Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

Features

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

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

Routing Suggestions:

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

_____

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

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

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

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

The *Medicare B Update!* is a comprehensive magazine published quarterly by First Coast Service Options, Inc. (FCSO) for Part B providers in Connecticut and Florida. In accordance with notification requirements established by the Centers for Medicare & Medicaid Services, approximate delivery dates for fiscal year 2005 are:

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

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

Who Receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education website(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM (please see the hardcopy/CD-ROM registration form on page 117 of the First Quarter 2005 *Update!*).

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

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

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

Clear Identification of State-Specific Content

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

Publication Format

The *Update!* is arranged into distinct sections.

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

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

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

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

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

Articles included in each *Update!* represent formal notice that specific coverage policies either have or will take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines. **The date the *Update!* is posted to the website is considered the notice date**, in the event there is a

dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.

Advance Beneficiary Notices (ABNs)

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

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

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

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

New Patient Liability Notice

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

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

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

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

*This instruction is a correction to an article published in the First Quarter 2005 (page 5) and the Second Quarter 2005 (page 4) of the **Medicare B Update!***

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

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

Nonassigned claims containing the modifier GA in which the patient has been found liable **must** have the patient's ***written consent*** for an appeal. Written appeals requests should be sent to:

Connecticut
Attention: Medical Review
Medicare Part B CT
PO Box 45010
Jacksonville, FL 32232-5010

OR

Florida
Attention: Medical Review
Medicare Part B Claims Review
PO Box 2360
Jacksonville, FL 32231-0018

Distribution of the *Medicare B Update!*

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

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

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

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

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

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

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

Features of the Electronic Publication

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

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

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

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

NOTE: Providers not sending back the form will be changed back to online if previous getting a hardcopy version.

Medicare B Update! Hardcopy/CD-ROM Registration Form

To receive the *Medicare B Update!* in hardcopy or CD-ROM format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. To receive a hardcopy or CD-ROM of the Fourth Quarter 2005 *Update!* your form must be faxed or postmarked on or before July 1, 2005.

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

Provider/Professional Association Name:

Medicare Provider Identification Number (PIN):

Address:

City, State, ZIP Code:

Contact Person/Title:

Telephone Number:

Rationale for needing a hardcopy:

Does your office have Internet access? YES ❑ NO ❑

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

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

Mail your completed form to:

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

or fax to 1 (904) 791-6292

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

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

CLAIMS

Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 11.1, Effective April 1, 2005

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

Provider Types Affected

Physicians billing Medicare carriers

Provider Action Needed

This is a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of CCI edits will be effective on April 1, 2005. Physicians may view the current CCI edits and the current mutually exclusive code (MEC) edits on the Centers for Medicare & Medicaid Service website at: *http://www.cms.hhs.gov/physicians/cciedits*.

The website will be updated with the Version 11.1 edits as soon as they are effective.

Background

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

The latest package of CCI edits, Version 11.1, is effective on April 1, 2005. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables: Column 1/Column 2 Correct Coding Edits and MEC Edits.

Additional Information

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

Related Change Request (CR) #: 3688
Medlearn Matters Number: MM3688
Related CR Release Date: February 4, 2005
Related CR Transmittal #: 466
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Clarification to the Health Professional Shortage Area Language in the Medicare Claims Processing Manual

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

Provider Types Affected

Psychiatrists and critical access hospitals (CAHs) billing Medicare carriers or fiscal intermediaries (FIs) in a HPSA

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is directing Medicare carriers and FIs to return any bonus payment to psychiatrists in mental health HPSAs that were incorrectly recovered in any overpayment actions taken since implementation of the HPSA mental health bonus payment on July 1, 2004, and to make bonus payment for those services that were initially withheld.

CAUTION – What You Need to Know

A Medicare bonus payment is payable for all professional services provided as authorized by license by psychiatrists in a mental health HPSA.

GO – What You Need to Do

Affected psychiatrists and CAHs should be aware of this action to be sure they receive correct payments for furnishing services to Medicare patients in mental health HPSAs.

Background

Federal law for Medicare bonus payments recognizes geographic-based, primary medical care and mental health HPSAs as eligible areas for receiving bonus payments. Consequently, physicians, including psychiatrists, furnishing services in primary medical care HPSAs are eligible to receive bonus payments.

Psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments for all professional services they provide in mental health HPSAs.

Effective July 1, 2004, carriers and FIs began making HPSA bonus payments to psychiatrists furnishing services in mental health HPSAs. Some carriers and FIs may have interpreted Medicare's instructions in such a way that they limited bonus payments in the mental health HPSAs to services they determined were mental health services and may have initiated over-payment recovery actions for bonuses they determined to be paid incorrectly. CMS has determined that these actions are incorrect.

CR 3736 clarifies the language in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 12, Section 90.4.5c to indicate that the bonus is payable for all professional services provided by psychiatrists in a mental health HPSA that they are licensed to provide. It also instructs carriers and FIs to review an overpayment actions taken on mental health HPSAs, cancel any overpayment recovery actions that have been initiated and are in process, and return any overpayments already collected.

Additional Information

These bonus payments were also addressed in Medlearn Matters articles MM3108 and MM3336. To view the details on the payments, you may retrieve these articles, respectively, at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3108.pdf* and *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3336.pdf*.

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 3736 in the CR NUM column on the right, and then click on the file for that CR.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3736
Medlearn Matters Number: MM3736
Related CR Release Date: April 15, 2005
Related CR Transmittal #: 524
Effective Date: May 16, 2005
Implementation Date: May 16, 2005

Health Professional Shortage Area (HPSA) Listing

Claims Filing Requirements

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

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

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

Appeal of HPSA Incentive Payments

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

CMS has provided clarification of these issues:

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

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

Geographic HPSA Designations

The following are counties/area names/parts designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment) for the state of Connecticut, as of July 14, 2004.

Connecticut – Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Fairfield/Southwest Bridgeport	0702.00, 0703.00, 0704.00, 0705.00, 0706.00, 0707.00, 0708.00, 0709.00, 0710.00, 0711.00, 0712.00	Urban
Fairfield/Central/East Bridgeport	0713.00, 0714.00, 0715.00, 0716.00, 0717.00, 0735.00, 0736.00, 0738.00, 0739.00, 0740.00, 0741.00, 0742.00, 0743.00, 0744.00	Urban
Fairfield/Central Norwalk	0440.00, 0441.00, 0444.00, 0445.00	Urban
Hartford/North Central Hartford	5005.00, 5008.00, 5009.00, 5010.00, 5011.00, 5012.00, 5013.00, 5014.00, 5015.00, 5016.00, 5017.00, 5018.00, 5020.00, 5021.00, 5022.00, 5031.00, 5032.00, 5033.00, 5034.00, 5035.00, 5036.00, 5037.00, 5038.00, 5039.00, 5040.00, 5041.00, 5042.00, 5044.00	Urban
Hartford/Charter Oak Terrace/Rice Heights	5001.00, 5002.00, 5003.00, 5004.00, 5019.00, 5027.00, 5028.00, 5029.00, 5030.00, 5043.00, 5045.00, 5046.00, 5049.00	Urban
New Haven/ Fair Haven	1421.00, 1422.00, 1423.00, 1424.00, 1425.00, 1426.01, 1426.02	Urban
New London/ Central Groton	7022.00, 7023.00, 7025.00, 7027. 00, 7028.00	Urban

The following are counties/area names/parts designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment) for the state of Florida, as of July 14, 2004.

Florida – Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Bradford (Terminated September 1, 2004)		Rural
Clay/Keystone Heights division		Urban
Dixie		Rural
Escambia	0038.00, 0039.00, 0040.00	Rural
Gadsden		Urban
Glades		Rural
Hardee		Rural
Hendry/Labelle	9604.00, 9603.00	Rural
Holmes		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown/Indiantown division		Urban
Sumter		Rural
Suwannee		Rural
Wakulla		Rural
Walton		Rural
Washington		Rural

The following are counties (all census tracts) designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment) for Mental Health for the state of Florida, as of July 14, 2004.

Florida – Mental Health

County	Type
Bradford	Rural
Columbia	Rural
Dixie	Rural
Gilchrist	Rural
Hamilton	Rural
Holmes	Rural
Jackson	Rural
Lafayette	Rural
Monroe	Rural
Putnam	Rural
St Johns	Urban
Suwannee	Rural
Union	Rural
Walton	Rural
Washington	Rural

Source: CMS Joint Signature Memorandum (JSM) #421, September 10, 2004

Unprocessable Unassigned Form CMS-1500 Claims

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

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

Provider Impact

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

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

Background

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

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

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

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

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

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

Implementation

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

Additional Information

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

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

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3500
Medlearn Matters Number: MM3500
Related CR Release Date: March 17, 2005
Related CR Transmittal #: 505
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Importance of Supplying Correct Provider Identification Information Required in Items 17, 17a, 24K, and 33 of the Form CMS-1500, and the Electronic Equivalent

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

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) would like to remind providers and their billing staffs of the importance of reporting the correct provider identification information in items 17, 17a, 24K, and 33 of the Form CMS-1500, or the electronic equivalent. This information is critical for accurate and timely processing and payment of your claims.

Additional Information

Please be aware of the following instructions:

Items 17 and 17a

On the Form CMS-1500, or electronic equivalent, the provider must submit the appropriate referring or ordering physician name in item 17, and the Unique Physician Identification Number (UPIN) of that referring/ordering physician in item 17a. These are required fields when a service was ordered or referred by a physician. When a claim involves multiple referring and/or ordering physicians, you must prepare a separate claim submission for each ordering/ referring physician.

Item 17

Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Item 17a

Enter the UPIN of the referring/ordering physician listed in item 17.

- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** - is a physician or, when appropriate, a nonphysician practitioner who orders nonphysician services for the patient. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or nonphysician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name and UPIN. This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services,
- Diagnostic radiology services,
- Portable X-ray services,
- Consultative services, and
- Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list shall also show the ordering/referring physician's name and UPIN. For example, a surgeon shall complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN appear in items 17 and 17a.

When a service is incident to the service of a physician or nonphysician practitioner, the name and assigned UPIN of the physician or nonphysician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the local Medicare carrier to obtain the UPIN. A list of toll free numbers of the Medicare carriers is available at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN of the physician supervising the limited licensed practitioner must appear in items 17 and 17a.

When a patient is referred to a physician who also orders **and** performs a diagnostic service, a separate claim form is required for the diagnostic service. Enter the original ordering/referring physician's name and UPIN in items 17 and 17a of the first claim form. Enter the ordering (performing) physician's name and UPIN in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).

Item 24K

Enter the **provider identification number (PIN)** of the performing provider of service/supplier in item 24K if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, or electronic equivalent, show the individual PIN of each performing provider in the corresponding line item. In the case of a service provided incident to the service of a physician or nonphysician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in item 24K. **UPINs are not appropriate identifiers for item 24K.**

Item 33

Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. **This is a required field.**

For a provider who is **not** a member of a group practice (e.g., private practice), enter the PIN at the bottom of item 33 for paper claims. The PIN should be entered on the **left** side, next to the PIN# field.

If a group practice is billing, then the **group PIN** is to be placed in item 33 for paper claims. Enter the group PIN at the bottom of item 33 on the **right** side, next to the GRP# field. Enter the PIN for the performing provider of service/supplier who is a member of that group practice in item 24K. **Suppliers billing a DMERC will use the National Supplier Clearinghouse (NSC) number in this item.**

NOTE: When implemented, the National Provider Identification (NPI) number will replace the PIN and UPIN. At that time, you will use the NPI number in items 17a, 24K, and 33.

The above instructions are included Chapter 26 of the Medicare Claims Processing Manual. That manual is available at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

The Medicare Benefit Policy Manual may be found at: *http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp*.

And, if you have questions, please contact your carrier/DMERC at their toll free number, available at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: N/A
Med learn Matters Number: SE0529
Related CR Release Date: N/A

Form CMS-1500 Claim Filing Requirements

As a result of our recent transition to the Multi-Carrier System (MCS), it is more important than ever that claims be completed correctly to avoid unprocessable claims. We are seeing many claims returned to providers for invalid or missing information. The Connecticut Medicare Education and Outreach Team has designed the following listing of required or conditional information for items 1-33 on Form CMS-1500. Comprehensive details were published in the Fourth Quarter 2002 *Medicare B Update!* (pages 6-11). More information is also available in the Medicare Carriers Manual referenced at the end of this article.

We are providing this information as tool to help billing specialists complete their claims accurately. If you have any questions regarding this tool, the toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Providers and suppliers have the option of entering either 6 or 8-digit dates in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. For instance, a provider of service or supplier will not be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

Item 1	Enter the type of health insurance coverage applicable to the claim by checking the appropriate box (e.g., **if a Medicare claim is being filed, check the Medicare box**).
Item 1a	Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. **This is a required field**.
Item 2	Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. **This is a required field**

Item 3	The patient's 8-digit birth date (MMDDCCYY) and sex.
Item 4	If the patient has insurance primary to Medicare, either through the patient or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. **If Medicare is primary, leave blank.**
Item 5	The patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number.
Item 6	Check the appropriate box for patient's relationship to insured when item 4 is completed.
Item 7	Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed
Item 8	Check the appropriate box for the patient's marital status and whether employed or a student
Item 9	Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. This field may be used in the future for supplemental insurance plans. **Note: Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the beneficiary wishes to assign his/her benefits under a MEDIGAP policy to the participating physician or supplier.** For more information regarding item 9, please refer to the section referenced below in the Internet Only Manual.
Item 9a	Enter the policy and/or group number of the Medigap insured *preceded* by **MEDIGAP, MG, or MGAP**. **Note:** Item 9d must be completed if the provider enters a policy and/or group number in item 9a.
Item 9b	The Medigap insured's 8-digit birth date (MMDDCCYY) and sex.
Item 9c	Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card. For example: 1257 Anywhere Street Baltimore, MD 21204 is shown as "1257 Anywhere St. MD 21204.".
Item 9d	Enter the 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.
Item 10a-10c	Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the state postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.
Item 10d	Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD**.**
Item 11	THIS ITEM MUST BE COMPLETED, IT IS A **REQUIRED FIELD.** BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER. If the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, the participating provider of service or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer. If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed. **Note:** Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11. If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12. If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insurer retired), enter the word "NONE" and proceed to item 11b. **Note**: For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. (See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3.) For more information regarding this item, please refer to the Internet Only Manual referenced below.

Item 11a	Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3
Item 11b	Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word "RETIRED."
Item 11c	Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is **required** if there is insurance primary to Medicare that is indicated in *item* 11.
Item 11d	Leave blank. Not required by Medicare.
Item 12	The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements." If the patient is physically or mentally unable to sign, a representative specified in Chapter 1, "General Billing Requirements" may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless patient or the patient's representative revokes this arrangement. **Note:** This can be "Signature on File" and/or a computer generated signature. The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim. **Signature by Mark (X) -** When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.
Item 13	The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked. **Note:** This can be "Signature on File" signature and/or a computer generated signature.
Item 14	Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.
Item 15	Leave blank. Not required by Medicare.
Item 16	If the patient is employed and is unable to work in current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.
Item 17	Enter the original ordering/referring physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the first claim form. Enter the ordering (performing) physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service). Surrogate UPINs - If the ordering/referring physician has not been assigned a UPIN (the NPI will be used when implemented), one of the surrogate UPINs listed below shall be used in item 17a. The surrogate UPIN used depends on the circumstances and is used only until the physician is assigned a UPIN. Enter the physician's name in item 17 and the surrogate UPIN in item 17a. All surrogate UPINs, with the exception of retired physicians (RET00000), are temporary and may be used only until a UPIN is assigned. The carrier shall monitor claims with surrogate UPINs For more information regarding this item, please refer to the Internet Only Manual referenced below
Item 17 a	When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician. Contractors use the following surrogate UPINs for physicians who have not been assigned individual UPINs. Claims received with surrogate numbers will be tracked and possibly audited. •Residents who are issued a UPIN in conjunction with activities outside of their residency status use that UPIN. For interns and residents without UPINs, use the 8-character surrogate UPIN RES00000; •Retired physicians who were not issued a UPIN may use the surrogate RET00000; •Physicians serving in the Department of Veterans Affairs or the U.S. Armed Services may use VAD00000; •Physicians serving in the Public Health or Indian Health Services may use PHS00000; •When the ordering/referring physician has not been assigned a UPIN and does not meet the criteria for

using one of the surrogate UPINs, the biller may use the surrogate UPIN "OTH00000" until an individual UPIN is assigned.
•The UPIN must be entered in item 17a for hepatitis B claims.
Note: **This field is required when a service was ordered or referred by a physician.**

Item 18 Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) X-ray date for chiropractor services (if an X-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an X-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, are on file, along with the appropriate X-ray and all are available for carrier review.
Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.
Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.
Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier 99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a modifier 99 should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item
Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.
Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share postoperative care.
Enter demonstration ID number "30" for all national emphysema treatment trial claims.
Enter the pin (or UPIN when effective) of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, chapter 1, section 30.2.9.1 for additional information.)
Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

For more information regarding this item, please refer to the Internet Only Manual referenced below.

Item 20 Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1 in the Internet Only Manual, Publication 100-04.

Note: **This is a required field when billing for diagnostic tests subject to purchase price limitations.**

Item 21 Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four codes in priority order (primary, secondary condition). An independent laboratory shall enter a diagnosis only for limited coverage procedures.
All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Item 22 Leave blank. Not required by Medicare.

Item 23 Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.
For physicians performing care plan oversight services, enter the 6-digit Medicare provider number of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.
Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA-covered procedures.

Note: Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

For more information regarding this item, please refer to the Internet Only Manual referenced below

Item 24a Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. **This is a**

required field. The claim will be returned as unprocessable if a date of service extends more than one day and a valid "to" date is not present.

Item 24b	Enter the appropriate place of service code(s) from the list provided in Section 10.5. Identify the location, using a place of service code, for each item used or service performed. **This is a required field.** **Note**: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.
Item 24c	Medicare providers are not required to complete this item.
Item 24d	Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. **This is a required field.** The claim will be returned as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.
Item 24e	Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, 2, 3, or 4. **This is a required field.** If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.
Item 24f	Enter the charge for each listed service.
Item 24g	Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided. For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure **Note**: This field should contain at least 1day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable. For more information regarding this item, please refer to the Internet Only Manual referenced below.
Item 24h-24j	Leave blank. Not required by Medicare.
Item 24k	Enter the PIN (the NPI will be used when implemented) of the performing provider of service/supplier if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, show the individual PIN (or NPI when implemented) in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN (or NPI when implemented) of the supervisor in item 24k.
Item 25	Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number. The participating provider of service or supplier Federal Tax ID number is required for a mandated Medigap transfer.
Item 26	Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.
Item 27	The following providers of service/suppliers and claims can only be paid on an assignment basis: • Clinical diagnostic laboratory services • Physician services to individuals dually entitled to Medicare and Medicaid • Participating physician/supplier services • Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers • Ambulatory surgical center services for covered ASC procedures • Home dialysis supplies and equipment paid under Method II • Ambulance services • Drugs and biologicals • Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine
Item 28	Enter total charges for the services (i.e., total of all charges in item 24f).
Item 29	Enter the total amount the patient paid on the covered services only.

Item 30 Leave blank. Not required by Medicare.

Item 31 In the case of a service that is provided incident to the service of a physician or nonphysician practitioner, when the ordering physician or nonphysician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or nonphysician practitioner shall be entered in item 31. When the ordering physician or nonphysician practitioner is not supervising the service, then enter the signature of the physician or nonphysician practitioner providing the direct supervision in item 31.

Note: **This is a required field**, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

- Providers of service (namely physicians) shall identify the supplier's name, address, ZIP code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.
- When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.
- If a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered shall be entered if other than home.
- If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.
- Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed, and the PIN.
- This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

This field is required. For more information regarding this item, please refer to the Internet Only Manual referenced below.

Item 33 Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. Enter the PIN (or NPI when implemented), for the performing provider of service/supplier who is not a member of a group practice.

This is a required field.

Source: CMS Internet Only Manual (IOM) – Pub 100-04, Chapter 26, Section 10

Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

Providers should emphasize to their beneficiaries the importance of immunizations. The following article contains information for providers and suppliers regarding the billing and processing of claims for pneumococcal, hepatitis B, and influenza virus vaccines. Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Part B deductible and coinsurance do not apply for PPV and influenza virus vaccine. Part B of Medicare also covers the hepatitis B vaccine and its administration. Part B deductible and coinsurance **do** apply for hepatitis B vaccine.

Pneumococcal Pneumonia Vaccinations. The Medicare Part B program covers pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable state law by any provider of services or any entity or individual with a supplier number. This includes revaccination of patients at highest risk of pneumococcal infection. Typically, these vaccines are administered once in a lifetime except for persons at highest risk. Effective July 1, 2000, Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Frequency of PPV Vaccinations. Typically, PPV is administered once in a lifetime. Claims are paid for beneficiaries who are at high risk of pneumococcal disease and have not received PPV within the last five years or are revaccinated because they are unsure of their vaccination status.

An initial PPV may be administered only to persons at high risk (see below) of pneumococcal disease. Revaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least five years have passed since receipt of a previous dose of pneumococcal vaccine.

High Risk of Pneumococcal Disease. Persons at high risk for whom an initial vaccine may be administered include:

- All people age 65 and older;
- Immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and

- Individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, Human Immunodeficiency Virus (HIV) infection, nephritic syndrome, sickle cell disease, or organ transplantation).

Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccinations of people age 65 or older that are not at highest risk are not appropriate.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available.

Instead, if the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past five years, the vaccine should be given. However, if the patient is certain he/she was vaccinated in the last five years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

Hepatitis B Vaccine. Effective for services furnished on or after September 1, 1984, P.L. 98-369 provides coverage under Part B for hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B. This coverage is effective for services furnished on or after September 1, 1984.

High-risk groups currently identified include (see exception below):

- ESRD patients;
- Hemophiliacs who receive Factor VIII or IX concentrates;
- Clients of institutions for the mentally retarded;
- Persons who live in the same household as an Hepatitis B Virus (HBV) carrier;
- Homosexual men; and
- Illicit injectable drug abusers.

Intermediate risk groups currently identified include:

- Staff in institutions for the mentally retarded; and
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

Exception: Persons in both of the above-listed groups in paragraph B, would not be considered at high or intermediate risk of contracting hepatitis B, however, if there were laboratory evidence positive for antibodies to hepatitis B. (ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy.)

For Medicare program purposes, the vaccine may be administered upon the order of a doctor of medicine or osteopathy, by a doctor of medicine or osteopathy, or by home health agencies, skilled nursing facilities, ESRD facilities, hospital outpatient departments, and persons recognized under the incident to physicians' services provision of law.

A charge separate from the ESRD composite rate will be recognized and paid for administration of the vaccine to ESRD patients.

Influenza Virus Vaccine. The influenza virus vaccine and its administration is covered when furnished in compliance with any applicable state law.
Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the vaccine. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.
Typically, one influenza vaccination is allowable per flu season.

Frequency of Vaccinations

Typically, PPV is administered once in a lifetime. Medicare may pay claims for beneficiaries who are at high risk of pneumococcal disease and have not received PPV within the last five years or are revaccinated because they are unsure of their vaccination status.

Typically, one influenza vaccination is allowable per flu season. Claims for beneficiaries who have received more than one influenza virus vaccine in a 12-month period will be reviewed to determine whether the service was reasonable and necessary (e.g., a patient receives an influenza injection in January for the current flu season and is vaccinated again in November of the same year for the next flu season.)

Billing for Additional Services

When a physician/supplier administers PPV, influenza virus, or hepatitis B vaccines without providing any other additional services during the visit, the provider may only bill for the vaccine and its administration.

These services are always separately payable, whether or not other services are also provided during the same encounter. The physician/supplier may bill for additional reasonable and necessary services in addition to the administration of PPV, influenza virus, and/or hepatitis B vaccines.

Nonparticipating Physicians and Suppliers

Nonparticipating physicians and suppliers (including local health facilities) that do not accept assignment may collect payment from the beneficiary but must submit an unassigned claim on the beneficiary's behalf. Entities, such as local health facilities, that have never submitted Medicare claims must obtain a provider identification number for Part B billing purposes.

Separate Claims for Vaccines and Their Administration

In situations in which the vaccine and the administration are furnished by two different entities, the entities should submit separate claims. For example, a supplier (e.g., a pharmacist) may bill separately for the vaccine, using the Healthcare Common Procedural Coding System (HCPCS) code for the vaccine, and the physician or supplier (e.g., a drugstore) who actually administers the vaccine may bill separately for the administration, using the HCPCS code for the administration.

This procedure results in carriers receiving two claims, one for the vaccine and one for its administration.

For example, when billing for influenza vaccine administration only, billers should list only HCPCS code G0008 in block 24D of the Form CMS-1500. When billing for the influenza vaccine only, billers should list only *CPT* code *90659* in block 24D of the Form CMS-1500. The same applies for PPV and hepatitis B billing using PPV and hepatitis B HCPCS codes.

CPT/HCPCS Codes

The following *CPT* codes are used for billing influenza virus, pneumococcal pneumonia, and hepatitis B vaccines:

90657 *Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use*

90658 *Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use*

90659 *Influenza virus vaccine, whole virus, for intramuscular or jet injection use;*

90732 *Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use*

90740 *Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use*

90743 *Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use*

90744 *Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use*

90746 *Hepatitis B vaccine, adult dosage, for intramuscular use; and*

90747 *Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use*

These codes are for the vaccines only and do not include their administration. The following HCPCS "G" codes are used to bill for administration of vaccines:

G0008 Administration of influenza virus vaccine when no physician fee schedule service on the same day;

G0009 Administration of pneumococcal vaccine when no physician fee schedule service on the same day when no physician fee schedule service on the same day; and

G0010 Administration of hepatitis B vaccine when no physician fee schedule service on the same day.

These three codes are reimbursed at the same rate as *CPT* code *90782* on the Medicare physician fee schedule (MPFS) for the year that corresponds to the date of service of the claim.

Billing Requirements

Physicians and suppliers submit claims on Form CMS - 1500. The unique physician identification number (UPIN) (or National Provider Identifier [NP]), when effective) must be entered in Item 17A of Form CMS-1500 for PPV (prior to July 1, 2000) and hepatitis B vaccines. Medicare does not require that the influenza vaccine be administered under a physician's order or supervision. Effective for claims with dates of service on or after July 1, 2000, PPV claims also no longer require that the vaccine be administered under a physician's order or supervision.

Diagnosis Codes

One of the following diagnosis codes must be reported as appropriate. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim the applicable following diagnosis code may be used.

V03.82 PPV
V04.8* Influenza
V05.3 Hepatitis B.

*Effective for influenza virus claims with dates of service October 1, 2003, and later, the correct diagnosis code to be used is V04.81.

If a diagnosis code for PPV, hepatitis B, or influenza virus vaccination is not reported on a claim and the carrier can determine that the claim is a PPV, hepatitis B, or influenza claim, the carrier may enter the proper diagnosis code and continue processing the claim.

These claims should not be returned, rejected, or denied for lack of a diagnosis code by the carrier. Effective for dates of service on or after October 1, 2003, carriers may no longer enter the diagnosis on the claim. Carriers must follow current resolution processes for claims with missing diagnosis codes.

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, the carrier or intermediary may correct the HCPCS code and pay the claim.

For example, if the reported diagnosis code is V04.8 (V04.81 if claim is October 1, 2003, and later) and the narrative description (if annotated on the claim) says "flu shot" but the HCPCS code is incorrect, contractors may change the HCPCS code and pay for the flu vaccine.

In addition, if a doctor of medicine or osteopathy does not order the influenza virus vaccine, the intermediary claims require UPIN code SLF000 to be reported.

Reimbursement Guidelines

Payment for PPV, influenza virus, and hepatitis B vaccines follows the same standard rules that are applicable to any injectable drug or biological. The allowable charge for the vaccine cannot exceed the lower of the actual charge or 95 percent of the median of all average wholesale prices (AWP).

The administration of PPV, influenza virus, and hepatitis B vaccines, (HCPCS codes G0009, G0008, and G0010), though not reimbursed directly through the MPFS, is reimbursed at the same rate as HCPCS code 90782 on the MPFS for the year that corresponds to the date of service of the claim.

Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 should be reimbursed at the same rate as HCPCS code 90741. Assignment for the administration is not mandatory, but is applicable should the provider be enrolled as a provider type "Mass Immunizer," submits roster bills, or participates in the centralized billing program.

Limiting charge does not apply to PPV, influenza virus vaccine, or hepatitis B vaccine and their administration. The administration of the influenza virus vaccine is covered in the flu shot benefit, rather than under the physicians' services benefit; therefore, it is not eligible for the ten percent Health Professional Shortage Area (HPSA) incentive payment.

Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. Thus, for example, Medicare may not pay for flu vaccinations administered to Medicare beneficiaries if a physician provides free

vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees.

Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.

Nongovernmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities (such as public health clinics [PHCs]) may bill Medicare for PPV, hepatitis B, and influenza virus vaccine administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

Simplified Roster Bills

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by PHCs and other individuals and entities that give the vaccine to a group of beneficiaries, e.g. at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. Roster billing is not available for hepatitis B vaccinations.

Properly licensed individuals and entities conducting mass immunization programs may submit claims using a simplified claims filing procedure known as roster billing to bill for the influenza virus vaccine benefit for multiple beneficiaries if they agree to accept assignment for these claims. They may not collect any payment from the beneficiary.

Effective November 1, 1996, roster billing is also available to individuals and entities billing for PPV.

Effective July 1, 1998, immunization of at least five beneficiaries on the same date is no longer required for any individual or entity to qualify for roster billing to carriers.

However, the rosters should not be used for single patient claims and the date of service for each vaccination administered must be entered.

Entities that submit claims on roster claims must accept assignment and may not collect any "donation" or other cost sharing of any kind from Medicare beneficiaries for PPV or influenza vaccinations. However, the entity may bill Medicare for the amount, which is not subsidized from its own budget. For example, an entity that incurs a cost of $7.50 per vaccination and pays $2.50 of the cost from its budget may bill Medicare the $5.00 cost which is not paid out of its budget.

Provider Enrollment Criteria. Those entities and individuals that desire to provide mass immunization services, but may not otherwise be able to qualify as a Medicare provider, may be eligible to enroll as a provider type "Mass Immunizer."

These individuals and entities must enroll with the carrier by completing the Provider/Supplier Enrollment Application, Form CMS-855. Specialized instructions for these individuals and entities are available in order to simplify the enrollment process.

Individuals and entities that use the specialized instructions to complete the form may not bill Medicare for any services other than PPV, influenza virus vaccines and their administration.

Modified CMS-1500. If the PHC or other individual or entity qualifies to use the simplified billing process, it may use a preprinted CMS-1500 that contains standardized information about the entity and the benefit.

Entities submitting roster claims to carriers must complete the following blocks on a single modified Form CMS-1500, which serves as the cover document for the roster for each facility where services are furnished. In order for carriers to reimburse by correct payment locality, a separate Form CMS-1500 must be used for each different facility where services are furnished.

Item 1	An X in the Medicare block
Item 2	(Patient's Name): "SEE ATTACHED ROSTER"
Item 11	(Insured's Policy Group or FECA Number): "NONE"
Item 17A	(I.D. Number or Referring Physician): This number is required for PPV claims with dates of service prior to July 1, 2000. This number is also required for Hepatitis B vaccines.
Item 20	(Outside Lab?): An "X" in the NO block
Item 21	(Diagnosis or Nature of Illness): Line 1: PPV = "V03.82", Influenza Virus: = "V04.8" ***Effective for claims with dates of service on or after October 1, 2003, use V04.81.***
Item 24B	(Place of Service (POS)): Line 1: "60" Line 2: "60" **Note**: POS Code '60" must be used for roster billing
Item 24D	(Procedures, Services or Supplies): Line 1: PPV: "90732" Influenza Virus: "90659" Line 2: PPV: "G0009" Influenza Virus: "G0008"
Item 24E	(Diagnosis Code): Lines 1 and 2: "1"
Item 24F	($ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC PPV or influenza virus vaccine claims only if your system is able to accept them.

Item 27	(Accept Assignment): An "X" in the YES block.
Item 29	(Amount Paid): "$0.00"
Item 31	(Signature of Physician or Supplier): The entity's representative must sign the modified Form CMS-1500.
Item 32	N/A
Item 33	(Physician's, Supplier's Billing Name): If the provider number is not shown on the roster billing form, the entity must complete this item to include the Provider Identification Number (not the Unique Physician Identification Number) or Group Number, as appropriate.

Sample rosters and samples of modified CMS Form-1500s are available to view, print, or download from our provider websites at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*, in the "Forms" area.

Source: Internet Online Manual (IOM) Pub 100-4, Chapter 18, Section 10
Pub 100-2, Chapter 15, Section 50.4.4.2

Billing Postoperative Management for Cataract Surgery—"Split-Split" Care

This information was previously published in the Fourth Quarter 2003 Medicare B Update! pages 13-14.

When an ophthalmologist performs the surgical procedure and part of the out-of-hospital follow-up care, then turns over the remainder of the follow-up care to an optometrist or another ophthalmologist, this is called split-split care. There are specific claim submission requirements for billing split-split care, to ensure both providers are appropriately reimbursed.

When billing for split-split care, the ophthalmologist who performed the surgery and part of the follow-up care should bill separate lines for the surgery and his/her portion of the follow-up care. The line for the surgery should be appended with modifier 54 (surgical care only); the line for the follow-up care should be appended with modifier 55 (postoperative management only). The date of service should be the date of surgery. In addition, he/she must indicate in item 19 of Form CMS-1500 (or in the appropriate narrative record of its electronic equivalent) the specific eye treated, when the patient was referred for follow-up care for co-management (the date care was relinquished), and the total number of days the beneficiary was in his/her care.

The ophthalmologist or optometrist who provided the follow-up care, for his/her portion of the post-operative care must use the *date of the surgery* for the date of service and append the line with modifier 55. He/she must indicate in item 19: the specific eye treated, when care of the beneficiary was assumed and relinquished, and the number of days the patient was followed during that portion of follow-up care.

The examples that follow assume *CPT 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [one stage procedure], manual or mechanical technique [eg, irrigation and aspiration or phacoemulsification])* was performed on March 1, 2004; the surgeon provided follow-up care through March 17 and referred the patient to another physician for the remainder of the 90-day follow-up period.

Example 1

A claim for the ophthalmologist performing the surgery and a portion of the follow-up care is billed like this:

19. RESERVED FOR LOCAL USE
LT EYE- ASSUMED CARE 03-01; RELINQUISHED CARE 03-17; TOTAL DAYS 17

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 366.50 3. 2. 4.

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE
1 03	01	05				22		66984	54 LT	1
2 03	01	05				22		66984	55 LT	1

Example 2

A claim for the ophthalmologist or optometrist providing the remainder of the follow-up care is billed like this:

19. RESERVED FOR LOCAL USE
LT EYE- ASSUMED CARE 03-18; RELINQUISHED CARE 05-29; TOTAL DAYS 73

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 366.50 3. 2. 4.

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE
1 03	01	05				22		66984	55 LT	1
2										

Emergency Department Services, Consultations, and Critical Care Visits

The purpose of this article is to clarify questions that have been received related to physician billing for the above referenced evaluation and management (E/M) services. The following instructions are specified in the Medicare Claims Processing Manual, Chapter 12, Section 30.

99281-99288: Emergency Department Visits

Use of Emergency Department Codes by Physicians Not Assigned to Emergency Department. Medicare can pay emergency department services codes regardless of whether the physician is assigned to the emergency department. Any physician seeing a patient registered in the emergency department can use these codes.

Use of Emergency Department Codes in Office. Medicare can not pay an emergency department code if the site of service is an office or outpatient setting or any site of service other than an emergency department. Emergency department codes should only be used if the patient is seen in the emergency department. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

Use of Emergency Department Codes to Bill Non-Emergency Services. Medicare can pay emergency department codes regardless of whether the services were emergency services. The only requirement for using the emergency department codes is that the patient be seen in the emergency department for an unanticipated service. Normally a lower level emergency department code would be reported for such a non-emergency condition.

If a physician asks a patient to meet he/she in the emergency department as an alternative to the physician's office and the patient is not registered as a patient in the emergency department, the physician should bill the appropriate office/ outpatient visit codes.

Emergency Department or Office/Outpatient Visits on Same Day as Nursing Facility Admission. Medicare can not pay for an emergency department visit provided on the same day as a comprehensive nursing facility assessment. Payment for E/M services on the same date provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date as the nursing facility admission.

Emergency Department and Critical Care Services Provided on the Same Day. If critical care is required upon the patient's presentation to the emergency department, only critical care codes *99291-99292* can be reported. Emergency department codes will not be paid for the same day. More information on critical care is provided below.

Physician Billing for Emergency Department Services Provided to Patient by Both Patient's Personal Physician and Emergency Department Physician. If a physician advises his/her own patient to go to an emergency department of a hospital for care and subsequently is asked by the emergency department physician to come to the hospital to evaluate the patient and to advise the emergency department physician whether the patient should be admitted to the hospital or be sent home, the physicians should bill as follows:

- If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital care (codes *99221-99223*) because all E/Mservices provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The emergency department physician who saw the patient in the emergency department should bill the appropriate level of the emergency department codes.
- If the emergency department physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the emergency department physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he/she provided in the emergency department. The patient's personal physician would not bill a consultation because he/she is not providing information to the emergency department physician for his or her use in treating the patient. If the patient's personal physician does not come to the hospital to see the patient, but only advises the emergency department physician by telephone, then the patient's personal physician can not bill.

Reporting of Visit When Patient is Seen in Emergency Department and Emergency Department Physician Requests Another Physician to See the Patient In Emergency Department or Office/Outpatient Setting. If the emergency department physician requests that another physician evaluate a given patient, the other physician should bill a consultation if the criteria for consultation (see below) are met. If the criteria for a consultation are not met and the patient is discharged from the emergency department or admitted to the hospital by another physician, the physician contacted by the emergency department physician should bill an emergency department visit. If the consulted physician admits the patient to the hospital and the criteria for a consultation are not met, he/she should bill an initial hospital care code.

99241 - 99275: Consultations

Consultation Versus Visit. Medicare can pay for a consultation when all of the criteria for the use of a consultation code are met:

- Specifically, a consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation)**.**

- A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.
- After the consultation is provided, the consultant prepares a written report of his/her findings that is provided to the referring physician.

Consultation Followed by Treatment. Medicare can pay for an initial consultation if all the criteria for a consultation are satisfied. Payment can be made regardless of treatment initiation unless a transfer of care occurs. A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. The receiving physician would report a new or established patient visit depending on the situation (a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years) and setting (e.g., office or inpatient).

A physician consultant can initiate diagnostic and/or therapeutic services at an initial or subsequent visit. Subsequent visits (not performed to complete the initial consultation) to manage a portion or all of the patient's condition should be reported as established patient office visit or subsequent hospital care, depending on the setting.

Consultations Requested by Members of Same Group. Medicare can pay for a consultation if one physician in a group practice requests a consultation from another physician in the same group practice as long as all of the requirements for use of the consultation codes are met.

Documentation for Consultations. A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record. A written report must be furnished to the requesting physician.
In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician and the consultant, the request can be documented as part of a plan written in the requesting physician's progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report can consist of an appropriate entry in the common medical record. In an office setting, the documentation requirement can be met by a specific written request for the consultation from the requesting physician or if the consultant's records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the requesting physician.

Consultation for Preoperative Clearance. Medicare can pay for the appropriate consultation code for a preoperative consultation for a new or established patient performed by any physician at the request of a surgeon, as long as all of the requirements for billing the consultation codes are met.

Postoperative Care by Physician Who Did Preoperative Clearance Consultation. If, subsequent to the completion of a pre-operative consultation in the office or hospital, the consultant assumes responsibility for the management of a portion or all of the patient's condition(s) during the postoperative period, the consultation codes should not be used. In the hospital setting, the physician who has performed a preoperative consultation and assumes responsibility for the management of a portion or all of the patient's condition(s) during the postoperative period should use the appropriate subsequent hospital care codes (not follow-up consultation codes) to bill for the concurrent care he or she is providing. In the office setting, the appropriate established patient visit code should be used during the postoperative period.

A physician (primary care or specialist) who performs a postoperative evaluation of a new or established patient at the request of the surgeon can bill the appropriate consultation code for E/M services furnished during the post-operative period following surgery as long as all of the criteria for the use of the consultation codes are met and that same physician has not already performed a preoperative consultation.

Surgeon's Request That Another Physician Participate in Postoperative Care. If the surgeon asks a physician who had not seen the patient for a preoperative consultation to take responsibility for the management of an aspect of the patient's condition during the postoperative period, the physician can not bill a consultation because the surgeon is not asking the physician's opinion or advice for the surgeon's use in treating the patient. The physician's services would constitute concurrent care and should be billed using the appropriate level visit codes.

Examples of Consultations:

- An internist sees a patient that he has followed for 20 years for mild hypertension and diabetes mellitus. The patient exhibits a new skin lesion and the internist sends the patient to a dermatologist for further evaluation. The dermatologist examines the patient and removes the lesion that is determined to be an early melanoma. The dermatologist dictates and forwards a report to the internist regarding his evaluation and treatment of the patient.
- A general ophthalmologist diagnoses a patient with a retinal detachment. He sends the patient to a retinal subspecialist to evaluate the patient because the general ophthalmologist does not treat this specific problem. The retinal subspecialist evaluates the patient and subsequently schedules surgery. He sends a report to the referring physician explaining his findings and the treatment option selected.
- A family physician diagnoses a patient with diabetes mellitus. The family physician asks the ophthalmologist for a base line evaluation to rule out diabetic retinopathy. The ophthalmologist examines the patient and sends a report to the family physician on his findings. The ophthalmologist tells the patient at the time of service to return in one year for a follow-up visit. This subsequent follow-up visit should be billed as an established patient visit in the office or other outpatient setting, as appropriate.

- A rural family practice physician examines a patient who has been under his care for 20 years and diagnoses a new onset of atrial fibrillation. The family practitioner sends the patient to a cardiologist at an urban cardiology center for advice on his care and management. The cardiologist examines the patient, suggests a cardiac catheterization and other diagnostic tests that he schedules and then sends a written report to the requesting physician. The cardiologist subsequently routinely sees the patient once a year as follow-up. Subsequent visits provided by the cardiologist should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Other routine care continues to be followed by the family practice physician.
- A family practice physician examines a female patient who has been under his care for some time and diagnoses a breast mass. The family practitioner sends the patient to a general surgeon for advice and management of the mass and related patient care. The general surgeon examines the patient and recommends a breast biopsy, that he schedules, and then sends a written report to the requesting physician. The general surgeon subsequently performs a biopsy and then routinely sees the patient once a year as follow-up. Subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Other routine care continues to be followed by the family practice physician.
- An internist examines a patient who has been under his care for some time, and diagnoses and diagnoses a thyroid mass. The internist sends the patient to a general surgeon for advice on management of the mass and related patient care. The general surgeon examines the patient, orders diagnostic tests, and suggests a needle biopsy of the mass. The surgeon then schedules the procedure and sends a written report to the requesting physician. The general surgeon subsequently performs a thin needle biopsy and then routinely sees the patient twice as follow-up for the mass. Subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other or other outpatient setting, as appropriate. Other routine care continues to be followed by the internist.
- A patient with underlying diabetes mellitus and renal insufficiency is seen in the emergency room for the evaluation of fever, cough and purulent sputum. Since it is not clear whether the patient needs to be admitted, the emergency room physician requests an opinion by the on-call internist. The internist can bill a consultation regardless if the patient is discharged from the emergency room or whether the patient is admitted to the hospital as long as the criteria for consultation have been met. If the internist admits the patient to the hospital, he/she can bill either an initial inpatient consultation or initial hospital care code but not both for the same date of service.

Examples That Do Not Satisfy the Criteria for Consultations:

- Standing orders in the medical record for consultations.
- No order for a consultation.
- No written report of a consultation
- After hours, an internist receives a call from her patient about a complaint of abdominal pain. The internist believes this requires immediate evaluation and advises the patient to go to the emergency room where she meets the patient and evaluates him. The emergency room physician does not see the patient. The internist should bill for the appropriate level of emergency department service, or if the patient is admitted to the hospital she would bill this visit as an inpatient admission.

99291-99292: Critical Care Visits and Neonatal Intensive Care

Use of Critical Care in Cases Which Are Not Medical Emergencies. Critical care includes the care of critically ill and unstable patients who require constant physician attention, whether the patient is in the course of a medical emergency or not. It involves decision making of high complexity to assess, manipulate, and support circulatory, respiratory, central nervous, metabolic, or other vital system function to prevent or treat single or multiple vital organ system failure. It often also requires extensive interpretation of multiple data bases and the application of advanced technology to manage the critically ill patient.

Critical care is usually, but not always, given in a critical care area such is the coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment can be made for critical care services provided in any location as long as the care provided meets the definition of critical care. Services for a patient who is not critically ill and unstable but who happens to be in a critical care, intensive care, or other specialized care unit are reported using subsequent hospital care codes (*99231-99233*) or hospital consultation codes (*99251-99263*).

Constant Attendance or Constant Attention as Prerequisite for Use of Critical Care Codes The duration of critical care to be reported is the time the physician spent working on the critical care patient's case, whether that time was spent at the immediate bedside or elsewhere on the floor, but immediately available to the patient.
For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be reported as critical care, even if it does not occur at the bedside.

Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) can not be reported as critical care since the physician is not immediately available to the patient. This work is the typical pre and post-service work that accompanies any E/M service. Time spent in activities that do not directly contribute to the treatment of the patient can not be reported as critical care, even if they are performed in the critical care unit at a patient's bedside (e.g., telephone calls to discuss other patients, reviewing literature).

For critical care to be billed, the physician must devote his/her full attention to the patient and, therefore, cannot render E/M services to any other patient during the same period of time.

The time spent with the individual patient and the service rendered should be recorded in the patient's record to support the claim for critical care services.

Hours and Days of Critical Care That Can Be Billed. Payment for critical care is not restricted to a fixed number of days. As long as the critical care criteria are met and the services are reasonable and necessary to treat illness or injury, Medicare can pay for critical care services. However, claims for seemingly improbable amounts of critical care on the same date can be subjected to review to determine if the physician has filed a false claim.

Critical Care Visits and Other Procedures Provided on Same Day by Same Physician. The following codes are not payable when they are provided on the same day by the same physician as the critical care codes: *36000, 36410, 36415, 36600, 71010, 71015, 71020, 91105, 92953, 93561, 93562, 94656, 94657, 94660, 94662, 94760, 94762, 99090,* and G0001. Payment for these procedure codes is bundled into critical care codes *99291* and *99292*.

No other procedure codes are bundled into the critical care codes. Therefore, other procedure codes can be billed separately. However, if the procedure that is provided on the same date as critical care has a global surgical period, payment for critical care is included in the payment for the procedure unless it is a separately identifiable E/M service above and beyond the typical work associated with the procedure

Counting of Units of Critical Care Services. Procedure code 99291 (critical care, first hour) is used to report the services of a physician providing constant attention to a critically ill patient for a total of 30 minutes to one hour on a given day. Only one unit of code *99291* can be billed by a physician for a patient on a given date.

If the total duration of critical care provided by the physician on a given day is less than 30 minutes, the appropriate E/Mt code should be used. In the hospital setting, it is expected that the level 3 subsequent hospital care code *99233* would most often be used.

Procedure code *99292* (critical care, each additional 30 minutes) is used to report the services of a physician providing constant attention to the critically ill patient for 15 to 30 minutes beyond the first hour of critical care on a given day.

The following illustrates the correct reporting of critical care services:

Total Duration of Critical Care	Code(s)
a. Less than 30 minutes	*99232* or *99233*
b. 30-74 minutes	*99291* x 1
c. 75-104 minutes	*99291* x 1 and *99292* x 1
d. 105-134 minutes	*99291* x 1 and *99292* x 2
e. 135-164 minutes	*99291* x 1 and *99292* x 3
f. 165-194 minutes	99291 x 1 and *99292* x 4

Critical Care Service and other E/M Services Provided on Same Day. If critical care is required upon the patient's presentation to the emergency department, only critical care codes *99291-99292* can be reported. Emergency department codes will not be paid for the same day. If there is a hospital or office/outpatient E/M service furnished early in the day and at that time the patient does not require critical care, but the patient requires critical care later in the day, both critical care and the E/M service can be paid. Physicians should submit documentation when critical care is billed on the same day as other E/M services.

Critical Care Services Provided During Preoperative Portion of Global Period of Procedure With 90 Day Global Period in Trauma and Burn Cases. Pre-operative critical care can be paid in addition to a global fee if the patient is critically ill and requires the constant attendance of the physician, *and* the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met. Codes *99291/99292 and* modifier 25 (significant, separately identifiable E/M services by the same physician on the day of the procedure) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM diagnosis code in the range 800.0 through 959.9 (except 930-939) that clearly indicates that the critical care was unrelated to the surgery is acceptable documentation. For more information regarding use of modifier 25, refer to the following issues of the *Medicare B Update!* – Second Quarter 2001 (page 5) May/June 1999 (page 23) and July/August 1999 (page 12).

Critical Care Services Provided During Postoperative Period of Procedure With Global Period in Trauma and Burn Cases. Medicare can pay for postoperative critical care in addition to a global fee if the patient is critically ill and requires the constant attendance of the physician, *and* the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met. Codes 99291/99292 *and* modifier 24 (Unrelated E/M service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM diagnosis code in the range 800.0 through 959.9 (except 930-939) that clearly indicates that the critical care was unrelated to the surgery is acceptable documentation.

Ambulatory Surgical Centers Reimbursement Guidelines for "Each Additional" Procedures

When a procedure code indicates "each additional" in the descriptor, the service can now be billed on one line indicating the total number of "each additional" services in the "DAYS OR UNITS" field.

The following is a current list of ASC approved codes that contain "each additional" in the descriptor:

15101	15401	64472	64783
15121	19126	64476	64832
15201	19291	64480	64837
15221	26125	64484	64859
15241	26861	64623	64901
15261	26863	64627	64902
15351	27692	64778	

Billing Clarification for Flu Roster Claims

This instruction is to clarify the place of service code to utilize when submitting roster claims to carriers. Individuals/entities administering influenza and PPV vaccinations in a mass immunization setting, regardless of the site where vaccines are given should use POS 60 for roster claims, paper claims and electronically filed claims.

For complete instructions regarding Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines, refer to the Third Quarter 2003 *Medicare B Update!* (pages 10-14).

Source: Internet Only Manual Publication 100-4 Chapter 18 Sections 10.2.5 and 10.3.1.

Billing Issue with Modifiers for Transportation of Portable X-rays (R0075)

This information was previously published in the Second Quarter 2005 Medicare B Update! (page 42)

It has been determined that there w as a problem with the submission of claims for procedure code R0075 when multiple patients are being transported.

Prior to dates of service January 1, 2004, the units field of the Medicare claim form was used to indicate the number of patients transported in order to determine the appropriate single payment.

Effective for dates of service on/after January 1, 2004, five new modifiers for HCPCS code R0075 were implemented to report the number of patients served during a single trip that the portable X-ray supplier makes to a particular location.

UN Two patients served

UP Three patients served

UQ Four patients served

UR Five patients served

US Six patients or more served

The carrier will process code R0075 based on the modifier not the number billed. Therefore, you should bill using the appropriate modifier.

Note: If less than 2 patients are served, code R0070 should be reported with no modifier since the descriptor for this code reflects only one patient seen.

Source: Pub. 100-04 Transmittal: 343 Change Request 3280

Sign up to our *eNews* electronic mailing list

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

COVERAGE/REIMBURSEMENT

AMBULANCE

Revision Regarding Submission Of Rural Air Ambulance Services Protocol For Contractor Review

According to Section 415 of the Medicare Modernization Act of 2003, the reasonable and necessary requirement for rural air ambulance transport may be "deemed" to be met when the service is provided pursuant to an established state or regional emergency medical services (EMS) agency protocol. The protocol must be recognized or approved by the Secretary of the Department of Health and Human Services, which administers Medicare through the Centers for Medicare & Medicaid Services (CMS).

CMS defines "established" to mean those protocols that have been reviewed and approved by the state EMS agencies or have been developed according to state EMS umbrella guidelines. Submission of protocols for review and subsequent approval will "deem" that the reasonable and necessary requirement for rural air ambulance transport has been met by the provider.

Providers that anticipate rural air ambulance transports pursuant to such a protocol may submit the written protocol to their carrier for review and approval in advance. Providers may submit protocols for review as follow:

By e-mail: medical.policy@fcso.com
Please include **Air Ambulance Protocol** in the subject line.

By USPS: First Coast Service Options, Inc
Medical Policy and Procedures ROC 19T
ATTN: Juanita R. Mitchell, RN
P.O. Box 2078
Jacksonville, Florida 32231-0048

By FAX: 1-904-997-5665

Providers will be notified of all protocol review decisions in writing within 30 days of receipt by FCSO.

Please include a contact name, telephone number and address with your submissions. Review decisions will be mailed to this address.

CMS has issued a "Medlearn Matters...Information for Providers" article pertaining to this requirement, which may be viewed at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3571.pdf*.

If additional information is needed, you may contact Juanita R. Mitchell, RN via e-mail at Juanita.Mitchell@fcso.com or by phone at 1-904-791-8015.

Source: Pub 100-08 Transmittal 93 Change Request 3571

AMBULATORY SURGICAL CENTERS

Clarification Regarding the HCPCS Code Q3001 Performed in an Ambulatory Surgery Center

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

Provider Types Affected

Physicians billing Medicare carriers for HCPCS code Q3001 performed in an ASC setting.

Provider Action Needed

STOP – Impact to You

HCPCS code Q3001 should be used by providers on claims when billing for radioelements for brachytherapy performed in an ASC setting, instead of the current procedural terminology (CPT) code 79900, effective January 1, 2005.

CAUTION – What You Need to Know

There has been confusion among ASCs and Medicare carriers regarding the use of HCPCS code Q3001. HCPCS Q3001 is carrier priced on the 2005 Medicare Physician Fee Schedule and should be used when billing for prostate brachytherapy procedures when performed in an ASC setting.

GO – What You Need to Do

Be aware of the current payment policy for Q3001 and Medicare carriers will process claims containing this code when the services are performed on or after January 1, 2005.

Background

The Centers for Medicare & Medicaid Services (CMS) is aware of confusion among carriers and providers hen HCPCS code Q3001 is used to bill for prostate brachytherapy procedures performed in an ASC setting.

Effective January 1, 2005, Q3001 is carrier priced under the 2005 Medicare Physician Fee Schedule Database (MPFSDB) and can be billed to Medicare carriers for Part B services. Previously, Q3001 was only paid under the Outpatient Prospective Payment System (OPPS) and billable only to Medicare fiscal intermediaries.

This instruction and CR 3789 clarify CMS' payment policy decision regarding the use of Q3001 on Medicare claims. HCPCS code Q3001 should be used instead of CPT 79900 when billing for prostate brachytherapy procedures performed in an ASC, on and after January 1, 2005.

Additional Information

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

From that Web page, look for CR 3789 in the CR NUM column on the right, and then click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3789
Related CR Release Date: April 8, 2005
Effective Date: January 1, 2005
Medlearn Matters Number: MM3789
Related CR Transmittal #: 520
Implementation Date: May 9, 2005

CONSOLIDATED BILLING

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

This information was previously published in the Second Quarter 2005 Medicare B Update! pages 26-29.
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: This article was revised on February 8, 2005 to correct punctuation in the first bullet point under "Major Category V". No other changes were made.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

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

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

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

Please take note of the following important points:

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

This notification provides a list of the exclusions, and some inclusions, to SNF CB, and the codes below are being added or removed from the annual update. Note the following:

Major Category I additions noted below means these codes:

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

Major Category III additions noted below means these services:

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

Major Category IV additions noted below means these services:

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

Major Category V additions to therapy inclusions noted below means:

- SNFs alone can bill and be paid for these services when delivered to beneficiaries in a SNF, whereas codes being removed from this therapy inclusion list now can be billed and potentially paid to other types of providers for beneficiaries **NOT** in a Part A stay or in a SNF bed receiving ancillary services billed on TOB 22x.

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

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

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

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

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

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

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

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

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

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

- **Add G0357+** - Intravenous, push technique, single or initial substance/drug
- **Add G0358+** - Intravenous, push technique, each additional substance/drug
- **Add G0359+** - chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
- **Add G0360+** - Each additional hour, 1 to 8 hours
- **Add G0361+** - initiation of prolonged chemotherapy infusion (more than 8 hours)

- **Add G0362+** - Each additional sequential infusion (different substance/drug), up to 1 hour
- **Add G0363+** - Irrigation of implanted venous access device for drug delivery systems

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

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

- Remove G0203 - screening mammography

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

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

- Add 82950 - Glucose; post glucose dose

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

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

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

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

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

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

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

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

Implementation

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

Additional Information

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

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

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

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

Skilled Nursing Facility Consolidated Billing

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This article was last published in the Second Quarter 2005 Medicare B Update! (pages 30-33).
NOTE: **This article was revised on February 9, 2005 to include clarifying language, but no substantive changes were made.**

Provider Types Affected

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

Provider Action Needed

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

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

Background

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

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

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

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

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

Based on the above-mentioned problems, Congress enacted the Balanced Budget Act of 1997 (BBA), Public Law 105-33, section 4432(b), and it contains a CB requirement for SNFs. Under the CB requirement, **an SNF itself must submit all Medicare claims for the services that its residents receive** (except for specifically excluded services listed below).

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

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

Effective Dates

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

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

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

Excluded Services

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

- Physicians' services furnished to SNF residents. These services are not subject to CB and, thus, are still billed separately to the Part B carrier.
- Certain diagnostic services include both a professional component (representing the physician's interpretation of the test) and a technical component (representing the test itself), and the technical component is subject to SNF CB. **The technical component of these services must be billed to and reimbursed by the SNF**. (See Medlearn Matters special edition article SE0440 for a more detailed discussion of billing for these diagnostic tests.)

- Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that **physical therapy, occupational therapy, and speech-language pathology services are subject to CB**, even when they are furnished by (or under the supervision of) a physician.
- Physician assistants working under a physician's supervision
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician
- Certified nurse-midwives
- Qualified psychologists
- Certified registered nurse anesthetists
- Services described in section 1861(s)(2)(F) of the Social Security Act (i.e., Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies)
- Services described in section 1861(s)(2)(O) of the Social Security Act, i.e., Part B coverage of epoetin alfa (EPO, trade name epogen) for certain dialysis patients. Note: darbepoetin alfa (DPA, trade name aranesp) is now excluded on the same basis as EPO
- Hospice care related to a resident's terminal condition
- An ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge

Physician "Incident To" Services

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

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

- Cardiac catheterization
- Computerized axial tomography (CT) scans
- Magnetic resonance imaging (MRIs)
- Ambulatory surgery that involves the use of an operating room
- Emergency services
- Radiation therapy services
- Angiography
- Certain lymphatic and venous procedures

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

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

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

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

Effects of CB

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

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

Additional Information

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

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

  It includes the following relevant information:

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

  The SNF PPS CB website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.
  It included the following relevant information:

  - Background
  - Historical questions and answers
  - Links to related articles
  - Links to publications (including transmittals and federal register notices)

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

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.
This information was previously published in the January 2005 Medicare B Update! Special Issue – 2005 HCPCS and MPFSDB Update! pages 70-72.

Note: This article was revised on February 8, 2005 to provide some clarifying language, but no substantive changes were made.

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 that provides details regarding the services to be provided "under arrangement" and the manner in which the SNF will pay the supplier for those services can help both parties arrive at a mutual understanding on these important 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 claim submitted to its Medicare intermediary almost all of the services a resident receives during a covered stay. The SNF should not include on the claim those services, which are excluded from the SNF's prospective payment system (PPS) per diem payment for the particular stay.

These excluded services continue to be separately billable under Part B by those outside suppliers that actually furnish the service. In this context, the term "supplier" can also refer to:

- A provider of services (such as a hospital), which would submit the bill for Part B services to its Medicare intermediary; and
- Practitioners who, in addition to performing their separately billable professional services, essentially act as a supplier by also furnishing other services that are subject to the consolidated billing requirement.

Outside entities (other than a provider of services) would generally submit their Part B bills to a Medicare carrier, but Part B bills for certain types of items or equipment are submitted to the Medicare durable medical equipment regional carrier (DMERC).

In addition, 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 *noncovered* stay.

Further, 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 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 under Part B). In these situations, 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 an outside entity that furnishes a service which is included in the SNF's 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
- 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) to the SNF's patients. 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 how long it will take for payment after the supplier presents an invoice to the SNF.

SNF's Responsibility

However, the absence of an agreement with its supplier (written or not) does not relieve the SNF of its responsibility to pay suppliers for services "bundled" in the SNF PPS payment from Medicare. 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 by the SNF of a supplier claim may occur. When patterns of such non-payment are identified, there are potentially adverse consequences to SNFs with regard to their Medicare agreement.

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 those 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, which 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 noncovered, 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 Medicare denies that Part B claim.

In this scenario, even though the supplier may have 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.

In Scenario 1, if the SNF refuses to pay the supplier even after the supplier brings the situation to the attention of the SNF, 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 services provided "under arrangement" would provide a basis for resolving the dispute and 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 suppliers that the SNF 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. In addition, the SNF should periodically remind the beneficiary or his/her representative of these rights/requirements throughout the resident's stay, and especially 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*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

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

Skilled Nursing Facility Consolidated Billing Related to Ambulance Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article. This was originally published in the First Quarter 2005 Medicare Part B Update! (pages 69-71).

Note: This instruction was revised on February 18, 2005 to include clarifying language, but no substantive changes were made.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, ambulance suppliers, and providers

Provider Action Needed

This special edition article describes SNF consolidated billing (CB) as it applies to ambulance services for SNF residents.

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

Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See Medlearn Matters Edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e. based on the reason the ambulance service is needed. This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or "bundling" requirement since 1983. Since the law describes CB in terms of services that are furnished to a "resident" of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)- (iv) as ending the beneficiary's SNF "resident" status. The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.)
- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below)
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance Trips to Receive Excluded Outpatient Hospital Services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis.

These services are the following:

- Cardiac catheterization
- Computerized axial tomography imaging (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite)
- Emergency room services
- Radiation therapy
- Angiography
- Lymphatic and venous procedures.

Since the receipt of one of these excluded types of outpatient hospital services is considered to end a beneficiary's status as an SNF resident for CB purposes, any associated ambulance trips are, themselves, excluded from CB as well; thus, an ambulance trip furnished in connection with the receipt of such services should be billed separately to Part B by the outside supplier.

Other Ambulance Trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers Between Two SNFs

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)). Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under §411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

Roundtrip to a Physician's Office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate. The preamble to the July 30, 1999 final rule (64 Federal Register 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Additional Information

See Medlearn Matters special edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare & Medicaid Services (CMS) Medlearn consolidated billing website is: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

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

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

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and federal register notices)

Related Change Request (CR) #: N/A — Medlearn Matters Number: SE0433
Related CR Release Date: — Related CR Transmittal #:
Effective Date: N/A — Implementation Date: N/A

Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers

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

NOTE: This article was revised on February 10, 2005 to include clarifying language, but no substantive changes were made.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, practitioners, and clinical social workers (CSWs)

Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to CSW services furnished to SNF residents during a Part A covered stay.

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

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns SNFs the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay.

Payment for this full range of services is included in the SNF PPS global per diem rate. The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB and a list of the services excluded from SNF CB, see Medlearn Matters Special Edition SE0431 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Since CSW services do not currently appear on this excluded list, they are included within the overall package of services that is subject to the SNF CB requirement. Although the inclusion of CSW services under the SNF CB requirement does not preclude Medicare coverage for these services, it makes the SNF responsible for including them in its Part A bill for the resident's covered stay. In fact, bundling CSW services in the Part A payment rate is not a new concept. The corresponding Medicare comprehensive billing requirement for inpatient hospital services, which similarly includes CSW services while excluding the services of certain other types of mental health professionals, has been in effect since 1983, and served as a model for SNF CB.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Also, the Centers for Medicare & Medicaid Services (CMS) Medlearn CB website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

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

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

It includes the following relevant information:

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

Related Change Request (CR) #: N/A Medlearn Matters Number: SE0439
Effective Date: N/A **Revised** Implementation Date: N/A

Skilled Nursing Facility Consolidated Billing as it Relates to Certain Diagnostic Tests

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

NOTE: This article was revised on February 10, 2005 to include clarifying language, but no substantive changes were made.

Provider Types Affected

Skilled Nursing Facilities (SNF), physicians, suppliers, providers, and radiology centers

Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to certain diagnostic tests that include both a technical component (representing the test itself) and a professional component (representing the physician's interpretation of the test). These tests commonly include diagnostic radiology procedures (such as X-rays) and laboratory tests, but can also include other types of diagnostic procedures (such as audiology services) as well.

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

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it not only changed the way SNFs are paid, but changed the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See Medlearn Matters Special Edition SE0431 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

It contains a detailed overview of SNF CB and a list of the services excluded from SNF CB.

However, one of the service categories that the law ***does*** exclude from the SNF CB provision is physician services, which are separately billable to the Medicare Part B carrier.

Since many diagnostic tests include both a technical component and a professional component, suppliers need to generate two bills. For example, with regard to diagnostic radiology services, such as x-rays, the physician service exclusion applies only to the professional component of the diagnostic radiology service (representing the physician's interpretation of the diagnostic test).

The physician service is billed directly to the Medicare Part B carrier.

Because the diagnostic radiology service's technical component is already included within the SNF's global per diem payment for its resident's covered Part A stay, the outside supplier that actually furnishes the technical component would look to the SNF (rather than to their Medicare carrier) for payment.

As indicated in the preceding discussion, these policies are not new, and have been in effect since the implementation of the SNF PPS in 1998. What has changed, though, is that the Centers for Medicare & Medicaid Services (CMS) installed electronic edits in 2002 that enable the claims processing system to detect automatically any claims that are inappropriately submitted to Medicare carriers or intermediaries for those services that are already included within the SNF's global per diem payment for a resident's covered Part A stay (such as the technical component of diagnostic tests).

As discussed above, because these services are already included within the SNF's payment for its resident's Medicare-covered stay, an outside entity that furnishes the services must look to the SNF, rather than to Medicare, for payment.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The CMS Medlearn consolidated billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

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

Also, the SNF PPS consolidated billing website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and federal register notices).

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0440
Related CR Release Date: N/A

Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage

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

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, End-Stage Renal Disease (ESRD) facilities, and hospitals

Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to dialysis coverage for SNF residents. See Medlearn Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf.

Clarification

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

Background

Dialysis furnished to a SNF resident during a covered Part A stay falls within the scope of the SNF benefit under the Social Security Act, Section 1861(h)(7), as long as the SNF elects to provide the dialysis itself, either directly or under an

"arrangement" with a qualified outside supplier in which the SNF itself assumes the Medicare billing responsibility. When covered in this manner, the dialysis would be included in the global Medicare Part A per diem payment that the SNF receives under the prospective payment system (PPS).

However, the SNF PPS legislation also gives SNFs the option of "unbundling" the dialysis and, thereby, allowing and outside supplier to furnish the dialysis services and submit a bill directly to its Medicare Part B carrier.

If the SNF elects this option, dialysis services that meet the requirements for separate coverage under the Part B dialysis benefit (as described in the Social Security Act, Section 1861(s)(2)(F) are excluded from SNF CB. As such, these services can be furnished and billed directly to the Medicare Part B carrier by the outside dialysis supplier itself. In addition, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section103) excluded from SNF CB those ambulance services that are necessary to transport a SNF resident offsite to receive the Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

As noted previously, if the SNF elects to provide the dialysis services under Part A, either directly or under an arrangement with an outside supplier, these services would be included in the SNF's PPS per diem payment (since dialysis services that SNFs furnished in this manner during the PPS base period would have been included on their cost reports and reflected in the PPS base). Further, since the Social Security Act (Section 1833 (d)) expressly prohibits payment under Part B for any service that is covered under Part A, such services would not be excluded from SNF CB, since they would no longer meet the statutory criteria (Section 1888(e)(2)(A) (ii)) of being items and services that meet the requirements for coverage under the separate Part B dialysis benefit of the Social Security Act (Section 1861 (s)(2)(F)).

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing website may be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

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

The SNF PPS Consolidated Billing website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.
It includes the following relevant information:

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

Related Change Request (CR) #: N/A Medlearn Matters Number: SE0435
Effective Date: N/A Implementation Date: N/A

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

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
Previously published in the Second Quarter 2005 Part B Update! (pages 29-30)

Note: This article was revised on March 1, 2005 to delete the reference to Chapter 17 of the Medicare Benefit Policy Manual in the Additional Information section of the article.

Provider Types Affected

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

Provider Action Needed

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

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

Background

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

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

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

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

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

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

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

Additional Information

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

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

Also, the Medicare Benefit Policy Manual Chapter 11 regarding billing and payment details for EPO and DPA can be found at the following CMS website: *http://www.cms.gov/manuals/102_policy/bp102c11.pdf*.

You can find the Medicare Claims Processing Manual, Pub. 100-04, Chapter 8, Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, at the following CMS website: *http://www.cms.hhs.gov/manuals/104_claims/clm104c08.pdf*.

The CMS Consolidated Billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*. It includes the following relevant information:

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

The CMS skilled nursing facility prospective payment system (SNF PPS) website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

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

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

Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services

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

Note: This article was revised on February 18, 2005 to include clarifying language but no substantive changes were made.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, providers, and imaging centers

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

Provider Action Needed

This special edition describes SNF CB as it relates to certain types of exceptionally intensive outpatient hospital services, such as magnetic resonance imaging (MRI) services, computerized axial tomography (CT) Scans, and radiation therapy.

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB, including a section on services excluded from SNF CB, see Medlearn Matters special edition article SE0431 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The original CB legislation (Section 4432(b) of the Balanced Budget Act of 1997, P. L. 105-33 (BBA 1997)) specified a list of services at Section 1888(e)(2)(A)(ii) of the Social Security Act that were excluded from this provision. As with the inpatient hospital bundling requirement (Section 1862(a)(14) of the Social Security Act) on which it was modeled, the SNF CB provision excluded primarily the services of physicians and certain other practitioners.

Moreover, these services were excluded categorically, without regard to the specific setting in which they were furnished. This legislation did not authorize the Department of Health and Human Services (DHHS) to create additional categorical exclusions from CB administratively, thereby reserving this authority for the congress itself. In fact, the congress subsequently did enact a number of additional CB exclusions that applied uniformly to services furnished in both hospital and non-hospital settings, in Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA 1999, P.L.106-113, Appendix F). While the original CB legislation did not authorize DHHS to simply carve out entire categories of services from CB without regard to setting, it did define the SNF CB provision in terms of services furnished to a resident of a SNF, and provided a degree of administrative discretion in defining when a beneficiary is considered to be a SNF "resident" for this purpose.

Using this authority, the Centers for Medicare & Medicaid Services (CMS) identified several types of exceptionally intensive outpatient hospital services that were well beyond the general scope of SNF care plans. These services include:

- Emergency services
- Cardiac catheterizations
- Computerized axial tomography (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery
- Radiation therapy
- Angiography
- Lymphatic and venous procedures.

CMS established that a beneficiary's receipt of such services in the outpatient hospital setting had the effect of temporarily suspending his/her status as a SNF resident for CB purposes, thus enabling the hospital to bill Part B separately for the services. (See Title 42 of the code of federal regulations (42 CFR), Section 411.15(p)(3)(iii).) The underlying rationale for this exclusion was that these services were so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively.

In the legislative history that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress explicitly recognized that this administrative exclusion is specifically limited to "…certain outpatient services from a Medicare participating hospital or critical access hospital…" (emphasis added). (See the House

Ways and Means Committee Report (H. Rep. No. 108-178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108-391 at 641)). This means that the exclusion does not encompass services that are furnished in other, non-hospital settings (such as freestanding clinics).

As noted previously, in addition to the existing exclusion of certain types of intensive outpatient hospital services under the regulations at 42 CFR 411.15(p)(3)(iii), Congress has elected to exclude several categories of services from CB in the statute itself, at Sections 1888(e)(2)(A)(ii)-(iii) of the Social Security Act. Unlike the administrative exclusion discussed above, which applies solely to services furnished in the outpatient hospital setting, the statutorily excluded services are separately billable to Part B regardless of the setting (hospital versus freestanding) in which they are furnished.

For example, as amended by Section 103 of BBRA 1999, Section 1888(e)(2)(A)(iii)(II) of the Social Security Act excludes certain types of intensive chemotherapy services, regardless of whether they are furnished in a hospital or freestanding setting. Additional legislation would be required to expand the exemption of CT scans, MRI services, and radiation therapy to apply to services furnished in non-hospital settings.

Chemotherapy and its administration and radioisotopes and their administration are identified in the statute by HCPCS code. These services are separately billable in all care settings, but the exclusion applies only to the codes specified in the Social Security Act and subsequent regulations. Therefore, other services given in conjunction with an excluded code (e.g., other pharmaceuticals, medical supplies, etc.) remain bundled and should be reimbursed by the SNF to the supplier.

Please note that the professional charge for the physician who performs/interprets the radiological procedure is NOT subject to CB. Since the physician service exclusion applies to the professional component of the diagnostic radiology service, the physician bills his/her service directly to the Medicare Part B carrier for reimbursement.

Additional Information

See Medlearn Matters special edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare and Medicaid Services (CMS) Medlearn CB website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*

It includes the following relevant information:

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

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

It includes the following relevant information:

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

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0432
Effective Date: N/A **Revised**
Implementation Date: N/A

Skilled Nursing Facility Consolidated Billing and Preventive/ Screening Services

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

NOTE: This article was revised on February 9, 2005 to include clarifying language, but no substantive changes were made.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, and providers

Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to preventive and screening services provided to SNF residents.

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

Background

When the SNF prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. See Medlearn Matters article SE0431 for a

detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's resident (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list preventive and screening services among the services identified for exclusion, these services are included within the scope of the CB provision.

However, reimbursement for covered preventive and screening services, such as vaccines and mammographies, is subject to special billing procedures. As discussed in the May 12, 1998 Federal Register (63 FR 26296), since preventive services (such as vaccinations) and screening services (such as screening mammographies) do not appear on the exclusion list, they are subject to CB. Accordingly, if an SNF resident receives, for example, a flu vaccine during a covered Part A stay, the SNF itself is responsible for billing Medicare for the vaccine, even if it is furnished to the resident by an outside entity.

Nevertheless, even though the CB requirement makes the SNF itself responsible for billing Medicare for a preventive or screening service furnished to its Part A resident, the SNF would not include the service on its Part A bill, but would instead submit a separate bill for the service. This is because the Part A SNF benefit is limited to coverage of "diagnostic or therapeutic" services (i.e., services that are reasonable and necessary to diagnose or treat a condition that has already manifested itself). (See Sections 1861(h) following (7), 1861(b)(3), and 1862(a)(1) of the Social Security Act.) Accordingly, the Part A SNF benefit does not encompass screening services (which serve to detect the presence of a condition while it is still in an early, asymptomatic stage) or preventive services (which serve to ward off the occurrence of a condition altogether). Such services are always covered under Part B, even when furnished to a beneficiary during the course of a covered Part A SNF stay. Under Section 1888(e)(9) of the Social Security Act, payment for an SNF's Part B services is made in accordance with the applicable fee schedule for the type of service being billed.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare & Medicaid Services (CMS) Medlearn CB website is at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

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

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

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and federal register notices).

Related Change Request (CR) #:N/A
Medlearn Matters Number: SE0436
Effective Date: N/A **Revised**
Implementation Date: N/A

Skilled Nursing Facility Consolidated Billing Related to Prosthetics/Orthotics

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

NOTE: This article was revised on February 10, 2005 to include clarifying language, but no substantive changes were made.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, and providers

Provider Action Needed

This Special Edition is an informational article that describes SNF consolidated billing (CB) as it applies to prosthetics and orthotics for SNF residents.

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

Background

The SNF CB provision of the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432(b)) is a comprehensive billing requirement under which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. This billing requirement is similar to the billing requirement that has been in effect for inpatient hospital services since 1983.

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's residents (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list prosthetic devices among the services identified for exclusion, such items initially were categorically included within the scope of the CB provision.

However, effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F, Section 103) provided for the exclusion of certain additional types of services from SNF CB. These services are listed in a separate Medlearn Matters article, SE0431, which also provides an overview of SNF CB. This article can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*

The original statutory exclusions enacted by the BBA consist of a number of broad service categories and encompass all of the individual services that fall within those categories. By contrast, the additional exclusions enacted in the BBRA are more narrowly targeted, and apply only to certain specified, individual services within a number of broader service categories that otherwise remain subject to CB.

For customized prosthetic devices, the exclusion applies only to those individual items that the legislation itself specifically identifies by healthcare common procedure coding system (HCPCS) code, while all other items within this category remain subject to CB. The individual HCPCS codes by which the excluded services are identified appear in annual and quarterly CB updates. These CB updates can be found at: *http://www.cms.hhs.gov/providers/snfpps/snfpps_pubs.asp*

The BBRA Conference Committee report (H. Rep. 106-479) characterized the individual services that this legislation targeted for exclusion as "…high-cost, low-probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system…."

The BBRA also gives the Centers for Medicare & Medicaid Services (CMS) limited authority to identify additional prosthetic codes for exclusion, in response to developments such as major advances over time in the state of medical technology, or reconfigurations of the HCPCS codes themselves. When new HCPCS codes are established for excluded services, the new codes are communicated through the annual and quarterly CB updates.

Moreover, while Congress elected to exclude from CB certain specific customized prosthetic devices that meet the criteria discussed above regarding high cost and low probability, it declined to exclude other types of prosthetic devices, and also declined to exclude orthotics as a class.

In contrast to prosthetics, those items in the orthotics category tend to be more standardized and lower in cost. Further, even those customized items that fall at the high end of the orthotics category generally are still significantly less expensive and more commonly furnished in SNFs than customized items that fall at the high end of the prosthetics category.

Accordingly, orthotics would not appear to meet the criteria of exceptionally high cost and low probability that served as the basis for the BBRA exclusions. Further, even if certain individual orthotic devices were to be identified as meeting these criteria, excluding them from the CB requirement could not be accomplished administratively, but would require further legislation by congress to add this service category to the statutory exclusion list.

In addition, CMS notes that in contrast to prosthetics (where the needs of a patient with a missing limb can often be addressed only through the use of a single, particular type of customized device), it is often medically feasible to use a relatively inexpensive orthotic device in place of a more expensive one. Thus, CMS believes that the SNF PPS appropriately places the financial responsibility for such devices (along with the decision-making authority for selecting among them) with the SNF itself, because it may be possible to address a particular SNF resident's condition with equal efficacy by selecting among a broader range of orthotic devices.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*

The Centers for Medicare & Medicaid Services (CMS) Medlearn CB website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*

It includes the following relevant information:

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

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

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and federal register notices)

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0437
Effective Date: N/A **Revised**
Implementation Date: N/A

Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers

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

NOTE: This article was revised on February 18, 2005. Specifically, line 4 of the "Clarification" statement below was modified to say "These "excluded" services…." instead of "These included services…" We regret this error.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs).

Provider Action Needed

This special edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to services provided by RHCs and FQHCs.

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

Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB places with the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay.

Payment for this full range of services is included in the SNF PPS global per diem rate. The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB and a list of the services excluded from SNF CB, see Medlearn Matters Special Edition SE0431 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Prior to January 1, 2005, RHC and FQHC services did not appear on the original list of services that were statutorily excluded from the SNF CB requirement. Consequently, when a SNF resident receives RHC or FQHC services during a covered Part A stay, the services were bundled into the SNF's comprehensive per diem payment for the covered stay itself, and were not separately billable as RHC or FQHC services to the fiscal intermediary (FI). This means that rather than submitting a separate bill to the FI for these services, the RHC or FQHC looked to the SNF for its payment.

However, Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) amended the law to specify that when a SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from an RHC or FQHC, those services are not subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC.

In effect, the amendment enables such RHC and FQHC services to retain their separate identity as excluded "practitioner" services. As such, these RHC and FQHC services remain separately billable to the FI when furnished to an SNF resident during a covered Part A stay. The MMA specifies that this provision became effective with services furnished on or after January 1, 2005.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Also, the Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

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

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

It includes the following relevant information:

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

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0438
Effective Date: January 1, 2005
Implementation Date: N/A

Skilled Nursing Facility (SNF) Consolidated Billing (CB) as It Relates to Therapy Services

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

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, practitioners, physical and occupational therapists, speechlanguage pathologists, rehabilitation agencies, hospitals, home health agencies

Provider Action Needed

This article is informational only and describes SNF Consolidated Billing (CB) as it applies to physical and occupational therapies and speech-language pathology services furnished to SNF residents during a Part A covered stay, residents of a Medicare-certified SNF who are not eligible for Part A care, and beneficiaries who reside in the non-certified portion of a nursing home.

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

Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. Consolidated billing assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. A covered Part A stay occurs when a beneficiary meets all of the requirements for coverage under Part A's extended care benefit, and resides in an institution or part thereof that is Medicare-certified as an SNF. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are services specifically excluded from this consolidated billing provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service.

The law specifically provides that physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services are not excluded from consolidated billing (Section 1888(e)(2)(A)(ii) of the Social Security Act and regulations at 42 CFR 411.15(p)(1)(i)). (References in this article to therapy cover only PT, OT, and SLP services.)

(See Medlearn Matters Special Edition article SE0431 for a detailed overview of SNF consolidated billing, including a section on services excluded from SNF consolidated billing.) This article can be found at:

http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

The consolidated billing legislation is very emphatic that PT, OT, and SLP services furnished to SNF residents are always subject to consolidated billing. This applies even when a resident receives the therapy during a noncovered stay in which a beneficiary who is not eligible for Part A extended care benefits still resides in an institution (or part thereof) that is Medicare-certified as a SNF. The legislation also applies regardless of whether or not the services are performed by, or under the supervision of, a practitioner (such as a physician) whose services would otherwise be excluded from consolidated billing.

Therapy services that are furnished to residents of a Medicare-certified SNF are subject to the SNF consolidated billing provision. Payment for therapy services furnished during a covered Part A stay is included in the SNF's global per diem PPS rate.

In a noncovered SNF stay, the beneficiary may be eligible for coverage of individual medical and other health services under Part B. Since the beneficiary still resides in a Medicare-certified institution (or part thereof) the therapy services are subject to the SNF consolidated billing provision. Under this provision, the claims for therapy services furnished during a noncovered SNF stay must be submitted to Medicare by the SNF itself. The SNF is responsible for reimbursing the provider. The SNF would bill its fiscal intermediary and be reimbursed under the Medicare fee schedule.

When a beneficiary resides in a nursing home (or part thereof) that is not certified as an SNF by Medicare, the Part A extended care benefit cannot cover the beneficiary's stay. However, the beneficiary may still be eligible for Part B coverage of certain individual services, including therapy. In this case, the beneficiary is not considered an SNF resident for Medicare billing purposes, and the therapy services are not subject to consolidated billing. Either the therapy provider or the facility may bill the Medicare carrier for Part B directly.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare and Medicaid Services (CMS) Medlearn Consolidated Billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

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

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

It includes the following relevant information:

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

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0518
Effective Date: N/A
Implementation Date: N/A

DIABETIC SERVICES

Infusion Pumps: C-Peptide Levels as a Criterion for Use

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

Provider Types Affected

Physicians, suppliers, and providers providing continuous subcutaneous insulin infusion and related drugs/supplies in the treatment of diabetic patients in the home setting and billing Medicare carriers or fiscal intermediaries (FIs).

Provider Action Needed

STOP – Impact to You

This article and related CR 3705 adds beta cell autoantibody testing as an alternative diagnostic per the updated C-peptide testing requirement for the use of insulin infusion pumps, effective for services performed on or after December 17, 2004.

CAUTION – What You Need to Know

Providers/suppliers treating Medicare diabetic patients with infusion pumps should be aware of this new Medicare coverage policy.

GO – What You Need to Do

Ensure that your staff is aware of this new coverage and that they bill according to the information in this article.

Background

On August 26, 1999, the Centers for Medicare & Medicaid Services (CMS) issued the first decision memorandum (DM) for continuous subcutaneous insulin infusion pumps (CSII) that utilized a C-peptide testing requirement for Medicare coverage of CSII pump therapy. On May 11, 2001, CMS issued a second DM for insulin pump: "C-Peptide Levels as a Criterion for Use," and on January 1, 2002, CMS revised the laboratory value for the C-peptide testing requirement for Medicare coverage of CSII pump therapy.

Effective for services performed on or after December 17, 2004, in addition to meeting criterion A or B, the beneficiary with diabetes must be insulinopenic per the fasting C-peptide testing requirement or, as an alternative must be beta cell auto antibody positive. Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. For patients with renal insufficiency and a creatinine clearance (actual or calculated from age, gender, weight, and serum creatinine) < 50 ml/minute, insulinopenia is defined as a fasting C-peptide level that is less than or equal to 200% of the lower limit of normal of the laboratory's measurement method. CMS establishes that fasting C-peptide levels will only be considered valid when a concurrently obtained fasting glucose is < 225 mg/dL.

Levels need only be documented once in the patient's medical records.

Coverage of all other uses of CSII that adheres with the Category B IDE clinical trials regulation (42 CFR 405.201) or routine cost under the clinical trials policy (Medicare NCD Manual Chapter 1, Part 4, Section 310.1) will continue.

Those billing for these services should note that Medicare carriers/intermediaries will accept, effective for services on or after December 17, 2004, CPT code 84681 (C-peptide) or CPT code 86337 (insulin antibodies) when diagnosis codes 250.00-250.93 are also reported on a claim.

Additional Information

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

From that web page, look for CR 3705 in the CR NUM column on the right, and click on the file for that CR.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3705
Medlearn Matters Number: MM3705
Related CR Release Date: March 30, 2005
Related CR Transmittal #: 27 and 513
Effective Date: December 17, 2005
Implementation Date: February 18, 2005

DRUGS AND BIOLOGICALS

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

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is revising certain payment limits included in the first quarter 2005 (1Q05) Medicare Part B Drug Pricing File used by Medicare carriers and intermediaries, including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs).

CAUTION – What You Need to Know

Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

GO – What You Need to Do

Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

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 new average sales price (ASP) method. The ASP method is based on data submitted to CMS by manufacturers at the 11-digit National Drug Code (NDC) level. CMS then determines the number of billable units per NDC based on published drug pricing information as well as other sources available to CMS.

Through receipt of additional information, CMS has determined certain payment limits in the 1Q05 Medicare Part B Drug Pricing File need revision. Tables 1 and 2 below identify the revised payment limits. The limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005.

The revised payment limits in this notification supersede the payment limits for these codes in any publication published prior to CR 3728.

Also, note that the ASP-based 1Q05 payment limit for J7510, Q4054, and Q4055 are now provided. The revised payment limit for 90740, a vaccine, is based on 95% of the average wholesale price (AWP). The revised payment limits for the blood clotting factor codes includes the $0.14 per I.U. furnishing fee. The payment limits in Table 2 are for certain new drugs.

Table 1

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
90740	Hepb vacc, ill pat 3 dose im	3 DOSE SCH	$113.91	$113.91	$113.91
J7190	Factor viii	I.U.	$0.66	$0.66	
J7191*	Factor viii (porcine)	I.U.	$1.86	$1.86	
J7192*	Factor viii recombinant	I.U	$1.06	$1.06	
J7193*	Factor ix non-recombinant	I.U.	$0.89	$0.89	
J7194*	Factor ix complex	I.U.	$0.63	$0.63	
J7195*	Factor ix recombinant	I.U.	$0.98	$0.98	
J7197*	Antithrombin iii injection	I.U.	$1.72	$1.72	
J7198*	Anti-inhibitor	I.U.	$1.23	$1.23	
J7510	Prednisone oral per 5 mg	5 MG	$0.05	$0.05	
Q0187*	Factor viia recombinant	1.2 MG	$1,051.45	$1,051.45	
Q2022*	Von Willebrand Factr Cmplx per IU	I.U.	$0.86	$0.86	
Q4054	Darbepoetin alfa, ESRD use	1MCG	$3.54	$3.54	
Q4055	Epoetin alfa, ESRD use	1,000 units	$9.32	$9.76	

* The ASP-based payment allowance limit for blood clotting factors and the furnishing fee for the blood clotting factors do not apply to inpatient claims.

Table 2

HCPCS Code	Drug Name	Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
J3490	Pegaptamib sodium	0.3 MG	$1,054.70	$1,054.70	
J9999	Histrelin implant	5 MG	$530.00	$530.00	
J9999	Natalizumab	5 MG	$31.94	$31.94	

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

Implementation

The implementation date is February 4, 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 3728 in the CR NUM column on the right and click on the file for that CR.

CMS will also update the Microsoft excel files on the CMS website to reflect these revised payment limits.

Those files are at: *http://www.cms.hhs.gov/providers/drugs/asp.asp*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3728
Medlearn Matters Number: MM3728
Related CR Release Date: February 3, 2005
Related CR Transmittal #: 140
Effective Date: January 1, 2005
Implementation Date: February 5, 2005

April 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective April 1, 2005, and New January 2005 Quarterly ASP File

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

CR 3667 discusses updates to the new methodology of paying for Medicare Part B covered drugs not paid on the basis of cost or prospective payment.

CAUTION – What You Need to Know

Effective January 1, 2005, Part B covered drugs and biologicals (that are not paid on a cost or prospective payment basis) are paid based on the new Average Sales Price (ASP) drug payment system, described below.

GO – What You Need to Do

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

Background

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

The ASP file, used in the ASP methodology, is based on data CMS receives quarterly from manufacturers.

Each quarter, the Centers for Medicare & Medicaid Services (CMS) will update your carrier and fiscal intermediary (FI) payment allowance limits with the ASP drug pricing files based on these manufacturers' data.

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, and CMS will update the payment allowance limits quarterly. However, there are exceptions to this general rule as summarized below:

- For **blood and blood products** (with certain exceptions like blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood 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.**
- For **infusion drugs** furnished through a covered item of Durable Medical Equipment (DME) on or after January 1, 2005, payment allowance limits 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 DME is implanted. **The payment allowance limits will not be updated in 2005.**
- For **influenza, pneumococcal, and hepatitis B vaccines** payment allowance limits are 95 percent of the AWP as reflected in the published compendia. **The payment allowance limits will be updated on a quarterly basis.**
- For **drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File** payment allowance limits are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, carriers/FIs will follow the methodology specified in the Medicare Claims Processing Manual for calculating the AWP, but substitute WAC for AWP. Please see Pub. 100-04, Chapter 17 (Drugs and Biologicals) at the following CMS website: *http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf*. The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting carrier/FI or via posting an MS excel file on the CMS website. If the payment limit is available from CMS, carriers/FIs will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File,** payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after December 1, 2004.

The April 2005 and new January 2005 ASP drug pricing files will contain three decimal places in the currency fields. In addition, the new January file contains revised payment limits for some drugs. The codes with a revised payment limit are identified in the column titled "Notes." The absence or presence of a HCPCS code and its associated payment limit in the pricing files do 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 carrier/FI processing your claim will make these determinations.

In addition, your carrier or FI is required to accomplish the following:

- Use the April 2005 ASP and NOC drug pricing files to pay for Medicare Part B drugs effective April 1, 2005. This file shall be used for dates of service from April 1, 2005 through June 30, 2005;
- Determine for any drug or biological not listed in the ASP or NOC drug pricing files, the payment allowance limits in accordance with the policies described in this transmittal , CR 3539, dated October 29, 2004 (see *http://www.cms.hhs.gov/manuals/pm_trans/R348CP.pdf*), and CR3232, dated December 16, 2004 (see *http://www.cms.hhs.gov/manuals/pm_trans/R397CP.pdf*), and FIs should seek payment allowances from their local carrier;
- Use the new January 2005 ASP drug pricing file for (1) those claims where the carriers/FIs are asked to retroactively adjust claims processed with the original January 2005 file and (2) those claims with dates of service on or after January 1, 2005 and before April 1, 2005 that are processed after April 4, 2005. **Your carrier or FI shall not search and adjust claims that have already been processed unless brought to their attention**;
- Overlay the old January 2005 file with the new January 2005 file; and
- For any drug or biological for which they (your carrier or FI) calculates a payment allowance limit, forward to CMS the following:
- The drug name,
- Dosage,
- Payment allowance limit, and
- National Drug Code (if available).

Note: The ASP and NOC drug pricing files will contain the 106 percent ASP, 106 percent WAC or WAC based payment allowance limits; therefore, no additional payment calculation is required by your carrier or FI. The payment limits for the blood clotting factor codes includes the $0.14 per I.U. furnishing fee.

Additional Information

The new January 2005 and April 2005 ASP and NOC Pricing Files are available from the following CMS website on or after March 17, 2005: *http://www.cms.hhs.gov/providers/drugs/asp.asp*.

You can find more information about the April 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2005, and New January 2005 Quarterly ASP File at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3667 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3667
Medlearn Matters Number: MM3667
Related CR Release Date: February 25, 2005
Related CR Transmittal #: 480
Effective Date: January 1, 2005
Implementation Date: April 4, 2005

July 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective July 1, 2005

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

Provider Types Affected

All Medicare 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 July 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 (6) percent. The Centers for Medicare & Medicaid Services (CMS) supplies 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:

- 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.
- 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. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003 (i.e., new drugs) are 95 percent of the first published AWP.
- 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.
- The payment allowance limits for drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the carriers/intermediaries follow the methodology specified in Chapter 17, Drugs and Biologicals, of the Medicare Claims Processing Manual for calculating the average wholesale price (AWP) but substitute WAC for AWP. Chapter 17 may be found at on the CMS website at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf*.
- The payment limit is 100 percent (100%) of the WAC for the lesser of the lowest brand or median generic. Carriers/intermediaries, at their discretion, may contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS website. If the payment limit is available from CMS, carriers/intermediaries will substitute CMS provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting carrier/intermediary or via posting an MS Excel file on the CMS website.
- The payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106% of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare carrier/intermediaries will determine payment limits for radiopharmaceuticals based on invoice pricing.

Note: The absence or presence of a HCPCS code and its associated payment limit in the payment 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 carrier/intermediary processing the claim shall make these determinations.

Implementation

The implementation date is July 5, 2005. The July 2005 ASP and NOC drug pricing files will be used by your carrier/intermediary to pay for Medicare Part B drugs from July 1, 2005 through September 30, 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 3783 in the CR NUM column on the right and click on the file for that CR.

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*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3783 Medlearn Matters Number: MM3783
Related CR Release Date: April 22, 2005 Related CR Transmittal #: 528
Effective Date: July 1, 2005 Implementation Date: July 5, 2005

Abarelix for the Treatment of Prostate Cancer

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

Provider Types Affected

Providers who care for Medicare beneficiaries with prostate cancer

Provider Action Needed

STOP – Impact to You

Effective March 15, 2005, you may bill for the use of abarelix (Plenaxis™) for certain patients with advanced, symptomatic prostate cancer.

CAUTION – What You Need to Know

Effective March 15, 2005, CMS is extending national coverage for the use of abarelix (Plenaxis™) as a palliative treatment, for the indications described below, in patients with advanced, symptomatic prostate cancer.

GO – What You Need to Do

Make sure that your billing staff is aware of this new coverage.

Background

Treatment Options for Prostate Cancer

Treatment options for prostate cancer vary depending on patient age, cancer stage, and individual medical conditions. Surgery (e.g., radical prostatectomy) or radiation is typically used for early-stage disease, whereas hormonal therapy, chemotherapy, and radiation (or combinations of these treatments) are used for more advanced disease.

Hormonal therapy for prostate cancer has evolved from orchiectomy and estrogens to the use, in recent years, of synthetic drugs known as gonadotropin-releasing hormone (GnRH) agonists, such as leuprolide (Lupron™) and goserelin (Zoladex™).

Abarelix

More recently, newer GnRH receptor antagonist compounds, such as abarelix (Plenaxis™), are, in contrast, thought to be devoid of agonist activity and to lack an initial androgen-stimulating effect. Abarelix (Plenaxis™) has been proposed as a substitute for GnRH agonists (with and without antiandrogens) in the treatment of patients with advanced prostate cancer, for whom a surge in androgen blood levels may pose a risk of "clinical flare." For this indication, abarelix is the first GnRH receptor antagonist that the Food and Drug Administration (FDA) has approved.

CMS determines that the evidence is adequate to conclude that abarelix (Plenaxis™) is reasonable and necessary as a palliative treatment in patients with advanced symptomatic prostate cancer who: (1) decline surgical castration; (2) when GnRH therapy is not appropriate, and (3) who present with one of the following indications:

- Risk of neurological compromise due to metastases
- Ureteral or bladder outlet obstruction due to local encroachment or metastatic disease, or
- Severe bone pain from skeletal metastases persisting on narcotic analgesia.

Please note that the following additional conditions for coverage must be met, in accordance with the Food and Drug Administration (FDA) labeling requirements, to ensure that abarelix (Plenaxis™) is used only in patients for whom the drug is indicated:

In evaluating this prostate cancer patient, the physician must attest to, and accept the following qualifications and responsibilities, and must have enrolled in the post-marketing risk management program that the drug manufacturer has established.

The physician must attest willingness and ability to:

- Diagnose and manage advanced symptomatic prostate cancer
- Diagnose and treat allergic reactions, including anaphylaxis
- Have access to medication and equipment necessary to treat allergic reactions, including anaphylaxis

- Have patients observed for development of allergic reactions for 30 minutes following each administration of abarelix (Plenaxis™)
- Understand the risks and benefits of palliative treatment with abarelix (Plenaxis™)
- Educate patients on the risks and benefits of palliative treatment with abarelix (Plenaxis™); and
- Report serious adverse events as soon as possible to the manufacturer and/or the FDA.

Finally, be aware that CMS has also determined that the evidence is not adequate to conclude that abarelix (Plenaxis™) is reasonable and necessary for indications other than those specified above. Therefore, all other uses of abarelix (Plenaxis™) are not covered. Further, in light of the concern regarding safety risks of abarelix (Plenaxis™), off-label uses that may appear in listed statutory drug compendia on which Medicare and its contractors rely to make coverage determinations will remain non-covered until CMS completes a reconsideration of this National Coverage Determination.

Additional Information

The following claims processing points should be noted:

- Use HCPCS code J0128 for claims when billing Medicare for abarelix used for treatment of prostate cancer patients in accordance with the requirements specified by the NCD.
- Medicare fiscal intermediaries will accept abarelix claims on types of bill 11X, 13X, 18X, 83X, and 85X.

  Also, use revenue code 0636 on the claim to reflect a drug requiring detailed coding.
- Medicare carriers and intermediaries will pay separately for abarelix chemotherapy injections when billed using an appropriate chemotherapy administration procedure code in addition to the visit furnished on the same day.
- For services performed on or after March 15, 2005, Medicare will deny claims for uses of abarelix that are not covered under the NCD, (NCD Manual Section 110.18). An appropriate remittance advice code will be sent to reflect the denial using MSN 6.5 *(Medicare cannot pay for this in injection because one or more requirements for coverage were not met, reason code 47 (this, these) diagnosis(es) is (are) not covered, missing, or are invalid),* and remark code M76 — *missing/incomplete invalid diagnosis or condition.*

You can find more information about abarelix for the treatment of prostate cancer by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3775 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at Chapter 1, Part 2, Section 110.18 of the Medicare National Coverage Determinations Manual that is an attachment to CR 3775.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3775 Medlearn Matters Number: MM3775
Related CR Release Date: April 25, 2005 Related CR Transmittal #: 532
Effective Date: March 15, 2005 Implementation Date: May 25, 2005

Anti-Cancer Chemotherapy for Colorectal Cancer

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

Provider Types Affected

Providers and suppliers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs) for anti-cancer chemotherapy

Provider Action Needed

This article is based on information contained in change request (CR) 3742, which states that the Centers for Medicare & Medicaid Services (CMS) will cover the off-label use of oxaliplatin (eloxatin™), irinotecan (camptosar®), cetuximab (erbitux™), or bevacizumab (avastin™) in clinical trials identified by CMS and sponsored by the National Cancer Institute (NCI).

This national coverage decision does not:

- Modify existing requirements for coverage of these and other anti-cancer chemotherapeutic agents for FDA-approved indications or for off-label indications listed in an approved compendium; or
- Change existing coverage for any off-label uses of these drugs provided outside the clinical trials identified.

Medicare carriers, DMERCs, and intermediaries will continue to make local coverage determinations for medically accepted uses of off-label indications based on guidance provided by the Secretary of the Department of Health and Human Services (DHHS).

Background

On January 28, 2005, CMS announced a national coverage determination (NCD) covering the off-label use of certain colorectal anti-cancer drugs in identified clinical trials of colorectal cancer and other cancer types. These clinical trials study the use of one or more off-label uses of these four drugs in colorectal and other cancer types.

Note: The clinical trials for which these drugs and other items and services are covered appear in Appendix A in the NCD at the following CMS website: *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90***.**

Anti-cancer chemotherapeutic agents are eligible for coverage in a clinical trial setting when the following occurs:

- They are used in accordance with Food and Drug Administration (FDA)-approved labeling
- Their use is supported in one of the authoritative drug compendia
- The Medicare contractor (carriers, fiscal intermediaries [FIs], DMERCs) determines an off-label use is medically accepted based on guidance provided by secretary of DHHS

Effective for services provided on or after January 28, 2005, CMS covers the following anti-cancer chemotherapeutic agents, which have been approved by the FDA for the treatment of colorectal cancer, when used in clinical trials identified by CMS and sponsored by the National Cancer Institute:

- oxaliplatin (eloxatin™)
- irinotecan (camptosar®)
- cetuximab (erbitux™)
- bevacizumab (avastin™)

Under the concept of linking Medicare coverage determinations to clinical studies, the investigational items and services provided in qualified scientific studies are covered (including clinical trials, practical trials, and systematic data collection systems) when:

- They provide for the accrual of supporting evidence of medical necessity
- They collect data to support decisions about whether or not a technology is reasonable and necessary

Note: The list of identified clinical trials for which the routine costs of the items and services are covered appears in the clinical trials section of the following CMS website: *http://www.cms.hhs.gov/coverage***.**

Non-routine clinical costs include items and services that are provided in either the investigational or the control arms of a clinical trial specified by CMS for coverage. The following non-routine items and services **are not covered** and include items and services:

- Provided solely to satisfy data collection, and that are not used in the direct clinical management of the patient
- Provided solely to determine trial eligibility
- Customarily provided by the research sponsors free-of-charge for any enrollee in the trial
- That are statutorily excluded from Medicare coverage
- That does not fall into a benefit category

This NCD, issued on January 28, 2005, does not withdraw Medicare coverage for items and services that may be covered according to the existing national coverage policy for Routine Costs in a Clinical Trial (See National Coverage Determination Manual, Section 310.1 at the following CMS website: *http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp*

Note: The existing requirements for coverage of oxaliplatin, irinotecan, cetuximab, bevacizumab, or other anticancer chemotherapeutic agents for FDA-approved indications or for indications listed in an approved compendium are not modified.

Medicare contractors will continue to make reasonable and necessary coverage determinations under the Social Security Act (Section 1861(t)(2)(B)(ii)(II))based on guidance provided by CMS for medically accepted uses of off-label indications of oxaliplatin, irinotecan, cetuximab, bevacizumab, or other anticancer chemotherapeutic agents provided outside of the identified clinical trials appearing on the CMS website noted previously.
Some important points to remember when billing Medicare for these anti-cancer drugs are as follows:

- FIs will accept claims for these drugs on types of bill (TOB) 11x, 12x, 13x, 18x, 21x, 22x, 23x, and 85x. Revenue code 0636 should be used.
- When billing carriers, DMERCs and FIs, on a claim other than an inpatient claim, include the QR modifier to show the drug was furnished during a clinical trial.
- Claims submitted to FIs should also contain an ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position to show that the claim involves a clinical trial.
- When using the modifier QR, also be sure to include a HCPCS code of *J9035, J9055, J9206, J9263, J8520, J8521, J9190, or J9201*, as appropriate for the anti-cancer drug being billed.
- Providers are also to include a modifier QR when billing for nonroutine costs associated with these clinical trials.
- DMERCs will accept claims with HCPCS codes of *J8520* and *J8521* as clinical trial codes for **oral anticancer** drugs, when accompanied by the modifier QR to show use in a clinical trial.
- When billing for covered routine costs associated with clinical trials as described in section 310 of the NCD Manual, be sure to include a modifier QV on the claim.
- Submit an appropriate cancer diagnosis code for the clinical trial on the claim.

Note: While this NCD is effective as of January 28, 2005, Medicare systems will be unable to process claims containing the modifier QR received before April 1, 2005. For that reason, do not send in claims for drugs or other nonroutine services covered under this NCD until April 1, 2005.

Do not hold claims for nonroutine services containing the modifier QV associated with this NCD.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction includes the NCD section 110.17 and it may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3742 in the CR NUM column on the right, and click on the file for that CR.

You should see two versions of CR 3742 on this website. The version of CR 3742 with a transmittal number of R30NCD will contain the NCD information and the version with a transmittal number of R512CP will contain the Medicare claims processing instructions.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3742
Medlearn Matters Number: MM3742
Related CR Release Date: March 29, 2005
Related CR Transmittal #: 30 and 512
Effective Date: January 28, 2005
Implementation Date: April 18, 2005

New HCPCS Codes for Intravenous Immune Globulin

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare for IVIG

Provider Action Needed

STOP – Impact to You

New HCPCS codes for IVIG will be effective April 1, 2005.

CAUTION – What You Need to Know

Effective April 1, 2005, for dates of service on or after April 1, 2005, codes J1563 and J1564 will no longer be paid by Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs). Codes J1563 and J1564 will be replaced with HCPCS codes Q9941 – Q9944.

GO – What You Need to Do

These new HCPCS codes are needed to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG. Be sure to bill the new codes when providing these services.

Additional Information

Effective April 1, 2005, the following codes are being added to the healthcare common procedure coding system (HCPCS) to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG.

HCPCS Code	Short Descriptor	Long Descriptor
Q9941	IVIG lyophil 1G	Injection, immune globulin, intravenous, lyophilized, 1g
Q9942	IVIG lyophil 10 MG	Injection, immune globulin, intravenous, lyophilized, 10 mg
Q9943	IVIG non-lyophil 1G	Injection, immune globulin, intravenous, n0n-lyophilized, 1g
Q9944	IVIG non-lyophil 10 MG	Injection, immune globulin, intravenous, non-lyophilized, 10 mg

- Based on the above table, providers must bill Q9941 or Q9943, as appropriate, in place of J1563. Similarly, those providers should bill Q9942 or Q9944, as appropriate, instead of J1564.
- Payments for the new Q-codes can be found in the respective quarterly Medicare Part B drug pricing files posted on the CMS website at: *http://www.cms.hhs.gov/providers/drugs*.
- The Medicare outpatient code editor (OCE) will be updated to include these coding changes upon installation of the April 2005 software version 6.1.
- The outpatient prospective payment system (OPPS) for the new Q codes can be found in the April update of OPPS addendum A and addendum B on the hospital outpatient website. OPPS payment is based on the ambulatory payment classification (APC).
- Coverage requirements for IVIG can be found in Chapter 15 of the Medicare Benefit Policy Manual.

This manual may be found at: http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp .

Additional information on IVIG may be found in Chapter 17 (Drugs and Biologicals), section 80.6 of the Medicare Claims Processing Manual at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

- The official instruction issued to your carrier regarding this change may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.
- From that web page, look for CR 3745 in the CR NUM column on the right, and click on the file for that CR.
- For additional information relating to this issue, please refer to your local carrier or FI. You may find the toll free phone number for your local carrier at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3745
Medlearn Matters Number: MM3745
Related CR Release Date: March 18, 2005
Related CR Transmittal #: 507
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Procedures A9522 – A9523

Information on this subject has been previously published in the First Quarter 2005 Medicare B Update! (page 23) and Second Quarter 2004 Medicare B Update! (page 71)

Effective for claims processed on or after October 19, 2004, pricing for procedures A9522 and A9523 was revised to reflect 3.2 mg per 2 ml vial. Previously providers were advised to submit A9522 with a 5 in the number billed and A9523 with 40 in the number billed based on the mci.

Effective immediately, providers should use the number billed field to indicate the total number of vials administered when billing procedure codes A9522 – A9523.

For example:

Procedure A9522
1 in the number billed = 5 mci
2 in the number billed = 10 mci
3 in the number billed = 15 mci

Procedure A9523
1 in the number billed = 40 mci
2 in the number billed = 80 mci
3 in the number billed = 120 mci

It has come to our attention that providers are still submitting claims with "5" or "40" in the number billed field. This has resulted in overpayment of services.

No Action Required by Providers

Providers do **not** need to take any action at this time. Payments made in error will be automatically corrected.

We apologize for any inconvenience this may have caused

Revised Coding Guidelines for Drug Administration Codes

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

Provider Types Affected

Physicians and providers billing carriers for drug administration procedures

Provider Action Needed

This article and related CR 3818 provide information on revisions to the 2005 drug administration coding guidelines. Implementation of these revised coding guidelines will help Medicare make prompt and correct payments for drug administration services.

Background

Since the release of Transmittal 129 (CR 3631 on the subject of 2005 Drug Administration Coding Revisions) on December 10, 2004, the Centers for Medicare & Medicaid Services (CMS) has received a number of questions pertaining to the G codes and the rules for the revised drug administration codes. (CR 3631 may be accessed at: *http://www.cms.hhs.gov/manuals/pm_trans/R129OTN.pdf*.

In addition, a Medlearn Matters article (MM3631) is available on this issue at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3631.pdf*.

In accordance with section 303 of the Medicare Modernization Act (MMA), which requires the secretary to promptly evaluate existing drug administration codes to ensure accurate reporting and billing, the common procedural terminology (CPT) editorial panel was asked to address

these questions and consider appropriate revisions to the drug administration coding guidelines. That panel approved revised drug administration coding guidelines.

As a result, CMS has approved revisions to the drug administration coding guidelines to resolve implementation issues associated with Transmittal 129. A summary of changes to the drug administration coding guidelines, which are effective as of March 15, 2005, is provided in the following chart.

Change	Coding guideline
Short duration infusion	An intravenous or intra-arterial push is now defined as an injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient; or an infusion of 15 minutes or less. The previous guideline stated 30 minutes or less for infusions.
Concurrent infusions	Beginning March 15, 2005, Medicare carriers will allow payment for only one concurrent infusion (code G0350) per patient per encounter. If more than one concurrent infusion is billed for the same encounter, the carrier will deny the subsequent encounter and a remittance advice remark code of N20 will be returned to denote the service is not payable with other service rendered on the same date. Also, the Medicare carrier will not pay for G0350 (Intravenous infusion, for therapy/diagnosis; concurrent infusion) if it is billed with modifier 59 unless this procedure is provided during a second encounter on the same day with the patient and accompanied by supporting medical documentation.
Initial code	The definition of "initial code" is amended to state that the initial code best describes the key or primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur. This is a clarification of the Transmittal 129 definition that the initial code is "the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code." If more than one initial service code is billed, the carrier will deny the second initial service code using remittance advice remark code M86 to show that it is not payable unless the patient has to return for a separately identifiable service on the same day or has two IV lines per protocol.
Hydration therapy	Transmittal 129 incorrectly stated: "Report G0346 to identify hydration furnished concurrent with G0359." To be consistent with section 30.5 C, Chapter 12 of the Medicare Claims Processing Manual, this statement should read, "Report G0346 to identify hydration **not** furnished concurrent with G0359." Separate payment is allowed for hydration therapy and chemotherapy infusion if they are provided sequentially on the same day, but not at the same time.

Separately identifiable services

Transmittal 129 stated, "If the patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol, these services are separately payable and reported with modifier 76." CMS has revised this statement to show that it is more appropriate to use modifier 59 in this situation.

Your Medicare carrier will not make any adjustments to claims that were processed and paid under the previous guidelines unless you call their attention to such claims. These guidelines are effective for dates of services on or after March 15, 2005.

To see the official instruction regarding revisions to the 2005 drug administration coding guidelines, go to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3818 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3818 Medlearn Matters Number: MM3818
Related CR Release Date: April 15, 2005 Related CR Transmittal #: 148
Effective Date: March 15, 2005 Implementation Date: May 16, 2005

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

DURABLE MEDICAL EQUIPMENT

April 2005 Quarterly Fee Schedule Update 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 billing Durable Medical Equipment Regional Carriers (DMERCs) and/or intermediaries

Provider Action Needed

This article is based on Change Request (CR) 3669, and it provides specific information regarding the April quarterly update for the 2005 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

Background

This article provides specific information regarding the April quarterly update for the 2005 DMEPOS fee schedule. The DMEPOS fee schedules are updated on a quarterly basis in order to 1) implement fee schedule amounts for new codes and 2) to revise any fee schedule amounts for existing codes that were calculated in error. Payment on a fee schedule basis is required for:

- Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)), and
- Parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Note: There are no changes to the PEN fee schedule file for April 2005.

HCPCS code K0670 (addition to lower extremity prosthesis…) is added, effective April 1, 2005 to the list of Healthcare Common Procedural Coding System (HCPCS) accepted by DMERCs and intermediaries. Also, DMERCs and regional home health intermediaries are adding HCPCS Code K0671 to the HCPCS effective April 1, 2005 as an accepted code. This code:

- Describes a rental portable oxygen concentrator system and
- Is to be used when billing Medicare for the portable equipment add-on fee for patients using lightweight oxygen concentrators that can function as both the patient's stationary equipment and portable equipment.

The following HCPCS codes are to be used to describe combination stationary/portable oxygen concentrators for Medicare billing purposes.

For claims for combination stationary/portable oxygen concentrators with **dates of service prior to April 1, 2005**, use:

- HCPCS code E1390 (stationary oxygen concentrator) **with**
- HCPCS code E0431 (portable gaseous oxygen system).

For claims with dates of service **on or after April 1, 2005**, use

- HCPCS code E1390 (stationary oxygen concentrator) in conjunction **with**
- HCPCS code K0671 (portable oxygen concentrator system).

Note: Payment for HCPCS code K0671 will be based on the current add-on fee schedule amounts for portable oxygen equipment.

Also, the quarterly updates process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual (Pub 100-04, Chapter 23, Section 60). This manual can be accessed at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

Implementation

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

Additional Information

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

From that web page, look for CR 3669 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3669
Medlearn Matters Number: MM3669
Related CR Release Date: January 28, 2005
Related CR Transmittal #: 451
Effective Date: April 1, 2005, for new codes added to the HCPCS, and
January 1, 2005, for all other HCPCS codes on the fee schedule
Implementation Date: April 4, 2005

Revised Manual Language to Item 24G CMS-1500 Instructions Regarding the Billing of Oxygen and Oxygen Equipment

Provider Types Affected

Providers and suppliers billing carriers and Durable Medical Equipment Regional Carriers (DMERCs) for oxygen and oxygen equipment

Provider Action Needed

STOP – Impact to You

Suppliers and providers should note that this instruction is based on information contained in Change Request (CR) 3753 regarding revised manual language for oxygen billing instructions for CMS-1500 contained in the Medicare Claims Processing Manual (Pub. 100-04).

CAUTION – What You Need to Know

The language contained in Chapter 26, Section 10.4, Item 24G of the CMS-1500 claim form regarding the billing of oxygen claims is being revised, and the Item 24G billing requirements will include a reference to the actual oxygen billing instructions contained in Chapter 20, Section 130.6 of the Medicare Claims Processing Manual.

GO – What You Need to Do

Please see the Background and Additional Information Sections of this instruction for further details regarding these changes.

Background

The Medicare Claims Processing Manual (Pub. 100-04) language contained in Chapter 26, Section 10.4, Item 24G provides an explanation of how to fill out Item 24G (Days or Units) of the CMS-1500 claim form, and the billing requirements for Item 24G can vary based on the type of service being billed.

The current language explaining the procedures for billing for oxygen is inaccurate and outdated and is removed by CR 3753. The language is being replaced with a direct reference to Chapter 20, Section 130.6 of the same manual that deals with billing for oxygen and oxygen equipment.

The following is the revised wording (bolded and italicized) that is being added to Item 24G (Pub. 100-04, Chapter 26, Section 10.4):

For instructions on submitting units for oxygen claims, see Chapter 20, Section 130.6.

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Section 130 (Billing for Durable Medical Equipment (DME) and Orthotic/ Prosthetic Devices), Subsection 130.6 (Billing for Oxygen and Oxygen Equipment) can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c20.pdf*.

Implementation

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

Additional Information

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

From that web page, look for CR 3753 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3753	Medlearn Matters Number: MM3753
Related CR Release Date: March 18, 2005	Related CR Transmittal #: 506
Effective Date: July 1, 2005	Implementation Date: July 1, 2005

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END STAGE RENAL DISEASE

Billing for Syringes Used in the Treatment of End-Stage Renal Disease Patients

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

Provider Types Affected

Physicians, providers, and suppliers billing carriers and intermediaries for end-stage renal disease (ESRD) services and supplies

Provider Action Needed

Providers billing HCPCS code A4657 for ESRD patients need to be aware of the proper use of this code when billing for syringes, especially when a pre-filled syringe is used in the administration of the drug contained in the syringe and no other syringe is used. In such instances, the supply charge associated with A4657 **cannot** be billed to Medicare.

Background

In some previous change requests (CRs) relating to ESRD, there was mention that Healthcare Common Procedure Coding System (HCPCS) code A4657 (syringe – with or without needle) was allowed for epoetin (EPO). However, physicians, providers, and suppliers should note that pre-filled syringes with medications used to administer the drug to an ESRD patient should not be billed with HCPCS code A4657 to Medicare. Also note that HCPCS code A4657 (syringe – with or without needle) should be billed only when an actual syringe is taken from the provider's supplies and used to administer the drug. Syringes that are pre-filled with medications should not require the use of another syringe to administer the medication.

When a drug is supplied in a pre-filled syringe (and no other syringe is used in the administration of the drug contained in the syringe) then the supply charge associated with HCPCS code A4657 **cannot** be billed to Medicare.

Only when a new syringe is used in the administration of the drug should HCPCS code A4657 be used. Note that this special edition article relates to billing for syringes used in the treatment of ESRD patients.

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 B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0527
Related CR Release Date: N/A

BILLING UNLISTED DIALYSIS PROCEDURE 90999

This article is to supplement instructions published in the January 2005 Medicare B Update! Special Issue (pages 51-53) in regard to the use of procedure 90999

Procedure 90999 represents an unlisted dialysis procedure, inpatient or outpatient. Per change request 3414, procedure code 90999 should be billed when the patient's status is one of the following scenarios:

- Hospital observation setting
- Transient patient traveling away from home (less than full month)
- Partial month without a complete assessment (for example, the patient was hospitalized before a complete assessment was furnished, dialysis stopped due to death or the patient had a transplant)
- Patient had a change in the MCP physician during the month

Indicate which scenario applies in either:

- item 19 on the CMS 1500 Claim Form, or
- the narrative record for electronic claims

When billing one of the above scenarios, documentation is not required. However, if the information is not indicated or specified in item 19, or electronic equivalent, then Medicare will request documentation.

The documentation should be maintained in the patient's medical records, describing the type of ESRD-related services provided during the visit.

Source: CMS Change Request 3414
CMS Pub 100-4, Chapter 26, Section 10.4

EVALUATION AND MANAGEMENT

Hospital Observation Services

Medicare will pay for initial observation care billed only by the physician who admitted the patient to hospital observation and was responsible for the patient during his/her stay in observation. The initial observation codes (99218-99220) include all the care rendered by the admitting physician on the date the patient was admitted to observation. All other physicians who see the patient while he/she is in observation must bill the appropriate office/other outpatient service codes, which include 99201-99205 (new patient) or 99211-99215 (established patient), or the appropriate outpatient consultation codes, which include 99241-99245 (new or established patient). If the patient is discharged on the same date as admission to observation, only the initial observation care code will be paid, since this code represents a full day of care.

If the patient remains in observation after the first date following the admission to observation, it is expected that the patient would be discharged on that second calendar date and CPT code 99217 would be billed for observation discharge services provided on that second date.

In the rare circumstance when a patient is held in observation status for more than two calendar dates, the physician must bill subsequent services furnished before the date of discharge using the outpatient/office visit codes (99211-99215).

Additional information regarding payment for hospital observation services (codes 99217-99220) can be found in the Medicare Claims Processing Manual, Chapter 12, Section 30.6.8 found on the CMS website located at *http://www.cms.hhs.gov*.

List of Medicare Telehealth Services

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

Providers Affected

Physicians and providers billing Medicare carriers for telehealth services

Provider Action Needed

STOP – Impact to You

Effective for services provided on or after January 1, 2005, the Centers for Medicare & Medicare Services (CMS) added Healthcare Common Procedure Coding System (HCPCS) codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 (for ESRD-related services) to the list of Medicare telehealth services, effective January 1, 2005. Medicare carriers will pay for these ESRD-related services when billed with the telehealth modifiers.

CAUTION – What You Need to Know

Providers treating ESRD beneficiaries should also be aware that the above telehealth modifiers "GT" or "GQ" are valid when billed with one of the above-mentioned HCPCS codes.

GO – What You Need to Do

Be sure staff is aware of the addition of these ESRD related services to the list of Medicare telehealth services and the appropriate billing procedures.

Background

In the final rule published November 7, 2003, (68 FR 63216) 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 the payments for managing patients on dialysis, CMS has received a number of comments from the nephrology community expressing concerns that the change in payments results in hardships for rural and isolated areas, especially in frontier areas where physicians would be required to make multiple long-distance trips during a month to see their patient or vice versa.

To address this issue, CMS added ESRD-related services under the monthly capitation payment (MCP) to the list of Medicare telehealth services in the physician fee schedule fine rule published November 15, 2004 (69FR 66276). ESRD-related services included in the MCP with 2 or 3 visits per month, and ESRD-related services with 4 or more visits per month, may be paid as Medicare telehealth service.

To bill for ESRD-related service under the MCP as a telehealth service, at least one visit must be furnished face to face "hands on" to examine the patient's vascular access site. Examination of the vascular access site must be done by a physician, clinical nurse, specialist, nurse practitioner, or physician assistant. Only the facilities, authorized under Section 1834 (m) of the Social Security Act, may serve as a Medicare telehealth-originating site.

Prior to the issuance of CR 3747, the list of Medicare telehealth services only included consultations (CPT codes 99241-99275); office and other outpatient visits (CPT codes 99201-99215); individual psychotherapy (CPT codes 90804 –

90809); pharmacologic management (CPT code 90862); and psychiatric diagnostic interview examination (CPT code 90801), effective for services on or after March 1, 2003.

This article and related CR 3747 informs that the ESRD-related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) are added to the list of Medicare telehealth services, effective for services furnished on or after January 1, 2005. The telehealth modifier "GT" (providing visits through the use of interactive audio and video telecommunications system) and modifier "GQ" (providing visits through the use of asynchronous telecommunications system) are valid when billed with these ESRD-related service HCPCS codes. The use of the telehealth modifiers indicates that a clinical examination of the vascular access site was furnished face-to-face "hands on" by a physician clinical nurse specialist, nurse practitioner, or physician assistant.

Addition of the above ESRD-related services to the list of Medicare telehealth service does not change the eligibility criteria, conditions of payment, payment or billing procedure regarding Medicare telehealth services as established in publication 100-2, Chapter 15, Section 270 and publication 100-4 Chapter 12, Section 190 of the Medicare Benefit Policy Manual. Thus, originating sites only include a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or Federally qualified health center.

Originating sites must be in a non-Metropolitans Statistical Area (MSA) county or a rural health professional shortage area. Also, the use of modifier "GQ" is only permitted in Federally funded telemedicine demonstration programs conducted in Alaska or Hawaii.

Clarification for originating sites billing for the telehealth originating site facility fee

With regard to ESRD-related services included in the MCP, the originating site facility fee payment may be made for each visit furnished through an interactive telecommunications system. When the physician or practitioner at the distant site furnishes an ESRD-related patient visit included in the MCP through an interactive telecommunications system, the originating site may bill for a telehealth facility fee.

Example: A 70-year-old ESRD beneficiary receives two ESRD-related visits through an interactive telecommunications system and the required face-to-face visit (to examine the vascular access site) during the month of November. In this scenario, the originating site should bill for two originating site facility fees as described by HCPCS code Q3014, and the MCP physician at the distant site should bill for ESRD related services with 2 to 3 visits as a telehealth service, e.g. G3018 GT.

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 3747 in the CR NUM column on the right, and then click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3747
Medlearn Matters Number: MM3747
Related CR Release Date: April 1, 2005
Related CR Transmittal #: 31 and 517
Effective Date: January 1, 2005
Implementation Date: May 2, 2005

LABORATORY

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

This information was previously published in the Second Quarter 2005 Medicare B Update! (pages 5-6).
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

NOTE: This article was revised on March 18, 2005 to include the following message:
Some Medicare carriers use a claims processing system (known as the VIPS Medicare Part B system) to process Medicare claims. These carriers will not implement this change at this time. Those carriers are:

- Empire Medicare Services
- Triple-S
- Blue Cross Blue Shield of Kansas
- GHI

Until further notice, physicians, laboratories, and independent diagnostic testing facilities who bill these carriers should continue to follow the billing instructions provided in CR3630 issued on December 23, 2004.

That CR can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R415CP.pdf*.

Also, a corresponding Medlearn Matters article related to CR3630 may be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3630.pdf* .

Provider Types Affected

Physicians, laboratories, and independent diagnostic testing facilities.

Provider Action Needed

This instruction implements a national abstract file of the Medicare Physician Fee Schedule (MPFS) containing healthcare common procedural coding system (HCPCS) codes billable as purchased diagnostic tests and interpretations, for every locality throughout the country.

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

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

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

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

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

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

Background

CR 3481 implements a national abstract file of the MPFS containing HCPCS codes billable as a purchased diagnostic test/interpretation, for every locality throughout the country. Effective with the implementation of the abstract file on April 4, 2005, carrier jurisdiction rules for purchased diagnostic tests/interpretations will be changed to allow suppliers to bill their local carriers for these services and receive the correct payment amount, regardless of the location where the service was performed. Carrier jurisdictional pricing rules for all other services payable under the MPFS will remain in effect.

Implementation

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

Additional Information

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

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

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

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

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Implementation of the Abstract File for Purchased Diagnostic Tests/ Interpretations (Supplemental to CR 3481)

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

Provider Types Affected

Physicians and Independent Diagnostic Testing Facilities (IDTFs) billing Medicare carriers for purchased diagnostic tests/interpretations

Provider Action Needed

STOP

Related CR 3694 r**eplaces** the requirement in CR 3481 instructing carriers to pay physicians for diagnostic tests and interpretations performed outside of the local carrier's jurisdiction.

CAUTION

All other instructions in CR 3481 remain in effect.

GO – What You Need to Do

Medicare carriers will continue to **pay physicians at the local rate, until further notice,** for services purchased outside of the carrier's jurisdiction **when submitted by a physician enrolled in the carrier's jurisdiction.** Physicians should continue to report their name and service facility location on claims for purchased tests/interpretations performed outside of the local carrier's jurisdiction.

Physicians use their own PIN to bill for both the purchased portion of the test and the portion of the test that they performed. **Suppliers (laboratories and IDTFs) are to bill local carriers** regardless of where the tests are performed and **carriers are to pay** suppliers **based on ZIP codes**.

Note: Physicians should continue to follow the billing instructions provided in Change Request 3630 (Transmittal 415, issued on December 23, 2004) until further notice.

Note: This article was revised on March 18, 2005 to include the following message:
Some Medicare carriers use a claims processing system (known as the ViPS Medicare Part B system) to process Medicare claims. These carriers will not implement this change at this time. Those carriers are:

- Empire Medicare Services
- Blue Cross Blue Shield of Kansas
- Triple-S
- GHI

Until further notice, physicians and independent diagnostic testing facilities who bill these carriers should continue to follow the billing instructions provided in CR 3630 issued on December 23, 2004. That CR can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R415CP.pdf*.

Also, a corresponding Medlearn Matters article related to CR 3630 may be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3630.pdf*.

Background

CR 3481 instituted a national abstract file of the Medicare Physician Fee Schedule (MPFS) containing Healthcare Common Procedure Coding System (HCPCS) codes billable as purchased diagnostic tests and interpretations for every locality throughout the country. Effective April 1, 2005, suppliers, including laboratories, physicians, and IDTFs, are to bill their local carrier for purchased diagnostics tests and interpretations, regardless of the location where the service was furnished. However, until further notice, CMS is delaying the implementation of the billing instructions specified in CR 3481 for purchased diagnostic service claims submitted by physicians due to a locality reporting issue.

Effective April 1, 2005, **carriers should price claims based on the ZIP code of the location where the service was rendered** when submitted by a laboratory or IDTF, using a CMS-supplied abstract file of the MPFS containing the HCPCS codes that are payable under the MPFS as either a purchased test or interpretation for the calendar year. Until further notice, carriers should pay the local rate for purchased interpretation claims when submitted by a physician. **Carriers should accept** and process **claims when billed by suppliers enrolled in the carrier's jurisdiction**, regardless of the location where the service was furnished. **Carriers should allow claims submitted by an IDTF** if the IDTF has previously enrolled to bill for purchased diagnostic test components it performs.

Implementation

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

Additional Information

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

Once at that site, look for CR 3694 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3694
Medlearn Matters Number: MM3694
Related CR Release Date: February 4, 2005
Related CR Transmittal #: 464
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

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Clarification on the Implementation of the Abstract File for Purchased Diagnostic Tests/Interpretations

This information is to reiterate and clarify instructions provided in change requests 3481 and 3694:

Change request 3481 implements a national abstract file of the Medicare Physician Fee Schedule containing HCPCS codes billed as a purchased diagnostic test/interpretation, for every locality in the country. This file allows a supplier to bill their local carrier for all purchased tests/interpretations rendered regardless of where the test was performed.

Change request 3694 recognizes the reasons for not implementing the abstract file for physician billings and therefore delays implementing change request 3481 for physicians.

Supplier Billing (IDTF and Laboratories)

Effective for claims with dates of service on or after April 1, 2005, suppliers (laboratories and IDTFs) will bill their local carrier for all purchased tests/interpretations regardless of where the service was rendered.

Physicians

Physicians must continue to submit services as outlined in change request 3630 (transmittal 415, issued December 23, 2004). Physicians will continue to report their name and facility location on claims for purchased tests/interpretations performed and will be paid the local rate for these services.

Source: CMS Pub 100-4 Transmittal 341, CR 3481
CMS Pub 100-4 Transmittal 464, CR 3694

New Remittance Advice (RA) Message for Referred Clinical Diagnostic/ Purchased Diagnostic Service Duplicate Claims

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

Provider Types Affected

Physicians/suppliers who bill Medicare carriers (excluding DMERCs) for referred clinical diagnostic laboratory and purchased diagnostic services.

Provider Action Needed

STOP – Impact to You

Effective April 1, 2005 a claim for a referred clinical diagnostic/purchased diagnostic service that is identified as duplicate will be denied. For full details of this edit, please see Medlearn Matters article MM3551 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3551.pdf*.

CAUTION – What You Need to Know

Effective with claims processed on or after July 1, 2005, CMS will implement a new Remittance Advice (RA) message for such duplicate claims. Carriers will use the following remark code *on remittance advice notices* generated for a referred clinical diagnostic/purchased diagnostic service claim line item denied as a duplicate of a previously paid service: "Your claim for a referred clinical diagnostic/purchased diagnostic service cannot be paid because payment has been made for this service in another carrier jurisdiction."

GO – What You Need to Do

Be ready to accept this new remark code indicating a duplicate claim submission.

Background

Effective April 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will implement a new Common Working File (CWF) edit to check for duplicate claims for referred clinical diagnostic laboratory services and purchased diagnostic services submitted by physicians/suppliers to more than one carrier. (Per Transmittal 124, Change Request 3551, published on October 29, 2004 and described in Medlearn Matters article MM3551)

As a reminder, claims submitted for referred clinical diagnostic/purchased diagnostic services will be considered duplicate when:

- The claims contain different carrier numbers;

AND

- All of the data matches on the following claim fields:
- Beneficiary name
- Beneficiary health insurance claim number (HICN)
- Current procedural terminology (CPT)/healthcare common procedure coding system (HCPCS) code
- Date of service
- CPT/HCPCS code/modifier.

The CWF duplicate claim edit will apply only to:

- Claims containing a CPT code that is included on the clinical laboratory fee schedule (available online at: *http://www.cms.hhs.gov/suppliers/clinlab/default.asp*, Clinical Laboratory Information Resource for Medicare);

OR

- An HCPCS code that is included on the Abstract File for Purchased Diagnostic Tests/Interpretations to be implemented in April 2005.

Effective for claims processed on or after July 1, 2005, CMS will implement a new remittance advice (RA) message for claim items denied due to the CWF duplicate claim edit for referred clinical diagnostic/purchased diagnostic service claims:

- Carriers will use the following remark code on remittance advice notices generated for a referred clinical diagnostic/purchased diagnostic service claim line item denied as a duplicate of a previously paid service: "Your claim for a referred clinical diagnostic/purchased diagnostic service cannot be paid because payment has been made for this service in another carrier jurisdiction."

Additional Information

The official instruction issued to the carrier 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 3679. Click on the link to open and view the file for the CR. CR 3551 may be accessed at: *http://www.cms.hhs.gov/manuals/pm_trans/R124OTN.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3679
Medlearn Matters Number: MM3679
Related CR Release Date: February 25, 2005
Related CR Transmittal #: 484
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Temporary Change in Carrier Jurisdictional Pricing Rules for Purchased Diagnostic Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This article was last published in the January 2005 Medicare B Update! Special Issue – 2005 HCPCS and MPFSDB Update (pages 49-50).

NOTE: This article was revised on January 12, 2005 to reflect that this change is effective January 25, 2005, and will remain in effect until further notice.

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).

Effective January 25, 2005, and until further notice, 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 CR3630 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 website at the following address: *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 CNMS-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*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3630
Medlearn Matters Number: MM3630
Related CR Release Date: December 23, 2004
Related CR Transmittal #: 415
Effective Date: January 25, 2005
Implementation Date: January 25, 2005

Automated Multi- Channel Chemistry Tests Processing Examples

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

The following are examples, which detail the payment process (as outlined in Chapter 16, Section 90 of the Medicare Claims Processing Manual). For more information, refer to the Medlearn Matters Article located at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3483.pdf*.

EXAMPLE 1

Provider submits both referred and non-referred individual codes, the system processes the codes by using the fee schedule amount for each state, when one or more tests have been referred to another laboratory for processing.

Billed Codes	Billed Amounts	Number of Test(s)	Pro-rated Amount *This is what will display on the detail line as the allowed amount.	State
84075	$8.00	1	$1.15	FL
82310	$8.00	1	$1.15	FL
82374-90	$5.00	1	$0.72	AL
82040-90	$6.00	1	$0.86	AL
82435-90	$5.00	1	$0.72	IN
82465-90	$7.00	1	$1.01	IN
TOTALS	**$39.00**	**6**	**$7.05**	

1. Identify all payable referred and non-referred AMCC test.
2. Add the unduplicated referred (4) and non-referred tests (2). 4 +2= (6)
3. Identify all payable referred (90 modifier) AMCC tests and sort by the state in which the service was referred.

Alabama	Indiana
82374-90	82435-90
82040-90	82465-90

4. Identify all non-referred AMCC tests and sort by the state.

   Florida
   84075
   82310

5. Count all referred (90 modifier) AMCC test for all states. (4)
6. Determine the clinical lab fee schedule amount for the total # of referred test for each state (identified in step 3) by accessing the CMS website at http://www.cms.hhs.gov/providers/pufdownload/clfdown.asp. To verify pricing for the # of test, locate the acronym "ATP" followed by the # of tests. (e.g. 2 tests= ATP02)
   ATP02= $4.44 (AL)
   ATP02= $7.28 (IN)
7. Divide the results from step 6 for each state by the total number of referred and non-referred AMCC test to obtain the unit price.
   $4.44 ÷ 6 = $0.74 (AL)
   $7.28 ÷ 6 = $1.21 (IN)
8. Multiply the unit price for each state by the total # of referred AMCC tests. This will result in a separate amount payable for the referred AMCC test in each state prorated by the total number of AMCC tests ordered.

   $0.74 x 2 = $1.48 (AL)
   $1.21 x 2 = $2.42 (IN)

9. Count all non-referred AMCC test for state (2).
10. Determine the clinical lab fee schedule amount for the total of non-referred test for each state. To verify pricing for the number of test access the CMS website at http://www.cms.hhs.gov/providers/pufdownload/clfdown.asp. To verify pricing for the number of test, locate the acronym "ATP" followed by the # of tests. (e.g. 2 tests= ATP02)

    ATP02= $7.28 (FL)

11. Divide result from step 10 for each state by the total number of referred and non-referred AMCC test to obtain the unit price.

    $7.28 ÷ 6= $1.21 (FL)

12. Multiply the unit price for each state by the total # of non-referred AMCC test. This will result in a separate amount payable for the non-referred AMCC test in each state, prorated by the total number of AMCC tests ordered.

    $1.21 x 2 = $2.42 (FL)

13. Add the prorated payable amounts for referred and non-referred test for each state.

Referred	$1.48	(AL)
Referred	$2.42	(IN)
Non-referred	+$2.42	(FL)
	$6.32	

The following chart outlines the prorated payable amount per line item. Steps 14-17 below details the calculations utilized to arrive at the prorated fees per detail (Column 5).

	Column 1	Column 2	Column 3	Column 4	Column 5
Billed Codes	**Detail Line BAMT**	**Total BAMT**	**Percentage**	**Total Prorate Payable Amount**	**Prorated Fee (Per Detail)**
84075	$8.00	$39.00	.205	$6.32	$1.30
82310	$8.00	$39.00	.205	$6.32	$1.30
82374-90	$5.00	$39.00	.128	$6.32	$0.81
82040-90	$6.00	$39.00	.153	$6.32	$0.97
82435-90	$5.00	$39.00	.128	$6.32	$0.81
82465-90	$7.00	$39.00	.179	$6.32	$1.13
Total					**$6.32**

14. Add the billed charges for all referred and non-referred AMCC tests ($39.00)
15. For each service, divide the detail charge (Column 1) by the total submitted charge (Column 2) to obtain a percentage (Column 3).
16. Take the result from step 15 and multiply the percentage (Column 3) by the prorated payable amount (Column 4) to obtain the prorated fee (Column 5).
17. Add the prorated fees, the amount should equal the prorated payable amount.

Note: Due to rounding the result may differ slightly from the prorated payable amount. Therefore, you will need to 'round-up'.

EXAMPLE 2

Provider submits a claim with a panel code in addition to an individual automated test(s).

Billed Codes	Billed Amounts	Number of Test(s)	Pro-rated Amount *This is what will display on the detail line as the allowed amount.	State
82040	$6.00	1	$1.02	FL
84100	$10.00	1	$1.70	FL
80051-90	$20.00	**4 (82374, 82435, 84132,84295)	$3.39	IN
*82435-90	$6.00	0	0	IN
84550-90	$8.00	1	$1.36	IN
TOTALS	$50.00	7	**$8.49**	

*This individual test is a duplicate of a component of the lab panel and therefore is not included in the calculation.
**The total number of components in a lab panel is counted toward the total number of test performed.

Taking the above situations in consideration, all calculation steps utilized in Example 1 apply.

EXAMPLE 3

Provider submits individual automated lab tests in addition to non-automated test. The total allowed amount would only include the fees for the automated test when calculating the prorated fee.

Billed Code	Billed Amounts	Number of Test(s)	Pro-rated Amount *This is what will display on the detail line as the allowed amount.	State
82435	$10.00	1	$1.43	FL
82040	$6.00	1	$0.82	FL
83718*	$11.44	0	0	FL
84075-90	$10.00	1	$1.43	IN
84100-90	$10.00	1	$1.43	IN
TOTALS	**$36.00**	4	**$5.11**	

*Non-automated test (paid separately)

Non-automated tests are paid at the full fee schedule amount and are not included when calculating the automated test (prorated test).

Taking the above situations in consideration, all calculation steps utilized in Example 1 apply.

Billing for Hemophilia Blood Clotting Factors (Medicare Claims Processing Manual (Pub. 100-04), Chapter 17, Section 80.4)

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

Provider Types Affected

Physicians and providers billing Medicare carriers and intermediaries for blood clotting factors

Provider Action Needed

STOP – Impact to You

Physicians and providers should note that this instruction is based on information contained in change request (CR) 3755 which states that **blood clotting factors** not paid on a cost or prospective payment system basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service.

CAUTION – What You Need to Know

Note: 1) Medicare carriers process claims from noninstitutional providers for blood clotting factors, while 2) blood clotting factor claims from institutional (including claims from hospital-based hemophilia centers) are processed by Medicare fiscal intermediaries (FIs).

GO – What You Need to Do

Be sure billing staff is aware of this requirement.

Background

Blood clotting factors not paid on a cost or prospective payment system basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service. As of January 1, 2005, the ASP (average sales price) plus 6% is used.

If a beneficiary is in a covered Part A stay in a prospective payment system (PPS) hospital, the clotting factors are paid in addition to the DRG/HIPPS payment (For FY 2005, this payment is based on 95% of average wholesale prices (AWP)). For a skilled nursing facility (SNF) subject to SNF/PPS, the payment is bundled into the SNF/PPS rate.

For hospitals subject to the outpatient prospective payment system (OPPS), the clotting factors, when paid under Part B, are paid based on an ambulatory payment classification, or the APC. For SNFs, the clotting factors, when paid under Part B, are paid based on cost.

Additional Information

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

From that web page, look for CR 3755 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) #: 3755 Medlearn Matters Number: MM3755
Related CR Release Date: April 8, 2005 Related CR Transmittal #: 521
Effective Date: May 9, 2005 Implementation Date: May 9, 2005

MEDICARE PHYSICIAN FEE SCHEDULE

1st Update to the 2005 Medicare Physician Fee Schedule Database

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article. This was originally published in the March 2005 Medicare B Update! Special Issue – 1st Update to the 2005 MPFSDB (page 1)

Note: This instruction was revised on April 4, 2005 to show the effective date for the PET codes referenced in the Background section is January 28, 2005.

Provider Types Affected

Physicians and providers billing Medicare carriers or Fiscal Intermediaries (FIs) for services paid under the Medicare Physician Fee Schedule

Provider Action Needed

Physicians and providers should be aware of the changes to the Medicare Physician Fee Schedule Database, and identify those changes that impact their practice.

Background

CR 3726 amends payment files issued based upon the November 15, 2004, final rules for the 2005 Medicare Physician Fee Schedule Database. Many of the changes relate to a national coverage determination (NCD) related to G codes and CPT codes for positron emission tomography (PET), which was effective January 28, 2005.

Additional Information

The changes to the fee schedule involve numerous CPT/HCPCS codes. These changes to the 1st Update to the 2005 Medicare Physician Fee Schedule Database are described in an attachment to CR 3726.

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

From that web page, look for CR 3726 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3726
Medlearn Matters Number: MM3726
Related CR Release Date: February 11, 2005
Related CR Transmittal #: 475
Effective Date: January 1, 2005
Implementation Date: April 4, 2005

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PREVENTIVE SERVICES

Diabetes Screening Tests

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the First Quarter 2005 Medicare B Update! pages 81-82.

Note: This article was revised on January 24, 2005 to reflect a new release date and transmittal number for CR 3637. CR 3637 was re-issued on January 21, 2005. The article was also revised to show that claim type 12x will also be paid in accordance with the Clinical Laboratory Fee Schedule when these services are billed on that claim type.

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 12x, 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*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3637
Medlearn Matters Number: MM3637
Related CR Release Date: Re-issued on January 21, 2005 **Revised**
Related CR Transmittal #: 446
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Diabetes Screening Tests

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

Provider Types Affected

All Medicare providers billing Medicare carriers or fiscal intermediaries for diabetes screening tests for Medicare patients

Provider Action Needed

STOP – Impact to You

This article provides further guidance and clarification of new Medicare coverage rules for diabetes screening tests performed on or after January 1, 2005.

CAUTION – What You Need to Know

The amount of testing covered by Medicare for qualified individuals is changed to one screening test every six months for individuals diagnosed with pre-diabetes and one screening test every twelve months for individuals not diagnosed with pre-diabetes or who were never tested before.

GO – What You Need to Do

Please refer to the Background and Additional Information sections of this article 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 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 article and related CR 3677 clarify that, for individuals diagnosed with pre-diabetes, the two screening tests per year are further limited to one screening test every six months. And, providers should note that these tests for individuals with a pre-diabetes diagnosis must be billed with a V77.1 diagnosis code **and** a "TS" modifier to reflect follow up service.

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

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

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. The following Health Care Common Procedure Coding System (HCPCS) codes for Diabetes Screening are to be billed for diabetes screening:

- 82947 – Glucose, quantitative, blood (except reagent strip)
- 82950 – Post-glucose dose (includes glucose)
- 82951 – Glucose tolerance test (GTT), three specimens (includes glucose)

Providers submitting pre-diabetes and diabetes screening claims should note that claims must contain the appropriate HCPCS codes listed above along with a diagnosis code of V77.1.

No coverage is permitted under the MMA benefit for individuals previously diagnosed as diabetic since these individuals do not require screening. Other diabetes screening blood tests for which the Centers for Medicare & Medicaid Services (CMS) has not specifically indicated national coverage continue to be noncovered.

CMS also provides the following definitions for the purpose of this article:

Diabetes: diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on 2 different occasions; a 2-hour post-glucose challenge > 200 mg/dL on 2 different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

Pre-diabetes: abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to125 mg/dL, or a 2-hour post-glucose challenge of 140 to 199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

Post-glucose challenge test: an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, or a 2-hour post-glucose challenge test alone.

Implementation

The implementation date for this article is April 4, 2005. It applies to services furnished on or after January 1, 2005.

Additional Information

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

From that web page, look for CR 3677 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*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3677
Medlearn Matters Number: MM3677
Related CR Release Date: January 28, 2005
Related CR Transmittal #: 457
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

RADIOLOGY

New Contrast Agents Healthcare Common Procedure Coding System Codes

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

Provider Types Affected

All providers, suppliers and physicians billing Medicare fiscal intermediaries (FIs) or carriers for contrast agents

Provider Action Needed

STOP – Impact to You

As of April 1, 2005, you must use the new "Q" codes that will be added to the HCPCS when you bill for contrast agents

CAUTION – What You Need to Know

Beginning on April 1, 2005, the new HCPCS codes for contrast agents will become effective, except for hospital outpatient departments, which should continue to use the current "A" codes.

GO – What You Need to Do

Physicians, suppliers, and providers should make sure your billing staff knows that they must use the new codes that have been added to the healthcare common procedure coding system as of April 1, 2005 in order to bill for contrast agents.

Background

Effective April 1, 2005, the HCPCS codes for contrast agents in the following table will be added to the HCPCS.

HCPCS Code	Short Descriptor	Long Descriptor
Q9945	LOCM <=149 mg/ml iodine, 1ml	Low osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9946	LOCM 150-199mg/ml iodine,1ml	Low osmolar contrast material, 150 - 199 mg/ml iodine concentration, per ml
Q9947	LOCM 200-249mg/ml iodine,1ml	Low osmolar contrast material, 200 - 249 mg/ml iodine concentration, per ml
Q9948	LOCM 250-299mg/ml iodine,1ml	Low osmolar contrast material, 250 - 299 mg/ml iodine concentration, per ml
Q9949	LOCM 300-349mg/ml iodine,1ml	Low osmolar contrast material, 300 - 349 mg/ml iodine concentration, per ml

HCPCS Code	Short Descriptor	Long Descriptor
Q9950	LOCM 350-399mg/ml iodine,1ml	Low osmolar contrast material, 350 - 399 mg/ml iodine concentration, per ml
Q9951	LOCM >= 400 mg/ml iodine,1ml	Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml
Q9952	Inj Gad-base MR contrast, ml	Injection, gadolinium-based magnetic resonance contrast agent, per ml
Q9953	Inj Fe-based MR contrast, ml	Injection, iron-based magnetic resonance contrast agent, per ml
Q9954	Oral MR contrast, 100 ml	Oral magnetic resonance contrast agent, per 100 ml
Q9955	Inj perflexane lip micros, ml	Injection, perflexane lipid microspheres, per ml
Q9956	Inj octafluoropropane mic,ml	Injection, octafluoropropane microspheres, per ml
Q9957	Inj perflutren lip micros, ml	Injection, perflutren lipid microspheres, per ml

To view payments for these new Q-codes, go to: *http://www.cms.hhs.gov/providers/drugs/default.asp* on the CMS website and look in the respective quarterly Medicare Part B drug pricing files posted there. In accordance with the standard methodology for drug pricing established by the Medicare Modernization Act of 2003 (MMA), the payment for these contrast agents will be based on the average sales price (ASP) plus 6 percent effective April 1, 2005.

Implementation

This change will be implemented in Medicare claims processing systems on April 4, 2005.

Related Instructions

Please note that:

- HCPCS codes Q9945 – Q9951* will replace codes A4644 – A4646; and
- HCPCS codes Q9952 – Q9954* will replace codes A4643 and A4647; **except that**
- Hospital outpatient departments shall continue to bill codes A4644 – A4646, A4643, and A4647 and shall not report codes Q9945 – Q9957.
- Non-institutional providers billing the carriers shall use Q9955 – Q9957 to report specific echocardiography contrast agents.
- All other echocardiography contrast agents not described by Q9955 –Q9957 shall be reported with A9700.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found on the web at: *http://www.cms.hhs.gov/manuals/pm_trans/R502CP.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*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3748
Medlearn Matters Number: MM3748
Related CR Release Date: March 11, 2005
Related CR Transmittal #: 502
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Billing Instructions for New Contrast Agents HCPCS Codes

Effective for dates of service on/after April 1, 2005, new contrast agents HCPCS codes were added to the healthcare common procedure coding system.

HCPCS codes Q9945 – Q9951 will replace codes A4644 – A4646
HCPCS codes Q9952 – Q9954 will replace codes A4643 and A4647

Since there is not a one to one match for the discontinued codes A4643-A4647, you will need to choose the appropriate Q9945-Q9957 procedure code that best describes the service rendered. Please remember to adjust the quantity-billed field appropriately based on the description of the new procedure code billed to ensure proper reimbursement is applied to the claim.

A UPIN is required for all new contrast agent HCPCS codes and will be denied as unprocessable if not provided. All unprocessable denied claims must be resubmitted as a new claim.

Two procedure codes (Q9951 and Q9953) are "individual consideration" procedures and require manual pricing. For this reason, the name, strength, and dosage administered to the patient is required in block 19 of the CMS 1500 claim form or the EMC equivalent field. **Important Note**: The quantity billed field for these two codes should be a 1 since the claim will be processed using the information given in block 19.

National pricing for the new contrast agent HCPCS codes can be obtained by accessing the "Medicare Part B Drugs Average Sales Price (ASP) Information Resource" Web page on the CMS website at *http://www.cms.hhs.gov/providers/drugs/asp.asp*.

Source: CMS Pub 100-4 Transmittal 502, CR 3748

Expanded Coverage and Billing Requirements for PET Scans for Cervical and Other Cancers

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers and fiscal intermediaries (FIs) for the subject PET scans.

Provider Action Needed

CR 3741, as summarized by this instruction, changes the national coverage for the use of 2-[F-18] Fluoro- D-Glucose Positron Emission Tomography scans (FDG-PET) for certain cancer indications.

Effective for services performed on or after January 28, 2005, the Centers for Medicare & Medicaid Services (CMS) expands national coverage of FDG-PET to include:

- Specific indications in patients with cervical cancer;
- Indications not previously specified in 5 other cancer diagnoses; brain, ovarian, pancreatic, small cell lung, and testicular **(but only when you and your patients are participating in specifically defined prospective clinical studies/trials);**
- Monitoring response to treatment when a change in therapy is indicated in a number of cancers that are already covered for diagnosis, staging, and restaging; and,
- A broad range of other cancers not previously specified **(but only when you and your patients are participating in specifically defined prospective clinical studies/trials).**

Note: For the coverage of specific indications, see Table 1 below.

Background

Positron Emission Tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems. In this procedure, a positron camera produces cross-sectional tomographic images obtained from intravenous positron emitting radioactive tracer substances (radiopharmaceuticals), such as 2-[F-18] Fluoro-D-Glucose (FDG). In general, FDG PET is covered in the following clinical situations:

Diagnosis

When the results may help avoid an invasive diagnostic procedure, or help determine the best anatomic location for an invasive diagnostic procedure.

Staging

When a cancer's stage remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound); when using PET could potentially replace one or more conventional imaging studies if it is expected that conventional study information is not sufficient for the patient's clinical management, and when the patient's clinical management would differ depending on the cancer's stage.

Restaging

After the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or metastasis, to determine the extent of a known recurrence, or if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is not adequate to determine the extent of a known recurrence, or if study information is not sufficient for the patient's clinical management. Restaging applies to testing after a course of treatment is completed and is covered subject to the above conditions.

Monitoring

Monitoring refers to evaluating tumor response to treatment during the planned course of therapy (i.e., when a change in therapy is anticipated).

CR 3741 expands the FDG PET national coverage policy (by revisions to the National Coverage Determinations (NCD) Manual – CMS Publication (Pub.) 100-03 and the Medicare Claims Processing Manual – CMS Pub. 100-04) by providing general Medicare coverage and billing requirements for FDG PET usage for brain, cervical, ovarian, pancreatic, small cell lung, testicular, and other cancer indications both previously specified and not previously specified.

In newly diagnosed and locally advanced cervical cancer (after negative conventional imaging for extrapelvic metastasis) CMS determines that the evidence is adequate to conclude that FDG PET to detect pretreatment metastases (staging) is reasonable and necessary as an adjunct test.

In addition, for brain, ovarian, pancreatic, small cell lung, and testicular cancers, CMS determines that the evidence is sufficient to conclude that FDG PET is reasonable and necessary only when the provider is participating in, and patients are enrolled in, one of the following types of prospective clinical studies:

- A clinical trial of FDG PET that meets the requirements of the Food and Drug Administration (FDA) category B investigational device exemption (42 CFR 405.201); or
- A FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management. Qualifying clinical studies must ensure that specific hypotheses are addressed; appropriate data elements are collected; hospitals and providers are qualified to provide the PET scan and interpret the results; participating hospitals and providers accurately report data on all enrolled patients not included in other qualifying trials through adequate auditing mechanisms; and, all patient confidentiality, privacy, and other federal laws must be followed.

In addition, coverage is also expanded under clinical studies (as defined above) for certain indications of brain, cervical, colorectal, esophageal, head and neck, lymphoma, melanoma, non-small cell lung, ovarian, pancreatic, small-cell lung, soft tissue sarcoma, thyroid, testicular, and other cancers not previously identified. Monitoring response to treatment when a change in therapy is indicated is now covered in a number of cancers (cervical, colorectal, esophageal, head and neck, lymphoma, melanoma, non-small cell lung, and thyroid) only in the context of a clinical study. Lastly, this guidance expands coverage in the context of a clinical study for a broad range of other cancers not previously specified. You can find these changes in the following table.

Table 1
Coverage of FDG PET for Cancer Indications
Effective January 28, 2005

Indication	Covered 1	Nationally Non-covered 2	Coverage with Evidence Development 3
Brain			X
Breast -Diagnosis -Initial staging of axillary nodes -Staging of distant metastasis -Restaging, monitoring *	 X X	 X X	
Cervical -Staging as adjunct to conventional imaging -Other staging -Diagnosis, restaging, monitoring *	 X		 X X
Colorectal -Diagnosis, staging, restaging -Monitoring *	 X		 X
Esophagus -Diagnosis, staging, restaging -Monitoring *	 X		 X
Head and Neck (non-CNS/thyroid) -Diagnosis, staging, restaging -Monitoring *	 X		 X
Lymphoma -Diagnosis, staging, restaging -Monitoring *	 X		 X
Melanoma -Diagnosis, staging, restaging -Monitoring *	 X		 X
Non-Small Cell Lung -Diagnosis, staging, restaging -Monitoring *	 X		 X
Ovarian			X
Pancreatic			X
Small Cell Lung			X
Soft Tissue Sarcoma			X
Solitary Pulmonary Nodule (characterization)	X		
Thyroid -Staging of follicular cell tumors -Restaging of medullary cell tumors -Diagnosis, other staging & restaging -Monitoring *	 X		 X X X
Testicular			X
All other cancers not listed herein (all indications)			X

1 Covered nationally based on evidence of benefit. Refer to National Coverage Determination Manual Section 220.6 in its entirety for specific coverage language and limitations for each indication.
2 Non-covered nationally based on evidence of harm or no benefit
3 Covered only in specific settings discussed above if certain patient safeguards are provided. Otherwise, non-covered nationally based on lack of evidence sufficient to establish either benefit or harm or no prior decision addressing this cancer. Medicare will notify providers and beneficiaries where these services can be accessed, as they become available, via Federal Register Notice and the CMS coverage website at: http://www.cms.hhs.gov/coverage

*** Monitoring = monitoring response to treatment when a change in therapy is anticipated.**

Perhaps a quick review of the term National Coverage Determination (NCD) would be helpful at this point. NCDs grant, limit, or exclude Medicare coverage for a specific medical item/service. They apply nationwide and are binding on all Medicare carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans for purposes of Medicare coverage. Moreover, an administrative law judge may not review an NCD.

Here are some specific details about the NCD issued as part of CR 3741 of which you should be aware:

- A particular use of FDG PET scans is not covered unless the NCD Manual specifically provides coverage of that use.
- All currently non-covered FDG PET indications based on lack of evidence or benefit remain in effect (i.e., HCPCS G0219 and G0252 remain in effect as non-covered PET indications).
- For all other currently non-covered FDG PET indications (not based on lack of evidence or benefit), Medicare will cover FDG PET scans meeting the clinical study/trial criteria outlined in this NCD.
- Effective for claims with dates of service on or after January 28, 2005, all HCPCS codes listed in Table 2 (below) will be used for all covered PET scan indications specified, and those listed in Table 3 (below) will become invalid. Additionally, a new HCPCS code (G0235 – PET not otherwise specified) has been added for non-coverage of PET scan indications not otherwise specified.

Note: While G0336 for coverage of PET scans for dementia and neurodegenerative diseases will be replaced with a CPT code for services on or after January 28, 2005, all other limiting conditions and indications for coverage apply. Refer to the National Coverage Determinations Manual, section 220.6.13, for complete coverage conditions for PET scans for dementia and neurodegenerative diseases.

Table 2
CPT Codes for Covered PET scan Indications
Effective for dates of service on or after January 28, 2005

CPT	Code Description
78459	*Myocardial imaging, positron emission tomography (PET), metabolic evaluation*
78491	*Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress*
78492	*Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress*
78608	*Brain imaging, positron emission tomography (PET); metabolic evaluation*
78609	*Brain imaging, positron emission tomography (PET); perfusion evaluation*
78811	*Tumor imaging, positron emission tomography (PET); limited area (eg, chest, head/neck)*
78812	*Tumor imaging, positron emission tomography (PET); base to mid thigh*
78813	*Tumor imaging, positron emission tomography (PET); whole body*
78814	*Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg chest, head/neck)*
78815	*Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh*
78816	*Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body*

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Table 3
HCPCS Codes Not Valid for Medicare for Dates of Service On or After January 28, 2005

G0030	G0046	G0223
G0031	G0047	G0224
G0032	G0125	G0225
G0033	G0210	G0226
G0034	G0211	G0227
G0035	G0212	G0228
G0036	G0213	G0229
G0037	G0214	G0230
G0038	G0215	G0231
G0039	G0216	G0232
G0040	G0217	G0233
G0041	G0218	G0234
G0042	(blank)	G0253
G0043	G0220	G0254
G0044	G0221	G0296
G0045	G0222	G0336

Additional Information

CMS reminds providers to issue advanced beneficiary notices to Medicare patients advising them of potential financial liability if all specified conditions for coverage of PET are not met.

You can find more information about the billing requirements for FDG PET scans for brain, cervical, ovarian, pancreatic, small cell lung, soft tissue sarcoma, testicular, and all other cancer Indications by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3741 in the CR NUM column on the right, and click on the file for that CR.

Please note that there will be two transmittals with CR 3741, one for the NCD issuance itself and the other for the changes to Medicare claims processing as a result of the NCD. The revised portion of the NCD Manual will be attached to CR 3741, transmittal number 31. The billing/claims processing changes to the Medicare Claims Processing Manual will be attached to CR 3741, transmittal number 527.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3741
Medlearn Matters Number: MM3741
Related CR Release Date: April 1, 2005
Related CR Transmittal #: 31 and 527
Effective Date: January 28, 2005
Implementation Date: April 18, 2005

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Billing Requirements for Positron Emission Tomography (PET) Scans for Dementia and Neurodegenerative Diseases

CMS has re-issued the following "Medlearn Matters... Information for Medicare Providers" article. This information was previously published in the 1st Quarter 2005 Medicare B Update! pages 46-47.

Important Note: This article was revised on April 22, 2005, to show change request (CR) 3426 was revised by CR 3640 (Transmittal 428, dated January 14, 2005). CR 3640 revised billing requirements in CR 3426 for PET scans for alzheimer's disease (AD) by 1) removing the edit for one scan per beneficiary's lifetime for PET AD scans, and 2) adding requirements for specifying ICD-9 diagnosis coding. In addition, section 60.1 of the Medicare Claims Processing Manual (Pub. 100-04) was updated to include specific payment information for claims for all PET scans for services submitted by critical access hospitals (CAHs). To see CR3640, go to the following CMS website: *http://www.cms.hhs.gov/manuals/pm_trans/R428CP.pdf*. Also, the Medlearn Matters article related to CR 3640 is located at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3640.pdf*.

Provider Types Affected

Physicians and providers.

Provider Action Needed

This instruction notifies physicians and providers that Medicare will provide coverage for 2-deoxy-2- [F-18] fluoro-D-glucose (FDG)-PET scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least 6 months duration. This service may be covered:

- When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and alzheimer's disease (AD) under specific requirements, **or**
- For use in a Centers for Medicare & Medicaid Services (CMS)-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

Background

Effective for dates of service on or after September 15, 2004, Medicare will provide coverage for FDG Positron Emission Tomography PET for one of the following:

- When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and Alzheimer's disease; **or**
- When used in a CMS-approved practical neurodegenerative disease clinical trial.

Clinical trial results are expected to help in determining if PET scans contribute to the effective diagnosis and treatment of Medicare beneficiaries with mild cognitive impairment or early dementia, and add information that will help monitor, evaluate, and improve clinical outcomes of patients with this disease.

Refer to the Medicare Claims Processing Manual, Publication 100-04, Chapter 13, Section 60, for general Medicare coverage and billing requirements for PET scans for dementia and neurodegenerative diseases.

Also, refer to the Medicare National Coverage Determinations (NCD) Manual, Publication 100-03, Section 220.6 for complete coverage policy and clinical trial requirements. The revision to the NCD Manual, Pub. 100-03, Section 220.6 is an NCD. NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans.

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

Key portions of these revised manuals are as follows:

FDG-PET Requirements for Use in the Differential Diagnosis of AD and FTD

According to the NCD on this issue, Medicare covers FDG-PET scans for either a) the differential diagnosis of both FTD and alzheimer's disease AD under specific requirements **or,** b) its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

For use in the differential diagnosis of FTD and AD, an FDG-PET scan is considered reasonable and necessary for patients with a recent diagnosis of dementia and documented cognitive decline of at least 6 months, who meet diagnostic criteria for both AD and FTD. These patients have been evaluated for specific alternative neurodegenerative diseases or causative factors, but the cause of the clinical symptoms remains uncertain.

The following additional conditions must be met before an FDG-PET scan can be ordered:

a) The patient's onset, clinical presentation, or course of cognitive impairment is such that FTD is suspected as an alternative neurodegenerative cause of the cognitive decline. Specifically, symptoms such as social disinhibition, awkwardness, difficulties with language, or loss of executive function are more prominent early in the course of FTD than the memory loss typical of AD

b) The patient has had a comprehensive clinical evaluation (as defined by the American Academy of Neurology (AAN)) encompassing a medical history from the patient and a well-acquainted informant (including assessment of activities of daily living), physical and mental status examination (including formal documentation of cognitive decline occurring over at least 6 months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging (MRI) or computed tomography (CT)

c) The evaluation of the patient has been conducted by a physician experienced in the diagnosis and assessment of dementia

d) The evaluation of the patient did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment

e) The FDG-PET scan is performed in a facility that has all the accreditation necessary to operate nuclear medicine

equipment. The reading of the scan should be done by an expert in nuclear medicine, radiology, neurology, or psychiatry, with experience interpreting such scans in the presence of dementia

f) A brain single photon emission computed tomography (SPECT) or FDG-PET scan has not been obtained for the same indication

The indication can be considered to be different in patients who exhibit important changes in scope or severity of cognitive decline, and meet all other qualifying criteria listed above and below (including the judgment that the likely diagnosis remains uncertain). The results of a prior SPECT or FDG-PET scan must have been inconclusive or, in the case of SPECT, difficult to interpret due to immature or inadequate technology. In these instances, an FDG-PET scan may be covered after 1 year has passed from the time the first SPECT or FDG-PET scan was performed.

g) The referring and billing provider(s) have documented the appropriate evaluation of the Medicare beneficiary. Providers should establish the medical necessity of an FDG-PET scan by ensuring that the following information has been collected and is maintained in the beneficiary medical record:

- Date of onset of symptoms
- Diagnosis of clinical syndrome (normal aging; mild cognitive impairment or MCI; mild, moderate or severe dementia)
- Mini mental status exam (MMSE) or similar test score
- Presumptive cause (possible, probable, uncertain AD)
- Any neuropsychological testing performed
- Results of any structural imaging (MRI or CT) performed
- Relevant laboratory tests (B12, thyroid hormone)
- Number and name of prescribed medications
- The billing provider must furnish a copy of the FDG-PET scan result for use by CMS and its contractors upon request
- These services should be billed with HCPCS code of G0336 (Pet imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. FTD)

FDG-PET Requirements for Use in the Context of a CMS-Approved Neurodegenerative Disease Practical Clinical Trial Utilizing Specific Protocol

With regard to use of the FDG-PET in the context of a CMS-approved clinical trial, the clinical trial must compare patients who do and those who do not receive an FDG-PET scan and have as its goal to monitor, evaluate, and improve clinical outcomes. In addition, it must meet the following basic criteria:

- Written protocol on file
- Institutional Review Board review and approval
- Scientific review and approval by two or more qualified individuals who are not part of the research team
- Certification that investigators have not been disqualified

Physicians should note that a **QV** modifier must be used when billing Medicare carriers for a CMS-approved neurodegenerative disease practical clinical trial. In addition, on such claims from trials that are billed to Medicare intermediaries, a second diagnosis code **(ICD-9-CM) of V70, 7,** along with the appropriate principal diagnosis code and **HCPCS code G0336** must be entered on the CMS-1450 or its electronic equivalent. There will be a link on the *http://cms.hhs.gov/coverage* website that will have a list of all the participating trial facilities once they have been selected.

Implementation

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

Additional Information

As previously mentioned, the Medicare Claims Processing Manual (Pub. 100-04), Chapter 13 (Radiology Services), Section 60 (Positron Emission Tomography (PET) Scans) is being updated by this instruction. It includes billing and claims processing requirements for PET Scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least 6 months duration who meet diagnostic criteria for both FTD and AD, or its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

In addition, the Medicare NCD Manual (Pub. 100-03), Chapter 1 (Coverage Determinations) Section 220 (Radiology), Subsection 6 (Positron Emission Tomography (PET)) Scans, is being updated by this instruction to include complete coverage policy and requirements for related clinical trials. These updated manual instructions are included in the official instruction issued to your carrier/intermediary, which can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR 3426 in the CR NUM column on the right, and click on the file for that CR.

If you have 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) #: 3426
Medlearn Matters Number: MM3426
Eelated CR Release Date: October 1, 2004
Related CR Transmittal #: 24
Effective Date: September 15, 2004
Implementation Date: October 4, 2004

SURGERY

Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare Advantage (MA) Plan and Use of the QR Modifier to Identify Patient Registry Participation

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

Provider Types Affected

All Medicare providers billing either a Medicare carrier or fiscal intermediary (FI) for implantable automatic defibrillators for Medicare beneficiaries who are members of Medicare Advantage plans

Provider Action Needed

STOP – Impact to You

Be aware that CMS is expanding the set of medical indications for the use of implantable automatic defibrillators and this instruction discusses the impact of this change for beneficiaries who are members of a MA plan and receive these services.

CAUTION – What You Need to Know

Effective January 27, 2005, CMS is expanding national coverage for implantable automatic defibrillators by including the following new indications:

1. Patients with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) Class II and III heart failure, and measured left ventricular ejection fraction (LVEF) ≤ 35%;
2. Patients with nonischemic dilated cardiomyopathy (NIDCM) > 9 months, NYHA Class II and III heart failure, and measured LVEF ≤ 35%;
3. Patients who meet all current CMS coverage requirements for a cardiac resynchronization therapy (CRT) device and have NYHA Class IV heart failure;
4. Patients with NIDCM > 3 months, NYHA Class II or III heart failure, and measured LVEF ≤ 35%.

(See Note below)

GO – What You Need to Do

Make sure that your billing staffs are aware of these new indications and also the basis for billing Medicare.

> **Note:** For beneficiaries under a MA plan, payment for defibrillator use effective January 27, 2005, is different for these new indications than it is for previously covered indications. When the beneficiary is under a MA plan, defibrillator use for these new indications is not part of the capitated rates and is to be paid fee-for-service (FFS). However, payment for previously covered indications for defibrillators implanted in these beneficiaries will be part of the MA capitated rates and is not to be paid FFS. In addition, data must be collected and reported through an approved data collection mechanism for beneficiaries that receive an implantable automatic defibrillator for the primary prevention (as opposed to secondary prevention) of sudden cardiac death. The above indications are considered primary prevention indications. Additional information regarding the ICD Abstraction Tool is available through a previously issued Special Edition MedLearn Article (SE0517) which is available at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0517.pdf*

Background

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

Medicare pays for the use of these defibrillators for only certain clinical indications.

Here is a synopsis of the history of indications and payment policies (indicating the effective dates) for implantable defibrillators, leading up to change request (CR) 3604:

Indications

- **July 1, 1991**

Documented episode of cardiac arrest due to ventricular fibrillation (VF), not due to a transient or reversible cause

- **July 1, 1999**

Documented sustained Ventricular Tachyarrhythmia (VT), either spontaneous or induced by an Electrophysiology (EP) study, not associated with an acute Myocardial Infarction (MI) and not due to a transient or reversible cause Documented familial or inherited conditions with a high risk of life-threatening VT, such as long QT syndrome or hypertrophic cardiomyopathy

- **October 1, 2003**

Coverage was expanded to include coronary artery disease with a documented prior MI, a measured left ventricular ejection fraction ≤0.35, and inducible, sustained VT or VF at EP study. (The MI must have occurred more than 4 weeks prior to defibrillator insertion. The EP test must be performed more than 4 weeks after the qualifying MI).

Payment Policies

- **October 1, 2003 (CRs 2880 & 2992)**

For covered defibrillator claims made on behalf of MA (formerly known as M+C) beneficiaries, payment for the expanded coverage (above) would be made on a FFS basis until Medicare capitation rates to MA organizations were adjusted to account for expanded coverage.

Also at this time, system changes were implemented to enable the automatic processing and payment of covered defibrillator claims on a FFS basis when the beneficiary was under a MA plan and the claims included either a KZ modifier attached to the defibrillator procedure codes when billing a carrier or a condition code of 78 when billing a fiscal intermediary.

- **January 1, 2005 (CR 3301)**

Because MA rates have been appropriately adjusted to account for the defibrillator coverage described in CRs 2880

and 2992, covered services for the indications in these CRs will no longer be paid FFS when the beneficiary is under a MA plan.

Now in CR 3604, Medicare announces expanded coverage for implantable defibrillators for additional indications, effective January 27, 2005. These indications are:

- Patients with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) Class II and III heart failure, and measured left ventricular ejection fraction (LVEF) ≤ 35%;
- Patients with nonischemic dilated cardiomyopathy (NIDCM) > 9 months, NYHA Class II and III heart failure, and measured LVEF ≤ 35%;
- Patients who meet all current CMS coverage requirements for a cardiac resynchronization therapy (CRT) device and have NYHA Class IV heart failure;
- Patients with NIDCM > 3 months, NYHA Class II or III heart failure, and measured LVEF ≤ 35%.

Please note this additional information:

- Since this new coverage exceeds the significant cost threshold for managed care organizations, services related to the newly covered indications will be paid only on a fee-for-service basis for patients enrolled in a managed care plan. To reiterate, for these new indications, Medicare will pay for covered defibrillators on a FFS basis for claims for beneficiaries under MA plans through December 31, 2005. (Coverage guidelines can be found in the National Coverage Determination Manual (NCDM), Section 20.4.). **As a reminder, remember that MA plan beneficiaries are responsible for paying applicable coinsurance, but are not responsible for paying Part A or Part B deductibles (so you should assume that the Part A or Part B deductible has been met). To indicate that the beneficiary is under an MA plan and the services provided are for one of the new indications, providers are to include a KZ modifier for carrier claims and a condition code of 78 for fiscal intermediary claims until the MA capitated rates are adjusted.**
- Payment for previously covered indications for defibrillator use, i.e., those indications approved prior to January 27, 2005, will be part of the MA capitated rates and are not to be paid on a FFS basis for beneficiaries under a MA plan.
- Except for reimbursing for the use of the defibrillators for the new indications, the processing of defibrillator claims for non-MA beneficiaries remains unchanged.
- For indications effective after January 27, 2005, patients must not have:
- Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;
- Had a coronary artery bypass graft (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA) within the past 3 months;
- Had an acute MI within the past 40 days;
- Clinical symptoms or findings that would make them a candidate for coronary revascularization; or
- Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year.
- All patients considered for implantation of a defibrillator must be able to give informed consent.
- Myocardial infarctions must be documented and defined according to the consensus document of the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction.
- Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.
- Providers must be able to justify the medical necessity of devices other than single lead devices. This justification should be available in the medical record.

You should also be aware that Medicare is requiring that patients receiving a defibrillator for the new indications (or for any other indication that is for the primary prevention of sudden cardiac arrest [no history of a previous cardiac arrest]) be enrolled in either a Food and Drug Administration-approved Category B Investigational Device Exemption (IDE) clinical trial, a trial under the Centers for Medicare & Medicaid Services Clinical Trial Policy, or a qualifying data collection system including approved clinical trials and registries to ensure the safety and quality of care.

Initially, CMS will maintain an implantable automatic defibrillator registry using a mechanism that Medicare participating hospitals already use to submit quality data to the Quality Improvement Organizations (QIOs). Hospital staff will fill out the data collection form (supplied by CMS) using the ICD Abstraction Tool and transmit it via QNet (Quality Network Exchange) to the QIO. Iowa Foundation for Medical Care (IFMC) will collect and maintain registry data and the QIOs will be able to ensure the quality of the data by sampling charts. Additional information regarding the ICD Abstraction Tool is available through a previously issued Special Edition MedLearn Article (SE0517), which is available at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0517.pdf.

Additional data collection systems (trials or registries) addressing at a minimum the hypotheses specified in this decision must meet the following basic criteria:

- Written protocol on file;
- Institutional Review Board review and approval;
- Scientific review and approval by two or more qualified individuals who are not part of the research team;
- Certification that investigators have not been disqualified.

For purposes of this coverage decision, CMS will determine whether specific registries or clinical trials meet these criteria.

Also, remember that the QR modifier was created for use on Part B claims to identify protocol covered services. The appropriate use of the QR modifier, in defibrillator claims, is to identify patients whose data is being submitted to a registry and to document meeting the coverage requirement for devices implanted for primary prevention of sudden cardiac arrest. Providers should only append the QR modifier on claims submitted on or after April 1, 2005. This modifier is not required when ICD-9-CM codes 427.1 ventricular tachycardia; 427.41 ventricular fibrillation; 427.42 ventricular flutter; 427.5 cardiac arrest; 427.9 cardiac dysrhythmia, unspecified appear on the claim, as these codes identify a patient receiving the device as secondary, not primary prevention, of sudden cardiac arrest.

On the other hand, if none of the above ICD-9 diagnosis codes apply to the device implant, patient data should be submitted to a registry and the QR modifier is required for claims submitted on or after April 1, 2005.

One final note:

- Providers billing Medicare fiscal intermediaries (FIs) should:
- Use the following G codes (payable under OPPS effective October 1, 2003): G0297, G0298, G0299, and G0300.

Note: These G codes are not payable under the Medicare physician fee schedule and, therefore, should not be billed to Medicare carriers.

- Use the following ICD-9-CM procedure code on 11X type of bills: 37.94
- Providers billing carriers should use procedure code 33249.

Additional Information

You can find more information about billing for implantable automatic defibrillators for beneficiaries in a MA plan by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3604 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3604
Medlearn Matters Number: MM3604
Related CR Release Date: March 8, 2005
Related CR Transmittal #: 497
Effective Date: January 27, 2005
Implementation Date: January 27, 2005
Implementation Date for QR Modifier: April 4, 2005

THERAPEUTIC SERVICES

Update to 100-04 and Therapy Code Lists

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

Provider Types Affected

Providers billing intermediaries and carriers for Part A inpatient and Part B outpatient services

Provider Action Needed

Providers should note that this article provides details from Change Request (CR) 3647, which updates the list of Healthcare Common Procedure Coding System (HCPCS) codes describing therapy services including physical therapy, occupational therapy, and speech-language pathology. It also clarifies the term "always therapy" codes. The term "therapy" as used in this article refers only to physical therapy, occupational therapy, and speech-language pathology. The term "therapists" refers to physical therapists, occupational therapists, speech-language pathologists, and, in some cases, to physicians, clinical nurse specialists, nurse practitioners, and physician assistants who may provide therapy services.

Background

Change Request (CR) 3647 updates the list of HCPCS codes that describe therapy services for physical therapy, occupational therapy, and speech-language pathology. Some of these changes are required to prevent conflicts with OPPS codes, which were effective January 1, 2005, and others are updates to the current list.

Financial limitations on therapy services were mandated by the Balanced Budget Act (BBA), and in order to limit the services, a list of the services to which limits would apply was developed and published as AB-03- 018 in February 7, 2003. The original list may be viewed at: *http://www.cms.hhs.gov/manuals/pm_trans/AB03018.pdf*.

Specialty codes 73 and 74 were incorrectly noted in transmittal AB-03-018 and have since been reassigned to specialties that are not therapy services.

This list is being updated due to new codes and new information about the codes listed. The limitations are not in effect in the year 2005, but are mandated to be implemented on January 1, 2006 unless new legislation is passed. Regardless of whether financial limitations are in effect, CMS uses this list to identify therapy services for policy purposes.

Applicable Outpatient Rehabilitation HCPCS Codes

CMS identifies the following codes as therapy services. See the notes below the table for details about each code.

The financial limits (when in effect) apply to services represented by the following codes, except as noted below.

Note: Listing of the following codes does not imply that services are covered.

Table 1: HCPCS Codes Identified as Therapy Services

64550+	*90901+*	*92506*	*92507*	*92508*	*92526*
92597	*92605******	*92606******	*92607*	*92608*	*92609*
92610+	*92611+*	*92612+*	*92614+*	*92616+*	*95831+*
95832+	*95833+*	*95834+*	*95851+*	*95852+*	*96105+*
96110+♦✓	*96111+*✓	*96115+*✓	*97001*	*97002*	*97003*
97004	*97010******	*97012*	*97016*	*97018*	*97020*
97022	*97024*	*97026*	*97028*	*97032*	*97033*
97034	*97035*	*97036*	*97039*	*97110*	*97112*
97113	*97116*	*97124*	*97139*	*97140*	*97150*
*97504***	*97520*	*97530*	*97532+*	*97533*	*97535*
97537	*97542*	*97597+*	*97598+*	*97602******	*97605******
*97606******	*97703*	*97750*	*97755*	*97799**	G0279+***
G0280+***	G0281	G0283	G0329	0029T+***	

***** The physician fee schedule abstract file does not contain a price for codes 96110, or 97799, since the carrier prices them. Therefore, the Fiscal Intermediary (FI) must contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

♦ Effective January 1, 2004, 96110 will be an active code on the physician fee schedule. Carriers shall no longer price this code.

****** Code 97504 should not be reported with code 97116. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed; both codes may be billed with modifier 59 to denote a separate anatomic site.

******* The physician fee schedule abstract file does not contain a price for codes G0279, G0280, 0020T, or 0029T since they are priced by the carrier. In addition, the carrier determines coverage for these codes. Therefore, the FI contacts the carrier to obtain the appropriate fee schedule amount.

********Codes are bundled. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, Medicare does not pay separately for these codes. If billed alone, either code will be denied using group code CO on the remittance advice notice with claim adjustment reason code 97 that says: "Payment is included in the allowance for another service/procedure."

Medicare will use reason code 97 to deny a procedure code that should have been bundled. Alternatively, reason code B15, which has the same intent, may also be used.

✓If billed by an outpatient hospital department, these are paid using the Outpatient Prospective Payment system (OPPS).

Underlined codes are always therapy services, regardless of the circumstances or who performs them. These codes always require therapy modifiers whenever they are billed.

+ Codes sometimes represent therapy services. These codes and all codes on the above list always represent therapy services when performed by therapists.

There are some circumstances when these codes will not be considered representative of therapy services and therapy limits (when they are in effect) will not apply. Codes marked + are not therapy services when:

- It is not appropriate to bill the service under a therapy plan of care, and
- They are billed by providers of services who are not therapists, i.e., physicians, clinical nurse specialists, nurse practitioners and psychologists.

The Codes marked + on the above list may not be used by therapists, or by physicians, or by nonphysician practitioners who are not therapists without a therapy modifier in situations where the service provided is integral to an outpatient rehabilitation therapy service. It is not the +code itself, but the circumstance under which a +code is billed that determines whether a modifier is required. Physicians and non-physician practitioners who can appropriately provide the services represented by the codes marked '**+**' on the above list should only use therapy modifiers (GP, GN, GO) with the above codes when the services are outpatient rehabilitation therapy services provided under a therapy plan of care**. Do not use the modifier when it is not needed.**

Therapy services, whether represented by "always therapy" codes, or "sometimes therapy codes in the above list performed as outpatient rehabilitation therapy services, must follow all the policies for therapy services (see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 5, and the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 15).

Additional HCPCS Codes

Codes that are not on the list of therapy services should not be billed with a modifier. There are thousands of such codes; but, for example, the following outpatient non-rehabilitation HCPCS codes should be billed without modifiers:

Table 2: Outpatient Non-Rehabilitation HCPCS Codes

95860	*95861*	*95863*	*95864*	*95867*	*95869*	*95870*
95900	*95903*	*95904*	*95934*	G0237	G0238	G0239

Note: The above list of codes is intended to facilitate the contractor's ability to pay claims under the Medicare Physician Fee Schedule (MPFS). It is not intended to be a list of all covered OPT services and does not assure coverage of these services.

Implementation

The implementation date for this instruction is July 5, 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/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3647 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3647
Medlearn Matters Number: MM3647
Related CR Release Date: April 1, 2005
Related CR Transmittal #: 515
Effective Date: January 3, 2005
Implementation Date: July 5, 2005

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HIPAA - The Health Insurance Portability and Accountability Act

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

This information was previously published in the Second Quarter 2005 Medicare B Update! pages 50-50. CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: This article was revised on January 31, 2005, to reflect a new CR release date and CR Transmittal number since the CR was re-issued. All other information in the article remains the same.

Provider Types Affected

All Medicare Providers.

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

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

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

The process for post-payment based enforcement is as follows:

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

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

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

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

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

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

Additional Information

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

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

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

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3440
Medlearn Matters Number: MM3440
Related CR Release Date: January 27, 2005 (CR Re-issued) **Revised**
Related CR Transmittal #: 450
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Claims Status Code/Claims Status Category Code Update

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

Provider Types Affected

All providers submitting health care claim status transactions to Medicare carriers, including durable medical equipment carriers (DMERCs), and fiscal intermediaries (FIs)

Provider Action Needed

This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective July 1, 2005, the Medicare Claims processing system will update its lists of health care claims status codes and health care claims status category codes with all applicable code changes posted online with the "new as of 10/04" and prior date designations.

Background

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets.

Claim status category codes and claim status codes are used in the health care claim status response (277) transaction:

- Claim status category codes indicate the general payment status of the claim.
- Claim status codes provide more detail about the status communicated in the general claim status category codes.

These codes are available online at: *http://www.wpc-edi.com/codes/Codes.asp*.

Additional Information

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

On the above page, scroll down the CR NUM column on the right to find the link for CR 3715. 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 or intermediary at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3715
Medlearn Matters Number: MM3715
Related CR Release Date: March 4, 2005

Electronically Requesting and Receiving Information Regarding Claims Using the ASC X12N276/277 Claims Status Inquiry/Response Transactions

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

Provider Types Affected

Physicians, providers and suppliers billing Medicare carriers and intermediaries.

Provider Action Needed

STOP – Impact to You

This special edition discusses how health care providers may want to implement the ASC X12N 276/277 Claims Status Inquiry/Response Transactions and benefit by being able to request and receive the status of claims **in one standard format, for all health care plans**.

CAUTION – What You Need to Know

Implementing the ASC X12N 276/277 would make electronic claim status requests and receipt of responses feasible for small providers, and eliminate the need to:

- Maintain redundant software, and
- Send and review claim status requests and responses manually.

GO – What You Need to Do

Providers who implement the ASC X12N 276/277 may create a more efficient follow up process and also achieve an increase in cash flow each month by greatly reducing the administrative costs incurred by supporting multiple formats and manually processing claim status requests.

Background

Even though there has been a significant increase in the number of providers who use electronic health care transactions, providers have faced the burden of sending information to various health plans in multiple formats. Even when different plans accept information in similar formats, they frequently have additional requirements that further complicate efficient information interchange. Consequently, providers have been burdened with additional administrative work in order to electronically process healthcare transactions (including claims status requests and responses). This has increased the costs and decreased the efficiency of processing claims status requests and responses.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes administrative simplification provisions meant to reduce and simplify the administrative demands faced by healthcare providers. HIPAA:

1) Directed the Federal government to adopt national standards for the transfer of certain health care data; and
2) Requires all payers to use national standard transaction formats and code sets, such as the health care claims status category codes and the health care claim status codes issued by the Claim Adjustment Status Code Maintenance Committee.

Medicare carriers and intermediaries must periodically update their claims system with the most current health care claim status codes for use with:

- The Health Care Claim Status Request (ASC X12N 276), and
- The Health Care Claim Response (ASC X12N 277).

The ASC X12N 276 (Claims Status Inquiry Transaction) is used to transmit request(s) for status of specific health care claim(s), and the ASC X12N 277 (Claims Status Response Transaction) can be used for any of the following:

- As a response to a health care claim status request (276);
- As a notification about health care claim(s) status, including front end acknowledgments; and
- As a request for additional information about a health care claim(s).

Most health care providers who are currently using an electronic format and who wish to request claim status electronically using the ASC X12N 276/277 may incur some conversion costs.

However, after implementation, providers will benefit by being able to request and receive the status of claims **in one standard format, from all health care plans**. This would make electronic claim status requests and receipt of responses feasible for small providers, and eliminate the need to:

- Maintain redundant software, and
- Send and review claim status requests and responses manually.

It is possible that providers who implement the ASC X12N 276/277 can create a more efficient follow up process and also achieve an increase in cash flow each month by greatly reducing the administrative costs incurred by supporting multiple formats and manually processing claim status requests.

It's time to start using this transaction.

Medicare can accept transmission of the ASC X12N 276 (your electronic request on the status of a previously submitted claim) and respond with an ASC X12N 277 (our electronic answer back to you**).**

Currently, CMS sends out over 10,000 responses (277s) per month, and you too can benefit from this process. It could help you reduce the time required to follow up with Medicare as well as with any payer from 20 minutes to a few seconds.

Additional Information

An informative article entitled "Realizing Savings from the HIPAA Transaction Standards: How to Get There from Here," which was prepared by Martin A. Brutscher, Partner, McBee Associates, Inc., can be reviewed at the following website: *http://www.mcbeeassociates.com/HFMA_white_paper.pdf*.

The article shows the types of results that may be available to providers who implement the ASC X12N 276/277 as well as other HIPAA transactions.

Also, the Medicare Claims Processing Manual (Pub. 100-04), Chapter 31 (ANSI X12N Formats), Section 20 (ANSI X12N 276/277 Claims Status Request/Response Transaction Standard) can be reviewed at the following Centers for Medicare & Medicaid Services (CMS) website: *http://www.cms.hhs.gov/manuals/104_claims/clm104c31.pdf*.

The X12 276/277 version 4010A1 implementation guide, as well as the claim status codes and category codes, may be downloaded without charge at: *http://www.wpc-edi.com/hipaa*.

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

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0524

Update to the Healthcare Provider Taxonomy Codes (HPTC) Version 5.0

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

Provider Types Affected

Providers who bill carriers including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

STOP – Impact to You

CMS has released the summary of changes reflected in the health care provider taxonomy code (HCPT) list version 5.0. Medicare carriers and DMERCs will update their HPTC tables with this new version effective on April 1, 2005.

CAUTION – What You Need to Know

The Health Insurance Portability and Accountability Act (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims accepted with invalid data are non-compliant.

GO – What You Need to Do

Please review the information included here and stay current on all HIPAA requirements to assure timely processing of your claims.

Background

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets. The provider taxonomy code set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care transaction.

HIPAA requires that submitted data, which is part of a named code set, must be valid data from that code set. The health care provider taxonomy is a named code set in the 837 professional implementation guide, thus carriers must validate the inbound taxonomy codes against their internal HPTC tables.

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The HPTCs are updated twice per year, in April and October. The summary of changes for Version 5.0 is noted in the table below:

TYPE OF CHANGE	PROVIDER TAXONOMY VALUE CODE
Additions	390200000X
	261QM1103X
	291900000X
	332000000X
	341800000X
	3418M1120X
	3418M1110X
	3418M1130X
Revisions	261QM1101X
	261QM1100X
	261QM1102X
	2865M2000X
	2865X1600X
	3416A0800X
	3416L0300X
	3416S0300X
Inactivation (will be deleted in future version)	2865C1500X

The HPTC code list is available in two forms from the Washington Publishing Company: *http://www.wpc-edi.com/codes/taxonomy*.

- A free Adobe PDF download or
- An electronic representation of the list which will facilitate automatic loading of the code set. This version is available for purchase.

Additional Information

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

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3716. 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/ DMERC at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3716
Medlearn Matters Number: MM3716
Related CR Release Date: February 18, 2005
Related CR Transmittal #: 479
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

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FRAUD

New Program Safeguard Contractor for Florida

The Centers for Medicare & Medicaid Services (CMS) recently awarded a new contract to EDS (Electronic Data Systems) and its subcontractor IntegriGuard, LLC, to establish the Florida Benefit Integrity Support Center. This project is part of the CMS Medicare Integrity Program (MIP) to engage program safeguard contractors (PSC) in pursuit of Medicare fraud, waste, and abuse in Florida.

As the prime contractor, EDS replaces TriCenturion, Inc., effective March 1, 2005, as the PSC responsible for combating and preventing Medicare fraud and abuse in Florida. In this capacity EDS is generally responsible for data analysis, investigation, and case development for the Florida Benefit Integrity Support Center.

The Florida Benefit Integrity Support Center does not replace the Medicare program administration work performed by First Coast Service Options, Inc., the current fiscal intermediary (Part A) and carrier (Part B) in Florida. First Coast Service Options will continue its current responsibilities including processing and paying claims, performing customer service, reviewing the medical necessity of claims unrelated to suspected fraud and abuse, and auditing facilities for Medicare expenses and reimbursement. As a note, allegations of suspected fraud, waste, and abuse in Florida are to be reported to First Coast Service Options, as it is this contractor responsibility to screen the allegations for possible errors in billing or processing or misunderstandings. Allegations of suspected fraud will be forwarded to the Florida Benefit Integrity Support Center only after possible errors or misunderstandings are ruled-out.

The Florida Benefit Integrity Support Center will create a focused resource to detect and deter fraud in the Medicare program. In this capacity, it will develop administrative solutions, investigations, and cases for referral to law enforcement, as well as provide ongoing support to law enforcement as needed. Additional responsibilities include coordination of benefit integrity activities in the region, and dissemination of relevant benefit integrity information to First Coast Service Options, health care providers, and Medicare beneficiaries.

Source: Stephen Quindoza, Medicare Operation Coordinator, Florida Benefit Integrity Support Center, EDS/IntegriGuard, LLC

GENERAL INFORMATION

Correction –HCPCS 90-Day Grace Period

This instruction corrects a statement published in the January 2005 *Medicare B Update!* Special Issue – 2005 HCPCS and MPFSDB Update (page 3) regarding a grace period for discontinued procedures. As published in the 3rd Quarter 2004 Medicare B Update! (page 22), the 90-day grace period for discontinued HCPCS codes has been eliminated.

Claims billed with a discontinued procedure code for dates of service on/after 1/1/05 will be returned as unprocessable. No appeal rights will exist.

We apologize for any inconvenience this may have caused.

Telephone Redetermination – Florida Only

We published an article in the January 2005 *Medicare B Update!* Special Issue – 2005 HCPCS and MPFSDB Update (page 41) titled "Telephone Redetermination – Clarification".

This article is a clarification to a web posting in the Education section of the **Connecticut** website. This information applies **only** to Connecticut providers and is to be disregarded by Florida providers.

We apologize for any inconvenience this may have caused.

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The Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006

The Second in a Series of Medlearn Matters Articles for Providers on Medicare's New Prescription Drug Coverage

Provider Types Affected

All Medicare providers and any staff who have contact with Medicare beneficiaries

Provider Action Needed

This special edition article provides updated information regarding the Medicare Prescription Drug Plans that will be available to Medicare beneficiaries in 2006. This new benefit was established by the Medicare Modernization Act (MMA), which was enacted in 2003.

This new drug coverage requires **every** Medicare beneficiary to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients. Help can be as simple as referring them to CMS beneficiary educational resources such as 1- 800-MEDICARE and *http://www.medicare.gov*. It is important to encourage your patients to learn more about the new coverage as it may save them money on prescription drug costs.

The Basic Plan

Beginning January 1, 2006, new Medicare prescription drug plans will be available to all people with Medicare. Insurance companies and other private companies will be working with Medicare to offer these drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phase out by May 15, 2006, or when a beneficiary's enrollment in a Medicare prescription drug plan takes effect, if earlier. The cards offered discounts, while the plans offer insurance coverage for prescription drugs.

Medicare prescription drug plans provide insurance coverage for prescription drugs, and like other insurance plans, participating beneficiaries will pay:

- A monthly premium (generally around $37 in 2006); and
- A share of the cost of their prescriptions (with costs varying depending on the drug plan chosen by the beneficiary).

In addition, drug plans can vary depending on the following:

- What prescription drugs are covered;
- How much the beneficiary pays; and
- Which pharmacies the beneficiary can use.

All drug plans will provide a standard level of coverage, which Medicare will set. However, for a higher monthly premium, some plans might offer more coverage and additional medications.

When a Medicare beneficiary joins a drug plan, it is important that they choose one that meets their prescription drug needs.

The following questions and answers provide key information that might be of interest to you, your staff, or your patient.

When can your patients enroll in this new plan?

If a beneficiary currently has Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), the beneficiary can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. In general, a beneficiary can join or change plans once each year between November 15 and December 31. If they join a Medicare prescription drug plan:

- By December 31, 2005, their coverage will begin on January 1, 2006; and
- After December 31, 2005, their coverage will be effective the first day of the month after the month they join.

Even if a beneficiary does not use many prescription drugs now, they still should consider joining a plan. If they don't join a plan by May 15, 2006, and they don't have a drug plan that covers as much or more than a Medicare prescription drug plan, they will have to pay more each month to join later.

What if the Medicare beneficiary cannot pay for a Medicare prescription drug plan?

Some people with an income at or below a set amount and with limited assets (including their savings and stocks, but not counting their home) will qualify for extra help.

The exact income amounts will be set in early 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions.

The type of extra help received will be based on income and assets. In mid-2005, SSA will send people with certain incomes information about how to apply for extra help in paying for their prescription drug costs. If they think they may qualify for extra help, they can sign up with the Social Security Administration (SSA) or their local Medicaid office as early as the summer of 2005.

Will this new plan work with other Medicare coverage that your patients may have?

Yes, Medicare prescription drug plans work with all types of Medicare health plans, and there will be:

- Medicare prescription drug plans that add coverage to the original Medicare plan (these plans will be offered by insurance companies and other private companies); and
- Medicare prescription drug plans that are a part of Medicare Advantage Plans (like HMOs), in some areas.

What if a Medicare beneficiary has a Medigap policy with drug coverage or prescription drug coverage from an employer or union?

The Medicare beneficiary will get a detailed notice from their insurance company or the employer or union informing them whether or not their policy covers as much or more than a Medicare prescription drug plan.

This notice will explain their rights and choices.

If a Medicare beneficiary's employer or union plan covers as much as or more than a Medicare prescription drug plan, they can:

- Keep their current drug plan. If they join a Medicare prescription drug plan later, their monthly premium won't be higher; or
- Drop their current drug plan, and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

If a Medicare beneficiary's employer or union plan covers less than a Medicare prescription drug plan, they can:

- Keep their current drug plan, and join a Medicare prescription drug plan to give them more complete prescription drug coverage; or
- Keep their current drug plan. However, if they join a Medicare prescription drug plan later, they will have to pay more for the monthly premium; or
- Drop their current drug plan and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

Additional Information

More information on provider education and outreach regarding drug coverage can be found at: *http://www.cms.hhs.gov/medlearn/drugcoverage.asp*.

The information contained in this article is based on a fact sheet for beneficiaries. To obtain a copy of this fact sheet for your patients, visit: *http://www.medicare.gov/Publications/Pubs/pdf/11065.pdf*.

You can also find additional information regarding prescription drug plans at: *http://www.cms.hhs.gov/pdps/*.

Further information on CMS implementation of the MMA can be found at the following CMS website: *http://www.cms.hhs.gov/medicarereform/*.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0502
Related CR Release Date: N/A

Your Important Role—Medicare Prescription Drug Plan

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

#3: Information for Providers, Physicians, Pharmacists and Their Staffs About Medicare Prescription Drug Coverage

Provider Types Affected

Medicare physicians, institutional providers, pharmacists, and any staff who have contact with Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

On January 1, 2006, a new benefit will be available to the 41 million Americans who receive health insurance coverage through the Medicare program. Medicare Prescription Drug Plans will help reduce the cost of prescription drugs. Your patients may ask you about this new benefit.

CAUTION – What You Need to Know

We need your help to make sure Medicare patients know about and understand this new benefit—information is just a click away. Through *Medlearn Matters* articles, we will give you access to various levels of information. You decide the level of involvement you want to have in helping Medicare patients.

GO – What You Need to Do

Stay informed, visit: *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the Web. This website includes links to all articles in this series and information providers need about the new coverage. At a minimum, refer your Medicare patients to 1-800-MEDICARE and *http://www.medicare.gov* on the Web.

Background

You and your staff are trusted sources of information for your patients. You may be the first source of information that Medicare beneficiaries use to explain Medicare Prescription Drug Coverage. Please encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. **If a beneficiary fails to actively choose a prescription drug plan, they may miss out on cost savings for prescription drugs.** Medicare Prescription Drug Coverage will:

- Help pay for prescriptions
- Provide extra help for people with limited income and resources
- Cover brand name and generic drugs.

CMS will include Medicare Prescription Drug Coverage details in the *2006 Medicare & You Handbook*, and send it to beneficiaries in October 2005.

Your Role and Involvement – You Choose

Your interest may range from wanting basic to detailed information on this coverage. For example, if you work in a rural locale, or in areas that serve a large population of beneficiaries with limited income and resources, you may have a greater interest in counseling your patients.

- **Basic –** You know that Medicare Prescription Drug Coverage exists and where to send people to learn about benefit details. You may display a poster (available later this spring) in your office or clinic, and make beneficiary-focused materials available in your office.
- **Intermediate –** You know more about Medicare Prescription Drug Coverage, such as:
  - " How beneficiaries can enroll
  - " Copayment amounts
  - " Where to find additional help for people with limited income and resources
  - " Where to find information on the following websites:

  http://www.medicare.gov
  http://www.cms.hhs.gov/medlearn/drugcoverage.asp

How to answer the basic questions.

- **Advanced –** You know detailed information about Medicare Prescription Drug Coverage and the plans available in your area. You, or someone on your staff, can answer detailed questions about the drug benefit. In some cases, you or your staff may counsel beneficiaries on their particular situation and the options that will work best for them.

To Stay Updated on New Information and Educational Resources

- Pay attention to correspondence from your national professional associations – they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listservs and read their newsletters.
- Keep current with information from your Medicare fee-for-service claims processing contractor; bookmark their website, read their bulletins, and register to receive electronic listserv messages.
- Bookmark and visit the provider educational Web page on Medicare Prescription Drug Coverage, *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the Web.
- Register to receive listserv email messages to alert you when new *Medlearn Matters* articles have been released on the new drug benefit (and other Medicare information); register at *http://www.cms.hhs.gov/medlearn/matters* on the Web.
- Participate in CMS Open Door Forums, to hear from and ask questions of CMS leadership on topics of interest to your particular provider type; for information about these forums visit *http://www.cms.hhs.gov/opendoor* on the Web.

Get Your Staff Involved

In addition, inform members of your staff who interact with Medicare patients every day about the information in this article:

- Physicians – supply this information to nursing and front office staff.
- Hospitals – supply this information to nursing, discharge planning, financial, and emergency room staff.
- Pharmacists - supply this information to your pharmacy technicians and front counter staff.

If you or your staff are willing to further advise and counsel people with Medicare, CMS will have tools to help you do this on *http://www.cms.hhs.gov/partnerships* (toolkit available by April 1, 2005).

Summary

CMS asks you to:

- Respond to questions from your patients in a way that encourages them to seek more information from the Medicare program.
- Inform members of your staff who interact with Medicare patients about the information resources available to them, and where they may refer patients to learn more about Medicare Prescription Drug Coverage.
- At a minimum, refer your Medicare patients who are looking for information on Medicare Prescription Drug Coverage to 1-800-MEDICARE or *http://www.medicare.gov* on the Web.

Related Change Request (CR) Number: N/A Medlearn Matters Number: SE0520
Related CR Release Date: N/A

Use of Group Health Plan Payment System for Medicare Disease Management Demonstration Serving Medicare Fee For Service Beneficiaries

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

Provider Types Affected

All Medicare providers

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) has begun a Medicare Disease Management Demonstration to improve care for chronically ill Fee-For-Service Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The Disease Management Organization, LifeMasters, is currently enrolling beneficiaries in Florida.

This Disease Management Organization is not an HMO, but is being paid, using the CMS Group Health System/MMCS, to pay a fixed monthly payment for disease management services as an "OPTION 1" cost plan or as an "OPTION 4" plan, which will be a phase in over the next few months. "OPTION 4" means the same as "OPTION 1" but will reference "Chronic Care Organizations" and will also help to differentiate the demonstration enrollees from an HMO enrollee.

With the exception of how CMS is paying this private organization, beneficiaries enrolled in this program will be considered covered under the traditional Medicare FFS program for all other purposes. Beneficiaries are not restricted in any way on how they receive their other Medicare services and will only receive coordinated care/disease management services from the following chronic care organization:

LifeMasters = H5413 (plan number) in the Medicare systems

Reminder: The Medicare beneficiaries participating in the Medicare Disease Management Demonstration are NOT enrolled in an HMO; they should be treated as traditional Fee-For-Service beneficiaries. No referrals for care are needed and all Fee-For-Service claims will be processed under traditional Medicare payment rules.

Background

This population based demonstration is intended to evaluate how disease management services can improve the health outcomes of Medicare beneficiaries diagnosed with advanced-stage illness from congestive heart failure, diabetes, or coronary heart disease. Up to 30,000 eligible Medicare Fee-For Service beneficiaries will be enrolled in the treatment arm of the study during the three-year project in Florida.

The project will help Medicare:

- Find better ways to improve the quality of life for people with diabetes and chronic heart disease;
- Determine the benefits of disease management programs for chronically ill persons; and
- Find ways to make these services available to people with Medicare.

The disease management participants will receive disease management services in addition to their usual Medicare benefits. All participants remain in the traditional Fee-For-Service Medicare program under the care of their own doctor. The program is voluntary and the decision whether or not to participate does not affect Medicare benefits.

Demonstration Location

Florida– LifeMasters will be providing services to 30,000 eligible Medicare beneficiaries with congestive heart failure, diabetes, and coronary heart disease in Florida. (Questions? Call 1-888-716-2838).

Medicare Eligibility File Inquiry Screens

When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, Medicare systems screens will display a line item indicating enrollment in an "Option 1" HMO Cost Plan or an "Option 4" plan. The

definition of Option 1 means that Medicare is still primary and Fee-For-Service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional Fee-For-Service program. **Even though this demonstration is coded with an HMO plan number, the beneficiaries are not enrolled in an HMO.** Beneficiaries or providers calling to confirm Medicare eligibility should be informed that they/the patient are Medicare eligible and that they are Fee-for-Service beneficiaries, not enrolled in an HMO cost plan.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0519
Effective Date: N/A

Use of Group Health Plan Payment System for Medicare Disease Management Demonstration Serving Medicare Fee For Service Beneficiaries

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

Provider Types Affected

All Medicare providers

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) has begun a four-state Medicare Disease Management Demonstration to improve care for chronically ill Fee-For-Service Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The Disease Management Programs that are currently enrolling beneficiaries are: CorSolutions in Louisiana; LHealth in Texas and HeartPartners in California and Arizona.

These Disease Management Organizations are not HMOs, but are being paid, using the CMS Group Health System/ MMCS to pay a fixed monthly payment for disease management services as an "OPTION 1" cost plan or as an "OPTION 4", which will be a phase in over the next few months. "OPTION 4" means the same as "OPTION 1" but will reference "Chronic Care Organizations." "OPTION 1" and "OPTION 4" are used to help differentiate the demonstration enrollees from an HMO enrollee.

With the exception of how CMS is paying these private organizations, beneficiaries enrolled in these programs will be considered covered under the traditional Medicare FFS program for all other purposes.

Beneficiaries will only receive coordinated care/disease management services from these chronic care organizations and they are not restricted in any way on how they receive their other Medicare services. The organizations and their respective plan numbers are:

HeartPartners = SeniorCo identified as H5408 in Medicare systems.
CorSolutions identified as H1902 in Medicare systems.
XLHealth identified as H4519 in Medicare systems.

Reminder: The Medicare beneficiaries participating in the Medicare Disease Management Demonstration are NOT enrolled in an HMO; they should be treated as traditional Fee-For-Service beneficiaries. No referrals for care are needed and a**ll Fee-For-Service claims will be processed under traditional Medicare payment rules.**

Background

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 mandated this demonstration to evaluate how disease management services, combined with a prescription drug benefit, can improve the health outcomes of Medicare beneficiaries diagnosed with advanced-stage illness from congestive heart failure, diabetes, or coronary heart disease. Up to 30,000 eligible Medicare Fee-For- Service beneficiaries will be enrolled in the treatment arm of the study during the three-year project in California, Arizona, Louisiana, and Texas.

The project will help Medicare:

- Find better ways to improve the quality of life for people with diabetes and chronic heart disease;
- Determine the benefits of disease management programs for chronically ill persons; and
- Find ways to make these services available to people with Medicare.

Participants will be assigned to either a disease management group or a usual care group. The disease management group will receive disease management services and prescription drug benefits in addition to their usual Medicare benefits at no additional cost except for a modest co-payment for prescription drugs.

All participants remain in the traditional Fee-For-Service Medicare program under the care of their own doctor. The program is voluntary and the decision whether or not to participate does not affect Medicare benefits.

Demonstration Locations

Louisiana - CorSolutions will be providing services to 5,000 Medicare beneficiaries with congestive heart failure, diabetes, and/or coronary heart disease residing in the Shreveport – New Orleans corridor of Louisiana. (Questions? Call 1-800-917-2204).

Texas - XLHealth will be providing services to 10,000 Medicare beneficiaries with congestive heart failure (CHF), cardiovascular disease (CVD), or diabetes with co-morbidities of CHF, CVD or lower extremity complications in Texas. (Questions? Call 1-888-284-0001).

California and Arizona - HeartPartners℠ (collaboration among PacifiCare Health Systems, Qmed, and Alere Medical) will be providing services to 15,000 Medicare beneficiaries with congestive heart failure in California and Arizona. (Questions? Call 1-866-242-3432).

Medicare Eligibility File Inquiry Screens

When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, Medicare systems screens will display a line item indicating enrollment in an "Option 1" HMO Cost Plan. The definition of Option 1 means that Medicare is still primary and Fee-For-Service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional Fee-For-Service program. Even though these demonstrations are coded with an HMO plan number, the beneficiaries are not enrolled in an HMO. Beneficiaries or providers calling to confirm Medicare eligibility should be informed that they/the patient are Medicare eligible and that they are Fee-for-Service beneficiaries, not enrolled in an HMO cost plan.

Related Change Request (CR) #: N/A Medlearn Matters Number: SE0425
Effective Date: N/A **Revised**

Modified Edits for Matching Claims Data to Beneficiary Records

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

STOP – Impact to You

Claims submitted to Medicare must match a Medicare beneficiary record on Health Insurance Claim Number, beneficiary's last name (surname) and the beneficiary's first name.

CAUTION – What You Need to Know

The name reported on the claim should always be the name shown on the beneficiary's Medicare card. If the name submitted does not match the name on Medicare's files for that beneficiary claim number, Medicare will return the claim as unprocessed.

GO – What You Need to Do

Be aware of this issue and advise your billing staff they should always use the name from the Medicare card when submitting the claim, even if the patient indicates the name on the Medicare card is incorrect.

Background

Over the past several months, the Centers for Medicare & Medicaid Services (CMS) reviewed its personal characteristics editing logic for processing Medicare claims. The review identified a weakness where processed claims were approved for payment under the wrong beneficiary account number. One of Medicare's key claims processing systems, known as the common working file (CWF), was approving claims where the beneficiary name and Health Insurance Claim Number did not match the name and number on the Medicare card.

The Office of the Inspector General in the Department of Health and Human Services recommended that CMS implement a modified process for matching the claim information to the beneficiary information on CWF files to eliminate erroneous payments caused by the existing matching criteria.

In October 2004, CMS made a software change to require an exact match on beneficiary first initial, surname, and health insurance claim number submitted on the claim. Since this change was implemented the number of unprocessable claims because of name/number mismatch tripled.

To resolve these unprocessed claims, providers should bill using the name and number as it appears on the beneficiary Medicare card. If the beneficiary insists the Medicare card is incorrect, the provider should advise the beneficiary to contact their local servicing social security field office to obtain a new Medicare card.

If you have any questions regarding this issue, contact your Medicare carrier, intermediary, or durable medical equipment regional carrier at their toll free number. You can find that number on the Web at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0516
Effective Date: N/A

Tool Available for Registering Patients with Implantable Cardioverter Defibrillators

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

Provider Types Affected

Physicians and other providers needing to register Medicare patients receiving the Implantable Cardioverter Defibrillator (ICD) as primary prevention of sudden cardiac death

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) requires that any Medicare patient receiving an ICD as primary prevention of sudden cardiac death be enrolled in a data collection system. CMS has an electronic tool available to Medicare participating hospitals to assist in submitting this data to the data collection system, also referred to as the registry.

CAUTION – What You Need to Know

CMS identifies Medicare patients receiving an ICD for primary prevention indications and requiring participation in a registry in the coverage policy at: *http://www.cms.hhs.gov/mcd/viewimplementation.asp?id=148*.

GO – What You Need to Do

Review this article for more details and work closely with your hospital to ensure it is participating in data collection and you are providing necessary data.

Background

CMS has released an Implantable Cardioverter Defibrillator Abstraction (ICDA) tool to facilitate the collection of information related to ICDs. The tool is available for download by each hospital's QualityNet Exchange Administrator from the following Internet location: *http://www.qnetexchange.org/icda*.

Please note that users must utilize this direct link to access the ICDA information. Once at this page, you will see a brief overview of the tool and then click on "ICDA Tools" to begin the download process for the tool and associated guides for using the tool. Also available on the web site is a "paper" tool. This is a one-page, printable version of the ICDA and contains a list of all data elements collected in the tool.

Providers are not required to use the paper tool. In addition, Frequently Asked Questions are available at the same web location.

CMS has already notified many providers of the availability of this tool through the Hospital Data Collection auto-notification public list and the Inpatient Point of Contact ListServe.

CMS covers ICDs for certain populations of patients as both primary and secondary prevention of sudden cardiac arrest. However, Medicare requires that any Medicare patient receiving an ICD or replacement ICD as primary prevention be enrolled in a data collection system. Submitting patient information through the ICDA tool satisfies the coverage requirement. The complete document describing the coverage policy and data submission requirements is located on the CMS website at: *http://www.cms.hhs.gov/mcd/viewimplementation.asp?id=148*.

Beneficiaries receiving an ICD for primary prevention can be identified through the absence of ICD-9-CM diagnosis codes for secondary prevention from the claim. A patient claim for which at least one of the following codes does not appear for secondary prevention could signify that the patient should be enrolled in a registry. Medicare Part B claims submitted on or after April 1, 2005 for implantation of an ICD for primary prevention should include a QR modifier to signify that the patient is enrolled in a registry.

Although CMS does not have a coding mechanism for Part A claims that is similar to the function of modifier QR on Part B claims, CMS will have the ability to match inpatient claims to identify and review registry participation through other mechanisms.

Because coding practices may vary slightly, providers should rely primarily on the coverage guidance provided at *http://www.cms.hhs.gov/mcd/viewimplementation.asp?id=148* to determine whether data submission is required. The following codes serve to assist in identifying patients with previous arrhythmias (secondary prevention) however depending on coding practices may not accurately reflect the requirements for coverage:

- 427.1 Ventricular tachycardia
- 427.41 Ventricular fibrillation
- 427.42 Ventricular flutter
- 427.5 Cardiac arrest
- 427.9 Cardiac dysrhythmia, unspecified

The ICDA tool allows for on-line collection of registry information, including patient identifiers, history and clinical characteristics, medications, ICD indications, device information, complications, and facility and provider information. The ICDA tool allows for the ability to import and export data utilizing existing XML standards.

Using the ICDA tool to collect standardized data assists CMS in making a reasonable and necessary determination for Medicare patients. At this time, users are encouraged to utilize the tool for data collection activities as it is a requirement of Medicare coverage for patients who receive the device for primary prevention of sudden cardiac arrest (patients without history of an arrest or arrhythmia).

Three individually recorded ICDA training sessions will be available for viewing and/or downloading from the ICDA site in the near future. Physicians and providers with dial-up Internet connections can download the recordings for viewing. QIOs can also download the recordings and transfer them to a CD for distribution to providers.

The three individual recorded sessions, which allow for subject matter-specific viewing, are as follows:

- ICDA 1.0 Installation and Setup
- ICDA 1.0 Abstraction Processes (New, Edit)
- ICDA 1.0 Import and Export

In addition, the ICDA User's Guide, available from the ICDA site, provides detailed instructions on the installation, set-up, and utilization of the tool.

Location of Software and Documents

The following software and associated documents are accessed from the "Tools" option available from the ICDA Overview page at *http://www.qnetexchange.org/icda*:

- Access the ICDA Version 1.0 Installation Instructions (pdf)
- Access the ICDA Installation (exe)
- User's Guide Download Instructions (pdf)
- ICDA User's Guide (exe)
- Using the ICDA User's Guide (pdf)

Complete, detailed installation instructions, including screen prints, are also provided in Chapter 2 of the ICDA Version 1.0 User's Guide.

Launching the ICDA Application

Users must launch the ICDA application using the shortcut/icon provided on their desktop, or through the ICDA Program Group in the Windows Start menu. Please refer to the ICDA User's Guide for instructions on setting up providers and users within the tool.

Please notify your internal point of contact if you have any questions. They may contact the QualityNet Help Desk if additional information and/or assistance are needed.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0517
Effective Date: N/A

CMS Seeks Provider Input on Satisfaction with Medicare Fee for Service Contractor Services

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

Provider Types Affected

A sample of 8,200 (or 2 percent of) Medicare providers served by 12 Medicare Fee-for-Service contractors (carriers and fiscal intermediaries), including hospitals, skilled nursing facilities (SNFs), rural health clinics, home health clinics, end-stage renal disease (ESRD) facilities, physicians, non-physicians, durable medical equipment (DME) suppliers, and ambulance service providers

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your Medicare Fee-for-Service (FFS) contractors (carriers and fiscal intermediaries, including durable medical equipment regional carriers [DMERCs] and regional home health intermediaries [RHHIs]). The Medicare Contractor Provider Satisfaction Survey (MCPSS) will be CMS's initial effort to use provider satisfaction as a standard of measurement to evaluate our FFS contractors' performance.

CMS values the opinions of the Medicare physician and provider community and understands the important role that FFS contractors play in representing the Medicare program to providers. The MCPSS represents an important opportunity for you to be heard.

CAUTION – What You Need to Know

The first year of the MCPSS is a pilot. CMS has selected 12 FFS contractors to participate in the pilot: 4 fiscal intermediaries (FIs): AdminaStar Federal, Noridian Administrative Services L.L.C., Riverbend GBA, and Empire Medicare Services; 4 Carriers: National Heritage Insurance Company (NHIC), Wisconsin Physician Services (WPS), TrailBlazer Health, and Empire Medicare Services; 2 durable medical equipment regional carriers (DMERCs): Health Now New York and AdminaStar Federal; and 2 regional home health intermediaries (RHHIs): Palmetto GBA and Anthem Health Plans of Maine.

A random sample of 8,200 providers (approximately 2% of providers) served by these twelve FFS contractors have been selected to participate in the pilot. If you have been selected, you should have received a notification packet with background information about the pilot, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet web site. The letter also includes a phone number that you can call to request a paper copy of the survey instrument to submit your responses by mail or fax, if you prefer to do so.

GO – What You Need to Do

Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the time to complete and submit your survey responses as soon as possible. The data collection period for the pilot will continue through the end of March.

Background

On January 17, 2005, CMS launched a pilot of the MCPSS. The survey will give providers the opportunity to rate their Medicare contractor on seven administrative functions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider reimbursement.

The survey contains a total of 76 questions and takes approximately 22 minutes to complete. Sampled providers will be able to access the survey on a secure Internet web site or may request a paper copy of the survey and submit via mail or fax. Data collection for the pilot will continue through March 2005.

CMS will use the results of the pilot to evaluate and refine the survey instrument, data collection procedures, analysis, and reporting of results for the national survey implementation. The results of the pilot will not be used to evaluate the Medicare contractors' performance. In the future, CMS plans to use the MCPSS to support and assist contractors in using provider feedback to identify and implement "best practices" and quality or process improvement initiatives.

CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS.

Additional Information

For questions or additional information about the MCPSS, please visit: *http://www.cms.hhs.gov/providers/mcpss/default.asp*.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0513
Effective Date: N/A

Clarification for Change Request 3267

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

Provider Types Affected

Hospitals and independent laboratories billing Medicare carriers or fiscal intermediaries (FIs) for laboratory services

Provider Action Needed

This article contains information provided in Change Request (CR) 3729 that clarifies policies previously issued in CR 3267 (Transmittal 228, July 16, 2004). It also informs hospitals and independent labs that 1) they may use collected and retained Medicare Secondary Payer (MSP) information for the billing of nonface- to-face reference lab services, and 2) they are required to collect MSP information from the beneficiary when billing for face-to-face encounters with Medicare patients for lab services.

Background

Treatment of hospitals for certain services under Medicare Secondary Payer (MSP) Provisions of the Medicare Prescription Drug Improvement & Modernization Act of 2003 (MMA) states:

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

"(b) REFERENCE LABORATORY SERVICES DESCRIBED. – Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation."

The Centers for Medicare & Medicaid Services (CMS) **will not require independent reference laboratories to collect MSP** information in order to bill Medicare for reference laboratory services as described in subsection (b) above.

Therefore, pursuant to the MMA (Section 943), CMS **will not require hospitals to collect MSP information** in order to bill Medicare for reference laboratory services (as described in subsection (b) above). **This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist.**

Therefore, in situations where hospital and independent labs have already collected and retained MSP information for beneficiaries, they may use the collected and retained MSP information for the billing of non-face-to-face reference lab services.

In addition, in situations when ther e is a face-to-face encounter with the beneficiary, hospitals and independent labs are required to collect MSP information from the beneficiary when billing for face-to- face lab services.

This clarification should have been made as part of CR 3267 (which clarified CR 3064, transmittal 11, February 27, 2004).

Implementation

The implementation date for this instruction is June 6, 2005.

Additional Information

CR 3267 (Transmittal 228, July 16, 2004) can be reviewed at the following CMS website: *http://www.cms.hhs.gov/manuals/pm_trans/R228CP.pdf*.

CR 3064, Transmittal 11, February 27, 2004) can be reviewed at the following CMS website: *http://www.cms.hhs.gov/manuals/pm_trans/R11MSP.pdf*.

The Medicare Secondary Payer Manual (Pub. 100-5) can be found at the following CMS website: *http://www.cms.hhs.gov/manuals/105_msp/msp105index.asp*.

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set) provides instructions on how to process reference lab claims submitted on Form CMS-1500, and can be found at the following CMS website: *http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf*.

After you get to Chapter 26, click on Section 10.2 (Items 1-11 - Patient and Insured Information) in the Table of Contents.

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

From that Web page, look for CR 3729 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #:3729 Medlearn Matters Number: MM3729
Related CR Release Date: March 4, 2005 Related CR Transmittal #: 26

Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

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

Provider Types Affected

All physicians, providers, and suppliers billing Medicare fiscal intermediaries (FIs) and carriers

Provider Action Needed

This instruction includes information contained in change request (CR) 3709 which directs Medicare contractors (carriers, intermediaries, and durable medical equipment regional carriers [DMERCs]) to issue special automated correspondence from their internal systems to physicians, providers, and suppliers informing them that claims that were expected to be crossed over to supplemental payers/insurers (as indicated on a previous remittance advice) were not crossed.

Background

Through the national COBA process, Medicare will automatically cross claims over to a supplemental payer/insurer that may pay after Medicare has made its payment decision on the claim. There may be situations (such as claim errors related to HIPPA) that prevent Medicare from crossing a claim over to the supplemental payer/insurer.

In those situations where Medicare is unable to cross the claim, CR 3709 directs Medicare contractors to issue special automated correspondence to notify physicians, suppliers, and providers when claims previously selected for crossover by Medicare were subsequently unable to be crossed to the supplemental payer/insurer.

The correspondence sent to the physician, supplier, or provider will contain specific claim information, including the internal control number (ICN)/document control number (DCN), health insurance claim (HIC) number, medical record number (if the letter is from an intermediary and the claim was for Part A services), patient control number (if present on the claim), beneficiary name, date of service, and the date the claim was processed. In addition, the letter will include the following message:

"The above claim(s) was/were not crossed over to the patient's supplemental insurer due to claim data errors."

Upon receipt of such correspondence, the physician, supplier, or provider is advised that the claim is not being crossed automatically and the provider may take appropriate action to obtain payment from the supplemental payer/insurer.

Implementation

The implementation date for CR 3709 is July 5, 2005.

Additional Information

Complete details of the COBA Error Notification process are included in the official instruction issued to your carrier/DMERC/intermediary. That instruction may be viewed at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3709 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3709 Medlearn Matters Number: MM3709
Related CR Release Date: February 11, 2005 Related CR Transmittal #: 474
Effective Date: July 1, 2005 Implementation Date: July 5, 2005

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The Centers for Medicare & Medicaid Services (CMS) Consolidation of the Claims Crossover Process

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

Physicians, providers, and suppliers should note that this special edition article is to inform you of system changes to implement a switch from 1) Medicare intermediaries, carriers, and durable medical equipment regional carriers (DMERCs) crossing supplemental claims to supplemental insurers to 2) a single entity, the coordination of benefits contractor (COBC), doing the same from one location.

Background

The Centers for Medicare & Medicaid Services (CMS) is consolidating the Medicare claims crossover process under a special COBC by means of the COBA initiative.

Currently, **supplemental payers/insurers** (including eligibility-file-based Medigap, Medicaid and employer plans) **must sign multiple crossover agreements** with Part A intermediaries and Part B carriers and durable medical equipment regional carriers (DMERCs) to accomplish an automatic, or eligibility-filebased, crossover to other insurers that pay after Medicare has made its payment decision on a claim.

In the future (under the new consolidated claims crossover process) **supplemental payers/insurers will sign one national crossover agreement** and work directly with the COBC (which represents CMS). The supplemental payer/insurer will:

- Send eligibility files to identify its covered members, and
- Receive outbound HIPAA ANSI X-12N 837 COB claims and National Council for Prescription Drug Programs (NCPDP) claims for use in calculating their secondary payment liability.

On July 6, 2004, CMS began testing the consolidated crossover process with approximately ten supplemental payers/insurers.

Note the following:

- Testing is focused on the outbound HIPAA ANSI X-12 837N COB claims that are translated from Medicare's Part A intermediary, Part B carrier, and DMERC processed claims.
- Initial -implementation will take place after successful testing is completed, and the 10 supplemental payers/insurers will be moved to full COBA crossover production through one entity, the COBC.
- Throughout the course of fiscal year 2005, CMS will begin transitioning all supplemental payers/insurers from the existing eligibility file-based crossover process to the national COBA process.

Detailed requirements for 1) eligibility file-based crossover and 2) claim-based (mandatory Medigap) crossover were previously issued by CMS in Change Request (CR) 3109 (Transmittal 98), and CMS subsequently issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. Transmittal 138 may be accessed at: *http://www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf*.

CR 3218 (Transmittal 138) provided:

- Major changes to many of the requirements previously published in CR 3109 (Transmittal 98) and
- Moved the implementation of claim-based crossover to a future date.

Physician, Provider, and Supplier Action

NOTE: Physicians, providers, and suppliers will not need to take any new actions with respect to the COBA automatic (or eligibility-file-based) crossover process.

The key difference between the existing automatic crossover process and the new COBA automatic crossover process is that, when a supplemental payer/insurer provides CMS with specific claim types and member information for those claims they wish to receive, **the claims will be crossed over to the supplemental payers/insurers only after the claims have left the Medicare claims payment floor.**

Thus, physician, provider, and supplier offices should receive payment and/or processing information from a patient's supplemental payer/insurer after the Medicare payment has been received (once the supplemental payer/insurer has transitioned to the COBA crossover process).

Physicians, providers, and suppliers will be able to reference a listing of eligibility file-based COBA trading partners on the COBA portion of the following CMS COB web site as supplemental payers/insurers are scheduled to move to full eligibility-file-based crossover production under the COBC: *http://www.cms.hhs.gov/medicare/cob/coba/coba.asp*.

(This listing is not currently available but will be available after supplemental payers/insurers have moved to full production with the COBC.)

Physicians, providers, and suppliers should note that the following important information will require your attention when a supplemental payer/insurer 1) has transitioned to the COBA eligibility-file-based crossover process and 2) is listed on the web site noted in the previous paragraph.

- Although the claim may cross to multiple supplemental payers/insurers, only one will print on your remittance advice. In this situation, if one of the supplemental payers/insurers is Medigap, the Medigap insurer will always print.
- Since payment from the supplemental payer/insurer should occur only after the Medicare payment has been issued, it is advised that you do not bill the supplemental payer/insurer for a minimum of 15 work days after receiving the Medicare payment. This will allow sufficient time for the claim to cross to the supplemental payer/insurer and the subsequent actions necessary to issue payment from the supplemental payer/insurer.
- In addition, prior to submitting a claim to the supplemental payer/insurer, it is advised that you use available self-service tools to research the status of your supplemental payment, e.g., the supplemental payer/insurer's website, claims automated "hot line," etc.
- There may be situations (such as claim errors related to HIPAA) that prevent the automatic crossover from occurring after you have received a Medicare remittance advice (electronic or supplemental paper) notifying you that the claim has crossed to the supplemental payer/insurer.
- Again, it is advised that you allow a minimum of 15 work days after Medicare payment has been issued before billing the supplemental payer/insurer to ensure that an automatic supplemental payment will not be issued. In addition, it is advised that you use the self-service tools of the supplemental payer/insurer to research the status of your supplemental claim prior to submitting it for supplemental payment.
- As a reminder, only the "official" Medicare remittance advice or HIPAA 835 Electronic Remittance Advice should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:
- You are billing the supplemental payer/insurer after the 15 work days from the Medicare- issued payment have expired, and
- You have used the available self-service tools to research the status of your supplemental payment.

Special Note for Physicians and Suppliers

Currently, Part B carriers and DMERCs assign identification numbers (known as In-key or OCNA numbers) to Medigap insurers that do **not** participate in the automatic, or eligibility-file-based, crossover process.

There are no current changes to this process and no current action is required of physicians, providers, and suppliers to change internal procedures related to Medigap claim-based crossovers.

Participating physicians and suppliers that bill Part B carriers and DMERCs for claim-based crossover will be informed approximately 90 days prior to implementing any changes to the claim-based crossover process. CMS expects this method of crossover to decrease sharply under the consolidated COBA crossover process, since most Medigap insurers will now have a single entity to which they can submit eligibility files to identify their covered members.

Related Instructions

On April 9, 2004, CMS issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. CR 3218 (Transmittal 138), may be viewed at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3218 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/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0504
Related CR Release Date: N/A

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Type of Service Changes

Effective for claims processed on or after January 1, 2005, the types of service (TOS) for some procedure codes have changed and as a result will require a UPIN. The following identifies the procedures codes and their respective UPIN requirement.

TOS corrections for 2005 Procedure Codes

Procedure Code	Old TOS	New TOS	UPIN Required?
A4595	9	P	No
A4605	9	P	No
E0849	A, 9	A, P, R	No
G0288	1	4	Yes
38242	5	2	No
76510	1	4	Yes
90656	1	V	No
93890	1	6	Yes
0066T	2	4	Yes

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

Procedure Codes added for 2005 requiring a UPIN

Procedure Codes	TOS	UPIN Required?
0067T- 0069T	4	Y

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

CMS Pub. 100-04, Transmittal 511
Date: March 28, 2005 Change Request 3788

Number of Drug Pricing Files That Must Be Maintained Online for Medicare by Durable Medical Equipment Regional Carriers

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

Note: CR 3584 was reissued on March 18, 2005, and this article was revised on March 21, 2005 to reflect the new CR release date and transmittal number. No other changes were made to the article.

Provider Types Affected

Durable medical equipment (DME) suppliers that bill Medicare DMERCs

Provider Action Needed

None, this article is informational only.

Beginning January 1, 2005, the payment limit for Part B drugs and biologicals will be based on the average sales price (ASP). Drugs will be paid based on either the lower of the submitted charge or the ASP and will continue to be priced based on date of service.

To facilitate the implementation of this ASP pricing methodology, CR 3584, beginning on July 1, 2005, increases (to eight) the number of online fee screens/pricing files that DMERC systems must maintain in order to determine the amount to pay for fee-for-service drug claims. This increase will allow DMERCs to maintain 2 years of drug pricing files to facilitate the implementation of the ASP pricing methodology.

Additional Information

The official instruction issued to your DMERC can be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3584 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3584
Medlearn Matters Number: MM3584
Related CR Release Date: March 18, 2005
Related CR Transmittal #: 509
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Prosthetics and Orthotics Ordered in a Hospital or Home Prior to a Skilled Nursing Facility Admission

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

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, and providers

Provider Action Needed

This article is informational only and describes who is responsible for billing when a customized device is ordered for beneficiary while in the hospital or home but delivered to the beneficiary at a skilled nursing facility.

Background

When a customized device is ordered while a beneficiary is an inpatient at a hospital, and the device is not delivered until after the beneficiary has moved to a Skilled Nursing Facility (SNF), the issue arises as to who is responsible for the billing of the item.

When a beneficiary is going from a hospital stay to a SNF Part A stay and needs an orthotic or prosthetic device, the facility where the medical need occurred is responsible for billing (rather than the supplier or provider of the device, which would bill for instances when need is established while the beneficiary is at home or in the community). Thus, if a prosthetic or orthotic device is medically necessary at the time the beneficiary is in the hospital, in the rare case when the prosthetic or orthotic is not delivered until the beneficiary has arrived at the SNF, the hospital remains responsible for billing for the item.

However, when the medical necessity for the prosthetic or orthotic device occurs after the time the Part A resident enters the SNF; the SNF is responsible for the billing of the prosthesis or orthosis. Given that most prosthetics (and all orthotic devices) are subject to SNF consolidated billing, the cost would be covered in the SNF's global per diem payment unless the item is specifically excluded from SNF consolidated billing.

Certain specified customized prosthetics are excluded and if the need for these devices was established in the SNF, the supplier is to bill the Durable Medical Equipment Regional Carrier (DMERC).

When a beneficiary requires a prosthesis or orthosis while in the home and then enters a SNF for a covered Part A stay, the DMERC would be billed by the party which supplied the device (not the SNF).

Medical necessity must have been established while the beneficiary was in the home.

If the beneficiary enters a SNF for a noncovered stay and thereafter develops a medical need for a customized device which the SNF orders, the SNF would bill the DMERC for the item, since SNF consolidated billing rules do not apply.

Additional Information

See the Medicare Claims Processing Manual, Pub. 100-4, Chapter 20, §110.3, "Pre-Discharge Delivery of DMEPOS for Fitting and Training," which covers instances in which a beneficiary may take delivery of DME, a prosthetic, or an orthotic for use at home during his or her last two days in an inpatient facility before returning home. This publication can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

Also, see Medlearn Matters Special Edition SE0437 for an article that provides specifics on how SNF consolidated billing applies to prosthetics and orthotics. This article can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf*.

In addition, the CMS Medlearn Consolidated Billing web site can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

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

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

It includes the following relevant information:

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

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0507
Effective Date: N/A

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Centralized Billing for Flu and Pneumococcal Vaccination Claims

Centralized billing is a process in which a provider, who provides mass immunization services for influenza and pneumococcal (PPV) immunizations, can send all claims to a single carrier for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the flu and PPV vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in centralized billing must contact CMS central office (CO), in writing, at the following address by June 1 of the year they wish to begin centrally billing.

Center for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-12-18
Baltimore, Maryland 21244

CRITERIA FOR CENTRALIZED BILLING

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

- To qualify for centralized billing, an individual or entity providing mass immunization services for flu and pneumonia must provide these services in at least three payment localities for which there are at least three different carriers processing claims.
- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.
- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the flu and PPV benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.
- The carrier assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned carrier for this year is TrailBlazer Health Enterprises.
- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.
- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.
- Centralized billers must submit their claims on roster bills in an **approved** electronic media claims standard format. Paper claims will not be accepted.
- Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. TrailBlazer Health Enterprises must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare health insurance claim number) as the carrier will not be able to process incomplete or incorrect claims.
- Centralized billers must obtain an address for each beneficiary so that a Medicare summary notice (MSN) can be sent to the beneficiary by the carrier. Beneficiaries are sometimes confused when they receive an MSN from a carrier other than the carrier that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, centralized billers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the processing carrier. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.
- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. TrailBlazer Health Enterprises will provide this information.
- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from TrailBlazer Health Enterprises. This is done by completing the Form CMS-855 (Provider Enrollment Application), which may be obtained from TrailBlazer Health Enterprises.

- If an individual or entity's request for centralized billing is approved, the approval is limited to the 12 month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. TrailBlazer Health Enterprises will not process claims for any centralized biller without permission from CMS CO.
- Each year the centralized biller must contact TrailBlazer Health Enterprises to verify understanding of the coverage policy for the administration of the PPV vaccine, and for a copy of the warning language that is required on the roster bill.
- The centralized biller is responsible for providing the beneficiary with a record of the PPV vaccination. The information in items 1 through 6 below must be included with the individual or entity's annual request to participate in centralized billing:

  1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations
  2. Estimates for the number of beneficiaries who will receive PPV vaccinations
  3. The approximate dates for when the vaccinations will be given
  4. A list of the states in which flu and PPV clinics will be held
  5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse); and
  6. Whether the nurses who will administer the flu and PPV vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering flu and PPV vaccinations.

Comprehensive Error Rate Testing Program - The Importance of Complying with Requests for Claim Documentation

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

Provider Types Affected

Medicare Fee-for-Service (FFS) physicians, providers and suppliers

Provider Action Needed

STOP – Impact to You

The 2004 national gross paid claims error rate was 10.1 percent. A portion of this error rate was due to providers not sending requested supporting documentation to the designated CERT contractor. Medicare FFS physicians, providers and suppliers must provide documentation and medical records that support their claims for covered Medicare services to the designated CERT contractor upon request. If you fail to submit documentation, the claim will be considered an error and you will receive a demand letter requesting refund of payment received for the '"erroneous" claim.

CAUTION – What You Need to Know

During a CERT review, you may be asked to provide more information related to a claim you submitted, such as medical records or certificates of medical necessity, so that the CERT review contractor (CRC) can verify that billing was proper. Be assured that forwarding specifically requested records to the designated CERT contractor does not violate privacy provisions under the Health Insurance Portability and Accountability (HIPAA) law.

GO – What You Need to Do

If you receive a letter from CMS regarding a CERT request for medical documentation, you should respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. Physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor. This special edition article provides an overview of the CERT program and stresses the importance of providing the requested medical documentation for the CERT review.

Background

The Government Performance and Results Act of 1993 established performance measurement standards for Federal agencies. To achieve the goals of this Act, CMS established the Comprehensive Error Rate Testing (CERT) program in November 2003. The purpose of the CERT program is to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. The results of these reviews are used to characterize and quantify local, regional and national error rate patterns. CMS uses this information to address the error rate through appropriate educational and interventional programs.

Methodology

The CERT program was originally administered by the Department of Health and Human Services, Office of the Inspector General (OIG) from 1996 - 2002. During this period, the OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that Medicare contractors erroneously allowed). Currently, CMS calculates a national paid claims error rate, a contractor specific error rate, services processed error rate (which measures whether the Medicare contractor made appropriate payment decisions on claims) and a **provider compliance error rate** (which measures how well providers prepared claims for submission). The CMS methodology includes:

- Randomly selecting a sample of claims submitted in a specific calendar year
- Requesting medical records from providers who submitted the claims
- Reviewing the claims and medical records to see if the claims complied with the Medicare coverage, coding, and billing rules; and
- **When providers fail to submit the requested documentation, treating the claims as errors and sending the providers overpayment letters.**

The designated CERT review contractor currently reviews over 140,000 randomly-selected claims and corresponding medical records each year, with a medical review staff that includes physicians and nurses who can use clinical judgment when necessary in reviewing medical records. Their medical review staff has access to national and local policies, contractor processing guidelines and automated edits.

If you fail to submit the requested information in a timely fashion, an "error" is registered against both the Medicare contractor (your Medicare Carrier or Fiscal Intermediary) and you, as the Medicare provider. (At this point, the CERT review contractor has no choice but to register the claim submission as "erroneous" because there is insufficient supporting documentation to determine otherwise.)
These errors have a corresponding negative impact on the other error rates that are calculated under the CERT program.

Your Role Is Critical To Improvement

Our research has shown that providers do not comply with the requests for information because:

- They believe it is a violation of the Health Insurance Portability and Accountability Act (HIPAA) to send patient records to the designated CERT contractor; or
- They are unaware of the CERT process, and they may not appreciate the importance of cooperating in a timely fashion.

Medicare beneficiaries have consented to the release of medical information necessary to process their Medicare claims. Providers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor. Be assured that forwarding specifically requested records to the designated CERT contractor does not violate HIPAA Privacy statutes.

If You Receive A Letter From CMS Regarding A CERT Medical Review…

1. Don't ignore it! Respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. The letter will provide a clearly defined list of the documentation required and where to submit the information.
2. Include any additional material that you believe supports the service(s) billed to the Medicare program.
3. Make sure your address files and telephone numbers that are on file with your carrier or fiscal intermediary are accurate to ensure that CERT documentation requests are received and allow time for you to respond timely.
4. Remember that physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.

Additional Information

In an effort to assist Medicare physicians, providers and suppliers with CERT compliance, we have several resources available to explain the CERT process and how your responsiveness is in everyone's best interest.

- CERT Web page (http://www.cms.hhs.gov/cert)
- CERT newsletters (http://www.cms.hhs.gov/cert/letters.asp)
- A designated telephone number for Medicare physicians, providers and suppliers for general information and questions regarding the CERT initiative — (804) 864-9940.

In addition, we are preparing a series of Fact Sheets, Frequently-Asked Questions, and future Medlearn Matters articles to provide further guidance regarding the CERT process.

Remember:
Review can result in identification of overpayments as well as underpayments.
If CERT changes the payment decision on your claim by denying or reducing payment, you can still file an appeal with your Medicare contractor.
It is in everyone's interest to code and pay claims correctly. Your support of this process helps protect the solvency of the Medicare program.
Your cooperation also allows your Medicare contractor to provide individualized education to you on your specific CERT errors.

Special Edition #: SE0526
Medlearn Matters Number: SE0526
Related Change Request (CR): N/A
Effective Date: N/A

Revisions to Payment for Services Provided Under a Contractual Arrangement

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers provided under a contractual arrangement

Provider Action Needed

This article includes information provided in Change Request (CR) 3628 which makes a slight revision to the language in the Centers for Medicare & Medicaid Services (CMS) Manual System on payment for services provided under a contractual arrangement.

Background

The Medicare Claims Processing Manual (Pub. 100-04, Chapter 1 (General Billing Requirements), Section 30.2.7 (Payment for services provided under a contractual arrangement)) has been revised as a result of the language published in the November 15, 2004 Physician Fee Schedule final rule (CMS-1429F) concerning section 952 of the Medicare Modernization Act (MMA). Instead of stating that the contractual arrangement between an entity and the other physician or provider should include pertinent Medicare program integrity safeguards, CMS is now stating that the entity and the physician or other person are subject to those program integrity safeguards per the following:

- The entity receiving payment and the physician or other person that furnished the service are both subject to the following program integrity safeguard requirements:
  - The entity receiving payment and the person that furnished the service are jointly and severally responsible for any Medicare overpayment to that entity; and,
  - The person furnishing the services has unrestricted access to claims submitted by an entity for services provided by that person.

The entity billing and receiving payment and the person reassigning his or her billing and payment rights are both responsible for compliance with the Medicare program integrity safeguards beginning on January 1, 2005 (the effective date of CMS-1429-F).

Also, a Medicare carrier may make payment to an entity (i.e., a person, group, or facility enrolled in the Medicare program) that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. Thus, the service may be furnished on or off the premises of the entity submitting the bill and receiving payment (excluding billing agents).

Note: A provider under a 'contractual arrangement' would need to know the billing provider's name and number, along with the beneficiary's information in order to obtain information specific to a claim.

Implementation

The implementation date for this instruction is March 15, 2005.

Additional Information

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

From that web page, look for CR 3628 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3628
Medlearn Matters Number: MM3628
Related CR Release Date: February 11, 2005
Related CR Transmittal #: 472
Effective Date: January 1, 2005
Implementation Date: March 15, 2005

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CONNECTICUT MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

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

Effective and Notice Dates

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

Electronic Notification

To receive quick, automatic notification when new LMRPs/LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.connecticutmedicare.com* , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

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

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

Phone: 1-866-419-9455

Medical Review Table of Contents

Advance Notice Statement

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

ADDITIONS/REVISIONS TO LMRPS/LCDS

Botulinum Toxins—Policy Revision

The latest revision for local coverage determination (LCD) botulinum toxins was effective October 1, 2004. This LCD has been revised to add ICD-9-CM code 705.21 Primary focal hyperhidrosis to the "ICD-9 Codes that Support Medical Necessity" section of the policy, and the "Indications and Limitations of Coverage and/or Medical Necessity" section has been revised accordingly.

These revisions are effective for services rendered on or after May 2, 2005. The full-text of this local coverage determination may be viewed on the provider education website *http://www.connecticutmedicare.com* on or after the effective date.

EPO (Epoetin alfa)—Policy Revision

This local coverage determination (LCD) was last updated on July 6, 2004.

A revision to this LCD was made to add the following additional diagnosis codes under the "ICD-9 Codes that Support Medical Necessity" for the following categories:

- Under Non-Renal Diagnosis (Q0136) added diagnosis code:

  285.22 Anemia in neoplastic disease.

- Under Renal Diagnosis (ESRD, Q0136 & Q4055) added diagnosis codes:

  403.01 Malignant hypertensive renal disease with renal failure
  403.11 Benign hypertensive renal disease with renal failure
  403.91 Unspecified hypertensive renal disease with renal failure
  404.02 Malignant hypertensive heart and renal disease with renal failure
  404.03 Malignant hypertensive heart and renal disease with heart failure and renal failure
  404.12 Benign hypertensive heart and renal disease with renal failure
  404.13 Benign hypertensive heart and renal disease with heart failure and renal failure
  404.92 Unspecified hypertensive heart and renal disease with renal failure
  404.93 Unspecified heart and renal disease with heart failure and renal failure

This policy revision is effective for claims processed on or after May 2, 2005 for services rendered on or after January 5, 2004 for diagnosis 285.22. For all other diagnosis codes listed above, this revision is effective for services rendered on or after May 2, 2005.

The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after these effective dates.

J1563: Intravenous Immune Globulin (IVIG)—Policy Revision

The local coverage determination (LCD) for intravenous immune globulin (IVIG) was last revised on January 1, 2005.

Change request 3745, dated March 18, 2005 deleted HCPCS codes J1563 (Injection, immune globulin, intravenous, 1g) and J1564 (Injection, immune globulin, intravenous, 10 mg) and replaced them with HCPCS codes, which appropriately distinguish lyophilized and non-lyophilized forms of IVIG. Therefore, HCPCS code J1563 has been deleted and replaced with Q9941 (Injection, immune globulin, intravenous, lyophilized, 1 gm) and Q9942 (Injection, immune globulin, intravenous, lyophilized, 10 mg). HCPCS code J1564 has been deleted and replaced with Q9943 (Injection, immune globulin, intravenous non-lyophilized, 1 gm) and Q9944 (Injection, immune globulin, intravenous non-lyophilized, 10 mg). The policy number has been changed to Q9941.

This revision is effective for services rendered on or after April 1, 2005. The full-text of this LCD is available on the provider education website *http://wwwconnecticutmedicare.com* on or after this effective date..

J9000: Antineoplastic Drugs—Policy Revision

This local coverage determination (LCD) was last updated on January 24, 2005.

A revision to this LCD was made to add the additional FDA approved indications under the "Indications and Limitations of Coverage and/or Medical Necessity" section for the following drugs:

J9600 Porfimer Sodium – Ablation of high-grade dysplasia (HGD) in barrett esophagus (BE) patients who do not undergo esophagectomy.

J9263 Oxaliplatin – For injection in combination with infusional 5-fluorouracil/leucovorin (5-FU/LV) for the adjunctive treatment of stage III colon cancer patients who have undergone resection of the primary tumor. The indication is based on an improvement in disease-free survival, with no demonstrated benefit in overall survival after median follow up of 4 years.

In addition, ICD-9-CM code 530.85 (barrett's esophagus [for ablation of high-grade dysplasia in BE patients who do not undergo esophagectomy]) was added to the list of diagnoses for J9600.

This policy revision is effective for claims processed on or after March 29, 2005 for services rendered on or after August 1, 2003, for HCPCS code J9600; and services rendered on or after November 4, 2004, for HCPCS code J9263.

The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after these effective dates.

11720: Nail Debridement—Policy Revision

This local coverage determination (LCD) was effective on January 1, 2005.

Verbiage under the "Indications and Limitations of Coverage and/or Medical Necessity" section, and under the "Other Comments" section of the Coding Guidelines was changed concerning when to refer to the Routine Foot Care policy.

The previous statement was: "For treatment of non-symptomatic mycotic nails, refer to the Routine Foot Care policy."

The revised statement is: "For nail debridement not related to symptomatic mycotic nails but associated with a systemic condition, refer to the Routine Foot Care policy."

This revision is effective for services rendered on or after January 1, 2005

The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

11730: Surgical Treatment of Nails— Policy Revision

This local medical review policy (LMRP) was last updated on January 5, 2004.

The policy was formatted into the new local coverage determination (LCD) format. Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, verbiage was changed to the following:

- Medicare will consider the surgical treatment of ingrown nails to be medically appropriate and reasonable for an ingrown toenail in the advanced stage in which the lateral nail fold bulges over the nail plate causing erythema, edema, and tenderness**,** and granulation of the epithelium inhibits serous drainage and precludes any chance of elevating the nail edge from the dermis of the lateral skin fold.

Limitations

The following are considered routine foot care and are not included in the surgical treatment of ingrown nails:

- cutting small chips of the nail
- excising less than the full length of the affected nail
- simple nonsurgical treatment of ingrown nails (e.g., trimming, cutting, lifting and clipping of the distal unattached nail margins)
- simple wedge excision of tissue or nail borders not requiring local anesthesia

Under the Documentation Requirements, verbiage was changed to the following, and omitting the requirement of clinical photographs:

For procedure codes *11730, 11732, 11750*, and *11765*, the following information must be clearly documented in the patient's medical record and submitted upon request for review.

1. Complete detailed description of the pre-operative findings.
2. Procedure being performed (making note to the nail margin involved).
3. Method of obtaining anesthesia (if not used, the reason for not using it).
4. A complete detailed description of the procedure.
5. Postoperative observation and treatment of the surgical site (e.g., minimal bleeding, sterile dressing applied).
6. Postoperative instructions given to the patient and any follow-up care (e.g., soaks, antibiotics, follow-up appointments).

This policy revision is effective for claims processed on or after February 1, 2005.

The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

86294:Urinary Tumor Markers for Bladder Cancer–Policy Revision

The latest revision for local coverage determination (LCD) Urinary Tumor Markers for Bladder Cancer was effective January 1, 2005. The 'Indications and Limitations of Coverage and/or Medical Necessity' section of this LCD for 'The Urinary Fluorescence In Situ Hybridization (FISH) Test has been revised to indicate that Medicare will also consider the Urinary FISH Test medically reasonable and necessary under the following circumstance:

In the initial diagnosis of persons with hematuria suspected of having bladder carcinoma in conjunction with and not in lieu of current standard diagnostic procedures.

This revision is effective for services performed on or after the FDA-approval date of January 24, 2005. The full-text of this local coverage determination may be viewed on the provider education website *http://www.connecticutmedicare.com* on or after this effective date.

97802: Medical Nutrition Therapy–Policy Revision

The local coverage determination (LCD) for Medical Nutrition Therapy was last revised on November 15, 2004. The policy has been revised to provide clarification regarding the time span allowed for the initial medical nutrition therapy services. Medicare covers 3 hours of medical nutrition therapy services in the beneficiary's initial calendar year. Initial medical nutrition therapy hours are limited to one calendar year.

Verbiage under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been changed to reflect this requirement.

This revision is effective for services rendered on or after March 8, 2005. Updated information can be found on the provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

COMPRENSIVE MEDICAL DATA ANALYSIS

90818: Individual Psychotherapy

The comprehensive data analysis department recently conducted an analysis of Medicare Part B claims data for CPT codes *90818* (*Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45-50 minutes face to face with the patient*) as a result of the Connecticut carrier being aberrant when compared to the nation.

Data revealed that incorrect place of service (POS) codes are being submitted. For claims submitted for CPT code *90878*, 97.60 percent of claim were submitted for CPT *90818* with POS 31 (Skilled nursing facility). The Medicare Claims Processing Manual section 20.1.1.1 states POS code 31 should only be used with services for patients in a Part A covered stay and POS 32 (Nursing facility) should be used with services for beneficiaries in a noncovered stay.

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

RETIREMENT OF EXISTING LMRPS

64400: Peripheral Nerve Blocks

Based on instructions received from CMS, all LMRPs are to be converted into the local coverage determination (LCD) format. LCD's are to be based on the determination as to whether a service is reasonable and necessary. After review of the policy it has been determined that this policy should be retired based on data analysis.The retirement of this local medical review policy (LMRP) is effective for services rendered on or after May 3, 2005.

In addition, it was determined that diagnosis range 200.0-208.9 was not to the highest level of specificity, therefore, it was changed to diagnosis range 200.00-208.91. This change is effective for claims processed on or after May 3, 2005 for dates of service on or after September 29, 2003. The full-text of this local coverage determination may be viewed on the provider education website *http://www.connecticutmedicare.com* on or after the effective date.

93925: Duplex Scan of Lower Extremity Arteries

The local medical review policy (LMRP) for duplex scan of lower extremity arteries is being retired, effective for services rendered on or after April 11, 2005. This decision is based on current data analysis and local standards of medical practice. Codes 93925 and 93926 are not aberrant in Connecticut. A policy may be developed in the future if services become aberrant. The full-text of this local coverage determination may be viewed on the provider education website *http://www.connecticutmedicare.com* on or after the effective date.

93930: Duplex Scan of Upper Extremity Arteries or Arterial Bypass Grafts

The local medical review policy (LMRP) for duplex scan of upper extremity arteries or arterial bypass grafts is being retired, effective for services rendered on or after April 11, 2005. This decision is based on current data analysis and local standards of medical practice. Codes 93930 and 93931 are not aberrant in Connecticut. A policy may be developed in the future if services become aberrant. The full-text of this local coverage determination may be viewed on the provider education website *http://www.connecticutmedicare.com* on or after the effective date.

ADDITIONAL INFORMATION ON LMRPS/LCDS

Macugen® (pegaptanib sodium injection)—Clarification of Coverage

Age-related macular degeneration (AMD) is the leading cause of irreversible severe vision loss in Americans over 55 years of age. While the non-neovascular or dry form of the disease is more prevalent, neovascular or wet AMD is responsible for the majority of cases of vision loss. Neovascular (wet) AMD is characterized by choroidal neovascularization (CNV) beneath the retina. The neovascular tissue often leaks blood and fluid, and, untreated, eventually progresses to scarring with destruction of the macula and loss of vision.

Macugen (pegaptanib sodium injection) received approval from the Food and Drug Administration (FDA) on December 17, 2004, for the treatment of neovascular (wet) AMD. The intended dose and regimen for Macugen is 0.3 mg administered once every six weeks by intravitreous injection into the eye to be treated.

Pegaptnib is a selective vascular endothelial growth factor (VEGF) antagonist that works by blocking VEGF, which is a secreted protein that selectively binds and activates its receptors located primarily on the surface of vascular endothelial cells. VEGF induces angiogenesis, and increases vascular permeability and inflammation, all of which are thought to contribute to the progression of the neovascular (wet) form of AMD. VEGF has been implicated in blood retinal barrier breakdown and pathological ocular neovascularization.

Coding Guidelines:

HCPCS code J3490	Macugen (pegaptanib sodium injection) Enter the name of the drug and dosage (0.3 mg) in item 19 of claim form CMS-1500 or the electronic equivalent field. If both eyes were treated, the number of milligrams (0.6 mg) would be noted.
CPT code *67028*	*Intravitreal injection of a pharmacologic agent (separate procedure)*
CPT code *92235*	*Fluorescein angiography (includes multiframe imaging) with interpretation and report*
CPT code *92135*	*Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral*
ICD-9-CM code 362.52	Exudative senile macular degeneration

Evaluation and Management (E/M) Service:

Modifier 25 Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service. If modifier 25 applies to the patient scenario on the date of the injection, an E/M service may be billed. Otherwise, an E/M service may not be billed on the date of the service.

Medical record documentation maintained by the performing physician must include the clinical indication/medical necessity for the Macugen injection. The office records should also indicate that fluorescein angiography (CPT code *92235*) was performed prior to the initial injection. Fluorescein angiography and/or scanning computerized ophthalmic diagnostic imaging (*92135*) may be performed prior to each subsequent injection as medically indicated. Documentation will not be required with the submission of each claim.

Procedure code *67028* is subject to standard payment adjustment rules for multiple procedures.

Procedure codes *92235* and *92135* are considered unilateral. Therefore, when performed on both eyes modifier 50 should be used and modifier RT or LT must be used for unilateral services.

Pricing for Macugen (pegaptanib sodium injection) therapy rendered in 2004 will be based on 95 percent of the average wholesale price (AWP) / 0.3 mg. And pricing for therapy rendered in 2005 will be based on the average sales price (ASP) plus 6 percent or $1,054.70 / 0.3 mg for participating providers and $1001.97 / 0.3 mg for non-participating providers.

Medicare coverage of Macugen (pegaptanib sodium injection) for the treatment of neovascular (wet) AMD is effective for therapy rendered on or after December 17, 2004.

Clarification of Psychotherapy Documentation Requirements

Effective February 22, 2005 the Medicare requirements for submitting psychotherapy notes will be changed. Change request 3457 states that providers can **no** longer be required to submit psychotherapy notes when the notes in question are protected by the Final Privacy Rule, 45 CFR, Section 164.501. Psychotherapy notes are defined as notes recorded by a mental health professional that 1) document or analyze the contents of a counseling session, and 2) are separated from the rest of the medical record. The definition of psychotherapy notes **does not** include the following information:

- Prescription medication and monitoring
- Counseling sessions start and stop times
- Modalities and frequencies of treatment rendered
- Results of clinical tests, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress in treatment

At various times providers will continue to receive documentation requests from Medicare. When documentation is requested, the provider must submit medical record information. The provider ***has the option to:***

- Submit original psychotherapy notes. This requires the patient to authorize release of the record. ***OR***
- In responding to these requests, the provider can extract information from the psychotherapy note and submit documentation in the form of a summary. This summary must include documentation outlining the patient's need for the services provided (i.e., that the services provided were reasonable and medically necessary).

The summary document **must** include all of the following information to support the medical necessity of the psychotherapy session:

- Description of emotional or behavioral symptoms that demonstrate inappropriate or maladaptive functioning that is a significant change in the patient's baseline level of functioning.
- Progress towards treatment goals since last session.
- Time spent in psychotherapy encounter/session.
- Description of treatment, including therapeutic interventions such as behavior modification, supportive interaction, and discussion of reality provided to the patient during the psychotherapy session .
- Degree of patient participation in the psychotherapy session.
- Patient reaction to the psychotherapy session.

If the provider does not submit information when requested, that clearly demonstrates that the service rendered was reasonable and medically necessary, the claim will be denied.

Please note: In addition to the psychotherapy notes, the additional development request (ADR) letter requires the submission of: any and all referring physicians' orders, initial evaluation and/or diagnostic interview, test results/reports and treatment plan/treatment plan updates.

Source: CMS Medlearn Matters article: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3457.pdf*

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

Attention: Correspondence

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

Attention: Financial Services

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

Attention: Fraud and Abuse

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

Attention: Freedom of Information (FOIA)

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

Attention: Medical Review

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

Attention: MSP

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

Attention: Pricing/ Provider Maintenance

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

Attention: Resolutions

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

MAILING ADDRESS EXCEPTIONS

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

Reviews/Appeals

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

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

Hearings

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

Post Office Box for Appeals/Hearings:

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

Electronic Media Claims/EDI

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

Post Office Box for EDI:

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

Claims

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

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

CONNECTICUT MEDICARE PHONE NUMBERS

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

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

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

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

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

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

Electronic Funds Transfer Information
1-203-639-3219

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

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

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

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

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

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

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

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

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

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

WEB SITES

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

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

FLORIDA MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

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

Effective and Notice Dates

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

Electronic Notification

To receive quick, automatic notification when new LMRPs/LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.floridamedicare.com* , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

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

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

1-904-791-8465

Medical Review Table of Contents

Advance Notice Statement

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

REVISIONS TO LMRPS/LCDS

Botulinum Toxins—Policy Revision

The latest revision for local coverage determination (LCD) for botulinum toxins was effective October 1, 2004. This LCD has been revised to add ICD-9-CM code 705.21 Primary focal hyperhidrosis to the "ICD-9 Codes that Support Medical Necessity" section of the policy, and the "Indications and Limitations of Coverage and/or Medical Necessity" section has been revised accordingly.

These revisions are effective for services rendered on or after May 2, 2005. The full-text of this local coverage determination may be viewed on the provider education website *http://www.floridamedicare.com* on or after the effective date.

EPO (Epoetin alfa)—Policy Revision

This local coverage determination (LCD) was last updated on July 6, 2004.

A revision to this LCD was made to add the following additional diagnosis codes under the "ICD-9 Codes that Support Medical Necessity" for the following categories:

Under Non-Renal Diagnosis (Q0136) added diagnosis code:

285.22 – Anemia in neoplastic disease.

Under Renal Diagnosis (ESRD, Q0136 & Q4055) added diagnosis codes:

403.01 Malignant hypertensive renal disease with renal failure
403.11 Benign hypertensive renal disease with renal failure
403.91 Unspecified hypertensive renal disease with renal failure
404.02 Malignant hypertensive heart and renal disease with renal failure
404.03 Malignant hypertensive heart and renal disease with heart failure and renal failure
404.12 Benign hypertensive heart and renal disease with renal failure
404.13 Benign hypertensive heart and renal disease with heart failure and renal failure
404.92 Unspecified hypertensive heart and renal disease with renal failure
404.93 Unspecified heart and renal disease with heart failure and renal failure

This policy revision is effective for claims processed on or after May 2, 2005 for services rendered on or after January 5, 2004 for diagnosis 285.22. For all other diagnosis codes listed above, this revision is effective for services rendered on or after May 2, 2005.

The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after these effective dates.

J0207: Amifostine (Ethyol®)—Policy Revision

This local coverage determination (LCD) was last updated on July 6, 2004.

A revision to this LCD was made to add the following additional off-label indication under the "Indications and Limitations of Coverage and/or Medical Necessity" for the treatment of:

- Mucositis, radiation therapy or radiation combined with chemotherapy induced – to reduce the incidence of mucositis in patients receiving radiation therapy or radiation combined with chemotherapy.

Additionally, ICD-9-CM codes were removed from the policy.

This policy revision is effective for claims processed on or after March 28, 2005.

The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J1563: Intravenous Immune Globulin (IVIG)—Policy Revision

The local coverage determination (LCD) for intravenous immune globulin (IVIG) was last revised on January 1, 2005.

Change request 3745, dated March 18, 2005 deleted HCPCS codes J1563 (Injection, immune globulin, intravenous, 1g) and J1564 (Injection, immune globulin, intravenous, 10 mg) and replaced them with HCPCS codes, which appropriately distinguish lyophilized and non-lyophilized forms of IVIG. Therefore, HCPCS code J1563 has been deleted and replaced with Q9941 (Injection, immune globulin, intravenous, lyophilized, 1 gm) and Q9942 (Injection, immune globulin, intravenous, lyophilized, 10 mg). HCPCS code J1564 has been deleted and replaces with Q9943 (Injection, immune globulin, intravenous non-lyophilized, 1 gm) and Q9944 (Injection, immune globulin, intravenous non-lyophilized, 10 mg). The policy number has been changed to Q9941.

This revision is effective for services rendered on or after April 1, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs—Policy Revision

This local coverage determination (LCD) was last updated on January 24, 2005.

A revision to this LCD was made to add the additional FDA approved indications under the "Indications and Limitations of Coverage and/or Medical Necessity" for the following drugs:

J9600 (Porfimer sodium) – Ablation of high-grade dysplasia (HGD) in barrett esophagus (BE) patients who do not undergo esophagectomy.

J9263 (Oxaliplatin) – For injection in combination with infusional 5-fluorouracil/leucovorin (5-FU/LV) for the adjunctive treatment of stage III colon cancer patients who have undergone resection of the primary tumor. The indication is based on an improvement in disease-free survival, with no demonstrated benefit in overall survival after median follow up of 4 years.

In addition, ICD-9-CM code 530.85 (Barrett's esophagus ([for ablationof high-grade dysplasia in BE patients who do not undergo esophagectomy]) was added to the list of diagnoses for J9600.

This policy revision is effective for claims processed on or after March 29, 2005 for services rendered on or after August 1, 2003 for HCPCS code J9600; and services rendered on or after November 4, 2004 for HCPCS code J9263.

The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after these effective dates.

PULMDIAGSVCS: Pulmonary Diagnostic Services – Policy Revision

The local coverage determination (LCD) for pulmonary diagnostic services – PULMDIAGSVCS was previously revised on January 1, 2005. Since that time, a coding guideline attachment has been added to this policy and procedure code *94150* was moved from the policy to the coding guideline section.

This change is effective for claims processed on or after February 2, 2005. The full-text of this LCD is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

11720: Nail Debridement—Policy Revision

This local coverage determination (LCD) was last revised on January 1, 2005.

Verbiage under the "Indications and Limitations of Coverage and/or Medical Necessity" section, and under the "Other Comments" section of the Coding Guidelines was changed concerning when to refer to the Routine Foot Care policy.

The previous statement was: "For treatment of non-symptomatic mycotic nails, refer to the Routine Foot Care Policy."

The revised statement is: "For nail debridement not related to symptomatic mycotic nails but associated with a systemic condition, refer to the Routine Foot Care policy."

This revision is effective for services rendered on or after January 1, 2005.

The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

11730: Surgical Treatment of Nails—Policy Revision

This local medical review policy (LMRP)/ local coverage determination (LCD) was last updated on January 12, 2004.

The policy was formatted into the new LCD format. The first paragraph of the coding guidelines was changed to read as follows: "Procedure code *11730* (*Avulsion of nail plate, partial or complete, simple; single*) should be used when removing part, or the entire nail, and is not necessary to destroy the nail matrix".

The former paragraph read: "Procedure code *11730* (*Avulsion of nail plate, partial or complete, simple; single*) should be used when removing part, or the entire nail through at least half the length of the nail, and is not necessary to destroy the nail matrix".

This policy revision is effective for claims processed on or after February 1, 2005.

The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

Sign up to our *eNews* electronic mailing list

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

64400: Peripheral Nerve Block—Policy Clarification

This article was last published in the Second Quarter 2005 *Medicare B Update!*. This article is being rewritten to provide clarification.

This policy was revised and converted to the local coverage determination (LCD) format. This major revision included the following changes to the policy:

- Additional ICD-9 codes were added to the policy
- The policy name and number was changed form *64405* (Greater Occipital Nerve Block/Neurolysis) to *64400* (Peripheral Nerve Blocks)
- The procedure code *64640* was deleted from the policy

Procedure code *64640* was removed from the policy because it was determined that this procedure *64640* (*Destruction by neurolytic agent; other peripheral nerve or branch*) involved neurolytic destruction and should be addressed in a separate policy in the future. The removal of this procedure code from the policy does not indicate that this procedure is no longer valid for Medicare. Providers may continue to perform and bill for this service as they have in the past based on medical necessity.

This revision was effective for services rendered on or after April 11, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com*.

86294: Urinary Tumor Markers for Bladder Cancer—Policy Revision

The latest revision for local coverage determination (LCD) urinary tumor markers for bladder cancer was effective January 1, 2005. The "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD for the urinary fluorescence in situ hybridization (FISH) test has been revised to indicate that Medicare will also consider the urinary FISH test medically reasonable and necessary under the following circumstance:

> In the initial diagnosis of persons with hematuria suspected of having bladder carcinoma in conjunction with and not in lieu of current standard diagnostic procedures.

This revision is effective for services performed on or after the FDA-approval date of January 24, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

90818: Individual Psychotherapy—Article Correction

An article published on page 110 of the First Quarter 2005 Medicare B Update! titled "90818: Individual Psychotherapy" was incorrectly placed in the "Florida Medical Review" section. This article only applies to Connecticut.

We apologize for any inconvenience this may have caused.

97802: Medical Nutrition Therapy—Policy Revision

The local coverage determination (LCD) for medical nutrition therapy was last revised on November 15, 2004.

The policy has been revised to provide clarification regarding the time span allowed for the initial medical nutrition therapy services. Medicare covers three hours of medical nutrition therapy services in the beneficiary's initial calendar year. Initial medical nutrition therapy hours are limited to one calendar year.

Verbiage under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been changed to reflect this requirement.

This revision is effective for services rendered on or after March 8, 2005. The full-text of this local coverage determination may be viewed on the provider education website *http://www.floridamedicare.com* on or after the effective date.

RETIREMENT OF EXISTING LMRPS

Ambulance Policies Retired

It was determined that information in the following local medical review policies (LMRP) did not meet criteria mandated by CMS for a local coverage determination (LCD). The coverage guidelines in these policies are provided in CMS national regulations. Therefore, the following LMRPs will be retired.

Policy Number	Policy Name
A0425	Ground Ambulance Services
A0430	Air ambulance Services
A0434	Specialty Care Transport

Coverage guidelines are located in Medicare Benefit Policy Manual, Pub. 100-2, Chapter 10 on the CMS website at *http://www.cms.hhs.gov/manuals/102_policy/bp102c10.pdf*.

The retirement of these LMRPs are effective for service rendered on or after April 1, 2005. Updated information may be found on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

WIDESPREAD MEDICAL REVIEW PROBES

Widespread Probe—Radiology Simulation-Aided Field Setting

The Statistical and Medical Data Analysis department conducted an analysis of the Medicare Part B claims data for the following *CPT* code: *77295 Therapeutic radiology simulation-aided setting; three-dimensional* as a result of the Florida carrier being aberrant when compared to the nation.

The following table depicts the carrier allowed dollars per 1,000 enrollees, nation allowed dollars per 1,000 enrollees and carrier to nation ratio. Additionally, $7,755,830 would not have been expended over a one-year period if Florida's practice pattern was similar to the nation.

January – June 2004

Carrier Allowed Dollars per 1,000 Enrollees	Nation Allowed Dollars per 1,000 Enrollees	Carrier to Nation Ratio
$2,993.	$1,278.	2.34

A widespread episode of care probe has been recommended as a result of this data analysis. Providers appear to be billing services at a higher rate than expected. The purpose of the widespread probe is to determine if services performed meet indications/medical necessity as outlined in the local medical review policy (LMRP). The medical review staff will apply the coverage criteria identified in the LMRP when performing the recommended widespread probe. A recommendation may be made to utilize the information found in the widespread probe for the purpose of future provider education.

ADDITIONAL INFORMATION ON LMRPS/LCDS

Clarification of Psychotherapy Documentation Requirements

Effective February 22, 2005 the Medicare requirements for submitting psychotherapy notes will be changed. Change request 3457 states that providers can **no** longer be required to submit psychotherapy notes when the notes in question are protected by the Final Privacy Rule, 45 CFR, Section 164.501. Psychotherapy notes are defined as notes recorded by a mental health professional that 1) document or analyze the contents of a counseling session, and 2) are separated from the rest of the medical record. The definition of psychotherapy notes **does not** include the following information:

- Prescription medication and monitoring
- Counseling sessions start and stop times
- Modalities and frequencies of treatment rendered
- Results of clinical tests, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress in treatment

At various times providers will continue to receive documentation requests from Medicare. When documentation is requested, the provider will be required to respond by submitting medical record information. The provider ***has the option to:***

- Submit original psychotherapy notes. This requires the patient to authorize release of the record. ***OR***
- In responding to these requests the provider can extract information from the psychotherapy note and submit documentation in the form of a summary. This summary must include documentation outlining the patient's need for the services provided (i.e., that the services provided were reasonable and medically necessary).

The summary document **must** include all of the following information to support the medical necessity of the psychotherapy session:

- Description of emotional or behavioral symptoms that demonstrate inappropriate or maladaptive functioning that is a significant change in the patient's baseline level of functioning
- Progress towards treatment goals since last session
- Time spent in psychotherapy encounter/session
- Description of treatment, including therapeutic interventions such as behavior modification, supportive interaction, and discussion of reality provided to the patient during the psychotherapy session
- Degree of patient participation in the psychotherapy session
- Patient reaction to the psychotherapy session

If the provider does not submit information when requested, that clearly demonstrates that the service rendered was reasonable and medically necessary, the claim will be denied.

Please note: In addition to the psychotherapy notes, the additional development request (ADR) letter requires the submission of: any and all referring physicians' orders, initial evaluation and/or diagnostic interview, test results/reports and treatment plan/treatment plan updates.

Source: CMS Medlearn Matters article: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3457.pdf*

Macugen® (pegaptanib sodium injection)—Clarification of Coverage

Age-related macular degeneration (AMD) is the leading cause of irreversible severe vision loss in Americans over 55 years of age. While the non-neovascular or dry form of the disease is more prevalent, neovascular or wet AMD is responsible for the majority of cases of vision loss. Neovascular (wet) AMD is characterized by choroidal neovascularization (CNV) beneath the retina. The neovascular tissue often leaks blood and fluid, and untreated, eventually progresses to scarring with destruction of the macula and loss of vision.

Macugen (pegaptanib sodium injection) received approval from the Food and Drug Administration (FDA) on December 17, 2004, for the treatment of neovascular (wet) AMD. The intended dose and regimen for Macugen is 0.3 mg administered once every six weeks by intravitreous injection into the eye to be treated.

Pegaptnib is a selective vascular endothelial growth factor (VEGF) antagonist that works by blocking VEGF, which is a secreted protein that selectively binds and activates its receptors located primarily on the surface of vascular endothelial cells. VEGF induces angiogenesis, and increases vascular permeability and inflammation, all of which are thought to contribute to the progression of the neovascular (wet) form of AMD. VEGF has been implicated in blood retinal barrier breakdown and pathological ocular neovascularization.

Coding Guidelines:

HCPCS code J3490 Macugen (pegaptanib sodium injection) Enter the name of the drug and dosage (0.3 mg) in item 19 of claim form CMS 1500 or the electronic equivalent field. If both eyes were treated, the number of milligrams (0.6 mg) would be noted.

CPT code *67028* *Intravitreal injection of a pharmacologic agent (separate procedure)*

CPT code *92235* *Fluorescein angiography (includes multiframe imaging) with interpretation and report*

CPT code *92135* *Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral*

ICD-9-CM Code 362.52 Exudative senile macular degeneration

Evaluation and Management (E/M) Service:

Modifier 25 Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service. If modifier 25 applies to the patient scenario on the date of the injection, an E/M service may be billed. Otherwise, an E/M service may not be billed on the date of the service.

Medical record documentation maintained by the performing physician must include the clinical indication/medical necessity for the Macugen injection. The office records should also indicate that fluorescein angiography (CPT code *92235*) was performed prior to the initial injection. Fluorescein angiography and/or scanning computerized ophthalmic diagnostic imaging (*92135*) may be performed prior to each subsequent injection as medically indicated. Documentation will not be required with the submission of each claim.

Procedure code *67028* is subject to standard payment adjustment rules for multiple procedures.

Procedure codes *92235* and *92135* are considered unilateral. Therefore, when performed on both eyes modifier 50 must be used and modifier RT or LT must be used for unilateral services.

Pricing for Macugen (Pegaptanib sodium injection) therapy rendered in 2004 will be based on 95 percent of the average wholesale price (AWP) / 0.3 mg. And pricing for therapy rendered in 2005 will be based on the average sales price (ASP) plus 6 percent or $1,054.70 / 0.3 mg for participating providers and $1001.97 / 0.3 mg for nonparticipating providers.

Medicare coverage of Macugen (Pegaptanib sodium injection) for the treatment of neovascular (wet) AMD is effective for therapy rendered on or after December 17, 2004.

FLORIDA MEDICARE PART B MAIL DIRECTORY

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

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

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

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

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

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

DURABLE MEDICAL EQUIPMENT (DME)

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

ELECTRONIC MEDIA CLAIMS (EMC)

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

MEDICARE PART B ADDITIONAL DEVELOPMENT

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

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

MISCELLANEOUS

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

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

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

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

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

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

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

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

FLORIDA MEDICARE PHONE NUMBERS

BENEFICIARY

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

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

PROVIDERS

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

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

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

OCR

Printer Specifications/Test Claims:
1-904-791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
1-803-735-1034

MEDICARE PART A

Toll-Free:
1-877-602-8816

WEB SITES

PROVIDER

Florida
http://www.floridamedicare.com

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

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

EDUCATIONAL RESOURCES

Join our FCSO *eNews* Electronic Mailing List and Receive Weekly Notices of Updates to the Provider Education Website

First Time Subscribers

We encourage you to register for our *eNews* mailing lists to receive urgent, critical, and new information affecting the Medicare program.

By signing up, you will receive regular messages providing you with updates to the provider website and key program alerts, critical program changes, seminar schedules, publications, and educational tips. Sign up today by clicking on the link below then 'FCSO eNews Lists/Interest Groups' link and select the desired interest group from the list.

http://www.floridamedicare.com/provider/content/special/mailing_list.htm

or

http://www.connecticutmedicare.com/provider/html/mainPage.asp

If you have previously signed up and are not receiving regular *eNews* notices, please sign up again. If you do not receive a confirmation email and/or start to receive weekly notices the following information may assist you resolving your issues.

Previously Signed Up but Not Receiving Regular Notices—Solutions

Organizations:

Because some organizations have enhanced their firewalls or security settings, we may not be able to successfully deliver our *eNews* notices to individuals within those organizations. Please check with your organization's IT staff to determine how they can identify our organization as an approved sender to your individual e-mail address. We recommend requesting them to ensure that mail from the '**ib.bcentral.com**' domain be permitted.

The same recommendation applies to some e-mail providers.

Email Providers (Internet Service Providers [ISPs])

E-mail providers like AOL, Yahoo!, Hotmail, and others are constantly changing their methods to classify e-mail. Our system delivers e-mail to all accounts the same way, and the vast majority get it in their main inbox. Some e-mail providers filter messages based on the 'From' address and may put your e-mail into the recipient's bulk or spam mail folder. We recommend that you add '**ib.bcentral.com**' domain to your 'Approved Sender' list. If your e-mail service provider does not offer such 'Approved Sender' lists, please request from them to allow notices from '**ib.bcentral.com**' domain to be delivered.

Still Experiencing Problems

If you are still experiencing problems not receiving FCSO *eNews* notices, we ask that you please send an email to us at providerwebsite@fcso.com indicating the actions you've taken and the issues you continue to experience. We will contact you to assist with resolving them.

Please pass this information along to other interested parties.

FCSO *eNews* Notices— Connecticut

We encourage you to register for our *eNews* mailing lists to receive urgent, critical, and new information. By signing up, you will receive regular messages providing you with updates to the provider website (*www:connecticutmedicare*) and key program alerts, critical program changes, seminar schedules, publications, and educational tips. Sign up today by clicking on the "FCSO eNews Lists/Interest Groups" link below and select the desired interest group from the list.

http://www.connecticutmedicare.com/provider/content/provider/partb/ct_mailing.list.htm

If you have signed up for this service in the past but have not received **regular** eNews notices, we ask that you please send an e-mail to us at *providerwebsite.com* indicating the interest groups for which you have registered. We're asking this to ensure your e-mail address is not one for which we are unable to deliver messages.

Because some organizations have enhanced their firewalls or security settings, we are not able to successfully transmit our eNews notices to individuals within those organizations. You may also wish to check with your organization's IT staff to determine how they can identify our organization as an allowable sender to your individual e-mail address.

The following is the list of interest groups currently available:

- ❑ CT: Part B (General)
- ❑ CT: Ambulance
- ❑ CT: Part B Anesthesia
- ❑ CT: ASC (Ambulatory Surgical Center)
- ❑ CT: Part B Cardiology
- ❑ CT: Part B Chiropractic
- ❑ CT: Part B LMRP/LCD
- ❑ CT: EDI (Technical)
- ❑ CT: PC-ACE Pro32

FCSO *eNews* Notices— Florida

We encourage you to register for our *eNews* mailing lists to receive urgent, critical, and new information. By signing up, you will receive regular messages providing you with updates to the provider website (*www.floridamedicare.com*) and key program alerts, critical program changes, seminar schedules, publications, and educational tips. Sign up today by clicking on the "FCSO eNews Lists/Interest Groups" link below and select the desired interest group from the list.

http://www.floridamedicare.com/provider/content/special/mailing_list.htm

If you have signed up for this service in the past but have not received **regular** eNews notices, we ask that you please send an e-mail to us at *providerwebsite.com* indicating the interest groups for which you have registered. We're asking this to ensure your e-mail address is not one for which we are unable to deliver messages.

Because some organizations have enhanced their firewalls or security settings, we are not able to successfully transmit our eNews notices to individuals within those organizations. You may also wish to check with your organization's IT staff to determine how they can identify our organization as an allowable sender to your individual e-mail address.

The following is the list of interest groups currently available for Medicare Part B:

- ❑ FL: Part A (General)
- ❑ FL: Part A ESRD
- ❑ FL: Part A LMRP/LCD
- ❑ FL: Part A SNF
- ❑ FL: Part A CAH
- ❑ FL: Part B (General)
- ❑ FL: Part B Anesthesia
- ❑ FL: Part B Cardiology
- ❑ FL: Part B Chiropractic
- ❑ FL: Part B LMRP/LCD
- ❑ FL: Part B Vision
- ❑ FL: Ambulance
- ❑ FL: ASC
- ❑ FL: EDI (Technical)

EDUCATIONAL RESOURCES

First Coast Service Options

Presents….

Medifest 2005

The Medifest Symposium gives you an opportunity to attend various Medicare educational courses designed specifically for providers, billing/office managers and staff. You may select the courses that best meet the needs of your practice/office. New for 2005, we have added Medicare Specialty Seminars on day three (day two for Panama City). You have the following three options:

- Only attend our traditional Medifest sessions
- Attend our traditional Medifest session and a 3-hour Specialty Seminar
- Only attend a 3-hour Specialty Seminar

June 28-30, 2005
Omni Jacksonville Hotel
245 Water Street, Jacksonville, Florida 32202
Phone: (904) 355-6664

August 2-4, 2005
The Naples Beach Hotel
851 Gulf Shore Blvd North, Naples, Florida 34102
Phone: (239) 261-2222

November 1-3, 2005
Orlando Airport Marriott
7499 Augusta National Drive, Orlando, Florida 32822
Phone: (407) 851-9000

Medicare Specialty Seminars Coming to a City Near You

June 30, 2005, (8:00 am to 11:00 am)

Omni Jacksonville Hotel, 245 Water Street, Jacksonville, FL 32202

- End Stage Renal Disease (ESRD) (A)
- Psychiatric Services (B)
- Ambulatory Surgical Centers (B)
- Pathology/Clinical Lab (B)
- Skilled Nursing Facility, Minimum Data Set Coding and Billing Efficiency (A)
- Evaluation and Management Documentation (B)

August 4, 2005, (8:00 am to 11:00 am)

Naples Beach Hotel, 851 Gulf Shore Blvd North, Naples, FL 34102

- Podiatry (B)
- Urology (B)
- Rehabilitation Services (A/B)
- Chiropractic Services (B)
- Evaluation and Management Documentation (B)
- Skilled Nursing Facilities (SNF) (A)

November 3, 2005 (8:00 am to 11:00 am)

Orlando Airport Marriott, 7499 Augusta National Drive, Orlando, FL 32822

- Oncology (B)
- Ophthalmology Services (B)
- Interventional Radiology (B)
- Cardiology (B)
- Skilled Nursing Facility, Minimum Data Set Coding and Billing Efficiency (A)
- End Stage Renal Disease (ESRD) (A)

EDUCATIONAL RESOURCES

MEDIFEST 2005, Jacksonville Registration Form

$137.00

June 28-29, 2005
Omni Jacksonville Hotel
245 Water Street
Jacksonville, Florida 32202
Please contact hotel for directions and/or reservations (904) 355-6664

Day 1

General Session 8:00 am to 8:30 am

Select one class per session (time slot).

9:00 AM - 10:30 AM SESSION 1

- ICD-9-CM for Beginners **(A/B)**
- CMS-1500 Claim Filing **(B)**
- Evaluation and Management (E/M) Coding **(B)**
- Navigating FCSO's Website **(A/B)**
- UB-92 Claims Filing **(A)**
- Fraud and Abuse **(A/B)**

11:00 AM – 12:30 PM SESSION 2

- MMA Prescription Drug Benefit **(A/B)**
- CPT Coding for Beginners **(A/B)**
- eLearning **(A/B)**
- Evaluation and Management (E/M) Documentation **(B)**
- HOPPS: Legislative Update **(A)**
- Global Surgery Guidelines **(B)**

2:00 PM – 3:30 PM SESSION 3

- Reimbursement Efficiency **(B)**
- Provider Enrollment **(A/B)**
- ANSI 101 (HIPAA) (A/B)
- Medicare Secondary Payer (MSP) **(B)**
- Reason Code Resolution **(A)**
- ARNP/PA **(B)**

4:00PM – 5:30 PM SESSION 4

- Primary Care **(B)**
- Appeals **(A)**
- Inquiries, Appeals and Overpayments **(B)**
- Medical Review/Data Analysis **(A/B)**
- Direct Data Entry **(A)**
- ANSI 102 (HIPAA) **(A/B)**

Day 2

Select one class per session (time slot).

8:00 AM - 9:30 AM SESSION 1

- ICD-9-CM for Beginners **(A/B)**
- ANSI 101 (HIPAA) **(A/B)**
- Evaluation and Management (E/M) Coding **(B)**
- Modifiers **(A)**
- MMA Prescription Drug Benefit **(A/B)**
- Fraud and Abuse **(A/B)**

10:00 AM – 11:30 AM SESSION 2

- Navigating FCSO's Website **(A/B)**
- ANSI 102 (HIPAA) **(A/B)**
- Reimbursement Efficiency **(B)**
- Medicare Secondary Payer (MSP) **(B)**
- ARNP/PA **(B)**
- Reimbursement Efficiency **(A)**

1:00 PM – 2:30 PM SESSION 3

- CPT Coding for Beginners **(A/B)**
- Evaluation and Management (E/M) Documentation **(B)**
- Global Surgery Guidelines **(B)**
- Medical Review/Data Analysis **(A/B)**
- Medicare Secondary Payer (MSP) **(A)**

3:00PM – 4:30 PM SESSION 4

- Inquiries, Appeals and Overpayments **(B)**
- CMS-1500 Claims Filing **(B)**
- Primary Care **(B)**
- Appeals **(A)**
- eLearning **(A/B)**

Day 3

Medifest Specialty Seminars
June 30, 2005
Cost $38.00

8:00 AM - 11:00 AM

- Ambulatory Surgery **(B)**
- Psychiatric Services **(B)**
- Pathology and Clinical Lab **(B)**
- End Stage Renal Disease (ESRD) **(A)**
- Evaluation and Management (E/M) Documentation Requirements **(B)**
- Skilled Nursing Facilities SNF **(A/B)**

Name_____ Telephone (____) _____

MEDIFEST 2005, Jacksonville Registration Form

Omni Jacksonville Hotel
245 Water Street
Jacksonville, Florida 32202
Please contact hotel for directions and/or reservations (904) 355-6664

Registrant's Name _____

Telephone Number _____

Email Address _____

Fax Number _____

Provider's Name _____

Street Address _____

FAXED REGISTRATION	CONFIRMATION NOTICE
1. Fax registration form to **(904) 791-6035.** 2. A confirmation and invoice will be faxed to you. 3. Make checks payable to: **FCSO Account #700390** 4. Mail the forms (after you have faxed them) and payment to: **Medifest Registration** **P.O. Box 45157** **Jacksonville, FL 32231** 5. Bring your Medifest confirmation notice to the event.	**Faxed registration**: A confirmation notice will be faxed or e-mailed to you within 14 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Training), please contact us at **(904) 791-8103.** **On-line registration:** When registering on-line for an education event, you will automatically receive your confirmation via e-mail notification.

First Coast Service Options, Inc. Presents

MEDICARE AMBULANCE TRAINING

DATE	LOCATION
JULY 20, 2005	EMBASSY SUITES HOTEL 225 EAST ALTAMONT DR. ALTAMONT SPRINGS FL 32701
SEPTEMBER 21, 2005	JACKSONVILLE FLORIDA (ADDRESS TO BE ANNOUNCED)

SESSION 1
9:30 AM TO 12:00 PM
AMBULANCE COVERAGE GUIDELINES, MEDICAL NECESSITY, AND THE USE OF THE GY MODIFIER

This course will include a review of the basic Medicare guidelines for ambulance services. Our Medical Policy Department will review Medicare guidelines for determining medical necessity, clarify the correct use of the GY modifier, and explain the medical review process

SESSION 2
1:30 PM TO 3:30 PM
MEDICARE BILLING AND REIMBURSEMENT

In this course we will review Medicare billing guidelines, including the correct use of modifiers. We will walk step by step through the process of calculating Medicare reimbursements and explain recent changes to the fee schedule. .

Both sessions are free, you may sign up for one or both sessions
You may register by faxing this completed form to (904) 791-6035
Or by completing our on-line registration at www.floridamedicare.com

Name _____

Street Address _____

City, State, ZIP Code _____

Telephone Number _____ Provider number _____

Email Address _____ or Fax Number _____

Date you wish to attend _____

❑ Session 1
❑ Session 2

ORDER FORM — 2005 PART B MATERIALS

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to BCBSFL – FCSO with the account number listed by each item.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

QUANTITY	ITEM	ACCOUNT NUMBER	COST PER ITEM
❒	***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Hardcopy or CD-ROM distribution is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet these criteria must register to receive the *Update!* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be utilized. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published during calendar year 2005(back issues will be sent upon receipt of order).	700395	$70.00 (Hardcopy) $30.00 (CD-ROM)
❒	**2005 Fee Schedule –** The revised Medicare Part B Physician and Non-Physician Practitioner Fee Schedule, effective for services rendered January 1, 2005, through December 31, 2005, is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Providers who do not have Internet access may purchase a hardcopy or CD-ROM. The Fee Schedule contains calendar year 2005 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	Hardcopy: $5.00 (CT) $10.00 (FL) CD-ROM: $6.00 (Specify CT or FL)

Please write legibly

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Please make check/money order payable to: BCBSFL – FCSO Account # (fill in from above)
(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
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FIRST COAST SERVICE OPTIONS, INC. P.O. BOX 2078 JACKSONVILLE, FL 32231-0048
P.O. BOX 9000 MERIDEN, CT 06454-9000

* ATTENTION BILLING MANAGER *