmas Holiday. ❖

Ambulance Medical Conditions List

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

Provider Types Affected

Providers and suppliers of ambulance services as well as Medicare contractors (carriers and fiscal intermediaries)

Provider Action Needed

This article is for educational guideline only. It explains use of the ambulance fee schedule – medical conditions list to help you document your patient's signs and symptoms on scene and during ambulance transportation. It will also tell you how to find the ambulance medical conditions code list.

Background

Under Medicare, the Healthcare Common Procedure Coding System (HCPCS) codes provide a uniform method for providers and suppliers to report professional services, while the International Classification of Diseases Nineth Edition Clinical Modification (ICD-9-CM) codes document the patient's diagnosis or clinical signs or symptoms. The ambulance fee schedule – medical conditions list, which this article and related CR 3619 discuss, gives you a crosswalk from the ICD-9-CM code (which your dispatch centers and/or ambulance crews may use to describe a patient's medical condition or signs and symptoms on scene and during the transport) to the HCPCS code.

Please note the following details:

- Using the ICD-9-CM diagnosis/ambulance medical condition code(s) (and their crosswalk to HCPCS codes) will not guarantee payment of the claim or payment for a certain level of service.
- Remember that you must retain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by your Medicare contractor or other oversight authority.

Additionally, your contractor will rely on medical record documentation (and not simply the HCPCS code or the condition code by themselves) to justify coverage.

- Also be aware that all current Medicare ambulance policies remain in place.

Note: Providers/suppliers should use the ICD-9-CM code (not the ambulance condition code) on the ambulance claim form.

Additional Information

You can find more information about the Ambulance Fee Schedule – Medical Conditions List by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3619 in the CR NUM column on the right, and click on the file for that CR. The Ambulance Fee Schedule – Medical Conditions List can be found as an attachment to 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*.

Related Change Request (CR) Number: 3619
Related CR Release Date: December 15, 2004
Related CR Transmittal Number: 395
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 395, CR 3619

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FINANCIAL SERVICES

Interest Payment on Clean Claims Not Paid Timely

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers and intermediaries, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

Physicians, providers, and suppliers should note that this article clarifies information relating to the calculation of interest due on claims not paid in a timely manner by Medicare.

Background

The Medicare Claims Processing Manual (Pub, 100-04, Chapter 1, Section 80.2.2) provides instructions for assessing and calculating interest due on non-periodic interim payment (PIP) claims not paid in a timely manner by fiscal intermediaries (FIs) and carriers. It states the following:

- Interest is required to be paid for clean claims not paid within 30 days after the day of receipt of a claim.
- Interest accrues until and including the day of late payment.

Related CR 3557 corrects Chapter 1, Section 80.2.2 of the Medicare Claims Processing Manual. For your convenience, the following revised language from Section 80.2.2 is provided with revisions in bold and italicized:

"Interest must be paid on clean claims if payment is not made within the applicable number of calendar days ***(i.e., 30 days)*** after the date of receipt as described above. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993. Interest is not paid on:

- Claims requiring external investigation or development by the provider's FI ***or carrier***
- Claims on which no payment is due
- Full denials
- Claims for which the provider is receiving PIP
- Home health prospective payment system (HH PPS) requests for anticipated payment (RAPs).

Interest is paid on a per bill basis at the time of payment. Interest is paid at the rate used for section 3902(a) of title 31, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department web page *http://www.publicdebt.treas.gov/opd/opdprmt2.htm* for the correct rate. Also, the FI or carrier notifies the provider of any changes to this rate.

Interest is calculated using the following formula:

Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

The interest period begins on the day after payment is due and ends on the day of payment. Note that the example below is for one 6-month period in which the interest rate was 5.625 percent.

Milestones	**Clean Paper Claim (in calendar days)**	**Clean Electronic Claim (in calendar days)**
Date Received	November 1, 2001	November 1, 2001
Payment Due	***December 1, 2001***	***December 1, 2001***
Payment Made	December 4, 2001	December 4, 2001
Interest Begins	December 2, 2001	December 2, 2001
Days for Which Interest Is Due	***3***	***3***
Amount of Payment	$100	$100
Interest Rate	5.625%	5.625%

See section 80.2.1.1 for the definition of EMC and paper claims.

The following formula is used:

For the clean paper claim: $100 x .05625 x ***3*** divided by 365 = ***$0.0462*** or, ***$0.05*** when rounded to the nearest penny.

For the clean electronic claim: $100 x .05625 x ***3*** divided by 365 = ***$0.0462,*** or ***$0.05*** when rounded to the nearest penny."

When interest payments are applicable, the FI or carrier reports the amount of interest on each claim on the remittance record to the provider.

Additional Information

The official instruction issued to your intermediary/carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R416CP.pdf*.

Implementation Date

The implementation date for this instruction is January 25, 2005

Note: **For the period beginning January 1, 2005, and ending June 30, 2005, the interest rate applicable on clean claims not paid timely is 4.250 percent.**

Related Change Request (CR) Number: 3557
Related CR Release Date: December 23, 2004
Related CR Transmittal Number: 416
Effective Date: January 25, 2005
Implementation Date: January 25, 2005

Source: CMS Pub 100-4 Transmittal 416, CR 3557

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Unsolicited/Voluntary Refunds

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

Provider Types Affected

All Medicare providers

Provider Action Needed

Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Background

Medicare carriers and intermediaries receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

Additional Information

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

Related Change Request (CR) #: 3274
Medlearn Matters Number: MM3274
Related CR Release Date: July 30, 2004
Related CR Transmittal #: 50
Effective Date: October 1, 2004/January 1, 2005
Implementation Date: October 1, 2004/January 3, 2005

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Corrected Zip Code Files for the Health Professional Shortage Areas

The Center for Medicare & Medicaid Services (CMS) has released information that some ZIP codes were left off the files provided for the automated payment of the health professional shortage areas (HPSA) bonus. Corrected files are now available on CMS website at *www.cms.hhs.gov/providers/bonuspayment*.

These corrected files will be used for processing HPSA bonus payments for 2005.

A special edition Medlearn Matters article addressing the implementation of the physician scarcity bonus an the HPSA bonus was published in the First Quarter 2005 *Medicare B Update* (page 10-14). This article is also available at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0449.pdf*.

Source: CMS Joint Signature Memorandum 05099, December 1, 2004

COVERAGE/REIMBURSEMENT

AMBULANCE

Reminder Notice of the Implementation of the Ambulance Transition Schedule

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

Provider Types Affected

Ambulance providers and suppliers

Provider Action Needed

STOP – Impact to You

During the current calendar year (CY) 2004, year three of a five-year transition to the ambulance fee schedule implementation, payment for ambulance services is based on a blend of 60 percent of the fee schedule amount plus 40 percent of the provider's reasonable cost or the supplier's reasonable charge for the service. As of January 1, 2005, the amounts payable under the ambulance fee schedule for CY2005 will consist of 80 percent of the fee schedule amount and 20 percent of providers' reasonable cost or suppliers' reasonable charge amount for the service.

CAUTION – What You Need to Know

The fee schedule applies to **ALL** ambulance services furnished as a benefit under Medicare Part B. Ambulance providers and suppliers are required to accept assignment, and therefore must accept Medicare allowed charges as payment in full. They may not bill or collect from the beneficiary any amount other than an unmet Part B deductible and the Part B coinsurance amounts.

GO – What You Need to Do

Be aware that the next phase of the fee schedule payment process goes into effect on January 1, 2005 and adjust accounts receivable processes as necessary.

Background

Section 4531(b)(2) of the Balanced Budget Act (BBA) of 1997 added a new section 1834(l) to the Social Security Act, which mandates implementation of a national fee schedule for ambulance services furnished as a benefit under Medicare Part B. On April 1, 2002, CMS implemented a new fee schedule that applies to all ambulance services. The schedule applies to all ambulance services: volunteer, municipal, private, independent, as well as institutional providers, i.e., hospitals and skilled nursing facilities. The fee schedule will be phased in over a five-year transition period, during which time the amounts payable for services provided will be a blend of fee schedule amount and the provider's reasonable cost or supplier's reasonable charge amount. (Ambulance services covered under Medicare will be paid based on the lower of the actual billed amount or the ambulance fee schedule amount.)

Ambulance providers and suppliers are currently paid a blended rate, consisting of 60 percent of the fee schedule amount and 40 percent of the provider's reasonable cost amount or the supplier's reasonable charge amount.

Providers and suppliers are reminded that the ambulance fee schedule is being implemented on a five-year transition period as follows:

Year	Fee Schedule Percentage	Cost/Charge Percentage
Year 1 (4/1/02 – 12/31/02)*	20%	80%
Year 2 (CY 2003)*	40%	60%
Year 3 (CY 2004)*	60%	40%
Year 4 (CY 2005)	80%	20%
Year 5 (CY 2006 and thereafter)	100%	0%

*Previous and current year percentages

Section 1834 (l) also requires mandatory assignment for all ambulance services. Ambulance providers and suppliers must accept the Medicare allowed charge as payment in full and not bill or collect from the beneficiary any amount other than any unmet Part B deductible and the Part B coinsurance amounts.

Implementation

Implementation of the next phase of the fee schedule will begin on January 3, 2005.

Related Instructions

Providers should note when billing ambulance services to intermediaries that all ancillary services and supplies provided are considered part of the base rate and are not separately billable under the ambulance fee schedule. For Part B suppliers billing Medicare carriers for ambulance services, separately billable supplies may be billed, depending on the supplier's billing method.

Suppliers should also note that Medicare carriers will deny claims for separately billed supplies and ancillary services furnished during an ambulance transport on or after January 1, 2006.

The payment increases for ambulance transports available under Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) effective July 1, 2004 have been implemented. No additional changes are required to implement this MMA provision. Please refer to Change Request 3099, Transmittals 88 and 220 for details.

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 3473 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please refer to your local carrier/intermediary. To find that toll free phone number, go to: *http://www.cms.hhs.gov/medlearn/tollnums.asp*

Related Change Request (CR) #: 3473
Medlearn Matters Number: MM3473
Related CR Release Date: October 22, 2004
Related CR Transmittal #: 320
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Ambulance Inflation Factor

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

Provider Types Affected

Providers and suppliers of ambulance services billing Medicare carriers and fiscal intermediaries (FIs) for those services

Provider Action Needed

None. This article is for your information only. It provides the ambulance inflation factor (AIF) for calendar (CY) 2005.

Background

Section 1834(l)(3)(B) of the Social Security Act (SSA) provides the basis for updating the payment limits that your contractors use to determine how much to pay you for claims that you submit for ambulance services. This update, the AIF, is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The Centers for Medicare & Medicaid Services (CMS) is required to issue this AIF so that your contractors can pay your Medicare ambulance claims accurately and in accordance with statutory requirements. **The AIF for calendar year 2005 is 3.3 percent.**

Remember that during the five-year transition period to the ambulance fee schedule, payments are based on a blended methodology. In the blend, the AIF is applied, separately, to both the fee schedule portion (incorporated in the ambulance fee schedule file) and the reasonable charge/cost portions of the blended payment amount. Then, these two amounts are added together to determine your total payment.

For CY 2005, the blending percentages used to combine these two components of the payment amounts for ambulance services are 80 percent of the ambulance fee schedule and 20 percent of the reasonable charge/cost. Remember also that Part B coinsurance and deductible requirements apply to these claims.

Additional Information

You can find more information about the AIF by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R411CP.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 A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3599
Related CR Release Date: December 23, 2004
Related CR Transmittal Number: 411
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 411, CR 3599, PCM #0436207

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Ambulance Medical Conditions List

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

Provider Types Affected

Providers and suppliers of ambulance services as well as Medicare contractors (carriers and fiscal intermediaries)

Provider Action Needed

This article is for educational guideline only. It explains use of the ambulance fee schedule – medical conditions list to help you document your patient's signs and symptoms on scene and during ambulance transportation. It will also tell you how to find the ambulance medical conditions code list.

Background

Under Medicare, the Healthcare Common Procedure Coding System (HCPCS) codes provide a uniform method for providers and suppliers to report professional services, while the International Classification of Diseases Nineth Edition Clinical Modification (ICD-9-CM) codes document the patient's diagnosis or clinical signs or symptoms. The ambulance fee schedule – medical conditions list, which this article and related CR 3619 discuss, gives you a crosswalk from the ICD-9-CM code (which your dispatch centers and/or ambulance crews may use to describe a patient's medical condition or signs and symptoms on scene and during the transport) to the HCPCS code.

Please note the following details:

- Using the ICD-9-CM diagnosis/ambulance medical condition code(s) (and their crosswalk to HCPCS codes) will not guarantee payment of the claim or payment for a certain level of service.
- Remember that you must retain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by your Medicare contractor or other oversight authority.

Additionally, your contractor will rely on medical record documentation (and not simply the HCPCS code or the condition code by themselves) to justify coverage.

- Also be aware that all current Medicare ambulance policies remain in place.

Note: **Providers/suppliers should use the ICD-9-CM code (not the ambulance condition code) on the ambulance claim form.**

Additional Information

You can find more information about the Ambulance Fee Schedule – Medical Conditions List by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3619 in the CR NUM column on the right, and click on the file for that CR.

The Ambulance Fee Schedule – Medical Conditions List can be found as an attachment to 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*.

Related Change Request (CR) Number: 3619
Related CR Release Date: December 15, 2004
Related CR Transmittal Number: 395
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 395, CR 3619, PCM #0435105

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DIAGNOSTIC SERVICES

Temporary Change in Carrier Jurisdictional Pricing Rules for Purchased Diagnostic Services

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

Provider Types Affected

Physicians, laboratories, and independent diagnostic testing facilities (IDTFs)

Provider Action Needed

This instruction implements a temporary change in carrier jurisdictional pricing rules for purchased diagnostic services to allow physicians/suppliers purchasing out-of-jurisdiction diagnostic tests/interpretations to bill their local carrier for these services.

It also instructs carriers to revoke any previously issued provider identification numbers (PINs) used to allow IDTFs physically located outside of the carrier's jurisdiction to bill and be paid for purchased diagnostic tests/interpretations payable under the Medicare Physician Fee Schedule (MPFS).

For claims with dates of service between January 25, 2005 and March 31, 2005, physicians/suppliers must bill their local carrier for all purchased diagnostic tests and interpretations, regardless of the location where the service was actually furnished.

Background

Effective for claims with dates of service on or after April 1, 2004**, Medicare carriers must use the zip code of the location where the service was rendered** to determine both the carrier jurisdiction for processing the claim and the correct payment locality for any service paid under the MPFS (see the Medicare Claims Processing Manual (Pub.100-04), Chapter 1, Section 10.1.1). Diagnostic tests and their interpretations are paid under the MPFS, and are therefore subject to the same payment rules as all other services paid under the MPFS.

Laboratories, physicians, and IDTFs may bill for purchased tests and interpretations, but under the current carrier jurisdictional pricing rules, these suppliers must bill the purchased test or interpretation to the carrier that has jurisdiction over the geographic location where the test or service is performed.

Since the implementation of carrier jurisdictional pricing edits on April 1, 2004, the Centers for Medicare & Medicaid Services (CMS) has received reports that, due to current enrollment restrictions, **some physicians/suppliers purchasing diagnostic tests/interpretations are unable to receive reimbursement for these services when the services are performed outside of their local carrier's jurisdiction**.

This article and related CR 3630 address these reported problems by temporarily changing the carrier jurisdictional pricing rules that apply when billing for an out-of-jurisdiction area purchased diagnostic service. **Carrier jurisdictional pricing rules for all other services** payable under the MPFS **remain in effect.**
Until further notice:

- Physicians/suppliers must bill their local carrier for all purchased diagnostic tests/interpretations, regardless of the location where the service was furnished
- The billing physician/supplier must:
- Ensure that the physician/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); and
- Be responsible for any existing billing arrangements between the purchasing entity and the entity providing the service.

NOTE**: 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 web site at the following address: *http://www.oig.hhs.gov/fraud/exclusions.html*. Physicians/suppliers may access this database, or use another available source, to determine whether another supplier is eligible to participate with Medicare prior to billing for a purchased diagnostic test or interpretation.**

When billing for an out-of-jurisdiction purchased diagnostic service, physicians/suppliers must use their own PIN to bill for the service and must report their local facility address in the service facility location area of the claim. (For these services only, the place of service is deemed to be the billing physician's/supplier's location, rather than the location where the service was actually performed. The billing physician/supplier should use the same address reported for the portion of the service that the physician/supplier performed when reporting the address for the purchased portion of the test.)

When submitting paper claims (form CMS-1500), physicians/suppliers billing their local carrier for a purchased test/interpretation performed outside of the carrier's jurisdiction must report their name and use their own PIN to bill both the purchased portion of the test and the portion of the test that they performed. When billing for a purchased interpretation, the billing physician/supplier should **not** report the PIN of the physician who performed the interpretation in item 19 of the claim. Instead, the billing physician/supplier must maintain a record of the name and address of the physician performing the purchased interpretation and supply it to the Medicare carrier upon request. In addition, when billing for the test/interpretation, the purchasing physician/supplier must enter the address of that portion of the service they actually performed as the address where the purchased service was preformed in block 32 of the CMS-1500 claim form.

When submitting a claim for a purchased service on the form CMS-1500, remember that the billing physician/supplier must check box 20 "Yes" or continue to bill for the technical and professional components on separate claim forms.

When using electronic claims submissions (ANSI X12 837, version 4010A) physicians/suppliers billing for the purchased test/interpretation performed outside their carrier's jurisdiction must report their name and their PIN to bill for the purchased diagnostic service. The billing physician/supplier should continue to report the 1C qualifier (Medicare Provider Number) in the reference identification segment of the 2310C (Purchased Service Provider Secondary ID) loop.

When reporting the 2400 PS1 segment (Purchased Service Information) of the 837 format, billing physicians/suppliers must report their own PIN. The reference identifier entered in the REF02 segment of the 2310C loop must also be the PIN of the billing physician/supplier, **not** the PIN of the physician/supplier who actually performed the service.

In addition, the billing physician/supplier must enter as the service facility location the **same** address as the location where they performed the non-purchased portion of the test. Enter this address in the appropriate service facility location (Service Facility Location Loop 2310D for claim level or 2420C for the line level on the claim).

Also, a physician/supplier billing a carrier for a purchased diagnostic test must continue to report on the claim the amount that the physician/supplier charged, net of any discounts. (Independent laboratories are exempt from reporting the amount charged for purchased tests.)

When billing for a diagnostic service purchased within the local carrier's geographical service area, the physician/supplier must continue to follow existing guidelines for reporting the location where the service was furnished. Physicians/suppliers are advised that:

- They must bill their local carrier for purchased diagnostic tests/interpretations, and they may no longer use, effective 14 days after receiving notification from the carrier, PINs issued in out-of-jurisdiction carrier sites to bill for these services; and
- They will not be penalized when they change the service facility location on the claim (even if the location reported on the claim does not correspond with the location where the service was actually performed).
- They should not use any PINs previously issued to any supplier that is physically located outside of the carrier's jurisdiction in order for such supplier to bill and be paid for purchased diagnostic services payable under the MPFS. In particular, this includes independent clinical diagnostic laboratories [Specialty Type "69"].

Medicare carriers will accept and process claims billed by suppliers (including radiologists, physicians, and IDTFs) enrolled in the carrier's jurisdiction based on the zip code entered on the claim, regardless of where the service was actually furnished. Suppliers billing for purchased diagnostic tests/interpretations must meet all other enrollment criteria, and must be eligible to bill for the purchased component of the test.

If your carrier determines (during the claims review process) that the service was performed at a location other than the service facility address entered on the claim, the carrier must hold the physician/supplier harmless for this discrepancy, and may not deny the claim on this basis.

NOTE: **For audit purposes, physicians/suppliers must maintain, and provide upon request, supporting documentation demonstrating that the test/interpretation was purchased, and documenting the location where the service was performed.**

Finally, carriers will not reopen claims, but will allow physicians/suppliers to resubmit claims under this revised policy, where such claims were denied due to problems with billing out-of-jurisdiction purchased services. Such claims may be resubmitted to the local carrier for processing, but they must be filed within the time limits established for timely filing of claims.

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R415CP.pdf*

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

Related Change Request (CR) #: 3630	Medlearn Matters Number: MM3630
Related CR Transmittal #: 415	Implementation Date: January 25, 2005
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END STAGE RENAL DISEASE

Payment for Outpatient End Stage Renal Disease (ESRD)-Related Services

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

Provider Types Affected

Physicians and practitioners.

Provider Action Needed

This one-time clarification is provided to assist physicians and practitioners in billing for end stage renal disease (ESRD) related services furnished to patients in hospital observation status and for various partial month scenarios (e.g., partial month without a complete assessment of the patient, patients who have a change in their monthly capitation payment [MCP] physician during the month, and transient patients). Also, clarification is provided for outpatient billing on ESRD-related services when the beneficiary changes modalities during the month (e.g., a home dialysis patient who switches to center dialysis and vice versa).

Background

In the final rule published November 7, 2003, (68 FR 63216) the Centers for Medicare & Medicaid Services (CMS) established new G codes for managing patients on dialysis with payments varying based on the number of visits provided within each month. Under this methodology, separate codes are billed for providing one visit per month, two to three visits per month and four or more visits per month.

The lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would have to provide at least four ESRD-related visits per month. The G codes are reported once per month for services performed in an outpatient setting that are related to the patient's ESRD.

Since changing our payments for managing patients on dialysis, we have received a number of comments from the nephrology community requesting guidance on billing for outpatient ESRD-related services provided to patients in hospital observation settings, transient patients, and in partial month scenarios where the comprehensive visit may not have been furnished. Additionally, questions have been raised regarding the appropriate billing code for patients switching modalities during the month (e.g., from home dialysis to center dialysis).

Therefore, the purpose of CR3414 and of this article is to provide immediate, short-term guidance as to the appropriate codes physicians and practitioners should use and how carriers should price claims regarding these specific ESRD-related scenarios. CMS has a proposal in the CY 2005 physician fee schedule rule (published August 5, 2004 and available on our web site regarding how ESRD-related visits furnished in the observation setting, transient patients and other partial months scenarios would be coded in the future. The address of that website is: *http://www.cms.hhs.gov/physicians.*

Policy Clarifications

1. Patients in Hospital Observation Status

General Policy

ESRD-related visits furnished to patients in hospital observation status that occur prior to December 31, 2004, should be coded using the unlisted dialysis procedure code. Physicians and practitioners should use the unlisted dialysis procedure code as described by CPT code 90999 when submitting claims for ESRD related visits furnished to patients in the hospital observation setting.

Guidelines for Physician or Practitioner Billing and Documentation

In submitting bills for outpatient ESRD-related visits furnished to patients in hospital observation status, physicians and practitioners should include documentation in the medical record describing the type of ESRD-related services provided during the visit. Only one claim should be submitted for all ESRD-related services provided during the visit.

Physicians and practitioners providing ESRD-related visits to beneficiaries in observational status should bill CPT code 90999 outside of the monthly capitation payment (MCP). If the MCP physician furnishes a complete assessment of the patient, he or she may bill the appropriate G code corresponding to the number of visits furnished during the month. However, the visit furnished in the observational setting must be billed separately from the MCP.

> **Example #1:** The MCP physician or practitioner furnishes an ESRD-related visit for a 70 year-old ESRD beneficiary in hospital observation status. Prior to the ESRD-related visit furnished in the observation setting, the MCP physician furnished a visit for this beneficiary that included a complete monthly assessment and two non-comprehensive visits without a complete assessment at a freestanding ESRD facility. In this scenario, the MCP physician should bill the appropriate two to three visit code (for example G0318), and CPT code 90999, for the visit furnished to the patient in the hospital observation status.

> **Example #2:** A physician other than the beneficiary's MCP physician furnishes an ESRD-related visit when the beneficiary is in hospital observation status. The MCP physician or practitioner furnishes one visit that included a complete assessment of the patient during the same month. In this scenario, the physician

furnishing the visit in the hospital observation setting should bill for the unlisted dialysis procedure code CPT 90999, and the MCP physician should bill for the appropriate one visit monthly capitation code (e.g., G0319).

Guidance for Pricing Claims

The unlisted dialysis procedure code as described by CPT 90999 is carrier-priced. When pricing claims for outpatient ESRD-related visits furnished to patients in hospital observation status, your carrier should consider pricing these ESRD-related visits based on the incremental increase between the one visit MCP code and the two to three visit MCP (e.g., the payment difference between G0319 and G0318).

Example: A 70 year-old ESRD beneficiary is in hospital observation status for two days and is visited once by a physician. The physician bills CPT code 90999 for the ESRD-related visit and payment is based on the difference between G0319 (ESRD-related services with one face-to-face visit per month) and G0318 (ESRD-related services with two to three face-to-face visits per month). Based on the CY 2004 physician's fee schedule, the RVUs for ESRD-related visits furnished when a beneficiary is in hospital observation status would be 1.36 (6.76 - 5.40 = 1.36).

2. Partial Month Scenarios

General Policy

Partial month scenarios should also be coded using the unlisted dialysis procedure code. Physicians and practitioners should use CPT code 90999 when submitting claims for ESRD-related visits furnished in the following scenarios:

Transient patients – Patients traveling away from home (less than full month).

Partial month without a complete assessment of the patient. For example, the patient was hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had a transplant.

Patients who have a change in their MCP physician during the month.

For purposes of this article, the term "month" means a calendar month. The first month the beneficiary begins dialysis treatments is the date the dialysis treatments begin through the end of the calendar month.

Thereafter, the term "month" refers to a calendar month.

Guidelines for Physician or Practitioner Billing

Transient Patients and Partial Month Without a Complete Assessment of the Patient

With regard to transient patients and partial month scenarios (as listed above) the physician or practitioner should specify the number of days he or she was responsible for the beneficiary's outpatient ESRD-related services during the month (e.g., similar to the methodology used for home dialysis patients, less than full month).

Only one code should be used to report the daily management of transient patients and for partial month scenarios. For example, if a transient patient is away from his or her home dialysis site for two weeks, then 14 units of the unlisted dialysis code as described by CPT 90999 is billed.

For transient patients, the physician or practitioner responsible for the transient patient's ESRD-related care should bill CPT code 90999. Only the physician or practitioner responsible for the traveling ESRD patient's care would be permitted to bill for ESRD-related services using CPT code 90999.

For partial month scenarios resulting from hospitalization, kidney transplant, transient patients, or if the patient expired, if the MCP physician or practitioner furnished a visit that included a complete monthly assessment of the patient, he or she should bill using the appropriate G code (G0308 through G0319) that reflects the number of visits furnished during the month.

Example #1: A 70 year-old ESRD beneficiary was hospitalized on the 10th through the 20th day of the month. On the third day of the month, the MCP physician or practitioner furnished a face-toface visit that included a complete outpatient assessment and a subsequent outpatient visit on the 25th day of the month.

While the patient was hospitalized, an inpatient ESRD-related visit was furnished. In this scenario, the MCP physician or practitioner may bill for the appropriate outpatient monthly capitation payment (e.g., G0318). The physician or practitioner who furnished the inpatient visit may bill for the appropriate inpatient ESRD-related service code, e.g., the 90935.

Example #2: A 70 year-old ESRD beneficiary vacationing in Florida is away from his or her home dialysis site from August 15 through September 7. On August 10, the MCP physician furnishes a face-to-face visit including a complete assessment of the patient. For the month of September, the MCP physician furnishes a visit with a complete assessment on the September 9 and a subsequent visit on the 25th of the month. A physician in Florida is responsible for the beneficiary's ESRD-related care from August 15 through September 7.

In this scenario, the physician or practitioner responsible for the transient patients ESRD-related care bills sixteen units of the unlisted dialysis procedure code (CPT 90999) for the month of August and seven units of CPT code 90999 for the month of September. The MCP physician bills G0319 (ESRD-related services with one visit) for the month of August and G0318 (ESRD-related services with two to three visits) for the month of September.

If the transient beneficiary is under the care of a physician or practitioner other than his or her regular MCP physician for an entire calendar month, the physician or practitioner responsible for the transient patient's ESRD-related care must furnish a complete assessment and bill for ESRD-related services under the MCP.

Patients Who Have a Change in their MCP Physician During the Month

CPT code 90999 should be billed in situations where an ESRD beneficiary permanently changes their MCP physician

during the month. For example, the new MCP physician has the ongoing responsibility for the evaluation and management of the patient's ESRD-related care and is not part of the same group practice or an employee of the first MCP physician. The new MCP physician should use CPT code 90999 when submitting claims for ESRD-related services for the remainder of the month, when the first MCP physician furnishes a complete assessment of the beneficiary during the month

If the first MCP physician does not furnish a complete assessment of the patient during the month the patient permanently changes their MCP physician, the new MCP physician may bill for the appropriate G code (G0308 through G0319) and the first MCP physician may bill CPT code 90999 for the partial month as described above.

> **Example:** An ESRD patient residing in Virginia Beach, Virginia, for the first 20 days of the month moves to Atlanta, Georgia. As a result, a different physician or practitioner is now responsible for the ongoing management of the beneficiary's ESRD-related care. Both the first and second MCP physician furnishes a visit with a complete assessment of the patient and establishes a monthly plan of care. In this situation, the first MCP physician should bill the G code that reflects the number of visits he or she furnished during the month and the second MCP physician should bill CPT code 90999. Thereafter, the new MCP physician would bill for the appropriate monthly capitation payment, e.g., G0318.
>
> In this example, if the first MCP physician does not provide a complete assessment of the patient, he or she should bill 20 units of CPT code 90999 but may not bill for the MCP during the month the beneficiary permanently changes his or her MCP physician. The second MCP physician may bill for the appropriate monthly capitation payment after furnishing a visit with a complete assessment of the ESRD beneficiary.

Guidance for Pricing Claims

With regard to pricing claims for ESRD-related services furnished to transient patients and the other partial month scenarios as described above, your carrier should consider using the payment amounts for the per diem codes G0324 through G0327. When using these codes, payment is based on the number of days the physician or practitioner was responsible for the beneficiary's outpatient ESRD-related services during the month.

> **Example #1:** A 17-year-old ESRD beneficiary is away from his or her home dialysis site for 2 weeks vacationing in Florida. The physician or practitioner responsible for the transient patient's ESRD-related care should bill 14 units of CPT code 90999. Under the per diem method, payment for CPT code 90999 would be based on G0326 and the RVUs would be 5.74 (.41 x 14 = 5.74).
>
> **Example #2:** A 10-year-old ESRD beneficiary is hospitalized for 20 days during the month and a complete (outpatient) assessment of the patient for that month was never furnished. The MCP physician should bill 10 units of CPT code 90999. Under the per diem method, payment is based on G0325 and the RVUs would be 3.60 (.36 x 10 = 3.60).

NOTE: The use of CPT code 90999 is intended to accommodate unusual circumstances where the outpatient ESRD-related services would not be paid under the MCP.

3. Patients Who Switch Modalities During the Month

General Policy

If a home dialysis patient receives dialysis in a dialysis center or other facility during the month, the physician or practitioner is paid the management fee for the home dialysis patient and cannot bill the codes in the range of G0308 through G0319.

This situation should be coded using the ESRD-related services G codes for a home dialysis patient per full month. Physicians and practitioners should use G0320 through G0323 when billing for outpatient ESRD related services when a home dialysis patient receives dialysis in a dialysis center or other facility during the month.

> **Example #1:** A 70-year-old ESRD beneficiary receives dialysis at home for the first 10 days of the month and at a dialysis center for the remaining 20 days. The MCP physician should bill G0323.
>
> **Example #2:** A 70-year-old ESRD beneficiary receives dialysis at a dialysis center for the first 10 days of the month and at home for the remaining 20 days. The MCP physician should bill G0323.

Claims Processing

Carriers will deny claims with G0308 through G0319 when submitted in the same month as G0320 through G0323 for the same ESRD beneficiary. In making the denial, the carrier will generate Remittance Advice (RA) codes B13 and M86.

4. Effective Date and Previously Submitted Claims

These clarifications are effective for claims with dates of service on or after January 1, 2004. Your carrier will not reprocess previously paid claims. Additionally, claims submitted for ESRD-related services for the situations described in CR3414 that have not yet been paid may be processed using the methods outlined in CR3414.

Additional Information

To view the entire set of instructions issued to your carrier on this clarification, go to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

Once at that site, scroll down the right CR NUM column to locate CR3414 and click on the file for that CR.

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) #: 3414
Medlearn Matters Number: MM3414
Related CR Release Date: September 17, 2004
Related CR Transmittal #: 300
Effective Date: January 1, 2004
Implementation Date: October 18, 2004

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EVALUATION AND MANAGEMENT

More Than One New Patient Office Visit within Three Years

For Medicare billing purposes, a new patient is defined as a patient who has not received any professional services from the physician or physician group practice within the previous three years.

If no evaluation and management service is performed, the patient may continue to be treated as a new patient. For example, if the professional component of a previous procedure is billed within the three-year period (e.g., a lab interpretation) and no evaluation and management service is performed, then the patient remains a new patient for an initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG, etc., in the absence of an evaluation and management service does not affect the designation of a new patient.

Effective for claims processed on or after March 1, 2005, if an initial office visit is billed more than once in three years, we will change the procedure code to that for an established patient office visit and reduce the allowance accordingly (i.e., 99201 to 99211).

GENERAL COVERAGE

Coverage of Routine Costs of Clinical Trials Involving Investigational Device Exemption Category A Devices

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

Provider Types Affected

Physicians and providers

Provider Action Needed

STOP – Impact to You

Effective for routine costs incurred on or after January 1, 2005, Medicare will cover the routine costs of clinical trials involving investigational device exemption (IDE) Category A devices (used in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition).

CAUTION – What You Need to Know

This extension of coverage refers to the routine services performed for such clinical trials. **The Category A device itself remains non-covered.**

GO – What You Need to Do

This extension of coverage refers to the routine services performed for such clinical trials. **The Category A device itself remains non-covered.**

Background

Prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Centers for Medicare & Medicaid Services (CMS) limited coverage of clinical trials to:

- IDE Category B trials (21 CFR 405.201); and
- Routine costs for qualifying clinical trials (National Coverage Determinations Manual 310.1).

The MMA (Section 731(b)) expands the ability of CMS to cover costs in clinical trials by authorizing coverage of routine costs in certain clinical trials involving IDE Category A devices effective for routine costs incurred on or after January 1, 2005.

This extension of coverage refers to the routine services performed for such a trial, and the Category A device itself remains non-covered.

Category A (experimental/investigational) devices are innovative medical devices about which the Food and Drug Administration (FDA) has major questions regarding safety and effectiveness. For a trial to qualify for payment of routine costs, it must meet certain criteria established by the Secretary of the Department of Health and Human Services to ensure that the trial conforms to appropriate scientific and ethical standards.

In addition, the MMA established additional criteria for trials initiated before January 1, 2010, to ensure that the devices involved in these trials be intended for use in the:

1) **Diagnosis;**
2) **Monitoring; or**
3) **Treatment of an immediately life-threatening disease or condition** ("a stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment).

Providers participating in the clinical trial are responsible for furnishing all information the Medicare contractor (fiscal intermediary or carrier) deems necessary for coverage determination and claims processing regarding:

- The device;
- The clinical trial; and
- The participating Medicare beneficiaries.

Also, the provider must contact their local Medicare intermediary or carrier before billing for this service.

Billing Instructions

For routine services performed in a clinical trial where a category A device is used for a patient with a life threatening condition:

- **Physicians billing with Form CMS-1500** must place the IDE number of the category A device in Item 23.
- **Physicians billing electronically** must place the IDE number on the 2300 investigational device exemption Number REF segment, data element REF02 (REF01=LX) of the 837p.
- **Hospitals** must place the category A IDE number on the 837I electronic claim format in 2300 investigational device exemption number REF segment, data element REF02 (REF01=LX). If billing on the UB-92 CMS-1450 paper form, the IDE number must be in form locator 43.
- **All providers** should place modifier QV on the claim to reflect routine costs in a clinical trial associated with an IDE category A device. Note, however, that CMS is working to obtain another modifier that will be required in addition to modifier QV. Further news will be provided on that modifier once CMS receives it.
- **All providers** should also note that Medicare will continue to deny claims submitted for the IDE category A device itself.

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

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/pm_trans/R131OTN.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 A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: CR 3548
Related CR Release Date: December 17, 2004
Related CR Transmittal Number: 131
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-20 Transmittal 131, CR 3548, PCM #0435503

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Chemotherapy Demonstration Project

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

Provider Types Affected

Physicians and non-physician practitioners billing Medicare carriers for chemotherapy services provided to cancer patients in an office-based practice in calendar year (CY) 2005

Provider Action Needed

This article and related CR 3670 provide information on the proper G-codes used when articipating in the Chemotherapy Demonstration Project associated with caring for cancer patients who receive chemotherapy services in an office-based practice.

Background

In the Medicare Physician Fee Schedule final rule published on November 15, 2004 in the Federal Register, the Centers for Medicare & Medicaid Services (CMS) announced a one-year demonstration project for intravenous infusion or push chemotherapy services provided in an office-based practice.

Practitioners participating in the project must provide and document specified services related to pain control management, minimization of nausea and vomiting, and the reduction of fatigue associated with chemotherapy. Submission of the applicable G-codes and claims will generate additional payment to the practitioner for submitting patient assessment data under this demonstration. Under this demonstration, cancer patients receiving chemotherapy are asked by practitioners about the degree to which they have been bothered by pain, nausea and/or vomiting, and fatigue symptoms. The patient's responses are reflected by reporting one G-code in the claim for each of the three symptoms that best approximates the patient's response. A G-code for each symptom (pain, nausea/vomiting, and fatigue) must appear on the claim for payment to be made under the demonstration.

By reporting the designated G-codes on the claim submitted for payment, the practitioner self-enrolls in the project and agrees to all of the terms and conditions of the demonstration. Payment under the demonstration applies only when the designated G-codes are billed in conjunction with chemotherapy service (defined as chemotherapy administered through intravenous push or infusion, using G-codes G0357 or G0359, respectively) to treat cancer. Reporting the G-codes on the claim is all that is required as far as the documentation of the patient's response.

The following is a list of the G-codes to be used to report the corresponding levels for each of the three symptoms. These codes are only valid for payment for CY 2005 dates of service, and must be pointed to a cancer diagnosis.

Chemotherapy Demonstration Project, (continued)

Code	G-Codes for Assessment of Nausea and/or Vomiting
G9021	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level one: not at all (for use in a Medicare approved demonstration project)
G9022	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level two: a little (for use in a Medicare approved demonstration project)
G9023	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level three: quite a bit (for use in a Medicare-approved demonstration project)
G9024	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level four: very much (for use in a Medicare-approved demonstration project)

Code	G-Codes for Assessment for Pain
G9025	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment level one: not at all (for use in a Medicare-approved demonstration project)
G9026	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment level two: a little (for use in a Medicare-approved demonstration project)
G9027	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration assessment level three: quite a bit (for use in a Medicare-approved demonstration project)
G9028	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment level four: very much (for use in a Medicare-approved demonstration project)

Code	G-Codes for Assessment for Lack of Energy (Fatigue)
G9029	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level one: not at all. (for use in a Medicare approved demonstration project)
G9030	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level two: a little. (for use in a Medicare approved demonstration project)
G9031	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level three: quite a bit. (for use in a Medicare approved demonstration project)
G9032	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level four: very much. (for use in a Medicare-approved demonstration project)

The following allowances will be made for the demonstration assessment codes and payment will be based on the lesser of 80 percent of the actual charge or the following allowances by code:

G9021 to G9024 - $43.34
G9025 to G9028 - $43.33
G9029 to G9032 - $43.33

Please report only one G code from each symptom assessment category.

The amounts listed above apply in all locations and are paid on an assignment basis... The usual Part B coinsurance and deductible apply. The demonstration project is applicable to services provided on or after January 1, 2005 and on or before December 31, 2005. Medicare beneficiaries who are enrolled in a Medicare advantage plan are excluded from the demonstration.

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

From that web page, look for CR 3670 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3670
Medlearn Matters Number: MM3670
Related CR Release Date: December 30, 2004
Related CR Transmittal #: 14
Effective Date: January 1, 2005
Implementation Date: January 17, 2005

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Ventricular Assist Devices for Destination Therapy

This provider education article discusses the expansion in Medicare coverage for ventricular assist devices (VADs) for destination therapy for certain services performed **on and after October 1, 2003.** The article also discusses VAD claims processing and provides VAD information resources.

Background

For services performed **on and after October 1, 2003,** coverage has been expanded for VADs when used as destination therapy under the following conditions:

- The VAD has received approval from the Food and Drug Administration (FDA) for that purpose.
- The VAD is used according to FDA-approved labeling instructions.
- The patient meets specified criteria.
- The procedure is performed in specified facilities.

Note**: All other indications for the use of VADs r emain the same.**

VAD Claim Processing Information

Services Provided to Patients in a Medicare+Choice (now Medicare Advantage) Plan

Until Medicare capitation rates to M+C organizations are adjusted to account for expanded VAD coverage, the following guidelines providers will be paid on a fee-for-service basis for VAD services that fall under the new indication for destination therapy.

Medicare did not have system changes in place to pay claims for risk M+C patients until January 5, 2004, therefore Medicare contractors held claims for risk M+C patients under the new indications for VADs submitted with modifier KZ or condition code 78 from October 1, 2003 until December 31, 2003.

Medicare contractors released these claims for payment with any applicable interest on or after January 5, 2004.

Services Provided to Fee-for-Service Patients

ICD-9-CM procedure code 37.62 was incorrectly included in diagnosis related group (DRG) 525 when it was created in 2003. Code 37.62 is clinically and financially dissimilar to the other procedures in DRG 525. Therefore, the following changes regarding the mapping of codes assigned to DRG 525 have been completed:

- ICD-9-CM procedure code 37.62 (implant of other heart assist system has been removed and assigned to DRG 104 (cardiac valve) and DRG 105 (other major cardiothoracic procedures with and without cardiac catheterization).
- Procedure codes that still map to DRG 525 are 37.63 (replacement and repair of heart assist system), 37.65 (implant of an external, pulsatile heart assist system), and 37.66 (implant of an implantable, pulsatile heart assist system).
- Payment for cases remaining in DRG 525 has been increased from approximately $75,000 to $90,000.
- Payment for cases with procedure code 37.62 has been decreased from approximately $75,000 to $35,000.
- CMS implemented a new GROUPER software program in place to correctly group these services on November 1, 2003; therefore, claims submitted between October 1, 2003 and October 31, 2003 were grouped and paid under the software programs in place on October 1, 2003.
- Claims with DRGs 104, 105, and 525 were adjusted on or after November 1, 2003 in order to correctly pay these services.

VAD Information Resources

http://www.cms.hhs.gov/manuals/cmsindex.asp
CMS Manual System, Pub. 100-3 Medicare National Coverage Determination, section 20.9. ❖

Source: CMS Pub 100-3 Transmittal 4, CR 2985, PCM #0331503

INJECTABLE DRUGS

Payment for Chemotherapy Administration Services, Nonchemotherapy Drug Infusion Services, and Drug Injection Services

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

Provider Types Affected

Physicians

Provider Action Needed

STOP – Impact to You

Physicians should note that this instruction affects payment for chemotherapy administration and nonchemotherapy drug infusion services furnished on or after January 1, 2004.

CAUTION – What You Need to Know

Understand the revised payment policy for chemotherapy administration and nonchemotherapy drug infusion services.

GO – What You Need to Do

Be sure that billing staff are aware of these changes and code claims accordingly.

Background

This instruction incorporates the policy included in Change Request (CR) 3028 (Transmittal 34, dated December 24, 2003) pursuant to the Medicare Modernization Act of 2003 (MMA, Section 303), which affects payment for chemotherapy administration and nonchemotherapy drug infusion services furnished on or after January 1, 2004. In addition, this instruction includes all the necessary business requirements for the payment policy on chemotherapy administration and nonchemotherapy drug infusion services not originally included in CR3028.

The Medicare physician fee schedule is used to pay for services that correspond to Current Procedural Terminology (CPT) codes for:

- Chemotherapy administration services;
- Therapeutic or diagnostic infusions (excluding chemotherapy); and
- Drug injection codes.

In addition, these CPT codes have had:

- Practice expense relative value units;
- Malpractice relative value units; but
- Zero physician work relative value units.

For services furnished **prior to January 1, 2004**, carriers allowed:

- Chemotherapy administration services **CPT code 96408** (Chemotherapy administration, intravenous; push technique) to be billed and **paid only once per day** (even if the physician administered multiple drugs).
- **Drug injection codes (90782 to 90788) to be billed and paid separately** (only if no other physician fee schedule service was being paid at the same time). For example, if CPT code 99211 was billed with a drug injection code, the carrier paid only for CPT code 99211.

For services furnished **on or after January 1, 2004**, carriers shall allow:

- Chemotherapy administration services **CPT code 96408** (Chemotherapy administration, intravenous; push technique) to be billed and **paid more than once per day.** Payment shall be allowed for CPT code 96408 for each drug administered.
- **Drug injection codes to be billed and paid separately** (only if no other physician fee schedule service is being paid at the same time). If CPT code 99211 is billed with a drug injection code, the carrier pays only for CPT code 99211.

For services furnished **on or after January 1, 2004, carriers shall not allow:**

- CPT code 99211 (with or without modifier 25) to be billed or paid **on the same day** as a chemotherapy administration service or a nonchemotherapy drug infusion service.

In addition, Medicare carriers have been instructed:

- To pay for evaluation and management services, other than 99211, provided by the physician on the same day as the chemotherapy administration codes of 96400, 96408 to 96425, 96520 or 96530 if the evaluation and management service meets the requirements of *Chapter 12, Section 30.6.6* of the *Medicare Claims Processing Manual (Pub 100-04)* even though the underlying codes do not have global periods.
- To pay for evaluation and management services, other than 99211, provided by the physician on the same day as the nonchemotherapy drug infusion service (90780 or 90781), if the evaluation and management service meets the requirements of *Chapter 12, Section 30.6.6* even though the underlying codes do not have global periods.
- To use an appropriate adjustment reason code when denying a service that is not separately payable. Medicare carriers will not adjust claims already processed unless such claims are brought to the attention of the carrier by the physician.

Chemotherapy Administration Services, etc., (continued)

Also, pursuant to Section 303 of the MMA, CMS has established work relative value units for:

- Chemotherapy administration services (CPT codes 96400, 96408 to 96425, 96520 and 96530);
- Nonchemotherapy drug infusion services (CPT codes 90780 to 90781); and
- Drug injection codes (CPT codes 90782 to 90788).

The work relative value for each code is equal to the work relative value unit for a level 1 office medical visit for an established patient (CPT code 99211). CPT code 99211 is a level 1 established patient office visit with physician work relative values of 17.

Implementation

The implementation date for this instruction is May 24, 2004.

Additional Information

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

From that web page, look for CR3192 in the CR NUM column on the right, and click on the file for that CR.

Revised portions of Chapter 12, Sections 20.3, and 30.5 are attached to the instruction at this Web site.

For other information from Chapter 12 and other portions of the *Medicare Claims Processing Manual*, visit: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*

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.*

In addition, CR3028, Transmittal 34, dated December 24, 2003, can be reviewed at the following CMS website: *http://www.cms.hhs.gov/manuals/pm_trans/r34otn.pdf.*

Related Change Request (CR) #: 3192
Medlearn Matters Number: MM3192
Related CR Release Date: April 23, 2004
Related CR Transmittal #: 147
Effective Date: January 1, 2004
Implementation Date: May 24, 2004

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Drugs Paid by Average Selling Price Beginning January 1, 2005

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 beginning January 1, 2005, the payment limit for Part B drugs and biologicals, not paid on a cost or prospective payment basis, will be paid based on the average sales price (ASP) plus 6 percent. Drugs will be paid based on date of service and the lower of:

1) The submitted charge; **or**
2) The ASP plus 6 percent

Background

According to the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), beginning January 1, 2004 through December 31, 2004, drugs and biologicals not paid on a cost or prospective payment basis are paid based on various standards specified in the statute, although the default payment limit standard is 85 percent of average wholesale price (AWP).

This instruction notifies contractors (Part B local carriers and durable medical equipment carriers (DMERCs)) that the MMA mandates that drugs and biologicals not paid on a cost or prospective payment basis are to be paid based on the ASP beginning January 1, 2005.

Therefore, beginning January 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will:

- Supply contractors with a drug payment limit file for drugs and biologicals
- Send quarterly updates of this file to contractors Payment will be based on:
- The lower of the submitted charge or the payment limit on this file
- The date-of-service

Finally, contractors will:

- Develop payment limits when CMS does not supply a payment limit for the drug on the file
- Continue to determine the payment limit for compounded drugs
- Continue to determine the payment limit for new drugs

Implementation

The implementation date for this instruction is January 1, 2005.

Drugs Paid by ASP, (continued)

Related Instructions

The Medicare internet only manual (IOM) has been edited with revised and new sections to reflect changes implemented with this instruction. These revised and new sections include the following:

The Medicare Claims Processing Manual (Pub. 100-4), Chapter 17 (Drugs and Biologicals):

- Section 10 (Payment Rules for Drugs and Biologicals) – **revised**
- Section 20 (Payment Allowance Limit for Drugs and Biologicals Not Paid on a Cost or Prospective Payment Basis) – **revised**
- Subsection 20.1 (MMA Drugs) – **new**

These revised and new sections of the Medicare Claims Processing Manual are included in the actual instruction (CR 3232) issued to your carrier or DMERC.

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 3232 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3232	Medlearn Matters Number: MM3232
Related CR Release Date: July 23, 2004	Related CR Transmittal #: 248
Effective Date: August 23, 2004	Implementation Date: January 3, 2005

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2005 Drug Administration Coding Revisions

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

Provider Types Affected

Physicians billing Medicare carriers for drug administration.

Provider Action Needed

Physicians should note that this article is based on change request (CR) 3631; it clarifies the 2005 drug administration coding revisions. In the final physician fee schedule rule published in the federal register on November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) announced that it would adopt G-codes for 2005 that correspond to the new current procedural terminology (CPT) drug administration codes that will become effective in 2006.

The new G-codes will apply on an interim basis until 2006. As CMS is adopting the G-codes, CMS is also adopting, in 2005, the CPT coding rules that will not officially appear until the CPT 2006 is published.

The relevant CPT drug administration codes approved by the CPT editorial panel are grouped into three categories:

- Hydration (i.e., codes G0345 and G0346);
- Therapeutic or diagnostic injections and intravenous infusions other than hydration (i.e., codes G0347 to G0354 and CPT codes 90783, 90788); and
- Chemotherapy administration (i.e., codes G0355 to G0363, CPT codes 96405-96406, 96420 to 96520, and 96530 to 96549).

Note: **The allowances for these codes reflect the application of the 2005 transitional payment adjustment of 3 percent, which by law is applicable only to drug administration codes.**

Background

The Social Security Act (Section 1848c(2)(J), as modified by the Medicare Modernization Act (MMA) (Section 303a)), requires CMS to promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for those services, taking into account the levels of complexity of the administration and resource consumption. The law further provides that CMS must use existing processes for the consideration of coding changes and, to the extent changes occur, use those processes to establish values for those services.

The American Medical Association's (AMA's) CPT editorial panel established a workgroup, with members from affected specialties, who met earlier in 2004 to develop recommendations on drug administration coding. The workgroup presented its recommendations to the CPT editorial panel in August, 2004. Based on those recommendations, the CPT editorial panel adopted several new drug administration codes and revised several existing codes.

Subsequently, the AMA's Relative Value Update Committee (RUC) met at the end of September 2004 to make recommendations to CMS on the practice expense resource inputs and work relative values for the new and revised drug administration codes.

2005 Drug Aministration, etc., (continued)

The 2005 CPT was already published prior to the adoption of the new and revised drug administration CPT codes. Therefore, the new and revised drug administration codes, and the CPT coding rules applicable to them, will appear in the 2006 CPT.

In the physician fee schedule final rule published in the federal register on November 15, 2004, CMS announced that it would adopt G-codes for 2005 that correspond to the new CPT codes that will become active in 2006. These new G codes are considered interim until 2006.

As CMS adopts the G-codes, CMS is also adopting in 2005 the CPT coding rules for the new drug administration codes in their current form that will not officially appear until the CPT 2006 is published.

Currently, Medicare allows chemotherapy administration codes to be used only for reporting chemotherapy administration when the drug being used is an anti-neoplastic and the diagnosis is cancer (see the Medicare Claims Processing Manual, Chapter 12, Section 30.5 at *http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf*).

Under the new codes, chemotherapy administration codes will apply to parenteral administration of nonradionuclide anti-neoplastic drugs and also anti-neoplastic agents provided for the treatment of noncancer diagnoses (e.g. cyclophosphamide for autoimmune conditions), or to substances such as monoclonal antibody agents and other biologic response modifiers.

At this time, CMS is not developing a national list of approved chemotherapy drugs. CMS will allow each Medicare carrier to develop such a list.

Another important change pertains to the creation of new codes to identify additional sequential infusions. Current CPT codes do not separately identify additional sequential infusions apart from additional hours of infusion. Consistent with the new codes adopted by the CPT editorial panel, CMS implemented new G codes to separately identify additional sequential infusions. There are also new codes to identify additional nonchemotherapy sequential intravenous pushes and intravenous chemotherapy pushes for additional drugs.

"Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes.

When administering multiple infusions, injections or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be used.

If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported. The initial code is the code that best describes the primary service the patient is receiving and the additional codes are secondary to the primary procedure.

The new drug administration G-codes and their descriptors for 2005 are described below. The allowances for these codes reflect the application of the 2005 transitional payment adjustment of three percent, which, by law (MMA section 303(a)(4)), is applicable only to drug administration codes.

New G-Codes for Hydration Services

For services furnished prior to January 1, 2005, CPT did not include distinct codes for hydration infusion services. Infusions involving hydration or nonchemotherapy drugs were billed using CPT codes 90780 and 90781.

For services furnished in 2005, CPT codes 90780 and 90781 will not be recognized under the Medicare physician fee schedule. The following new G-codes should be used instead:

- **G0345**, "Intravenous infusion, hydration; initial, up to one hour"; and
- **G0346**, "Intravenous infusion, hydration; each additional hour, up to eight (8) hours (list separately in addition to code for procedure)."

Codes G0345 and G0346 are intended to report a hydration IV infusion consisting of a prepackaged fluid and/or electrolyte solutions (e.g., normal saline, D5-1/2 normal saline +30mEq KC1/liter), but are not used to report infusion of drugs or other substances.

Hydration IV infusion typically requires direct physician supervision for purposes of consent, safety oversight, or intra-service supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff who administer these do not typically require advanced training. After initial setup, infusion typically entails little patient risk and thus little monitoring.

Report G0346 for hydration infusions of greater than thirty minutes beyond one-hour increments, or hydration greater than thirty minutes provided as a secondary or sequential service after a different initial infusion or chemotherapy service is provided.

New G-Codes for Nonchemotherapy Therapeutic or Diagnostic Injections and IV Infusions (Other than Hydration)

IV Infusions

For services furnished in 2005, nonchemotherapy infusions for therapy or diagnosis are reported using new G-codes:

- **G0347**, "Intravenous infusion, for therapy/diagnosis (specify substance or drug); initial, up to one hour;" and
- **G0348**, "Intravenous infusion, for therapy diagnosis (specify substance or drug); each additional hour, up to eight (8) hours (list separately in addition to code for primary procedure)."

G0348 is used to report additional hour(s), beyond the first hour, of sequential infusion as well as the second and subsequent hours of the initial drug. Report G0348 for

2005 Drug Aministration, etc., (continued)
infusion intervals of greater than thirty minutes beyond one-hour increments.

Also, prior to January 1, 2005, distinct codes did not exist to report concurrent and/or sequential nonchemotherapy infusions involving a different drug. For 2005, there are new G codes that distinctly describe these services:

- **G0349**, "Intravenous infusion, for therapy/ diagnosis (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)," used to report the first hour of a sequential infusion of a second nonchemotherapy drug; and
- **G0350**, "Intravenous infusion, for therapy/ diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)."

If a significant separately identifiable evaluation and management (E & M) service is performed, the appropriate E & M service code should be reported utilizing modifier 25 in addition to codes G0347-G0354.

For an E & M service provided on the same day, a different diagnosis is not required.

If performed to facilitate a therapeutic/diagnostic infusion or injection, the following are included and are not reported separately:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes and supplies.

Nonchemotherapy Injections

After January 1, 2005, Codes 90782 and 90784 will not be recognized under the Medicare physician fee schedule, and CPT codes 90783 and 90788 remain in effect. For 2005, 90782 is replaced by:

- **G0351,** "Therapeutic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular."

Code 90784 (currently used for IV push of nonchemotherapy drugs) is replaced in 2005 by the following two codes that separately identify the initial and additional nonchemotherapy IV push:

What is Intravenous/Intra-Arterial Push?
Intravenous or intra-arterial push is defined as an injection/infusion of short duration (i.e., thirty minutes or less) in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient.

- **G0353**, "Therapeutic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug;" and
- **G0354,** "Therapeutic or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)."

For services furnished prior to 2005, codes 90782 to 90788 were only payable under the Medicare physician fee schedule if there were no other services billed on the same date by the same provider (status indicator "T"). Otherwise, these services were bundled into the other service(s) for which payment was made.

For services furnished on or after January 1, 2005, services described by codes G0351, G0353, G0354, and CPT codes 90783 and 90788, may be paid in addition to other physician fee schedule services billed by the same provider on the same day of service (the status indicator of "T" is removed and replaced with the "A" status indicator).

Note: **Certain Medicare policies, including but not limited to, correct coding edits for the services described by codes G0351, G0353, G0354, and CPT codes 90783 and 90788 may apply.**

Use code G0351 for non-anti-neoplastic hormonal therapy injections and use G0356 for anti-neoplastic hormonal injection therapy.

Use G0354 to report an intravenous push subsequent to another drug administration service, if appropriate.

Do not report G0345-G0354 with codes (including injections and intravenous chemotherapy, intra-arterial chemotherapy, and other chemotherapy) for which IV push or infusion is an inherent part of the primary procedure (e.g., administration of contrast material for a diagnostic imaging study).

New G-Codes for Chemotherapy Administration

For services furnished on or after January 1, 2005, chemotherapy administration codes apply to parenteral administration of nonradionuclide anti-neoplastic drugs and also to anti-neoplastic agents provided for the treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents and other biologic response modifiers. Administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration. Such services are reported using codes from the range G0347 to G0354.

Currently, CPT has one code for subcutaneous or intramuscular chemotherapy administration, 96400. For services in 2005, there are new G-codes that uniquely describe the administration of hormonal and nonhormonal anti-neoplastics:

- **G0355**, "Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic;" and
- **G0356**, "Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic." CPT code 96400 is not recognized under the Medicare physician fee schedule in 2005.

The following two CPT codes are still recognized for Medicare purposes in 2005:

2005 Drug Aministration, etc., (continued)

- **CPT Code 96405**, "Chemotherapy administration, intralesional; up to and including 7 lesions;" and
- **CPT Code 96406**, "Chemotherapy administration, intralesional; more than 7 lesions."

The expanded definition of chemotherapy as described above will apply to these codes beginning January 1, 2005.

Currently, CPT has one code for chemotherapy administration with IV push technique, 96408. For services in 2005, there are two new G-codes to report the initial push and additional pushes:

- **G0357**, "Chemotherapy administration, intravenous; push technique, single or initial substance/drug;" and
- **G0358**, "Chemotherapy administration, intravenous; push technique, each additional substance/drug (List separately in addition to code for primary procedure)."

CPT code 96408 is not recognized under the Medicare physician fee schedule in 2005.

For services furnished prior to January 1, 2005, chemotherapy intravenous infusions (other than prolonged infusions, as discussed below) were billed using CPT code 96410 for the first hour and code 96412 for each additional hour. There was not a distinct code to report a sequential chemotherapy infusion involving a different drug.

For services furnished in 2005, chemotherapy intravenous infusions are reported using the following new G-codes, which include a separate code for additional drugs infused:

- **G0359**, "Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug;"
- **G0360**, "Chemotherapy administration, intravenous infusion technique, each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure);" and
- **G0362**, "Chemotherapy administration, intravenous infusion technique; each additional sequential infusion, (different substance/drug) up to one hour (List separately in addition to code for primary procedure)."

Beginning January 1, 2005, under the Medicare physician fee schedule, the following G code should be used instead of code 96414:

- **G0361**, "Chemotherapy administration, intravenous initiation of prolonged chemotherapy infusion (more than eight hours), requiring the use of a portable or implantable pump"

Report **G0360** for infusion intervals of greater than thirty minutes beyond one-hour increments.

Use **G0362** in conjunction with G0359, if appropriate. Report G0362 only once per sequential infusion. Report G0360 for additional hour(s) of sequential infusion.

If a significant separately identifiable E & M service is performed, the appropriate E & M CPT code should be reported utilizing modifier 25 in addition to codes G0355-G0363, 96405-96406, 96420-96520, 96530-96549. For an E & M service provided on the same day, a different diagnosis is not required.

If performed to facilitate the chemotherapy infusion or injection, the following are included and are not reported separately:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes and supplies
- Preparation of chemotherapy agent(s).

For declotting a catheter or port, see CPT code 36550.

Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (e.g., antibiotics, steroidal agents, anti-emetics, narcotics analgesics) administered independently or sequentially as supportive management of chemotherapy administration should be separately reported using G0346, G0348, G0350, G0354, or CPT codes 90783 or 90799 as appropriate.

Report the specific service as well as code(s) for the specific substance or drug(s) provided.

Intra-Arterial Chemotherapy

CPT codes 96420, 96422, 96423, and 96425 are recognized for Medicare purposes in 2005. Report CPT code 96423 for infusion intervals of greater than thirty minutes beyond one-hour increments.

Other Chemotherapy

CPT codes 96440, 96445, 96450, and 96520 are recognized for Medicare purposes in 2005.

Medicare will pay for G0363 Irrigation of implanted venous access device for drug delivery systems if it is the only service provided that day. If there is a visit or other drug administration service provided on the same day, payment for G0363 is included in the payment for the other service.

CPT codes 96530 and 96542 are recognized for Medicare purposes in 2005.

Add-On Codes

Eight of the new drug administration G codes have the following parenthetical descriptor included as a part of the code, "List separately in addition to code for primary procedure." These eight codes are: G0346, G0348, G0349, G0350, G0354, G0358, G0360, and G0362. Each of these codes has a status indicator of "ZZZ" meaning this service is allowed if billed with another drug administration service.

Do not interpret this parenthetical descriptor to mean that the add-on code can be billed only if it is listed with another drug administration primary code. For example, code G0346 ordinarily will be billed with code G0345. However, there may be instances where only the add-on code, G0346, is billed because an "initial" code from another section in the drug administration, instead of G0345, is billed as the primary code.

2005 Drug Aministration, etc., (continued)

Billing of Code 99211

Continue to implement the policy in section 30.5 of chapter 12 of Pub 100-04 with respect to the billing of code 99211 with a nonchemotherapy or chemotherapy drug infusion code. Also apply this policy to 99211 when billed with a diagnostic or therapeutic injection code furnished in 2005.

Table 1: 2005 Drug Administration G Codes

Old Code	New Code	Descriptor	Add-On Code
90780	**G0345**	Intravenous infusion, hydration; initial, up to one hour	
90781	**G0346**	Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for procedure)	Yes
90780	**G0347**	Intravenous infusion, for therapy/diagnosis (specify substance or drug); initial, up to one hour	
90781	**G0348**	Intravenous infusion, for therapy diagnosis (specify substance or drug); each additional hour, up to eight hours (List separately in addition to code for procedure)	Yes
90781	**G0349**	Intravenous infusion, for therapy/diagnosis (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for procedure)	Yes
N/A	**G0350**	Intravenous infusion, for therapy/diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for procedure)	Yes
90782	**G0351**	Therapeutic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	
90784	**G0353**	Therapeutic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	
N/A	**G0354**	Therapeutic or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)	Yes
96400	**G0355**	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal antineoplastic	
96400	**G0356**	Chemotherapy administration, subcutaneous or intramuscular; hormonal antineoplastic	
96408	**G0357**	Chemotherapy administration, intravenous; push technique, single or initial substance/drug	
96408	**G0358**	Chemotherapy administration, intravenous; push technique, each additional substance/drug (List separately in addition to code for primary procedure)	Yes
96410	**G0359**	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug	
96412	**G0360**	Chemotherapy administration, intravenous infusion technique, each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)	Yes
96414	**G0361**	Chemotherapy administration, intravenous initiation of prolonged chemotherapy infusion (more than eight hours), requiring the use of a portable or implantable pump	
96412	**G0362**	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion, (different substance/drug) up to one hour (List separately in addition to code for primary procedure)	Yes
N/A	**G0363**	Irrigation of implanted venous access device for drug delivery systems	

2005 Drug Amination, etc., (continued)

The following codes represent active CPT drug administration codes under the Medicare physician fee schedule in 2005:

- CPT code 90783 and 90788;
- CPT codes 96405 to 96406; and
- CPT codes 96420 to 96520 and 96530 to 96549.

Partial List of Drugs Commonly Considered to Be Monoclonal Antibodies and Hormonal Anti-neoplastics

As noted above, chemotherapy administration codes apply to:

- Parenteral administration of nonradionuclide anti-neoplastic drugs; and
- Anti-neoplastic agents provided for the treatment of noncancer diagnoses (e.g. cyclophosphamide for auto-immune conditions); or
- To substances such as monoclonal antibody agents and other biologic response modifiers.

The following drugs are commonly considered to fall under the category of monoclonal antibodies:

- Infliximab
- Rituximab
- Alemtuzumab
- Gemtuzumab
- Trastuzumab.

Drugs commonly considered to fall under the category of hormonal anti-neoplastics include:

- Leuprolide acetate; and
- Goserelin acetate.

The drugs cited are not intended to be a complete list of drugs that may be administered using the chemotherapy administration codes. Local carriers may provide additional guidance as to which drugs may be considered to be chemotherapy drugs under Medicare.

Implementation

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

Additional Information

To see 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 CR 3631 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Related Change Request (CR) #: 3631	Medlearn Matters Number: MM3631
Related CR Transmittal #: 129	Related CR Release Date: December 10, 2004
Effective Date: January 1, 2005	Implementation Date: January 17, 2005

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January 2005 Quarterly Average Sale Price Medicare Part B Drug Pricing

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

Provider Types Affected

All providers

Provider Action Needed

No provider action is necessary. This article is informational only and explains how Medicare pays for certain drugs that are not paid on a cost or prospective payment basis, effective January 1, 2005.

Background

According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005 drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the average sales price (ASP) plus six percent. The Centers for Medicare & Medicaid Services (CMS) will supply its carriers/intermediaries with the ASP drug-pricing file for Medicare Part B drugs. The ASP is based on quarterly drug information supplied to CMS by drug manufacturers.

Thus, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions

There are exceptions to this general rule, as summarized below:

1. The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
2. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted.

The payment allowance limits will not be updated in 2005.

3. The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
4. The payment allowance limits for drugs not included in the ASP Medicare Part B Drug Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing.

Note that 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. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Implementation

The implementation date is January 3, 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 3539 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.

Related Change Request (CR) Number: 3539
Related CR Release Date: October 29, 2004
Related CR Transmittal Number: 348
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 348, CR 3539

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Drug Administration Coding Changes and Reimbursement

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This article informs physicians, providers, and suppliers that the Centers for Medicare & Medicaid Services (CMS) will implement drug administration coding and payment changes recommended by the American Medical Association's (AMAs) Current Procedural Coding Terminology (CPT) Editorial Panel and Relative Value Update Committee (RUC).

CMS will also provide reimbursement that reflects the additional resource costs of multiple administrations of chemotherapy and non-chemotherapy drugs.

Additionally, this article clarifies billing procedures for services related to management of significant adverse drug reactions related to chemotherapy drugs and treatments.

Background

Creating New Billing Codes for Drug Administration in 2005

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 includes provisions for evaluating drug administration codes used by physicians to bill for administering drugs to patients, and if additional codes for clarifications are needed, the MMA requires a prompt process for adding these new codes.

CMS uses the *American Medical Association's (AMAs) Current Procedural Coding Terminology (CPT*) system for coding of physicians' services. The CPT Editorial Panel established a work group that recently made recommendations to the CPT Editorial Panel to adopt selected new drug administration codes and refined several existing codes.

These new codes, which address concerns that physicians have raised about the drug administration codes, will reflect the additional resources costs associated with infusing a second cancer drug. Also, in 2005, oncologists and other physicians will be able to bill Medicare for more than one administration of both non-chemotherapy and chemotherapy drugs.

Subsequent to the completion of the CPT Editorial Panel's work, the AMA's Relative Value Update Committee (RUC) met to make recommendations to CMS regarding the resource inputs for the new and refined drug administration codes.

CMS will act to implement these new codes beginning January 1, 2005. These new and refined CPT codes will be included in the CPT system and become operational in 2006, and CMS will establish G codes for 2005 to be operational in advance of their formal inclusion in the CPT system.

In addition, CMS plans to use the RUC's recommended values for the new and refined drug administration codes beginning January 1, 2005. The work and practice expense inputs for each of the new drug codes are available at CMS website *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0462.pdf*. Enclosure 1 contains the work Relative Value Units (RVUs), staff time and medical equipment practice expense inputs, and Enclosure 2 contains the medical supplies practice expense inputs for each of the codes.

Clarifying Billing for Managing Significant Adverse Drug Reactions

The CPT Workgroup recommended additional codes to capture services provided by physicians and their staff in conjunction with drug administration. These include physician time required to monitor and attend to patients who develop significant adverse reactions to chemotherapy drugs, or otherwise have complications in the course of chemotherapy treatment.

While the CPT Workgroup recommended new codes to recognize these services, the CPT Editorial Panel believes that existing codes can be used. However, some physicians may not be aware of their ability to bill these services using existing CPT codes, and they are not being appropriately compensated for all the services they provide in conjunction with chemotherapy administration. Physicians can bill existing codes that reflect the time, resources, and complexity of services they and their staff provide for management of significant adverse drug reactions. Note that this is in addition to the billing normally allowed for the physician's care of a cancer patient. The existing codes that can and should be used include the following:

- **Bill for Doctor Visit**. If a patient has a significant adverse reaction to drugs during a chemotherapy session and the physician intervenes, the physician can bill for a visit in addition to the chemotherapy administration services.
- **Bill for Higher Level Doctor Visit**. If the patient had already seen the doctor prior to a chemotherapy session for a problem that is unrelated to the supervision of the administration of chemotherapy drugs, the doctor may bill a visit service for a significant adverse drug reaction. The total time, resources and complexity of the physician's interaction with the patient may justify a higher level of a visit service.
- **Bill for Prolonged Service**. If the patient already had a physician visit prior to the chemotherapy session and experienced a significant adverse reaction to drugs on the same day, the physician can bill a prolonged service code, in addition to the doctor visit. There are several code combinations to use, depending on the number of minutes involved. The physician must have a face-to-face encounter with the patient and must spend at least 30 minutes beyond the threshold or typical time for that level of visit for the physician to bill the prolonged service code.
- **Bill for Critical Care Service**. If the patient already had a physician visit prior to the chemotherapy session and experienced a life-threatening adverse reaction to the drugs, the physician can bill for a critical care service in addition to the visit if the physician's work involves at least 30 minutes of direct face-to-face involvement managing the patient's life-threatening condition. Examples of life threatening conditions are: central nervous failure; circulatory failure; and shock, renal, hepatic, metabolic and/or respiratory failure.

Assuring Accuracy of Drug Payments

CMS is continuing its work to ensure that drug pricing data under the new average sales price (ASP) system are accurate, and CMS published first-quarter ASP data for the drugs that make up over 70 percent of oncology drug expenses.

CMS revised the method manufacturers used to apply rebates and discounts in order to make the ASP prices more accurate and is awaiting the independent report from the Government Accountability Office (GAO) on the adequacy of Medicare payments for drugs under the ASP system.

CMS is also considering a number of interesting comments about payment for cancer care that were submitted on the physician fee schedule proposed rule. CMS is considering these comments carefully and will announce its decisions in the final rule in the beginning of November. CMS plans to continue to work with oncology groups to identify ways in which oncology practices, particularly small practices and practices in relatively rural areas, can obtain the most favorable drug prices possible and is taking these steps now to allow the maximum time possible for oncology practices to plan for 2005.

Additional Information

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.

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

Source: CMS Special Edition Medlearn Matters SE0462

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CONSOLIDATED BILLING

Annual Update of HCPCS Codes Used for Home Health (HH) Consolidated Billing Enforcement

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

Provider Types Affected

Physicians, providers, home health agencies (HHAs), and suppliers

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2005. Affected providers should be aware of these changes.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the HHA. As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes.

With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA).

Medicare periodically publishes routine update notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Additional Information

This notification provides the annual HH consolidated billing update effective January 1, 2005. The following table describes the HCPCS codes and the specific changes to each that this notification is implementing on January 3, 2005:

Code	Description of Code	Type Change	Replacement Code or Code Being Replaced
Non-Routine Supplies			
A4347	Male external catheter	Delete	Replacement code: A4349
A4324	Male ext cath w/adh coating	Delete	Replacement code: A4349
A4325	Male ext cath w/adh strip	Delete	Replacement code: A4349
A4349	Male ext catheter, with or without adhesive, disposable, each	Add	Replaces codes: A4347, A4324, A4325
A7040	One way chest drain valve	Add	
A7041	Water seal drainage container and tubing for use with implanted chest tube	Add	
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	Add	
A7527	Tracheostomy/laryngectomy tube plug/stop, each	Add	
Therapies			
97601	Wound care selective	Delete	Replacement codes: 97597, 97598
97597	removal of devitalized tissue from wound(s), selective debridement; surface area less than or equal to 20 square centimeters	Add	Replaces code: 97601
97598	removal of devitalized tissue from wound(s), selective debridement; total wound(s) surface area greater than 20 square centimeters	Add	Replaces code: 97601
97605	Negative pressure wound therapy (eg. vacuum assisted drainage collection); total wound(s) surface area less than or equal to 50 square centimeters	Add	
97606	Negative pressure wound therapy (eg. vacuum assisted drainage collection); total wound(s) surface area greater than 50 square centimeters	Add	

The last update to the HH consolidated billing was issued under Transmittal 226, CR 3350. This CR can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R226CP.pdf*

The official instruction issued to your carrier/intermediary (including Durable Medical Equipment Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs)) 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 3525 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/intermediary at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*

Related Change Request (CR) #: 3525
Medlearn Matters Number: MM3525
Related CR Release Date: October 29, 2004
Related CR Transmittal #: 340
Effective Date: January 1, 2005
Implementation Date: January 3, 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.

2005 Annual Update for Skilled Nursing Facility Consolidated Billing for the Common Working File and Medicare Carriers

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

Provider Types Affected

Skilled Nursing Facilities (SNFs)

Provider Action Needed

STOP – Impact to You

The 2005 update for SNF consolidated billing (CB) is available. These codes are used in applying the SNF CB edits that only allow services that are excluded from CB to be separately paid by Medicare carriers.

CAUTION – What You Need to Know

These new code files are posted to the Centers for Medicare & Medicaid Services (CMS) website at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*

GO – What You Need to Do

The edits for claims received for beneficiaries in both Part A SNF stays and covered and non-covered Part A SNF stays allow services that are excluded from consolidated billing to be separately paid by the carrier.

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/R328CP.pdf*

For additional information relating to this issue, 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) #: 3535
Medlearn Matters Number: MM3535
Related CR Release Date: October 22, 2005
Related CR Transmittal #: 328
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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Skilled Nursing Facility (SNF) Consolidated Billing Service Furnished Under an "Arrangement" with an Outside Entity

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

Provider Types Affected

Any physician, provider or supplier who renders a Medicare-covered service subject to consolidated billing to a SNF resident.

Provider Action Needed

No provider action is necessary. This article is informational only and clarifies the instruction contained in CR 3248, issued on May 21, 2004. It explains that an "arrangement" between a Medicare skilled nursing facility (SNF) and its supplier is validated not by the presence of specific supporting written documentation but rather by their actual compliance with the requirements governing such "arrangements." However, supporting written documentation delineating the "arranged-for" services for which the SNF assumes responsibility and the manner in which the SNF will pay the outside entity for those services can help the parties arrive at a mutual understanding on these points.

Background

Under the SNF consolidated billing provisions of the Social Security Act (the Act) the Medicare billing responsibility is placed with the SNF itself for most of its residents' services. (See sections 1862(a)(18), 1866(a)(1)(H)(ii), and 1888(e)(2)(A)). The SNF must include on its Part A bill submission to its Medicare intermediary almost all of the services a resident receives during a covered stay, excluding those services which are not covered under the SNF's global prospective payment system (PPS) per diem payment for the particular stay.

These excluded services (e.g., those provided by physicians and certain other practitioners) continue to be separately billable to Part B directly to the Medicare carrier by those "outside entities" that actually provide the service. Also, Part B consolidated billing makes the SNF itself responsible for the submission of Part B bills for any *physical, occupational or speech-language therapy services* received by a resident during a *non-covered* stay.

In addition, the SNF must provide any Part A or Part B service that is subject to SNF consolidated billing either directly with its own resources or through an outside entity (e.g., a supplier) under an "arrangement," as set forth in Section 1861(w) of the Act. If an outside entity provides a Medicare-covered service that is subject to SNF consolidated billing to a SNF resident during a covered stay, the outside entity must look to the SNF for payment (rather than billing their carrier under Part B). The reason is because under an arrangement, Medicare's payment to the SNF represents payment in full for the arranged-for service, and the SNF in turn is responsible for making payment to outside entities if the service provided is subject to the SNF's global prospective payment system (PPS) per diem payment.

Problem Situations

Since the start of the SNF PPS, problematic situations have arisen when the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. These problems are usually connected with either of two scenarios, namely:

- An SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier or practitioner; or
- A supplier fails to ascertain a beneficiary's status as an SNF resident when the beneficiary (or other individual acting on behalf of the beneficiary) seeks to obtain such services directly from the supplier without the SNF's knowledge.

Documenting Arrangements

SNFs should document, in writing, arrangements with suppliers that render services on an ongoing basis (e.g., pharmacies, laboratories and x-ray suppliers). Documentation of a valid arrangement, including mutually agreeable terms, should help to avoid confusion and friction between SNFs and their suppliers. Suppliers need to know which services fall under the consolidated billing provisions so they do not improperly bill Medicare carriers under Part B or other payers (like Medicaid and beneficiaries) directly for services.

It is also important that when ordering or providing services "under arrangement," the parties reach a mutual understanding of all the payment terms, e.g., how to submit an invoice, how payment rates are determined, and the "wait" time between billing and payment.

SNF's Responsibility

However, the absence of a valid arrangement (written or not) does not nullify the SNF's responsibility to pay suppliers for services "bundled" in the SNF PPS global per diem rate. The SNF must be considered the responsible party (even in cases where it did not specifically order the service) when beneficiaries in Medicare Part A stays receive medically necessary supplier services, because the SNF has already been paid under the SNF PPS. Examples of this obligation occur when:

- The physician performs additional diagnostic tests during a scheduled visit that had not been ordered by the SNF; or
- A family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for "incident to" services.

Establishing a valid arrangement prior to ordering services from a supplier minimizes the likelihood of a payment dispute between the parties. However, occasional disagreements between the parties that result in non-payment of a supplier claim may occur. When patterns of such denials are identified, there are potentially adverse consequences to SNFs. The reason is because all SNFs, under the terms of their Medicare provider agreement, must comply with program regulations. These regulations require a valid arrangement to be in place between the SNF and any outside entity providing resident services subject to consolidated billing. Moreover, in receiving a bundled per-diem payment under the SNF PPS that includes such services, the SNF is accepting Medicare payment and financial responsibility for the service.

Under section 1862(a)(18) of the act, there is no valid "arrangement" if a SNF obtains services subject to consolidated billing from an outside supplier but refuses to pay the supplier for said services. This situation could result in the following consequences:

- The SNF is found in violation of the terms of its provider agreement; and/or
- Medicare does not cover the particular services at issue.

The SNF's provider agreement includes a section requiring a specific commitment to comply with the requirements of the consolidated billing provision (see section 1866(a)(1)(H)(ii) of the act and the regulations at 42 CFR 489.20(s)). Also section 1866(g) of the act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

Additional Guidance

In the absence of a valid "arrangement" between a SNF and its supplier, the problems that arise tend to fall into one of the following problem scenarios.

Problem Scenario 1

A SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay. This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing.

Based on the inaccurate impression that the resident's SNF stay is non-covered, the supplier inappropriately submits a separate Part B claim for the service and may also improperly bill other insurers and the resident. Then the supplier only learns of the actual status of the resident's Medicare-covered SNF stay when that Part B claim is denied.

In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary's status as an SNF resident and the specific nature of the beneficiary's SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

The Centers for Medicare & Medicaid Services (CMS) realizes that unintentional mistakes occasionally may occur when furnishing such information. However, the SNF is responsible for making a good faith effort to provide accurate information to its supplier and to pay the supplier once the error is pointed out. If in scenario 1 above the SNF refuses to pay the supplier even after the accuracy of its initial information is called to its attention, the SNF would risk being in violation of its provider agreement by not complying with consolidated billing requirements. As stated previously, supporting written documentation for the disputed service would provide a basis for resolving the dispute and aid in ensuring compliance with the consolidated billing requirements.

By making sure that it sends accurate and timely information to its supplier regarding a resident's covered stay, the SNF can often prevent disputes such as those described in Scenario 1 from arising. The communication of accurate and timely resident information by the SNF to the supplier is especially important when a portion of an otherwise "bundled" service remains separately billable to Part B (e.g., the professional component representing a physician's interpretation of an otherwise "bundled" diagnostic test).

Problem Scenario 2

> A resident temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF. The SNF refuses to pay for the offsite services and the supplier bills the beneficiary/family member directly.

As in the previous scenario, the SNF remains responsible for any services included in the SNF "bundle" of services subject to consolidated billing that are furnished to the resident by an outside entity, *even in the absence of a valid arrangement with the SNF.*

The SNF can take steps to prevent problems like this from occurring by making sure that the resident or his/her representative fully understands the applicable requirements. For example, under Section 1802 of the Act, Medicare law guarantees to a beneficiary the right to choose any qualified entity willing to provide services to him/her. By selecting a particular SNF, the beneficiary has in effect exercised this right of choice regarding the entire array of services for which the SNF is responsible under the consolidated billing requirement and agrees to use only those outside suppliers that the CNF selects or approves to provide services.

The staff of the SNF should explain these rights and requirements to the beneficiary and his/her family members or representative(s) during the admission process, periodically throughout each resident's stay, and upon the resident's temporarily leaving the facility.

The supplier in this scenario also retains responsibility for preventing problems from arising by understanding and complying with the consolidated billing requirements. Therefore, before providing beneficiary services, the supplier should determine whether that beneficiary currently receives any comprehensive Medicare benefits (e.g., SNF or home health), which could include the supplier's services. If the beneficiary is a resident of an SNF with which the supplier does not have a valid "arrangement," the supplier should consult with the SNF before actually furnishing any services, which may be subject to the consolidated billing provision. Further, the supplier should know that the beneficiary cannot be charged for the bundled service in accordance with the regulations at 42 CFR 489.21(h).

Additional Information

The Medicare Claims Processing Manual has been revised to include language reflecting this clarification.

That revision is attached to the official instruction issued to your carrier/intermediary regarding this change.

The official instruction may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R412CP.pdf*.

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

Related Change Request (CR) #: 3592
Medlearn Matters Number: MM3592
Related CR Release Date: December 23, 2004
Related CR Transmittal #: 412
Effective Date: May 21, 2004
Implementation Date: January 24, 2005

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Annual Update of Healthcare Common Procedure Coding System Codes Used for Skilled Nursing Facility Consolidated Billing

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

Provider Types Affected

Skilled Nursing Facilities, physicians, providers, and suppliers

Provider Action Needed

Affected providers should note that this article and the related CR3542 contain the annual update of HCPCS codes used for SNF CB. It provides an updated list of exclusions and some inclusions to SNF CB, and only applies to codes affected by Medicare Fiscal Intermediary (FI) claims processing.

Background

The Social Security Act (Section 1888) codifies SNF prospective payment system (PPS) and consolidated billing (CB). 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. The 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.

This notification provides a list of the exclusions, and some inclusions, to SNF CB, and applies only to codes affected by Medicare FI claims processing.

A separate notification is published for codes affected by Medicare carrier claims processing.

2005 Annual Update

CR3542 is the 2005 annual update in the routine and comprehensive process that the Centers for Medicare & Medicaid Services (CMS) has established for updating SNF CB edits affected by HCPCS coding changes in each quarter.

It is the first quarterly SNF CB update for Fiscal Year (FY) 2005, and it incorporates a list of new temporary codes (such as K codes, if applicable), as well as the annual update of all HCPCS codes.

Since this is the only quarter in which new permanent HCPCS codes are produced, the instruction is referred to as an annual update. Other updates for the remaining quarters of the FY will occur **as needed** due to the creation of new temporary codes prior to the next annual update. In lieu of any other update, editing based on these codes remains in effect.

In several past instructions, the (CMS) established the process of periodically updating the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. Services that appear on this list of HCPCS codes submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers (including durable medical equipment regional carriers (DMERCs)) will not be paid by Medicare to providers, other than a SNF, when **included** in SNF CB.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech language pathology services whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay.

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

Note: A revised SNF Help File, separate from the code list, is not included in CR3542. The Help File provides billing guidance only to FIs, SNFs, and suppliers on HCPCS codes. It includes codes affected by SNF CB and many other codes, and it will be updated from the current version separately after release of this notification with the new code list.

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

The official instruction issued to your intermediary contains a comprehensive list of HCPCS codes involved in editing claims submitted to FIs for services subject to SNF consolidated billing (CB).

In that list, new codes listed subsequent to prior publications appear in bold in HCPCS code charts, and boldface is also used outside of the code charts in cases as noted when type of bill (i.e., bill type) or revenue codes, rather than HCPCS codes, are used to perform editing. Bolding is also used to highlight titles, captions, and other billing information for SNFs. Codes from previous lists not appearing have been deleted. For complete details and to see the comprehensive list, 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 CR3542 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*

Related Change Request (CR) #: 3542
Medlearn Matters Number: MM3542
Related CR Release Date: November 5, 2004
Related CR Transmittal #: 360
Effective Date: January 1, 2005 (for services provided on or after that date)
Implementation Date: January 3, 2005

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Correction to January 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

Skilled nursing facility (SNF) and ambulance suppliers billing Medicare carriers or intermediaries for patients in a SNF stay

Provider Action Needed

STOP – Impact to You

Transmittal 360 (CR 3542) of the Medicare Claims Processing Manual (published on November 5, 2004) was the 2005 skilled nursing facility annual update. CR 3613 provides a correction to the annual SNF CB update for calendar year 2005 by adding one code under major category I.H. (Ambulance Services) that was inadvertently omitted, namely A0999 – unlisted ambulance service.

CAUTION – What You Need to Know

HCPCS 53660, 95974, and G0168 had been reported twice in major category I.F. – this duplication of codes has also been corrected.

GO – What You Need to Do

To ensure accurate claims processing, please review the information included here and stay current with instructions for SNF CB.

Additional Information

The official instruction issued regarding this change can be found at:
http://www.cms.hhs.gov/manuals/pm_trans/R421CP.pdf.

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

Related Change Request (CR) #: 3613
Medlearn Matters Number: MM3613
Related CR Release Date: December 30, 2004
Related CR Transmittal #: 421
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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LABORATORY

Emergency Change to Carrier Instructions for the End Stage Renal Disease (ESRD) 50/50 Rule Implementation

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

Provider Types Affected

Physicians and suppliers billing Medicare Part B carriers for automated multi-channel chemistry test(s)

Provider Action Needed

Physicians and suppliers should note that this article reflects an update to *change request (CR) 2813, end stage renal disease (ESRD) reimbursement for automated multi-channel chemistry test(s) (ACC).* In CR2813, the Centers for Medicare & Medicaid Services (CMS) directed Medicare carriers to implement certain changes to enable full implementation, on January 2005, of new guidelines to enforce the "ESRD 50/50" rule related to payment policy for ESRD-related AMCC tests.

This article and the related CR 3609 notifies carriers to discontinue the implementation of the business requirements associated with CR 2813 until further notice. Those who bill carriers for such tests are also hereby notified of this delay.

Background

ESRD 50/50 Rule

The Office of Inspector General (OIG) conducted several audits and concluded that Medicare payments for ESRD-related automated multi-channel chemistry (AMCC) tests were not in compliance with CMS payment policy for these services (i.e., the ESRD 50/50 rule). In response to the OIG report findings, CMS issued instructions (CR 2277 and CR 3239) to Medicare carriers regarding procedures to enforce compliance with the payment policy for ESRD-related AMCC Tests (i.e., the ESRD 50/50 rule).

The ESRD 50/50 rule requires the billing laboratory to maintain a count of AMCC tests ordered to track the number of tests included in the composite payment rate paid to the ESRD facility, or the monthly capitation payment made to the furnishing physician, versus the number of covered non-composite tests performed for the same beneficiary on the same date of service.

The proportion of composite versus non-composite tests calculated by the billing laboratory is used to determine whether separate payment may be made for all tests performed on that day.

50/50 Rule Implementation, (continued)

In *change request (CR) 2813, end stage renal disease (ESRD) reimbursement for automated multi-channel chemistry test(s)*, CMS directed Medicare carriers to make the necessary systems changes to implement front-end edits in preparation for the standard system implementation of CR 2813 in the January 2005 release.

Further, in *CR 3501, release medlearn article for change request (CR) 2813 (end stage renal disease reimbursement for automated multi-channel chemistry test(s)*, CMS authorized carriers to do the following:

- Post a provider education article related to CR 2813 on the CMS Medlearn Matters web site.
- Supplement CR 2813 with any localized information that would benefit the provider community in implementing the new billing procedures.

Implementation of Billing Procedures and Guidelines

Since the release of CR 2813, CMS has met with members of the laboratory industry to discuss:

1) The ESRD 50/50 rule; and
2) The changes to current billing procedures that would be necessary to be compliant with this policy.

Subsequently, CMS has learned that the industry may not be ready to implement these new guidelines by January 2005, because of:

- The complexity of systems changes needed to implement the billing procedures specified in CR 2813; and
- The delay in releasing these guidelines to the industry until the publication of CR 3501 in October 2004.

For these reasons, CMS:

- Will not require suppliers to bill for ESRD-related AMCC tests in accordance with CR 2813 at this time; and
- Is reevaluating the carrier implementation strategy for the "ESRD 50/50" rule compliance guidelines.

Instructions for Carriers

CR 3609 instructs carriers to do the following until further notice:

- Discontinue the implementation of the business requirements associated with CR 2813.
- Remove modifiers CD, CE, and CF from the local carrier modifier table by December 31, 2004.
- Continue to follow existing guidelines for processing claims for ESRD AMCC tests and making payment determinations for these services.
- Continue to reject the line item(s) on a claim for an ESRD AMCC test(s) when submitted with a modifier CD, CE, or CF.

CR 3609:

- Pertains only to the carrier changes associated with the implementation of CR 2813.
- Does not apply to the intermediaries or to the providers that bill intermediaries.

Intermediaries and providers who submit claims to intermediaries should continue to follow the existing guidelines for billing ESRD-related AMCC tests, in accordance with CR 3239 and CR 2277.

CMS will provide further direction to the carriers concerning the carrier implementation of the ESRD 50/50 rule compliance guidelines in a future CR.

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at:
http://www.cms.hhs.gov/manuals/pm_trans/R405CP.pdf

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

Related Change Request (CR) #: 3609
Medlearn Matters Number: MM3609
Related CR Release Date: December 17, 2004
Related CR Transmittal #: 405
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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Routine Venipuncture

For 2005, the clinical laboratory fee schedule will not include code G0001 and will include code 36415 Collection of venous blood by venipuncture. Procedure 36415 was released as not payable by Medicare in the 2005 HCPCS update file. However, code 36415 has now been activated to be payable by Medicare effective January 1, 2005. Thus, the HCPCS coverage indicator should be corrected to "C". The status indicator for OPPS should be "A". CPT code 36416 relating to a capillary specimen collection remains not payable by Medicare as a separate service.

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

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2005

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

Provider Types Affected

Clinical diagnostic laboratories

Provider Action Needed

CR 3429 announces changes to the list of codes associated with the 23 negotiated laboratory national coverage determinations (NCDs). These changes are:

- A result of coding analysis completed by the Centers for Medicare & Medicaid Services (CMS); and
- Necessary to implement the cardiovascular and diabetes screening benefits added to Medicare under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Also, nationally uniform software was developed by Computer Sciences Corporation and incorporated into the shared systems so that laboratory claims subject to any of the 23 NCDs are processed uniformly throughout the nation, effective January 1, 2003.

In addition, the laboratory edit module for the NCDs is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. (See the Medicare Claims Processing Manual, Pub. 100-4, Chapter 16, Section 120.2.)

CR 3429 announces changes that will be included in the January 2005 release of the edit module for clinical diagnostic laboratory services.

In accordance with the coding analysis published on the coverage internet site on July 26, 2004, CMS is implementing the following:

- For the urine culture and serum iron studies NCD, CMS is deleting the following ICD-9-CM code from the list of ICD-9-CM codes covered by Medicare: V72.84 (Pre-operative examination, unspecified).

Coverage for this code will terminate for services furnished on or after January 1, 2005. See: *http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=127*

In accordance with the coding analysis published on the coverage Internet site on July 27, 2004, CMS is implementing the following changes:

- For the tumor antigen by immunoassay CA 125 NCD, CMS is adding the following ICD-9-CM diagnosis codes to the list of ICD-9-CM codes covered by Medicare:
- V10.41 (Personal history of malignant neoplasm, cervix uteri); and
- V10.42 (Personal history of malignant neoplasm, other parts of uterus).

Coverage for these codes will begin for services furnished on or after January 1, 2005. See: *http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=132*

In accordance with the coding analysis published on the coverage Internet site on July 28, 2004, CMS is implementing the following change:

- For the Prothrombin Time (PT) test NCD, CMS is removing the following ICD-9-CM diagnosis code from the list of ICD-9-CM codes covered by Medicare: V43.60 **(**Unspecified joint replaced by other means).

Coverage for this code will terminate for services furnished on or after January 1. See: *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=131*

To accommodate the new cardiovascular and diabetes screening benefits that were added to Medicare by the MMA, CMS is removing the following ICD-9-CM codes from the list of ICD-9-CM codes not covered by Medicare:

- V77.1 (Screening for Diabetes Mellitus);
- V81.0 (Screening for ischemic heart disease);
- V81.1 (Screening for hypertension); and
- V81.2 (Screening for other unspecified cardiovascular conditions).

In order to implement the new cardiovascular and diabetes screening benefits that were added to Medicare by the MMA, CMS is making the following changes.

The lipid NCD edit is being subdivided into two parts:

1. For Current Procedural Terminology (CPT) codes 80061 (lipid panel), 82465 (cholesterol, serum total), 83718 (lipoprotein, direct, HDL), and 84478 (triglycerides), CMS is adding the following ICD-9-CM diagnosis codes to the list of ICD-9-CM codes covered by Medicare:

   - V81.0 (Screening for ischemic heart disease);

- V81.1 (Screening for hypertension); and
- V81.2 (Screening for other unspecified cardiovascularcConditions).

2. The covered codes list for the remaining CPT codes in the lipid NCD (83715 [lipoprotein, blood: electrophoretic separation and quantitation]), 83716 (High resolution fractionation and quantitation of lipoprotein cholesterols), and 83721 (direct measurement, LDL cholesterol)) remain unchanged.

For the diabetes benefit, the blood glucose NCD edit is being subdivided into two parts.

1. For CPT code 82947, CMS is adding the following ICD-9-CM diagnosis code to the list of ICD-9-CM diagnosis codes covered by Medicare: V77.1 (Screening for diabetes mellitus).
2. The covered codes for the remaining CPT codes in the blood glucose NCD (82948 (Glucose, blood, strip) and 82962 (Glucose (monitors)) remain unchanged.

Please note that, effective October 1, 2003, all claims for clinical diagnostic laboratory services submitted to Medicare must include ICD-9-CM diagnosis codes. coding guideline #1 of the laboratory NCDs has been amended to reflect this requirement and the guideline now states that "Any claim for a clinical diagnostic laboratory service must be submitted with an ICD-9-CM diagnosis code. Codes that describe symptoms and signs, as opposed to diagnosis, should be provided for reporting purposes when a diagnosis has not been established by the physician."

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

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

From that web page, look for CR 3429 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3429
Medlearn Matters Number: MM3429
Related CR Release Date: November 26, 2004
Related CR Transmittal #: 380
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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Independent Laboratory Billing for the Technical Component of Physician Pathology Services to Hospital Patients

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

Provider Types Affected

Independent laboratories

Provider Action Needed

This instruction implements section 732 of the Medicare Modernization Act (MMA) that extends the provision of Section 542 of Benefits Improvement Protection Act of 2000 (BIPA) for services furnished in 2005 and 2006. Section 542 of BIPA allows the carrier to continue to pay independent laboratories under the physician fee schedule for the technical component of physician pathology services furnished to patients of a covered hospital.

Background

In the final physician fee schedule rule published in the Federal Register on November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated that it would implement a policy to pay only hospitals for the technical component (TC) of physician pathology services furnished to hospital inpatients. Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services provided for a hospital inpatient.

The regulation provided that (for services furnished on or after January 1, 2001) a carrier would no longer pay claims to the independent laboratory under the physician fee schedule for the TC of physician pathology services for hospital inpatients. Similar treatment was provided under the outpatient prospective payment system for the TC of physician pathology services to hospital outpatients. This change was to take effect for services furnished on or after January 1, 2001. The delay was intended to allow independent laboratories and hospitals sufficient time to negotiate arrangements.

However, Section 542 of BIPA provided that Medicare carriers could continue to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital. The BIPA-542 provision applied only to services furnished during 2001 and 2002.

For this provision, covered hospital means a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which the laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and the laboratory submitted claims for payment for the TC service to a carrier. The TC could have been submitted separately or combined with the professional component and reported as a combined service.

Section 732 of the MMA extends the BIPA-542 provision for services furnished during 2005 and 2006. Your carrier will require independent laboratories that had an arrangement on or prior to July 22, 1999 with a covered hospital to bill for

these services to provide a copy of this agreement or other documentation substantiating that an arrangement was in effect between the hospital and independent laboratory as of that date.

However, note that carriers will return claims for the TC of physician pathology services as unprocessable when submitted by those independent laboratories that did not have an arrangement established with a covered hospital on or prior to July 22, 1999, to bill for these services under the Medicare Physician Fee Schedule.

Implementation

The implementation date for this instruction is January 3, 2005.

Related Instructions

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 12 (Physician/Practitioner Billing) has been revised to reflect the changes in this CR.

The updated manual instructions are attached to the official instruction released to your carrier. 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 CR3467 in the CR NUM column on the right, and click on the file for that CR.

Additional Information

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

Related Change Request (CR) #: 3467
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PREVENTATIVE SERVICES

Initial Preventive Physical Examination

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

STOP – Impact to You

Effective for dates of service on or after January 1, 2005, Section 611 of the Medicare modernization act provides for coverage under Part B of an initial preventive physical examination (IPPE) for new Medicare beneficiaries, but only if the beneficiary's eligibility also begins on or after January 1, 2005

CAUTION – What You Need to Know

This new benefit is subject to certain eligibility and other limitations as described in this article.

GO – What You Need to Do

Understand the new rules for providing this important new benefit to ensure prompt and accurate payment for services.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA Section 611) provides for coverage under Medicare Part B of an initial preventive physical examination (IPPE), including a screening electrocardiogram (EKG) for new beneficiaries (subject to certain eligibility and other limitations) effective for services furnished on or after January 1, 2005.

In addition, pursuant to final regulations published on November 15, 2004 (42 CFR 410.16, added by 69 FR 66236, 66420) CMS amended 42 CFR sections 411.15 (a)(1) and 411.15 (k)(11) to allow payment for an IPPE not later than 6 months after the date the beneficiary's first coverage period begins under Medicare Part B.

This physical examination is a once-a-lifetime benefit for a beneficiary and it must be performed within six months after the effective date of the beneficiary's first Part B coverage, but only if such Part B coverage begins on or after January 1, 2005. A physical examination given on January 10, 2005, for example, to a beneficiary whose Medicare Part B was effective initially on December 1, 2004 would not be covered under this benefit. If a beneficiary is first covered by Part B on January 1, 2005, then a physical provided on January 10, 2005 would be covered by this new benefit.

This provision provides for payment for an IPPE examination to be performed in various provider settings by:

- Physicians, or
- Qualified non-physician practitioners (NPPs).

Services Included in the Initial Examination

The initial examination means all of the following services:

- Review of an individual's medical and social history, with attention to modifiable risk factors for disease detection, including past medical and surgical history, such as experiences with illnesses, hospital stays, operations, allergies, injuries and treatments, current medication and supplements, family history (including diseases that may be hereditary or place the individual at risk), history of alcohol, tobacco, and illicit drug use, diet, and physical activities;
- Review of an individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified NPP may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations;
- Review of the individual's functional ability and level of safety based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations, including, at a minimum, a review of hearing impairment, activities of daily living, falls risk, and home safety;
- An examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's medical and social history (refer to service element 1) and current clinical standards;\
- Performance and interpretation of an EKG;
- Education, counseling, and referral as deemed appropriate by the physician or qualified NPP, based on the results of the review and evaluation services described in the previous five elements;
- Education, counseling, and referral, including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are covered separately under Medicare Part B. These include: (1) pneumococcal, influenza, and hepatitis B vaccines and their administration; (2) screening mammography; (3) screening pap smear and screening pelvic examinations; (4) prostate cancer screening tests; (5) colorectal cancer screening tests; (6) diabetes outpatient self-management training services; (7) bone mass measurements; (8) screening for glaucoma; (9) medical nutrition therapy for individuals with diabetes or renal disease; (10) cardiovascular screening blood tests; and (11) diabetes screening tests.

A new healthcare common procedure coding system (HCPCS) code, G0344 (IPPE; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment), will be used for billing the IPPE. As required by statute, this benefit always includes a screening EKG, which should be billed appropriately using new HCPCS codes G0366 (Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report) for the full EKG service; G0367 (tracing only, without interpretation and report; performed as a component of the initial preventive examination) when only the tracing is performed; and G0368 (interpretation and report only, performed as a component of the initial preventive examination) when only the interpretation and report are performed. These three codes reflect the global, technical, and professional components of the screening EKG, respectively.

If the primary physician or qualified NPP does not perform the EKG during the IPPE visit, another physician or entity may perform and/or interpret the EKG. But, the referring provider must ensure that the performing provider bills the appropriate G code for the screening EKG and **not a CPT code** in the 93000 series.

Physicians and qualified NPPs should bill G0366 for the full EKG service (tracing, interpretation, and report), or G0367 when only the tracing is performed, or G0368 when only the interpretation or reporting is performed. Hospitals can only perform the EKG tracing, so they should bill G0367 when they perform the tracing component of the EKG.

While some components for a medically necessary evaluation and management (E/M) service will be reflected in the new HCPCS code of G0344, Medicare will, when it is clinically appropriate, allow payment for a medically necessary E/M service (CPT codes 99201-99215) at the same visit as the IPPE. That portion of the visit must be medically necessary to treat the patient's illness or injury or to improve the function of a malformed body member and will be reported with modifier –25.

A physician or qualified NPP, in various provider settings, may bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of section 1861 of the act, if provided during this IPPE.

The MMA did not make any provision for the waiver of Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be applied to the required deductible, which is $110 for calendar year 2005, if the deductible has not been met, with the exception of federally qualified health centers (FQHCs), and the usual coinsurance provisions would apply.

Special Instructions for Rural Health Clinics (RHCs)/FQHCs

- RHCs/FQHCs should follow normal procedures for billing for RHC/FQHC services. Payment for the professional services will be made under the all-inclusive rate and the payment should be requested on a type of bill 71x (RHC) or 73x (FQHC) with revenue code 052x. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit.
- Medicare will pay for the technical component of the IPPE EKG performed in provider-based RHCs/FQHCs when billed under the base provider's number using the above requirements for that particular base provider type. Medicare will pay for the technical component of the IPPE EKG performed in independent RHCs/FQHCs when billed by the practitioner to its carrier, when billed in accordance with the information provided in this article for practitioners.

Maryland Hospitals

Maryland hospitals will be paid for an IPPE, on both an inpatient and an outpatient basis, in accordance with the Maryland State Cost Containment Plan.

Critical Access Hospitals (CAHs)

CAHs billing on type of bill 85x will be paid on a reasonable cost basis for the IPPEs and the EKGs.

Indian Health Service (IHS) Hospitals

IHS hospitals will be paid on the all-inclusive rate for the IPPE and/or EKG and should bill using type of bill 13x with revenue code 051x.

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

Chapter 18, Section 80 (Initial Preventive Physical Examination), and Chapter 12, Section 30.6.1.1 (Initial Preventive Physical Examination) of the Medicare Claims Processing Manual (Pub 100-04) are new and included in the official instruction issued to your carrier/intermediary. That official instruction can be found by going to:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3638 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 or intermediary at their toll-free number, which may be found at:

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

Related Change Request (CR) #: 3638
Medlearn Matters Number: MM3638
Related CR Release Date: December 22, 2004
Related CR Transmittal #: 417
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Cardiovascular Screening Blood Tests

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

The information in this article provides guidance for the new national coverage policy related to cardiovascular screening tests covered, effective for services performed on or after January 1, 2005.

Background

In accordance with Section 612 of the Medicare Modernization Act (MMA), Medicare coverage is provided for cardiovascular screening blood tests (tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for that disease) effective for services performed on or after January 1, 2005.

The MMA permits coverage of tests for cholesterol and other lipid or triglycerides levels for this purpose. Therefore, effective January 1, 2005, coverage is provided for the following:

- Total cholesterol test
- Cholesterol test for high density lipoproteins
- Triglycerides test

Effective, January 1, 2005, Medicare provides coverage for the cardiovascular screening blood test for beneficiaries every five years (i.e., 59 months after the last covered screening tests.) Medicare has determined that it is not necessary to test more frequently since lipid and cholesterol levels for people often stay fairly consistent beyond age 65.

Medicare Part B covers cardiovascular screening blood tests when ordered by the physician who is treating the beneficiary for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms.

The implementation of this new benefit permits Medicare beneficiaries who have not been previously diagnosed with cardiovascular disease to receive cardiovascular screening blood tests for risk factors associated with cardiovascular disease. This includes individuals who have no prior knowledge of heart problems but recognize that their behavior or lifestyle may be at risk because of diet or lack of exercise.

Payment is provided under the Medicare clinical laboratory fee schedule. There is no deductible or copayment for this benefit.

HCPCS/CPT Codes/Diagnosis Codes

The following HCPCS/*CPT* Codes are to be billed for the cardiovascular screening blood tests:

80061 *Lipid panel*
82465 *Cholesterol, serum, or whole blood, total*
83718 *Lipoprotein, direct measurement; high-density cholesterol*
84478 *Triglycerides*

(The tests should be performed as a panel; however, they are also available as individual tests.) The following diagnosis codes must be submitted on the claim for when billing for cardiovascular screening blood test:

V81.0 Special Screening for ischemic heart disease
V81.1 Special Screening for hypertension
V81.2 Special Screening for other and unspecified cardiovascular conditions

Medicare will pay for cardiovascular disease screening under the Medicare clinical laboratory fee schedule. Providers and suppliers that bill for the cardiovascular disease screening benefit must point the screening diagnosis (V81.0, V81.1, V81.2) to the line item service.

Other cardiovascular screening blood tests (for which CMS has not specifically indicated approval for national coverage) continue to be non-covered.

How Intermediaries and Carriers Will Treat Claims

Medicare intermediaries and carriers will treat claims as follows:

- Intermediaries/carriers will accept claims with *CPT* codes *80061* (Lipid panel), *82465* (Cholesterol, serum or whole blood, total), *83718* (Lipoprotein, direct measurement; high density cholesterol, HDL Cholesterol), or *84478* (Triglycerides) when there is a reported diagnosis of V81.0 (Special screening for ischemic heart disease), V81.1 (Special screening for hypertension), or V81.2 (Special screening for other and unspecified cardiovascular conditions).
- Intermediaries/carriers will deny claims with code *80061* when there is already evidence of a paid claim within the prior 60 months that was billed with a diagnosis code of V81.0, V81.1, or V81.2, and with a procedure code of *80061, 82465, 83718,* or *84478.*
- Intermediaries/carriers will deny claims with procedure codes of *82465, 83718,* or *84478* when billed within 60 months of a previous paid claim with a diagnosis code of V81.0, V81.1, 0r V81.2 and a procedure code of *80061*.

Additional Information

The Medicare Claims Processing Manual, Chapter 18, Section 100 is new. The new manual instructions are attached to the official instruction (CR 3411) released to your carrier/intermediary. You may view that instruction by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R408CP.pdf*.

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 A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3411
Related CR Release Date: December 17, 2004
Related CR Transmittal Number: 408
Effective Date: January 1, 2005
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Diabetes Screening Tests

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

This article notifies providers that Medicare will permit coverage for the following diabetes screening tests for services performed on or after January 1, 2005 for individuals who satisfy the eligibility requirements of being at risk for diabetes:

- Fasting plasma glucose test; and
- Post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults or a two-hour post glucose challenge test alone).

CAUTION – What You Need to Know

Coverage will be provided for two screening tests per

calendar year for individuals diagnosed with pre-diabetes, and one screening test per year for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested. This coverage does not apply to individuals previously diagnosed as diabetic.

GO – What You Need to Do

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

Background

This coverage is mandated by Section 613 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). Initially, coverage was limited to a fasting plasma glucose test. However, coverage is now provided for the following two screening blood tests:

- Fasting plasma glucose test, and
- Post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, or a two-hour post-glucose challenge test alone).

Any individual with one (1) of the following individual risk factors for diabetes is eligible for this new benefit:

- Hypertension,
- Dyslipidemia,
- Obesity (with a body mass index greater than or equal to 30 kg/m2), or
- Previous identification of elevated impaired fasting glucose or glucose intolerance.

Or, an individual with any two (2) of the following risk factors for diabetes is also eligible for this new benefit:

- Overweight (a body mass index >25, but<30kg/m2),
- A family history of diabetes,
- Age 65 years or older, or
- A history of gestational diabetes mellitus or giving birth to a baby weighing > 9 lb.

Effective for services performed on or after January 1, 2005, Medicare will pay for diabetes screening tests under the Medicare clinical laboratory fee schedule. To indicate that the purpose of the test(s) is for diabetes screening, a screening diagnosis code is required in the diagnosis section of the claim:

- Two screening tests per calendar year are covered for individuals diagnosed with pre-diabetes.
- One screening test per year is covered for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested.

Those providers billing fiscal intermediaries should note the following:

- The diabetes screening tests will be paid only when submitted on types of bills (TOB) 12x, 13x, 14x, 22x, 23x, and 85x.
- Claims submitted on TOBs 13x, 14x, 22x, and 23x will be paid in accordance with the clinical laboratory fee schedule.
- Critical access hospitals (TOB 85x) will be paid based on reasonable cost.
- Maryland hospitals submitting Part B claims to fiscal intermediaries on TOBs 12x, 13x, or 85x will be paid according to the Maryland Cost Containment plan.

Nationally Non-Covered Indications

- No coverage is permitted under the MMA benefit for individuals previously diagnosed as diabetic.
- Other diabetes screening blood tests for which Medicare has not specifically indicated national coverage continue to be non-covered.

Implementation

The implementation date is January 3, 2005 and applies to services furnished on or after January 1, 2005.

Related Instructions

Updated manual instructions are included in the official instruction issued to your carrier or intermediary and can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that web page, look for CR 3637 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3637	Medlearn Matters Number: MM3637
Related CR Release Date: December 21, 2004	Related CR Transmittal #: 409
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ELECTRONIC MEDIA CLAIMS

Carrier and DMERC 835 Flat File Change and Replacement of Deactivated Reason Code A2

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

Provider Types Affected

All providers who submit claims to Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

STOP – Impact to You

This one-time notification informs you of the deactivation of reason code A2 for DMERCs.

CAUTION – What You Need to Know

Providers should be aware of the corrected companion document and the deactivated reason code.

GO – What You Need to Do

Be aware that reason code A2 is being replaced by reason code 121 (indemnification adjustment) as of January 3, 2005.

Background

CR 2657 has changed the 835 flat file for carriers and DMERCs to accommodate quantity in metric units, which may have up to seven numeric positions and up to three decimal points. The updated flat file is posted at: *http://www.cms.hhs.gov/providers/edi/hipaadoc.asp*

In addition, as noted above and effective as of January 1, 2005, reason code A2 will be replaced by reason code 121 (indemnification adjustment) on remittance advices.

Additional Information

The official instruction released to your carrier or DMERC may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R103OTN.pdf*

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

Related Change Request (CR) #: 3236
Medlearn Matters Number: MM3236
Related CR Release Date: July 30, 2004
Related CR Transmittal #: 103
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

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