

# Intermediary NEWS



November 2003

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SHOULD BE SHARED WITH  
ALL HEALTH CARE  
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MANAGERIAL MEMBERS OF  
THE PROVIDER/SUPPLIER  
STAFF.  
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## Electronic VS. Hardcopy Bulletins

In the past, Maryland Medicare has published articles/bulletins via electronic and paper media. All articles/bulletins are posted to the Maryland Medicare web site at <http://www.marylandmedicare.com/>. These articles include information from Program Memoranda, Local Medical Policies, coverage, and billing issues. Maryland Medicare Part A has elected to publish future bulletins and articles via electronic transmission on the Maryland Medicare web site rather than hardcopy bulletins. We will, however, continue to publish the Intermediary News in hardcopy on a quarterly basis. Providers with internet access now have the capability to electronically subscribe to our web site and automatically receive the latest provider news. Subscribing to our list-serv enables the intermediary to contact the provider when our web site has been updated to keep you informed of the latest changes in the Medicare Program. This service is free. The only requirement is that providers have a valid e-mail address. Once you subscribe to the list(s) of your choice you can unsubscribe from the list(s) at any time. If a provider does not have internet access, Medicare will provide a single hardcopy of the article. Providers that do not have web site access need to contact Maryland Medicare to be placed on a list so that you may obtain a hardcopy of any of our publications. In order to be placed on this list, contact Don Doyle at 410-561-4036. Only one hardcopy will be provided per provider. We strongly encourage providers to obtain internet access in order to subscribe to our list-serv, as this is a much quicker means of disseminating information to the provider community. To sign up for our List-Serv, please visit [www.marylandmedicare.com](http://www.marylandmedicare.com) and select "Electronic Mailing Lists" on our main page. Please follow the directions and enter all fields required.

PROVIDER RELATIONS  
TOLL FREE PHONE NUMBER

**866-488-0545**

# Intermediary NEWS



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*“CareFirst of Maryland, Medicare Part A publishes the Intermediary News as an informational reference source for providers furnishing services / supplies in our Medicare contract area. This information is intended to assist providers and not replace Medicare program requirements as set forth in statute, regulations and manual instructions. It is the responsibility of each provider to familiarize themselves with Medicare coverage requirements. CareFirst of Maryland, Medicare Part A makes efforts to ensure the information in this publication is accurate and current. Please note that the Medicare program is constantly changing, therefore it is the responsibility of the provider to remain informed of the Medicare program requirements.”*

PROVIDER RELATIONS

**TOLL FREE PHONE NUMBER**

**866-488-0545**



**HOLIDAY SCHEDULE for NOVEMBER & DECEMBER 2003**

Thanksgiving Day <b>OFFICES CLOSED</b>	Thursday, November 27, 2003	No onlines or cycles No HIMR
Day after Thanksgiving <b>OFFICES CLOSED</b>	Friday, November 28, 2003	Regular processing day
Christmas Eve <b>OFFICES CLOSED</b>	Wednesday, December 24, 2003	Regular processing day
Christmas Day <b>OFFICES CLOSED</b>	Thursday, December 25, 2003	No onlines or cycles No HIMR
New Years Eve <b>OFFICES CLOSED</b> <b>12:00 PM EDT</b>	Wednesday, December 31, 2003	Regular processing Day
New Years Day <b>OFFICES CLOSED</b>	Thursday, January 1, 2004	No onlines or cycles No HIMR

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

The purpose of this article is to implement claims processing procedures to ensure that automated multi-channel chemistry tests are paid in accordance with Provider Reimbursement Manual (PRM) §2711.

### A. Background:

The Office of Inspector General (OIG) conducted several studies which identified that Medicare payments for ESRD laboratory related services are not paid in compliance with our payment policy. In response to the payment vulnerabilities identified by the OIG, the claims processing instructions contained in this bulletin direct all intermediaries to implement changes to ensure that ESRD laboratory claims that are identified by the provider are paid in accordance with our payment policy.

Medicare provides reimbursement for certain routine clinical diagnostic laboratory tests rendered to a ESRD beneficiary within the composite rate payment to the ESRD facility. PRM §2711 states that separate payment may be made for the clinical diagnostic laboratory test rendered on a particular date of service when 50 percent or more of the covered tests billed for that particular date of service are non-composite rate tests.

### B. Policy:

Clinical diagnostic laboratory tests included under the composite rate payment are paid through the composite rate paid by the intermediary. To determine if separate payment is allowed for non-composite rate tests for a particular date of service, 50 percent or more of the covered tests must be non-composite rate tests.

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

- 1) Payment is at the lowest rate for services performed by the same provider, for the same beneficiary, for the same date of service.

- 2) Identify for a particular date of service the AMCC tests ordered that are included in the composite rate and those that are not included. The composite rate tests are defined for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), and Hemofiltration (Attachment 1) and for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Attachment 2).
- 3) If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.
- 4) If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that Date of Service (DOS) are separately payable.
- 5) A non-composite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary.

### C. Implementation:

Three pricing modifiers discretely identify the different payment situations for ESRD AMCC tests. The physician that orders the tests is responsible for identifying the appropriate modifier when ordering the tests.

- CD – AMCC test 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 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 test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable

ESRD clinical diagnostic laboratory tests identified with modifiers “CD”, “CE” or “CF” may not be billed as organ or disease panels. Effective October 1, 2003, all ESRD clinical diagnostic laboratory tests must be billed individually.

The intermediary standard system must calculate the number of AMCC tests provided for any given date of service. Sum all AMCC tests with a CD modifier and divide by the sum of all tests with a CD, CE and CF modifier for the same beneficiary and billing provider for any given date of service.

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

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

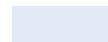
All tests for a date of service must be billed on the monthly ESRD bill. Providers must send in an adjustment if they identify additional tests that have not been billed.



**IV.**

Chemistry	CPT Code	Monthly	Weekly	13 X quarter
1 Albumin	82040	X		
2 Alkaline phosphatase	84075	X		
3 ALT (SGPT)	84460			
4 AST (SGOT)	84450	X		
5 Bilirubin, total	82247			
6 Bilirubin, direct	82248			
7 Calcium	82310	X		
8 Chloride	82435			
9 Cholesterol	82465			
10 CK, CPK	82550			
11 CO2 (bicarbonate)	82374	X		
12 Creatinine	82565	X		
13 GGT	82977			
14 Glucose	82947			
15 LDH	83615	X		
16 Phosphorus	84100	X		
17 Potassium	84132	X		
18 Protein, total	84155	X		
19 Sodium	84295	X		
20 Triglycerides	84478			
21 Urea nitrogen (BUN)	84520	X		
22 Uric Acid	84550			

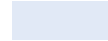
= non-composite rate test

 = composite rate test

**Attachment 2**

Chemistry	CPT Code	Monthly	Weekly	13 X quarter
1 Albumin	82040	X		
2 Alkaline phosphatase	84075	X		
3 ALT (SGPT)	84460			
4 AST (SGOT)	84450	X		
5 Bilirubin, total	82247			
6 Bilirubin, direct	82248			
7 Calcium	82310	X		
8 Chloride	82435	X		
9 Cholesterol	82465			
10 CK, CPK	82550			
11 CO2 (bicarbonate)	82374	X		
12 Creatinine	82565		X	
13 GGT	82977			
14 Glucose	82947			
15 LDH	83615	X		
16 Phosphorus	84100	X		
17 Potassium	84132	X		
18 Protein, total	84155	X		
19 Sodium	84295			
20 Triglycerides	84478			
21 Urea nitrogen (BUN)	84520			X
22 Uric Acid	84550			

= non-composite rate test

 = composite rate test

## Examples of the Application of the 50/50 Rule

The following examples are to illustrate how claims should be paid. The percentages in the action section represent the number of composite rate tests over the total tests. If this percentage is 50 percent or greater, no payment should be made for the claim.

**Example 1:**

Provider Name: Jones Hospital

DOS 2/1/02

Claim/Svcs. 82040 Mod 1	Claim/Svcs. 84295 Mod 3
82310 Mod 1	82040 Mod 1 (Returned as duplicate)
82374 Mod 1	84075 Mod 2
82435 Mod 1	82310 Mod 2
82947 Mod 3	84155 Mod 2

**ACTION:** 9 services total, 2 non-composite rate tests, 3 composite rate tests beyond the frequency, 4 composite rate tests;  
 $4/9 = 44.4\% < 50\%$  pay at ATP 09

**Example 2:**

Provider Name: Bon Secours Renal Facility

DOS 2/15/02

Claim/Svcs. 82040 Mod 2 and Mod 91	Claim/Svcs. 82040 Mod 1
84450 Mod 2	84075 Mod 2
82310 Mod 2	82435 Mod 2
82247 Mod 3	82550 Mod 3
82465 No modifier present	82947 Mod 3
82565 Mod 3	82977 Mod 3
84550 Mod 3	

**ACTION:** 11 services total, 6 non-composite rate tests, 4 composite rate tests beyond the frequency, 1 composite rate test;  
 $1/11 = .09\% < 50\%$ , pay at ATP 11.

**Example 3:**

Provider Name: Sinai Hospital Renal Facility

Bene 1: DOS 4/02/02

Claim/Svcs. 82565 Mod 1	Claim/Svcs. 84450 Mod 1
83615 Mod 1	82565 Mod 2
82247 Mod 3	84550 Mod 3
82248 Mod 3	82248 Mod 3 (Duplicate)
82040 Mod 1	

**ACTION:** 8 total services, 4 composite  $4/8 = 50\%$ , therefore no payment is made

**Example 4:**

Provider Name: Dr. Andrew Ross

Bene 1: DOS 6/01/02

84460 Mod 3	82040 Mod 1
82247 Mod 3	84075 Mod 1
82248 Mod 3	84450 Mod 1

**ACTION:** 6 services total, 3 non-composite rate tests and 3 composite rate tests;  $3/6 = 50\%$ , therefore no payment.  
 An overpayment should be recovered for the ATP 03 payment amount.

(Source: Change Request 2277; Program Memorandum A-03-033)

CMS Companion Document for the Accredited Standards Committee (ASC) X12N 276/277 Health Care Claim Status Request & Response  
 X12N 276/277 Companion Document

The table provided below indicates those segments or data elements in the X12N 276/277 Implementation Guide version 4010A1 that allow for Medicare to specify its business requirements. The information describes specific requirements used by CareFirst Medicare A 00190. The information in this document is subject to change. Changes will be communicated in the Intermediary News, periodic news bulletin and/or on CareFirst Medicare A Web site: [www.marylandmedicare.com](http://www.marylandmedicare.com).

# CMS Companion Document for the Accredited Standards Committee (ASC) X12N 276/277 Health Care Claim Status Request & Response

## X12N 276/277 Companion Document

The table provided below indicates those segments or data elements in the X12N 276/277 Implementation Guide version 4010A1 that allow for Medicare to specify its business requirements. The information describes specific requirements used by CareFirst Medicare A 00190. The information in this document is subject to change. Changes will be communicated in the Intermediary News, periodic news bulletin and/or on CareFirst Medicare A Web site:

[www.marylandmedicare.com](http://www.marylandmedicare.com).

### General Requirements:

Data elements that are defined by a previous qualifier will contain valid and appropriate information for the noted qualifier.

#### Examples:

- If ISA07 has a value of “28” indicating a fiscal intermediary ID Number, then ISA08 will contain a valid Fiscal Intermediary ID Number.
- If NM108 has a value of “24” indicating an EIN, then NM109 will contain a valid EIN for the identified provider.

CareFirst Medicare A will process your request for claim status information in batch form.

Upon receipt of your 276, we will generate the following: Local reject report for interchange control errors within 24 hours. 277 within 24 hours.

CareFirst Medicare A will process your 276 as identified in the implementation guide and create a 277 as identified in the implementation guide. At least the minimum response data will be sent.

CareFirst Medicare A keeps its online paid claims file for 27 months. After that time, paid claims are stored in an off-line paid claims history file. A 276 inquiry for a claim that has reached history, will result in a 277 response with a health care claim status code “35” (claim not found).

The 276 transaction must utilize delimiters as defined in the standard. The delimiters selected must not occur in the transmitted data elements. The delimiters used in a 277 response or in an acknowledgment may not necessarily be the same as the delimiters submitted in the original 276 request transaction.

All alphabetic characters in the 277 transaction will be upper case. If lower case characters are included in the 276 request, they will be converted to upper case for data storage and return processing purposes.

Multiple functional groups (GS to GE segments) can be sent in one interchange (ISA to IEA segments). Multiple 276s or 277s (ST through SE) can be included in a single functional group.

For Medicare the subscriber and patient are the same person. The Dependent Level hierarchical level is never used.

(Source CR-2742, AB-03-141)

Page	Data Segment Name	Segment or Data Element	Supported Value(s)	Requirement
<b>276 Request Transaction</b>				
B.4	<b>Interchange Control Header</b>	ISA05	ZZ	Interchange Identity Qualifier for ISA06 Submitter uses the “ZZ” value.
B.4	<b>Interchange Control Header</b>	ISA06		Interchange sender ID. Submitter chooses and enters a value later used by the contractor for sending back the 277.
B.4	<b>Interchange Control Header</b>	ISA07	27, 28	Carrier submitter uses a “27”; intermediary submitter uses a “28” as the Interchange I.D. Qualifier for ISA08.
B.5	<b>Interchange Control Header</b>	ISA08		Interchange Receiver ID. Submitter uses the CMS assigned Medicare carrier or intermediary number.
28 addenda	<b>Functional Group Header</b>	GS01		Submitter uses code “HR” to designate the 276.
28 addenda	<b>Functional Group Header</b>	GS02		Submitter uses codes agreed to by trading partners.
28 addenda	<b>Functional Group Header</b>	GS03		Submitter uses code agreed to by trading partners.
29 addenda	<b>Functional Group Header</b>	GS05		Submitter uses the recommended HHMM format.
55	<b>Payer Name</b>	NM108	PI	Submitter uses the code “PI” to identify that the carrier or intermediary identifier will follow.
56	<b>Payer Name</b>	NM109		Submitter uses the identifier provided by the carrier or intermediary.
57	<b>Payer Contact Information</b>			This segment is not needed for Medicare.
63	<b>Information Receiver Name</b>	NM108	46	(This is the individual or organization requesting to receive the status information.
63	<b>Information Receiver Name</b>	NM109		Submitter uses identification code as assigned by the carrier or intermediary.
68	<b>Provider Name</b>	NM108	SV	Submitter uses the “SV” qualifier for the Medicare prov number in NM109.
69	<b>Provider Name</b>	NM109		Submitter enters the Medicare provider number.
75	<b>Subscriber Name</b>	NM108	MI	Submitter uses the “MI” qualifier for the patient's Medicare health insurance claim (HIC) number entered in NM109.
76	<b>Subscriber Name</b>	NM109		Submitter enters the patient's Medicare health insurance claim (HIC) number.
14 addenda	<b>Group Number</b>	REF		This segment is not used for inquiries to Medicare.

## Maryland Medicare Part A

Page	Data Segment Name	Segment or Data Element	Supported Value(s)	Requirement
<b>277 Response Transaction</b>				
B.4	<b>Interchange Control Header</b>	ISA05	27, 28	Contractor enters the valid code as a qualifier for ISA106 for Carrier or Intermediary Identification Number as assigned by CMS. Carriers enter “27” and intermediaries enter “28.”
B.4	<b>Interchange Control Header</b>	ISA06		Contractor enters the Carrier or Intermediary Identification Number as assigned by CMS.
B.4	<b>Interchange Control Header</b>	ISA07	ZZ	Contractor enters the “ZZ” Qualifier for ISA108.
B.5	<b>Interchange Control Header</b>	ISA08		Contractor enters the ID number assigned by the 276 submitter in the 276, ISA06.
28 addenda	<b>Functional Group Header</b>	GS01		Contractor uses code “HN” to designate the 277.
28 addenda	<b>Functional Group Header</b>	GS02		Contractor uses the code agreed to by trading partners.
28 addenda	<b>Functional Group Header</b>	GS03		Contractor uses the code agreed to by trading partners.
29 addenda	<b>Functional Group Header</b>	GS05		Contractor enters the recommended HHMM format.
131	<b>Payer Name</b>	NM108	PI	Contractor enters the “PI” qualifier for NM109.
132	<b>Payer Name</b>	NM109		Contractor enters identification code.

(Source CR-2742, AB-03-141)

*The effective/implementation date for this article is October 27, 2003*

## TESTS GRANTED WAIVED STATUS UNDER CLIA – New Waived Tests – October 1, 2003

### I. GENERAL INFORMATION

#### A. Background:

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver.

Listed below are the latest tests approved by the FDA as waived tests under the CLIA. The Current Procedural Terminology (CPT) codes for these new tests must have the modifier QW to be recognized as a waived test.

Genzyme OSOM Mono Test, Effective: March 6, 2003, CPT code: 86308QW;

GI Supply, Div. Chek-Med Systems HP One, Effective: March 24, 2003, CPT code: 87077QW;

ADC CLIA Waived Marijuana (THC) Test, Effective: 4/29/2003, CPT code: 80101QW;

ADC CLIA Waived Multiple Drug Test Card, Effective: 4/29/2003, CPT code: 80101QW; and

ADC CLIA Waived Marijuana (THC) and Cocaine Test, Effective: 4/30/2003, CPT code: 80101QW.

#### B. Policy:

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver.

(Source Change Request 2791)

**Effective date** for this article is June 1, 2003.

**Implementation date** for this article is October 1, 2003.

## Core Elements and Required Statements for a Valid Privacy Authorization

This article provides the core elements and required statements necessary for a valid privacy authorization. The “Standards for Privacy of Individually Identifiable Health Information” (“Privacy Rule”) of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 set forth the provisions for when an individual’s authorization is required for uses and disclosures of protected health information (PHI), and lists the core elements and required statements necessary for a valid authorization. (45 CFR 164.508). An authorization is a document that an individual uses to give a covered entity permission to use or disclose his or her PHI for a particular purpose (e.g., marketing or to a third party specified by the individual). A covered entity is not required to obtain an authorization for the use or disclosure of PHI for treatment, payment, or health care operations, as well as for certain public priority activities under specified conditions (e.g., health care oversight, law enforcement), except as indicated in 45 CFR 164.508(a). The regulatory compliance date of the Privacy Rule was April 14, 2003.

These instructions are compatible with the disclosure of information requirements found in §1106 of the Social Security Act, the DHHS Privacy Act Regulations (45 CFR Part 5b), the Medicare Carriers Manual (MCM) Part 3 §10010 and the Medicare Intermediary Manual (MIM) Part 3 §3763.

The CMS is in the process of clearing a standard authorization through the Paperwork Reduction Act. This process will take several months to complete. This PM outlines the core elements and required statements needed for a valid

authorization. If an FI or carrier wants to add more to their authorization, they may do so, as long as the core elements and required statements remain. The FIs and carriers must also accept an authorization from another entity, provided it includes all of the core elements and required statements addressed below, and no provisions are added that conflict with these core elements and statements.

The core elements of a valid authorization must contain at least the following elements:

1. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
2. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
3. The name or other specific identification of the person(s) or class of persons, to whom the covered entity may make the requested use or disclosure;
4. A description of each purpose of the requested use or disclosure. The statement, “at the request of the individual” is a sufficient description of the purpose when the beneficiary initiates the authorization and does not, or elects not to, provide a statement of the purpose;
5. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure; and
6. The signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative’s authority to act for the individual must also be provided. Although the HIPAA Privacy Rule only requires a description of the representative’s authority to act for the individual, the CMS is requiring that documentation showing their authority be attached to the authorization (e.g., Power of Attorney).

In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

1. The individual’s right to revoke the authorization in writing, how the individual may revoke the authorization, and the exceptions to the right to revoke. To assist you in this, you may choose to use the following:  

“You have the right to take back (“revoke”) your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to:

CareFirst of Maryland Inc.  
 1946 Greenspring Drive  
 Timonium, MD 21093  
 1-866-488-0545
2. The inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization. You may choose to use the following:  

“I understand refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.”;
3. The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer protected. You may choose to use the following:  

“Your personal medical information that you authorize Medicare to disclose may be subject to re-disclosure and no longer protected by law.”; and
4. The authorization must be written in plain language.
5. A signed copy of the authorization must be provided to the individual.

(Source CR 2816, AB-03-147)

*The effective/implementation date* for this article is October 10, 2003.

## Reminder Notice of the Implementation of the Ambulance Transition Schedule

### Background:

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

As discussed in previous bulletins, the fee schedule will be phased in over a 5-year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers.

This bulletin is a reminder that the transition schedule and percentages updates effective each January 1 of 2004, 2005, and 2006.

### Policy:

The ambulance fee schedule is subject to a 5-year transition period as follows:

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

\*Previous and current year percentages

The foregoing schedule signifies that, during the transition schedule, the Medicare allowed amount for ambulance services, mileage, and separately billable supplies will comprise a blended rate. The blended rate will include a portion of the fee schedule, and a portion of the provider's reasonable cost or the supplier's reasonable charge. (For providers billing ambulance services to FIs, all supplies and services rendered are considered part of the base rate and are not separately billable under the ambulance fee schedule. For Part B suppliers billing ambulance services, separately billable supplies may be billed, depending on the supplier's billing method.)

During Year 1, the fee schedule amount was comprised of only 20 percent of the blended amount and the remaining 80 percent of the blended amount was based on the provider's reasonable cost or the supplier's reasonable charge. During Year 2, the fee schedule amount was comprised of 40 percent of the blended amount and the provider's reasonable cost or the supplier's reasonable charge was comprised of the remaining 60 percent. During Year 3, the fee schedule amount will comprise 60 percent of the blended amount and the provider's reasonable cost or the supplier's reasonable charge will comprise the remaining 40 percent. During Year 4, the fee schedule amount will comprise 80 percent of the blended amount and the provider's reasonable cost or the supplier's reasonable charge will comprise the remaining 20 percent. Beginning with Year 5, i.e., for services and supplies furnished, and mileage incurred, beginning January 1, 2006, and each year thereafter, the full fee schedule comprises the entire Medicare allowed amount and no portion of the provider's reasonable cost or the supplier's reasonable charge shall be considered.

To view the CMS issued Memorandum in its entirety please visit [http://www.cms.gov/manuals/pm\\_trans/AB03146.pdf](http://www.cms.gov/manuals/pm_trans/AB03146.pdf)

The **effective date** and **implementation date** of this bulletin is January 1, 2004.

(Source: Program Memorandum AB-03-146; Change Request 2834)

## Conflicting Policies with Provider Reimbursement Manual 15-1, Section 2771

**Purpose:** The purpose of this article is to clarify the policy on how certified transplant centers (CTCs) should bill the costs of acquiring organs.

**Background:** Section 2771 of the Provider Reimbursement Manual 15-1 requires CTCs to establish a standard acquisition charge (SAC) that reflects the average cost associated with acquiring each type of organ. This section also specifies that when a CTC provides an organ to an organ procurement organization (OPO), it must bill its SAC to the OPO. However, it has also come to CMS's attention that the Medicare Intermediary Manual 13-2, §3612, is not completely consistent with §2771 of the Provider Reimbursement Manual 15-1. Section 3612 allows the CTC to bill either the SAC or the departmental charges actually incurred for retrieval services provided to the OPO.

CMS has learned that many CTCs are billing departmental charges to OPOs for organ retrieval services, and that some intermediaries have begun to make adjustments to CTC cost reports when they find that departmental charges, rather than the CTC's SAC, were billed to OPOs.

**Policy:** Due to the recently discovered discrepancy between the two manual sections, CMS is instructing intermediaries to allow either method of billing (SAC or departmental charges) by a CTC to an OPO for organ retrieval services. Because either billing method is currently allowable, intermediaries are instructed not to make adjustments to the CTC cost reports based on which of these charging methodologies is used. The D-6 will continue to be audited by the intermediaries. No adjustments will be made if the CTC is billing either the SAC established for the particular organ, or if the CTC is billing the hospital's actual departmental charges for the various services provided to the OPO for retrieval of the organs.

CTCs must still bill the SAC to third party payers, including Medicare, for organs acquired and transplanted. Departmental charges cannot be billed for this purpose.

*The Implementation/Effective for this article is October 10, 2003.*  
(Source: Program Memorandum A-03-081; Change Request 2847)

## Changes in Transitional Outpatient Payment (TOP) for 2004

As of January 1, 2004, TOPs are being discontinued for all community mental health centers (CHMCs) and all hospitals except cancer and children's hospitals as described in sections 1886(d)(1)(B) (iii) and (v) of the Act. Be advised that one last interim TOP (for those that are being discontinued) will be paid in January of 2004 for services furnished thru December 31, 2003.

This change becomes effective January 1, 2004 and will be implemented January 5, 2004.

(Source: Change Request 2908, Publication 100-20, Transmittal 15)

## Clarification for billing under the 2300 Provider Number by Hospital-Based Renal Dialysis Facilities (RDF)

This article contains clarifying information for hospital-based renal dialysis facility (RDF) billing requirements related to provider number usage. In several instances, hospital-based chronic RDFs are using the hospital provider number rather than the assigned RDF provider number.

The hospital-based renal facility has an assigned RDF provider number in the 2300 - 2499 series. It is required that the assigned RDF provider number be used on the CMS-1450 billing form (or electronic equivalent) when billing for Part B outpatient renal services. These facilities are not to use the hospital provider number on these bills. The hospital provider numbers shall only be used, by the hospital, when billing for transplant services and related transplant services for past inpatient hospitalizations, in addition to other non-renal inpatient and outpatient hospital services. End Stage RDFs based in Children's Hospitals will bill for Part B outpatient maintenance dialysis services using the hospital provider number in the 3300-3399 series.

When a hospital-based chronic RDF does not have an assigned RDF provider number, that facility should contact the CMS Regional Office for that area, and request a number.

The Provider Number series for Dialysis Providers are as follows:

- 2300-2499** Chronic Renal Dialysis Facilities (**Hospital-Based**)
- 2500-2899** Non- Hospital Renal Facilities
- 2900-2999** Independent Special Purpose Renal Dialysis Facility
- 3300-3399** Children's Hospitals (Excluded from PPS)
- 3500-3699** Renal Disease Treatment Centers (**Hospital Satellites**)
- 3700-3799** Hospital Based Special Purpose Renal Dialysis Facility

*All facilities shall use their appropriately assigned provider numbers on the 72x bill.*

*In the event that a facility changes from one type to another the provider number must reflect the facility's present type.*

**Example:** Baptist Hospital provider number is 100093 and the Hospital-Based Chronic Renal Dialysis 2300 - 2499 series Provider number is 102327. The correct provider number for billing ESRD services on the **72x-bill type** is 102327.

(Source: Change Request 2877, A-03-082)  
Effective/Implementation date for this article is January 1,2004.



## Guidance Regarding Claims Containing Healthcare Common Procedure Coding System (HCPCS) Codes K0622 through K0626

The October 2003 Outpatient Prospective Payment System (OPPS) Outpatient Code Editor (OCE) Version 4.3 and Non-OPPS OCE Version 19.0 releases were not updated to include new HCPCS codes for compression garments effective for claims with dates of service on or after October 1, 2003, as indicated in Transmittal AB-03-100, CR 2802. The codes and short descriptors are:

K0622	Short Descriptor: Confrm band non sterl<3in/rol
K0623	Short Descriptor: Confrm band sterile<3in/roll
K0624	Short Descriptor: Lite compress wdth<3in/3yrd
K0625	Short Descriptor: Self adher wdth<3in/roll
K0626	Short Descriptor: Self adher wdth>/=5in/roll

Do not report the above listed K codes until January 2004, at which time the OPPS OCE v 5.0 and the Non-OPPS OCE v19.1 will be updated to include these codes.

In situations where additional services were rendered that would be reported on the same claim as the K codes, remove the charges for the K codes from the claim in order to receive payment for the remaining services. In this instance, submit an adjustment claim reflecting the K codes after January 5, 2004, in order to receive payment for the K codes.

(Source - Joint Signature Memorandum October 15,2003)

*Effective/Implementation date* for this article is October 1, 2003

### Crossover “How it Works”

- Crossover occurs only when we have an agreement with the other company to crossover. The company requesting the crossover provides Medicare with a list of the HIC numbers that they want claims crossed over for.
- Once this information is entered into the system, we will crossover even if the provider does not put the secondary information on the claim or puts different secondary information on the claim. Therefore, it is possible that we are crossing over to a company that's name is not even shown on the claim. However, the partner ID will always show on claim page (6) through DDE (under “Payment Data”) when we have crossed over the claim.
  - The valid values are:
    1. Primary
    2. Secondary
    3. Tertiary
- To verify the crossover, you need to look for the “CROSSOVER IND” (this will have a 1, 2, or 3 in the field if it was crossed over) and the “PARTNER ID” identifies the trading partner. This will confirm to whom we have crossed over to.
- If the beneficiary/provider feels the claim was crossed over incorrectly, they need to contact the crossover company and request it be changed.

## Current Trading Partners

ID	NAME
B20065001,2	Blue Cross National Capital Area
B21093002	Blue Cross of Maryland Group/NASCO
B21093004	Blue Cross of Maryland FEP
B21093001	Blue Cross of Maryland IMD
B19899001	BCBS Delaware
B55164001	BCBS Minnesota
A20904001	APWU-American Postal Workers Union
I19103004	Independence Blue Cross
H68154001,2	HDM Corp for: Wailey and Associates, Inc. Physicians Mutual Ins. Co. Continental General Ins. Co. Aid Association For Lutherans Bankers Fidelity Life North American Insurance Company for: Celtic Life Insurance Savers Life Insurance Usable Life Insurance Oxford Life Insurance Christian Fidelity Insurance World Insurance Company Pyramid Life Insurance Aegon Special Markets Group-Peoples Benefit Life Unified Life Insurance Company Mutual Protective Insurance Company - Medico Life Insurance American Family Insurance PacifiCare Health Plan Administrators, Inc. Central Benefits National Insurance Company AGE/USI Stirling & Stirling, Inc. Arkansas Blue Cross Blue Shield Blue Cross Blue Shield of Alabama Healthcare Service Corporation - BCBS of Illinois and Texas Highmark Services Company CoreSource United Medical Resources, Inc. Erin Group Administrators, Inc. Capital Blue Cross - Pennsylvania

## Current Trading Partners (continued)

ID	NAME
	Epoch Group, LC USAA Life Insurance Co. AFLAC Blue Cross Blue Shield of Massachusetts American Capitol Insurance Company Union Pacific Railroad Employees health System Blue Cross Blue Shield of Mississippi C&R Consulting Inc. New Era Life Enterprises BeneSys Inc. Alternative Professional Services, Inc. Amalgamated Life Insurance Company TMG Healthl UNICARE Life and Health HealthScope Benefits Inc.
M68175001	Mutual of Omaha
O98225001	Olympic Health
P61101061	Pioneer Life
P29203001	Sierra Military Health Services
W33755001	Wakely & Associates, Inc. for: Lincoln Heritage Life Insurance Company State Mutual Insurance Company Union Fidelity Life Insurance Company Federal Home Life Insurance Company GE Life Assurance and Annuity Company GE Capital Assurance Company
<b>MEDICAIDS</b>	
Z21201001	Maryland Medicaid
Z20001001	DC Medicaid
Z65102001	Missouri Medicaid
Z06106001	Connecticut Medicaid
Z87505001	New Mexico Medicaid
Z32309001	Florida Medicaid

## **Provider Reimbursement Manual Update for Data Collection for Skilled Nursing Facilities**

The following sections of the Provider Reimbursement Manual have been updated for Hospital Based Skilled Nursing Facilities.

<b>HEADER SECTION NUMBERS</b>	<b>PAGES TO INSERT</b>	<b>PAGES TO DELETE</b>
3604 (Cont.) - 3604 (Cont.)	36-27 - 36-28.3 (5 pp.)	36-27 - 36-28.3 (5 pp.)
3690 (Cont.) - 3690 (Cont.)	36-505 - 36-506 (2 pp)	36-505 - 36-506 (2 pp)
3695 (Cont.) - 3695(Cont.)	36-725 - 36-726.1 (3 pp)	36-725 - 36-726 (2 pp)

NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Beginning on or After October 1, 2003.

**This article facilitates data collection for Hospital based Skilled Nursing Facilities (SNF). The responses to this data collection effort will be used to determine the impact on direct patient care as a result of increased Resource Utilization Group (RUG) payments in accordance with a notice published in the Federal Register Vol. 68, No. 149 – August 4, 2003, which provided for an increase in the RUG payments to Hospital based Skilled Nursing Facilities (SNF) for services rendered on or after October 1, 2003.**

This transmittal also clarifies which payment system must be applied to Inpatient Rehabilitation Facilities (IRFs) and Long term Care Hospitals (LTCHs) based on responses to revised worksheet S-2 questions.

**REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE:** Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after April 30, 2003. There are no edit implications for the above referenced revision.

To view this change in it's entirety please visit [http://www.cms.gov/manuals/pm\\_trans/R11P236.pdf](http://www.cms.gov/manuals/pm_trans/R11P236.pdf)

(Source: Provider Reimbursement Manual Transmittal 11)

The following sections of the Provider Reimbursement Manual have been updated for Skilled Nursing Facilities.

<b>HEADER SECTION NUMBERS</b>	<b>PAGES TO INSERT</b>	<b>PAGES TO DELETE</b>
3508 – 3508 (Cont.)	35-13 – 35-18 (6 pp.)	35-13 – 35-18 (6 pp.)
3590 (Cont.) – 3590 (Cont.)	35-303 – 35-306 (4 pp.)	35-303 – 35-306 (4 pp.)
3595 (Cont.) – 3595 (Cont.)	35-515 – 35-516.1 (3 pp.)	35-515 – 35-516 (2 pp.)
3595 (Cont.) – 3595 (Cont.)	35-545 – 35-546 (2 pp.)	35-545 – 35-546 (2 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods beginning on or After October 1, 2003.

**REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE:** Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after December 31, 2002. There are no edit implications for the above referenced revision.

To view this change in it's entirety please visit [http://www.cms.gov/manuals/pm\\_trans/R13P235.pdf](http://www.cms.gov/manuals/pm_trans/R13P235.pdf)

(Source: Provider Reimbursement Manual Transmittal 13)

## Special Billing Instructions for Hospital Inpatients Administering Billing for Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines

When vaccines are provided to inpatients of a hospital, they are covered under the vaccine benefit. However, bill your intermediary on bill type 13X using the discharge date of the hospital stay to avoid editing in the Common Working File (CWF) as a result of hospital bundling rules. (See subsection I for an exception.)

[Simplified Billing of Influenza Virus Vaccine by Mass Immunizers.](#) – Some potential “mass immunizers” have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed preventive immunizations, simplified (roster) billing procedures are available to mass immunizers. A mass immunizer is defined as any entity that gives the influenza virus vaccine to a group of beneficiaries, e.g., at Public Health Clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date is required. (See subsection I for an exception to this requirement for inpatient hospitals.)

The simplified process involves use of the billing form (HCFA-1450) with preprinted standardized information relative to you and the benefit. Mass immunizers, attach a standard roster to a single pre-printed HCFA-1450 that contains variable claim information regarding the service provider and individual beneficiaries.

The roster must contain, at a minimum, the following information:

- Provider name and number;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient health insurance claim number; and
- Beneficiary signature or stamped “signature on file”.

NOTE: A stamped “signature on file” can be used in place of the beneficiary’s actual signature provided you have a signed authorization on file to bill Medicare for services rendered. In this situation you are not required to obtain the patient signature on the roster. However, you have the option of reporting “signature on file” in lieu of obtaining the patient’s actual signature.

The modified HCFA-1450 shows the following preprinted information in the specific form locators (FLs):

- The words “See Attached Roster” in FL 12, (Patient Name);
- Patient Status code 01 in FL 22 (Patient Status);
- Condition code M1 in FLs 24-30 (Condition Code);
- Condition code A6 in FLs 24-30 (Condition Code);

Revenue code 636 in FL 42 (Revenue Code), along with HCPCS code 90732 in FL 44 (HCPCS Code);

Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0009 in FL 44 (HCPCS Code);

“Medicare” on line A of FL 50 (Payer);

The words “See Attached Roster” on line A of FL 51 (Provider Number); and Diagnosis code V03.82 in FL 67 (Principal Diagnosis Code).

Providers conducting mass immunizations are required to complete the following FLs on the preprinted HCFA-1450:

- Fl 4 (Type of Bill)
- Fl 47 (Total Charges)
- Fl 85 (Provider Representative); and
- Fl 86 (Dates)

Medicare Secondary Payer (MSP) utilization editing is by-passed in CWF for all mass immunizer roster bills. However, if the provider knows that a particular group health plan covers the PPV and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

If you do not mass immunize, continue to bill for the influenza virus vaccine using normal billing procedures, i.e., submission of the HCFA-1450 or electronic billing for each beneficiary.

**Inpatient Roster Billing.**--The following billing instructions apply when you roster bill for the influenza virus vaccine and PPV provided to your inpatients under the procedures outlined in subsection G and H:

*You do not have to wait until patients are discharged to provide the vaccine. You may provide it anytime during the patient's stay;*

The roster should reflect the actual date of service;

The requirement to provide the vaccine to five or more patients at the same time to meet the requirements for mass immunizers will be waived when vaccines are provided to inpatients. Therefore, the roster may contain fewer than five patients or fewer than five patients on the date of discharge; and

The roster should contain information indicating that the vaccine was provided to inpatients to avoid questions regarding the number of patients or various dates.

(Source: Hospital Manual Section 435)

## Medicare 2004 Deductible and Coinsurance

Effective January 1, 2004 the Medicare deductible and coinsurance will be as follows:

### Part A Inpatient Hospital Insurance

- \$ 876.00 deductible per benefit period
- \$ 219.00 co-insurance per day for days 61 through 90
- \$ 438.00 lifetime reserve per day for a total of 60 non-renewable days

### Skilled Nursing Coinsurance

- \$ 109.50 per day for the 21st through 100th day each benefit period

### Part B Medical Insurance

- \$100.00 per calendar year

### Part B Premium

- \$66.60 per month

### Part A Premium for those who have worked less than 30 quarters

- \$343.00 per month

(Source U.S. Department of Health and Human Services)

**Effective/Implementation** date January 1, 2004

## 72 Hour Rule Reminder

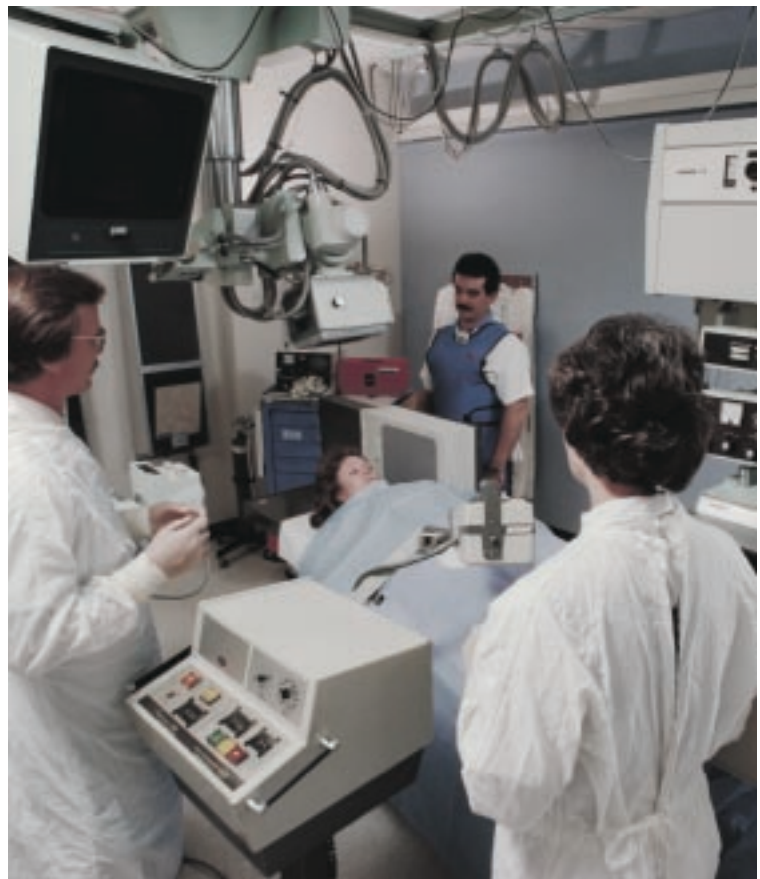
Pre-admission Diagnostic Services (Effective For Services Furnished On or After January 1, 1991). Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the hospital (or by another entity under arrangements with the hospital), within 3 days prior to the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, services provided by the hospital on Sunday, Monday, or Tuesday are included in the inpatient Part A payment. This provision does not apply to ambulance services. (See §236.) For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (PPS) as well as those hospitals and units excluded from PPS. For services provided on or after October 31, 1994, for hospitals and units excluded from PPS, this provision applies only to services furnished within 1 day prior to the date of the beneficiary's admission.

An entity is considered to be “wholly owned or operated” by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or HCPCS codes:

- 254 - Drugs incident to other diagnostic services
- 255 - Drugs incident to radiology
- 30X - Laboratory
- 31X - Laboratory pathological
- 32X - Radiology diagnostic
- 341 - Nuclear medicine, diagnostic
- 35X - CT scan
- 40X - Other imaging services
- 46X - Pulmonary function
- 48X - Cardiology, with HCPCS codes 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544-93552, 93561, or 93562
- 53X - Osteopathic services
- 61X - MRI
- 62X - Medical/surgical supplies, incident to radiology or other diagnostic services
- 73X - EKG/ECG
- 74X - EEG
- 92X - Other diagnostic services

Source: Hospital Manual 415.6



## ICD-9 Procedure Code Reporting

Effective immediately **ICD-9 Procedure Codes should no longer be used on outpatient bills.** Providers should continue to report ICD-9 Procedure Codes on inpatient bills only. HCPCS/CPT codes should be reported on all outpatient bills describing the procedure/service that was rendered.

Reason Code	Total Claims Suspended during July, August, September 2003	Type of Error	Resolution by Provider
30715 – 5.9%	9,006	The patients last or first name does not match the information found in 'HIQA'	Verify the spelling of the patient's last and first name on page 1 and page 5 of the DDE system. The spelling on the claim form must match HIQA
U680D	6,340	MSP Information is not indicated on the claim record, but the dates of service are within an MSP period.	Please make sure to check HIQA for possible valid MSP policies prior to submitting claim to Medicare.
36381	3,874	A therapy revenue code has been submitted, on a claim, with dates of service of 7/1/03 or greater, and there is no fee amount on file for the associated CPT code. *This reason code will bypass Maryland waiver claims*	No provider action required. CPT pricing must be added to system internally by FI.
15701	3,342	Billing – Payer ID omitted or incorrect	Educate internal billing staff or vendor.
32404	3,124	HCPCS billing error	Educate internal billing staff or vendor. Verify HCPCS is still valid
12302	2,790	Billing – number of covered and non-cov'd days do not equal the number of days in the from and through dates.	Educate internal billing staff or vendor.
38092	2,750	A multi-channel lab HCPCS code is present on both a previously processed claim and this processing claim, and the provider numbers are equal, and both claims are for the same date of service.	No provider action required. **No Medicare payment can be made.
12206	2,641	Billing – inconsistency between the statement from and thru dates, patient status code, occurrence span code(s) and/or covered and non-covered days field.	Educate internal billing staff or vendor.
U680A	2,616	MSP Information is not indicated on the claim record, but the dates of service are within an MSP period.	Please make sure to check HIQA for possible valid MSP policies prior to submitting claim to Medicare.
31023	2,296	The total charge line is equal to '0' or it is not numeric for this nonpayment claim. If applicable, please provider denial reason for non-covered charges on your remarks page (page 4). Please also include appropriate occurrence/occurrence span codes, if necessary. Educate internal billing staff or vendor.	
<b>Total</b>	<b>38,779</b>		

## July, August, September 2003 Bulletins

The following is a list of bulletins added to our website during July, August and September 2003. Please visit our website at; [www.marylandmedicare.com](http://www.marylandmedicare.com) for these latest updates. These bulletins can be found under the 'Provider Bulletins' selection on our homepage.

### Major Topics Covered July Bulletins

Payment Update for Long-term Care Hospital Prospective Payment System Rat Year 2004.
Delay in Implementation of Outpatient Therapy Caps to September 1, 2003. 1. Disclosure of Information Requirements Related to Hospice Claims. 2. Correction: Coverage and Billing Requirements for Electrical Stimulation for the Treatment of Wounds.
October 2003 Quarterly Update for Skilled Nursing Facility (SNF) Consolidated Billing.
Quarterly Update of Healthcare Common Procedure Coding System (HCPCS Codes Used for Home Health Consolidated Billing Enforcement.
Medicare Program – Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer For FY 2004.
Remittance Advice Remark and Reason Code Update.
Addition of Patient Status Code 42, Deletion of Patient Status Codes 71 and 72, and Information on New Patient Status Code 65.
Payment Problems Related to the Medicare Physician Fee Schedule (MPFS) Delay.
October Quarterly Update for 2003 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule.
Diagnosis Code for Screening Pap Smear and Pelvic Examination Services.
Reporting of Revenue Codes Under the Outpatient Prospective Payment System (OPPS).
Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 1, 2003.
Clarification Regarding Coverage of Hyperbaric Oxygen (HBO) Therapy for the Treatment of Diabetic Wounds of the Lower Extremities.
Frequency of Billing.
Non Reportable Codes.
Codes Not Recognized by Medicare.
Testing and Other Help Available Before the October 16, 2003 Compliance Date for Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Standards.
CMS HIPAA Update.
8371 Companion Guide (Date of Revision: 7/22/03).
Changes in Methodology for Determining Payment for Outliers Under Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems.

### August Bulletins

Revision to Skilled Nursing Facility (SNF) HO PAY File.
Third Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule.
Clarification on Billing Requirements for Pre-Admission Diagnostic Services Treated As Inpatient Services for Non-OPPS Providers.
Review of Form CMS – 1450 (previously Form HCFA – 1450) for Inpatient and Outpatient Bills.
Payment Denial for Medicare Services Furnished to Alien Beneficiaries Who Are Not Lawfully Present in the United States.
Claims Processing and Payment of Incomplete Screening Colonoscopies.
Adjustment to the Rural Mileage Payment Rate for Ground Ambulance Services.
Final Update to the 2003 Medicare Physician Fee Schedule Database.
October Outpatient Code Editor (OCE) Specifications Version (V4.3)

Pneumococcal Vaccine Payment Increase Effective October 1, 2003.
Payment Rate for Oxaliplatin (Eloxatin) Under the Hospital Outpatient Prospective Payment System (OPPS).
Payment for the Fecal Leukocyte Examination Under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) Certificate for Provider-Performed Microscopy (PPM) Procedures During CY 2003.
Addition of Three New International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Diagnosis Codes to be Effective as Part of the October 1, 2003, ICD-9-CM Update.
Guidelines for Medicare Part B Laboratory Testing.
Levocarnitine for Use in the Treatment of Carnitine Deficiency in ESRD Patients.
Fiscal Year (FY) 2004 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH), and Other Bill Processing Changes.
Update to Health Care Claims Status Category Codes and Health Care Claim Status Codes for Use With the Health Care Claim Status Request and Response ASC X12N 276/277.
Standard Paper Remittance (SPR) Advice.
CMS HIPAA Update
Medicare Coverage Database.
4 New Finalized LMRPs.
Adjustment to the Rural Mileage Payment Rate for Ground Ambulance Services.
The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2002 for Inpatient Prospective Payment System (IPPS) Hospitals.

### September Bulletins

Notice of Interest Rate for Medicare Overpayments and Underpayments.
Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2004.
Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Update.
Instructions to Exhibit 5, Column 4 of CMS 339.
October 2003 Update of the Hospital Outpatient Prospective Payment System (OPPS).
Correction to Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement.
Guidelines for Skilled Nursing Facility (SNF) Consolidated Billing.
Bexxar Coverage/Payment Criteria.
Billing Guidelines for Outpatient Rehabilitation Services.
October Medicare Outpatient Code Editor (OCE) Specifications Version 19.0 for Bills from Hospitals That Are Not Paid Under the Outpatient Prospective Payment System (OPPS).
Virtual Colonoscopy.
Payment Amount for the Influenza Virus Vaccine (CPT 90658 and 90659) When Payment is Based on 95 Percent of the Average Wholesale Price (AWP).
The New Online CMS Manual System Announcement.
ESRD Network Manual.
HIQA & ELGA.
New Diagnosis Code for Influenza Virus Vaccine Claims.
Revision to Attachment 2 in CR 2880 (Modifier and Condition Code for Providers to Use When Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare+Choice Plan).
ICD-9-CM Annual Updates for Local Medical Policies.

PROVIDER RELATIONS  
TOLL FREE PHONE NUMBER

**866-488-0545**

M E D I C A R E P R O V I D E R N E W S L E T T E R

**Intermediary**  
**NEWS**

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