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

Highlights In This Issue…

Features

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

- ❑ Physician/Provider
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_____

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

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

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

A Physician's Focus

An Ongoing Focus of Medicare—Improving Quality of Health Care

A principal focus of the Medicare program is to ensure that Medicare beneficiaries have access to high quality health care. Unfortunately, health care quality varies for Medicare beneficiaries, and there are many reasons for this. Care is improving in some areas, but there remain significant gaps between what is known to be good care and the care that is delivered. These gaps signal a need for improvement in the quality of health care being delivered. Fortunately, quality can be measured, and more and more CMS is using these quality measures to improve the quality of health in doctors' offices, nursing homes, hospitals, and other areas of the health care delivery system.

During the past year, the Centers for Medicare & Medicaid Services (CMS) has issued a number of press releases on quality of care initiatives that is in keeping with their commitment to assure quality health care for all Medicare beneficiaries. These initiatives include:

- Home Health Quality Initiative
- Hospital Quality Initiative
- Nursing Home Quality Initiative
- Physician Focused Quality Initiative.

CMS made some more recent announcements including efforts to make it easier for consumers to assess hospital quality, making payment increases and policy changes to improve quality and access for acute care hospitals, improving safety and quality in long-term care facilities, improving care and quality of life for hemodialysis patients via the "fistula first" initiative, and boosting quality through new plans for quality improvement organizations. There are over fifty quality improvement organizations throughout the country that work with consumers, physicians, hospitals and other providers of care to refine our health care delivery systems to make sure patients get the right care at the right time. These quality efforts are paving the way for a transformation in health care where quality matters, where it can and will be measured and improved, and most important where quality will be rewarded.

It is becoming increasingly clear that a focus will be to improve quality in the Medicare program through a system that links payment to quality. The Medicare Modernization Act of 2003 (MMA) provides a financial incentive for hospitals to report quality of care data by linking quality to the payments hospitals receive for treating Medicare beneficiaries. Under the MMA, hospitals that submit quality information to CMS will be eligible to receive the full Medicare payment for services in 2005, those who do not report will receive a 0.4 percentage point reduction in their annual Medicare update rate. These payment incentives aid in quality reporting and in facilitating gathering quality information to provide improvements in care. The time has come where Medicare has taken the step towards quality improvement, and has put financial incentives for quality directly into its payment system. Linking payment to quality holds all providers of health care accountable for the care they deliver, and will help improve the quality of care that so many Americans, especially Medicare beneficiaries, want and deserve.

CMS, through its numerous quality initiatives, is serving as a catalyst for improving the quality of care delivered in our health care systems. The time has come for all to join in and play a role in improving health care quality. Quality matters.

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THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

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

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

Who Receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education Web site(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM (please see the hardcopy/CD-ROM registration form on page 6 of the Second Quarter 2004 *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) 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 Web site at *http://cms.hhs.gov/manuals/pm_trans/AB02114.pdf* and *http://cms.hhs.gov/manuals/pm_trans/AB02168.pdf*.

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

ABN Modifiers

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

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

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

Modifier "GA" and Appeals

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

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

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

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

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

CLAIMS

2005 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction is a reminder that the complete HCPCS file is updated and released annually by the Centers for Medicare & Medicaid Services (CMS) to the Medicare contractors. The 2005 version of the HCPCS file contains existing, new, revised, and discontinued HCPCS codes for 2005. Your Medicare contractor will use the file for processing claims for services on or after January 1, 2005.

All Medicare physicians, providers, and suppliers: there is no longer a 90-day grace period for billing discontinued HCPCS codes as of January 1, 2005.

Background

Medicare providers submitting claims to Medicare contractors for Part B services use a HCPCS code to indicate the service that was provided. HCPCS consist of Level I codes, which are the American Medical Association's (AMA's) Current Physician Terminology Codes (CPT-4) and Level II codes, which are alphanumeric and maintained by CMS.

The alpha-numeric index and the table of drugs will be posted to the CMS website by the end of October.

The CMS website address for that posting will be: *http://www.cms.hhs.gov/providers/pufdownload/default.asp#alphanu*

There is no longer a 90-day grace period for discontinued codes in order to be compliant with HIPAA standards. To view further information regarding the elimination of this 90-day grace period, see the *Medlearn Matters* article MM3093, which may be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3093.pdf*

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier and fiscal 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 CR3422 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) #: 3422
Medlearn Matters Number: MM3422
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 283
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

STOP – Impact to You

Medicare will soon issue the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2004.

CAUTION – What You Need to Know

Remember that, as of October 1, 2004, Medicare no longer can provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes.

GO – What You Need to Do

Be ready to use the updated codes on October 1, 2004. Refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

Background

This instruction is a reminder that Medicare carriers and intermediaries will use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:

- Dates of service on or after October 1, 2004; and
- Discharges on or after October 1, 2004 for institutional providers.

The Centers for Medicare & Medicaid Services (CMS) has been evolving the use of ICD-9-CM codes as follows:

- Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on Form CMS- 1450.
- On April 1, 1989, the use of ICD-9-CM codes became

mandatory for all physician services submitted on Form CMS-1500.

- Effective October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59) (see Change Request [CR] 2725, dated June 6, 2003, at *http://www.cms.hhs.gov/manuals/pm_trans/B03045.pdf*).
- Effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR 3094 dated February 6, 2004 at: *http://www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf*).

Updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the proposed changes to the Hospital Inpatient Prospective Payment System and are effective each October first. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004.

After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following website: *http://www.cms.hhs.gov/medlearn/icd9code.asp*

The update should be available at this site in June.

Implementation

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

Related Instructions

The Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service) has been revised. The updated manual instructions are included in the official instruction issued to your carrier, and it can be found by going to*:* *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that website, look for CR3303 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*.

Additional Information

The new, revised, and discontinued ICD-9-CM diagnosis codes are posted annually on the following CMS website: *http://www.cms.hhs.gov/medlearn/icd9code.asp*

Providers can view the new updated codes at this website in June and providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

In addition, the National Center for Health Statistics (NCHS) also will place the new ICD-9-CM Addendum on their website (*http://www.cdc.gov/nchs/icd9.htm*) in June, which is also available for providers to visit.

Related Change Request (CR) #: 3303
Medlearn Matters Number: MM3303
Related CR Release Date: June 18, 2004
Related CR Transmittal #: 210
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

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 Florida, as of July 14, 2004.

Florida – 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 (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.

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/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

Florida – Mental Health
Source: CMS Joint Signature Memorandum (JSM) #421, September 10, 2004

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

"Incident to" Services

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

Provider Types Affected

All Medicare providers of professional services

Provider Action Needed

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

Background

The intent of this article is to clarify "incident to" services billed by physicians and nonphysician practitioners to carriers. "Incident to" services are defined as those services that are furnished incident to physician professional services in the physician's office (whether the office is located in a separate building or is an office within an institution) or in a patient's home. These services are billed as Part B services to your carrier as if you personally provided them, and are paid under the physician fee schedule.

Note: "Incident to" services are also relevant to services supervised by certain nonphysician practitioners such as physician's assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. These services are subject to the same requirements as physician-supervised services. The service is priced at the rate paid to the supervisor, who is the person responsible for the appropriate rendering of the service. Remember that "incident services" supervised by nonphysician practitioners are reimbursed at the rate paid the supervisor and not at the physician fee schedule rate. For clarity's sake, this article will refer to "physician" services as inclusive of nonphysician practitioners.

To qualify as "incident to," services must be part of your patient's normal course of treatment, during which a physician **personally performed an initial service** and remains **actively involved** in the course of treatment. You do not have to be physically present in the patient's treatment room while these services are provided, but you must provide **direct supervision**, that is, you must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for "incident to" service.

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

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

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

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

Your Office

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

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

Hospital or SNF

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

Offices in Institutions

In institutions including SNF, your office must be confined to a separately identifiable part of the facility and cannot be construed to extend throughout the entire facility. Your staff may provide service "incident to" your service in the office to outpatients, to patients who are not in a Medicare-covered stay or in a Medicare-certified part of a SNF. If your employee (or contractor) provides services outside of your "office" area, these services would not qualify as "incident to" unless you are physically present where the service is being provided. One exception is that

certain chemotherapy "incident to" services are excluded from the bundled SNF payments and may be separately billable to the carrier.

In Patients' Homes

In general, you must be present in the patient's home for the service to qualify as an "incident to" service. There are some exceptions to this direct supervision requirement that apply to homebound patients in medically underserved areas where there are no available home health services only for certain limited services found in Pub 100-02. Chapter 15 Section 60.4 (B). In this instance, you need not be physically present in the home when the service is performed, although general supervision of the service is required. You must order the services, maintain contact with the nurse or other employee, and retain professional responsibility for the service. All other "incident to" requirements must be met. A second exception applies when the service at home is an individual or intermittent service performed by personnel meeting pertinent state requirements (e.g., nurse, technician, or physician extender), and is an integral part of the physician's services to the patient.

Ambulance Service

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

Additional Information

To provide additional clarity, we present the following scenarios:

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

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

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

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

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

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

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

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

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

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

MMA - Physician Education for the Revisions to the Health Professional Shortage Area (HPSA) Bonus Payment Processes and Implementation of the Physician Scarcity Area (PSA) Bonus Payments

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

SPECIAL NOTE: The language in this Medlearn Matters article reflects proposed billing and claims processing guidance consistent with the Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) bonus requirements discussed in the Notice of Proposed Rulemaking (NPRM) for the 2005 Physician Fee Schedule which was published on August 5, 2004. This language reflects our current implementation efforts and is subject to change consistent with publication of the final rule. Additional information will be posted when the final rule is published. Also, please note that this article was re-released on September 20, 2004 to reflect additional instructions for physician use of modifiers when billing anesthesia services (page 6) and to show that the list of zip codes eligible for automatic payment of the PSA bonus will be posted on the CMS website on or about October 1, 2004.

Provider Types Affected

Physicians who provide services in designated HPSAs or in PSAs.

Provider Action Needed

STOP – Impact to You

Medicare is revising the processes for paying HPSA bonuses and will be implementing the provision of the Medicare Modernization Act (MMA) that authorizes bonus payments for physician services in PSAs. This article conveys information based on the NPRM published on August 5, 2004.

CAUTION – What You Need to Know
These proposed policies apply to relevant services provided in HPSAs or PSAs on or after January 1, 2005.

GO – What You Need to Do
Affected physicians should make sure that their billing staffs are aware of the pending HPSA and PSA bonus payment policy changes and are prepared to bill Medicare in accordance with the final rule, when published, to receive the correct bonus payments for services rendered on or after January 1, 2005. Understanding the areas that qualify for the bonus payments, knowing when to use related modifiers, and knowing what information is available from your Medicare carrier are all essential to submitting correct claims. This article provides an overview of these requirements.

Background

PSA Overview

MMA Section 413(a) requires that a new five-percent bonus payment be established and paid for services rendered by physicians in geographic areas designated as PSAs. Under the NPRM, physician scarcity designations will be based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in every county. In addition, based on rural census tracts of metropolitan statistical areas identified through the latest modification of the Goldsmith Modification (i.e., the Rural-Urban Commuting Area Codes), additional PSAs will be identified based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in each identified rural area.

Medicare will automatically pay this new bonus on a quarterly basis without the need for a modifier on the claim for services provided in zip code areas that:

- Fall fully within a county designated as a PSA; or
- Fall partially within a county designated as a PSA and are considered to be dominant for that county, based on a determination of the United States Postal Service; or
- Fall within a rural area of a metropolitan statistical area identified through the latest modification of the Goldsmith modification that is determined to be a PSA.

In some cases, a service may be provided in a county that is considered to be a PSA, but the zip code is not considered to be dominant for that area. In these cases, the bonus payment cannot be made automatically. To receive the bonus for such services, physicians will need to include a new modifier of AR to reflect a physician service provided in a PSA.

Some key points to remember regarding the PSA bonus are the following:

- Medicare will pay a five percent PSA bonus on a quarterly basis, and the bonus will be based on what Medicare actually paid not on the Medicare-approved payment amount.
- A single service may be eligible for the PSA bonus and the HPSA bonus, which is discussed later.
- Payment will be based on where the service is performed and not on the address of the beneficiary.
- The PSA bonus will be paid on services rendered on or after January 1, 2005 through December 31, 2007.
- Only the provider designations of General Practice (01), Family Practice (08), Internal Medicine (11), and Obstetrics/Gynecology (16) will be paid the bonus for the zip codes designated as primary care PSAs. All other physician provider specialties will be eligible for the specialty physician scarcity bonus for the zip codes designated as specialty PSAs.
- Dentists, chiropractors, podiatrists, and optometrists are not eligible for the physician scarcity bonus as either primary care or specialty physicians.
- Services submitted with the AR modifier will be subject to validation by Medicare.
- On or about October 1, 2004, CMS will post the zip codes that will be eligible for automatic payment of the physician scarcity bonus on its Web site.

HPSA Overview

MMA Section 413(b) requires CMS to revise some of the policies that address HPSA bonus payments.

Section 1833(m) of the Social Security Act provides bonus payments for physicians who furnish medical care services in geographic areas that are designated by the HRSA as primary medical care HPSAs under section 332 (a)(1)(A) of the Public Health Service (PHS) Act.

In addition, for claims with dates of service on or after July 1, 2004, psychiatrists (provider specialty 26) furnishing services in mental health HPSAs are also eligible to receive bonus payments. But keep in mind that if a zip code falls within both a primary care and mental health HPSA, only one bonus will be paid on the service.

MMA Changes

Effective January 1, 2005, you no longer have to include the QB (physician providing a service in a rural HPSA) or QU (physician providing a service in an urban HPSA) modifier on claims to receive your HPSA bonus payment, which will be paid to you automatically, if you provide care in zip code areas that either:

- Fall entirely in a county designated as a full-county HPSA; or
- Fall entirely within the county, through a USPS determination of dominance; or
- Fall entirely within a partial county HPSA.

However, if you provide care in zip code areas that do not fall entirely within a full county HPSA or partial county HPSA, you must continue to enter either the QB or QU modifier on your claim to receive the bonus. The following are the specific instances in which you will need to enter a modifier:

- When you provide services in zip code areas that do not fall entirely within a designated full county HPSA bonus area;
- When you provide services in a zip code area that falls partially within a full county HPSA but is **not** considered to be in that county based on the USPS dominance decision;
- When you provide services in a zip code area that falls partially within a non-full county HPSA;
- When you provide services in a zip code area that was not included in the automated file of HPSA areas based on the date of the data run used to create the file.

To determine if you qualify to automatically receive the bonus payment, you can review the information provided on the CMS Web site. If the zip code of the location where you render services does not appear there, you should check your carrier's Web site for HPSA designations to determine if the location where you render services is within a HPSA bonus area, but still requires the submission of a modifier. More information on these Web aids will be provided in the *Additional Information* section of this article.

Some points to remember include the following:

- Medicare carriers will continue to base your bonus on the amount you are actually paid (not the Medicare approved payment amount for each service) and will pay you the ten-percent bonus on a quarterly basis.
- The HPSA bonus pertains only to physician's professional services. Should you bill for a service that has both a professional and technical component, only the professional component will receive the bonus payment.
- The key to eligibility is not that your beneficiary lives in an HPSA nor that your office or primary location is in an HPSA, but rather that you actually render the service in an HPSA.
- A single service may be eligible for both the HPSA bonus payments and the new physician scarcity bonus.
- To be considered for the bonus payment, you must include the name, address, and zip code of the location where the service was rendered on all electronic and paper claim submissions.
- Physicians must verify the eligibility of their area for a bonus with their carrier before submitting services with a HPSA modifier for areas they think may still require the submission of a modifier to receive the bonus payment.
- Services submitted with the QB or QU modifier will be subject to validation by Medicare.

Additional Information

CMS will make substantial revisions to Section 90 of Chapter 12 of the Medicare Claims Processing Manual. An official Change Request (CR) will be released at a later date. We will provide instructions later on how to access that CR, but key revisions/additions that are proposed, based on the NPRM are listed as follows:

HPSA Designations

Effective January 1, 2005, payment files for the automated payment of the HPSA bonus payment will be developed and updated annually. Once the annual designations are made, no interim changes will be made to the automated payment files to account for HRSA updates to designations throughout the year. New designations and withdrawals of HPSA designations during a calendar year will be included in the next annual update.

For newly designated HPSA areas (those added during the year), physicians will be able to receive the bonus by self-designating through the use of the QB or QU modifier. They will also need to submit the modifier for any designated areas not included in the automated file due to the cut off date of the data used. This will only be necessary if the zip code of where they provide their service is not already on the list of zip codes that will automatically receive the bonus payment. Physicians must not continue to self-designate through the use of the modifiers for HPSA designations that are withdrawn during the year, but are not part of the automated files.

Prior to the beginning of each calendar year beginning with 2005, CMS will post on its Web site zip codes that are eligible to automatically receive the bonus payment as well as information on how to determine when the modifier is needed to receive the bonus payment. Through regularly scheduled bulletins and listservs, carriers must notify all physicians to verify their zip code eligibility via the CMS Web site for the area where they provide physician services.

To determine whether a modifier is needed, physicians must review the information provided on the CMS website for HPSA designations to determine if the location where they render services is, indeed, within a HPSA bonus area. Physicians may also base the determinations on letters of designations received from HRSA. They must be prepared to provide these letters as documentation upon the request of the carrier and should verify the eligibility of their area for a bonus with their carrier before submitting services with a HPSA modifier.

Census Tract Information Available for Areas That Are Not Automatically Paid

For services rendered in zip code areas that cannot automatically receive the bonus, it will be necessary to know the census tract of the area to determine if a bonus should be paid and a modifier submitted. Census tract information may be found on the Federal Financial Institutions Examination Council's website at: *http://www.ffiec.gov/geocode/default.htm*

Census tract data can also be retrieved by visiting the U.S. Census Bureau website at *http://www.census.gov*

Once the website is accessed follow the following steps:

1. Click on American Fact Finder from the list on the left side of the screen.
2. In the Search box on the left side of the screen, mark "geography" and enter "1990 census" and click GO.
3. Click on "Show more selection methods and more geographic types."
4. Click on the MAP tab.

5. Under "Select a year and program" select "1990 Decennial Census."
6. Under "Select an option, then click on the map," click on the "Select" button and from the drop down menu, select "Census Tract." DO NOT CLICK ON THE MAP.
7. Scroll down the page to: "To reposition the map" and enter the address for which you want to determine the census tract.
8. The map will show the street and the census tract number will be in dark gold.

Once the census tract is identified, the CMS website must be accessed to determine if the census tract where the service was rendered is in an eligible HPSA. Neither CMS nor the Medicare carriers can provide information on the functionality of these websites.

Services Eligible for HPSA and Physician Scarcity Bonus Payments
Information in the Professional Component/Technical Component (PC/TC) Indicator Field of the Medicare Physician Fee Schedule Database

Carriers use the information in the Professional Component/Technical Component (PC/TC) indicator field of the Medicare Physician Fee Schedule Database to identify professional services eligible for HPSA and physician scarcity bonus payments. The following are the rules to apply in determining whether to pay the bonus on services furnished within a geographic HPSA or physician scarcity bonus area.

PC/TC Indicator	Bonus Payment Policy
0	Pay bonus
1	Globally billed. Only the professional component of this service qualifies for the bonus payment. The bonus cannot be paid on the technical component of globally billed services. ACTION: Carriers return the service as unprocessable and notify the physician that the professional component must be re-billed if it is performed within a qualifying bonus area. If the technical component is the only component of the service that was performed in the bonus area, there wouldn't be a qualifying service.
1	Professional Component (modifier 26). Carriers pay the bonus.
1	Technical Component (modifier TC). Carriers do not pay the bonus.
2	Professional Component only. Carriers pay the bonus.
3	Technical Component only. Carriers do not pay the bonus.
4	Global test only. Only the professional component of this service qualifies for the bonus payment. ACTION: Carriers return the service as unprocessable. They instruct the provider to re-bill the service as separate professional and technical component procedure codes.
5	Incident to codes. Carriers do not pay the bonus.
6	Laboratory physician interpretation codes. Carriers pay the bonus.
7	Physical therapy service. Carriers do not pay the bonus.
8	Physician interpretation codes. Carriers pay the bonus.
9	Concept of PC/TC does not apply. Carriers do not pay the bonus.

NOTE: Codes that have a status of "X" on the Medicare Physician Fee Schedule Database (MFSDB) have been assigned PC/TC indicator 9 and are not considered physician services for MFSDB payment purposes. Therefore, neither the HPSA bonus payment nor the PSA bonus payment will be paid for these codes.

Anesthesia Codes (CPT Codes 00100 Through 01999) That Do Not Appear on the Medicare Fee Schedule Data Base (MFSDB)

Anesthesia codes (CPT codes 00100 through 01999) do not appear on the MFSDB. When a medically necessary anesthesia service is furnished within a HPSA or physician scarcity area by a physician, a HPSA bonus and/or PSA bonus is payable.

To claim a bonus payment for anesthesia, physicians bill codes 00100 through 01999 with modifiers QY, QK, AD, AA, or GC to signify that the anesthesia service was performed by a physician along with the QB or QU modifier.

Billing and Payment in a Physician Scarcity Area (PSA)

Section 413a of the MMA requires that a new 5% bonus payment be established for physicians in designated PSAs. Physician scarcity designations will be based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in every county. In addition, based on rural census tracts of metropolitan statistical areas identified through the latest modification of the Goldsmith Modification (i.e., Rural-Urban Commuting Area Codes), additional PSAs will be identified based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in each identified rural area.

Claims Coding Requirements for the Physician Scarcity Bonus

Medicare will automatically pay the physician scarcity bonus on a quarterly basis for services provided in zip code areas that fully fall within a county designated as a PSA, partially fall within a county designated as a PSA and are considered to be dominant for that county based on a determination by the United States Postal Service (USPS), or fall within a rural area identified through the latest modification of the Goldsmith Modification that is determined to be a PSA.

In some cases, a service may be provided in a county that is considered to be a PSA, but the zip code is not considered to be dominant for that area. The bonus payment cannot automatically be made. In order to receive the bonus for those areas, physicians must include the following modifier on the claim: AR - Physician providing service in a Physician Scarcity Area.

National Standard Format (NSF) Claims

For NSF electronic claims (for all places of service other than "home," or other than the place of service (POS) codes that are treated as "home"), in order to be considered for the HPSA and/or PSA bonus, physicians must enter the address and zip code of where the service was provided in the EA1-10.0 record. Physicians should check with their carrier to determine which POS codes their carrier treats as "home."

Administrative and Judicial Review

Per section 413(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, there will be no administrative or judicial review respecting:

- The identification of a county or area;
- The assignment of a specialty of any physician;
- The assignment of a physician to a county; or
- The assignment of a postal zip code to a county or other area.

Web Aids

As mentioned earlier, CMS and the carriers will have web aids to assist physicians with these changes. The CMS web page will be found at: *http://www.cms.hhs.gov/providers/bonuspayment*

It will be operational on or about October 1, 2004. This page will provide lists of zip codes automatically eligible to receive the HPSA payment. One list will be for geographic primary medical care HPSAs and one list will be for mental health HPSAs. Neither the QB nor QU modifier will need to be included on the claim to receive the bonus for services rendered in those zip codes. To determine if a zip code that is not on this list is still eligible for a bonus, you must check your carrier's web page. Links to those web pages will be provided. You will then need to submit one of the modifiers with those services in order to receive the bonus.

The CMS web page will also have lists of zip codes automatically eligible to receive the PSA bonus. One list will be for primary care physicians and one list will be for specialty care physicians. If a zip code of the location where you are providing services does not appear on the appropriate list, you must then check the PSA county list. If you provide services in one of the designated counties, but your zip code is not on the list, you will need to submit the AR modifier with the claim to receive the bonus.

Each carrier will:

1. Post a web page on their site dedicated to HPSA designations (which will be operational on or about October 1, 2004);
2. Include on that web page a listing of all designated HPSA areas, including on a quarterly basis those that are newly-designated or withdrawn during the year;
3. Include a link to the CMS HPSA/PSA web site.

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

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0449
Related CR Release Date: N/A
Effective Date: January 1, 2005 (Proposed)

Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 10.3, Effective October 1, 2004

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

Provider Types Affected

Physicians

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 October 1, 2004.

Physicians may view the current CCI edits and the current mutually exclusive code (MEC) edits on the Centers for Medicare & Medicaid website at: *http://www.cms.hhs.gov/physicians/cciedits*

The website will be updated with the Version 10.3 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 10.3, is effective on October 1, 2004.

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/04_claims/clm104index.asp*

Related Change Request (CR) #: 3349
Medlearn Matters Number: MM3349
Related CR Release Date: July 23, 2004
Related CR Transmittal #: 242
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 11.0, Effective January 1, 2005

Provider Types Affected

Physicians

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 January 1, 2005. Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits on the Centers for Medicare & Medicaid (CMS) web site at: *http://www.cms.hhs.gov/physicians/cciedits*

The web site will be updated with the Version 11.0 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 11.0, is effective on ary 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) #: 3491
Medlearn Matters Number: MM3491
Related CR Release Date: October 22, 2004
Related CR Transmittal #: 324
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Signature Requirements

Medicare requires a legible identity for services provided/ordered. The method used (e.g., hand written, electronic, or signature stamp) to sign an order or other medical record documentation for medical review purposes in determining coverage is not a relevant factor. Rather, an indication of a signature in some form needs to be present.

Providers using alternative signature methods (e.g., a signature stamp) should recognize that there is a potential for misuse or abuse with a signature stamp or other alternate signature methods. For example, a rubber stamped signature is much less secure than other modes of signature identification. The individual whose name is on the alternate signature method bears the responsibility for the authenticity of the information being attested to. Physicians should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.

All state licensure and state practice regulations continue to apply. Where state law is more restrictive than Medicare, the contractor applies the state law standard. The signature requirements described here do not assure compliance with Medicare conditions of participation.

This instruction does not supersede the prohibition for certificates of medical necessity (CMN). CMN is a term specifically describing particular form for prescribing durable medical equipment. As stated on CMN forms, "Signature and date stamps are not acceptable" for use on CMNs. No other forms or documents are subject to this exclusion.

Source: CMS Pub. 100-8 Transmittal: 59 Date: November 28, 2003 Change Request 2937

Type of Service Changes

Effective for claims processed on or after October 1, 2004, the type of service (TOS) for some procedure codes have changed and will now require a UPIN. With this change, there are also some codes that will no longer require a UPIN. The following identifies the procedures codes and their respective UPIN requirement.

Procedure Code	Old TOS	New TOS	UPIN Required 10/1/04
0040T	5	4	Yes
Q3031	9	5	Yes
38242	5	1	No
91122	1	5	Yes

CMS Pub. 100-04 Transmittal: 153
Date: April 30, 2004 Change Request 3189

Temporary Change in Carrier Jurisdictional Pricing Rules for Purchased Diagnostic Services

Provider Types Affected

Laboratories, physicians, 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).

Until further notice, physicians/suppliers must bill their local carrier for all purchased diagnostic tests andinterpretations, regardless of the location where the service was 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 because of 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 instruction addresses these reported problems by temporarily changing the carrier jurisdictional pricing rules that apply when billing for an out-of-jurisdiction area purchased diagnostic services. **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);
  - 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, Medicare, or other Federal health programs. The OIG exclusions database is available to the public on the OIG web site at the following address:** *http://www.oig.hhs.gov/fraud/exclusions.html*

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, the physician/supplier must report the address of its own facility in the service facility location area of the claim. (For these services only, the place of service is deemed to be the billing physician/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.)
Physicians/suppliers billing for a test or interpretation purchased outside of the carrier's jurisdiction, and using:

- CMS-1500 claim form submissions
  - Must enter the address of their facility in block 32 of the CMS-1500 claim form
- Electronic claims submissions
  - Must enter the address of their facility in the Billing Provider loop 2010AA of the ANSI X12 837 electronic claim format, version 4010/4010A.

(See the Medicare Claims Processing Manual (Pub. 100-04), Chapter 1, Section10.1.1.1 for further guidance concerning the submission of electronic claims.)

Note that for out-of-jurisdiction purchased diagnostic services only, Medicare carriers will use the zip code of the billing entity's location to determine both the carrier jurisdiction over the claim and the correct payment locality for the amount payable under the MPFS.

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 may no longer use provider identification numbers (PINs) issued in out-of-jurisdiction carrier sites to bill for these services.
- For purchased diagnostic services performed outside of the carrier's jurisdiction, they will not be penalized by the OIG 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 laboratories, 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 that 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.

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/transmittals/comm_date_dsc.asp*

From that Web page, look for CR 3464 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3464
Medlearn Matters Number: MM3464
Related CR Release Date: October 22, 2004
Related CR Transmittal #: 315
Effective Date: November 22, 2004
Implementation Date: November 22, 2004

COVERAGE/REIMBURSEMENT

MEDICARE PHYSICIAN FEE SCHEDULE

2004 Fee Schedule for Clinical Psychologist and Clinical Social Worker Services – Procedure 90818

The 2004 fee schedule for clinical psychologist and clinical social worker services was published in the Third Quarter 2004 *Medicare B Update*! (page 21). Procedure code 90818 was not listed on the Florida fee schedule listing. Therefore, the following outlines the allowances for procedure 90818 when billed by a clinical psychologist or clinical social worker.

Clinical Psychologists Allowance

LOC 01/02	LOC 03	LOC 04
97.31	100.14	103.21

Clinical Social Worker Allowance

LOC 01/02	LOC 03	LOC 04
72.98	75.10	77.41

Full Replacement of CR 3415, Third Update to the 2004 Medicare Physician Fee Schedule Database. CR 3415 Is Rescinded

Information from CR 3415 originally published in the "September 2004 Medicare B Update! Special Issue - Third Update to the 2004 MPFSDB" posted on our provider education websites September 3, 2004
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers.

Provider Action Needed

Physicians, providers, and suppliers should note the changes to the Medicare physician fee schedule database and identify those changes that affect their practice.

Background

Payment files were issued to carriers based upon the November 7, 2003 and January 7, 2004 final rules.

This instruction amends those payment files and replaces CR 3415.

CR 3415 included changes to the professional component/technical component (PC/TC) indicator for *Current Procedural Terminology (CPT)* codes *96400*, *96408*, *96425*, *96520*, and *96530* from a 5 to 0. **Changes to the PC/TC indicator for these codes should not have been included.**

Implementation

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

Additional Information

The actual changes to the fee schedule involve numerous CPT/HCPCS codes and the actual effective dates vary. These changes to the revised third update to the 2004 Medicare physician fee schedule database are:

CPT/HCPCS	ACTION
G0336	Description: PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. fronto-temporal dementia Short Descriptor: PET imaging brain Alzheimer's Procedure Status = C PC/TC = 1 Site of Service = 1 Global Surgery = XXX Multiple Procedure Indicator = 0 Bilateral Procedure Indicator = 0 Assistant at Surgery Indicator = 9 Co-Surgery Indicator = 0 Team Surgery Indicator = 0 Type of Service = 4 Diagnostic Supervision = 9 Note: Effective for services performed on or after September 15, 2004.
G0336–TC	Description: PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. fronto-temporal dementia Short Descriptor: PET imaging brain Alzheimer's Procedure Status = C PC/TC = 1 Site of Service = 1 Global Surgery = XXX

G0336-TC, continued

Multiple Procedure Indicator = 0
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator =9
Co-Surgery Indicator = 0
Team Surgery Indicator = 0
Type of Service = 4
Diagnostic Supervision = 9
Note: Effective for services performed on or after September 15, 2004

G0336 – 26 Description: PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. fronto-temporal dementia
Short Descriptor: PET imaging brain Alzheimer's
Procedure Status = A
WRVU = 1.50
Non-Facility PE RVU = .51
Facility PE RVU = .51
Malpractice RVU = .05
PC/TC = 1
Site of Service = 1
Global Surgery = XXX
Multiple Procedure Indicator = 0
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 9
Co-Surgery Indicator = 0
Team Surgery Indicator = 0
Type of Service = 4
Diagnostic Supervision = 9
Note: Effective for services performed on or after September 15, 2004

G0341 Description: Percutaneous islet cell transplant, includes portal vein catheterization and infusion (To report imaging bill 75887 or 75885)
Short Descriptor: Percutaneous islet cell trans
Procedure Status = A
WRVU = 6.98
Non-Facility PE RVU = 2.73
Facility PE RVU = 2.73
Malpractice RVU = 0.48
PC/TC = 0
Site of Service = 1
Global Surgery = 000
Multiple Procedure Indicator = 2
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 9
Co-Surgery Indicator = 1
Team Surgery Indicator = 0
Type of Service = 2
Diagnostic Supervision = 9
Note: Effective for services performed on or after October 1, 2004

G0342 Description: Laparoscopy for Islet Cell Transplant, includes portal vein catheterization and infusion
Short Descriptor: Laparoscopy Islet cell Trans
Procedure Status = A

G0342, continued

WRVU = 11.92
Non-Facility PE RVU = 5.32
Facility PE RVU = 5.32
Malpractice RVU = 1.46
PC/TC = 0
Site of Service = 1
Global Surgery = 090
Pre Op = 0.09
Intra Op = 0.81
Post Op = 0.10
Multiple Procedure Indicator = 2
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 2
Co-Surgery Indicator = 1
Team Surgery Indicator = 0
Type of Service = 2
Diagnostic Supervision = 9
Note: Effective for services performed on or after October 1, 2004

G0343 Description: Laparotomy for Islet Cell transplant, includes portal vein catheterization and infusion
Short Descriptor: Laparotomy Islet cell transp
Procedure Status = A
WRVU = 19.85
Non-Facility PE RVU = 8.82
Facility PE RVU = 8.82
Malpractice RVU = 2.05
PC/TC = 0
Site of Service = 1
Global Surgery = 090
Pre Op = 0.09
Intra Op = 0.81
Post Op = .10
Multiple Procedure Indicator = 2
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 2
Co-Surgery Indicator = 1
Team Surgery Indicator = 0
Type of Service = 2
Diagnostic Supervision = 9
Note: Effective for services performed on or after October 1, 2004

23410 Bilateral Status Indicator = 1
33979 Bilateral Status Indicator = 0
33980 Bilateral Status Indicator = 0
52320 Endobase Code = 52000
52325 Endobase Code = 52000
52327 Endobase Code = 52000
52327 Bilateral Status Indicator = 1
52330 Endobase Code = 52000
52332 Endobase Code = 52000
52334 Endobase Code = 52000
52341 Endobase Code = 52000
52342 Endobase Code = 52000
52343 Endobase Code = 52000
52344 Endobase Code = 52000
69440 Bilateral Surgery Indicator = 1
69450 Bilateral Surgery Indicator = 1
69501 Bilateral Surgery Indicator = 1

69502 Bilateral Surgery Indicator = 1
69505 Bilateral Surgery Indicator = 1
69511 Bilateral Surgery Indicator = 1
69530 Bilateral Surgery Indicator = 1
69535 Bilateral Surgery Indicator = 1
69540 Bilateral Surgery Indicator = 1
69550 Bilateral Surgery Indicator = 1
69552 Bilateral Surgery Indicator = 1
69554 Bilateral Surgery Indicator = 1
69601 Bilateral Surgery Indicator = 1
69602 Bilateral Surgery Indicator = 1
69603 Bilateral Surgery Indicator = 1
69604 Bilateral Surgery Indicator = 1
69605 Bilateral Surgery Indicator = 1
69610 Bilateral Surgery Indicator = 1
69620 Bilateral Surgery Indicator = 1
69631 Bilateral Surgery Indicator = 1
69632 Bilateral Surgery Indicator = 1
69633 Bilateral Surgery Indicator = 1
69635 Bilateral Surgery Indicator = 1
69636 Bilateral Surgery Indicator = 1
69637 Bilateral Surgery Indicator = 1
69641 Bilateral Surgery Indicator = 1
69642 Bilateral Surgery Indicator = 1
69643 Bilateral Surgery Indicator = 1
69644 Bilateral Surgery Indicator = 1
69645 Bilateral Surgery Indicator = 1
69646 Bilateral Surgery Indicator = 1
69650 Bilateral Surgery Indicator = 1
69660 Bilateral Surgery Indicator = 1
69661 Bilateral Surgery Indicator = 1
69662 Bilateral Surgery Indicator = 1
69666 Bilateral Surgery Indicator = 1
69667 Bilateral Surgery Indicator = 1
69670 Bilateral Surgery Indicator = 1
69700 Bilateral Surgery Indicator = 1
69711 Bilateral Surgery Indicator = 1
69714 Bilateral Surgery Indicator = 1
69715 Bilateral Surgery Indicator = 1
69717 Bilateral Surgery Indicator = 1
69718 Bilateral Surgery Indicator = 1
69720 Bilateral Surgery Indicator = 1
69725 Bilateral Surgery Indicator = 1
69740 Bilateral Surgery Indicator = 1
69745 Bilateral Surgery Indicator = 1
69799 Bilateral Surgery Indicator = 1
69801 Bilateral Surgery Indicator = 1
69802 Bilateral Surgery Indicator = 1
69805 Bilateral Surgery Indicator = 1
69806 Bilateral Surgery Indicator = 1
69820 Bilateral Surgery Indicator = 1
69840 Bilateral Surgery Indicator = 1
69905 Bilateral Surgery Indicator = 1
69910 Bilateral Surgery Indicator = 1
69915 Bilateral Surgery Indicator = 1
69930 Bilateral Surgery Indicator = 1
69949 Bilateral Surgery Indicator = 1
69950 Bilateral Surgery Indicator = 1
69955 Bilateral Surgery Indicator = 1
69960 Bilateral Surgery Indicator = 1
69970 Bilateral Surgery Indicator = 1
69979 Bilateral Surgery Indicator = 1
96400 PC/TC = 0
96408 PC/TC = 0
96425 PC/TC = 0
96520 PC/TC = 0
96530 PC/TC = 0
0001T Co-Surgery Indicator = 2

For complete details, please see the official instruction issued to your carrier and 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 CR3505 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3505
Medlearn Matters Number: MM3505
Related CR Release Date: October 1, 2004
Related CR Transmittal #: 306
Effective Date: January 1, 2004
Implementation Date: October 4, 2004

Third Update to the 2004 Medicare Physician Fee Schedule Database - Correction

The Centers for Medicare & Medicaid Services (CMS) issued change request 3505 (*http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3505.pdf*) on October 1, 2004, which replaces change request 3415. Change request 3415 has been rescinded. Payment files were issued to carriers based upon the November 7, 2003 and January 7, 2004, final rules. Change request 3505 amends those payment files. Change request 3415 included changes to the PC/TC indicator for CPT codes 96400, 96408, 96425, 96520, and 96530 from a 5 to 0. Changes to the PC/TC indicator for these codes should not have been included.

Source: CMS Pub. 100-04 Transmittal: 306
Date: October 1, 2004 Change Request 3505

Third Update to the 2004 MPFSDB - Allowance Changes for Certain Procedures

For the procedure codes listed with changes to the relative value units (RVUs) as a result of the third update to the 2004 Medicare physician fee schedule database, allowances are:

Connecticut

CODE/MOD	PARTICIPATING	NONPARTICIPATING	LIMITING CHARGE
G0336	2716.73	2580.89	2968.03
G0336 TC	2630.59	2499.06	2873.92
G0336 26	82.56	78.43	90.20
G0341	408.20	387.79	445.96
G0342	747.80	710.41	816.97
G0343	1230.31	1168.79	1344.11

Florida

	PARTICIPATING			NONPARTICIPATING			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
G0336	2132.94	2330.62	2451.37	2026.29	2214.09	2328.80	2330.24	2546.20	2678.12
G0336 TC	2055.25	2249.23	2367.18	1952.49	2136.77	2248.82	2245.36	2457.28	2586.14
G0336 26	76.39	78.73	81.36	72.57	74.79	77.29	83.46	86.01	88.89
G0341	379.77	396.46	414.75	360.78	376.64	394.01	414.90	433.13	453.11
G0342	702.09	744.85	791.45	666.99	707.61	751.88	767.03	813.75	864.66
G0343	1149.74	1213.40	1282.33	1092.25	1152.73	1218.21	1256.09	1325.64	1400.95

Source: CMS Change Request 3505, Transmittal 306, MM3505

AMBULANCE

Correction to Ambulance Fee Schedule Update for 2003

This is a correction to an article titled "CY 2003 Ambulance Fee Schedule Updates [Source: CMS Transmittal AB02173, CR 2489] posted to the Florida Medicare website on 12/13/02.

The Ambulance Fee Schedule rate for HCPCS A0433 (localities 01 and 02) was published as 456.33. The correct fee schedule is 456.23. Claims for 2003 services were reimbursed using the correct amount of 456.23.

AMBULATORY SURGICAL CENTER

MMA-Ambulatory Surgical Center (ASC) Payment Rates and Wage Index Values Remain in Effect for Fiscal Year (FY) 2005

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

Provider Types Affected

Ambulatory surgical centers

Provider Action Needed

This instruction advises that the **current** ACS payment rates and wage index values **remain** in effect for FY 2005.

Background

Section 626(a) of the Medicare Modernization Act (MMA) mandates a 0 percent increase for inflation in FY 2005, the last quarter of calendar year 2005, and each calendar year from 2006 through 2009. The implementation of new wage index values for FY 2005 is deferred until CMS has had an opportunity to determine the impact of changes in the FY 2005 inpatient hospital wage index on payment amounts for individual ASCs. Therefore, **payments to ASCs for services furnished on or after October 1, 2004 will not change.**

Until further notice, carriers will continue to use the FY 2004 wage index to calculate payments to ASCs and the

payment rates that were effective for services furnished on or after April 1, 2004.

The labor-related portion of ASC payment rates is defined currently as 34.45 percent of the payment rate. Carriers are currently using the FY 2004 hospital inpatient wage index to calculate payments for ASC services.

Transmittal AB-03-116 (CR 2871), issued August 8, 2003, updated ASC facility payment rates for inflation and updated the wage index values used to adjust ASC payments for geographic wage differences effective for services furnished on or after October 1, 2003.

CR 2871 may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/AB03116.pdf.*

Transmittal 51 (CR 3082), issued February 4, 2004, notified contractors about a change in ASC payment rates effective April 1, 2004, resulting from enactment of section 626(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). CRs 3082 may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R51OTN.pdf.*

Effective **for services furnished on or after October 1, 2004,** the ASC payment group rates will remain as follows:

Group 1	$333	Group 6	$826 ($676 + $150 for intraocular lenses (I0Ls)
Group 2	$446	Group 7	$995
Group 3	$510	Group 8	$973 ($823 + $150 for IOLs)
Group 4	$630	Group 9	$1339
Group 5	$717		

Additional Information

The Centers for Medicare & Medicaid Services (CMS) website for Ambulatory Surgical Center Information can be found at: *http://www.cms.hhs.gov/suppliers/asc.*

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

From that web page, look for CR3394 in the CR NUM column on the right, and then click on the file for that CR.

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

Related Change Request (CR) #: 3394
Medlearn Matters Number: MM3394
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 288
Effective Date: October 1, 2004
Implementation Date: October 1, 2004

CHIROPRACTIC

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

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

Provider Types Affected

Chiropractors

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

This article completely replaces MM3063 on the same subject. On or after October 1, 2004, when you provide acute or chronic active/corrective treatment to Medicare patients, you must add the AT modifier to every claim that uses HCPCS codes 98940, 98941, or 98942. If you don't add this modifier, your care will be considered maintenance therapy

and will be denied because maintenance chiropractic therapy is not considered medically reasonable or necessary under Medicare.

In addition, carriers may develop local coverage determinations (LCDs) that indicate an appropriate frequency of service for a given clinical indication. You may submit claims for services that exceed the frequency limits that the LCDs established, with or without the AT modifier, depending on whether you believe that the care you have rendered is either active treatment or maintenance therapy. But, be aware that in either case your claims will continue to be autodenied if the services exceed the frequency limits of reasonable and necessary services specified in the LCD.

GO – What You Need to Do

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

Background

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

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

However, the presence of the AT modifier may not, in all instances, indicate that the service is reasonable and necessary. Carriers may develop LCDs that indicate an appropriate frequency of service. You may submit claims for services that exceed the frequency limits established within the LCD, with or without the AT modifier, depending on whether you believe that you have rendered active treatment or maintenance therapy, respectively.

In either case, your claims will be autodenied if the services exceed the frequency limits of reasonable and necessary services specified in the LCD. And, if contractors' LCDs do not specify frequencies that define the limit of reasonable and necessary care, they may deny your claim, if appropriate, after medical review.

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

Important Dates to Know
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Related Instruction

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

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

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

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

Additional Information

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

Related Change Release (CR) #: 3449
Medlearn Matters Number: MM3449
Related CR Release Date: September 3, 2004
Related CR Transmittal #: 18
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

DIAGNOSTIC TESTS

Procedures A9522-A9523

Effective for services processed on or after October 19, 2004, the Medicare allowance for HCPCS codes **A9522** (Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per mci) and **A9523** (Supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxetan, per mci) will be based on 92 percent of the average wholesale price.

Providers are not required to submit an invoice when billing for HCPCS code A9522-A9523.

DURABLE MEDICAL EQUIPMENT

2004 Jurisdiction List

Below is the updated list of procedure codes for Durable Medical Equipment Regional Carrier (DMERC) and local carrier jurisdictions. The DMERC that serves Connecticut (Region A) is HealthNow (*http://www.umd.nycpic.com*); for Florida (Region D) it is Palmetto Government Benefits Administrators (*http://www.palmettogba.com*). The DMERCs and local carriers publish this list to inform providers and suppliers which contractor they should be billing for these codes.

HCPCS	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4210	Needle Free Injection Device	DME REGIONAL Carrier
A4211	Medical, Surgical, and Self- Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4212	Non Coring Needle or Stylet	Local Carrier with or without Catheter
A4213 - A4215	Medical, Surgical, and Self- Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4216 - A4217	Saline	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier.
A4220	Refill Kit for Implantable Pump	Local Carrier
A4221 - A4250	Medical, Surgical, and Self- Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4253 - A4259	Diabetic Supplies	DME REGIONAL Carrier
A4260	Levonorgestrel Implant	Local Carrier
A4261	Cervical Cap for Contraceptive	Local Carrier Use
A4262 - A4263	Lacrimal Duct Implants	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier.
A4266 - A4269	Contraceptives	Local Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME REGIONAL Carrier
A4281 - A4286	Accessory for Breast Pump	DME REGIONAL Carrier
A4290	Sacral Nerve Stimulation Test Lead	Local Carrier
A4300 - A4301	Implantable Catheter	Local Carrier

A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other, DME RE-GIONAL Carrier.
A4310 - A4359	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent
A4361 - A4434	Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME RE-GIONAL Carrier.
A4450 - A4455	Tape;Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other, DME RE-GIONAL Carrier.
A4458	Enema Bag	DME REGIONAL Carrier
A4462	Abdominal Dressing	Local Carrier if incident to a physician's service (not separately payable). If other, DME RE-GIONAL Carrier.
A4465	Non-elastic Binder for Extremity	DME REGIONAL Carrier
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other, DME RE-GIONAL Carrier.
A4483	Moisture Exchanger	DME REGIONAL Carrier
A4490 - A4510	Surgical Stockings	DME REGIONAL Carrier
A4521 - A4538	Diapers	DME REGIONAL Carrier
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME REGIONAL Carrier
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4570	Splint	Local Carrier
A4575	Topical Hyperbaric Oxygen Chamber Disposable	DME REGIONAL Carrier
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME RE-GIONAL Carrier.
A4606	Oxygen Probe for Oximeter	DME REGIONAL Carrier
A4608	Transtracheal Oxygen Catheter	DME REGIONAL Carrier

A4609 - A4610	Tracheal Suction Catheter	DME REGIONAL Carrier
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME REGIONAL Carrier
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other, DME Regional Carrier.
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier.
A4630 - A4640	DME Supplies	DME REGIONAL Carrier
A4641 - A4646	Imaging Agent; Contrast Material	Local Carrier
A4647	Contrast Material	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier.
A4651 - A4932	Supplies for ESRD	DME REGIONAL Carrier
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier.
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier.
A5500 - A5511	Therapeutic Shoes	DME REGIONAL Carrier
A6000	Non-Contact Wound Warming	DME REGIONAL Carrier Cover
A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6025	Silicone Gel Sheet	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6154 - A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6412	Eye Patch	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.

A6441 - A6512	Surgical Dressings	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6550 - A6551	Supplies for Negative Pressure Wound Therapy Electrical Pump	DME REGIONAL Carrier
A7000 - A7039	Accessories for Nebulizers, Aspirators, and Ventilators	DME REGIONAL Carrier
A7042 - A7043	Pleural Catheter	Local Carrier
A7044 - A7046	Respiratory Accessories	DME REGIONAL Carrier
A7501-A7526	Tracheostomy Supplies	DME REGIONAL Carrier
A9150	Non-Prescription Drugs	Local Carrier
A9270	Noncovered Items or Services	DME REGIONAL Carrier
A9280	Alarm Device	DME REGIONAL Carrier
A9300	Exercise Equipment	DME REGIONAL Carrier
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier.
A9901	Delivery	DME REGIONAL Carrier
A9999	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier.
B4034 - B9999	Enteral and Parenteral Therapy	DME REGIONAL Carrier
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME REGIONAL Carrier
E0110 - E0118	Crutches	DME REGIONAL Carrier
E0130 - E0159	Walkers	DME REGIONAL Carrier
E0160 - E0175	Commodes	DME REGIONAL Carrier
E0176 - E0199	Decubitus Care Equipment	DME REGIONAL Carrier
E0200 - E0239	Heat/Cold Applications	DME REGIONAL Carrier
E0240 - E0248	Bath and Toliet Aids	DME REGIONAL Carrier
E0249	Pad for Heating Unit	DME REGIONAL Carrier
E0250 - E0304	Hospital Beds	DME REGIONAL Carrier
E0305 - E0326	Hospital Bed Accessories	DME REGIONAL Carrier
E0350 - E0352	Electronic Bowel Irrigation System	DME REGIONAL Carrier
E0370	Heel Pad	DME REGIONAL Carrier
E0371 - E0373	Decubitus Care Equipment	DME REGIONAL Carrier
E0424 - E0484	Oxygen and Related Respiratory Equipment	DME REGIONAL Carrier
E0500	IPPB Machine	DME REGIONAL Carrier
E0550 - E0585	Compressors/Nebulizers	DME REGIONAL Carrier
E0590	Drug Dispensing Fee	DME REGIONAL Carrier
E0600	Suction Pump	DME REGIONAL Carrier
E0601	CPAP Device	DME REGIONAL Carrier
E0602 - E0604	Breast Pump	DME REGIONAL Carrier
E0605	Vaporizer	DME REGIONAL Carrier
E0606	Drainage Board	DME REGIONAL Carrier

E0607	Home Blood Glucose Monitor	DME REGIONAL Carrier
E0610 - E0615	Pacemaker Monitor	DME REGIONAL Carrier
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME REGIONAL Carrier
E0618 - E0619	Apnea Monitor	DME REGIONAL Carrier
E0620	Skin Piercing Device	DME REGIONAL Carrier
E0621 - E0636	Patient Lifts	DME REGIONAL Carrier
E0637 - E0638	Standing Devices	DME REGIONAL Carrier
E0650 - E0675	Pneumatic Compressor and Appliances	DME REGIONAL Carrier
E0691 - E0694	Ultraviolet Light Therapy Systems	DME REGIONAL Carrier
E0700	Safety Equipment	DME REGIONAL Carrier
E0701	Helmet	DME REGIONAL Carrier
E0710	Restraints	DME REGIONAL Carrier
E0720 - E0745	Electrical Nerve Stimulators	DME REGIONAL Carrier
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME REGIONAL Carrier
E0749	Implantable Osteogenic Stimulators	Local Carrier
E0752	Implantable Nerve Stimulator Electrodes	Local Carrier
E0754	Patient Programmer for use with IPG	Local Carrier
E0755	Reflex Stimulator	DME REGIONAL Carrier
E0756 - E0759	Implantable Nerve Stimulator	Local Carrier
E0760	Ultrasonic Osteogenic Stimulator	DME REGIONAL Carrier
E0761	Electromagnetic Treatment Device	DME REGIONAL Carrier
E0765	Nerve Stimulator	DME REGIONAL Carrier
E0776	IV Pole	DME REGIONAL Carrier
E0779 - E0780	External Infusion Pumps	DME REGIONAL Carrier
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME REGIONAL Carrier. This item may be billed to the DME REGIONAL Carrier whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME REGIONAL Carrier
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME REGIONAL Carrier
E0830	Ambulatory Traction Device	DME REGIONAL Carrier
E0840 - E0900	Traction Equipment	DME REGIONAL Carrier
E0910 - E0930	Trapeze/Fracture Frame	DME REGIONAL Carrier
E0935	Passive Motion Exercise Device	DME REGIONAL Carrier
E0940	Trapeze Equipment	DME REGIONAL Carrier
E0941	Traction Equipment	DME REGIONAL Carrier
E0942 - E0945	Orthopedic Devices	DME REGIONAL Carrier
E0946 - E0948	Fracture Frame	DME REGIONAL Carrier
E0950 - E1298	Wheelchairs	DME REGIONAL Carrier
E1300 - E1310	Whirlpool Equipment	DME REGIONAL Carrier

E1340	Repair or Non-routine Service	Local Carrier if repair of implanted DME. If other, DME REGIONAL Carrier.
E1353 - E1391	Additional Oxygen Related Equipment	DME REGIONAL Carrier
E1399 E1405 - E1406	Miscellaneous DME Additional Oxygen Equipment	Local Carrier if implanted DME. If other, DME REGIONAL Carrier. DME REGIONAL Carrier
E1500 - E1699	Artificial Kidney Machines and Accessories	DME REGIONAL Carrier
E1700 - E1702	TMJ Device and Supplies	DME REGIONAL Carrier
E1800 - E1840	Dynamic Flexion Devices	DME REGIONAL Carrier
E1902	Communication Board	DME REGIONAL Carrier
E2000	Gastric Suction Pump	DME REGIONAL Carrier
E2100 - E2101	Blood Glucose Monitors with Special Features	DME REGIONAL Carrier
E2120	Pulse Generator for Tympanic Treatment of Inner Ear	DME REGIONAL Carrier
E2201 - E2399	Wheelchair Accessories	DME REGIONAL Carrier
E2402	Negative Pressure Wound Therapy Pump	DME REGIONAL Carrier
E2500 - E2599	Speech Generating Device	DME REGIONAL Carrier
G0001 - G9016	Misc. Professional Services	Local Carrier
J0120 - J0850	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump If other, DME REGIONAL Carrier.
J0880	Injection	Local Carrier
J0895 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump If other, DME REGIONAL Carrier.
J3590	Unclassified Biologics	Local Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump If other, DME REGIONAL Carrier.
J7190 - J7192	Factor VIII	Local Carrier
J7193 - J7195	Factor IX	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300 - J7303	Intrauterine Copper Contraceptive	Local Carrier
J7308	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir	Local Carrier if incident to a physician's service or used in an implanted infusion pump If other, DME REGIONAL Carrier.
J7317 - J7320	Injection	Local Carrier
J7330	Autologous Cultured Chondrocytes Implant	Local Carrier
J7340 - J7350	Dermal and Epidermal – Tissue of Human Origin	Local Carriers

J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier.
J7608 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
J7799	NOC, Other than Inhalation Drugs through DME	DME REGIONAL Carrier
J8499	Prescription Drug, Oral, Non Chemotherapeutic	DME REGIONAL Carrier
J8510 - J8999	Oral Anti-Cancer Drugs	DME REGIONAL Carrier
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier.
K0001 - K0108	Wheelchairs	DME REGIONAL Carrier
K0114 - K0116	Spinal Orthotics	DME REGIONAL Carrier
K0195	Elevating Leg Rests	DME REGIONAL Carrier
K0415 - K0416	Antiemetic Drugs	DME REGIONAL Carrier
K0452	Wheelchair Bearings	DME REGIONAL Carrier
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME REGIONAL Carrier
K0462	Loaner Equipment	DME REGIONAL Carrier
K0552	External Infusion Pump Supplies	DME REGIONAL Carrier
K0601 - K0605	External Infusion Pump Batteries	DME REGIONAL Carrier
K0606 - K0609	Defibrilator Accessories	DME REGIONAL Carrier
K0618 - K0619	TLSOs	DME REGIONAL Carrier
K0620	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME REGIONAL Carrier.
L0100 - L2090	Orthotics	DME REGIONAL Carrier
L2106 - L2116	Orthotics	DME REGIONAL Carrier
L2126 - L4398	Orthotics	DME REGIONAL Carrier
L5000 - L5999	Lower Limb Prosthetics	DME REGIONAL Carrier
L6000 - L7499	Upper Limb Prosthetics	DME REGIONAL Carrier
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME REGIONAL Carrier.
L7900	Vacuum Erection System	DME REGIONAL Carrier
L8000 - L8490	Prosthetics	DME REGIONAL Carrier
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other, DME REGIONAL Carrier.
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME REGIONAL Carrier
L8505	Artificial Larynx Accessory	DME REGIONAL Carrier
L8507 - L8514	Voice Prosthesis	DME REGIONAL Carrier
L8600 - L8699	Prosthetic Implants	Local Carrier

L9900	Miscellaneous Orthotic or Prosthetic Component or device Accessory	Local Carrier if used with implanted prosthetic. If other, DME REGIONAL Carrier.
M0064 - M0301	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardio- kymography	Local Carrier
Q0081	Infusion Therapy	Local Carrier if incident to a physician's service or used in an implanted infusion pump If other, DME REGIONAL Carrier.
Q0083 - Q0085	Chemotherapy Administration	Local Carrier if incident to a physician's service or used in an implanted infusion pump If other, DME REGIONAL Carrier.
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0136	Injection, Epoetin Alpha	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
Q0137	Injection Darbepoetin	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
Q0144	azithromycin dihydrate	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
Q0163 - Q0181	Anti-emetic	DME REGIONAL Carrier
Q0182 - Q0183	Artificial Skin	Local Carrier
Q0187	Factor VIIA	Local Carrier
Q1001 - Q1005	New Technology IOL	Local Carrier
Q2022	Von Willebrand Factor	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3019 - Q3020	ALS Transport	Local Carrier
Q3025 - Q3026	Vaccines	Local Carrier
Q3031	Collagen Skin Test	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q4054 - Q4055	Injection	DME REGIONAL Carrier when for Method II ESRD beneficiaries. If other, Local Carrier.
Q4075 - Q4077	Injection	Local Carrier if incident to a physi cians service or used in an implanted infusion pump If other, DME REGIONAL Carrier.
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME REGIONAL Carrier
V2100 - V2513	Lenses	DME REGIONAL Carrier
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
V2530 - V2531	Contact Lenses, Scleral	DME REGIONAL Carrier
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.

V2600 - V2615	Low Vision Aids	DME REGIONAL Carrier
V2623 - V2629	Prosthetic Eyes	DME REGIONAL Carrier
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME REGIONAL Carrier
V2781	Progressive Lens	DME REGIONAL Carrier
V2782 - V2784	Lenses	DME REGIONAL Carrier
V2785	Processing—Corneal Tissue	Local Carrier
V2786 V2790	Lense Amniotic Membrane	DME REGIONAL Carrier Local Carrier
V2797	Vision Supply	DME REGIONAL Carrier
V2799	Miscellaneous Vision Service	DME REGIONAL Carrier
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME REGIONAL Carrier
V5362 - V5364	Speech Screening	Local Carrier

MMA - Reasonable Charge Update for 2005 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, Therapeutic Shoes, and Certain Intraocular Lenses

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

Provider Types Affected

Physicians, providers, and suppliers.

Provider Action Needed

This instruction provides details regarding the calculation of reasonable charges for the payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2005.

Background

Payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses by regulations contained in 42 Code of Federal Regulations (CFR) 405.501.

This instruction provides details regarding the calculation of reasonable charges for payment of claims for **splints, casts**, dialysis supplies, dialysis equipment, **and intraocular lenses** furnished in calendar year 2005.

- For **therapeutic shoe HCPCS codes A5500, A5501, A5503-A5507, K0628, and K0629** the Medicare Modernization Act of 2003 (MMA, Section 627) changes the payment methodology from reasonable charge to the prosthetic and orthotic fee schedule. Further information on the pricing update for therapeutic shoes will be provided in a separate article for the 2005 update of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

For splints and casts the following applies:

- The 2005 gap-filled amounts will be based on the 2004 amounts increased by 3.3 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2003.
- **For splints and casts** furnished by hospital outpatient departments, payment is built into the outpatient prospective payment system (OPPS) payment amounts..
- **For splint or cast materials,** payment is only made on a reasonable charge basis for splint or cast materials used by physicians or other practitioners to reduce a fracture or dislocation, and this payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.
- For **intraocular lenses (HCPCS codes of V2630, V2631, and V2632)**, payment is only made on a reasonable charge basis for lenses implanted at a physician's office.

Implementation

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

Additional Information

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

From that web page, look for CR3430 in the CR NUM column on the right, and click on the file for that CR.

That CR has a detailed list of HCPCS codes for splints and casts with associated gap-filled payment amounts that your carrier will use in making payment in 2005 based on the lower of the actual charge or the gap-filled payment amount.

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

Related Change Request (CR) #: 3430
Related CR Transmittal #: 297
Implementation Date: January 3, 2005
Medlearn Matters Number: MM3430
Effective Date: January 1, 2005
Related CR Release Date: September 10, 2004

October Quarterly Update for 2004 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction provides information for updating and implementing the October Quarterly 2004 fee schedule amounts for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). It implements fee schedule amounts for new codes and revises any fee schedule amounts for existing codes that were calculated in error.

Background

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings (Socials Security Act, Sections 1834(a), (h), and (i)). In addition, payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102.

This instruction implements fee schedule amounts for new codes, deletes certain codes, and revises any fee schedule amounts for existing codes that were calculated in error in prior updates. Specifically, the changes for this update are as follows:

- **Codes A4363, E1400 thru E1404, K0137 thru K0139, K0168 thru K0181, K0190 thru K0192, K0277 thru K0279, K0284, K0400, K0417, K0419 thru K0439, and K0530** were deleted from the Healthcare Common Procedure Coding System (HCPCS) effective 12/31/1999. These codes were inadvertently included in the 2004 fee schedule file, and they are being removed with this update.
- **Codes E1019 and E1021 are also being removed as they are not valid 2004 HCPCS codes.**
- The 2004 Puerto Rico schedule amounts for **codes A4351 and A4352** were based on incorrect pricing information. The durable medical equipment regional carriers (DMERCs) must revise the base fee schedule amounts for these codes as part of the October quarterly update.
- **Codes K0630 thru K0649, representing Lumbar Sacral Orthosis products** were added to the HCPCS effective April 1, 2004 and their fee schedule amounts were implemented on July 1, 2004. However, the Centers for Medicare & Medicaid Services has determined that the fee schedule amounts for codes K0630, K0631, K0632, K0634, K0635, K0636, K0637, K0639, K0640, K0642, K0644, K0645, and K0646 were based on incorrect pricing information and has recalculated those fee schedule amounts. The revised amounts will be implemented on October 4, 2004 as part of this update.
- **Codes K0650 thru K0669** were added to the HCPCS effective July 1, 2004. Because data is not yet available, implementation of the fee schedule amounts for these items will be delayed until the January 2005 update.

Implementation

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

Additional Information

To view the official instruction issued to your DMERC or intermediary on this issue, please see: *http://www.cms.hhs.gov/manuals/pm_trans/R272CP.pdf.*

Also, the quarterly update process for the DMEPOS fee schedule is located in Section 60 of Chapter 23 of the Medicare Claims Processing Manual, which may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

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

Related Change Request (CR) #: 3377
Medlearn Matters Number: MM3377
Related CR Release Date: August 10, 2004
Related CR Transmittal #: 272
Effective Date: January 1, 2004 for revised 2004 fee schedule amounts
Implementation Date: October 4, 2004

Revised 2004 Update of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedules - Correction

This is a correction to fees posted February 13. 2004

Section 628 of the Medicare Prescription Drug, Improvement, and Modernization Act (DIMA) of 2003 specifies that the fee update for clinical laboratory services for FY 2004 through 2008 is **0 percent**. The revised fee update for clinical laboratory services requires revised fees for traveling to perform a specimen collection for either a nursing home or homebound patient. For dates of service January 1, 2004 though December 31, 2004, the payment for code P9603 (per mileage trip basis) is $.825 and for code P9604 (flat rate trip basis) is $8.25.

In accordance with section 302(c) of the DIMA, the fee schedule update factors for 2004 for DME, other than items classified as class III devices by the Food and Drug Administration), prosthetic devices, prosthetics, orthotics and surgical dressings are equal to **0 percent**. In addition, the 2004 payment limits for therapeutic shoes will be frozen at the 2003 amounts.

Section 418 of the DIMA eliminates the application of the clinical laboratory fee schedule by a hospital laboratory with fewer than 50 beds in a qualified rural area for outpatient laboratory testing for cost reporting periods beginning during the 2-year period beginning on July 1, 2004. Payment for these outpatient laboratory tests will be reasonable costs during the applicable time period. Additional instructions regarding which qualified rural areas apply to this provision will be provided in a separate instruction.

The corrected fees for Florida are:

Code	Fee	Code	Fee	Code	Fee	Code	Fee
A4290	139.81	A6214	10.29	A6247	23.78	E0759	558.88
A4561	19.22	A6216	0.05	A6248	16.24	E0781	242.46
A4562	47.78	A6219	0.95	A6251	1.99	E0782	3748.29
A6010	30.96	A6220	2.58	A6252	3.25	E0783	7528.79
A6011	2.28	A6222	2.13	A6253	6.34	E0785	434.52
A6021	21.02	A6223	2.42	A6254	1.21	E0786	7343.88
A6022	21.02	A6224	3.61	A6255	3.03	K0560	1813.25
A6023	190.30	A6229	3.61	A6257	1.53	L8600	500.79
A6024	6.19	A6231	4.66	A6258	4.30	L8603	351.71
A6154	14.38	A6232	6.88	A6259	10.94	L8606	184.62
A6196	7.35	A6233	19.19	A6266	1.92	L8610	513.68
A6197	16.44	A6234	6.54	A6402	0.12	L8612	541.78
A6199	5.29	A6235	16.82	A6403	0.43	L8613	242.57
A6200	9.50	A6236	27.25	A6407	1.88	L8614	15353.47
A6201	20.80	A6237	7.91	A6410	0.39	L8619	6586.07
A6202	34.88	A6238	22.79	A7042	169.52	L8630	270.19
A6203	3.35	A6240	12.24	A7043	23.31	L8631	1813.25
A6204	6.23	A6241	2.57	E0749	222.28	L8641	293.24
A6207	7.34	A6242	6.07	E0752	372.52	L8642	240.71
A6209	7.48	A6243	12.31	E0754	916.00	L8658	251.57
A6210	19.92	A6244	39.28	E0756	6767.01	L8659	1564.96
A6211	29.37	A6245	7.27	E0757	4,834.90	L8670	446.41
A6212	9.70	A6246	9.92	E0758	4,255.80		

The corrected fees for Connecticut are:

Code	Fee	Code	Fee	Code	Fee	Code	Fee
A4290	104.86	A6199	5.29	A6216	0.05	A6236	27.25
A4561	18.63	A6200	9.50	A6219	0.95	A6237	7.91
A4562	46.38	A6201	20.80	A6220	2.58	A6238	22.79
A6010	30.96	A6202	34.88	A6222	2.13	A6240	12.24
A6011	2.28	A6203	3.35	A6223	2.42	A6241	2.57
A6021	21.02	A6204	6.23	A6224	3.61	A6242	6.07
A6022	21.02	A6207	7.34	A6229	3.61	A6243	12.31
A6023	190.30	A6209	7.48	A6231	4.66	A6244	39.28
A6024	6.19	A6210	19.92	A6232	6.88	A6245	7.27
A6154	14.38	A6211	29.37	A6233	19.19	A6246	9.92
A6196	7.35	A6212	9.70	A6234	6.54	A6247	23.78
A6197	16.44	A6214	10.29	A6235	16.82	A6248	16.24

Corrected fees for Connecticut - continued

Code	Fee	Code	Fee	Code	Fee	Code	Fee
A6251	1.99	A6407	1.88	E0781	264.87	L8613	250.55
A6252	3.25	A6410	0.39	E0782	3356.05	L8614	15354.57
A6253	6.34	A7042	165.63	E0783	7528.79	L8619	6591.62
A6254	1.21	A7043	23.50	E0785	369.34	L8630	360.25
A6255	3.03	E0749	261.51	E0786	7343.88	L8631	1756.30
A6257	1.53	E0752	361.63	K0560	1756.79	L8641	374.30
A6258	4.30	E0754	865.16	L8600	505.14	L8642	227.73
A6259	10.94	E0756	6569.18	L8603	351.17	L8658	326.35
A6266	1.92	E0757	4693.57	L8606	172.59	L8659	1519.23
A6402	0.12	E0758	4131.42	L8610	469.40	L8670	446.41
A6403	0.43	E0759	546.09	L8612	575.41		

Source: CMS Pub. 100-20 Transmittal: 31 Date: December 19, 2003 Change Request 3013

DRUGS AND BIOLOGICALS

J7190: Hemophilia Clotting Factors Billing Clarification

This article provides clarification of the coding guidelines for hemophilia drugs. Medicare Part B of Florida will process the following procedures based on **each international unit (I.U.)** of drug administered:

J7190	Factor VIII (anti-hemophilic factor, human) per IU
J7191	Factor VIII (anti-hemophilic factor, porcine) per IU
J7192	Factor VIII (anti-hemophilic factor, recombinant) per IU
J7193	Factor IX (anti-hemophilic factor, purified, non-recombinant) per IU
J7194	Factor IX complex, per IU
J7195	Factor IX (anti-hemophilic factor, recombinant) per IU
J7197	Antithrombin III (human), per IU
J7198	Anti-inhibitor, per IU
Q0187	Factor VIIa (cogulation factor, recombinant) per 1.2 mg
Q2022	von Willebrand factor complex, human, per IU

Clotting factors are billed to the carrier per IU. The following examples illustrate how to file claims on Form CMS – 1500 for hemophilia clotting factor procedures:

Example: Procedure J7192 (10,600 units)

DOS	Procedure (Item 24D	Charges (Item 24F)	Units (Item 24G)
7/1/04	J7192	$1300.00	999
7/1/04	J7192	$1300.00	999
7/1/04	J7192	$1300.00	999
7/1/04	J7192	$1300.00	999
7/1/04	J7192	$1300.00	999
7/1/04	J7192	$1300.00	999
7/1/04	J7192	$1300.00	999
7/1/04	J7192	$1300.00	999
7/1/04	J7192	$1300.00	999
7/1/04	J7192	$793.00	610

Previously Medicare Part B providers in Florida and Connecticut were requested to bill claims with a QB (quantity billed) of 999 on each detail line of Form CMS 1500 until the total dosage amount administered to the patient was met. This required multiple detail lines to be billed if the patient received 1,000 or more IU.

Effective for claims received on or after January 1, 2005, to simplify billing methods, Medicare Part B of FL and CT are requesting claims to be filed with the total number of IU administered in item 19 (or the EMC equivalent) and a one (1) in item 24G. The claim will be manually priced based upon the total number of IU indicated in item 19. Please be aware that if the information is not given, a development request will be sent which could result in payment delays.

The following example illustrates how to file a claim on Form CMS 1500 for hemophilia clotting factors.

Example: Procedure J7197 (20,250 units)
Item 19= 20,250 IU

DOS	Procedure (Item24D)	Charges (Item24F)	Units (Item24G)
01/01/05	J7197	$30,375.00	1

MMA - Billing Instructions for ADVATE rAHF-PFM on Medicare Claims

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

Provider Types Affected

Hospitals, providers, and independent ESRD facilities

Provider Action Needed

STOP – Impact to You

This is a one-time notification to ensure that providers, hospitals, and independent ESRD facilities are aware of the correct HCPCS code to use when billing for Advate.

CAUTION – What You Need to Know

Advate rAHF-PFM was approved by the Food and Drug Administration (FDA) on July 25, 2003; the payment limit that should be used for Advate is the same payment limit that is currently assigned to HCPCS code J7192. This payment limit will apply to all Advate claims submitted for services from January 1, 2004 through December 31, 2004. Also, effective for dates of services on or after July 25, 2003, claims submitted to Medicare fiscal intermediaries for Advate will be rejected if reported with any other code except J7192**.** Claims submitted to carriers for dates of service on or after July 25, 2003, without J7192 will be adjusted to reflect J7192 and carriers will append modifier "CC" to reflect this adjustment.

GO – What You Need to Do

Make sure that your billing staff knows that HCPCS code J7192 must be used when billing for the drug, Advate, effective for dates of services on or after July 25, 2003.

Background

Beginning January 1, 2004, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides that the payment limits for most drugs and biologicals not paid on a cost or prospective payment basis are based on 85 percent of the Average Wholesale Price (AWP) reflected in the published compendia as of April 1, 2003, for those drugs and biologicals furnished on and after January 1, 2004.

However, one of the exceptions to this general rule is the payment limit for blood clotting factors. Specifically, the payment limits for blood clotting factors are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.

Advate is a blood clotting factor that was approved by the FDA on July 25, 2003 for the treatment of people with hemophilia A. Advate should be reported using the existing HCPCS code J7192.

Implementation Date

This change will be implemented in Medicare claims processing systems on September 27, 2004.

Additional Information

For the calendar year 2004, the Advate payment limit for providers and for independent ESRD facilities can be found in the 2004 MMA drug pricing file that was issued in CR 3105. A Medlearn Matters article on this CR can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3105.pdf.*

The MMA Drug Payment Limits Pricing Files for Dates of Service 1/1/2004 and after are available at: *http://cms.hhs.gov/providers/drugs/default.asp*.

For hospital Outpatient Prospective Payment System (OPPS), the payment rate for Advate can be found in the latest quarterly update of the OPPS Outpatient Code Editor that is posted on the CMS OPPS website.

The CMS Hospital Outpatient Prospective Payment System web site can be found at: *http://www.cms.hhs.gov/providers/hopps/*.

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

Related Change Request (CR) #:3331
Medlearn Matters Number: MM3331
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 109
Effective Date: July 25, 2003
Implementation Date: September 27, 2004

MMA Drug Pricing Update – Payment Limits for J1000 (Depo-estradiol cypionate inj)

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

Provider Types Affected

Physicians, providers, and independent End Stage Renal Disease (ESRD) facilities

Provider Action Needed

Providers should be aware that payment limits for Healthcare Common Procedure Coding System (HCPCS) drug code J1000 (Depo-estradiol cypionate inj) are changing for services furnished on or after January 1, 2004, and on or before December 31, 2004.

Background

This article advises providers that Medicare carriers and fiscal intermediaries (FIs) will update the payment limits for HCPCS drug code J1000 (Depo-estradiol cypionate inj) effective with dates of service on or after January 1, 2004, and on or before December 31, 2004.

From January 1, 2004 through December 31, 2004, the Medicare payment limits apply for the specific HCPCS drug codes listed below that are not paid on a cost or prospective payment basis. The payment limit listed in the table for J1000 supersedes the payment limit published in Change Request (CR) 3105, dated January 30, 2004.

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

	HCPCS	Average Wholesale Price %	2004 Payment Limit
Other than ESRD Drugs Separately Billed by Independent ESRD Facilities	J1000	85	$2.33
ESRD Drugs Separately Billed by Independent ESRD Facilities	J1000	95	$2.60

Carriers and FIs will not search and adjust claims that have already been processed unless brought to their attention.

Implementation

The implementation date for this instruction is September 27, 2004.

Related Instructions

CR3105, Transmittal 75, dated January 30, 2004, can be found at the following Centers for Medicare & Medicaid Services (CMS) website: *http://www.cms.hhs.gov/manuals/pm_trans/R75CP.pdf.*

Additional Information

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

From that web page, look for CR 3418 in the CR NUM column on the right, and then 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) #: 3418
Medlearn Matters Number: MM3418
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 110
Effective Date: January 1, 2004
Implementation Date: September 27, 2004

MMA Drug Pricing Update – Payment Limit forJ9045 (Carboplatin Injection) and J9310 (Rituximab Cancer Treatment)

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

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

Affected providers are advised that Medicare carriers are updating the payment limits (listed in this article) for HCPCS drug code J9045 (Carboplatin injection) and J9310 (Rituximab cancer treatment), effective with dates of service on or after April 1, 2004, and on or before December 31, 2004.

Background

The payment limits for Carboplatin injection and Rituximab cancer treatment, Medicare Part B drugs meeting the exceptions process described in Section 303(b) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) are being updated for claims with such services provided between April 1, 2004 through December 31, 2004, inclusive. The old and new rates for J9045 (Carboplatin injection) and J9310 (Rituximab cancer treatment) with the new rate for dates of service on or after April 1, 2004 and on or before December 31, 2004 are as follows where payment is not made on a cost or prospective payment basis:

Status	HCPCS	Short Description	AWP %	2004 Payment Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)
OLD	J9045	Carboplatin injection	88	$137.54
NEW	J9045	Carboplatin injection	86	$135.15
OLD	J9310	Rituximab cancer treatment	81	$427.28
NEW	J9310	Rituximab cancer treatment	83	$438.38

The payment limits for J9045 and J9310 supercede the payment limits published in Change Request (CR) 3161 (Transmittal 119) dated March 15, 2004. Note that the absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug.

Implementation

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

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/transmittals/comm_date_dsc.asp.*

From that web page, look for CR3419 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3419
Medlearn Matters Number: MM3419
Related CR Release Date: August 24, 2004
Related CR Transmittal #: 106
Effective Date: April 1, 2004
Implementation Date: September 24, 2004

Payment Amounts for the Influenza Virus Vaccine (CPT 90658) and the Pneumoccocal Vaccine (CPT 90732) When Payment is Based on 95 Percent of the Average Wholesale Price (AWP)

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

Provider Types Affected

Physicians, non-physician practitioners, providers, and suppliers

Provider Action Needed

STOP – Impact to You

Effective September 1, 2004, the Medicare Part B payment allowance for the Influenza Virus Vaccine [CPT 90658] is $10.10 and for the Pneumoccocal Vaccine [CPT 90732] is $23.28 (when payment is based on 95 percent of the AWP).

CAUTION – What You Need to Know

Annual Part B deductible and coinsurance amounts do not apply

GO – What You Need to Do

Please take note of this pricing information to ensure accurate claims processing. Your carrier or fiscal intermediary will not search their files to adjust claims that were processed prior to the October 1, 2004 implementation date unless you bring such claims to their attention.

Additional Information

The official instruction issued regarding this change can be found online, referenced via CR 3490, at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

On the above online page, scroll down while referring to the CR column on the right to find the link for CR 3490. 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 fiscal intermediary on their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

Related Change Request (CR) #: 3490
Medlearn Matters Number: MM3490
Related CR Release Date: September 17, 2004
Related CR Transmittal #:114
Effective Date: September 1, 2004
Implementation Date: October 1, 2004

END-STAGE RENAL DISEASE (ESRD)

Clarification Regarding Procedure Codes G0308-G0319

Payment for inpatient dialysis or evaluation and management service procedure codes were not allowed during the same calendar month as the Monthly Capitation Payment (MCP) for the procedure code 90918-90921 range. Instead, ESRD related procedures were denied or the MCP was prorated when billed during the same calendar month. The same process was implemented for the new procedure codes G0308-G0319 effective January 1, 2004.

CMS has clarified that the new ESRD in-center "G" procedure codes are based on visits not days. Therefore, Medicare will discontinue prorating G0308-G0319 or denying evaluation and management or inpatient/outpatient dialysis services when billed in the same calendar month.

> **EXAMPLE:** A 70-year-old patient has four face-to-face visits with the nephrologist for three weeks during a calendar month; then, the patient has inpatient visits or dialysis with the same or different physician for the fourth week in the same calendar month. The nephrologist may bill the full four visit procedure code (G0317) for the first three weeks during the calendar month.

As a result of this clarification, we will reprocess claims with dates of service January 1, 2004 – October 7, 2004. Providers who have claims incorrectly denied or reduced because of this issue do **not** need to take any action.

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

Note**: *This article was re-issued on August 17 to conform with the re-issued CR2813 on June 4. The effective and implementation dates and the transmittal number are the only changes resulting from this re-issuance.***

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

Provider Types Affected

Physicians, suppliers, and ESRD facilities.

Provider Action Needed

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

Background

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

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

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

Defining Non-Composite Payment Rate Tests

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

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

- **CD –** AMCC test that has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.
- **CE –** AMCC test that has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.
- **CF –** AMCC that is not part of the composite rate and is a separately billable test that has been ordered by an ESRD facility or MCP physician.
- In addition, the ESRD clinical laboratory test identified with modifiers "CD", "CE," or "CF" may not be billed as organ or disease panels. Upon the effective date of this requirement, all ESRD clinical laboratory tests must be billed individually.

Carrier Standard System Calculation

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

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

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

ESRD Facilities

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

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

Laboratories

Laboratories must identify the following:

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

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

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

Implementation

The implementation date is January 3, 2005. The partial implementation on October 4, 2004, includes the calculation of payments at the lowest rate for these automated tests, application of the 50/50 rule, comparing claims to prior claims in history for the same date of service, and the rejection of any line items with the "CD," "CE," and "CF" modifiers.

Related Instructions

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

The official instruction issued to your carrier on these changes may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R198CP.pdf*

This transmittal, which is Transmittal 198, also has some helpful examples of billing these tests as well as tables to show which tests are part of the composite rate and which are not.

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

Related Change Request (CR) #: 2813
Medlearn Matters Number: MM2813
Related CR Release Date: April 30, 2004
Related CR Transmittal #:198
Effective Date: October 4, 2004
Implementation Date: January 3, 2005

EVALUATION AND MANAGEMENT

Nursing Facility Visits (Codes 99301 – 99313)

Note: This article was revised on October 15, 2004, to delete an unnecessary bullet point from the original article and to add a statement on the use of CPT codes 99315 and 99316 for SNF/NF discharge day management services.
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, Non-Physician Practitioners (NPP), Skilled Nursing Facilities (SNFs).

Provider Action Needed

This article conveys revised payment policy so that NPPs may provide other covered, medically necessary visits prior to and after the initial visit by the physician in an SNF. This instruction states that Medicare policy requires a face-to-face visit with the resident for the SNF/Nursing Facility (NF) discharge day management service. The instruction also clarifies that a split/shared evaluation and management (E/M) visit may not be reported in the SNF or NF setting.

Background

Section 483.40 (c)(4) at Title 42 of the Code of Federal Regulations (CFR) did not define what the law meant by "initial" physician visit and therefore left the meaning open to interpretation, which impacted access to medically necessary care by other providers.

Therefore, the Centers for Medicare & Medicaid Services (CMS) has increasingly been asked to clarify "initial" visit and to allow NPPs to provide medically necessary visits when needed prior to the initial visit by the physician.

To ensure that all residents of nursing facilities have appropriate access to medical care, CMS has defined "initial visit" (comprehensive assessment) according to Survey and Certification memorandum (S&C-04-08) released on November 13, 2003 to State Survey Agencies and Medicare Part A and B contractors. Prior to release of that memorandum, NPP visits could not be paid prior to the initial visit by the physician in an SNF per 42 CFR 483.40 (c)(4) and (e) and in an NF per requirements at 42 CFR 483.40(f).

The Medicare Claims Processing Manual is now being revised per the Survey and Certification memorandum (S&C-04-08, dated November 13, 2003) so that NPPs may provide other covered, medically necessary visits prior to and after the initial visit by the physician. This instruction states that Medicare policy requires a face-to-face visit with the resident for the SNF/NF discharge day management service. The revision also states that a split/shared E/M visit may not be reported in the SNF/NF setting.

This definition will now permit medically necessary visits to be provided by NPPs prior to and after the "initial (comprehensive assessment) by the physician. Medicare contractors are being instructed to implement this payment policy revision as soon as possible.

CMS reminds providers of the following:

- Payment requirements for NPPs may differ from Federal survey and certification requirements.
- Medicare will pay only a physician for the initial/comprehensive E/M visit in a SNF or NF.
- The Medicare carrier will pay the physician who reports the initial visit (comprehensive assessment) using one of the SNF/NF CPT codes in the 99301-99303 range, and generally 99303 is used for this purpose.
- Medicare will pay the NPP for covered, medically necessary E/M visits prior to and after the initial/comprehensive visit reported by the physician and also for other required visits to comply with federal regulations at the option of the physician in the SNF setting and at the option of the state in the NF setting. Such visits should be reported with the appropriate CPT code in the 99301- 99302 and 99311-99313 range.
- Medicare will pay for annual NF assessments (other than the initial comprehensive assessment performed and reported by the physician), readmissions to the facility, or a major change in status in the resident when such services are submitted by the physician/NPP using CPT code of 99301 or 99302.
- Payment for services rendered by nurse practitioners (NP) and clinical nurse specialists (CNS) employed at an NF may be reassigned to the NF by the NP or CNS. In such cases, the NF should bill the appropriate Medicare carrier for the professional service using the UPIN of the NP or CNS.
- When a NF employs a physician assistant (PA), the NF will always bill the Medicare carrier for the professional service using the PA's UPIN.
- Medicare will pay for the SNF/NF discharge day management day service when it is performed face-to-face by the physician or NPP with the patient and is reported for the actual day of service. CPT codes 99315 and 99316 are used for this service.
- A split/shared service is not applicable in the SNF/NF setting.

Implementation

Medicare will implement these instructions on October 25, 2004.

Related Instructions

Survey and Certification memorandum (S&C-04-08), dated November 13, 2003, entitled Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) can be found at: *http://www.cms.hhs.gov/medicaid/survey-cert/sc0408.pdf.*

Additional Information

The Medicare Claims Processing Manual (Pub 100-4), Chapter 12 (Physician/Nonphysician Practitioners), Section 30 (Correct Coding Policy), Subsection 6.13 (Nursing Facility Visits (Codes 99301-99313)) is being revised. The updated manual instructions are included in the official instruction issued to your carrier and can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR3096 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3096
Medlearn Matters Number: MM3096
Related CR Release Date: September 24, 2004 Revised
Related CR Transmittal #: 302
Effective Date: November 13, 2003
Implementation Date: October 25, 2004

HCPCS

Corrections Involving HCPCS Codes 0040T and A9603

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

Provider Types Affected

Physicians and providers

Provider Action Needed

STOP – Impact to You

Physicians and providers should note that this instruction includes Healthcare Common Procedure Coding System (HCPCS) corrections involving HCPCS codes 0040T and A9603.

CAUTION – What You Need to Know

This instruction places an end date on HCPCS code A9603 as of December 31, 2003. Also, HCPCS code A9603 is a duplicate of HCPCS code A9517, and H**C**PCS code A9517 is the correct HCPCS code that must be billed for this service. **HCPCS code 0049T was incorrectly categorized in the HCPCS database as a laboratory service and given a lab certification number. The lab certification number and category are being removed from the Medicare claim processing system so claims containing HCPCS code 0040T can be processed for payment, as of July 6, 2004.**

GO – What You Need to Do

In reference to HCPCS code 0040T, there is nothing you need to do. The error mentioned above is being corrected in the Medicare claim processing system.

However, when billing for "radiopharmaceutical therapeutic imaging agent, I-131 sodium iodide capsule, per mci," use HCPCS code **A9517** and not **A9603**. Refer to the *Background* and *Additional Information* sections of this instruction for further details regarding these changes.

Background

Each year in the United States, health care insurers process over five billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. The HCPCS was developed for this purpose, and it is used for identifying items and services.

The HCPCS is not a methodology or system for making coverage or payment determinations. The existence of a code does not, of itself, determine coverage or noncoverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or modification of HCPCS codes are made independent of the

process for making determinations regarding coverage and payment.

Implementation Date

This instruction has an implementation date of July 6, 2004.

Additional Information

The official instruction issued to your contractor 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 3258 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 A customer service representatives is 1-877-602-8816.

In addition, a comprehensive overview of the HCPCS can be found at the following Centers for Medicare & Medicaid Services website: *http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp*.

Related Change Request (CR) Number: 3258
Related CR Release Date: May 7, 2004
Related CR Transmittal Number: 174
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

NONPHYSICIAN PRACTITIONERS

MMA-Nurse Practitioners as Attending Physicians in the Medicare Hospice Benefit

This information was previously published in the Fourth Quarter 2004 Medicare B Update! pages 27-28
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
For providers billing Local Part B carriers, and Local Part B carriers, for all applicable requirements, June 28, 2004.
For providers billing intermediaries, use of the GV modifier is to be implemented June 28, 2004, per the revised Medicare Claims Processing Manual (Pub. 100-04), Section 30.2 (Payment Rates).
For intermediary billing and systems, for all other applicable requirements, October 4, 2004.

NOTE: This transmittal replaces Pub. 100-04, Transmittal 205, which was issued on June 15, 2004. The manual instruction has been modified in Chapter 11 (Processing Hospice Claims), Section 40.1.3 (Attending Physician Services). All other information remains the same.

Provider Types Affected

Nurse practitioners, hospices.

Provider Action Needed

STOP – Impact to You

Nurse practitioners and hospices should note that nurse practitioners are being added to the definition of an attending physician for beneficiaries who have elected the hospice benefit.

CAUTION – What You Need to Know

Beginning December 8, 2003, Medicare pays for services provided by nurse practitioners to Medicare beneficiaries who have elected the hospice benefit and have selected a nurse practitioner as their attending physician.

GO – What You Need to Do

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

Background

This instruction implements Section 408 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which amends the Social Security Act (Section 1861(dd)(3)(B)) and (Section 1814(a)(7) to include nurse practitioners in the definition of an attending physician for beneficiaries who have elected the hospice benefit.

Beginning December 8, 2003, Medicare pays for services, with the exception of certifying the terminal illness with a prognosis of 6 months or less, if the illness runs its usual course, provided by nurse practitioners to Medicare beneficiaries who have elected the hospice benefit and have selected a nurse practitioner as their attending physician. A physician will be required to certify the terminal illness and 6 month prognosis.

Hospice agencies will bill their Regional Home Health Intermediary (RHHI) for attending physician services performed by a nurse practitioner employed by or under contract to the hospice agency. Also, nurse practitioners providing attending physician services, who are not employed by or under contract with a hospice agency, will bill the Medicare local Part B carrier.

Medicare Local Part B carriers and intermediaries will pay for these physician services rendered by nurse practitioners on or after December 8, 2003, at the lesser of actual charges or 85 percent of the physician fee schedule.

Instructions for care plan oversight for this provision will be provided under separate instruction.

Implementation Instructions/Dates

Medicare carriers have been instructed to search for and reopen denied claims for professional services of nurse practitioners serving as the hospice beneficiary's attending physician that were billed with modifier GV and where the services were furnished on or after December 8, 2003.

Where such services were not billed with modifier GV, Medicare carriers **will not reopen** the claims unless the nurse practitioner brings such claims to the attention of the carrier. If the nurse practitioner prefers, they can rebill such services rendered on or after December 8, 2003, with modifier GV to have the claims reprocessed.

RHHIs will accept all claims for attending physician services performed by a nurse practitioner in a hospice on or after December 8, 2003.

Hospice agencies are no longer required to submit copies of Notices of Election (NOEs) to Medicare carriers; **however,** when such agencies bill RHHIs, the hospice agency should continue submitting the NOEs to the RHHIs.

The implementation date for this instruction is June 28, 2004 for providers who bill local Part B carriers.

For providers billing intermediaries, use of modifier GV is also to be implemented on June 28, 2004, as presented in the Medicare Claims Processing Manual update in the transmittal, section 30.2, Form Locator (FL) 42, Revenue Code 0657.

Related Instructions

The following Internet Only Medicare Manuals (IOM) have been edited with revised and new sections to reflect the requirements to implement section 408 of the MMA.

- The Medicare Claims Processing Manual (Pub. 100-4), Chapter 11 (Processing Hospice Claims)
- The Medicare Benefit Policy Manual (Pub. 100-2), Chapter 9 (Coverage of Hospice Services Under Hospital Insurance).

Additional Information

The official instruction (CR 3226) issued to your carrier/intermediary regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that web page, look for CR 3226 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) #: 3226
Medlearn Matters Number: MM3226
Related CR Release Date: September 24, 2004
Related CR Transmittal #: 304
Effective Date: December 8, 2003
Implementation Dates:

RADIOLOGY

Allowance for Procedure R0070

The portable X-ray transportation code R0070 is priced by FCSO annually based on a special study of costs. The past two years, a group of portable X-ray suppliers has volunteered to provide expenses and supporting documentation that are used to calculate the price. The 2004 allowance for this code is $98.42 and is not subject to physician fee schedule update factors. Updates to the price are made solely on information from the cost study if they are warranted.

This group of suppliers has again volunteered to provide cost information for 2005, but information from other suppliers would be welcome. If you own a portable X-ray business and are willing to provide cost information on your business for the 2005 study, please contact Robert Petty at (904)-791-6274.

Positron Emission Tomography (PET) Scans for Dementia and Neurodegenerative Diseases

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

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:

h)

- 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); and,
- 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; and
- 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
Related CR Release Date: October 1, 2004
Related CR Transmittal #: 24
Effective Date: September 15, 2004
Implementation Date: October 4, 2004

MSN Messages and Reason Codes for Mammography

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

Provider Types Affected

Providers and suppliers who bill for mammography services.

Provider Action Needed

Suppliers and providers should note that this article discusses changes in Medicare Summary Notices (MSNs), which are sent to Medicare beneficiaries, and Remittance Advice (RA) messages sent to providers and suppliers regarding mammography claims.

Background

Revised instructions for the Medicare Claims Processing Manual have been issued regarding which MSN message and ANSI X-12 8351 Adjustment Reason Code will be used on the RA when Medicare processes mammography claims. The Spanish translation for each new MSN message has also been added to the revised manual.

Remittance Advice Messages

For providers/suppliers who bill carriers, the remittance advice messages will be as follows:

- For claims submitted by a facility not certified to perform digital mammographies, the RA will contain reason code *B6 "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty,"* along with remark code *N92 "This facility is not certified for digital mammography."*
  For claims submitted by a facility not certified to perform film mammographies, carriers will use existing reason code B6, *"This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty" along with remark code N110 "This facility is not certified for film mammography."*
  1 American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X-12 transactions are part of the *Transactions and Code Sets Rule* selected by HIPAA.
- For claims that were submitted with an invalid or missing FDA identification number, use existing reason code *16 "Claim/service lacks information which is needed for adjudication,"* along with remark code *MA128 Missing/incomplete/invalid six digit FDA approved identification number."*

Implementation

The implementation date of these changes is September 25, 2004.

Related Instructions

The Medicare Claims Processing Manual (Pub 100-4), Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services), Subsection 20.8 (Beneficiary and Provider Notices), Subsubsections 20.8.1 (MSN Messages) and 20.8.2 can be found on the CMS website 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 CR2617 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) #: 2617
Medlearn Matters Number: MM2617
Related CR Release Date: June 25, 2004
Related CR Transmittal #: 295
Effective Date: September 25, 2004
Implementation Date: September 25, 2004

SURGERY

Coverage by Medicare Advantage Organizations for National Coverage Determination (NCD) Services Not Previously Included in the Medicare Advantage's Capitated Rates

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

Provider Types Affected

Physicians, providers, and suppliers billing for the services mentioned below

Provider Action Needed

STOP – Impact to You

Medicare Advantage (MA) rates were recently adjusted to account for three National Coverage Determination (NCD) services. These services are implantable automatic defibrillators (effective 10/1/03), ventricular assist devices (effective 1/1/04), and lung volume reduction surgery (effective 1/1/04). MA organizations are liable for payment for these NCD services beginning January 1, 2005.

CAUTION – What You Need to Know

For services rendered prior to January 1, 2005, payment for services relating to the three NCD services mentioned above are paid by Medicare on a fee-for-service basis for MA plan enrollees. Note that, prior to January 1, 2005, beneficiaries are not responsible for Part A or Part B deductibles associated with these services, though they are responsible for coinsurance amounts appropriate under Medicare fee-for-service rules.

GO – What You Need to Do

Be aware that these services will not be paid on a fee-for-service basis on or after January 1, 2005. Instead, the MA plan will be responsible for making payment. Note also that MA enrollees receiving services for lung volume reduction surgery services must receive these services in designated hospitals.

Background

When Medicare issued these NCDs initially, new coverage was introduced and the cost of that coverage was not reflected in the rates paid to MA plans. Thus, Medicare paid for these services separately on a fee-for-service basis until such time as the cost could be considered in determining MA rates. The Centers for Medicare & Medicaid Services will factor these costs into the MA payment rates as of January 1, 2005. At that time, Medicare will no longer pay for these services on the fee-for-service basis.

Additional Information

Procedure codes associated with these services are reflected in the following table:

Procedure Codes	Description
32491	Removal of lung, other than total pneumonectomy; excision plication of emphysematous lung(s) (bullous or non-bullous), for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure.
33979	Insertion of Ventricular Assist Device, implantable intracorporeal, single ventricle
G0302	Preoperative pulmonary surgery services for preparation for LVRS, complete course of services to include a minimum of 16 days of service
G0303	Preoperative pulmonary surgery services for preparation for LVRS, 10-15 days of services
G0304	Preoperative pulmonary surgery services for preparation for LVRS, 1-9 days of services
G0305	Post discharge pulmonary surgery services after LVRS, minimum of 6 days of services
ICD-9 CM 37.66 ICD-9 CM 32.22	Insertion of implantable heart assist system Lung Volume Reduction Surgery

Inpatient Procedure Codes	Description
G0302	Preoperative pulmonary surgery services for preparation for LVRS, complete course of services to include a minimum of 16 days of service
G0303	Preoperative pulmonary surgery services for preparation for LVRS, 10-15 days of services
G0304	Preoperative pulmonary surgery services for preparation for LVRS, 1-9 days of services
G0305	Post discharge pulmonary surgery services after LVRS, minimum of 6 days of service
ICD-9 CM 37.66 ICD-9 CM 32.22	Insertion of implantable heart assist system Lung Volume Reduction Surgery

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

Related Change Request (CR) #: 3301
Medlearn Matters Number: MM3301
Related CR Release Date: N/A (CR is not available)
Related CR Transmittal #: N/A
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Percutaneous Transluminal Angioplasty (PTA)

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

Provider Types Affected

Hospitals, physicians, and suppliers.

Provider Action Needed

Effective October 12, 2004, Medicare will expand its coverage to include PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent. This must be for an FDA-approved indication when furnished in accordance with FDA-approved protocols governing post-approval studies. This is an addition to coverage in the context of an FDA-designated Category B Investigational Device Exemption(IDE) clinical trial.

Background

Percutaneous Transluminal Angioplasty involves inserting a balloon catheter into a narrow or occluded blood vessel to recanalize and dilate the vessel by inflating the balloon. The objective of PTA is to improve the blood flow through the diseased segment of a vessel so that vessel patency is increased and embolization is decreased. PTA (with and without the placement of a stent) is used for dilating lesions of peripheral, renal, and coronary arteries.

PTA is covered to treat atherosclerotic obstructive lesions:

- in the lower extremities, and the upper extremities not including head or neck vessels;
- in treatment of a single coronary artery for patients for whom the likely alternative treatment is coronary bypass surgery and who exhibit certain characteristics;
- of the renal arteries for patients in whom there is an inadequate response to a thorough medical management of symptoms and for whom surgery is the likely alternative; and
- of arteriovenous dialysis fistulas and grafts when performed through either a venous or arterial approach.

PTA treatments that are **not** covered include:

- in the carotid artery when used to treat obstructive lesions outside of FDA-approved protocols governing Category B IDE clinical trials and outside of FDA-required post approval studies;
- to treat obstructive lesions of the vertebral and cerebral arteries;
- for all other indications for which CMS has not specifically indicated coverage.

Additional Information

All providers should note that Fiscal Intermediaries (FIs) and carriers will follow the same procedures for processing post-approval study devices that are currently in place for Category B IDEs. For example, a letter of verification that the device is a post-approval study device should be sent to the carrier or intermediary before billing for the device.

In addition, providers billing carriers:

- Place no more than one Pre-Market Approval (PMA) number (that begins with a "P") in either item 23 of the CMS-1500 paper claim format or in the 2300 Investigational Device Exemption (IDE) Number Ref Segment, data element REF02 (REF01=LX) of the 837p claim format
- Use the QA modifier to reflect PTA post-approval study devices claim
- Use 37799, unlisted procedure, vascular surgery, as the procedure code
- Use 433.10 as the diagnostic code

For providers billing FIs:

- Place no more than one PMA number (that begins with a "P") in form locator 43 of the CMS-1450 paper form or in 2300 IDE Number Ref Segment, data element REF02 (REF01=LX) of the 837i
- Use revenue code 0624 for post-approval study devices in form locator 42 of the CMS-1450 paper claim form or 2400 Institutional Service Line SV201 Segment, data element 234 of the 837i
- Use 433.10 as the diagnostic code
- Use the inpatient procedure codes of 39.50 (angioplasty or atherectomy of non-coronary vessel) and 39.90 (insertion of non-coronary artery stent or stents)

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 3489 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please call your carrier/intermediary at their toll free number at:
http://www.cms.hhs.gov/medlearn/tollnums.asp.

Related Change Request (CR) #: 3489 Medlearn Matters Number: MM3489
Related CR Release Date: October 15, 2004 Related CR Transmittal #: 314 and 25
Effective Date: October 12, 2004 Implementation Date: October 12, 2004

THERAPEUTIC SERVICES

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

IMPORTANT NOTE: This instruction has been replaced by MM3339, the Medlearn Matters article for CR3339, Transmittal 15, titled: NCD: Sensory Nerve Conduction Threshold Test (sNCT), dated June 18, 2004. To see MM3339, go to: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3339.pdf*

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

Providers should know that the Centers for Medicare & Medicaid Services (CMS) has reviewed its policy on sNCT and reaffirms its original national non-coverage decision on sNCT.

Background

Based on a reconsideration of current Medicare policy for sNCT, CMS reaffirms its original national noncoverage policy regarding the Current Perception Threshold/Sensory Nerve Conduction Threshold Test (sNCT). The National Coverage Determination Manual (Pub. 100-03; Chapter 1; Subsection 160.23) has been updated to reflect this most recent non-coverage determination as a result of the reconsideration review.

The revision to the National Coverage Determination Manual is an NCD, and NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans.

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

Implementation

The effective date and the implementation date for this instruction is April 1, 2004.

Additional Information

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

On that web page, look for CR2988 in the CR NUM column on the right, and click on the file for that CR.

The revised portions of the NCD Manual are included with that CR.

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

OTHER SERVICES

MMA-Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial

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

Provider Types Affected

All providers involved in an NIH sponsored clinical trial

Provider Action Needed

STOP – Impact to You

In the specific context of an NIH sponsored clinical trial:

For services performed on or after October 1, 2004, Medicare will cover islet cell transplantation for trial participants (patients) with Type I diabetes. The islet cell transplant may be done alone or in combination with a kidney transplant. Immunosuppressive therapy to prevent rejection of the transplanted islet cells and routine follow-up care will be necessary for each trial participant.

CAUTION – What You Need to Know

Partial pancreatic tissue transplantation or islet cell transplantation performed outside the context of a clinical trial continues to be noncovered.

GO – What You Need to Do

Please stay current on instructions pertaining to NIH sponsored clinical trials to ensure accurate claims processing.

Background

As a result of Section 733 of the Medicare Modernization Act (MMA), for services performed/discharged on or after October 1, 2004, Medicare will cover islet cell transplantation for patients with Type I diabetes who are participating in an NIH sponsored clinical trial.

For dates of service on and after October 1, 2004, for such beneficiaries, Medicare carriers will accept claims for islet cell transplantation with a type of service code of 2 and a HCPCS of G0341 (Percutaneous islet cell trans), G0342 (Laparoscopy islet cell trans), or G0343 (Laparotomy islet cell transp). Physicians should also use the QV modifier for islet cell transplantation and routine follow-up care related to this NIH trial.

Where beneficiaries are enrolled in a Medicare Advantage (MA) plan, Medicare carriers or intermediaries should make payment directly to providers of these islet cell transplants in accordance with Medicare payment rules, except that MA beneficiaries receiving the services are not responsible for the Part A and Part B deductibles. Such beneficiaries will be liable, however, for any applicable coinsurance amounts that the MA organization has in place for clinical trial benefits.

Providers billing Medicare intermediaries for these services should do so on an 11x type of bill. Such claims will be paid by the intermediary only for IPPS hospitals participating in the trial, and claims for beneficiaries in MA plans should also include condition code 30 so the deductible will not be applied.

For fee-for-service beneficiaries, deductibles and coinsurance will apply.

Additional Information

The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3385, at: *http://www.cms.hhs.gov/manuals/pm_trans/R261Cp.pdf.*

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

Related Change Request (CR) #: 3385
Medlearn Matters Number: MM3385
Related CR Release Date: July 30, 2004
Related CR Transmittal #: 261
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Treatment of Obesity

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

Provider Types Affected

All Providers.

Provider Action Needed

No action is necessary. This article is informational only. Current language in the National Coverage Determinations (NCD) Manual states that "obesity itself cannot be considered an illness." This language is being removed as a result of a recent decision by the Secretary of Health and Human Services. The change in the manual language will not directly affect current Medicare coverage of obesity treatments. Treatments for obesity alone remain noncovered and treatments of diseases resulting in or exacerbated by obesity remain unchanged.

Providers should note, however, that removal of the language does permit interested parties to submit NCD requests for anti-obesity interventions to the Centers for Medicare & Medicaid Services to determine if scientific and medical evidence demonstrate their effectiveness in improving Medicare beneficiaries' health outcomes.

Background

Nationally Covered Indications

Services performed in connection with the treatment of obesity are covered by Medicare only when such services are an integral and necessary part of a course of treatment for diseases such as hypothyroidism, Cushing's disease, hypothalamic lesions, cardiovascular diseases, respiratory diseases, diabetes, and hypertension.

Nationally Noncovered Indications

The treatment of obesity alone (i.e., where obesity cannot be shown to be an integral part of a disease process) is not considered reasonable and necessary for the treatment of an illness or injury and is not covered under the Medicare program. Supplemental fasting is not covered under the Medicare program as a general treatment for obesity.

Other

Supplemented fasting with adequate monitoring of the patient is eligible for a local coverage determination at the discretion of your Medicare contractor where weight loss is necessary before surgery to ameliorate the complications posed by obesity when it coexists with pathological conditions such as cardiac and respiratory diseases, diabetes, or hypertension (and other more conservative techniques to achieve this end are not regarded as appropriate).

Implementation

The implementation date for this instruction is October 1, 2004.

Additional Information

The official instruction issued to your Medicare contractor 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 3502 in the CR NUM column on the right and click on the file for that CR. Attached to CR 3502 is the actual revised language for the Medicare NCD Manual.

If you have any questions, please contact your Medicare contractor at:
http://www.cms.hhs.gov/medlearn/tollnums.asp.

Related Change Request (CR) #: 3502
Medlearn Matters Number: MM3502
Related CR Release Date: October 1, 2004
Related CR Transmittal #: 23
Effective Date: October 1, 2004
Implementation Date: October 1, 2004

Autologous Blood-Derived Products for Chronic, Non-Healing Wounds

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

Provider Types Affected

All Medicare providers

Provider Action Needed

No action is necessary. This article is informational only. The Centers for Medicare & Medicaid Services (CMS) has determined, upon reconsideration of existing policy, that autologous blood-derived products for chronic non-healing cutaneous wounds, both platelet-derived growth factor (PDGF) in platelet-poor plasma and platelet-rich plasma (PRP), **will remain noncovered** as CMS continues to believe that the clinical effectiveness of these autologous blood-derived products is not adequately proven in scientific literature.

Background

Patient-donated blood is centrifuged to produce an autologous gel for the treatment of chronic non-healing cutaneous wounds that persist for 30 days or longer and fail to complete the healing process properly.

Autologous blood-derived products for chronic non-healing wounds include both PDGF products, such as Procuren and more recent products, and PRP products.

PRP differs from previous products because it contains whole cells, including white cells, red cells, plasma, platelets, fibrinogen, stem cells, macrophages, and fibroblasts. Physicians use PRP in clinical settings. PDGF does not contain cells and was marketed as a product to be used by patients at home.

In 1992 CMS issued a national Medicare noncoverage determination in relation to platelet-derived wound healing formulas containing growth factors in the treatment of non-healing wounds. The determination was based on a lack of sufficient published data to determine the safety and efficacy of such formulas, and a public health service technology assessment.

Recently, CMS reconsidered the 1992 decision and concluded that the clinical effectiveness of autologous PDGF products continues to be inadequately proven in scientific literature, and it remains non-covered for treatment of chronic, non-healing cutaneous wounds. Additionally, the clinical evidence does not support a benefit in the application of autologous PRP for the treatment of chronic, non-healing wounds, and CMS has determined it is not reasonable and necessary and is nationally non-covered.

It will remain at the local contractor's discretion whether to pay for becaplermin, a non-autologous growth factor product approved by the FDA for the treatment of chronic non-healing subcutaneous wounds. Also, the routine costs of autologous PRP products for the treatment of chronic non-healing wounds associated with category B investigational device exemption clinical trials are covered by Medicare in accordance with 42 CFR 405.201 – 405.215, 411.15, and 411.406 or section 310.1 of the National Coverage Determinations Manual.

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 3384 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 A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: MM3384
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 19
Effective Date: July 23, 2004
Implementation Date: July 23, 2004

Magnetic Resonance Spectroscopy for Diagnosing Brain Tumors

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction notifies physicians, providers and suppliers that upon reconsideration, the Centers for Medicare & Medicaid Services (CMS) determined that magnetic resonance spectroscopy (MRS) used as a diagnostic tool for distinguishing indeterminate brain lesions and/or as an aid in conducting brain biopsies is not reasonable and necessary, and CMS reaffirms its existing noncoverage policy for all indications of MRS.

Background

Magnetic resonance spectroscopy (MRS) is an application of magnetic resonance imaging (MRI). It is a noninvasive diagnostic test that uses strong magnetic fields to measure and analyze the chemical composition of human tissues. On March 22, 1994, CMS considered MRS an investigational procedure and issued a national noncoverage determination for all indications of MRS.

Upon thorough review and reconsideration of the existing noncoverage policy, as well as the available evidence for the use of MRS as a diagnostic tool for distinguishing indeterminate brain lesions, and/or as an aid in conducting biopsies, CMS determined that the evidence is not adequate to conclude that MRS is reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act.

Therefore, CMS reaffirms its existing noncoverage policy at Section 220.2.1 (Magnetic Resonance Spectroscopy) of the National Coverage Determinations (NCD) Manual for all indications of MRS. This addition to Section 220.2.1 is a national coverage determination (NCD), and NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. In addition, an administrative law judge may not review an NCD (see Section 1869(f)(1)(A)(i) of the Social Security Act).

Implementation

The implementation date for this reaffirmation of the NCD is September 10, 2004.

Additional Information

In addition to the updated manual instructions found at Section 220.2.1 (MRS) of the Medicare NCD Manual (Pub 100-03), Chapter 1, as outlined above, Sections 220.2 (MRI), and 220.3 (Magnetic Resonance Angiography) are being reprinted with clerical/technical edits/clarifications. There are no substantive revisions and no changes to existing NCD policy. The updated manual instructions are included in the official instruction issued to your contractor, and it can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3425 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3425
Related CR Release Date: September 10, 2004
Related CR Transmittal Number: 21
Effective Date: September 10, 2004
Implementation Date: September 10, 2004

HIPAA - The Health Insurance Portability and Accountability Act

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

All providers

Provider Action Needed

Be aware of the current remittance advice remark and reason codes to understand actions taken on your claims.

Background

The Centers for Medicare & Medicaid Services (CMS) maintains the remittance advice remark code list, one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG).

The complete list of these codes may be found at: *http://www.wpc-edi.com/codes/Codes.asp*.

The list is updated three times per year.

By July 6, 2004 all Medicare carriers and fiscal intermediaries (FIs), including the durable medical equipment carriers (DMERCs) and the regional home health intermediaries (RHHIs), will have incorporated all current remark code changes in their Medicare systems.

Remark Codes Changes

The following table summarizes remark code changes made from November 1, 2003 to February 29, 2004.

New	Codes
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.
N214	Missing/incomplete/invalid history or history of the related initial surgical procedure(s).
N215	A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own determination.
N216	Patient is not enrolled in this portion of our benefit package.

Modified Remark Codes (Effective April 1, 2004)

M119	Missing/incomplete/invalid/deactivated/ withdrawn National Drug Code.
N115	This decision is based on a local medical review policy (LMRP) or local coverage determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd*, or if you do not have web access, you may contact the contractor to request a copy of the LMRP/LCD.

Modified Remark Codes (Effective February 1, 2004)

M51	Missing/incomplete/invalid procedure code(s) and/or dates.
M69	Paid at the regular rate because you did not submit documentation to justify the modified procedure code.
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
MA92	Missing/incomplete/invalid plan information for other insurance.

Deactivated Remark Codes

None

Claim Adjustment Reason Code Changes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes.

The committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about changes, additions, modifications, and retirement of reason codes. The updated list is posted three times per year, after each meeting, and the list may be found at: *http://www.wpc-edi.com/codes/Codes.asp*.

The committee approved the following reason codes as new codes as of February 2004:

Code	Current Narrative
161	Provider performance bonus
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks code for specific explanation.

Related Change Request (CR) Number: 3227
Related CR Release Date: April 30, 2004
Related CR Transmittal Number: 154
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Revised American National Standards Institute X12N 837 Professional Health Care Claim Companion Document

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

STOP – Impact to You

Physicians, suppliers, and providers should note that this instruction provides revisions to the American National Standards Institute (ANSI) X12N 837 Professional Health Care Claim Companion Document.

CAUTION – What You Need to Know

The revisions to the ANSI X12N 837 Professional Health Care Claim Companion Document correct errors and omissions in the Companion Document (CD) provided previously by Change Request (CR) 2900, Transmittal 29, dated December 19, 2003.

GO – What You Need to Do

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

Background

The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable health information to be exchanged electronically, and the Administrative Simplification Act (ASA), one of the HIPAA provisions, requires standard formats to be used for electronically submitted health care transactions.

The American National Standard Institute (ANSI) developed these, and the ANSI X12N 837 Implementation Guide (IG) has been established as the standard of compliance for claim transactions.

A Companion Document is defined as a set of statements, which supplements the X12N 837 Professional IG, and it clarifies contractors' expectations regarding data submission, processing, and adjudication.

This instruction revises the X12N 837 Professional Health Care Claim Companion Document and corrects errors and omissions in the CD (previously provided by Change Request (CR) 2900, Transmittal 29, dated December 19, 2003).

This instruction also provides additional language to the CD to cover items not previously addressed.

Also note that the Companion Document supplements, but does not contradict, requirements in the X12N 837 Professional IG. A summary of changes to the document includes the following:

- Addition of a new statement indicating "All diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes, pointed to or not, will be rejected;"
- Addition of two negative value statements for the 2400 loop (SV102 and CR102/CR106) which were omitted from the previous document;
- Revision to the calendar date statement, which changes it from "should" to "must;"
- Revisions to the maximum CLM statement which allows your carrier to specify the actual [value] and changes "will" to "will/may;"
- Revisions to ISA06 and ISA08 statements which changes both from "required" to "optional;"
- Correction made to option B of modifier statement; and
- Removal of calendar date statement from 997 section.

The specific language provided in the Companion Document is based on recommendations/decisions made by the Electronic Data Interchange Functional Workgroup (EDIFWG). The EDIFWG consists of members from the Centers for Medicare & Medicaid Services (CMS), Part B contractors, and shared system maintainers.

To view the actual details of the changes for this CD, please see the additional information section for instructions on how to access the official CMS instruction issued to your carrier.

Implementation

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

Additional Information

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

From that web page, look for CR3177 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.*

Also, IGs for all transactions are available electronically for each transaction at the following website*:* *http://www.wpc-edi.com.*

Related Change Request (CR) #: 3177
Medlearn Matters Number: MM3177
Related CR Release Date: April 23, 2004
Related CR Transmittal #: 73
Effective Date: May 24, 2004
Implementation Date: May 24, 2004

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

All providers

Provider Action Needed

STOP – Impact to You

The June 2004 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes.

CAUTION – What You Need to Know

The most current and complete list will be found online at: *http://www.wpc-edi.com/codes/Codes.asp*

Please note that in case of a discrepancy, the code text included on the Washington Publishing Company (WPC) web site will supersede any corresponding text in a CR. In addition, with respect to Health Care Claim Adjustment Reason Codes, few temporary reason codes (D16-D20) were added for the cases where commercial payers do not make use of the available remark codes when the reason code used is too generic to help providers decide on the follow-up action. ***Medicare will not use these new temporary reason codes but rather will continue the current use of the combination of reason and appropriate remark codes.***

GO – What You Need to Do

The above noted codes are updated three times a year. Please advise billing staff to stay current with the latest approved and valid codes, in accordance with effective and implementation dates, to ensure accurate Medicare claims processing.

Background

The Remittance Advice Remark Code list is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). This list is maintained by The Centers for Medicare & Medicaid Services (CMS) and is updated three times a year. The complete list of current codes is available online at the WPC web site: *http://www.wpc-edi.com/codes/Codes.asp*

The Health Care Claim Adjustment Codes are maintained by the Claim Adjustment Reason Code and Status Code Maintenance Committee. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and decides on any additions, modifications, or retirement of reason codes. The updated list is posted three times a year and the complete list of current codes is available online at the WPC website: *http://www.wpc-edi.com/codes/Codes.asp*

Additional Information

The most recent changes approved for the Remittance Advice Remark Codes and the Claim Adjustment Reason Codes can be found in the official instruction issued to your carrier or fiscal intermediary, including Durable Medical Equipment Regional Carriers (DMERCs). That official instruction is found in CR 3466, which is available at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

Once at that page, scroll down the CR NUM column on the right to find the link for CR 3466. Click on the link to open and view the file for the CR.

The CR attachments also include information on the process of decision making that results in updates to the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. It also includes a table of changes; however, please note that the most current and complete list is online at the WPC web site. This CR includes changes made only from March through June of 2004.

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

Related Change Request (CR) #: 3466	Medlearn Matters Number: MM3466
Related CR Release Date: October 15, 2004	Related CR Transmittal #: 313
Effective Date: January 1, 2005	Implementation Date: January 3, 2005

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

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

Provider Types Affected

All providers

Provider Action Needed

STOP – Impact to You

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all payers to use the applicable health care claim status category codes and health care claim status codes.

CAUTION – What You Need to Know

Medicare intermediaries (FIs) and carriers must periodically update their claim system with the most current health care claim status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277.

GO – What You Need to Do

Providers will need to be aware of the new codes that may appear on their response to a claim status inquiry.

Background

Medicare FIs and carriers must periodically update their claim system with the most current health care claim status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277. Under HIPAA, all payers must use health care claim status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee.

At each X12 trimester meeting (generally held in the months of February, June and October) the Committee may update the claim status category codes and health care claim status codes. Included in the code list are specific details, such as the date a code was added, changed, or deleted.

Per HIPAA, health plans must be able to conduct the standard electronic transactions mentioned in the regulation. The named HIPAA transaction for claim status is the ASC X12N 276/277 4010A1 Health Care Claim Status Request and Response. The code sets for use with the 276/277 are the Health Care Claim Status Category Codes and Health Care Claim Status Codes.

Medicare contractors are already using these code sets because of prior instructions. However, recently some new codes and code changes were made with the designation "new as of 2/04." Medicare FIS and carriers will start using the "new as of 2/04" codes as of January 3, 2005.

Additional Information

Claim status codes are used in the Health Care Claim Status Notification (277) transaction in the STC01- 2, STC10-2 and STC11-2 composite elements. They indicate the detail about the general status communicated in the Claim Status Category Codes carried in STC01-1, STC10-1 and STC11-1.

Claim status codes communicate information about the status of a claim, i.e., whether it's been received, pended, or paid.

For users who are new to the Claim Status transaction, please review the *276/277 Implementation Guide* for using claim status codes.

The Claim Status transaction is not used as a financial transaction.

Claim status category codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-1, STC10-1 and STC11-1 composite elements. They indicate the general category of the status (accepted, rejected, additional information requested, etc.), which is then further detailed in the claim status codes carried in STC01-2, STC10-2 and STC11-2.

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

By January 3, 2005, Medicare FIS and carriers must have all applicable code changes and new codes that are posted on the website with the "new as of 2/04" designation and prior dates available for use in production.

The official instruction issued to your contractor 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 3361 in the CR NUM column on the right, and click on the file for that CR.

Related Change Request (CR) Number: 3361
Related CR Release Date: July 23, 2004
Related CR Transmittal Number: 230
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 230, CR 3361, PCM #0420809

GENERAL INFORMATION

FRAUD, WASTE, AND ABUSE

CMS Program Integrity Initiative

August 30, 2004

The Centers for Medicare & Medicaid Services (CMS) today announced efforts to protect the nation's largest federal

health programs through the use of enhanced tools that will help to better identify and reduce fraud and abuse and prevent improper payments.

CMS is building on its current program integrity efforts by increasing the use of claims data and further analyzing that information to more efficiently detect improper payments, vulnerabilities in all Medicare and Medicaid programs, and potential areas of fraud and abuse. CMS seeks to use its analysis to more effectively educate providers and beneficiaries in an effort to prevent and minimize waste, fraud, and abuse. CMS' program integrity efforts are being expanded beyond fee-for-service Medicare to also encompass oversight of the discount drug card program, Part D prescription drug benefit and the new Medicare Advantage plans. CMS will also continue to focus on program integrity efforts relating to the Medicaid program.

CMS is also taking a number of steps to enhance its program integrity efforts in response to the increased programmatic responsibilities assumed under the MMA and the demonstrated need for more coordinated efforts to identify and correct program vulnerabilities (as illustrated by the increase in power wheelchair spending and with hospital outliers).

Increased Oversight Role to Protect the Medicare Trust Funds

- The enhanced CMS Program Integrity oversight extends beyond fee-for-service Medicare and will now include the Medicare-Approved Drug Discount Card Program, the new Medicare prescription drug benefit and the Medicare Advantage plans.
- CMS has contracted with IntegriGuard, a program safeguard contractor (PSC), to monitor activities associated with drug cards. A critical task of this PSC is a weekly assessment of the sponsor's drug pricing information to identify any "bait and switch" activities. Additionally the PSC will be working to identify fraudulent activities surrounding the discount drug card program including counterfeit drug cards and identity theft schemes.
- CMS is also continuing to work with law enforcement agencies to aggressively pursue all cases where companies posing as drug card sponsors have compromised Medicare beneficiaries.

Increased Oversight of the Medicaid Program

CMS is expanding the Medicare-Medicaid (Medi-Medi) match program where claims data from both programs is analyzed together to detect patterns that may not be evident when billings for either program are viewed in isolation. As a result of combining the data, CMS can identify previously undetected patterns, such as "time bandits," providers who bill for a total of more than 24 hours in a day in both programs. This project allows CMS to identify vulnerabilities in both programs and work with the states, where appropriate, to take action to protect the federal share of Medicaid dollars. CMS' goal is to ultimately review this data in "real time."

- The Medi-Medi program began in 2001 with the State of California. After two years of data matching and expansion to six more states, this program has posted results of $75 million worth of cost avoidance, identification of program vulnerabilities, savings, and recoupments. More than 90 cases have been referred to federal and state law enforcement agencies that are in various stages of development and/or ongoing investigation. Given its success in the first seven states, CMS is expanding the Medicare and Medicaid data evaluation to the states of Ohio and Washington. Federal expenditures in these states exceed $28 billion.
- Expansion of the Medicare-Medicaid match project will also help in better oversight of prescription drug fraud since many Medicaid prescription drug beneficiaries will see their drug benefits through Medicare beginning in 2006.
- To support one of CMS' top priorities, combating fraud, waste, and abuse in the Medicare-Medicaid provider enrollment process, a workgroup has been established that explored the feasibility of coordinating the Medicare and Medicaid provider enrollment processes in ways that increase the overall effectiveness and efficiency of those systems. A pilot project involving three states began in fiscal year 2004. The intent of this project was to produce a "one-stop" or a combined provider enrollment form applicable to both programs. This effort has been very successful and has resulted in identifying efficiencies that have been beneficial to both programs.

CMS has issued a proposed regulation calling on states to report improper payments in Medicaid and State Children's Health Insurance programs to HHS. Under the proposed rule, which is open for public comment until September 27, CMS will require states to estimate these improper payments by reviewing a monthly sample of Medicaid and SCHIP claims. This information will be used to determine the accuracy of the payments based on whether the individual was eligible for the program, medical review and data processing. Once CMS receives this information from all 50 states and the District of Columbia the national error rate will be calculated. The regulation can be found at In addition to announcing its enhanced steps to analyze program data, CMS today issued a proposed regulation calling on states to report improper payments in Medicaid and State Children's Health Insurance programs to HHS. Under the proposed rule, which is open for public comment until September 27, CMS will require states to estimate these improper payments by reviewing a monthly sample of Medicaid and SCHIP claims. This information will be used to determine the accuracy of the payments based on whether the individual was eligible for the program, medical review and data processing. Once CMS receives this information from all 50 states and the District of Columbia the national error rate will be calculated. (The proposed rule can be found at: *http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/04-19603.htm*.)

Greater Emphasis on Identifying, Responding to and Resolving Problems

- Building on its current data collection efforts, CMS will increase the use of electronic data to more efficiently detect improper payments, program vulnerabilities, and potential areas of fraud and abuse in both the Medicare and Medicaid programs.
- CMS is tracking and trending Medicare and Medicaid claims data on a national level so it can identify problems at the health care provider and service specific levels. This information can be used to proactively identify potential problematic utilization spikes so that their underlying cause can be determined.
- CMS is monitoring this information and work across the Agency to identify program vulnerabilities faster and more efficiently so problems can be addressed and possibly resolved through additional provider education and informational efforts.
- Through the collection and analysis of these data, CMS will be better able to effectively use provider and beneficiary education efforts to prevent and minimize waste, fraud, and abuse. CMS will continue to work closely with the Medicare contractors, the private companies that process and pay Medicare claims, to make sure appropriate education and guidance is given to the provider community on billing problems identified.

Expansion of Existing Successful Oversight Efforts

- A new CMS satellite office is being established in Los Angeles to reduce the unusually high rates of improper payments identified in the Medicare and Medicaid programs in California. Current CMS oversight efforts have identified many storefront operations set up to defraud the Medicare and Medicaid programs by billing for services never provided. CMS already has a satellite office in Miami that has been very successful in identifying fraudulent activities in that area.
- In addition to continuing the Comprehensive Error Rate Testing (CERT) program, which has successfully helped to reduce the Medicare national paid claims error rate from 14 percent in 1996 to 5.8 percent in 2003, CMS is implementing an initiative to determine the payment error rate for the Medicaid program and the State Children's Health Insurance Program. Combined, these programs will allow CMS to be able to identify and respond to improper payments quickly thereby stopping taxpayer dollars from going out the door. Through the work of the CERT program, CMS is able to better target problem areas and take the appropriate corrective action.

Source: CMS website, Headlines dated August 30, 2004

Important News about Flu Shots for Medicare Beneficiaries

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction provides important information to physicians and other providers regarding flu vaccinations for Medicare beneficiaries for the 2004 – 2005 influenza season. Despite the flu vaccine shortage, Medicare beneficiaries are being encouraged to obtain the flu vaccine from their regular physician.

Background

One of the principal pharmaceutical companies manufacturing flu vaccine was unable to provide the quantity of vaccine needed for this flu season, and this caused the flu vaccine supply to be reduced by almost one half of the expected amount. **This shortage does not, however, include pneumococcal vaccine.**

Because of the limited availability of flu vaccines this season, the Centers for Disease Control and Prevention (CDC) is recommending that individuals be given priority for getting the flu vaccine who are 1) at high risk for serious flu complications; or 2) in contact with people at high risk for serious flu complications.

Individuals in the following groups are included in the high-risk category, and they should receive a flu vaccination this season:

- Individuals age 65 or older
- Individuals with a chronic condition such as heart or lung disease
- Nursing home residents
- Pregnant women
- Health care workers who provide direct patient care
- Infants and toddlers ages 6-23 months
- Children on aspirin therapy
- Individuals who care for or live with infants younger than six months of age.

Please note that CDC also recommends that the majority of individuals with Medicare should not take FluMist because it is approved only for people ages 5 – 49. The only Medicare beneficiaries who should take FluMist are healthy disabled persons ages 5 – 49.

These recommendations and other information for health care professionals, including Qs & As developed by CDC, can be found at: *http://cdc.gov/flu/* on the Web.

Medicare Billing for Flu Vaccines

Because Medicare beneficiaries generally fall into this high-risk category, they are being encouraged to obtain the flu vaccine from their regular physician. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, the billing procedure will vary depending on whether the physician or provider is enrolled in the Medicare program.

If you are a Medicare-enrolled physician or provider and have the flu vaccine available, you must bill Medicare for the cost of the vaccine and the beneficiary will pay nothing; i.e., there is no deductible or coinsurance payment. Medicare rules require you to bill the Medicare Program on an assignment basis.

Please remember that Medicare allows for roster billing when you administer flu vaccine to a number of beneficiaries at one location (e.g., a physician's office).

The specific rules to follow for roster billing can be found in Chapter 18, Section 10.3 of the Claims Processing Manual, at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*

If you do not have the vaccine available, you should refer your patients to 1-800-MEDICARE (1-800-633- 4227; TTY users should call 1-877-486-2048) or to *http://www.medicare.gov* where they can get the phone number for their state health department. Health departments throughout the United States are attempting to ensure that as many high-risk individuals as possible will get a flu vaccine.

If you are not a Medicare-enrolled physician or provider who gives a flu vaccine to a Medicare beneficiary, you can ask the beneficiary for payment at the time of service. The beneficiary can then request Medicare reimbursement. Medicare reimbursement will be approximately $18 for each flu vaccine.

To request reimbursement, the beneficiary will need to obtain and complete form CMS 1490S by calling 1-800-MEDICARE, or they may access and download the form at *http://www.cms.hhs.gov/forms* on the Web.

In order to receive reimbursement, you will need to provide the beneficiary with a receipt for the flu vaccine that has the following information written or printed on it:

- The doctor's or provider's name and address
- Service provided ("flu vaccine")
- Date flu vaccine received
- Amount paid.

If you are currently not enrolled in Medicare but want to enroll to bill Medicare directly for the flu vaccine, your enrollment application will be expedited. CMS 855 enrollment applications and carrier contact information can be found on the following CMS website: *http://www.cms.hhs.gov/providers/enrollment*.

Additional Information

Please note that beneficiaries have been advised to contact the Inspector General's hotline at 1-800-HHSTIPS (1-800-447-8477) to file a complaint if they believe their physician or provider charged an unfair amount for a flu vaccine.

If your patients have questions regarding flu vaccine, please refer them to *http://www.medicare.gov* on the Web or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877- 486-2048.

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

Source: CMS Special Edition Medlearn Matters SE0464

Flu Vaccine Issues

The Center for Disease Control and Prevention is working with the state health departments and Aventis to identify locations of existing vaccine supplies.

Any problems with flu vaccine access or distribution should be reported to the CDC.

Health care providers can call the Clinical Inquiry Line at 1-877-554-4625 with questions related to flu vaccine.

Health providers interested in rerouting his/her stock of vaccine to others should contact their local health department.

Reports of price inflation should be directed to Jim Harrison at 404-639-8250. The following information should be provided when possible:

- Name of person calling in report
- Affiliation of person calling in report
- **Phone number of person calling in report**
- Name of entity inflating prices (i.e. company, individual, etc.)
- Phone number of entity inflating prices
- Name of a contact person at entity inflating prices
- Vaccine presentation (10-dose vials, etc.)
- **Price**

The phone number of person calling in report and the price are essential.

Update to Medicare Deductible, Coinsurance, and Premium Rates for Calendar Year (CY) 2005

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction updates Medicare deductibles, coinsurance, and premium rates for CY 2005.

Background

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) or Part A benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but they are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30- 39 quarters of covered employment. **When voluntary enrollment takes place more than 12 months after a person's initial enrollment period for HI benefits, the monthly premium is increased by 10 percent.**

Under the Supplementary Medical Insurance (SMI) plan or Part B, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay) that are set by statute. **When SMI enrollment by a beneficiary takes place more than 12 months after the initial enrollment period, the monthly premium increases by 10 percent for each full 12-month period during which the individual could have been enrolled, but was not.**

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements.

Inpatient Hospital Services

A beneficiary is responsible for an inpatient hospital deductible amount for inpatient hospital services furnished in a spell of illness (which is deducted from the amount payable by the Medicare program to the hospital).

- **More than 60 Days.** When a beneficiary receives such services for more than 60 days during a spell of illness, he/she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per day for the 61st-90th day spent in the hospital.
- **After the 90th Day.** An individual has 60 lifetime reserve days of coverage, which he or she may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to onehalf of the inpatient hospital deductible.
- **Skilled Nursing Facility (SNF) (21st through 100th day).** A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of SNF services furnished during a spell of illness.

For CY 2005, the premium, deductible, and coinsurance amounts are as follows:
Year 2005 Medicare Part A Deductible, Coinsurance, and Premium Amounts:

- Deductible: $912.00 per benefit period
- Coinsurance:
- $228.00 a day for days 61-90 in each period
- $456.00 a day for days 91-150 for each lifetime reserve day used
- $114.00 a day in a SNF for days 21-100 in each benefit period

Premium per month:

- $375.00 for those who must pay a premium
- $412.50 for those who must pay both a premium and a 10 percent increase
- $206.00 for those who have 30-39 quarters of coverage
- $226.60 for those with 30-39 quarters of coverage who must pay a 10 percent increase

Year 2005 Medicare Part B Deductible, Coinsurance, and Premium Amounts:

- Deductible: $110.00 per year
- Coinsurance: 20 percent
- Premium per month: $78.20

The following table compares Medicare Part A deductible, coinsurance, and premium amounts for Years 2001 through 2005:

Implementation

Year	Inpatient Hospital Deductible, 1st 60 Days ($)	Inpatient Hospital Coinsurance, 61st-90th Days ($)	60 Lifetime Reserve Days Coinsurance ($)	SNF Coinsurance ($)
2001	792	198	396	99.00
2002	812	203	406	101.50
2003	840	210	420	105
2004	876	219	438	109.50
2005	912	228	456	114

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

Related Instructions

CR 3121 (Transmittal 3), "New Part B Annual Deductible," was issued on March 12, 2004. CR 3121 updated the 2005 Part B deductible based on section 629 of the Medicare Prescription Drug, Improvement and Modernization Act. The same information held in CR 3121 is being communicated in CR 3463.

Therefore, CR 3463 is replacing CR 3121 to prevent unintended consequences that may result from implementing both CR 3463 and CR 3121 together.

Additional Information

The Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01), Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations) has been revised and the updated manual instructions are attached to the official instruction released to your carrier/intermediary. You may view that instruction by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR3463 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) #: 3463
Medlearn Matters Number: MM3463
Related CR Release Date: September 10, 2004
Related CR Transmittal #: 10
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider TeleTYpewriter Service Now Available

In accordance with Section 508 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, First Coast Service Options, Inc. (FCSO) provider call center has implemented a TeleTypewriter (TTY) line to service the provider community. A TTY equipment is a special device permitting hard of hearing, or speech impaired individuals to use the telephone by typing messages back and forth to one another instead of talking and listening. To communicate via TTY line, both parties involved in the conversation need to have TTY equipment.

Florida Providers
The TTY number for **Florida** Medicare Part A and Part B providers is **1-877-660-1759.** This service is available Monday-Friday, from 8:00 a.m. to 4:30 p.m. Eastern and Central time zones.

Connecticut Providers
The TTY number for **Connecticut** Part B providers is **1-877-236-7851.** This service is available Monday-Friday, from 8:00 a.m. to 4:30 p.m. Eastern time zone.

SKILLED NURSING FACILITY CONSOLIDATED BILLING

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

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

Provider Types Affected

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

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.

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 noncovered 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 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
Implementation Date: N/A

October 2004 Quarterly Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used For Skilled Nursing Facility (SNF) Consolidated Billing Enforcement

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

Provider Types Affected

Institutional providers billing claims to the Medicare Fiscal Intermediaries (FIs).
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 CB enforcement list.

CAUTION – What You Need to Know

Services included on the SNF CB enforcement list will be paid to SNF Medicare providers only. Services excluded from the SNF CB 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 list of HCPCS codes that are subject to the CB provision of the SNF Prospective Payment System (SNF PPS). Services appearing on this list submitted on claims to Medicare Fiscal Intermediaries (FIs) and Carriers, including Durable Medical Equipment Regional Carriers (DMERCs) will not be paid to any Medicare providers, other than a SNF, when included in SNF CB.

For non-therapy services, the SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, the SNF CB applies to physical, occupational, or speech-language therapy services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services excluded from the SNF CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay.

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. New updates are required by changes to the coding system, not because the services subject to the SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

The codes below are listed as being added or removed from the annual update, mentioned above. Deletions from

Major Category I F. below, specifically HCPCS code 36489, is being removed because the HCPCS was discontinued as of December 31, 2003. additions to what is noted as Major Category III 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. Additions to therapy inclusions, Major Category V below, mean 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.

Outpatient Surgery and Related Procedures (Major Category I F., FI Annual Update, INCLUSION)
Remove 36489? – placement of cv catheter
Note on code above**:**
Code discontinued effective December 31, 2003.

Customized Prosthetic Devices (Major Category III, FI Annual Update, EXCLUSION)
For FI claims processing, remove K0556*, K0557*, K0558*, K0559* - Addition to lower extremity, below knee/above knee, custom fab. **For carrier claims processing**, these codes will remain payable for dates of service prior to January 1, 2004.
Add L5673****** - addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
Add L5679****** - addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism

Chemotherapy Administration *(Major Category III, FI Annual Update, EXCLUSION)*
Remove 36489******* - placement of cv catheter
Notes on codes above:
***** Codes were replaced by L5673, L5679, L5681 and L5683.
****** Codes are added to exclusion list retroactive to 1/1/04.
******* Code discontinued effective 12/31/03.

Therapies *(Major Category V, FI Annual Update, for FI billing use revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)*
Remove G0295^ Electromagnetic stimulation, to one or more areas (Not covered by Medicare) (This code was not previously included on carrier coding files.)
Remove G0237^^ - Therapeutic procd strg endur
Remove G0238^^ - Oth resp proc, indiv
Remove G0239^^ - Oth resp proc, group
Remove G0302^^ - pre-op LVRS service
Remove G0303^^ - pre-op service LVRS 10-15dos
Remove G0304^^ - pre-op service LVRS 1-9dos
Remove G0305^^ - post-op service LVRS min 6dos

Add G0329 ^^^ - electromagnetic therapy, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

Notes on Codes above**:**
^ This code was erroneously added to file. Code was not previously included on carrier coding files.
^^ These codes are not considered therapy codes and are not payable to a SNF. They were inadvertently added to the table.
^^^ This code was added to the therapy inclusion list effective July 1, 2004. (Information concerning this code was not received in time to issue a July 2004 update.)

Additional Information

Each January, separate instructions are published for FIs, Carriers and DMERCs for the annual notice on the SNF CB. The 2004 annual updates for FIs can be found on the CMS website at:
http://www.cms.hhs.gov/manuals/pm_trans/R19CP.pdf.
This instruction is referred to as CR2926.
Overall information regarding SNF CB can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.
Quarterly updates now apply to FIs, Carriers and DMERCs. There has been one joint FI/Carrier/DMERC quarterly update published subsequent to the 2004 annual updates. This update can be found at:
http://www.cms.hhs.gov/manuals/pm_trans/R92CP.pd.f.
That instruction is also known as CR3070.
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 CR3348 in the CR NUM column on the right, and then click on the file for that CR.

Related Change Request (CR) #: 3348
Medlearn Matters Number: MM3348
Related CR Release Date: July 9, 2004
Related CR Transmittal #: 224
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

This article was re-issued on August 30, 2004.

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

IMPORTANT NOTE: MM3333 corrects MM2944, which incorrectly indicates that services provided in a noncovered SNF stay are both subject to consolidated billing (CB) and reimbursed through the prospective payment system. MM3333 provides the corrected language (by removing the language indicating that the services are subject to the prospective payment system when provided to beneficiaries in a noncovered SNF stay) as follows: "Physical, occupational, and speech therapy services are subject to CB when provided to beneficiaries in either a Part A covered skilled nursing facility (SNF) stay or during a non-covered stay. A small number of these services are considered surgery when performed by a physician and may be separately paid by the carrier. They are considered therapy when performed by a physical and occupational therapist and continue to be subject to CB." To see MM3333, go to: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3333.pdf*

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

Provider Types Affected

Physicians and other providers billing Medicare carriers for services provided at SNFs.

Provider Action Needed

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

Background

Physical, occupational, and speech therapy services are subject to CB when provided to beneficiaries in either a Part A-covered SNF stay or during a noncovered stay. (The preceding sentence is an amendment to the original language, per MM3333.)

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

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

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

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

Implementation

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

Related Instructions

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

"A number of therapy services are considered separately payable when provided by a physician and shall be paid separately by the Medicare carrier. However, these services are considered therapy when provided by a physical or

occupational therapist; will be subject to CB; and payment for them is included in the prospective payment rate provided to the SNF by the FI (Medicare fiscal intermediary).

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

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

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

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

Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Services

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

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.

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. 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*.

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 an SNF, the initial ambulance trip that brings a beneficiary to an 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 section 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 Registe*r 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 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 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) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0433

FINANCIAL SERVICES

Unsolicited/Voluntary Refunds

All Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open accounts receivable). Intermediaries generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds. The Centers for Medicare & Medicaid Services reminds providers that:

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

Source: CMS Pub 100-6 Transmittal 42, CR 3274

MEDICARE SECONDARY PAYER

Clarification of Medicare Secondary Payer (MSP) Rules in Relation to a Temporary Leave of Absence

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

Provider Types Affected

All providers.

Provider Action Needed

STOP – Impact to You

MSP rules state that if an employee retains their employment status, Medicare remains the secondary payer.

CAUTION – What You Need to Know

There has been confusion regarding MSP rules when an employee takes a company-approved leave of absence. Because the employee still has employee status, health coverage through their employer is retained.

GO – What You Need to Do

Stay current with rules pertaining to employees and retained employment rights to ensure accurate billing and claims processing. This article clarifies that Medicare remains a secondary payer for employees on an approved leave of absence.

Background

Examples of retained employment rights can include: company-approved temporary leave of absence for any reason, furlough, temporary layoff, sick leave, short-term or long-term disability, leave for teachers and seasonal workers who normally do not work year round, and for employees who have health coverage that extends beyond or between active employment periods. The employees in the latter category are sometimes referred to as having an "hours bank" arrangement.

Additional Information

You may also refer to the revised Publication 100-05, Chapter 1, Section 50B, which is part of the official instruction issued to your carrier/intermediary regarding this change. That instruction may 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 3447. 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 fiscal intermediary at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*

Related Change Request (CR) #: 3447 Medlearn Matters Number: MM3447
Related CR Release Date: September 24, 2004
Related CR Transmittal #: 19
Effective Date: October 25, 2004
Implementation Date: October 25, 2004

Medicare Secondary Payer Application to Former Spouses and Certain Family Members with Coverage Under the Federal Employees Health Benefits Program

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

Provider Types Affected

All Medicare providers

Provider Action Needed

This is an informational article to alert providers that former spouses of certain federal employees, former employees, or annuitants, may qualify to enroll in a health benefits plan under the Federal Employees Health Benefit Plan (FEHB) and the correct order of payment.

A determination has been made that Medicare will be the primary payer for such former spouses, once they are entitled to Medicare based on age or disability.

Background

Certain former spouses of people who have Federal Employees Health Benefits are entitled to coverage under the Spouse Equity Act because their divorce decree gives them the right to a portion of a future retirement annuity and/or to a survivor annuity, and because their former spouse is either an active worker, someone who is entitled to a future annuity, or is an annuitant.

The Medicare law in Section 1862 (b)(1)(A) of the Social Security Act, states that Medicare is secondary payer for individuals age 65 or over who have group health coverage by virtue of their own or a spouse's current employment status. The question was raised as to whether FEHB coverage provided to former spouses under the Spouse Equity Act is secondary to Medicare under this provision. Also, the question has been raised

as to whether FEHB coverage provided to the spouse and family members under the Spouse Equity Act is secondary to Medicare under the disability provision.

Under the Spouse Equity Act, the individual is no longer on the former spouse's policy. The coverage is considered to be a separate, self-only policy, i.e., not dependent coverage but a policy separate from the former spouse. The employer makes no contributions to the coverage. Since the language in the Spouse Equity Act gives the former spouse the right to enroll in FEHB whether or not the spouse himself or herself is enrolled, the FEHB former spouse coverage is not considered employment based. Consequently, Medicare is the primary payer for the former spouse, once they are entitled to Medicare under the working aged provision. Under the Medicare secondary for the disabled provision, Medicare would be primary for the former spouse as well as any covered family members since the coverage is not considered employment based.

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 3120 in the CR NUM column on the right, and click on the file for that CR.

Related Change Request (CR) #: 3120
Medlearn Matters Number: MM3120
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 18
Effective Date: November 29, 2004
Implementation Date: November 29, 2004

GENERAL INFORMATION

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

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

Provider Types Affected

All Medicare physicians, providers, and suppliers.

Provider Action Needed

Be advised that only the most recent version of the Standard Paper Remittance (SPR) Advices will be used. The 835 version 4010A1 flat file is the appropriate format to produce SPRs. Also, no data may be included in paper remittance advices that are not included in an electronic remittance advice (ERA).

Background

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

CMS has issued a memorandum to all Medicare carriers and fiscal intermediaries, including durable medical equipment carriers and regional home health intermediaries, stating that, effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the SPRs; no other format for SPRs will be used.

Additional Information

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

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

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

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

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0451
Effective Date: N/A
Implementation Date: January 1, 2005

MMA - Medicare Replacement Drug Demonstration

IMPORTANT: This is an updated version of this article. The article has been revised to reflect two additional drugs (Somavert and Mesnex) that are covered under this demonstration, as noted in the revised table that starts on page 4, and to announce that there are still many enrollment slots available. It is not too late to request or submit an application!

We need your help to reach beneficiaries who could benefit from this demonstration. These beneficiaries include people who have been diagnosed with rheumatoid arthritis, multiple sclerosis, osteoporosis, pulmonary hypertension, secondary hyperparathyroidism, Paget's Disease, Hepatitis C, CMV retinitis, or certain kinds of cancer. If you treat Medicare beneficiaries who currently use or could benefit from the drugs listed in the table starting on page 4, Medicare may be able to help them pay for these drugs.

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

Provider Types Affected

All Medicare physicians and providers but we are especially interested in reaching out to physician specialists in family practice, internal medicine, geriatrics, rheumatology, oncology and neurology, as well as pharmacists, nurse practitioners, hospital outpatient departments, cancer and infusion centers, and group practice administrators.

Provider Action Needed

STOP – Impact to You

A new demonstration mandated under Section 641 of the Medicare Modernization Act allows up to 50,000 people with Medicare who have certain life-threatening diseases to obtain specified drugs they can take themselves at home for their condition.

CAUTION – What You Need to Know

A signed physician certification will need to be filled out for any of your patients who are: applying to participate in this demonstration. By signing this certification, you are certifying that the patient has the condition indicated and you have prescribed or intend to prescribe a coverable drug for this condition in accordance with the demonstration requirements. Your signed certification is necessary for the patient's application to participate in the demonstration to be considered complete. **For your convenience, physician certification forms may also be faxed to (410) 683-2933. Please note** that nurse practitioners who write prescriptions for these coverable drugs may also sign the certification form.

GO – What You Need to Do

Review the list below of coverable conditions and drugs available under this demonstration. If you have any patients you think might be interested and eligible to apply, **let them know**. Be aware that both Fee-for-Service and Medicare Advantage beneficiaries are eligible to apply for the demonstration. If they would like to request an application or have any questions related to the demonstration, or need assistance completing the application, they can call a toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387). There is also helpful information on our website (*http://*www.medicare.gov), including an application package that can be downloaded.

Note to Hospitals: **Please share this information with staff who come into contact with Medicare beneficiaries who may be eligible for this demonstration (e.g., social workers or staff who assist with Medicaid eligibility determinations).**

Background

The Medicare Replacement Drug Demonstration is a time-limited Medicare demonstration that will cover certain drugs and biologicals that are prescribed as replacements for existing covered Medicare drugs and biologicals before Medicare's prescription drug program begins in 2006. This demonstration was authorized by Section 641 of the Medicare Modernization Act.

The Centers for Medicare & Medicaid Services (CMS) has contracted with TrailBlazer Health Enterprises, a Medicare carrier, to assist in implementing the demonstration. TrailBlazer will manage the eligibility determination and enrollment process as well as coordinate outreach efforts to beneficiary advocacy groups, physicians, and others interested in this demonstration. TrailBlazer has sub-contracted with Caremark to administer the drug benefit.

Medicare realizes the important role drugs play in treating serious diseases. When Medicare first began, drugs played a much smaller role in medical care. Only drugs that are administered in a physician's office have been covered under Medicare Part B. In recent years, many new medications have been developed that replace some of these drugs, allowing patients with serious and life-threatening illnesses to take these drugs in their own home. For a beneficiary to be eligible for this demonstration, he or she must meet the following criteria:

- Beneficiary must have Medicare Part A and Part B.
- Medicare must be the beneficiary's primary health insurance.
- Beneficiary must reside in one of the 50 states or the District of Columbia.
- Beneficiary must have a signed certification form from his/her doctor stating that he/she has prescribed or intends to prescribe for the beneficiary one of the covered medications for the specified condition.
- The beneficiary may not have any other insurance that has comprehensive drug coverage (such as Medicaid, an employer or union group health plan, or TRICARE) that would cover this medication.

The table on the following page shows the drugs and conditions that will be covered under the demonstration.

Drugs Covered Under the Medicare Replacement Drug Demonstration
(Updated August 9, 2004)

Demonstration Covered Indication	Drug/Biological—Compound Name (Brand Name)
Rheumatoid Arthritis	Adalimumab (Humira) Anakinra (Kineret) Etanercept (Enbrel)
Multiple Sclerosis	Glatiramer acetate (Copaxone) Interferon beta –1a (Rebif, Avonex) Interferon beta –1b (Betaseron)
Osteoporosis (patient must be homebound)	Calcitonin – nasal (Miacalcin – nasal)
Pulmonary Hypertension	Bosentan (Tracleer)
Secondary Hyperparathyroidism	Doxercalciferol (Hectoral)
Paget's Disease	Alendronate (Fosamax) Risedronate (Actonel)
Hepatitis C	Pegylated interferon alfa-2a (Pegasys) Pegylated interferon alfa-2b (PEG-Intron)
CMV Retinitis	Valcyte (Valganciclovir)
Acromegaly	Pegvisomant (Somavert)
Anti-Cancer	
• Cutaneous T-cell Lymphoma	Bexarotene (Targretin)
• Non-small cell lung cancer	Gefitinib (Iressa)
• Epithelial ovarian cancer	Altretamine (Hexalen)
• Chronic Myelogenous Leukemia	Imatinib Mesylate (Gleevec)
• GI Stromal Tumor	Imatinib Mesylate (Gleevec)
• Multiple Myeloma	Thalidomide (Thalomid)
Breast Cancer	Hormonal therapy
• Stage 2-4 only	Anastrozole (Arimidex) Exemestane (Aromasin) Letrozole (Femara) Tamoxifen (Nolvadex) Toremifene (Fareston)
Prophalactic agent to reduce ifosfamideinduced hemorrhagic cystitis	Mesna-oral tablest (Mesnex)

For more information on this demonstration, please visit *http://www.medicare.gov* or call our toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387) between 8 am and 7:30 pm Eastern time, Monday – Friday. You can also use the toll-free number if you have questions about the demonstration or the application.

We also have a beneficiary brochure available that describes the demonstration and its benefits.

Copies of the brochure can be requested at: *outreach.mrdd@trailblazerhealth.com*

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0443 (REVISED)
Related CR Release Date:
Related CR Transmittal #:
Effective Date: Immediately
Implementation Date: Immediately

MMA-Implementation of New Medicare Redetermination Notice

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

Providers Affected

All Medicare physicians, providers, and suppliers.

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

The newly initiated Redetermination Appeals Process provides for timely notification of beneficiaries and providers via the MRN. Be sure to understand how these new procedures affect your appeal rights.

Background

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

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

Additional Information

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

- An Introductory section.
- A Summary Statement about the appeal decision.
- A Summary of the Facts section including information specific to the appeal and background information.
- A Decision section stating whether the claim is covered by Medicare and whether the beneficiary is responsible for payment.
- An Explanation of the Decision section outlining the logic and specific reasons that led to the redetermination. This must include relevant clinical or scientific evidence used in making the redetermination.
- A Who is Responsible for the Bill section with information on limitation of liability, waiver of recovery, and physician/supplier refund requirements.
- A What to Include in Your Request for Independent Appeal section to explain what policy was used to make the decision and identify specific documentation required to appeal at the Independent Appeal Level.
- An Additional Relevant Information section to present any additional relevant information, not including any sensitive medical information.
- A section on Important Information About Your Appeal Rights including contact information and an explanation of the next level of the appeal process.

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

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

Use of Group Health Plan Payment System to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries

Providers Affected

Physicians, providers, and suppliers

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (Section 721 of the Medicare Modernization Act [MMA]) in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional Fee-For-Services (FFS) Medicare program.

CAUTION – What You Need to Know

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.

GO – What You Need to Do

See the *Background* and *Additional Information* sections for more information on this notification.

Background

This instruction notifies providers that CMS will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (Section 721, MMA) in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional FFS Medicare program.

In order to implement these large programs most efficiently, CMS plans to accomplish the following:

- Each program will be assigned a new option code (designated as "Option Code 4" in this instruction); and
- Each organization will be set up as an "Option 4 Chronic Care Organization" in Medicare's Group Health System/ PICS, which is otherwise used for Medicare Advantage (formerly Medicare + Choice) health plans.

By enrolling beneficiaries in these "Option Code 4" Chronic Care Organizations, CMS will be able to pay the organizations a fixed monthly amount for each beneficiary. Also, as an "Option Code 4" Chronic Care Organization," CMS can continue processing all FFS claims under traditional Medicare payment rules.

With the exception of how CMS is paying these 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. They are not restricted in any way on how they receive their other Medicare services.

Because the Group Health Plan system/MMCS is being used to pay demonstration sites, when a provider makes an inquiry to certain Common Working File (CWF) screens, it appears that the beneficiary is enrolled in a Health Maintenance Organization (HMO), when they are eligible for coverage under the traditional Medicare FFS program.

To avoid this confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on CWF provider inquiries, **this instruction directs the CWF to suppress any reference to HMO information on provider inquiries for beneficiaries enrolled in these programs.**

In the event the provider is advised by the beneficiary or through some other means that the beneficiary is enrolled with one of these Chronic Care Organizations, the providers should treat the beneficiary as an ordinary FFS beneficiary who requires no referral from the Chronic Care Organizations to receive services in a FFS setting.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier or fiscal 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 CR3410 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3410
Medlearn Matters Number: MM3410
Related CR Release Date: July 30, 2004
Related CR Transmittal #: 256
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

MMA - Medicare-Approved Drug Discount Cards and Transitional Assistance Program: A Summary of New Initiative of Interest to Physicians and Other Health Care Professionals

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

Provider Types Affected

Physicians and other health care professionals

Provider Action Needed

This instruction provides important information on a new initiative to increase enrollment of low-income Medicare beneficiaries in a Medicare-Approved drug discount card and a $600 credit.

Background

In an earlier Medlearn Matters article, an overview of the Medicare-Approved Drug Discount Card Program was provided.

(See SE0422 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0422.pdf*)

This program is authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The program is designed to help people who are covered by Medicare with the cost of prescription drugs, and the regulation outlining the new drug discount card program is the first action resulting from the MMA. It emphasizes the importance of eliminating the practice of Medicare beneficiaries having to pay full price for prescription drugs. Beginning in May 2004, individuals began enrolling in the program.

Seniors and individuals with disabilities will be able to use these cards to save 10 to 15 percent on their total drug costs, with savings of up to 25 percent or more on individual prescriptions. All Medicare beneficiaries, except those who already have Medicaid outpatient drug coverage, will be able to enroll in Medicare-approved drug discount card programs with benefits beginning in June 2004, and continuing until the Medicare prescription drug benefit is implemented in 2006.

Medicare beneficiaries will be allowed to enroll in only one drug card program at a time. The cost of enrollment can be no more than $30 annually, and beneficiaries can change cards during an open enrollment period prior to 2005 or under special circumstances. Beginning in 2006, all people with Medicare will have access to a voluntary prescription drug benefit.

Transitional Assistance Program

A key part of the Medicare-approved prescription drug discount card program is a **subsidy of up to $600 a year** for eligible low-income beneficiaries. Individuals may qualify for the $600 credit on their discount card to help pay for prescription drugs if they:

- Have an annual income in 2004 of no more than $12,569 if single or $16,862 if married; and
- Receive help from their state in paying their Medicare premiums or cost sharing.

Note that these income limits can change every year. Also, residents of Puerto Rico or a U.S. territory are not eligible for the $600 credit from Medicare. However, they may be eligible for similar assistance provided by the territory in which they reside. Beneficiaries cannot qualify for the $600 if they already have outpatient prescription drug coverage from certain other sources.

Current Initiative

The Centers for Medicare & Medicaid Services (CMS) current initiative creates a streamlined Medicare-approved drug discount card enrollment process for about 1.1 million beneficiaries who receive help from their state in paying their Medicare premiums or cost sharing. These state programs are called Medicare Savings Programs. Starting in mid-October, these beneficiaries will receive an enrollment kit in the mail from a Medicare-approved drug discount card sponsor. The enrollment kit will contain a discount card with a Medicare-approved logo, a member handbook, a discount drug list, and pharmacy directory. An enclosed letter will explain to the beneficiary his or her assignment to a Medicare-approved drug discount card and eligibility for a $600 credit, and information about the right to decline or switch to a different Medicare-approved drug discount card. The letter instructs the beneficiary to call either the company offering the discount card or 1-800-MEDICARE (1-800-633-4227).

On November 1, 2004, the beneficiary can begin using the card to obtain discounts. In order to get the $600 credit, the beneficiary must call 1-800-MEDICARE or to the card sponsor's toll free number. On the call, the beneficiary completes the attestation for the $600 credit.

Beneficiaries who wish to choose a different card can call 1-800- MEDICARE to learn about their other choices.

If a beneficiary is not eligible for the $600 credit because of other prescription drug coverage, he or she has the option to keep the drug card and benefit from any associated discounts. In this instance, the beneficiary would be responsible for paying the enrollment fee.

Beneficiaries who wish to decline enrollment in the card must call the drug card sponsor at the toll free number.

As a result of this new program for enrollment in the drug card program, all beneficiaries in Medicare Savings Programs can start getting large savings on their drug costs.

Additional Information

Where to Refer Medicare Beneficiaries for Information on Prescription Drug Discount Programs

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

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

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

Beneficiaries can get information about how the discount drug card program operates, who can qualify and how to join, as well as some comparative information on card sponsors at 1-800 MEDICARE (1- 800-633-4227; TTY users should call 1-877-486-2048).

This Call Center is available 24 hours per day, 7 days per week, and connects beneficiaries with customer service representatives who can answer questions and perform price comparisons for discount cards and other assistance programs. Beneficiaries should prepare a list of current prescription drugs and dosages prior to contacting the Call Center. Also, beneficiaries may request a copy of their individualized price comparison results.

- **The Prescription Drug and Other Assistance Programs Website at:**

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

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

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

This resource can be found at: *http://www.medicare.gov/publications*. It provides beneficiaries with information on choosing a card, enrolling, and submitting complaints. This guide also features sample enrollment forms and worksheets to assist beneficiaries in selecting the discount card that is right for them.

- **State Health Insurance Counseling and Assistance Programs (SHIP)**

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

For More Information

The following information resources are available for physicians and other health care professionals:

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

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0457
Related CR Release Date: N/A

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

Note: *This article was revised on October 27, 2004 to correct the web address for State Health Insurance Counseling and Assistance Programs (SHIPs).*

Provider Types Affected

Physicians and other health care professionals

Provider Action Needed

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

Background

As part of the Medicare Modernization Act of 2003 (MMA), the Medicare-Approved Drug Discount Cards and Transitional Assistance Program begins in 2004 to help Medicare beneficiaries save on prescription drugs. Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare's seal of approval can help Medicare beneficiaries save on prescription drug costs. This article is designed to give an overview of the new Medicare-Approved Drug Discount Cards and Transitional Assistance Program. It will also explain where you may refer Medicare patients for information on selecting and enrolling in the drug discount card that best suits their needs.

Medicare-Approved Drug Discount Cards

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

Transitional Assistance Program

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

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

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

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

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

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

The Prescription Drug and Other Assistance Programs Web Site at Medicare.gov

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

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

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

http://www.medicare.gov

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

State Health Insurance Counseling and Assistance Programs

Beneficiaries may also contact their SHIP counselor for information on prescription drug cost assistance programs. To find the telephone number for the nearest SHIP, call 1-800-MEDICARE (1-800-633-4227) or visit *http://www.medicare.gov/Contacts/Related/Ships.asp on the web*.

Information Resources for Physicians and Other Health Care Professionals

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

Related Change Request (CR) #: N/A
Special Edition: SE0422
Effective Date: Informational Only ***Revised: 10/29/2004***

MMA - Medicare-Approved Drug Discount Cards and Transitional Assistance Program: A Summary of New Initiative of Interest to Physicians and Other Health Care Professionals

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

Provider Types Affected

Physicians and other health care professionals

Provider Action Needed

This instruction provides important information on a new initiative to increase enrollment of low-income Medicare beneficiaries in a Medicare-Approved drug discount card and a $600 credit.

Background

In an earlier Medlearn Matters article, an overview of the Medicare-Approved Drug Discount Card Program was provided.

(See SE0422 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0422.pdf*)

This program is authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The program is designed to help people who are covered by Medicare with the cost of prescription drugs, and the regulation outlining the new drug discount card program is the first action resulting from the MMA. It emphasizes the importance of eliminating the practice of Medicare beneficiaries having to pay full price for prescription drugs. Beginning in May 2004, individuals began enrolling in the program.

Seniors and individuals with disabilities will be able to use these cards to save 10 to 15 percent on their total drug costs, with savings of up to 25 percent or more on individual prescriptions. All Medicare beneficiaries, except those who already have Medicaid outpatient drug coverage, will be able to enroll in Medicare-approved drug discount card programs with benefits beginning in June 2004, and continuing until the Medicare prescription drug benefit is implemented in 2006.

Medicare beneficiaries will be allowed to enroll in only one drug card program at a time. The cost of enrollment can be no more than $30 annually, and beneficiaries can change cards during an open enrollment period prior to 2005 or under special circumstances. Beginning in 2006, all people with Medicare will have access to a voluntary prescription drug benefit.

Transitional Assistance Program

A key part of the Medicare-approved prescription drug discount card program is a **subsidy of up to $600 a year** for eligible low-income beneficiaries. Individuals may qualify for the $600 credit on their discount card to help pay for prescription drugs if they:

- • Have an annual income in 2004 of no more than $12,569 if single or $16,862 if married; and
- • Receive help from their state in paying their Medicare premiums or cost sharing.

Note that these income limits can change every year. Also, residents of Puerto Rico or a U.S. territory are not eligible for the $600 credit from Medicare. However, they may be eligible for similar assistance provided by the territory in which they reside. Beneficiaries cannot qualify for the $600 if they already have outpatient prescription drug coverage from certain other sources.

Current Initiative

The Centers for Medicare & Medicaid Services (CMS) current initiative creates a streamlined Medicare-approved drug discount card enrollment process for about 1.1 million beneficiaries who receive help from their state in paying their Medicare premiums or cost sharing. These state programs are called Medicare Savings Programs. Starting in mid-October, these beneficiaries will receive an enrollment kit in the mail from a Medicare-approved drug discount card sponsor. The enrollment kit will contain a discount card with a Medicare-approved logo, a member handbook, a discount drug list, and pharmacy directory. An enclosed letter will explain to the beneficiary his or her assignment to a Medicare-approved drug discount card and eligibility for a $600 credit, and information about the right to decline or switch to a different Medicare-approved drug discount card. The letter instructs the beneficiary to call either the company offering the discount card or 1-800-MEDICARE (1-800-633-4227).

On November 1, 2004, the beneficiary can begin using the card to obtain discounts. In order to get the $600 credit, the beneficiary must call 1-800-MEDICARE or to the card sponsor's toll free number. On the call, the beneficiary completes the attestation for the $600 credit.

Beneficiaries who wish to choose a different card can call 1-800- MEDICARE to learn about their other choices.

If a beneficiary is not eligible for the $600 credit because of other prescription drug coverage, he or she has the option to keep the drug card and benefit from any associated discounts. In this instance, the beneficiary would be responsible for paying the enrollment fee.

Beneficiaries who wish to decline enrollment in the card must call the drug card sponsor at the toll free number.

As a result of this new program for enrollment in the drug card program, all beneficiaries in Medicare Savings Programs can start getting large savings on their drug costs.

Additional Information

Where to Refer Medicare Beneficiaries for Information on Prescription Drug Discount Programs

In addition to the Medicare-approved drug discount cards, there are other programs available that provide assistance in paying for prescription drugs. Alternatives such as individual state pharmacy assistance programs and manufacturers' discount programs may be a better fit for certain individuals. Medicare recognizes that physicians and other health care professionals have limited time available to counsel patients. Therefore, the following resources are available to help individuals with questions

about the Medicare-approved drug discount cards:

- **The 1-800-MEDICARE (1-800-633-4227) Toll-Free Call Center:**
  Beneficiaries can get information about how the discount drug card program operates, who can qualify and how to join, as well as some comparative information on card sponsors at 1-800 MEDICARE (1- 800-633-4227; TTY users should call 1-877-486-2048). This Call Center is available 24 hours per day, 7 days per week, and connects beneficiaries with customer service representatives who can answer questions and perform price comparisons for discount cards and other assistance programs. Beneficiaries should prepare a list of current prescription drugs and dosages prior to contacting the Call Center. Also, beneficiaries may request a copy of their individualized price comparison results.

- **The Prescription Drug and Other Assistance Programs Website at:**

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

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

- **Medicare's Guide to Choosing a Medicare-Approved Drug Discount Card**
  This resource can be found at: *http://www.medicare.gov/publications*. It provides beneficiaries with information on choosing a card, enrolling, and submitting complaints. This guide also features sample enrollment forms and worksheets to assist beneficiaries in selecting the discount card that is right for them.

- **State Health Insurance Counseling and Assistance Programs (SHIP)**

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

For More Information

The following information resources are available for physicians and other health care professionals:

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

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0457
Related CR Release Date: N/A

CMS and FCSO Offer Help to Address Potential Medicare Billing and Payment Impacts Due to 2004 Hurricanes

The hurricanes that hit Florida in 2004 severely impacted many of First Coast Service Options' (FCSO) Medicare customers. In response to the devastating impacts and potential damage, and in keeping our promise to provide superior customer service, FCSO is working closely with the Centers for Medicare & Medicaid Services (CMS) to determine how best to help impacted health care providers and beneficiaries as they recover. FCSO and CMS have established a response team to assist providers impacted by these hurricanes. Here are some helpful tips related to communication, benefit payments and operational processes that may warrant special consideration:

- First, we encourage impacted health care providers to communicate billing and payment concerns by calling our Medicare Part A Customer Service Center at 1-877-602-8816 or our Medicare Part B Customer Service Center at 1-866-454-9007.
- Hospitals and skilled nursing facilities whose cash flow has been or will be adversely impacted by the 2004 hurricanes may be granted an accelerated payment. FCSO and CMS have implemented a process to expedite these requests. Medicare Part A impacted providers who need to pursue an accelerated payment should contact Provider Audit and Reimbursement Specialist, Jeff Guy at 904-791-6695.
- Providers unable to submit electronic claims can reduce claims to paper. However, we are unable to issue payments within 14 days. Payments will be issued after the 27th day following receipt of the claim for clean claims.
- In filing an appeal request, the 2004 hurricanes are an example of "good cause" in asking for a time extension.
- If you cannot receive mail at your present location, you may set up a temporary "pay to" address.
- This can be accomplished with the CMS-855 form by faxing to the Provider Enrollment specially designated hurricane fax line at 904-301-1827.
- Impacted providers may use another physician's computer to transmit claims; however, someone from FCSO Medicare EDI must be involved in order to maintain the security of the records. If you are an impacted provider who needs to explore the feasibility of this option, please contact Medicare EDI Manager, Jim Gray at 904-791-8288.
- The CMS Atlanta regional office has also established a response team whose members are ready and available to assist providers at 1-404-562-7390.
- If you were under a mandatory evacuation notice and had to be transported by ambulance, Medicare will consider payment under certain conditions. Here's a link to the August 18, 2004, CMS-approved policy on "Ambulance Transport Due to Disasters."

(http://www.floridamedicare.com/provider/content/special/Amb-Transport-due-to-Disater.pdf)

Additional information is available at *http://www.floridamedicare.com*. If you have additional questions, please contact our Medicare Part A Customer Service Center at 1-877-602- 8816 or our Medicare Part B Customer Service Center at 1-866-454-9007, as we have designated points-of-contact for various types of issues related to the 2004 hurricanes.

CONNECTICUT MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local medical review policies (LMRPs)/local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LMRPs are provided instead. Providers may obtain full-text LMRPs/LCDs on our provider education Web site, *http://www.connecticutmedicare.com*. Final LMRPs/LCDs, draft LMRPs/LCDs available for comment, LMRP/LCD statuses, and LMRP/LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs/LCDs; the date the LMRP/LCD is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs/LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It's very easy to do; simply sign on to the provider education Web site, *http://www.connecticutmedicare.com;* click on the yellow "Join our electronic mailing list" bar and follow the prompts.

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LMRP/LCD, contact Medical Policy at:

Attention: Medical Policy
First Coast Service Options, Inc.
P.O. Box 9000
Meriden, CT 06450-9000

Phone: 1-866-419-9455

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.

NEW LCD IMPLEMENTATION

11720: Nail Debridement

This local coverage determination is being developed to define coverage for nail debridement of all symptomatic mycotic nails.

Medicare will consider the treatment of fungal (mycotic) infection of the nails a covered service when the medical record substantiates:

- Clinical evidence of mycosis of the nail, by generally accepted clinical findings such as discoloration, onycholysis, subungual debris, thickening, or secondary skin infection;

One of the following must be documented for mycotic toenails:

- The ambulatory patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected nail plate(s) or;
- The non-ambulatory patient suffers from pain, or secondary infection resulting from the thickening and dystrophy of the infected nail plate(s).

In addition to the above, use of appropriate anti-fungal treatment or the contraindication of such treatment, must also be documented, to qualify nail debridement as a medically necessary and reimbursable service.

The following CPT codes are included in this policy:

- 11720 Debridement of nail(s) by any method(s); one to five
- 11721 Debridement of nail(s) by any method(s); six or more

The following ICD-9 codes that support medical necessity are listed in this policy:

- 110.1 Dermatophytosis of nail (Onychomycosis)
- 112.3 Candidiasis of skin and nails
- 117.0 – 117.9 Other mycoses

Patients need not have an underlying systemic condition to be covered for mycotic nail care. For treatment of non-symptomatic mycotic nails, refer to the Routine Foot Care policy.

The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com*. This policy is effective for services rendered on or after January 1, 2005.

72192: Computed Tomography of the Pelvis

Computed Tomography of the Pelvis (CT Scan of the Pelvis) is a noninvasive yet accurate x-ray procedure, which results in images from passing x-rays through an organ at many angles. The variation and density of each tissue allows for variable penetration of the x-rays. Each density is computed by utilizing a coefficient (or numeric value), which is digitally computed into shades of gray. These shades of gray are then displayed on a monitor as thousands of dots in various shades.

The CT scan of the pelvic area includes the bladder, prostate, ovaries, uterus, lower retroperitoneum and iliac lymph node chains. CT scans are generally performed to study the pelvic viscera. In males, this includes the bladder and prostate and in females, the bladder, uterus and adnexa. The CT scan of the pelvis is useful in evaluating cysts, tumors, masses, metastasis to one or more of these organs, and iliac lymph nodes. Intravenous contrast material may be administered when enhanced views are needed.

Data analysis for CPT code 72192 (CT scan of the pelvis without dye) revealed that eight (8) of the top twenty (20) diagnoses billed by providers may not have been medically necessary.

This local coverage determination (LCD) is being developed to define indications and limitations for computed tomography of the pelvis. The LCD contains coverage guidelines for the following CPT codes: 72192 (CT scan of the pelvis without dye), 72193 (CT scan of the pelvis with dye) and 72194 (CT scan of the pelvis with and without dye).

This LCD is effective for services rendered on or after January 1, 2005. The full text LCD is available on our provider education website at *http://www.connecticutmedicare.com*.

92135: Scanning Computerized Ophthalmic Diagnostic Imaging

Scanning computerized ophthalmic diagnostic imaging allows for early detection of glaucomatous damage to the nerve fiber layer or optic nerve of the eye. It is the goal of these diagnostic imaging tests to discriminate among patients with normal intraocular pressures (IOP) who have glaucoma, patients with elevated IOP who have glaucoma, and patients with elevated IOP who do not have glaucoma. These tests can also provide more precise methods of observation of the optic nerve head and can more accurately reveal subtle glaucomatous changes over the course of follow-up exams than visual field and/or disc photos can. This can allow earlier and more efficient efforts of treatment toward the disease process.

Retinal disorders are the most common causes of severe and permanent vision loss. Scanning computerized ophthalmic diagnostic imaging is also used for the evaluation and treatment of patients with retinal disease, especially certain macular abnormalities. It details the microscopic anatomy of the retina and the vitreo-retinal interface.

Many forms of scanning computerized ophthalmic diagnostic imaging tests currently exist (e.g., confocal laser scanning ophthalmoscopy (topography), scanning laser polarimetry, optical coherence tomography (OCT), and retinal thickness analysis. Although these techniques are different, their objective is the same.

This local coverage determination (LCD) has been developed to define the indications and limitations of coverage and/or medical necessity for this service and will be effective for services rendered on or after January 1, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

93224: Electrocardiographic Monitoring for 24 hours (Holter Monitoring)

Ambulatory electrocardiography or holter monitoring are terms used to describe the continuous 24-hour monitoring of an electrocardiogram in a symptomatic patient who is ambulatory or potentially ambulatory. The recording is completed either on a magnetic tape or digital medium. The data is then computer-analyzed at a later time, and a physician interprets the computer-generated report.

Electrocardiographic monitoring can be performed on ambulatory patients over a set period of time (usually 24 hours). The monitoring device (holter monitor) allows the patient to resume their normal lifestyle and activities while recording episodes of arrhythmia. This gives the physician documented episodes of arrhythmias or absence of arrhythmias to correlate with the patient's symptoms.

The National Coverage Determination (NCD) Manual, section 20.15, defines the indications and medical necessity for performing these services. Therefore, a local coverage decision (LCD) has been developed to define the corresponding ICD-9-CM codes for procedure codes 93230-93233. The full-text of this LCD is available on the provider education website *http://www.connecticutmedicare.com*. This LCD is effective for services rendered on or after January 1, 2005.

93701: Cardiac Output Monitoring by Thoracic Electrical Bioimpedance

Thoracic electrical bioimpedance (TEB) devices, a form of plethysmography, monitor cardiac output by noninvasively measuring hemodynamic parameters, including stroke volume, systemic vascular resistance and thoracic fluid status.

According to the Medicare Part B statistical medical data obtained from January 1, 2003 to June 1, 2003, cardiac output monitoring by thoracic electrical bioimpedance services were determined to be aberrant in Connecticut; therefore, a local coverage determination (LCD) has been developed to provide clarity of coverage and limitations of TEB and establish the ICD-9-CM codes that support medical necessity.

This policy was presented to the Carriers Advisory Committee June 15, 2004. It will be effective for services rendered on or after January 1, 2005. The full-text LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

J9208: Ifosfamide (Ifex®)

Ifosfamide is classified as an alkylating agent of the nitrogen mustard type. Because of the risk of hemorrhagic cystitis; Ifosfamide is generally administered in combination with a prophylactic agent, such as Mesna.

According to the Medicare Part B statistical medical data obtained from January 1, 2003 to June 1, 2003, J9208 was determined to be aberrant in Connecticut; therefore, a local coverage determination (LCD) has been developed to define the indications and limitations of coverage clarify the appropriate use of Ifosfamide, and establish appropriate ICD-9-CM coding for Ifosfamide

This policy was presented to the Carriers Advisory Committee June 15, 2004. It will be effective for services rendered on or after January 1, 2005. The full-text LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

J9209: Mesna (Mesnex®)

Mesna is FDA approved to reduce the incidence of Ifosfamide-induced hemorrhagic cystitis. Mesna is not effective in preventing hematuria due to pathologic conditions such as thrombocytopenia.

According to the Medicare Part B statistical medical data obtained from January 1, 2003 to June 1, 2003, J9209 was determined to be aberrant in Connecticut; therefore, a local coverage determination (LCD) has been developed to define the indications and limitations of coverage, clarify the appropriate use of Mesna, and establish appropriate ICD-9-CM coding for Mesna.

This policy was presented to the Carriers Advisory Committee June 15, 2004. It will be effective for services rendered on or after January 1, 2005. The full-text LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

APBI: Accelerated Partial Breast Irradiation

Survival after breast-conservation therapy (BCT) is equivalent to survival after mastectomy for patients diagnosed with tumors categorized as stage I or II. The standard of care for local management is breast-conserving surgery to excise the tumor with adequate margins (lumpectomy), followed by whole-breast external-beam radiation therapy (WB-EBRT).

Accelerated Partial Breast Irradiation (APBI) differs from WB-EBRT in two ways. First, the radiation targets only a segment surrounding the tumor rather than the entire breast. Second, since the duration of treatment is 4 to 5 days rather than 5 to 6 weeks, radiation is delivered in fewer fractions at larger doses per fraction. APBI comprises several techniques, including interstitial brachytherapy via catheters, the MammoSite radiation treatment system, accelerated external beam radiotherapy, and intra-operative radiotherapy delivery.

When compared with whole breast irradiation, APBI offers the potential advantages of convenience and decreases radiation dose to healthy breast tissue. However, published studies are limited in patient size and follow-up period. Given access to care issues, a local coverage determination (LCD) has been developed to define the indications and limitations of coverage, establish a procedure to diagnosis relationship, and clarify the appropriate use of APBI after breast-conserving surgery for early stage breast cancer. In addition, a coding guideline has also been developed to assist in billing this type of service.

APBI after breast-conserving surgery is considered medically necessary for patients with early stage breast cancer when all of the following criteria are met:

Diagnosis: Invasive ductal carcinoma or ductal carcinoma in situ
Size:greater than or equal to 3 cm.
Margin status: Negative – at least 2mm in all directions
Nodal status: Negative axillary lymph node dissection or sentinel lymph node evaluation

This LCD is effective for services rendered on or after January 1, 2005. The full text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

ADDITIONS/REVISIONS TO LMRPs/LCDs

11055: Routine Foot Care

This local coverage determination (LCD)/local medical review policy (LMRP) was last updated on April 1, 2004.

This policy has been converted into the new LCD format and revised to include debridement of nails since that is also included in covered routine foot care. The following CPT codes have been added to the policy:

- 11720 Debridement of nail(s) by any method(s); one to five, and
- 11721 Debridement of nail(s) by any method(s); six or more

In evaluating whether the routine services can be reimbursed, a presumption of coverage may be made by Medicare where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For purposes of applying this presumption, Class findings must be documented for all underlying conditions.

Class A Findings

- Nontraumatic amputation of foot or integral skeletal portion thereof.

Class B Findings

- Absent posterior tibial pulse;
- Advanced tropic changes such as: hair growth, nail changes, pigmentary changes, skin texture, skin color, (three required); and
- Absent dorsalis pedal pulse.

Class C Findings

- Claudication;
- Temperature changes;
- Edema;
- Parathesias; and
- Burning.

Active care requirements mandated by Medicare guidelines are included in the policy for services performed by a podiatrist.

The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com*. This policy is effective services rendered on or after January 1, 2005.

88271:Urinary Fluorescent In Situ Hybridization (FISH) Test for Recurrent Bladder Cancer)

The local medical review policy (LMRP) Urinary Tumor Markers for Bladder Cancer was effective January 5, 2004. Bladder cancer is the fifth most common cancer in the United States, with over 50,000 newly diagnosed cases and over 10,000 deaths annually. The diagnosis of primary and recurrent bladder cancer is one of the most difficult problems in urology and cytology. Ninety percent of bladder cancer cases are classified as transitional cell carcinomas (TCC), while the remaining 10 percent are predominantly squamous cell or adenocarcinomas. There are four clinically relevant subgroups of TCC, as defined by pathologic staging carcinoma in situ (pTIS), non-invasive papillary TCC (pTa), minimally invasive TCC (pT1), and muscle invasive tumors (pT2-4). Each subgroup is distinct with respect to clinical outcome. At presentation, 75% of tumors are 'superficial' (i.e., pTa, pT1 or pTIS), of which 50 to 80 percent will have one or several recurrences, and 15 to 25 percent will progress to invasive tumors. The tumors with invasion limited to the lamina propria (stage pT1) pose the greatest clinical problem. Local progression to potentially life-threatening muscle-invasive cancer (pT2-4) occurs in 20 to 30 percent of these tumors after conservative surgical treatment.

After initial diagnosis and treatment, patients with urothelial carcinoma are routinely monitored every three months for the first two years then usually twice a year for three or more years. Up to 50 percent of patients will have recurrence of bladder cancer within five years. The current monitoring is done by cystoscopy, an invasive procedure, and by urine cytology. Standard cytology has been regarded as an additional diagnostic tool to select patients for cystoscopic evaluation. However, studies show that the sensitivity of cytology in urinary specimens is limited, since most of the noninvasive cancers (stage pTa) are missed. Therefore, cytology alone is unreliable to serve as a basis for therapy decisions.

Several diagnostic tests are available for the management of bladder cancer. Radioimmunoassay and immuno-histochemical determinations of the serum levels of certain proteins or carbohydrates serve as tumor markers. When elevated, serum concentration of these markers may reflect tumor size and grade. Three other tests which are to be performed in conjunction with standard diagnostic procedures include: The Urinary Fluorescence In Situ Hybridization (FISH) Test, The Bladder Tumor Antigen Stat (BTAstat) Test, and The Nuclear Matrix Protein 22 (NMP-22) Test.

The Urinary FISH Test for recurrent bladder cancer is an FDA approved multitarget, multicolor fluorescence in situ hybridization (FISH) probe set that uses DNA technology designed to detect aneuploidy for chromosomes 3, 7, 17, and loss of the 9p21 locus in voided urine specimens from patients with transitional cell carcinoma of the bladder (urothelial carcinoma). In situ hybridization is a technique that allows the visualization of specific nucleic acid sequences within a cellular preparation. Specifically, DNA FISH involves the precise annealing of a single stranded fluorescently labeled DNA probe to complementary target sequences. The hybridization of the probe with the cellular DNA site is visible by direct detection using fluorescence microscopy. Results from this Urinary FISH Test are intended for use as a noninvasive method for monitoring tumor recurrence in conjunction with cystoscopy in patients previously diagnosed with bladder cancer.

The Bladder Tumor Antigen Stat (BTAstat) Test for recurrent bladder cancer is an FDA approved, one-step, qualitative, immunochromatographic assay for the detection of a bladder tumor-associated antigen in voided urine. This antigen is a human complement factor H-related protein (hCFHrp)) similar in composition, structure and function to human complement factor H (hCFH). Like hCFH, the BTA interacting with complement factor C3b interrupts the complement cascade and may confer a selective growth advantage to cancer cells in vivo by allowing the cells to evade the host immune system. In cell culture, hCFHrp is expressed by several bladder cell

lines, but not by most normal cells. To interpret the results for the BTAstat test, urine is allowed to react with a colloidal gold-conjugated antibody and the results are determined qualitatively by the presence or absence of a line on the test stick.

The bladder tumor antigen stat test is indicated as an aid in the management of bladder cancer patients in conjunction with cystoscopy. BTAstat test results may be affected by the presence of blood or infection and, therefore, should not be performed on patients exhibiting these signs or symptoms. BTAstat testing has a sensitivity of 68 percent and a specificity of 71 percent. The BTAstat test is more sensitive than urine cytology, but not as specific.

Nuclear matrix is a non-chromatin structure that supports nuclear shape and organizes DNA. It is also involved in DNA replication, transcription and processing of RNA. Nuclear matrix protein 22 (NMP22), a tumor marker, is a nuclear mitotic apparatus protein involved in the distribution of chromatin to daughter cells and is located in the nuclear matrix of all cell types. NMP22 is released from the nuclei of tumor cells after they die and can be detected in the urine. Normally, only very low levels of NMP22 can be detected in the urine, but elevated levels may be associated with bladder cancer.

The NMP-22 Test is an FDA-approved, in vitro immunoassay intended for the qualitative detection of NMP-22 nuclear matrix protein in urine of persons with risk factors or symptoms of bladder cancer or with a history of bladder cancer. This test is indicated for use as an aid in diagnosing and monitoring bladder cancer patients, in conjunction with standard diagnostic procedures.

This policy has been updated and revised to include the indications and limitations of coverage and/or medical necessity for the bladder tumor antigen stat (BTAstat) test and the nuclear matrix protein 22 (NMP-22) test, as well as appropriate CPT code and utilization guidelines. Therefore, the name of the policy has been changed to 'Urinary Tumor Markers for Bladder Cancer'. In addition, this policy has been converted into the local coverage determination (LCD) format. An attachment to the LCD has also been developed to clarify appropriate coding.

This revision will be effective for services rendered on or after January 1, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

90901: Biofeedback

The local medical review policy (LMRP) for Biofeedback – 90901 was previously revised on October 1, 2004 for ICD-9-CM Updates. Since that time, additional ICD-9-CM codes 344.00-344.09 (quadriplegia and quadriparesis) were added to biofeedback training by any modality (90901). In addition, the LMRP has been converted to the local coverage determination (LCD) format.

These changes are effective for services rendered on or after November 15, 2004. The full-text of this LCD is available on the provider education website *http://www.connecticutmedicare.com*.

97802: Medical Nutrition Therapy (MNT)

This policy was last revised effective April 1, 2003. Since that time, a revision to this policy has been made to add ICD-9 CM code 593.9 (Unspecified disorder of kidney and ureter) to the "ICD-9 Codes that Support Medical Necessity" section of the policy. In addition, the policy was converted to the local coverage determination (LCD) format. This revision is effective October 1, 2002, the effective date of the policy. The full-text of this LCD is available on the provider education website *http://www.connecticutmedicare.com*.

J2792: Rho (D) Immune Globulin Intravenous

The local medical review policy (LMRP) for Rho (D) Immune Globulin Intravenous became effective on January 5, 2004.

This policy revision is being made to clarify indications and limitations when administering Rho (D) for its FDA approved purposes. Medicare will consider Rho (D) Immune Globulin Intravenous medically necessary for the following Food and Drug Administration (FDA) approved indications:

- The suppression of Rh isoimmunization, and
- The treatment of immune thrombocytopenic purpura (ITP) for non-splenectomized Rho (D) positive individuals in clinical situations requiring an increase in platelet count to prevent excessive hemorrhage.

This policy revision includes the addition of two HCPCS codes: J2788 (Injection, Rho d immune globulin, human, minidose, 50 mcg) and J2790 (injection, Rho d immune globulin, human, full dose, 300 mcg). Guidelines for initial and subsequent dosing are defined. Also, the policy has been converted to the local medical determination (LCD) format.

This revision will be effective for services rendered on or after January 1, 2005. The full-text LCD is available on our provider education website at *http://www.connecticutmedicare.com*.

NCSVCS: The List of Medicare Noncovered Services

The latest revision for local medical review policy (LMRP) for the List of Medicare Noncovered Services was effective September 30, 2004. The list of noncovered services is divided into two main headings: Local Noncoverage Decisions and National Noncoverage Decisions. A service or procedure on the "local" list has been determined as noncovered by the Connecticut carrier. Decisions of noncoverage at the national level have been determined by the Centers for Medicare & Medicaid Services (CMS). National noncovered services cannot be covered by the local carrier.

The following procedure has been added to the list of local noncoverage decisions:

- 0017T Destruction of macular drusen, photocoagulation

Age-related macular degeneration (AMD) is a painless, insidious process. In its earliest stages, it is characterized by minimal visual impairment and the presence of 'large' or 'soft' drusen, i.e., subretinal accumulations of cellular debris adjacent to the basement membrane of the retinal pigment epithelium.

Large drusen appear as large, pale yellow or pale gray domed elevations and result in thickening of the space between the retinal pigment epithelium and its blood supply, the choriocapillaris. Clinical and epidemiologic studies have shown that the presence of large and/or numerous soft drusen increases the risk of the development of choroidal neovascularization (CNV) in eyes with AMD. For example, in patients with bilateral drusen, the three-year risk of developing CNV is estimated to be 13 percent, rising to 18 percent for those over the age of 65. The emergence of CNV greatly increases the risk of subsequent irreversible loss of vision.

Two different kinds of low energy laser therapies, argon and infrared laser, have been investigated as techniques to eliminate drusen by photocoagulation in an effort to prevent the evolution to CNV, ultimately leading to improved preservation of vision. The lasers used are those that are widely used for standard photocoagulation of extrafoveal choroidal neovascularization. Therefore, the treatment of macular drusen represents an additional indication for an existing laser approved by the U.S. Food and Drug Administration (FDA).

Definitive data regarding the role of laser therapy as a prophylactic treatment to prevent progression to CNV must await the completion of clinical trials currently in progress. While the currently available results suggest some short-term improvement in visual acuity, the outcome of greatest interest is the reduction of severe vision loss from atrophy and CNV. Long-term results are also important to evaluate safety issues. Laser therapy can damage the retinal pigment epithelium and photoreceptors, and it is unknown whether the short-term improvement in visual acuity may be counterbalanced by a more rapid progression of visual loss if and when CNV occurs. Therefore destruction of macular drusen with laser therapy as a prophylactic treatment to prevent progression of choriodal neovascularization (CNV) is considered investigational due to lack of data regarding impact on health outcomes.

This policy has also been converted into the local coverage determination (LCD) format. This revision will be effective for services rendered on or after January 1, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

MAHD/ED: Metabolically Active Human Dermal/Epidermal Replacement

Metabolically Active Human Dermal/Epidermal Replacements (MAHD/ER) was effective March 24, 2003. This policy has been revised to include indications and limitations for Xenograft and Allograft. In addition, the name of this policy has been change to SKINSUB: Skin Substitutes. This policy has been converted to a local coverage determination (LCD) format and includes coding guidelines for services associated with graft site preparation and the application of grafts.

This revision will be effective for services rendered on or after January 1, 2005. The full text of this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

VISCO Viscosupplementation Therapy For Knee

Viscosupplementation Therapy for Knee was last updated on September 29, 2003. This policy has been revised to incorporate and define the indications and limitations of coverage and/or medical necessity, to clarify the appropriate ICD-9-CM codes to use when billing Orthovisc® (J3590) and to provide access to care. Orthovisc® is a sterile, non-pyrogenic, clear, viscoelastic solution of hyaluronan which was approved by the FDA on 02/04/2004 for the treatment of osteoarthritis of the knee joints in patients who have failed to respond, or who have had inadequate responses to other treatment. In addition, this policy has been converted to a local coverage determination (LCD) format and includes coding guidelines to assist with coding issues when billing these services.

This revised policy was presented to the Carriers Advisory Committee June 15, 2004. It will be effective for services rendered on or after January 1, 2005. The full-text LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

WIDESPREAD MEDICAL REVIEW PROBES

90806: Widespread Probe Review Referral Individual Psychotherapy

The Statistical and Medical Data Analysis department conducted an analysis of the Medicare Part B claims data for the following CPT codes: *90806 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45-50 minutes face to face with the patient)* and *90807 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in a an office or outpatient facility, approximately 45-50 minutes fact to face with the patient with medical evaluation and management services)* as a result of the Connecticut 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 $5,190,610 would not have been expended over a one-year period if Connecticut's practice patterns were similar to the nation.

July – December 2003			
Procedure Code	**Carrier Allowed Dollars per 1,000 Enrollees**	**Nation Allowed Dollars per 1,000 Enrollees**	**Carrier to Nation Ratio**
90806	$8,997	$5,887	1.53
90807	$4,420	$1,783	2.48

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 over extended periods of time. 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.

CORRECTIONS TO PUBLISHED ARTICLES

J9000: Antineoplastic Drugs - Correction

The LCD for Antineoplastic Drugs was last published in the 4th Quarter 2004 Connecticut Medicare B Update!

The revision to the policy included updating multiple drug codes with the addition of ICD-9-CM codes based on the Compendia-Based Drug Bulletin and/or the Antineoplastic Drugs Workgroup. ICD-9-CM code 158.9 (Peritoneum, unspecified) was added to Doxorubicin HCI (J9000) but was inadvertently left out of the article. Also, the article indicated that ICD-9-CM codes 154.2 and 154.3 were added to Mitomycin (J9280, J9290, & J9291), however, these diagnosis codes were already included in the policy for this drug.

RETIREMENT OF EXISTING LMRPs

J0150: Adenosine

Based on data analysis, and a review of the policy, it has been determined that this policy is no longer necessary and therefore, was retired.

This local medical review policy (LMRP) retirement was effective for services rendered on or after August 26, 2004.

Multiple Policies Being Retired

The following LMRPs were retired effective for services rendered on or after September 30, 2004. The decision to retire these policies was based on data analysis and standards of local practice, or the existence of National Coverage Determinations (NCDs).

Policy Number	Policy Name
17000	Treatment of Plantar Warts
61863	Deep Brain Stimulation (Coverage is addressed in the Medicare National Coverage Determination Manual.)
62311	Epidural/Intrathecal Infusions, Catheters and Pumps (Will be replaced with an article addressing billing and coding instructions/guidelines.)
72141	Magnetic Resonance Imaging of the Spine
90801	Psychiatric Diagnostic Interview Examination
90846	Family Psychotherapy
90857	Interactive Group Psychotherapy
90862	Pharmacological Management with no more than Minimal Medical Psychotherapy
92065	Orthoptic/Pleoptic Training
94004G V1.2	Treatment of Ulcers of the Feet
94LMRP005-96100	Psychological Exam
96105	Neuropsychological Exam
94LMRP005 V1.0-90802	Special Clinical Psychiatric Diagnostic or Evaluative Procedures
94LMRP005 V1.0-90870	Electroconvulsive Therapy
94LMRP005 V1.0-90880	Medical Hypnotherapy
PSYCH/CHRONIC PAIN	Behavioral and Psychiatric/Psychological Assessment and Psychotherapy in the Management of Chronic Pain

ADDITIONAL INFORMATION ON LMRPs/LCDs

2005 ICD-9-CM Coding Changes

The 2005 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2004. Updated diagnosis codes must be used for all services billed on or after October 1, 2004. Effective for dates of service on and after October 1, 2004, no further 90-day grace periods will apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued.

Connecticut Medicare has reviewed all local medical review policies (LMRP/LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2005 ICD-9-CM update. The table on the following pages lists the LMRP/LCDs affected, the publication in which diagnosis criteria appeared, and the specific conditions revised as a result of the 2005 ICD-9-CM update:

2005 ICD-9-CM Part B LMRP Changes

LMRP/LCD Title	2005 Changes
31525 Diagnostic Laryngoscopy	Add 530.86 (Infection of esophagostomy) and 530.87 (Mechanical complication of esophagostomy) for procedure codes 31525 and 31575.
44388 Diagnostic Colonoscopy	Change descriptor for 250.00 (Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled) for procedure codes 44388, 44389, 44390, 44391, 44392, 44393, 44394, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, and 45386.
62263 Epidural	Change descriptor for 250.60 ([non-insulin dependent type] [NIDDM type] [adult-onset type**] was taken out of the descriptor**) and 250.61 ([non-insulin dependent type] [IDDM] **was taken out of the descriptor**) for procedure codes 62263, 62264, 0027T, 62280, 62281, 62282, 62310, 62311, 62318, 62319, 64479, 64480, 64483, and 64484.
70551 Magnetic Resonance Imaging of the Brain	Change descriptor for 290.41 (Vascular dementia, with delirium) and 294.8 (Other persistent mental disorders due to conditions classified elsewhere) for procedure codes 70551, 70552, and 70553.
76070 Bone Mineral Density Studies	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) for procedure codes G0130, 76070, 76071, 76075, 76076, 76078, 76977, and 78350.
82330 Ionized Calcium	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) and 588.8 to 588.81-588.89 (Other specified disorders resulting from impaired renal function) for procedure code 82330.
83735 Serum Magnesium	Change 252.0-252.9 to 252.00-252.9 (Disorders of parathyroid gland) and 588.8 to 588.81-588.89 (Other specified disorders resulting from impaired renal function) for procedure code 83735. Change descriptor for 293.0 (Delirium due to conditions classified elsewhere), 307.22 (Chronic motor or vocal tic disorder), 307.51 (Bulimia nervosa), and 760.71 (Noxious influences affecting fetus or newborn via placenta or breast milk, alcohol) for procedure code 83735.
88141 PAP Smears Laboratory Testing	Change descriptor for 795.00-795.09 (Abnormal Papanicolaou smear of cervix and cervical HPV) for procedure codes 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, and 88175. Change 622.1 to 622.10-622.12 (Dysplasia of cervix [uteri]) for procedure codes 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, and 88175.
94LMRP005 V1.0-90845 Medical Psychoanalysis	Change descriptor for 290.0-290.9 (Dementias) for procedure code 90845.
94LMRP005 V1.0-90865 Narcosynthesis	Change descriptor for 300.12 (Dissociative amnesia) for procedure code 90865.

LMRP/LCD Title	2005 Changes
90901 Biofeedback	Add 788.38 (Overflow incontinence) for procedure code 90911.
93965 Non-Invasive Evaluation of Extremity Veins	Add 453.40-453.42 (Venous embolism and thrombosis of deep vessels of lower extremity) for procedure codes 93965, 93970, and 93971.
BOTULINUM TOXINS (Botulinum Toxins)	Change descriptor for 780.8 (Generalized hyperhidrosis) for procedure code J0585.
G0245 Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes	Change descriptor for 250.60 and 250.62 ([non-insulin dependent type] [NIDDM type] [adult-onset type] **was taken out of the descriptor**) and 250.61 ([non-insulin dependent type] [IDDM] **was taken out of the descriptor**) for procedure codes G0245, G0246, and G0247.
J9212 Interferon	Change descriptor for 070.41 (Acute hepatitis C with hepatic coma) and 070.51 (Acute hepatitis C without mention of hepatic coma) for procedure codes J9213 and J9214.

Coding Guidelines for Epidural/Intrathecal Infusions, Catheters and Pumps Used for Pain Management

A neuroaxial trial of medications with or without catheter and portable pump consists of a trial of either epidural or intrathecal preservative free medications delivered via a continuous infusion technique administered via an indwelling catheter for patients with malignant or non-malignant pain who have failed more conservative treatment. A trial of medications may also be given as a single bolus "Single Shot" trials are commonly/frequently used for testing a patient's response to intrathecal baclofen. Medications currently used include (but not limited to) morphine sulfate, hydromorphone, sufentanil, fentanyl, bupivicane, clonidine, and baclofen.

The catheter may be placed with or without fluoroscopic guidance with or without laminectomy. The catheter may be tunneled or non-tunneled and connected to a portable pump if infusion is used.

I. Neuroaxial trial of medications with or without catheter and portable pump

1. CPT codes that may be used to report this service include: 62311, 62318, 62319, 96520, and 01996. CPT codes 62311, 62318 and 62319 are mutually exclusive per Correct Coding Initiative (CCI). E&M services may be billed during the trial period as appropriate with medical necessity clearly documented in the patient's medical record.
2. If the trial of intrathecal/epidural medications will be performed as an in-patient, the admitting physician may use CPT 99221-99223 to report the first hospital inpatient encounter.
3. If trial consists of a single injection, use CPT 62311. If epidural or subarachnoid catheter is inserted and attached to a portable pump use CPT 62318 for cervical or thoracic area or 62319 for lumbar or sacral area.
4. Refill and maintenance of portable pump, CPT 96520, is a covered service under Medicare Part B. The providers should bill for rental of pumps to "Medicare durable medical equipment regional contractor (DMERC) Region A."

I. Implantation of intrathecal catheter/pump

1. CPT codes that may be used to report this service include: 62350, 62351, 62360, 62361, and 62362.The following codes are mutually exclusive: 62360, 62361 and 62362 per CCI. All E&M services during the hospitalization are inclusive of the procedure unless there are complications.
2. CPT code in box 24D of the CMS 1500 form and link it to the applicable ICD-9-CM in box 24E of the form.
3. For implantation of an intrathecal catheter and programmable pump without laminectomy use CPT 62350, 62362 and appropriate evaluation code along with appropriate fluoroscopy code.
4. For implantation of an intrathecal catheter and programmable pump with laminectomy use CPT 62351, 62362 and appropriate evaluation code along with appropriate fluoroscopy code.

III. Removal/Revision of Implanted Catheter/Pump

1. CPT codes that may be used to report this service include: 62350, 62351, 62355, 62361, and 62365.
2. Use the appropriate CPT code(s) for removal of catheter, replacement of catheter, removal of pump, and replacement of pump and appropriate evaluation code along with appropriate fluoroscopy code. Place the appropriate CPT code in box 24D of the Form CMS 1500 and link it to the applicable ICD-9-CM code for the condition for which the removal was necessary in box 24E of the form.

IV Refilling and Maintenance of Implanted Intrathecal pump

An implanted intrathecal pump delivers continuous intrathecal preservative free medications via an implanted catheter. The provider will perform electronic analysis of the intrathecal pump (with or without reprogramming) in order to optimize pain control and/or minimize patient side effects. The implanted pump will require electronic analysis (with or without reprogramming) after the patient has had magnetic resonance imaging. When system failure is suspected, the intrathecal pump will require electronic analysis and the catheter system will need to be evaluated, including possible sideport study. Documentation in patient's medical record must establish the medical necessity for refilling or maintenance of the implanted intrathecal pump.

1. CPT codes that may be used to report this service include: 95990, 95991, 62368, 99211-99215, and J code(s) for medications. Documentation in the medical record must indicate the dosage of medications used to refill the pump as well as the tubing. (Note: Provider has to order and pay for 20 cc's of medication in order to have a full 18cc's to fill the pump. The extra medication is necessary to allow for tubing, etc.)
2. The reimbursement for the refill kit (A4220) is included in CPT code 95990 and should not be billed separately.
3. Provider should indicate in Box 19 for the Form CMS 1500 the date of the implantation of the pump.

An appropriate evaluation and management (E/M) code may be used when a separate and identifiable E/M service is delivered along with refilling and/or maintenance on the same day of service. The medical necessity must be clearly documented in the patient's medical record.

V. Side Port Study

1. CPT codes that may be used to report this service include 62284, E1399 (for side port kit) and either 76005 or one of the interpretation codes: 72265, 72270.
2. When a provider deems it necessary to perform any of these services under fluoroscopic guidance, he/she should use CPT code 76003. If the provider does not own the radiology equipment attach modifier 26.
3. During insertion of a catheter for pump trial or permanent pump placement, confirmation of intrathecal catheter placement with contrast injection (myelography) is billed with CPT 72265 (lumbosacral), 72240 (cervical), or 72255 (thoracic). These codes should not be billed in addition to CPT code 76005.

Independent Diagnostic Testing Facility

Additional codes have been identified which should be allowed for an Independent Diagnostic Testing Facility (IDTF).

Therefore, the following list of HCPCS codes have been added to the list of allowable codes by Provider Specialty 47 (IDTF).

A4642	A9504
A9507	A9508
A9510	A9511
A9512	A9513
A9514	A9515
A9516	A9517
A9519	A9520
A9521	A9523
A9524	A9600
A9605	A9699
A9700	Q3000
Q3001	Q3002
Q3003	Q3004
Q3005	Q3006
Q3007	Q3008
Q3009	Q3010
Q3011	Q3012

This change is effective for services processed on or after August 30, 2004.

Self-Administered Drug (SAD) list Update

The Center for Medicare & Medicaid Services issued instructions to contractors regarding Medicare payment for drugs and biologicals "incident to" a physician's service. Guidelines provide contractors a process for determining if an injectable drug is *usually self-administered* and therefore, not covered by Medicare. Providers may read the instructions in its entirety in CR 2200 and CR 2311.

Contractors are also required to establish a Self-Administered Drug (SAD) list on their website, listing drugs which have been evaluated and determined to be usually self-administered.

The following drug has been added to the Connecticut Medicare B SAD list:

J3490 Enfuvirtide (Fuzeon™)

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs. The Connecticut Medicare B SAD list is located at *http://www.connecticutmedicare.com*. This change is effective for services rendered on or after 11/26/04.

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.

1. Use this PO Box when submitting claims
   - **Medicare Part B CLAIMS**
     P.O. Box 44234
     Jacksonville, FL 32231-4234

2. Use this PO Box when submitting appeal/hearing requests. *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. This P.O. Box is only for appeals and hearings. If you believe the payment or determination is incorrect and want a claim to be reconsidered, then send it to the attention of the appeals 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.

   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.

   - **Medicare Part B APPEALS/ Hearings**
     P.O. Box 45041
     Jacksonville, FL 32232-5041

3. Use this PO Box when submitting the following scenarios:

a. Correspondence 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.

b. Financial Services (formerly Accounting) use this P.O. Box to return duplicate payments or overpayment refunds.

c. Fraud and Abuse – use this P.O. Box 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.

d. Freedom of Information –use this P.O. Box when requesting information available under the Freedom of Information Act.

e. 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.

f. Provider Enrollment -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 participation requests, and UPIN requests.

g. Medical Review -Questions regarding Local Medical Review Policies and correct documentation for evaluation and management services are handled by this department. Documentation for off-label chemotherapy use should also be submitted to the Medical Review Department.

h. 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.

- **Medicare Part B CORRESPONDENCE**
  P.O. Box 45010
  Jacksonville, FL 32232-5010

4. Use this physical address when submitting inquiries to the Carrier Medical Director; this includes requests for Individual Considerations.
   - **Frank A. Delli Carpini M.D**
     Carrier Medical Director
     FCSO – Medicare Part B
     321 Research Parkway
     Meriden, CT 06450

Attention: EDI

Use this P.O. Box when submitting information to the Electronic Data Interchange (EDI) department. EDI handles questions and provides information on electronic claims submission (EMC).

Attention: CT Medicare EDI – 14T
First Coast Service Options, Inc.
P.O. Box 44071
Jacksonville, FL 32231-4071

CONNECTICUT MEDICARE PHONE NUMBERS

Provider Services

First Coast Service Options, Inc.
Medicare Part B
1-(866)-419-9455 ***(toll-free)***
1-(877)-236-7851 ***(TTY)***

Beneficiary Services

First Coast Service Options, Inc.
Medicare Part B
1-(800)-MEDICARE
1-(877)-486-2048 (*TTY*)

Inquiries to:

Medicare Second Payer
Provider Enrollment
Telephone Redeterminations
1-866-535-6790

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)-MEDICARE

Durable Medical Equipment

HealthNow NY
DMERC Medicare Part B
1-(800)-MEDICARE

Railroad Retirees

Palmetto GBA
Medicare Part B
1-877-288-7600

Quality of Care

Qualidigm
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 (CHOICES)
1-(800)-994-9422

Area Agency on Aging
1-(800)-994-9422

Department of Social Services/ ConnMap
1-(800)-443-9946

ConnPace/ Assistance with Prescription Drugs
1-(800)-423-5026

Coordination of Benefits
1-(800)-999-1118
1-(800)-318-8782 TTY/TDD

WEB SITES

PROVIDER

Connecticut
www.connecticutmedicare.com
Centers for Medicare & Medicaid Services
www.cms.gov or *www.cms.hhs.gov*

BENEFICIARY

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

EDUCATIONAL RESOURCES

Information and Education Resources for Medicare Providers, Suppliers, and Physicians

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

This article is informational only and is intended to notify Medicare physicians and other providers about the information and education resources that the Centers for Medicare & Medicaid Services (CMS) have developed to help meet their Medicare business needs.

Background

One of the goals of CMS is to give Medicare's 1.2 million physicians and other providers the information they need to understand the program, be aware of changes, and bill correctly. By making information and education resources easily accessible, understandable, and as timely as possible, physicians and other providers will be better able to submit bills correctly the first time, receive reimbursements more quickly, and spend less time dealing with paperwork. All of this can result in more time to spend on patient care. We are committed to accomplishing this goal by offering Medicare physicians and other providers a variety of educational products and services and using various information delivery systems to reach the broadest and most appropriate audiences possible.

Three-Pronged Provider Information and Outreach Approach

CMS relies on the cooperative efforts of its Medicare contractors, Regional Offices (RO), and Central Office (CO) provider communications staff to deliver a seamless information and outreach approach to Medicare physicians and other providers.

1) Medicare Contractors

Medicare contractors, also called fiscal intermediaries and carriers, serve as the primary point of contact for most Medicare physicians and other providers. These contractors provide toll-free telephone lines for inquiries, conduct outreach and education, and often interact with local professional associations. Their outreach and education activities include in-person seminars, bulletins and newsletters, speaker appearances, and quick dissemination of timely information via web sites and provider-specific electronic listservs (mailing lists).

If you have questions about the Medicare program, you should first get in touch with your fiscal intermediary or carrier. To find fiscal intermediary and carrier contact information, please visit: *http://www.cms.hhs.gov/medlearn/tollnums.asp.*

2) CMS Regional Offices

Staff at CMS' ROs provide oversight of Medicare contractors and play a key role in resolving issues that physicians and other providers cannot get resolved. Our RO are active with the physician and other provider communities at state and local levels through their relationships with state and local associations and big billers, and through outreach activities such as hosting provider-oriented meetings and furnishing speakers at professional conferences.

CMS Regional Offices are located at various locations around the country. You can find their contact information at: *http://www.cms.hhs.gov/about/regions/professionals.asp*

3) CMS Central Office in Baltimore, Maryland

The provider communications staff at the CMS Central Office work closely with both Medicare contractor and RO staff to ensure that consistent and coordinated Medicare information and resources are available to all physicians and other providers. Education and outreach activities from the CMS CO are generally targeted to national associations with consistency and timeliness as our top priorities. Given the hectic schedules of today's health care professionals, most of our current initiatives are aimed at fostering a "self-service"

environment so that physicians and other providers can access information and education 24 hours a day, 7 days a week. As a result, we have significantly increased the use of the internet as a key tool for continuous-improvement customer service.

Our efforts have resulted in a variety of products and services, such as:

- **Medlearn Matters Articles** ~ One of the best sources for the latest Medicare information is "Medlearn Matters…Information for Medicare Providers" national articles, which are available at *http://www.cms.hhs.gov/medlearn/matters*. These articles are designed to give physicians and other providers and their staff easy to understand information related to new and recently changed Medicare rules and policies. The articles are written in consultation with clinicians and billing experts and focus on how these changes affect physician and other provider business functions. On the Medlearn Matters web page, you'll find a searchable table for easy access to each article and its corresponding program instructions, if applicable. You can join the Medlearn Matters listserv to receive electronic notification when new articles are released. Medicare contractors also publish Medlearn Matters articles in their bulletins and on their websites. This CO initiative serves to enhance and support contractors' local provider education efforts by promoting the availability of nationally consistent educational materials.
- **Medicare Learning Network** ~ The Medlearn Matters articles are part of a broader inventory of physician and other provider educational products found under the Medicare Learning Network. The Medicare Learning Network is the brand name for official CMS physician and other provider educational products and is designed to promote national consistency of Medicare provider information developed for CMS initiatives. Products range from web-based training courses, comprehensive training guides, brochures, and fact sheets to CD-ROMs and videos. All MLN products are free of charge and can be ordered or downloaded from the Medlearn web page located at *http://www.cms.hhs.gov/medlearn*, which also gives easy access to other resources such as educational web guides, electronic listservs, and provider-specific web pages. Check back often for the latest products, resources, and provider-oriented links.
- **CMS Provider Web Pages** ~ CMS has designed provider-specific web pages to assist individual physician and other provider types in obtaining information relevant to them more quickly. These web pages are a customized, one-stop web-based resource for the provider, supplier, and physician audience that also includes highlights on items such as new regulations and hot topics, links to general information on enrollment, billing, conditions of participation, publications, education, data, and statistics, and links to "specialty" information. For example, the Medicare Physician web Page at *http://www.cms.hhs.gov/physicians* includes links to the Medicare Physician Fee Schedule Look-Up Tool, National Correct Coding Initiative edits, Practicing Physicians Advisory Council, Physicians Regulatory Issues Team, Medicare Coverage Database, and the CMS On-line Manual. We also have specialty physician web pages where we will continue to add links of special interest to physician specialties. The first specialty physician web page, "Medicare Information for Anesthesiologists," is available at *http://www.cms.hhs.gov/physicians/anesthesiologist/default.asp*.

From the CMS Home Page at *http://www.cms.hhs.gov*, you can access select physician and other provider pages from the "Professionals" drop-down menu. You can also see a complete listing of available provider and supplier web pages by clicking on *http://www.cms.hhs.gov/providers* or *http://www.cms.hhs.gov/suppliers*. All pages have a comment section for you to electronically submit suggestions. We are always adding new pages, so check the site often.

- **Other Popular Provider Web Pages** ~ In addition to the pages mentioned above, other frequently visited pages include the CMS Online Manual System at *http://www.cms.hhs.gov/manuals*; the CMS Quarterly Provider Update at *http://www.cms.hhs.gov/providerupdate*, which gives a listing of regulations and major policies currently under development during the quarter, regulations and major policies completed or cancelled, and new or revised manual instructions; the Medicare Coverage Homepage at *http://www.cms.hhs.gov/coverage*, which contains complete coverage information including links to CMS coverage databases, frequently asked questions, and "What's New" lists.
- **Listserv Messages** ~ CMS has a number of listservs that transmit important Medicare notices and reminders to subscribers. For example, listservs have been established for most provider-specific web pages as well as for updates on the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Medicare Learning Network, and the Quarterly Provider Update. To view and subscribe to one or more listserv, please visit *http://www.cms.hhs.gov/mailinglists*.
- **Open Door Forums** ~ CMS is very interested in hearing from and interacting with the physicians and other providers who deliver quality health care to our nation's beneficiaries. We continue to emphasize our responsiveness through an ongoing series of Open Door Forums that provide an environment for interactive dialogue. Forums are chaired by senior-level Agency officials and co-chaired by CMS Regional Office officials. For more information, please visit *http://www.cms.hhs.gov/opendoor*.
- **Exhibit Program** ~ CMS hosts exhibit booths at provider, supplier, and physician association meetings. The CMS Exhibit Program provides an excellent opportunity for CMS Central and Regional Office staff to have direct contact with the Medicare provider, supplier, and physician community to listen to issues, concerns, and challenges and to share timely and relevant information. If you are interested in having a CMS exhibit at your national conference, please contact David Clark at *dclark@cms.hhs.gov*.

Physician and Other Provider Feedback

Although we try our best to be responsive to the Medicare physician and other provider community's education and information needs, we can't do it alone. Your feedback on the effectiveness and usefulness of our educational resources is very important to us as it helps ensure that we are "getting it right." Please submit your comments or suggestions at *http://www.cms.hhs.gov/providers* by selecting "Feedback" from the blue template located at the top of the page. There is also a feedback link on the Medlearn web pages for your suggestions on new educational products at *http://www.cms.hhs.gov/medlearn/suggestform.asp*. We look forward to hearing from you.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0454
Effective Date: N/A
Implementation Date: N/A

FLORIDA MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local medical review policies (LMRPs)/local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LMRPs/LCDs are provided instead. Providers may obtain full-text LMRPs/LCDs on our provider education Web site, *http://www.floridamedicare.com*. Final LMRPs/LCDs, draft LMRPs/LCDs available for comment, LMRP/LCD statuses, and LMRP/LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs/LCDs; the date the LMRP/LCD is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs/LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It's very easy to do; simply sign on to the provider education Web site, *http://www.floridamedicare.com;* click on the yellow "Join our electronic mailing list" bar and follow the prompts.

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LMRP/LCD, contact Medical Policy at:

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

1-904-791-8465

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Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

NEW LCD IMPLEMENTATION

11000: Debridement Services

Debridement is the removal of necrotic or damaged tissue, exudates, metabolic waste, or foreign material from a wound. Several methods of debridement are utilized to promote wound healing by exposing healthy tissue and allowing adequate epitheliazation and the formation of good granulation tissue. Methods of wound debridement include autolytic, chemical, mechanical, surgical, and biological.

According to the Medicare Part B statistical medical data obtained from January 1, 2003 to June 1, 2003, debridement services were determined to be aberrant in Florida; therefore, a local coverage determination (LCD) has been developed to define the indications and limitations of coverage.

The LCD defines coverage for the following CPT codes:

11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface
11001	Debridement of extensive eczematous or infected skin; each additional 10% of the body surface
11040	Debridement; skin, partial thickness
11041	Debridement; skin, full thickness
11042	Debridement; skin, and subcutaneous tissue
11043	Debridement; skin, subcutaneous tissue, and muscle)
11044	Debridement; skin, subcutaneous tissue, muscle, and bone
97601	Removal of devitalized tissue from wound(s); selective debridement, without anesthesia, including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97602	Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia, including topical application(s), wound assessment, and instruction(s) for ongoing care, per session).

In addition, this LCD has identified a procedure to diagnosis relationship and documentation requirements with a LCD attachment that includes coding guidelines. This LCD is effective for services rendered on or after January 1, 2005. The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

APBI: Accelerated Partial Breast Irradiation

Survival after breast-conservation therapy (BCT) is equivalent to survival after mastectomy for patients diagnosed with tumors categorized as stage I or II. The standard of care for local management is breast-conserving surgery to excise the tumor with adequate margins (lumpectomy), followed by whole-breast external-beam radiation therapy (WB-EBRT).

Accelerated Partial Breast Irradiation (APBI) differs from WB-EBRT in two ways. First, the radiation targets only a segment surrounding the tumor rather than the entire breast. Second, since the duration of treatment is 4 to 5 days rather than 5 to 6 weeks, radiation is delivered in fewer fractions at larger doses per fraction. APBI comprises several techniques, including interstitial brachytherapy via catheters, the MammoSite radiation treatment system, accelerated external beam radiotherapy, and intra-operative radiotherapy delivery.

When compared with whole breast irradiation, APBI offers the potential advantages of convenience and decreases radiation dose to healthy breast tissue. However, published studies are limited in patient size and follow-up period. Given access to care issues, a local coverage determination (LCD) has been developed to define the indications and limitations of coverage, establish a procedure to diagnosis relationship, and clarify the appropriate use of APBI after breast-conserving surgery for early stage breast cancer. In addition, a coding guideline has also been developed to assist in billing this type of service.

APBI after breast-conserving surgery is considered medically necessary for patients with early stage breast cancer when all of the following criteria are met:

Diagnosis: Invasive ductal carcinoma or ductal carcinoma in situ
Size:greater than or equal to 3 cm.
Margin status: Negative – at least 2mm in all directions
Nodal status: Negative axillary lymph node dissection or sentinel lymph node evaluation

This LCD is effective for services rendered on or after January 1, 2005. The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

ADDITIONS/REVISIONS TO LMRPs/LCDs

11055: Routine Foot Care

Revised Policy- This local coverage determination (LCD)/local medical review policy (LMRP) was last updated on January 1, 2002.

This policy has been converted into the new LCD format and revised to include debridement of nails since that is also included in covered routine foot care. The following CPT codes have been added to the policy:

- 11720 Debridement of nail(s) by any method(s); one to five, and
- 11721 Debridement of nail(s) by any method(s); six or more

In evaluating whether the routine services can be reimbursed, a presumption of coverage may be made by Medicare where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For purposes of applying this presumption, Class findings must be documented for all underlying conditions.

Class A Findings
- Nontraumatic amputation of foot or integral skeletal portion thereof.

Class B Findings
- Absent posterior tibial pulse;
- Advanced tropic changes such as: hair growth, nail changes, pigmentary changes, skin texture, skin color, (three required); and
- Absent dorsalis pedal pulse.

Class C Findings
- Claudication;
- Temperature changes;
- Edema;
- Parathesias; and
- Burning.

Active care requirements mandated by Medicare guidelines are included in the policy for services performed by a podiatrist.

The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com*. This policy will be effective for services rendered on or after January 1, 2005.

11720: Nail Debridement

This local coverage determination (LCD)/local medical review policy (LMRP) was last updated on January 1, 2002. A revision was made rewording the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections to no longer be specific to toenails. This policy was converted into the new LCD format.

Medicare will consider the treatment of fungal (mycotic) infection of the nails a covered service when the medical record substantiates:

- Clinical evidence of mycosis of the nail, by generally accepted clinical findings such as discoloration, onycholysis, subungual debris, thickening, or secondary skin infection;

One of the following must be documented for mycotic toenails:

- The ambulatory patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected nail plate(s) or;
- The non-ambulatory patient suffers from pain, or secondary infection resulting from the thickening and dystrophy of the infected nail plate(s).

In addition to the above, use of appropriate anti-fungal treatment, or the contraindication of such treatment, must also be documented to qualify nail debridement as a medically necessary and reimbursable service.

The following CPT codes are included in this policy:

- 11720 Debridement of nail(s) by any method(s); one to five
- 11721 Debridement of nail(s) by any method(s); six or more

The following ICD-9 codes that support medical necessity are listed in this policy:

- 110.1 Dermatophytosis of nail (Onychomycosis)
- 112.3 Candidiasis of skin and nails
- 117.0 – 117.9 Other mycoses

Patients need not have an underlying systemic condition to be covered for mycotic nail care. For treatment of non-symptomatic mycotic nails, refer to the Routine Foot Care policy. This policy will be 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*.

88271: Urinary Fluorescent In Situ Hybridization (FISH) Test for Recurrent Bladder Cancer

The local medical review policy (LMRP) Urinary Tumor Markers for Bladder Cancer was effective January 5, 2004. Bladder cancer is the fifth most common cancer in the United States, with over 50,000 newly diagnosed cases and over 10,000 deaths annually. The diagnosis of primary and recurrent bladder cancer is one of the most difficult problems in urology and cytology. Ninety percent of bladder cancer cases are classified as transitional cell carcinomas (TCC), while the remaining 10 percent are predominantly squamous cell or adenocarcinomas. There are four clinically relevant subgroups of TCC, as defined by pathologic staging carcinoma in situ (pTIS), non-invasive papillary TCC (pTa), minimally invasive TCC (pT1), and muscle invasive tumors (pT2-4). Each subgroup is distinct with respect to clinical outcome. At presentation, 75 percent of tumors are 'superficial' (i.e., pTa, pT1 or pTIS), of which 50 to 80 percent will have one or several recurrences, and 15 to 25 percent will progress to invasive tumors. The tumors with invasion limited to the lamina propria (stage pT1) pose the greatest clinical problem. Local progression to potentially life-threatening muscle-invasive cancer (pT2-4) occurs in 20 to 30 percent of these tumors after conservative surgical treatment.

After initial diagnosis and treatment, patients with urothelial carcinoma are routinely monitored every three months for the first two years then usually twice a year for three or more years. Up to 50 percent of patients will have recurrence of bladder cancer within five years. The current monitoring is done by cystoscopy, an invasive procedure, and by urine cytology. Standard cytology has been regarded as an additional diagnostic tool to select patients for cystoscopic evaluation. However, studies show that the sensitivity of cytology in urinary specimens is limited, since most of the noninvasive cancers (stage pTa) are missed. Therefore, cytology alone is unreliable to serve as a basis for therapy decisions.

Several diagnostic tests are available for the management of bladder cancer. Radioimmunoassay and immunohistochemical determinations of the serum levels of certain proteins or carbohydrates serve as tumor markers. When elevated, serum concentration of these markers may reflect tumor size and grade. Three other tests, which are to be performed in conjunction with standard diagnostic procedures, include: The Urinary Fluorescence In Situ Hybridization (FISH) Test, The Bladder Tumor Antigen Stat (BTAstat) Test, and The Nuclear Matrix Protein 22 (NMP-22) Test.

The Urinary FISH Test for recurrent bladder cancer is an FDA approved multitarget, multicolor fluorescence in situ hybridization (FISH) probe set that uses DNA technology designed to detect aneuploidy for chromosomes 3, 7, 17, and loss of the 9p21 locus in voided urine specimens from patients with transitional cell carcinoma of the bladder (urothelial carcinoma). In situ hybridization is a technique that allows the visualization of specific nucleic acid sequences within a cellular preparation. Specifically, DNA FISH involves the precise annealing of a single stranded fluorescently labeled DNA probe to complementary target sequences. The hybridization of the probe with the cellular DNA site is visible by direct detection using fluorescence microscopy. Results from this Urinary FISH Test are intended for use as a noninvasive method for monitoring tumor recurrence in conjunction with cystoscopy in patients previously diagnosed with bladder cancer.

The Bladder Tumor Antigen Stat (BTAstat) Test for recurrent bladder cancer is an FDA approved, one-step, qualitative, immunochromatographic assay for the detection of a bladder tumor-associated antigen in voided urine. This antigen is a human complement factor H-related protein (hCFHrp)) similar in composition, structure and function to human complement factor H (hCFH). Like hCFH, the BTA interacting with complement factor C3b interrupts the complement cascade and may confer a selective growth advantage to cancer cells in vivo by allowing the cells to evade the host immune system. In cell culture, hCFHrp is expressed by several bladder cell lines, but not by most normal cells. To interpret the results for the BTAstat test, urine is allowed to react with a colloidal gold-conjugated antibody and the results are determined qualitatively by the presence or absence of a line on the test stick.

The bladder tumor antigen stat test is indicated as an aid in the management of bladder cancer patients in conjunction with cystoscopy. BTAstat test results may be affected by the presence of blood or infection and, therefore, should not be performed on patients exhibiting these signs or symptoms. BTAstat testing has a sensitivity of 68 percent and a specificity of 71 percent. The BTAstat test is more sensitive than urine cytology, but not as specific.

Nuclear matrix is a non-chromatin structure that supports nuclear shape and organizes DNA. It is also involved in DNAreplication, transcription and processing of RNA. Nuclear matrix protein 22 (NMP22), a tumor marker, is a nuclear mitotic apparatus protein involved in the distribution of chromatin to daughter cells and is located in the nuclear matrix of all cell types. NMP22 is released from the nuclei of tumor cells after they die and can be detected in the urine. Normally, only very low levels of NMP22 can be detected in the urine, but elevated levels may be associated with bladder cancer.

The NMP-22 Test is an FDA approved, in vitro immunoassay intended for the qualitative detection of NMP22 nuclear matrix protein in urine of persons with risk factors or symptoms of bladder cancer or with a history of bladder cancer. This test is indicated for use as an aid in diagnosing and monitoring bladder cancer patients, in conjunction with standard diagnostic procedures.

This policy has been updated and revised to include the indications and limitations of coverage and/or medical necessity for the bladder tumor antigen stat (BTAstat) test and the nuclear matrix protein 22 (NMP-22) test, as well as appropriate CPT code and utilization guidelines. Therefore, the name of the policy has been changed to 'Urinary Tumor Markers for Bladder Cancer'. In addition, this policy has been converted into the local coverage determination (LCD) format. An attachment to the LCD has also been developed to clarify appropriate coding.

This revision will be effective for services rendered on or after January 1, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

90901: Biofeedback

The local medical review policy (LMRP) for Biofeedback – 90901 was previously revised on October 1, 2004 for ICD-9-CM updates. Since that time, additional ICD-9-CM codes 344.00-344.09 (quadriplegia and quadriparesis) 728.85, (spasm of muscle), and 728.87 (muscle weakness) were added to biofeedback training by any modality (90901). In addition, the LMRP has been converted to the local coverage determination (LCD) format.
These changes are effective for services rendered on or after November 15, 2004. The full-text of this LCD is available on the provider education website *http://www.floridamedicare.com.*

92135: Scanning Computerized Ophthalmic Diagnostic Imaging

The latest revision for local medical review policy (LMRP) Scanning Computerized Ophthalmic Diagnostic Imaging was effective March 16, 2004. Scanning computerized ophthalmic diagnostic imaging allows for early detection of glaucomatous damage to the nerve fiber layer or optic nerve of the eye. It is the goal of these diagnostic imaging tests to discriminate among patients with normal intraocular pressures (IOP) who have glaucoma, patients with elevated IOP who have glaucoma, and patients with elevated IOP who do not have glaucoma. These tests can also provide more precise methods of observation of the optic nerve head and can more accurately reveal subtle glaucomatous changes over the course of follow-up exams than visual field and/or disc photos can. This can allow earlier and more efficient efforts of treatment toward the disease process.

Retinal disorders are the most common causes of severe and permanent vision loss. Scanning computerized ophthalmic diagnostic imaging is also used for the evaluation and treatment of patients with retinal disease, especially certain macular abnormalities. It details the microscopic anatomy of the retina and the vitreo-retinal interface.

Many forms of scanning computerized ophthalmic diagnostic imaging tests currently exist (e.g., confocal laser scanning ophthalmoscopy (topography), scanning laser polarimetry, optical coherence tomography (OCT), and retinal thickness analysis. Although these techniques are different, their objective is the same.

It has been determined that specific diagnosis codes, which are currently in the policy, are inappropriate for this service. Therefore, the following ICD-9-CM codes are being removed from the 'ICD-9-CM Codes that Support Medical Necessity' section of the policy.

Diagnoses related to the central nervous system, exclusively:
225.0-225.9, 377.51-377.54, 377.61-377.63, 377.9, and 854.00-854.19

Peripheral pathology not visible 362.60-362.66

Anterior anatomy: 364.73, 364.74 and 364.77

The Indications and Limitations of Coverage and/or Medical Necessity section of the policy has also been revised. This policy has been converted into the local coverage determination (LCD) format as well. These revisions are effective for services rendered on or after January 1, 2005. The full-text of this local coverage determination may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

93303: Transthoracic and Doppler Echocardiography and Doppler Color Flow Velocity Mapping

This local medical review policy was last revised effective October 1, 2003. Since that time a major revision to the policy has been made. The original policy was struck through completely.

The policy was revised to update the indications and limitations based on the current American College of Cardiology/American Heart Association (2003) Guideline Update for the Clinical Application of Echocardiography).

In addition, the name of the policy has been changed to "Transthoracic Echocardiography (TTE)". The policy was also converted to the local coverage determination (LCD) format. This revision will be effective for services rendered on or after January 1, 2005. The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

97003: Occupational Therapy Policy for Rehabilitation Services

The local medical review policy (LMRP) for Occupational Therapy for Rehabilitation Services - 97003 was last revised effective January 1, 2001. Since that time, coverage guidelines have been added to the policy for electrical stimulation for the treatment of wounds, per program memorandums AB-02-161 and AB-03-093. These changes are effective for services performed on or after 4/1/2003. In addition, language changes were made to the policy to reflect clarifications per CMS Change Request 2859 and 2779. These changes clarify the time period when a physician must evaluate the patient and corrects omission of non-physician practitioners. These changes are effective for services performed on or after February 11, 2004.

The full-text of this LMRP may be found on the provider education website *http://www.floridamedicare.com*.

97802: Medical Nutrition Therapy (MNT)

This policy was last revised effective April 1, 2003. Since that time a revision to this policy has been made to add ICD-9 CM code 593.9 (Unspecified disorder of kidney and ureter) to the "ICD-9 Codes that Support Medical Necessity" section of the policy. In addition, the policy was converted to the local coverage determination (LCD) format.

This revision is effective October 1, 2002, the effective date of the policy. The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

G0166: External Counterpulsation

This policy was last revised effective April 1, 2000. Since that time, the policy has been revised to clarify indications and limitations of service and documentation requirements for subsequent treatments.

Using the Medicare Part B Extraction Summary system (BESS) statistical medical data obtained for the time period January 1, 2003 through June 30, 2003, the Florida to Nation ratio for procedure code G0166 was 3.23.

Therefore, this policy has been revised to further define the indications and documentation requirements for a second or subsequent course of therapy.

This policy has been converted to the local coverage decision (LCD) format and the revision will be effective for services rendered on or after January 1, 2005. The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

J0640: Leucovorin (Wellcovorin®)

Revised Policy - This LMRP/LCD was last updated on 09/23/2003.

Under the off-labeled indications section of this policy for gastric and esophageal carcinoma, Fluorouracil can be used in combination with Leucovorin. A revision was made to also allow Floxuridine to be used in combination with Leucovorin for these indications. This revision is based on the Antineoplastic Drugs policy (J9000) which allows Floxuridine (J9200) to be used in combination with Cisplatinum, Taxol, and Leucovorin.

This revision is effective for services rendered on or after September 29, 2003. The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

J2430: Pamidronate (Aredia®, APD)

Pamidronate (Aredia®, APD) was last updated on February 7, 2003. A review of this policy revealed an inconsistency between the FDA approved indications and dual diagnosis requirements. The current policy only required a dual diagnosis for osteolytic lesions related to breast cancer. The policy is being revised to require a dual diagnosis for osteolytic lesions related to myeloma as well. In addition, the dual diagnosis language has been revised to more accurately reflect the FDA approved indications. This policy has been converted to a local coverage determination (LCD) format.

This revised policy was presented to the Carriers Advisory Committee June 5, 2004. It will be effective for services rendered on or after January 1, 2005. The full-text LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes

J2792: Rho (D) Immune Globulin Intravenous

The local medical review policy (LMRP) for Rho (D) Immune Globulin Intravenous became effective on August 21, 2000.

Recent data identified extraordinary utilization of J2792 (Rho (D) immune globulin intravenous.) among Florida providers.

This policy revision is being made to clarify indications and limitations when administering Rho (D) for its FDA approved indications. Medicare will consider Rho (D) Immune Globulin Intravenous medically necessary for the following Food and Drug Administration (FDA)-approved indications:

- The suppression of Rh isoimmunization, and
- The treatment of immune thrombocytopenic purpura (ITP) for non-splenectomized Rho (D) positive individuals in clinical situations requiring an increase in platelet count to prevent excessive hemorrhage.

This policy revision includes the addition of two HCPCS codes: J2788 (Injection, Rho d immune globulin, human, minidose, 50 mcg) and J2790 (Injection, Rho d immune globulin, human, full dose, 300 mcg). Guidelines for initial and subsequent dosing are defined.

Also, the policy has been converted to the local medical determination (LCD) format. This revision will be effective for services rendered on or after January 1, 2005. The full-text LCD is available on our provider website at *http://www.floridamedicare.com*.

NCSVCS Policy

Revised Policy - The LCD for NCSVCS was last updated on September 30, 2004.

CPT codes 93720 – 93722 are being deleted from The List of Medicare Noncovered Services policy because they are covered in the Pulmonary Diagnostic Services policy effective July 6, 2004.

- 93720 – Plethysmography, total body: with interpretation and report
- 93721 - …tracing only, without interpretation and report
- 93722 - …interpretation and report only

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

NCSVCS: The List of Medicare Noncovered Services

Revised Policy - This policy was last revised effective September 30, 2004. Since that time, the policy has been revised.

An evaluation of the following procedures was performed: Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording (92612), Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording (92614), and Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording (92616). These procedures have been locally noncovered since January 1, 2003. After further evaluation it has been determined that these procedures are no longer considered investigational or experimental.

Therefore, the List of Medicare Noncovered Services Local Medical Review Policy was revised to remove CPT codes 92612, 92613, 92614, 92615, 92616, and 92617 from the local noncoverage decisions section of the policy.

This revision is effective for services rendered on or after 11/15/2004. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com*.

NCSVCS: The List of Medicare Noncovered Services

The latest revision for local medical review policy (LMRP) for the List of Medicare noncovered services was effective September 30, 2004. The list of noncovered services is divided into two main headings: Local Noncoverage Decisions and National Noncoverage Decisions. A service or procedure on the "local" list has been determined as noncovered by the Florida carrier. Decisions of noncoverage at the national level have been determined by the Centers for Medicare & Medicaid Services (CMS). National noncovered services cannot be covered by the local carrier.

The following procedure has been added to the list of local noncoverage decisions:

- 0017T Destruction of macular drusen, photocoagulation

Age-related macular degeneration (AMD) is a painless, insidious process. In its earliest stages, it is characterized by minimal visual impairment and the presence of 'large' or 'soft' drusen, i.e., subretinal accumulations of cellular debris adjacent to the basement membrane of the retinal pigment epithelium.

Large drusen appear as large, pale yellow or pale grey domed elevations and result in thickening of the space between the retinal pigment epithelium and its blood supply, the choriocapillaris. Clinical and epidemiologic studies have shown that the presence of large and/or numerous soft drusen increases the risk of the development of choroidal neovascularization (CNV) in eyes with AMD. For example, in patients with bilateral drusen, the

three-year risk of developing CNV is estimated to be 13 percent, rising to 18 percent for those over the age of 65. The emergence of CNV greatly increases the risk of subsequent irreversible loss of vision.

Two different kinds of low energy laser therapies, argon and infrared laser, have been investigated as techniques to eliminate drusen by photocoagulation in an effort to prevent the evolution to CNV, ultimately leading to improved preservation of vision. The lasers used are those that are widely used for standard photocoagulation of extrafoveal choroidal neovascularization. Therefore, the treatment of macular drusen represents an additional indication for an existing laser approved by the U.S. Food and DrugAdministration (FDA).

Definitive data regarding the role of laser therapy as a prophylactic treatment to prevent progression to CNV must await the completion of clinical trials currently in progress. While the currently available results suggest some short-term improvement in visual acuity, the outcome of greatest interest is the reduction of severe vision loss from atrophy and CNV. Long-term results are also important to evaluate safety issues. Laser therapy can damage the retinal pigment epithelium and photoreceptors, and it is unknown whether the short-term improvement in visual acuity may be counterbalanced by a more rapid progression of visual loss if and when CNV occurs. Therefore destruction of macular drusen with laser therapy as a prophylactic treatment to prevent progression of choriodal neovascularization (CNV) is considered investigational due to lack of data regarding impact on health outcomes.

This policy has also been converted into the local coverage determination (LCD) format.

This LCD will be effective for services rendered on or after January 1, 2005. The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

MAHD/ER: Metabolically Active Human Dermal/Epidermal Replacements

Metabolically Active Human Dermal/Epidermal Replacements (MAHD/ER) was effective March 24, 2003. This policy has also been revised to include indications and limitations for Xenograft and Allograft. In addition, the name of the policy has been changed to SKINSUB: Skin Substitutes. This policy has been converted to a local coverage determination (LCD) format and includes coding guidelines for services associated with graft site preparation and the application of grafts.

This revision will be effective for services rendered on or after January 1, 2005. The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

VISCO Viscosupplementation Therapy For Knee

Viscosupplementation Therapy for Knee was last updated on September 8, 2003. This policy has been revised to incorporate and define the indications and limitations of coverage and/or medical necessity, to clarify the appropriate ICD-9-CM codes to use when billing Orthovisc® (J3590) and to provide access to care. Orthovisc® is a sterile, non-pyrogenic, clear, viscoelastic solution of hyaluronan which was approved by the FDA on February 4, 2004 for the treatment of osteoarthritis of the knee joints in patients who have failed to respond, or who have had inadequate responses to other treatment. In addition, this policy has been converted to a local coverage determination (LCD) format and includes coding guidelines to assist with coding issues when billing these services.

This revised policy was presented to the Carriers Advisory Committee June 5, 2004. It will be effective for services rendered on or after January 1, 2005. The full-text LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

RETIREMENT OF EXISTING LMRPs

Multiple Policies Being Retired

The following LMRPs were retired effective for services rendered on or after September 30, 2004, unless specified otherwise. The decision to retire these policies was based on data analysis and standards of local practice, or the existence of National Coverage Determinations (NCDs).

Policy Number	Policy Name
00103	Anesthesia Services (Ocular Procedures)
01996	Concurrent Care
11920	Cosmetic/Reconstructive Surgery (Coverage is addressed in the Medicare National Coverage Determination Manual.)
20000	Musculoskeletal System
21076	Oral and Maxillofacial
30400	Rhinoplasty
32851	Lung Transplantation (Coverage is addressed in the Medicare National Determination Manual.)
33999	Pacemaker Lead Extraction, Unusually Difficult
35470	Percutaneous Transluminal Angioplasty
48554	Pancreas Transplantation (Coverage is addressed in the Medicare National Determination Manual.)
51725	Urodynamic Testing
51784	Anal or Urethral Sphincter Electromyography
52647	Laser Prostatectomy
54250	Nocturnal Penile Tumescence and /or Rigidity Test
54325	Injection of Corpora Cavernosa
55250	Sterilization (Coverage is addressed in the Medicare National Determination Manual.)
58340	Infertility (Coverage is addressed in the Medicare National Coverage Determination Manual.)
59840	Elective Abortion (Coverage is addressed in the Medicare National Coverage Determination Manual.)
61711	Extracranial-Intracranial Surgery
61793	Stereotactic Radiosurgery
61863	Deep Brain Stimulation (Coverage is addressed in the Medicare National Determination Manual.)
64573	Vagus Nerve Stimulation (Coverage is addressed in the Medicare National Coverage Determination Manual.)
65772	Corneal Relaxing Incisions
69210	Impacted Cerumen Removal (Will be replaced with an article addressing billing and coding instructions/guidelines.)
69930	Cochlear Implant Surgery/Device/Rehab (Coverage is addressed in the Medicare National Coverage Determination Manual.)
77750	Clinical Brachytherapy
82435	Chloride
82746	Folic Acid
86430	Rheumatoid Factor **(effective for services rendered on or after September 2, 2004)**
87621	Human Papillomavirus DNA Assay, Amplified Probe Technique
88230	Cytogenetic Studies

Policy Number	Policy Name
88300	Surgical Pathology
90732	Pneumococcal Vaccinations (Coverage is addressed in the Medicare Claims Processing Manual, Chapter 18 - Preventative and Screening Services.)
90740	Hepatitis B Vaccine (Coverage is addressed in the Medicare Claims Processing Manual, Chapter 18-Preventative and Screening Services.)
90880	Hypnotherapy
90899	Transcendental Meditation
92002	General Ophthalmological Services
92502	Special Otorhinolaryngologic Services
95805	Sleep Testing
95816	Electroencephalography (EEG)
95860	Electromyography
E0782	Implantable Infusion Pumps
J0636	Vitamin D Analogs in Chronic Renal Disease
J1750	Iron Dextran
J7310	Vitasert™ Implant
J9202	Goserelin Acetate Implant
L8600	Breast Prosthesis
L8603	Collagen Implant
L8612	Extraocular Reservoir
L8642	Hallux Implant
L8699	Implantable Tissue Expander
PAINREH	Pain Rehabilitation (Coverage is addressed in the Medicare National Coverage Determination Manual.)
R0070	Portable X-Ray Supplier Services
RSFNFR	Medicare B Coverage of Routine Services for Nursing Facilities Residents

CORRECTIONS TO PUBLISHED ARTICLES

93701: Cardiac Output Monitoring by Thoracic Electrical Bioimpedance – Correction

We published an article in the Fourth Quarter 2004 *Medicare B Update!* (page 67) to include additional diagnoses that support the indications and limitations of coverage and/or medical necessity for Cardiac Output Monitoring by Thoracic Electrical Bioimpedance – 93701. However, ICD-9-CM code 996.03 was published incorrectly. The correct ICD-9-CM code is **996.83**. Florida Medicare apologizes for any inconvenience this may have caused.

The full-text of this LCD may be found on the provider education website *http://www.floridamedicare.com*.

93975: Duplex Scanning – Correction

We published an article in the Fourth Quarter 2004 *Medicare B Update!* (Page 67) to include additional diagnoses that support the indications and limitations of coverage and/or medical necessity for Duplex Scanning – 93975. However, ICD-9-CM codes V67.00 and V67.09 were inadvertently omitted from the article for procedure codes 93975 and 93976. The addition of diagnoses V67.00 and V67.09 is effective for services rendered on or after July 26, 2004. Florida Medicare apologizes for any inconvenience this may have caused.

The full-text of this LCD may be found on the provider education website http://*www.floridamedicare.com*.

J9000: Antineoplastic Drugs – Correction

Correction - The LCD for Antineoplastic Drugs was last published in the 4th Quarter 2004 *Florida Medicare B Update*! The revision to the policy included updating multiple drug codes with the addition of ICD-9-CM codes based on the Compendia-Based Drug Bulletin and/or the Antineoplastic Drugs Workgroup. ICD-9-CM code 158.9 (Peritoneum, unspecified) was added to Doxorubicin HCI (J9000) but was inadvertently left out of the article. Also, the article indicated that ICD-9-CM codes 154.2 and 154.3 were added to Mitomycin (J9280, J9290, & J9291), however, these diagnosis codes were already included in the policy for this drug. The full text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* when it becomes available.

WIDESPREAD MEDICAL REVIEW PROBES

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. 97.60 percent of claim submitted for CPT 90818 were billed 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 non-covered stay.

We encourage providers to examine their current billing practices and ensure only appropriate POS codes are submitted.

99244 - Widespread Probe Summary for Office Consultation

Procedure code 99244 was identified as aberrant for Florida during FY2003 based on the January through June 2003 data obtained from Statistical Medical Data Analysis (SMDA). This data revealed a total of $16,959,681 was paid to different providers of various specialties. Based on the conclusions of the specialty findings a widespread probe for CPT code 99244 was recommended to ensure providers are meeting the definition of the code. A widespread probe of one hundred (100) claims from twenty (20) providers from various specialties for the time period from July 1, 2003 through December 31, 2003 was performed. The providers reviewed represented the following specialties: Ophthalmology, Anesthesiology, Neurology, Orthopedic Surgery, Hematology/Oncology, Gastroenterology, Otolaryngology, Cardiology, Physical Medicine, and Rehabilitation, Internal Medicine, and Urology. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed and appropriately coded for the level of care billed.

SUMMARY

- Procedure code 99244 was billed on all one hundred (100) claims.
- Fifty-six (56) of the one hundred (100) services were allowed as billed.
- Thirty-four (34) of the one hundred (100) services were down coded because the level of care was not supported in the documentation:
    - Twenty-five (25) of the thirty-four (34) services were down coded to E/M code 99243.
    - Nine (9) of the thirty-four (34) services were down coded to E/M code 99242.
- Ten (10) of the one hundred (100) services were not considered consults and were recoded to the appropriate E/M code:
    - Eight (8) services were recoded to E/M code 99204
    - Two (2) services were recoded to E/M code 99203.
- Eleven (11) different specialties were represented, and no provider specific drivers were noted.
- Of the thirty four (34) services down coded, the majority were down coded based on documentation that failed to support the moderate level of medical decision complexity required for E/M code 99244. The remaining services were down coded based on the documentation that failed to support the comprehensive history required for E/M code 99244.
- Of the allowed (56) or down coded (34) services the documentation established that the patient was referred for consultation for the services billed.
- The remaining ten (10) services were recoded to the appropriate E/M code based on the submitted documentation. These services failed to establish the referral for an E/M consultation visit.

99245: Widespread Probe Review Results – Office Consultation

Procedure code 99245 was identified as aberrant for Florida during FY2003 based on the January through June 2003 data obtained from Statistical Medical Data Analysis (SMDA). This data revealed a total of $10,596,359 was paid to different providers of various specialties. Based on the conclusions of the specialty findings a widespread probe for CPT code 99245 was recommended to ensure providers are meeting the definition of the code and validate the level of care provided. A widespread probe of one hundred (100) claims from twenty (20) providers for the time period from July 1, 2003 through December 31, 2003 was performed. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed and appropriately coded for the level of care billed.

SUMMARY

- Procedure code 99245 was billed on all one hundred (100) claims.
- Seventeen (17) of the one hundred (100) services were allowed as billed.
- Five (5) of the one hundred (100) services were denied, as the procedure billed was not supported by the documentation.
- Seventy four (74) of the one hundred (100) services were down coded because the level of care was not supported in the documentation:
    - Fifty-two (52) of the seventy-four (74) services were down coded to E/M code 99244.
    - Seventeen (17) of the seventy-four (74) services were down coded to E/M code 99243.
    - Five (5) of the seventy-four (74) services were down coded to E/M code 99242.
- Four (4) of the one hundred (100) services were not considered consults and were recoded to the appropriate E/M code:
    - Two (2) services were recoded to E/M code 99204
    - One (1) service was recoded to E/M code 99215.
    - One (1) service was recoded to E/M code 99253.
- Eight (8) different specialties were represented, and no provider specific drivers were noted
- The majority of the services were down coded based on documentation that failed to support the high level of medical decision complexity required for E/M code 99245.
- The documentation established that the patient was referred for consultation for the services that were allowed (17) or down coded (74).
- The remaining four (4) services were recoded to the appropriate E/M code based on the submitted documentation.

99291: Widespread Probe – Critical Care Services – Correction

We published an article in the Fourth Quarter 2004 *Medicare B Update!* (page 69) which indicated the procedure code for *Critical care, evaluation and management of the critically ill injured patient, first 30-74 minutes)* as 99211. The correct procedure code is 99291. Florida Medicare apologizes for any inconvenience this may have caused.

99291: Widespread Probe Review Results- Critical Care, Evaluation and Management of the Critically Ill or Critically Injured Patient, first 30-74 minutes

Procedure code 99291 was identified as aberrant as defined in, and accordance with, the Statistical Medical Data Analysis (SMDA) Comprehensive Data Analysis (CDA) Standard Operating Procedure No 1.01 for the FY January-June 2003. The aberrant data revealed a carrier to nation ratio of allowed dollars of 1.60 with a potential savings of $9,866,562. Based on the conclusions of the above-mentioned findings, a widespread probe was recommended for CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient, first 30-74 minutes). A widespread probe of one hundred (100) claims with one hundred and forty-three (143) services was performed. These claims were requested from twenty (20) providers for the time period from January to June 2003. The claims were reviewed to determine if providers were billing correctly and beneficiaries met criteria for critical care services in accordance with the guidelines published in the 2003 Current Procedural Terminology (CPT) Coding book.

Summary of the Findings
Review findings were as follow:

- Seventy-eight (78) services were allowed according to documentation submitted for review.
- Twenty-two (22) services were denied due to documentation, which did not support that services billed were rendered.
- One (1) service was down coded to CPT 99233 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.
- Eleven (11) services were down coded to 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity).
- Nineteen (19) services were down coded to CPT 99232 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity).
- One (1) service was down coded to 99233 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity).
- Eleven (11) services were down coded to CPT 99255 (Initial inpatient consultation for a new or established

patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity). Although the beneficiaries met medical criteria guidelines. Documentation supported evidence that the services rendered were consultations.

- Seventy-two (72) claims out of ninety-seven (97) claims billed for CPT 99291 (Critical care, evaluation and management of the critically ill or critically injured patient, first 30-74 minutes also billed at least one (1) 99292 (each additional 30 minutes (List separately in addition to code for primary service). Claims, which were denied or down coded that also billed CPT 99292 resulted in having 99292 denied.
- Seven (7) claims with CPT 99291 that were allowed also billed CPT 99292. CPT 99292 was denied on these claims due to documentation not supporting the billing of additional critical care management time.
- Time was deducted from the critical care management time for separately billable procedures. This time was low in relation to the number and type of procedures performed. This would often result in enough time accumulated to warrant the billing of 99292 (each additional 30 minutes (List separately in addition to code for primary service).

Based on these findings, overpayments will be assessed on providers when medical records do not sufficiently support the medical necessity of the code billed. Education will be provided via publication in an upcoming *Medicare Part B Update!* article.

Colonoscopy Billing Errors

The comprehensive data analysis department recently conducted an analysis of Florida Medicare Part B claims data for the following aberrant CPT codes:

45378 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure),
45383 with ablation of tumor(s), polyp(s), or other lesions not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384 with removal of tumor(s), polyp(s), or other lesions by hot biopsy forceps or bipolar cautery

Data revealed Ambulatory Surgery Centers (ASC's) and performing physicians are submitting claims that do not contain the same colonoscopy procedure code for services performed on the same date of service to the same beneficiary. Examples:

- ASC submits a facility claim with procedure code 45378 (diagnostic colonoscopy) and the performing physician submits a claim for services furnished at the ASC with procedure code G0105 (screening colonoscopy) for the same date of service to the same beneficiary.
- ASC submits a facility claim for 45383 and physician submits a claim for services furnished at the ASC with procedure code 45384 for the same beneficiary and date of service.

Procedures should be reported with the HCPCS/CPT code that most comprehensively describes the service performed. Please evaluate your billing procedures for the presence of these billing errors and implement any necessary changes.

ADDITIONAL INFORMATION ON LMRPs/LCDs

2005 ICD-9-CM Coding Changes

The 2005 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2004. Updated diagnosis codes must be used for all services billed on or after October 1, 2004. Effective for dates of service on and after October 1, 2004, no further 90-day grace periods will apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued.

Florida Medicare has reviewed all local medical review policies (LMRP/LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2005 ICD-9-CM update. The table on the following pages lists the LMRP/LCDs affected, the publication in which diagnosis criteria appeared, and the specific conditions revised as a result of the 2005 ICD-9-CM update:

2005 ICD-9-CM Part B LMRP Changes

LMRP/LCD Title	2005 Changes
31525 Diagnostic Laryngoscopy	Add 530.86 (Infection of esophagostomy) and 530.87 (Mechanical complication of esophagostomy) for procedure codes 31525 and 31575.
43235 Diagnostic and Therapeutic Esophagogastroduodenoscopy	Change descriptor for 307.51 (Bulimia nervosa) and 307.53 (Rumination disorder) for procedure codes 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, and 43258.
70450 Computed Tomography Scans	Change descriptor for 290.0-290.9 (Dementias), 293.0 (Delirium due to conditions classified elsewhere), 293.81 (Psychotic disorder with delusions in conditions classified elsewhere), 293.82 (Psychotic disorder with hallucinations in conditions classified elsewhere), 293.83 (Mood disorder in conditions classified elsewhere), 294.0-294.9 (Persistent mental disorders due to conditions classified elsewhere), and 310.0-310.9 (Specific nonpsychotic mental disorders due to brain damage) for procedure codes 70450, 70460, and 70470.
70551 Magnetic Resonance Imaging of the Brain	Change descriptor for 310.0-310.9 (Specific nonpsychotic mental disorders due to brain damage) for procedure codes 70551, 70552, and 70553.
76070 Bone Mineral Density Studies	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) for procedure codes G0130, 76070, 76071, 76075, 76076, 76078, 76977, and 78350.
82108 Aluminum	Change descriptor for 294.8 (Other persistent mental disorders due to conditions classified elsewhere) for procedure code 82108.
82310 Total Calcium	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) for procedure code 82310. Change descriptor for 293.0 (Delirium due to conditions classified elsewhere) for procedure code 82310.
82330 Ionized Calcium	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) and 588.8 to 588.81-588.89 (Other specified disorders resulting from impaired renal function) for procedure code 82330.

LMRP/LCD Title	2005 Changes
83735 Magnesium	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) and 588.8 to 588.81-588.89 (Other specified disorders resulting from impaired renal function) for procedure code 83735. Change descriptor for 293.0 (Delirium due to conditions classified elsewhere) and 307.51 (Bulimia nervosa) for procedure code 83735.
83970 Parathormone (Parathyroid Hormone)	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) and 588.8 to 588.81-588.89 (Other specified disorders resulting from impaired renal function) for procedure code 83970.
84100 Serum Phosphorus	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) for procedure code 84100. Change descriptor for 293.0 (Delirium due to conditions classified elsewhere) for procedure code 84100.
86706 Hepatitis B Surface Antibody and Surface Antigen	Change V01.7 to V01.71-V01.79 (Other viral diseases) for procedure codes 86706 and 87340.
88141 Pap Smears	Change descriptor for 795.00-795.09 (Abnormal Papanicolaou smear of cervix and cervical HPV) for procedure codes 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, and 88175. Change 622.1 to 622.10-622.12 (Dysplasia of cervix [uteri]) for procedure codes 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, and 88175.
90801 Psychiatric Diagnostic Interview Examination	Change descriptor for 300.00-316 (Anxiety, dissociative and somatoform disorders, personality disorders, and other nonpsychotic mental disorders) for procedure code 90801.
90845 Psychoanalysis	Change descriptor for 300.01 (Panic disorder without agoraphobia), 300.12 (Dissociative amnesia), 300.13 (Dissociative fugue), and 300.4 (Dysthymic disorder) for procedure code 90845.
90901 Biofeedback	Add 788.38 (Overflow incontinence) for procedure code 90911.
92015 Ophthalmological Diagnostic Services	Change descriptor for 041.82 (Bacteroides fragilis) for procedure code 92285.
93965 Non-Invasive Evaluation of Extremity Veins	Add 453.40-453.42 (Venous embolism and thrombosis of deep vessels of lower extremity) for procedure codes 93965, 93970, and 93971.
95115 Allergen Immunotherapy	Add 477.2 (Allergic rhinitis due to animal (cat) (dog) hair and dander) for procedure codes 95115, 95117, and 95165.
95250 Continuous Glucose Monitoring System (CGMS)	Change descriptor for 250.02, 250.12, 250.22, 250.42, 250.52, 250.62, 250.72, and 250.82. ([non-insulin dependent type] [NIDDM type] [adult-onset type] **was taken out of the descriptor)** for procedure code 95250.
A4644 Low Osmolar Contrast Media (LOCM)	Change V46.1 to V46.11-V46.12 (Other dependence on respirator) for procedure codes A4644, A4645, and A4646
BOTULINUM TOXINS (Botulinum Toxins)	Change descriptor for 780.8 (Generalized hyperhidrosis) for procedure code J0585.
G0245 Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes	Change descriptor for 250.60 and 250.62 ([non-insulin dependent type] [NIDDM type] [adult-onset type] **was taken out of the descriptor**) and 250.61 ([non-insulin dependent type] [IDDM] **was taken out of the descriptor**) for procedure codes G0245, G0246, and G0247.
J7190 Hemophilia Clotting Factors	Change descriptor for 286.5 (Hemorrhagic disorder due to intrinsic circulating anticoagulants) for procedure codes J7190, J7191, J7192, J7193, J7194, J7195, J7198, Q0187, Q2022, and J7199.
J9212 Interferon	Change descriptor for 070.41 (Acute hepatitis C with hepatic coma) and 070.51 (Acute hepatitis C without mention of hepatic coma) for procedure codes J9213 and J9214.

Independent Diagnostic Testing Facility

Additional codes have been identified which should be allowed for an Independent Diagnostic Testing Facility (IDTF). Therefore, the following list of HCPCS codes have been added to the list of allowable codes by provider specialty 47 (IDTF).

A4642	A9504	A9507	A9508
A9510	A9511	A9512	A9513
A9514	A9515	A9516	A9517
A9519	A9520	A9521	A9523
A9524	A9600	A9605	A9699
A9700	Q3000	Q3001	Q3002
Q3003	Q3004	Q3005	Q3006
Q3007	Q3008	Q3009	Q3010
Q3011	Q3012		

This change is effective for services processed on or after August 30, 2004.

Self-Administered Drug (SAD) list Update

The Center for Medicare & Medicaid Services issued instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. Guidelines provide contractors a process for determining if an injectable drug is *usually self-administered* and therefore, not covered by Medicare. Providers may read the instructions in its entirety in CR 2200 and CR 2311.

Contractors are also required to establish a Self-Administered Drug (SAD) list on their website, listing drugs which have been evaluated and determined to be usually self-administered.

The following drug has been added to the Florida Medicare B SAD list:

J3490 Enfuvirtide (Fuzeon™)

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs. This is effective for services rendered on or after November 26, 2004. The Florida Medicare B SAD list is located at *http://wwwfloridamedicare.com*.

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

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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

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1-904-791-8016
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1-904-791-6895
PC-ACE Support:
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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

BENEFICIARY

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http://www.medicarefla.com

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

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❒	**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. (***Tentatively available after November 15, 2004***.)	700400	Hardcopy: $5.00 (CT) $10.00 (FL) CD-ROM: $6.00 (Specify CT or FL)

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*** ATTENTION BILLING MANAGER ***