

# Intermediary NEWS



April 2003

**THIS PUBLICATION  
SHOULD BE SHARED WITH  
ALL HEALTH CARE  
PRACTITIONERS AND  
MANAGERIAL MEMBERS OF  
THE PROVIDER/SUPPLIER  
STAFF.  
BULLETINS AND  
INTERMEDIARY NEWS ISSUED  
AFTER OCTOBER 1, 1999  
ARE AVAILABLE AT  
NO-COST FROM  
OUR WEBSITE AT  
[www.marylandmedicare.com](http://www.marylandmedicare.com)**

## **Clarification of 3-Day Payment Window vs. 1-Day Payment Window for Hospitals Excluded from Inpatient Prospective Payment System (IPPS)**

### **Background:**

Long-term care hospitals (LTCHs) and inpatient rehabilitation hospitals (IRFs) are not subject to the 3- Day Payment Window (72-hour rule) for pre-admission services. Hospitals excluded from IPPS are subject to the 1-Day Payment Window (24-hour rule) for pre-admission services, even though these types of facilities are now under their own prospective payment system (PPS). With the implementation of IRF PPS, it was mistakenly assumed that because they were coming under a PPS, the 72-hour rule would apply. Due to current edits within the Common Working File (CWF), IRFs and LTCHs are currently subject to the 72-hour rule. In summary, only acute inpatient hospitals are subject to the 3-day payment window. LTCHs and IRFs are only subject to the 1-day payment window.

Therefore, the potential exists for claims to have processed incorrectly. Providers who may have had claims where the service lines rejected incorrectly will be notified when the system has been corrected. Once the system has been updated providers will be able to submit adjustments to these claims.

*(Source: Program Memorandum A-03-008; Change Request 2537)*

## **Clarification of Single Drug Pricer (SDP)**

The Centers for Medicare & Medicaid Services (CMS) has provided the following clarification regarding the Single Drug Pricer (SDP) that will be used for blood clotting factors furnished to hospital inpatients.

The presence or absence of a particular drug on the SDP file does not represent a determination that the Medicare program either covers or does not cover that drug. The amounts shown on the SDP file indicate the maximum Medicare payment allowance if the Medicare contractor determines the drug meets the program's requirements for coverage. Similarly, the absence of a particular drug from the SDP file means that if the Medicare contractor determines the drug is covered by Medicare, the local contractor must then determine the program's payment allowance by applying the program's standard drug payment policy rules.

PROVIDER RELATIONS  
TOLL FREE PHONE NUMBER

**866-488-0545**

# Intermediary NEWS



April 2003

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*(This is informational only for home health providers)*

*“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**



## Clarification of Single Drug Pricer (SDP) con't

Medicare contractors separately determine whether a particular drug meets the program's general requirements for coverage and if so, whether payment may be made for the drug in the particular circumstance under which it was furnished. Examples of this latter determination include but are not limited to, determinations as to whether a particular drug and route of administration are reasonable and necessary to treat the beneficiary's condition, whether a drug may be excluded from payment because it is usually self-administered, and whether a least costly alternative to the drug exists.

*Reference: Program Memorandum AB-03-014, Change Request 2544*

*CMS transmittals are available in their entirety on the CMS website.*

## All Providers! Automated Workshop Registration is Now Available!

Please register for our workshops using our on-line registration located via our website. The list of workshops available is listed below. To register, visit the homepage of [Marylandmedicare.com](http://Marylandmedicare.com), click on Provider Training and follow the instructions for easy, automated registration.

Date	Workshop	Location
4/10/2003	Basic Medicare	CareFirst.Inc, Timonium
4/24/2003	Claims Correction	CareFirst.Inc, Timonium
5/08/2003	Advanced Medicare	Johns Hopkins Bayview, Baltimore
5/15/2003	Basic Medicare	CareFirst.Inc, Timonium
5/22/2003	Claims Correction	CareFirst.Inc, Timonium
6/12/2003	Basic Medicare	CareFirst.Inc, Timonium
6/26/2003	Claims Correction	CareFirst.Inc, Timonium
7/10/2003	Basic Medicare	CareFirst.Inc, Timonium
7/24/2003	MSP/Admissions	Johns Hopkins Bayview, Baltimore
8/07/2003	Claims Correction	CareFirst.Inc, Timonium
8/21/2003	Basic Medicare	CareFirst.Inc, Timonium
9/11/2003	Advanced Medicare	CareFirst.Inc, Timonium
9/18/2003	Claims Correction	CareFirst.Inc, Timonium
9/25/2003	Basic Medicare	CareFirst.Inc, Timonium
10/09/2003	Advanced Medicare	Northwest Hospital, Randallstown
10/16/2003	Basic Medicare	CareFirst.Inc, Timonium
10/23/2003	Claims Correction	CareFirst.Inc, Timonium
11/06/2003	Basic Medicare	CareFirst.Inc, Timonium
11/20/2003	Claims Correction	CareFirst.Inc, Timonium

Registration begins at 8:00 a.m. and the workshop begins at 8:30 a.m.

## IMPORTANT DDE Updates Effective January 6, 2003

*The following changes have been made to the DDE System effective January 6, 2003.*

✓DDE Claim Page 1:

The discharge hour field has been updated to include hour and minute information in the numeric form of HHMM;

✓ DDE Claim Page 3:

A field has been added for one investigational device exemption number (IDE) per claim (at the claim level);

✓ DDE Claim Page 5:

The following fields have been removed: employment status code, employer name, and employer address information;

New fields have been added for the subscriber's date of birth and gender.

**Note: These fields are required for Medicare secondary claims.**

In addition; DDE will allow for correct processing of the unique physicians identifier number in the 2310A (Attending Physician) loop.

Source: CR 2211 dated 8/14/02. Health Insurance Portability and Accountability Act (HIPAA) Institutional 837 Health Care Claim - Direct Data Entry (DDE) Updates.



### Disclosing Information About One Provider or His/Her Claims to Another Provider to Facilitate Proper Billing

In order to facilitate proper billing, it is sometimes necessary for the Medicare fee-for-service contractors to share information about one provider with another provider. Likewise, it is also sometimes necessary to share beneficiary claims information created by one provider with another provider.

The disclosure of this information is permitted as long as both providers have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment or health care operations of the provider that receives the information. When information is disclosed, it must be limited to minimum necessary to accomplish the specific purpose of the disclosure.

# Benefit Integrity CORNER



## BENEFIT INTEGRITY CORNER

### BENEFIT INTEGRITY TRANSITION

All CareFirst of Maryland, Inc., Medicare Part A Benefit Integrity Functions will be assumed by the Program Safeguard Contractor (PSC), TriCenturion, LLC, effective April 7, 2003.

Sanctioned and reinstated providers from the surrounding states (Delaware, Pennsylvania, Virginia, and West Virginia) have been added to the list for your convenience.

**The Office of Inspector General (OIG) has notified us of a recent reinstatement action involving the following providers:**

***Angel, Marilyn W.***

Pharmacist  
R.R. 9, Box 16  
Greensburg, PA 15601  
Effective Date: January 14, 2003

***Baird, David B. Jr.***

Family Physician/GP  
1212 A Cross Hill Court  
Lansdale, PA 19446  
Effective Date: February 4, 2003

***Baird, David B. Jr.***

Family Physician/GP  
141 S. Front St.  
Souderton, PA 18964  
Effective Date: February 4, 2003

***Belgrave, Claude D. Jr.***

Family Physician/GP  
128A E. Little Creek Rd.  
Norfolk, VA 23505  
Effective Date: December 4, 2002

***Belgrave, Claude D. Jr.***

Family Physician/GP  
22 CC Spaulding Dr.  
Hampton, VA 23666  
Effective Date: December 4, 2002

***Easley, Wayland A.***

Dentist  
1009 Vineal St.  
Pittsburgh, PA 15212  
Effective Date: January 2, 2003

***Fleming, Deirdre Lynne Reese***

Nurse/Nurses Aide  
906 Goodes Ferry Rd.  
South Hill, VA 23970  
Effective Date: November 8, 2002

***Huff, Linda G.***

Nurse/Nurses Aide  
P.O. Box 24  
Gloucester, VA 23061  
Effective Date: December 3, 2002

***Huff, Linda G.***

Nurse/Nurses Aide  
P.O. Box 335  
Gloucester, VA 23060  
Effective Date: December 3, 2002

***Mason, Melvyn***

Contracting Firm  
6615 Greenhill Rd.  
Lumberville, PA 18933  
Effective Date: January 14, 2003

***Miles, Robert L. Jr.***

Family Physician/GP  
9224 Oregold Ct.  
Laurel, MD 20708  
Effective Date: February 4, 2003

***Pinelli, Steven J.***

Dentist  
232 Elm Dr.  
Waynesburg, PA 15370  
Effective Date: January 14, 2003

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

The Office of Inspector General (OIG) has notified us of a recent administrative sanction action involving the following providers:

***Pinelli, Steven J.***

Dentist  
4326 Northern Pike  
Monroeville, PA 15146  
Effective Date: January 14, 2003

***Thompson, Janette A.***

Podiatrist  
501 Hawkesbury Lane  
Silver Spring, MD 20904  
Effective Date: January 7, 2003

***Scott, Jewel L.***

Technician  
301 13th St., N.W. #307  
Washington, DC 20010  
Effective Date: February 4, 2003

The Office of Inspector General (OIG) has notified us of a recent administrative sanction action involving the following providers:

***Anderson, Susan Colleen***

Nurse/Nurses Aide  
11554 Buckskin Court  
Lusby, MD 20657  
Effective Date: December 19, 2002  
Type of Action: 1128(b)4

***Bowie, Charles Douglas Jr.***

Dentist  
4205 Liberty Heights Ave.  
Baltimore, MD 21207  
Effective Date: January 20, 2003  
Type of Action: 1128(a)2

***Adamczyk, Bonnie Mock***

Nurse/Nurses Aide  
1019 Cameron Ave.  
Sidman, PA 15955  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

***Breeden, Connie***

Nurse/Nurses Aide  
4205 Liberty  
284 Country Estates Blvd.  
Crimora, VA 24431  
Effective Date: January 20, 2003  
Type of Action: 1128(a)4

***Archer, Michele***

Beneficiary  
2720 W. Oakdale St.  
Philadelphia, PA 19132  
Effective Date: March 20, 2003  
Type of Action: 1128(a)1

***Brown, Mary Goddard***

Nurse/Nurses Aide  
4205 Liberty  
68 Barville Mountain Rd.  
Reedsville, PA 17084  
Effective Date: February 20, 2003  
Type of Action: 1128(a)4

***Baran, Robin***

Nurse/Nurses Aide  
511 E. Spruce St.  
Philipsburg, PA 16866  
Effective Date: February 20, 2003  
Type of Action: 1128(a)4

***Carter, Andrea***

Nurse/Nurses Aide  
501 Palmer St. #403  
Milton, DE 19968  
Effective Date: February 20, 2003  
Type of Action: 1128(a)2

***Beach, Jeffrey A.***

Nurse/Nurses Aide  
164 Church Rd.  
Mountain Top, PA 18707  
Effective Date: January 20, 2003  
Type of Action: 1128(a)4

***Cheatom, Gregory***

Nurse/Nurses Aide  
99 Boggston Ave.  
Pittsburgh, PA 15210  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

### **Clevenger, Patricia**

Ambulance Company Owner  
Route 1, Box 145  
Cottageville, WV 25239  
Effective Date: February 20, 2003  
Type of Action: 1128(a)1

### **Cole, Kim L**

Nurse/Nurses Aide  
1344 S. Mount Vernon Ave., Apt. H  
Williamsburg, VA 23185  
Effective Date: March 20, 2003  
Type of Action: 1128(b)4

### **Cooper, Debra A.**

Nurse/Nurses Aide  
404 Atherly St. N.E.  
Roanoke, VA 24012  
Effective Date: December 19, 2002  
Type of Action: 1128(b)4

### **Costiloe, Wanda June**

Nurse/Nurses Aide  
1304 Rebecca Court  
Oakdale, PA 15071  
Effective Date: March 20, 2003  
Type of Action: 1128(b)4

### **Creef, Brenda S.**

Nurse/Nurses Aide  
3505 Stoney Ridge Rd.  
Midlothian, VA 23112  
Effective Date: December 19, 2002  
Type of Action: 1128(b)4

### **Davis, Christopher**

Optical Owner  
1726 W. Glenwood Ave.  
Philadelphia, PA 19132  
Effective Date: January 20, 2003  
Type of Action: 1128(a)1

### **Delpizzo, Elizabeth M.**

Psychologist  
P.O. Box 429  
Center Valley, PA 18034  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Delucia, Toni L.**

Nurse/Nurses Aide  
82 Glenview Ave.  
Oil City, PA 16301  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Dottle, Maureen Duncan**

Nurse/Nurses Aide  
4138 Grandview Dr.  
Gibsonia, PA 15044  
Effective Date: March 20, 2003  
Type of Action: 1128(b)

### **Drake, Melissa Ann.**

Nurse/Nurses Aide  
P.O. Box 38  
Maysel, WV 25133  
Effective Date: December 19, 2002  
Type of Action: 1128(a)1

### **Dressel, Tammy A.**

Nurse/Nurses Aide  
9222 Orbitan Rd.  
Baltimore, MD 21234  
Effective Date: January 20, 2003  
Type of Action: 1128(b)4

### **Drew, Arviette D.**

Nurse/Nurses Aide  
811 Cavalier Blvd.  
Portsmouth, VA 23701  
Effective Date: December 19, 2002  
Type of Action: 1128(b)4

### **Ellis-Bales, Theresa**

Nurse/Nurses Aide  
1430 Dundalk Ave.  
Baltimore, MD 21222  
Effective Date: March 20, 2003  
Type of Action: 1128(b)4

### **Fahey, Sandra L.**

Nurse/Nurses Aide  
5676 Roundtree Dr.  
Woodbridge, VA 22193  
Effective Date: January 20, 2003  
Type of Action: 1128(b)4

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

### **Ford, Eugene R.**

Nurse/Nurses Aide  
152 Samuels Ave.  
Hazleton, PA 18201  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Gill, Missy L.**

Nurse/Nurses Aide  
P.O. Box 242  
Appalachia, VA 24216  
Effective Date: November 20, 2002  
Type of Action: 1128(b)4

### **Mays, Gail A.**

Nurse/Nurses Aide  
13903 Walnut Creek Rd.  
Midlothian, VA 23112  
Effective Date: January 20, 2003  
Type of Action: 1128(b)4

### **Generose, Catherine**

Nurse/Nurses Aide  
152 Samuels Ave  
Hazleton, PA 18201  
Effective Date: February 20, 2003  
Type of Action: 1128(a)3

### **Giunta, Joseph Liborio**

Plastic Surgeon  
214 Fairfield Dr.  
Winchester, VA 22602  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Glasses Made Eazy, Inc. Optical**

1726 W. Glenwood Ave.  
Philadelphia, PA 19132  
Effective Date: January 20, 2003  
Type of Action: 1128(a)1

### **Golden Optical, Inc. Optical**

3166 Kensington Ave.  
Philadelphia, PA 19143  
Effective Date: January 20, 2003  
Type of Action: 1128(a)1

### **Grainey, Joan**

Nurse/Nurses Aide  
444 Sunnymeade Rd.  
Huntingdon, PA 16652  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Grier, Lisha D.**

Nurse/Nurses Aide  
730 Hayes Ave.  
Virginia Beach, VA 23452  
Effective Date: November 20, 2002  
Type of Action: 1128(b)4

### **Griffin, Constance R.**

Nurse/Nurses Aide  
806 Roam Ct., Apt. H  
Newport News, VA 23605  
Effective Date: November 20, 2002  
Type of Action: 1128(b)4

### **Hardy, Michelle D.**

Nurse/Nurses Aide  
2501 Roslyn Ave.  
Baltimore, MD 21216  
Effective Date: March 20, 2003

### **Hatfield, William G.**

Chiropractor  
977 Seminole Trail  
Charlottesville, VA 22901  
Effective Date: January 20, 2003  
Type of Action: 1128(a)3

### **Haynes, Carylon J.**

Nurse/Nurses Aide  
18500 Mountain Laurel Ter.  
Gaithersburg, MD 20879  
Effective Date: February 20, 2003  
Type of Action: 1128(a)2

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

### **Hill, Edgar H. Jr.**

Nurse/Nurses Aide  
606 Flagstaff Ct.  
Virginia Beach, VA 23462  
Effective Date: December 19, 2002  
Type of Action: 1128(b)4

### **Hodjati, Hassan H**

Surgeon  
14809 Brich Springs Ct.  
Silver Spring, MD 20905  
Effective Date: December 19, 2002  
Type of Action: 1128(b)3

### **Ivey, Varner Jean**

Nurse/Nurses Aide  
P.O. Box 1264  
Franklin, VA 23851  
Effective Date: March 20, 2003  
Type of Action: 1128(b)4

### **Jaggi, Sheryl L.**

Nurse/Nurses Aide  
224 E. Columbus Ave.  
Corry, PA 16407  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Jones, Naomi**

Nurse/Nurses Aide  
3240 Old Sixth Ave. Rd.  
Duncansville, PA 16635  
Effective Date: March 20, 2003  
Type of Action: 1128(b)4

### **Kabato, Zenawi**

Nurse/Nurses Aide  
10742 Main St., Apt. 101  
Fairfax, VA 22030  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Keen, Susie C.**

Nurse/Nurses Aide  
P.O. Box 2587  
Grundy, VA 24614  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Kelly, Joseph L. III**

Internist  
309 W. Freemason St., #3  
Norfolk, VA 23510  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Kempton, James E.**

Optometric Practice Employee  
257 Painter Rd.  
Media, PA 19063  
Effective Date: January 20, 2003  
Type of Action: 1128(a)1

### **Konopa, Terri L.**

Nurse/Nurses Aide  
339 N. Loudoun St., Apt. 2  
Winchester, VA 22601  
Effective Date: January 20, 2003  
Type of Action: 1128(b)4

### **Kulp, Melinda Goodling**

Nurse/Nurses Aide  
34 Westpointe Dr.  
Ephrata, PA 17522  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Latchford, Dorothea R.**

Health Care Aide  
18 Valley St., Apt. 2  
Lewistown, PA 17044  
Effective Date: January 20, 2003  
Type of Action: 1128(a)2

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

### **Latchford, Lloyf E.**

Health Care Aide  
P.O. Box 200  
Camp Hill, PA 17001  
Effective Date: January 20, 2003  
Type of Action: 1128(a)2

### **Leamer, Sandra**

Nurse/Nurses Aide  
334 Main St.  
Barnesboro, PA 15714  
Effective Date: February 20, 2003  
Type of Action: 1128(b)

### **Lee, Winfred**

Counselor  
647 Morton Place, N.E.  
Washington, DC 20002  
Effective Date: December 19, 2002  
Type of Action: 1128(a)2

### **Lewis, Verna M.**

General Practice Physician  
726 Orchard Lake Dr.  
Daleville, VA 24083  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Lyons, Doris C.**

Nurse/Nurses Aide  
509 Hollygate Lane  
Chesapeake, VA 23322  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Mallory, Charles Douglas**

Counselor  
2100 Mediterranean Ave #37  
Virginia Beach, VA 23451  
Effective Date: March 20, 2003  
Type of Action: 1128(b)4

### **Masorti, Jonathan M.**

Chiropractor  
1187 S. Garners St.  
State College, PA 16801  
Effective Date: January 20, 2003  
Type of Action: 1128(b)3

### **Mason, Sheryl L.**

Nurse/Nurses Aide  
7210 Hunt Rd.  
Jarratt, VA 23867  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Maxon, Monica Ann**

Nurse/Nurses Aide  
P.O. Box 372  
Vestabrg, PA 15368  
Effective Date: January 20, 2003  
Type of Action: 1128(b)3

### **Mays, Gail A.**

Nurse/Nurses Aide  
13903 Walnut Creek Rd.  
Midlothian, VA 23112  
Effective Date: January 20, 2003  
Type of Action: 1128(b)4

### **McAnally, Bryan M.**

Nurse/Nurses Aide  
139 Lassiter Circle  
Finksburg, MD 21048  
Effective Date: January 20, 2003  
Type of Action: 1128(a)2

### **McCarthy, Thomas A.**

990 Hickory St.  
Macungie, PA 18062  
Effective Date: March 20, 2003  
Type of Action: 1128(b)4

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

### **Momah, Clement I.**

Endocrinologist  
879 Ellicott Dr.  
Bel Air, MD 21015  
Effective Date: November 20, 2002  
Type of Action: 1128(b)4

### **Mondock, Penny Ann**

Nurse/Nurses Aide  
231 Stemmler Rd.  
Boswell, PA 15531  
Effective Date: March 20, 2003  
Type of Action: 1128(b)4

### **Morgan, Michael P.**

Counselor  
1358 Sheppard Ave.  
Norfolk, VA 23518  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Murphy, David M.**

Osteopath  
5930 Timothy Rd.  
Harrisburg, PA 17112  
Effective Date: February 20, 2003  
Type of Action: 1128(b)3

### **Northeastern Home Health Service**

Home Health Agency  
C/O 29 Brandywyn Dr.  
Mountain Top, PA 18707  
Effective Date: February 20, 2003  
Type of Action: 1128(a)1

### **Lyons, Doris C.**

Nurse/Nurses Aide  
509 Hollygate Lane  
Chesapeake, VA 23322  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Osman, Mohamed Awad**

Ambulance Company Owner  
7646 Beth Rd., Apt. F  
Richmond, VA 23228  
Effective Date: November 20, 2002  
Type of Action: 1128(a)1

### **Packey, Darrel Rowan**

Nurse/Nurses Aide  
123 Dunbar Dr.  
Pittsburgh, PA 15235  
Effective Date: March 20, 2003  
Type of Action: 1128(b)4

### **Petry, Samantha L.**

Nurse/Nurses Aide  
Alderson FPC, Box A  
Alderson, WV 24910  
Effective Date: November 20, 2002  
Type of Action: 1128(a)4

### **Petry, Samantha L.**

Nurse/Nurses Aide  
P.O. Box A  
Alderson, WV 24910  
Effective Date: November 20, 2002  
Type of Action: 1128(a)4

### **Ritch, Sherry L.**

Nurse/Nurses Aide  
5504 Windsor Mill Rd.  
Baltimore, MD 21207  
Effective Date: March 20, 2003  
Type of Action: 1128(a)2

### **Rohs, Elizabeth Hawkins**

Nurse/Nurses Aide  
20 Zummo Way  
Norristown, PA 19401  
Effective Date: January 20, 2003  
Type of Action: 1128(b)4

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

### **Sanders, Kendall**

Health Care Aide  
7930 Brock Bridge Rd.  
Jessup, MD 20794  
Effective Date: March 20, 2003  
Type of Action: 1128(a)2

### **Schaeffer, Susan**

Nurse/Nurses Aide  
278 Grandview Rd.  
Hummelstown, PA 17036  
Effective Date: February 20, 2003  
Type of Action: 1128(a)4

### **Schrader, Angela**

Nurse/Nurses Aide  
P.O. Box 294  
Staffordsville, VA 24167  
Effective Date: January 20, 2003  
Type of Action: 1128(b)4

### **Shannon, Penny M.**

Nurse/Nurses Aide  
2089 Eagle Rock Rd.  
Virginia Beach, VA 23456  
Effective Date: November 20, 2002  
Type of Action: 1128(b)4

### **Sperandio, Christopher Paul**

Podiatrist  
7406 Brook Rd.  
Richmond, VA 23227  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Strange-Boston, Donald C.**

DME Company  
14232 Hickory Oaks Lane  
Ashland, VA 23005  
Effective Date: February 20, 2003  
Type of Action: 1128(a)1

### **Taylor, James E.**

Private Citizen  
794 Hartly Rd.  
Hartly, DE 19953  
Effective Date: January 20, 2003  
Type of Action: 1128(a)1

### **Taylor, Sondra J.**

Nurse/Nurses Aide  
717 72nd St.  
St. Newport News, VA 23605  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Watt, James S.**

Psychiatrist  
29320 Signboard Rd.  
Ruther Glen, VA 22546  
Effective Date: March 20, 2003  
Type of Action: 1128(a)2

### **Walter, Cecilia**

Nurse/Nurses Aide  
130 Wynnview Lane  
Mars, PA 16046  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Weisse, Carl E.**

Chiropractor  
C/O 800 S. 10th St.  
Philadelphia, PA 19147  
Effective Date: December 10, 2002  
Type of Action: 1128(b)1

### **Weisse, Carl E.**

Chiropractor  
800 S. 10th St.  
Philadelphia, PA 19147  
Effective Date: December 10, 2002  
Type of Action: 1128(b)1

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

### **Williams, Kathleen E.**

Nurse/Nurses Aide  
825 S. Newberry St.  
York, PA 17403  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

### **Zakrzewski, Paul.**

Nurse/Nurses Aide  
210 S. Sunset Dr.  
Shrewsbury, PA 17336  
Effective Date: March 20, 2003  
Type of Action: 1128(a)

### **Zajacs, Lisa C.**

Nurse/Nurses Aide  
901 S. Washington St.  
Evans City, PA 16033  
Effective Date: February 20, 2003  
Type of Action: 1128(b)4

***An employer of a sanctioned provider cannot be reimbursed under Medicare or Medicaid for the salary paid to a sanctioned provider, nor can an employer bill either program for services rendered to Medicare and Medicaid beneficiaries by this provider. In addition, a provider who hires a sanctioned individual without making the proper inquiries may be subject to Civil Monetary Penalty Law (CMPL) action by the OIG. Direct questions or inquiries to the CareFirst of Maryland, Inc., Medicare Part A Benefit Integrity Unit at 410-561-4111.***

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

Sections of the Social Security Act Under Which Exclusions are Imposed

<b>1128(a)(1)</b>	<b><i>Program-related conviction</i></b>
<b>1128(a)(2)</b>	<b><i>Conviction relating to patient abuse or neglect</i></b>
<b>*1128(a)(3)</b>	<b><i>Felony conviction relating to health care fraud</i></b>
<b>*1128(a)(4)</b>	<b><i>Felony conviction relating to controlled substance violations</i></b>
<b>1128(b)(1)</b>	<b><i>Conviction relating to fraud</i></b>
<b>1128(b)(2)</b>	<b><i>Conviction relating to obstruction of an investigation</i></b>
<b>1128(b)(3)</b>	<b><i>Conviction relating to controlled substances</i></b>
<b>1128(b)(4)</b>	<b><i>License revocation or suspension</i></b>
<b>1128(b)(5)</b>	<b><i>Suspension or exclusion under a Federal or State healthcare program</i></b>
<b>1128(b)(6)</b>	<b><i>Excessive claims or furnishing of unnecessary or substandard items or services</i></b>
<b>1128(b)(7)</b>	<b><i>Fraud, kickbacks, and other prohibited activities</i></b>
<b>1128(b)(8)</b>	<b><i>Entities owned or controlled by a sanctioned individual</i></b>
<b>1128(b)(9)</b>	<b><i>Failure to disclose required information</i></b>
<b>1128(b)(10)</b>	<b><i>Failure to supply requested information on subcontractors and suppliers</i></b>
<b>1128(b)(11)</b>	<b><i>Failure to provide payment information</i></b>
<b>1128(b)(12)</b>	<b><i>Failure to grant immediate access</i></b>
<b>1128(b)(13)</b>	<b><i>Failure to take corrective action</i></b>
<b>1128(b)(14)</b>	<b><i>Default on health education loan or scholarship obligation</i></b>
<b>1128(b)(15)</b>	<b><i>Individuals controlling sanctioned entities</i></b>
<b>1128Aa</b>	<b><i>Imposition of a civil monetary or assessment</i></b>
<b>1156(b)</b>	<b><i>Peer Review Organization recommendation</i></b>

**\* Expansion of authority under the Health Insurance Portability and Accountability Act of 1996.**

## Proper usage of condition codes 20, 21 & occurrence code 32:

**Condition Code 20 Demand bill:** The condition code 20 is used for Skilled Nursing (SNF) inpatient and Home Health claims when the beneficiary demands that Medicare be billed for a determination of coverage. Use condition code 20 only for SNF inpatient and HHA claims with charges in the non-covered field. Medical Review will review the claim and medical records and make the determination of coverage.

Note: In all other settings, when an ABN is presented and the beneficiary demands billing, the claim is billed using the occurrence code 32 and the date the ABN was presented. The charges should be in the covered field. In this case, do not use the condition code 20.

**Condition Code 21 Billing for Denial:** Condition code 21 is used for billing services that are statutorily excluded from Medicare coverage. The beneficiary is assumed liable and no ABN is required. Charges should be billed in the non-covered field. Do not use the occurrence code 32.

**Occurrence Code 32 ABN Presented:** Occurrence code 32 is used on claims when an advanced beneficiary notice (ABN) was properly presented to the beneficiary for services believed to be non-covered. Only services for which an ABN was given should be included on the claim and the charges should be in the covered field.

Note: If other services provided on the same day are believed to be covered and it is impossible to separate the billing because of overlapping dates, show all the charges on one claim. The charges are billed in the covered field. The claim must include the occurrence code 32 with the date the ABN was presented and the modifier GA on the HCPCS line(s) for services in which an ABN was presented. Since this is an exception process, providers are reminded to use this mechanism only when it is impossible to separate the billing periods.

Occurrence code 32 should not be used when billing condition code 20 or 21.

(Source 2219 & 2336)

## Payment for Bad Debts

The Centers for Medicare & Medicaid Services (CMS) has issued transmittal 1872, dated January 24, 2003, to reiterate the payment policy for bad debts in connection with Outpatient Rehabilitation Services.

The transmittal states " There is no payment for bad debts ... with respect to services paid under the Medicare physician fee schedule. Under a fee schedule payment is not based on incurred costs; rather payment is made based on a schedule for the specific service furnished. Whether a fee schedule has its basis in charges or is resource-based, the payment is not related to a specific provider's cost outlay for a service and does not embody the concept of unrecovered cost. Bad debts are allowable only to an entity to whom payment is made on the basis of reasonable cost."

## *Heart Transplant Updates*

Background.--On April 6, 1987, HCFA Ruling 87-1, "Criteria for Medicare Coverage of Heart Transplants" was published in the Federal Register. For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet certain criteria. Facilities that wish to obtain coverage for their Medicare patients submit an application and documentation showing their initial and ongoing compliance with each criterion.

The facility mails the application to the address below in a manner which provides it with documentation that it was received, e.g., return receipt requested.

Director  
Division of Integrated Delivery Systems  
Centers for Medicare and Medicaid Services  
Mailstop C4-25-02  
7500 Security Blvd.  
Baltimore, MD 21244

## *Artificial Hearts and Related Devices*

Medicare does not cover the use of artificial hearts, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplant (often referred to a "bridge to transplant"). Medicare does cover a Ventricular Assist Device (VAD) when used as a bridge to transplant when specific criteria are met, but does not cover this device when used as an artificial heart. The following criteria must be fulfilled in order for Medicare coverage to be provided for a VAD used as a bridge to transplant. (See section 65-15 of the Coverage Issues Manual for further detail.) VADs also are used as temporary support systems. Charges for artificial heart ventricular assist devices and related services are reported as noncovered except in the following situations:

1. The VAD must be used in accordance with the FDA approved labeling instructions.

This means that the VAD is used as a temporary mechanical circulatory support for approved transplant candidates as a bridge to cardiac transplantation.

2. The patient is approved and listed as a candidate for heart transplantation by a Medicare approved heart transplant center.

3. The implanting site, if different than the Medicare approved transplant center, must receive written permission from the Medicare approved heart transplant center under which the patient is listed prior to implantation of the VAD.

ICD-9-CM procedure code 37.66, Implantation of an implantable pulsatile heart assist system, is and will continue to be listed as a noncovered procedure in the Medicare Code Editor (MCE) due to the stringent conditions that must be met by hospitals in order to receive payment. If this procedure is listed in accordance with the above criteria, payment is appropriate and you are to override the MCE noncovered edit.

# Coverage and Billing of Sacral Nerve Stimulation

This Program Memorandum (PM) is a consolidation of PM AB-01-166, Change Request 1936, dated November 15, 2001, and PM A-02-020, Change Request 2098, dated March 21, 2002. This PM supercedes AB-01-166 and A-02-020, please discard these two PMs.

## Coverage

A sacral nerve stimulator is a pulse generator that transmits electrical impulses to the sacral nerves through an implanted wire. These impulses cause the bladder muscles to contract, which gives the patient ability to void more properly.

Effective January 1, 2002, sacral nerve stimulation is covered for the treatment of urinary urge incontinence, urgency-frequency syndrome and urinary retention. Sacral nerve stimulation involves both a temporary test stimulation to determine if an implantable stimulator would be effective and a permanent implantation in appropriate candidates. Both the test and the permanent implantation are covered.

The following limitations for coverage apply to all indications:

- o Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.
- o Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) that are associated with secondary manifestations of the above three indications are excluded.
- o Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50% or greater improvement through test stimulation. Improvement is measured through voiding diaries.
- o Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.

# Billing Instructions

## Applicable HCPCS Codes

- 64561 - Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
- 64581 - Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
- 64585 - Revision or removal of peripheral neurostimulator electrodes
- 64590 - Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling
- 64595 - Revision or removal of peripheral neurostimulator pulse generator or receiver
- A4290 - Sacral nerve stimulation test lead, each
- E0752 - Implantable neurostimulator electrodes, each
- E0756 - Implantable neurostimulator pulse generator
- C1767 - Generator, neurostimulator (implantable)
- C1778 - Lead, neurostimulator (implantable)
- C1883 - Adaptor/extension, pacing lead or neurostimulator lead (implantable)
- C1897 - Lead, neurostimulator test kit (implantable)

NOTE: The "C" codes listed above are only applicable when billing under the hospital outpatient prospective payment system (OPPS). They should be reported in place of codes A4290, E0752 and E0756.

## Payment Requirements for Test Procedures (HCPCS codes 64585, 64590, 64595)

Payment is as follows:

- Hospital outpatient departments - OPPS
- Critical Access Hospital (CAH) - Reasonable cost
- Comprehensive Outpatient Rehabilitation Facility - Medicare physician fee schedule (MPFS)
- Skilled Nursing Facility - MPFS
- Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs) - All inclusive rate, professional component only. The technical component is outside the scope of the RHC/FQHC benefit. Therefore, the provider of that technical service bills their carrier on Form HCFA-1500 and payment is made under the MPFS. For provider-based RHCs/FQHCs payment for the technical component is made as indicated above based on the type of provider the RHC/FQHC is based with.

Deductible and coinsurance apply

**Payment Requirements for Implantation Procedures (HCPCS codes 64561, 64581)**

Payment is as follows:

- Hospital outpatient departments - OPPS
- Hospital inpatient - hospital prospective payment system (PPS)
- CAH - payment is made on a reasonable cost basis

Deductible and coinsurance apply.

**Payment Requirements for Device Codes, A4290, E0752 and E0756**

Payment is made on a reasonable cost basis when these devices are implanted in a CAH.

**Payment Requirements for Codes C1767, C1778, C1883 and C1897**

Only hospital outpatient departments report these codes. Payment is made under OPPS.

**Payment Requirements for Codes C1767, C1778, C1883 and C1897**

The applicable bill types for test stimulation procedures are 13X, 14X, 71X, 73X, 75X and 85X.

RHCs and FQHCs bill you under bill type 71X and 73X for the professional component. The technical component is outside the scope of the RHC/FQHC benefit. The provider of that technical service bills their carrier on Form HCFA-1500 or electronic equivalent.

The technical component for a provider-based RHC/FQHC is typically furnished by the provider. The provider of that service bills you under bill type 13X, 14X, 22X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.)

The applicable bill types for implantation procedures and devices are 11X, 13X, and 85X.

## Applicable Revenue Codes

The applicable revenue code for the test procedures is 920 except for RHCs/FQHCs who report these procedures under revenue code 521.

Revenue codes for the implantation can be performed in a number of revenue centers within a hospital such as operating room (360) or clinic (510). Therefore, instruct your hospitals to report these implantation procedures under the revenue center where they are performed.

The applicable revenue code for the device codes C1767, C1778, C1883 and C1897, provided in a hospital outpatient department is 272, 274, 275, 276, 278, 279, 280, 289, 290 or 624 as appropriate. The applicable revenue code for device codes A4290, E0752 and E0756 provided in a CAH is 290.

§4020, Review of Health Insurance Claim Form – HCFA-1500, of Part 3, Chapter IV of the Medicare Carriers Manual.

## Necessary Changes to Implement Special Add-On Payments for New Technologies

Section 533(b) of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1886(d)(5) of the Act to add subparagraphs (K) and (L) and establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare. In the September 7, 2001, final rule (66 FR 46902), we established that cases using approved new technology would be appropriate candidates for an additional payment when: the technology represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries; the payment for such cases can be demonstrated to be inadequately paid otherwise under the diagnosis-related group (DRG) system; and data reflecting the costs of the technology would be unavailable to use to recalibrate the DRG weights.

Under 42 CFR 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, if the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for indirect medical education (IME) and disproportionate share hospitals (DSH) but excluding outlier payments). PRICER will calculate the total covered costs for this purpose by applying the cost-to-charge ratio (that is used for inpatient outlier purposes) to the total covered costs of the discharge. Payment for eligible cases will be equal to:

- The full DRG payment (see example 1 that follows); plus

- The lesser of
  1. 50 percent of the costs of the new medical service or technology (see example 2); or
  2. 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment (see example 3); plus
- Any applicable outlier payments if the costs of the case exceed the DRG, plus adjustments for IME and DSH, and any approved new technology payment for the case plus the fixed loss outlier threshold. The costs of the new technology are included in the determination of whether a case qualifies for outliers.

This instruction implements the above payment mechanism into the claims processing systems.

Below are three illustrative examples of this policy for cases involving an eligible technology estimated to cost \$3,000 in a DRG that pays \$20,000.

Example One: Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is \$19,000. Medicare would pay \$20,000, the full DRG payment. Even though the case involved a new technology eligible for add-on payments, the total covered costs of the case did not exceed the DRG payment, therefore, no additional payment is made.

Example Two: Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is \$25,000. Because, in this case, 50 percent of the costs of the new medical service or technology is less than 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment, Medicare would pay 50 percent of the costs of the new technology (in addition to the DRG payment). Therefore, for this case, Medicare would pay \$21,500 (the DRG payment of \$20,000 plus one-half of \$3,000, the estimated cost of the new technology).

Example Three: Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is \$22,000. Medicare would pay one-half of the amount by which the costs of the case exceed the DRG payment, up to the estimated cost of the new technology. Therefore, for this case, Medicare would pay \$21,000 (the DRG payment of \$20,000 plus one-half of the costs above that amount).

## **Identifying Claims Eligible for the Add-On Payment for New Technology**

Technologies eligible for add-on payments will be identified based on the applicable codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Claims submitted with an ICD-9-CM code indicating that a new technology was involved in the treatment of the patient is then eligible for add-on payments as described above.

The system maintainers must pass (if present) the "principal" and up to five "other procedure" codes to PRICER. If an eligible code is present, PRICER will calculate an add-on payment if appropriate.

It is expected that this will add six new fields (7 positions each) to the end of the claim data record sent to PRICER by the system maintainer.

Additionally, we have requested from the National Uniform Billing Committee (for consideration at their meeting this month) a new value code (FL 39-41 of the UB-92 or electronic equivalent) for YOUR use only. This value code will be defined as "New Technology Add-On Payment." This value code must be passed to CWF and the PS&R. We will provide the specific information regarding that new value code when it becomes available (after December 18). The amount shown in this value code will need to be paid to PIP providers on a claim-by-claim basis the same as outlier payments are paid to PIP providers.

## **Processing Claims Between October 1, 2002 and April 1, 2003**

In the August 1, 2002, Federal Register, we approved Xigris™ (identified by ICD-9-CM code 00.11) for new technology pass-through payments for discharges on or after October 1, 2002. During the interim period before a new PRICER becomes available, providers will bill claims as usual and you will make the appropriate payment without the new technology add-on payment.

Your FI will mass adjust claims with ICD-9-CM code 00.11 and Type of Bill 11X for claims between October 1, 2002, and April 1, 2003, and process through the new PRICER. The mass adjustments will be completed by July 1, 2003.

(Source: Program Memorandum A-02-124; Change Request 2301)

# Providers Q&A

**Q:** Is it a compliance issue if we choose not to get an Advanced Beneficiary Notice (ABN) for a particular service and not charge the patient?

**A:** No, it has been verified through the Office of Inspector General and the Centers for Medicare and Medicaid Services that it is not a compliance issue if you write off a charge because you choose not to get an ABN for a particular service. Furthermore, these charges can not be written off of your cost report as bad debts.

*(Source: CMS Regional Office & OIG)*



# Special Instructions for Processing Home Health Prospective Payment System (HH PPS) Claims on and after January 1, 2003

*(Informational only for home health providers)*

## **BYPASSING TIMELY FILING EDIT FOR HH PPS EPISODES SPANNING OCTOBER 1, 2001**

Federal regulations regarding the timely filing period for Medicare claims (42 CFR 424.44) define that period in terms of the date a service is provided. Services provided in the first three quarters of a calendar year are considered timely if received by December 31 of the year following the service year. Services provided in the last quarter of a calendar year are considered timely if received by December 31 of the second year following the service year. HH PPS claims represent an episode of care of up to 60 days. These episodes may easily span from the third quarter into the fourth quarter of a given calendar year. Since the payment methodology of HH PPS prevents these claims from being split into discrete September and October billing periods, HH PPS episode claims with any service dates on or after October 1 must be considered timely if received by December 31 of the second year following the service year.

CMS has learned that Medicare systems are not currently programmed to allow this. The edit enforcing timely filing of HH PPS claims is setting based on the Request for Anticipated Payment (RAP) or claim "From" date, not recognizing that a claim with a "From" date in September will frequently contain services spanning into October. As a result, HH PPS claims with dates spanning October 1, 2001 will be erroneously denied as untimely if received on or after January 1, 2003 unless RHHIs take action to prevent this. In order to prevent it, RHHIs are instructed to manually bypass the timely filing edit if the edit sets on HH PPS claims with a claim "Through" date on or after October 1, 2001. CMS will issue an instruction in coming months to correct Medicare systems programming so that this problem is resolved before it recurs for episodes spanning October 1, 2002.

**Bypassing Timely Filing Edit for Provider Adjustments Subsequent to Common Working File (CWF) Generated Partial Episode Payment Adjustments.**

Since the implementation of HH PPS in October 2000, various Medicare systems problems have prevented the correct functioning of an automated post-payment recovery process that was part of the initial HH PPS design. This recovery process was designed to adjust the payment of claims that were paid as full episodes, but were later identified to receive partial episode payment (PEP) adjustments due to overlapping HH PPS claims. These problems are outlined in Program Memorandum (PM) A-02-107. That PM also provides instructions for the final corrections to the process, which will be implemented no later than April 1, 2003. In the interim, many PEP adjustments are partially processed in Medicare systems. The originally paid claim is cancelled on CWF, but the adjustment claim to replace the original is not yet processed by the Shared Systems.

Home Health Agency (HHA) providers in many instances have a need to correct these same claims through the submission of provider initiated adjustments. These adjustments cannot be processed because the original claim the provider is seeking to adjust has been cancelled in CWF. Reflecting their individual resource constraints, different RHHI sites have developed different approaches for handling these provider initiated adjustments.

Each of the following approaches is acceptable to CMS, although the first approach is encouraged to the extent possible. The first approach is to manually modify the provider initiated adjustment, performing the same actions the Shared System would take if the automated recovery process were functioning. This involves making changes to the claim's type of bill, patient status code, and statement covers period dates. The resulting 'dual adjustment,' which makes both the provider initiated changes and the system identified changes, can then be returned to CWF to complete processing. Other approaches involve holding all the provider initiated adjustments until the Shared System's automated recovery process is functioning or returning the provider initiated adjustments to the provider for resubmission after that process is functioning. Shared System corrections are expected within the next several weeks which will allow the PEP automated recovery process to function for all but a subset of claims on which denied lines resulting from the adjustment fall outside the claim statement period. This subset will require special treatment described below.

Due to the significant delay that has already occurred in processing the provider initiated adjustments, any of the approaches described above may result in the adjustment being subject to the timely filing edit. RHHIs are instructed to manually bypass the timely filing edit if the edit sets on a provider initiated HH PPS adjustment (type of bill 3x7) which was delayed because its corresponding original claim was cancelled by CWF during the timely filing period for the services on the adjustment.

Bypassing the edit provides an exception to timely filing due to the Medicare program's administrative error, as defined in regulation at 42 CFR 424.45.

## HOLDING CWF GENERATED PARTIAL EPISODE PAYMENT ADJUSTMENTS IF DENIED LINES FALL OUTSIDE CLAIM STATEMENT PERIOD

When implemented as part of the January Medicare systems release, PM A-02-068 will create an automated post-payment recovery process for HH PPS episodes that were paid as full episodes, but were later identified for payment as PEP adjustments due to the presence of overlapping Medicare HMO enrollment periods. This process is largely modeled on the process described above for PEP adjustments due to overlapping HH PPS claims (hereafter, the "basic PEP process"). At the time PM A-02-068 was written, it was expected that the problems with the basic PEP process would be corrected prior to January 1, 2003. As noted above, the basic PEP process will now be corrected within several weeks, with one exception. If the adjustment to a claim identified for automated recovery requires line items to be denied, these line items are shown as non-covered on the claim but the claim statement period is adjusted to only include the covered line items. CWF cannot currently accept claims or adjustments with line item dates outside the statement period. These claims or adjustments are rejected with CWF edit 61#I. CWF changes to allow this will be completed by April 1, 2003. While this edit may reject claims adjustments due to the basic PEP process, CMS expects that the new process for overlapping HMO periods will be the source of the majority of the adjustments rejected. RHHIs are instructed to hold all home health adjustments rejected with CWF edit 61#I until the April CWF changes are implemented.

# Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

*(This is informational only for home health providers)*

## I. GENERAL INFORMATION

### A. Background:

In April 2001, CMS established via Program Memorandum (PM) the process of periodically updating the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs), will not be paid on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Note that items incidental to physician services, as well as supplies used in institutional settings, are not subject to HH consolidated billing.

A subsequent PM, AB-02-092 (Change Request 2247) published July 2, 2002, established that updates of the HH consolidated billing code list would occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes). These temporary codes may describe services subject to consolidated billing in addition to the permanent list of HCPCS codes that is updated annually.

This PM is the second quarterly HH consolidated billing update for calendar year 2003. This update adds a single non-routine supply code to the list of codes subject to consolidated billing. This code was identified through additional review of the annual HCPCS update that was reflected in the first quarterly update. However, it was identified too late for inclusion in Medicare systems changes for the January quarter. Other updates for the remaining quarters of the calendar year will occur as needed due to the creation of new temporary codes representing services subject to HH consolidated billing prior to the next annual update.

The new code to be added is: A6440: Zinc Paste  $\geq 3"$   $< 5"$  w/roll

The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

### B. Policy:

Section 1895 of the Social Security Act codifies the HH PPS.

*(Source Change Request 2515; Program Memorandum AB-03-002)*



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

PROVIDER RELATIONS  
**TOLL FREE PHONE NUMBER**

**866-488-0545**

**Intermediary**  
**NEWS**

**HCFA**