

Intermediary NEWS



January 2005

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SHOULD BE SHARED WITH
ALL HEALTH CARE
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MANAGERIAL MEMBERS OF
THE PROVIDER/SUPPLIER
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Update to Medicare Deductible, Coinsurance, and Premium Rates for Calendar Year (CY) 2005

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

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

Background

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) or Part A benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but they are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 3039 quarters of covered employment. **When voluntary enrollment takes place more than 12 months after a person's initial enrollment period for HI benefits, the monthly premium is increased by 10 percent.**

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

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

Inpatient Hospital Services

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

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

Provider Relations

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866-488-0545

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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.”

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For CY 2005, the premium, deductible, and coinsurance amounts are as follows:

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

- Deductible: \$912.00 per benefit period
- Coinsurance:
 - * \$228.00 a day for days 61-90 in each period
 - * \$456.00 a day for days 91-150 for each lifetime reserve day used
 - * \$114.00 a day in a SNF for days 21-100 in each benefit period
- Premium per month:
 - * \$375.00 for those who must pay a premium
 - * \$412.50 for those who must pay both a premium and a 10 percent increase
 - * \$206.00 for those who have 30-39 quarters of coverage
 - * \$226.60 for those with 30-39 quarters of coverage who must pay a 10 percent increase

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

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

The following table compares Medicare Part A Deductible, Coinsurance, and Premium Amounts for Years 2001 through 2005:

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

Implementation

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

Related Instructions

CR 3121 (Transmittal 3), "New Part B Annual Deductible," was issued on March 12, 2004. CR 3121 updated the 2005 Part B deductible based on section 629 of the Medicare Prescription Drug, Improvement and Modernization Act. The same information held in CR 3121 is being communicated in CR 3463. Therefore, CR 3463 is replacing CR 3121 to prevent unintended consequences that may result from implementing both CR 3463 and CR 3121 together.

Additional Information

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

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3463 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:

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

Related Change Request (CR) #: 3463

Medlearn Matters Number: MM3463

Related CR Release Date: September 10, 2004

Related CR Transmittal #: 10

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

Frequently Asked Questions – 1st Quarter Fiscal Year 2005

1. Question: What is the proper use of modifier GZ, GY and GA?

Answer: Modifier GA is used when an item or service is expected to be denied as not reasonable and necessary and an advanced beneficiary notice (ABN) was given to the beneficiary. You are required to use an occurrence code 32 along with your modifier GA. The services should be billed as covered. If you do not use modifier GA and occurrence code 32 on the claim, it will be reviewed as any other claim and may or may not be denied. If the claim is denied, the provider will be liable. Modifier GZ is used when an item or service is expected to be denied as not reasonable and necessary and an ABN was not signed by the beneficiary and you furnish the services anyway. Medicare will review the claim like any other claim without regard to the “GZ” modifier. If Medicare pays the claim, the GZ modifier is irrelevant. However, if Medicare denies the claim, the provider will be liable. This modifier does not need to be used when payment is expected by Medicare. The provider has the option to choose to use or not to use modifier GZ. Modifier GY is used when you are filing for statutorily excluded services. ABNs are not an issue in this case. Modifier GY is used (a) when you think a claim will be denied because it is not a Medicare benefit or because Medicare law specifically excludes it, (b) when you think a claim will be denied because it is not a benefit under the law, or (c) when you submit a claim to obtain a denial from Medicare to bill a secondary payer (use condition code 21) in this case. Medicare will deny the claim.

2. Question: Can I bill more than one unit of 97601 (selective debridement) per patient on a given treatment day?

Answer: We would not expect to see 97601 billed in multiple units per treatment session. The CPT Manual defines this as the removal of devitalized tissue from wound(s) indicating multiple wounds per session.

3. Question: What are the CORF physicians requirements regarding the plan of treatment?

Answer: Per CMS Pub. 100-2, CH 12, §30 E, CORF services must be furnished under a written plan of treatment established by a physician. The physician may be either a physician associated with the CORF, or the referring physician if the physician provides a detailed plan of treatment that must contain the diagnosis, the type, amount frequency, and duration of services to be performed, and the anticipated rehabilitation goals.

The CORF physician must review the plan of treatment at least once every 60 days. Following the review, the physician should certify that the plan of treatment is being followed and that the patient is making progress in attaining the established rehab goals.

4. Question: What is Adenosine Injection (HCPCS J0152) used for and is it the same as Adenocard (J0150)?

How do I know the difference? How do I code appropriately?

Answer: Medicare allows coverage for Adenosine as a pharmacologic stress agent for Myocardial Perfusion Imaging. Pharmacologically, Adenosine and Adenocard are both adenosine injection. The concentrations and indications for usage, however, are much different. Adenosine (trade name Adenoscan) is used for the myocardial perfusion studies diagnostic and is coded per 30 mg vial. Adenocard is the trade name used for treatment of supraventricular tachycardia and is coded per 6 mg vial. They are not interchangeable.

5. Question: When should a provider have a beneficiary sign an Advanced Beneficiary Notice (ABN)?

Answer: Providers should have the beneficiary sign an ABN in advance of furnishing services that Medicare is likely to deny payment for them. The ABN is to inform a Medicare beneficiary before they receive a specified item or service that it may not be paid for. It allows the beneficiary to make an informed decision whether or not to receive the item or service for which they may have to pay out of pocket or through other insurance.

6. Question: Can I bill the beneficiary for non-covered charges without having the patient sign an Advanced Beneficiary Notification (ABN)?

Answer: The only time a beneficiary can be held liable for non-covered charges without signing an ABN is in the event they are being billed for statutorily excluded services or items.

7. Question: Does Medicare cover drug and alcohol rehabilitation?

Answer: Coverage is available for both diagnostic and therapeutic services furnished for the treatment of drug abuse and alcoholism. Hospitals may provide structured inpatient alcohol rehabilitation programs to the chronic alcoholic. These programs are composed primarily of coordinated educational and psychotherapeutic services provided on a group basis. Depending on the subject matter, a series of lectures, discussions, films, and group therapy sessions are led by either physicians, psychologists, or alcoholism counselors from the hospital or various outside organizations.

In addition, individual psychotherapy and family counseling (CMS Pub. 100-3, §130.2) may be provided in selected cases. These programs are conducted under the supervision and direction of a physician.

8. Question: Will Medicare cover dental surgery in a hospital?

Answer: Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. However, the extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is covered. The guidelines can be found in CMS Pub. 100-2, CH 16, §140.

9. Question: Does Medicare cover pulmonary rehabilitation?

Answer: Pulmonary rehab, as a complete program like cardiac rehab is not a covered service. Medicare will cover for pulmonary rehab and endurance exercises. The services must be ordered by a physician, reasonable and necessary for the individualized treatment of the patient's condition, and must be re-certified by the physician every 30 days. Refer to the Outpatient Pulmonary Rehabilitation Services Local Coverage Determination (LCD) on www.marylandmedicare.com.

10. Question: What are the Medicare guidelines for Gastric Bypass Surgery?

Answer: Gastric bypass surgery, which is a variation of the gastrojejunostomy, is performed for patients with extreme obesity. Gastric bypass surgery for extreme obesity is covered under the program if: (1) it is medically necessary for the individual to have such surgery, AND (2) the surgery is to correct an illness which caused the obesity or was aggravated by the obesity. Refer to CMS Pub. 100-3, §100.1.

11. Question: Will Medicare cover a combined left and right heart catheterization?

Answer: In order for Medicare to cover combined left and right heart catheterization, providers must report a diagnosis from the list of codes supporting medical necessity for the left and the right heart catheterization. For conditions that appear on both lists, reporting the diagnosis code once on the claim is sufficient, as long as the documentation in the medical record supports medical necessity for doing both. A diagnosis code may not support medical necessity by itself. Refer to the Cardiac Catheterization Local Coverage Determination (LCD) on www.marylandmedicare.com.

12. Question: Do we need a written order for therapy?

Answer: Yes, therapy services must be furnished to an individual who is under the care of a physician and certifies that the patient's therapy services are reasonable and necessary to the treatment of the individual's illness or injury. A written plan of treatment is required and if established by the therapist must be reviewed and signed by the physician. Refer to the Physical Medicine and Rehabilitation Local Coverage Determination (LCD) on www.marylandmedicare.com. Additional information can be found in 42CFR 482.12 and CMS Pub. 100-2, CH 15, §220.3.2.

13. Question: Can I bill more than one unit on a therapy evaluation (CPT 97001, 97003, 92506, 92610) or re-evaluation (CPT 97002, 97004)?

Answer: No. Only one unit can be billed for a therapy evaluation or re-evaluation. These codes are not defined by a specific time frame; therefore, only one unit may be billed regardless of the amount of time spent delivering the service. Refer to CMS Pub. 100-4 CH 5, §20.2. Also, see the Physical Medicine and Rehabilitation LCD on www.marylandmedicare.com.

14. What are the basic elements for documentation for therapy services?

Answer: The necessary documentation for therapy services should include the following:

- Physician Orders
 - * Modality or type of care to be furnished
 - * Duration and frequency of service
 - * Date and signed by physician

- Plan of Treatment (Initial and current plan of care signed and dated by the physician)
 - * Type and nature of care to be furnished
 - * Functional goals and estimated rehabilitation potential
 - * Treatment objectives
 - * Frequency of visit
 - * Estimated duration of treatment
 - * Signed and dated by physician

- Physician Certification and/or Re-certifications (Certification is obtained at the time the plan of treatment is established)
 - * The services are or were furnished while the patient was under care of a physician.
 - * A plan for furnishing such services is or was established by the physician, physical therapist, occupational therapist, or speech pathologist and periodically reviewed by the physician.
 - * Services are or were required by the patient.
- Evaluations and/or Re-evaluations
 - * Evidence of the assessment
 - * Functional goals and or disabilities
 - * Patient baseline and goals
 - * Discharge planning
 - * Frequency, duration, type of treatment
 - * Short term and long term goals
- Progress Notes (Treatment Summary for Billing Period)
 - * Initial functional communication status of the patient at your provider setting
 - * Present functional status of the patient for this billing period
 - * Changes in the plan of treatment if appropriate
 - * Documented patient progress

Cardiac Rehabilitation Services

1. Question: What is the physician's involvement for cardiac rehab?

Answer: The physician fulfills two roles in cardiac rehab. The first is direct supervision and the second is "incident-to".

2. Question: What is involved in 'direct physician supervision'?

Answer: The physician must be a) in the exercise program area and b) immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require the physician be physically present in the exercise room itself. The supervision requirement would **not** be met by a physician who is involved in an activity (e.g. cardiac catheterization, another emergency) or is too remote from the exercise program area that would prevent him/her from being immediately available and accessible. Each provider should insure that protocols are established, posted, and verified to insure that a designated physician(s) fulfills this requirement.

3. Question: What is meant by 'in the exercise program area'?

Answer: The supervision requirement is met when the physician is in such proximity to the CR exercise area that he/she can respond as noted in 'b' in question 2. The supervision requirement would **not** be met by a physician who is so physically displaced from the exercise program area preventing him/her from being immediately available and accessible.

4. Question: How is the 'incident-to' requirement met?

Answer: In order to be covered under the 'incident-to' benefit in an outpatient hospital department, services must be furnished as an integral, although incidental part of a physician's professional service in the course of diagnosis or treatment of an illness or injury. The benefit does not require that a physician perform a personal professional service on each occasion of service by a non-physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program.

5. Question: A patient had a coronary bypass surgery in 1998, can they participate in Cardiac Rehab?

Answer: Medicare coverage of cardiac rehabilitation is considered reasonable and necessary for patients with a clear medical need, who are referred by their attending physician and have had coronary bypass surgery. There is no time limit for the surgery. The guidelines for cardiac rehab services can be found in CMS Pub. 100-3 §20.10.

Skilled Nursing Facility (SNF)

1. Question: When should an Other Medicare Required Assessment (OMRA) be completed?

Answer: This type of assessment is used only for those beneficiaries who remain in a Part A SNF stay after all rehabilitation therapy has been discontinued, but continue to have another skilled nursing service. The OMRA must be performed with an assessment reference date that is the 8th, 9th or 10th day after therapy ends. This would cause the claim to be

downcoded to a lower level of nursing care. (CMS Pub. 100-4, CH 6, §30.2-30.3; Federal Register, Volume 64, July 30, 1999 page 41656)

2. Question: When should a MDS assessment schedule be started again?

Answer: A new MDS assessment schedule should be started if the patient is out of the facility greater than 24 hours or if the patient has been discharged from skilled care and readmitted. (CMS Pub. 100-6, CH 6, §30.2- 30.3; Federal Register, Volume 64, July 30, 1999 page 41658)

3. Why does an Intermediary need to review a Skilled Nursing Facility demand bill?

Answer: Your facility may determine upon admission that the level of care will be non-covered or excluded and therefore Medicare will not pay. You must advise the beneficiary that, in your opinion, Medicare will not pay for these services. If the beneficiary disagrees and requests you to submit a bill to the Intermediary, you must submit a "demand bill". The Intermediary will determine whether the provider is incorrectly determining and advising beneficiaries and/or beneficiaries' representatives that services are not covered by Medicare where, in fact, some or all of the services may be covered. The Intermediary also determines by review of the "demand bill" if adequate notice of non-coverage of skilled care was provided to the beneficiary and/or the beneficiaries representatives.

4. Question: What documents should be submitted by a Skilled Nursing Facility (SNF) in response to a Medical Review Additional Development Request (ADR)

Answer: SNF providers should submit all documents listed in the ADR as well as any other supporting documentation, including, but not limited to physician's orders, history and physical, MDS, progress notes, nurses' notes, therapy orders, plan of care, certifications, and treatment notes.

Comprehensive Error Rate Testing (CERT) Requirements for Documentation are Vital - Revised

Note: Change in CERT Documentation Initial Request Letter from 45 days to 90 days (refer to <http://www.cms.hhs.gov/cert/> for sample letter the CERT contractor uses to request medical records).

The Comprehensive Error Rate Testing (CERT) program was initiated by the Centers for Medicare & Medicaid Services (CMS) to improve the processing and medical decision making involved with payment of Medicare claims. Under CERT, an independent contractor (AdvanceMed) will select a random sample of claims processed by each Medicare contractor. From the requested documentation, the clinical staff of AdvanceMed will determine the accuracy of the contractor's decision to pay or deny the claim.

During the AdvanceMed review process, one or more of your claims may be selected for review and you will be asked to provide medical record information. **If a claim is selected for review, it is critical that you send all appropriate and supportive documentation to the CERT Contractor to verify all services billed on each claim line.**

If the requested documentation is not sent to AdvanceMed timely or the documentation is insufficient to support payment of all services on the claim, the claim that is sampled will be counted as an error and the contractor is required to collect the overpayment. This is true regardless of whether or not that documentation is physically located with the provider who received the request. Insufficient documentation errors are frequently associated with lab tests, ESRD services, and skilled nursing facility services. Therefore, coordination with other providers/health care facilities to obtain the necessary medical record documentation for AdvanceMed is imperative. Services will continue to be denied and refunds requested when all medical record documentation is not received by AdvanceMed.

CMS has determined that many providers do not comply with these requests. Possible reasons are providers believe it is a HIPAA violation to send patient records to AdvanceMed.

Providing the requested documentation does not violate the minimum necessary provision of the HIPAA Privacy Rule and does not require beneficiary authorization. Others are unaware of the process and/or fail to see the importance of cooperating in a timely fashion.

Because of the number of non-responding providers, CareFirst of MD, Inc. is attempting to educate the provider community about the CERT program, emphasizing the importance of providers responding to the CERT contractor's requests for medical records, and the consequences for not doing so.

Failure to comply with the request for the medical records will result in a referral to the Office of the Inspector General (OIG).

What constitutes sufficient medical record documentation for the CERT Contractor, AdvanceMed?

AdvanceMed's record request letter includes a list of medical record components that may need to be submitted. These include:

- Physician Progress Notes
- Physician Orders
- Nurses Notes
- Medication Records
- Graphic Reports
- Operative Reports
- Pathology Reports
- Consultant Notes
- All Lab Reports
- Diagnostic Test Results (regardless of where they are performed)
- History and Physical
- Certificate of Medical Necessity
- Skilled Nursing Facility Records including MDS
- Emergency Room Records
- Outpatient Hospital Records
- ESRD Records
- Itemized Full Bill

This is not an all-inclusive list. Please make sure to submit any additional medical record documentation (treatment plans, physical therapy progress notes, etc.) that substantiates each of the services billed to Medicare.

How serious is CMS about referring providers to the Office of Inspector General (OIG) who are not responsive to AdvanceMed's documentation requests?

Under the CERT Program, AdvanceMed is the CMS Program Safeguard contractor tasked with reviewing the supporting clinical documentation for Medicare services rendered and billed. The failure to respond to record requests from AdvanceMed is a matter of very serious concern to CMS. Non-response errors account for over 50% of CERT errors today. Non-response errors, with respect to CERT, encompass situations where there was no response from the provider, as well as situations where the provider responded, but did not supply the requested medical record documentation. AdvanceMed makes up to 4 contacts via letter and up to 2 contacts via phone in an attempt to obtain the medical record documentation.

The 4th and final letter contains verbiage indicating "Failure to send the requested information may also result in a referral to the Medicare contractor fraud unit and to the Office of the Inspector General..."

CMS has procedures in place to refer non-responders to the Office of the Inspector General. Please take this warning seriously. In order to prevent an error from being charged to the Medicare Program and a fraud and abuse or OIG referral from occurring, please respond to medical record requests from AdvanceMed by sending all of the requested information within 45 days of the initial request letter.

The following are the time frames which are allotted for providers to respond to each request as appropriate:

Initial request - 90 days

Second request - 25 days

Third request - 10 days

Final Request - Immediately

If the requested documentation is still not received by AdvanceMed after the fourth request, the Office of Inspector General (OIG), as directed by the Department of Health and Human Services (DHHS) will send out the OIG Final request to instruct the provider to forward the documentation directly to the CERT contractor. The OIG letter states "The requested documentation must be received within 10 days of the date of this letter. If it is not received within this time frame, action will be taken to deny and recover payment for all services billed on the claim. There will be no further notice prior to this action. Failure to send the requested information may also result in an on-site audit by the OIG or referral to the Medicare Contractor Fraud Unit."

Failure to comply with the OIG request may result in a denial and recovery of payments for all services provided on the dates in question under the Medicare program Section 1833 (e) Title XVIII of the Social Security Act. Title 42 of the Federal Regulations (CFR) Part 405, Section 371 (d) authorizes suspension of payment, without notice, for failure to furnish such information.

Where do providers send the requested documentation?

Do NOT send the documentation to CareFirst of MD Inc., Medicare Part A. Please follow the instructions in the AdvanceMed letter and attachments, and forward the requested information to AdvanceMed at the following address in a timely manner:

AdvanceMed/ A CSC Company
CERT Operations Center
1530 E. Parham Road
Richmond, VA 23238.

If you have any questions you can contact our Provider Service line at 1-866-488-0545.

Instructions for Completion of CMS-1450 Billing Form

Provider Types Affected

All Providers who bill Medicare Fiscal Intermediaries (FIs) including the Regional Home Health Intermediaries (RHHIs)

Provider Action Needed

This is primarily for informational purposes, but providers should note that The National Uniform Billing Committee (NUBC) has approved the use of new value codes with an effective date of January 1, 2005.

Background

According to section 42CFR 424.5(a)(5), providers of services need to submit a claim for payment prior to any Medicare reimbursement. The CMS-1450 Part A claim form is used to collect claims information for payments.

The Medicare Claims Processing Manual is being revised and the key revisions clarify the following Forms Locators (FL):

- **FL 8** deals with non-covered days and it is a required entry for inpatient claims. The current revision includes as non-covered days those days after the date of covered services ended, such as non-covered level of care, or emergency services after emergency has ended in a non-participating institution.
- **FL 22** – The patient status code is required for all Part A inpatient, Skilled Nursing Facility (SNF), hospice, home health agency, and outpatient hospital services. This code indicates the patient’s status as of the “Through” date of the billing period (FL 6). The patient status code revisions made by CR3417 are as follows:
- Code 02 is modified to show that the patient was discharged/transferred to a short-term general hospital **for inpatient care**.
- Code 05 now indicates that the patient was discharged/transferred to a **non-Medicare PPS children’s hospital or non-Medicare PPS cancer hospital for inpatient care**.

Note that with regard to use of patient status code 05, a Medicare distinct part unit/facility must meet certain Medicare requirements and is exempt from the inpatient prospective payment system; children’s hospitals and cancer hospitals are two examples.

Other distinct part units/facility types have specific patient status codes, including:

- SNFs (various codes)
- Inpatient rehabilitation facilities (IRFs) including rehabilitation distinct part units of a hospital (Code 62)
- Medicare certified long term care hospitals (LTCH) (Code 63)
- Psychiatric hospitals or psychiatric distinct part units of a hospital (Code 65).

Also, the use of patient status code 43 relates to a discharge/transfer to a government operated health care facility such as a Department of Defense hospital, a Veterans Administration hospital or a Veterans Administration nursing facility and is used whenever the destination of a discharge is a federal health care facility, whether or not the patient resides there.

FL 24-30 would contain condition codes that apply to the relevant billing period. Condition code 59, non-primary ESRD facility, may now be used and this code indicates that an ESRD beneficiary received nonscheduled or emergency dialysis services at a facility other than his/her primary ESRD facility. Code 59 was actually effective on October 1, 2004.

B4 is now a condition code for an admission unrelated to a discharge on the same day and this code is for discharges on or after January 1, 2004, though is not effective until January 1, 2005. Also, condition code D4 has been expanded for use in LTCHs, IRFs, and inpatient SNFs in addition to inpatient acute care hospitals.

FL 39-41 refers to value codes and has included two new codes that will become effective on January 1, 2005:

- A8 Weight of Patient in kilograms
- A9 Height of Patient in centimeters

Additional Information

The actual revisions to the Medicare Claims Processing Manual are included in the official instructions issued to your FI or RHHI. That instruction may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that site, scroll down the CR NUM column on the right to find CR3417, then click on the file for that CR.

If you have any questions regarding these requirements, contact your FI or RHHI at their toll-free provider number, which may be found on the Medicare web site at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>

Note: This article was revised on October 14, 2004, to include condition code 59 on page 2. All other information is the same as in the original article.

Related Change Request (CR) #: 3417

Medlearn Matters Number: MM3417

Related CR Release Date: September 24, 2004

Revised Related CR Transmittal #: 311

Effective Date: January 3, 2005

Implementation Date: January 5, 2005

Instructions for Completion of Form CMS-1450

Provider Types Affected

Providers who submit Form CMS-1450 to Medicare intermediaries for billing

Provider Action Needed

Stop – Impact to You

The National Uniform Billing Committee (NUBC) has approved the use of a new condition code and value code.

Caution – What You Need to Know

A new condition code Form Locator (FL) 24-30 (80 – Home Dialysis – Nursing Facility) and a new value code FL 39-41 (P1-Do Not Resuscitate Order (DNR)) have been added to the updated instructions and a definition has been removed from patient status code for FL 19 (Type of Admission/Visit).

Go-What You Need to Do

To ensure accurate claims processing, please review the information included here and stay current with updated instructions for completion of form CMS-1450 for billing (Medicare Claims Processing Manual, Chapter 25, Section 60).

Background

Section 42 CFR 424.5(a)(5) requires providers of services to submit a claim for payment prior to any Medicare reimbursement.

The CMS-1450 Part A claim form is used to collect claim information for payment. Instructions for completion are the

same for inpatient and outpatient claims unless otherwise stated.

Please note the following updates:

- For Type of Admission/Visit (FL 19) the definition from code 9 “Information Not Available” will be removed (but the code will be kept).
- Effective April 1, 2005, Medicare intermediaries, including Regional Home Health Intermediaries (RHHIs), will accept, in FL 24-30, the condition code 80 “Home Dialysis – Nursing Facility.”
- Effective January 1, 2005, Medicare intermediaries will accept, in FL 39-41, the value code of P1 –Do Not Resuscitate Order (DNR). This code is for public health data reporting only. This code indicates that a DNR order was written at the time of or within the first 24 hours of the patient’s admission to the hospital and is clearly documented in the patient’s medical record.

Additional Information

The official instruction issued regarding this change can be found online, referenced via CR 3543, at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above online page, scroll down the CR NUM column on the right to find the link for CR 3543. Click on the link to open and view the file for the CR.

The revised Chapter 25, Section 60 of the Medicare Claims Processing Manual is attached to CR 3543 and this chapter provides the updated instructions for completion of form CMS-1450 for billing.

If you have questions regarding this issue, you may also contact your intermediary/RHHI on their toll free number, found online at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>

Related Change Request (CR) #: 3543

Medlearn Matters Number: MM3543

Related CR Release Date: November 12, 2004

Related CR Transmittal #: 368

Effective Date: January 1, 2005 and April 1, 2005 as noted in the article

Implementation Date: April 4, 2005

Line Item Dates of Service (LIDOS) Edit Implementation October 4, 2004, Change Requests 3031, 3264, & 3337

Change Request 3337, Transmittal 199 of the Medicare Claims Processing Section of the Internet Only Manual, states outpatient claims that do not contain a line item date of service for every revenue code line will be rejected. This requirement is not really appropriate for dialysis, hospice, or home health claims for supplies. Dialysis and hospice claims are submitted on a monthly basis, and supplies used during a 60 day home health benefit period (under the Prospective Payment System (PPS), Types of Bill (TOB) = 32x and 33x) are far too numerous to individually enumerate. The LIDOS requirement is too cumbersome for these types of claims.

The policy for these three types of providers is to place any date between the from and the through date, inclusive of those dates (Statement Covers Period), on the claim at the line level. This is a workaround that providers may use to avoid having claims rejected. Claims will be accepted with the workaround for type of bills 72x, 81x, 82x, 32x, and 33x.

In response to inquiries, the Centers for Medicare & Medicaid Services has informed various dialysis, home health and hospice providers that it is acceptable to continue rolling up the services onto a single, dated line, as long as that line has a date that falls within the statement dates of the claim. Some providers have asked whether this meant that breaking out claims by individual dates of service was not allowed, either practice is allowable.

Source: JSM 406

Use of Transmission Date in the Service Date Field for Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Claims

Provider Types Affected

Inpatient Rehabilitation Facilities

Provider Action Needed

This instruction is a notification that the Centers for Medicare & Medicaid Services (CMS) will now require that the date of the transmission of the IRF Patient Assessment Instrument (PAI) be recorded in the “Service Date/Assessment Date” field of the UB-92 (Field Locator 45 of the Revenue Code 0024 line) or electronic equivalent (on the 837i, the field is located in 2400 ASSESSMENT DATE DTP). Should this transmission date be 28 or more calendar days from the discharge date of the claim, the 25 percent penalty will be applied to the payment rate associated with the case mix group for such claim. **Failure to supply a valid date will cause the claim to be returned unprocessed to the provider.**

Background

When the IRF PPS was implemented January 1, 2002, CMS did not require a “service” date on the Revenue Code 0024 line of the IRF PPS claim (Change Request (CR) 1921, Transmittal A-01-131, dated November 1, 2001).

At that time, CMS stated that this field was optional and a date could be entered if the IRF PAI record was submitted more than 28 calendar days after discharge. If so, a 25 percent penalty would be applied to the claim.

CMS will now require that the date of the transmission of the IRF PAI be recorded in the “Service Date” field of the UB-92 (Field Locator 45) or electronic equivalent (on the 837i, the field is located in 2400 ASSESSMENT DATE DTP). The requirement is effective for discharges on or after October 1, 2004.

Should this transmission date be 28 or more calendar days from the discharge date of the claim, the 25 percent penalty will be applied. The total payment amount field will then be reduced by the penalty amount so that the final total payment amount will be 75 percent of the payment rate associated with the case mix group for that claim.

Implementation

The implementation date for this instruction is January 3, 2005 and it will apply to discharges on or after October 1, 2004.

Related Instructions

The Medicare Claims Processing Manual (Pub 100-04), Chapter 3 (Inpatient Hospital Billing) Section 140 (Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)), Subsection 140.3.4 (Payment Adjustment for Late Transmission of Patient Assessment Data) is being revised. The updated manual instructions are included in the official instruction issued to your intermediary that can be found at the following CMS web sites:

http://www.cms.hhs.gov/manuals/transmittals/com_date_dsc.asp

From that Web page, look for CR3433 in the CR NUM column on the right, and click on the file for that CR.

CR1921, Transmittal A-01-131, dated November 1, 2001, “Additional Instructions for Implementing the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)” can be reviewed at the following CMS web site: http://cms.hhs.gov/manuals/pm_trans/A01131.pdf.

Additional Information

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

Related Change Request (CR) #: 3433

Medlearn Matters Number: MM3433

Related CR Release Date: August 27, 2004

Related CR Transmittal #: 291

Effective Date: Effective for discharges on or after October 1, 2004

Implementation Date: January 3, 2005

Medicare “Must Bill” Policy for Reimbursement of Dual-Eligible Bad Debts

Purpose

The purpose of this notice is to provide further clarification related to bad debt reimbursement policies.

Policy

All provider types must bill individual state Medicaid programs for dual-eligibles' co-pays and deductibles in order to claim the un-reimbursed amount as a bad debt on the Medicare cost report. A rejection notice (remittance advice) must be received and maintained for Intermediary verification at time of desk review or field audit. This will not impact the majority of the providers currently billing the state. If you are a Provider and are not currently billing the state, you should change your billing practices to comply with this notice. Failure to do so will result in the disallowance of claimed Medicare Bad Debts.

A claim for bad debt cannot be made until either a payment or denial is received from the state. A bad debt should not be established prior to, or at the time of billing. After a payment or denial is received from the state the write-off of the bad debt can be made if the debt is uncollectible.

This article is effective for cost reporting periods beginning on or after January 1, 2004.

Source:

JSM: 370

Dated: August 3, 2004

Medical Review Documentation Requirements

Documentation is one of the most important factors for claim reimbursement for medically reviewed claims. The determination of medical necessity of the service or if the service was actually provided is dependent on the information received from the provider. An Additional Development Request (ADR) solicits medical records needed for clinical review. The ADR includes a list of information needed for review of the items billed. The medical records must support the services and level of care provided. Insufficient documentation is one of the leading causes for denials. The Medical Review department reviews a wide spectrum of claims and documentation requirements vary. Most often the omission of documentation such as test results, physician's orders/certification, report of procedures, treatment plan, or history and physical are responsible. Always use the checklist on the ADR to assure that documentation supports the services billed. Title XVIII of the Social Security Act, SSA Section 1833(e) requires services to be documented and prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

If documentation is not up to standard to support your case, then denials of service may result. In addition to knowing Medicare regulations, it is important to be familiar with the Local Coverage Determinations (LCDs) published by CareFirst of MD, Inc. The LCDs outline criteria requirements for numerous medical, surgical, and diagnostic procedures. A section labeled DOCUMENTATION REQUIREMENTS is located in all LCDs. This is an excellent resource if a policy is applicable to any service billed on your claim.

Professional staff should sign and date their documentation using their credentials. Some services billed require the skills of a therapist. If the entry is not authenticated with the credentials of a therapist, the claim will be denied for not meeting Medicare requirements.

Provider education is paramount to CareFirst of MD, Inc. to reduce the denial rate and increase awareness of proper documentation to support services submitted. If you have any questions you can contact our Provider Service line at 1-866-488-0545.

MMA-Implementation of New Medicare Redetermination Notice

Providers Affected

All Medicare physicians, providers, and suppliers.

Provider Action Needed

Stop – Impact to You

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

Caution – What You Need to Know

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

Go-What You Need to Do

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

Background

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

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

Additional Information

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

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

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

Note: This article was revised on September 30, 2004, to show that providers and patients will receive the Medicare Redetermination Notice for any partially favorable or unfavorable decision made on a redetermination request made on or after October 1, 2004.

Related Change Request (CR) #: 2620

Medlearn Matters Number: MM2620

Related CR Release Date: February 6, 2004

Revised Related CR Transmittal #: R97CP

Effective Date: October 1, 2004

Implementation Date: July 6, 2004

Procedures for Additional Development Requests (ADRs) Related to Claims in Medical Review

The purpose of this article is to assist providers in identifying claims suspended for additional development by Medical Review and clarifying the process for submitting the requested documentation to Medical Review to ensure accurate and timely accounting of claims received. Following the recommended procedures below will assist Medical Review in adjudicating your claims through the system as quickly as possible.

Identifying ADR Claims

Claims will be suspended to status location SB6000 within one or two days of submission for additional development. The claim then moves to status location SB6001 and providers with Direct Data Entry (DDE) capabilities can access the ADR on line. To access the ADR:

- Go to the claim inquiry screen
- Place an "S" or "U" outside the claim in question and access the claim
- Locate the reason code beginning with a 5 (lower left corner)
- Place the cursor over the reason code and key F1 to view the ADR

If the provider does not have DDE capabilities, a hard copy ADR will be mailed to the provider two to five days after the day the claim went to SB6001. The ADR will identify the specific information that is needed to review the claim.

The claims will remain in the SB6001 status location to allow the provider 45 days to submit the documentation.

When documentation is received the claim will then be moved to status location SM5013. The claim will remain in the SM5013 location until it is adjudicated.

Providers have 30 days from the date that the ADR was generated to respond with medical records. In accordance with CMS instructions, if no documentation is received within 45 days, the claim will automatically deny with reason code – 56900 (failure to submit requested documentation). This denial will count against the provider's overall error rate and could result in a more intensive level of medical review.

It is the provider's responsibility to check the status of the claim to ensure that records were received and logged into the system. For further consideration of payment, the claim will have to go through the appeals process.

The appeals process will delay payment to the provider. We urge providers to **submit ALL requested documentation in a timely manner.**

What Can Providers Do To Help Claims Process Promptly

- Check status location SB6001 on a regular (daily) basis for applicable ADRs.
- Respond timely to all ADRs.

- Ensure all information that was requested on the ADR is included. Documentation requests are specific to individual reason codes (5XXXX).
- Attach a copy of the ADR to each individual set of medical records.
- If responding to multiple ADRs for the same beneficiary, **separate each response and attach a copy of the ADR to each individual set of medical records.**
- **Documentation for each claim should be separately identified.**
- **Multiple sets of documentation should not be bundled as one unit unless a cover sheet is attached indicating the number of claims enclosed in the packet.**
- Send documentation to:
CareFirst of MD, Inc.
Medicare Part A Medical Review
1946 Greenspring Drive
Timonium, MD 21093-4141
- Allow five working days mail time for posting and then check the SM5013 status location to ensure receipt of the information (this step is critical in the process). Notify Melanie Maxwell, Supervisor – Medical Review immediately at 410-561-4108 if your records have not been logged in as received (SM5013) so they will not auto deny with 56900.
- Regularly check the remittance advice for denied and paid claims.
- If a claim denies you will have to file an appeal.

The above steps will allow us to properly match information with each claim and to process claims promptly.

How Long Does It Take For Claims to Pay

- Claims are reviewed based on receipt of the requested documentation.
- Normal inventory averages 30 days of work on hand and therefore takes approximately 30 days for medical review to process after receipt of all information.
- Actual payment will be made on the next Tuesday after the claim is processed, due to the weekly payment requirement.

Note: Claims are received by medical review after passing all consistency edits. After medical review has performed their review, claims are subject to Medicare Secondary Payer (MSP) and Common Working File (CWF) (cable) edits. Claims that suspend for edits other than medical review will take additional time to process.

If you have any questions you can contact our Provider Service line at 1-866-488-0545.

Quality Improvement Organization Condition Codes

Effective immediately, all claims submitted with bill types 11X or 18X must have a condition code C1 through C7 submitted in the condition code field of the claim.

If the claim is not submitted with one of the following codes, it will be returned to the provider.

C1	Approved as Billed
C3	Partial Approval
C4	Admission/Services Denied
C5	Post payment Review Applicable
C6	Admission Preauthorization
C7	Extended Authorization

Guidelines for Cardiac Rehabilitation Coverage in the Outpatient Hospital Setting

Recent medical record review performed by CareFirst of MD, Inc., Medicare Part A Fiscal Intermediary has shown that there continues to be confusion about Medicare coverage criteria for cardiac rehabilitation services.

Definition

Cardiac rehabilitation is a comprehensive program of medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling designed to restore certain patients with coronary heart disease to active and productive lives. Cardiac rehabilitation, as described in the medical literature, is divided into three phases:

- Phase I - the immediate in-hospital post cardiac event phase
- Phase II - the outpatient post hospitalization recuperation phase
- Phase III - the long-term maintenance phase. **Phase III level programs are considered to be general maintenance programs by Medicare and are not covered**

This bulletin encompasses outpatient, post-hospital cardiac rehabilitation, or Phase II cardiac rehabilitation. The program consists of a series of supervised exercise sessions with continuous ECG monitoring. Clinically optimal results are expected if these sessions are conducted three times per week over a 12-week period.

Diagnoses

Cardiac rehabilitation is only covered for three groups of patients:

- Patients who begin the program within 12 months of an acute myocardial infarction (MI). The date of the MI must be documented in the medical record.
- Patients who are status post coronary artery bypass (CABG) surgery (no time restriction). The date of the CABG should be documented in the medical record.
- Patients with stable angina pectoris

The diagnosis of stable angina should be substantiated with a physician history, hospital discharge summary, or physician statement to confirm the diagnosis of stable angina (413.9). Elements of the history that are supportive of the diagnosis include a description of the patient's chest discomfort, the circumstances under which it occurs, and the methods used to relieve it. When the patient establishes a predictable pattern of chest pain, such that the angina can be reliably anticipated with certain activities, and that pattern has been stable for several months, the patient can be said to have "chronic stable angina". Of course, if the chest pain only occurs with activities that require marked exertion, there is no need for the patient to enlist in a cardiac rehabilitation program. Therefore, the documentation that would be useful would include that the patient has a pattern of symptoms that are likely to be improved by cardiac rehabilitation, and that the patient's status has been stable for over one month. Again, if the patient only develops chest pain with significant exertion, a cardiac rehabilitation program is not needed.

Regardless of the therapeutic or diagnostic interventions that may have occurred, a patient with the diagnosis of stable angina may be considered for cardiac rehabilitation. If a patient's stable angina resolves after undergoing coronary angioplasty and/or coronary artery stenting, then the patient is not eligible for cardiac rehabilitation. Likewise, if a patient's stable angina remains or returns after undergoing coronary artery angioplasty or stenting, then the patient may be considered for cardiac rehabilitation.

Analysis of data over the past several months indicates that ICD-9 diagnosis code 413.9, stable angina, has been used by some physicians to report not only patients who currently experience angina, but also for patients who have had an interventional procedure (angioplasty and/or stent) which has resolved their symptoms. If symptoms are no longer present, then cardiac rehabilitation is not available as a preventive measure.

These are the **only** diagnoses that are covered by Medicare at this time.

A patient with unstable angina does not qualify for cardiac rehabilitation services. In addition, congestive heart failure, post-heart or heart/lung transplant, status post coronary angioplasty, and post non-CABG cardiac surgery are not included as covered conditions for cardiac rehabilitation in CMS Pub 100-3, CH 1, §20.10, and cardiac rehabilitation for these conditions is excluded from coverage.

'Incident to' and Direct Supervision Requirements for Cardiac Rehabilitation

The "incident to" policy has several provisions, one of which is the "direct supervision" requirement. In order to be covered under the 'incident-to' benefit in an outpatient hospital department, services must be furnished as an integral, although incidental part of a physician's professional service in the course of diagnosis or treatment of an illness or injury. In order for a hospital or clinic staff to provide "incident to" services, *there must be a physician associated with the facility performing a service to which the staff's services are "incident."* In addition, "incident to" requires that the designated physician be directly involved in the care of the patient who is receiving the "incident to" services and that this physician, or another, directly supervises the service. The benefit does not require that a physician perform a personal professional service on each occasion of service by a non-physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program. The patient's medical record should reflect that the patient has seen a physician and that this physician has documented that the patient's treatment regimen and progress are meeting the patient's goals and plan of treatment for the patient. This documentation should be contained in the patient's medical record. Also, any alterations to the patient's program by the physician should be documented in the medical record.

"Direct supervision" requires that a physician, either the "incident to" physician, or another physician who is standing in for that physician, be present in the exercise program area while the exercise portion of Cardiac Rehabilitation is being performed. There can be some discretion as to what constitutes the "exercise program area," but it is presumed that it does not include the whole hospital. Generally, the Emergency Department is not considered part of the exercise program area. Because the physician must be available at all times, he or she cannot be simultaneously performing invasive procedures or employed in a position where invasive procedures are likely. First hand knowledge of ongoing activity is required

Examples may be helpful:

Scenario One: A community cardiologist performs an evaluation and sends her patient to a hospital Cardiac Rehabilitation Program. The program, which does not have an onsite medical director, uses the cardiologist's evaluation and orders to initiate the Cardiac Rehabilitation services. The doctor in the emergency room is listed on a bulletin board in the exercise program area as the person to call in the case of an emergency.

Comments: In this instance, the Cardiac Rehabilitation Program cannot bill Medicare for the services provided. The "incident to" provision has not been met, in that, although the program personnel are employed by the hospital, the physician is not, and therefore the services provided cannot be incident to her. In addition, the doctor designated for responding to emergencies is not in the exercise program area.

Scenario Two: The program above hires a medical director.

This doctor is either on site, or is signed out to another doctor who remains in the exercise program area whenever the medical director is absent. The exercise program area is defined as the immediate exercise room, and the adjacent cardiology suite which is across the hall. In this scenario, a community cardiologist sees a patient, does a full workup, and writes out a prescription for cardiac rehabilitation. The patient comes to the facility and is examined and evaluated by the medical director who concurs with the diagnosis and prescribed therapy. He writes a note to that effect, and signs a personalized treatment plan developed for the patient.

Comments: In this instance, the patient has arrived with all the information needed to begin the Cardiac Rehabilitation Program. However, the service is being provided incident to the medical director of the facility, and therefore he establishes direct personal contact with the patient. Additionally, because this program has a protocol which assures the presence of a physician in the exercise program area, both "incident to" and "direct supervision" requirements have been met.

Note: It is perhaps helpful to understand that the "incident to" and "direct supervision" requirements are not entirely medical safety issues. They are also legal requirements. The Social Security Act requires that Medicare payable services belong to a benefit category. Cardiac Rehabilitation Programs only fall under a benefit category when the services are provided under direct supervision of a physician.

Stress Test

A prospective candidate for a cardiac rehabilitation program must be evaluated for his suitability to participate. A valuable diagnostic test for this purpose is the stress test. A Cardiac Rehabilitation program may include a stress test, or it may accept one performed by the patient's attending physician.

All patients must have a pre-entry stress test that is positive for exercise-induced ischemia.

Nursing Assessment

For an initial evaluation to be separately billable, it must be performed by a physician. The physician would bill Medicare Part B with the code that best represents the service performed and the facility charge would be billed to Part A in the same manner as any other physician service.

Nursing assessments are an integral part of assessing and monitoring the patient's cardiovascular status as well as the progress made during the cardiac rehab program. However, nursing assessments are not separately billable. All services provided during cardiac rehab are covered within the cardiac rehab HCPCS code.

Physician Orders

The documentation should include physician's orders or script signed and dated prior to the start of care.

ECG Rhythm Strips

Monitoring ECG rhythm strips constitutes an important and necessary procedure which should be done while the cardiac patient is engaged in the exercise program. Documentation should include the rhythm strips for each session billed.

Frequency and Duration

CMS Pub 100-3, CH 1, §20.10 defines the usual duration of CR by stating that "services provided in connection with a cardiac rehabilitation exercise program may be considered reasonable and necessary for up to 36 sessions, usually 3 sessions a week in a single 12 week period. Coverage for continued participation in cardiac exercise programs beyond 12 weeks would be allowed only on a case-by-case basis with exit criteria taken into consideration." In monitoring this, several points should be considered:

1. Coverage is limited, except on a case by case basis, to twelve weeks
 - a) In counting weeks, CareFirst of MD, Inc. would not consider interruptions for reasons of health (e.g., re-hospitalization, episode of illness, etc) to be part of the 12 week span and will automatically allow exception to the 12 week (but not the 36 session) limitation.
 - b) If the cardiac rehab program is interrupted for unforeseen reasons (patient fatigue, necessary travel, etc.), CareFirst of MD, Inc. would not consider the interruption to be part of the 12 week span and will automatically allow exception to the 12 week (but not the 36 session) limitation.
 - c) Holidays, vacations and inclement weather do not impact the 12 week limitation.
2. Coverage is limited, except on a case by case basis, to thirty six sessions regardless of the number of weeks.
3. Interruptions in a cardiac rehab program do not reset the 36 session limitation although they may allow additional sessions on a case by case basis.
 - a) If the beneficiary starts cardiac rehab, is interrupted for reasons of health or any other reason and then restarts the program, the count of sessions should continue where it left off.
 - b) If the beneficiary starts cardiac rehab, is interrupted by a second qualifying event (cardiac surgery or acute MI) and then restarts the program, the count of sessions should continue where it left off.
 - c) If the beneficiary starts cardiac rehab, stops the program for any reason and then restarts the program with a different provider, the count of sessions should continue where it left off. It is therefore incumbent upon cardiac rehabilitation providers to obtain medical records from past cardiac rehabilitation providers.
4. If the beneficiary completes 36 sessions of a cardiac rehab program and then has a second qualifying event (cardiac surgery or acute MI), additional sessions may be appropriate on a case by case basis depending on medical necessity.

Documentation Requirements

Following is a list of the information that should be maintained and made available to Medicare upon request. All applicable documentation of medical necessity must be provided. This documentation must be legible and should include, but is not limited to:

- Physician orders
- History and physical
- Initial evaluation and reevaluations
- Plan of treatment
- Progress notes
- Attendance records
- Initial stress test
- ECG rhythm strips
- Short delays in the program (e.g., absence due to other medical illnesses) must be clearly documented
- All claims with the diagnosis of stable angina require additional medical documentation to support the diagnosis of stable angina
- Medical necessity for extended programs must be clearly documented
- Ideally, the supervising physician should be listed on each patient's daily exercise note, even if he or she did not see the patient on that day. (A physician's signature is not required, but could be useful to document compliance with the "direct physician supervision" requirement.)

Additionally, each Cardiac Rehabilitation Program should have documentation that assures that "incident to," and "direct supervision" requirements are being met. A standard operating procedure that requires that there is an appropriate facility-based physician involved in the care of every patient, and that guarantees that a designated physician is available each time Cardiac Rehabilitation is performed, would be helpful to reviewers.

If you have any questions you can contact Janice Austin, RN at 410-561-4158.

Guidelines for Billing Evaluation/Management Services in the Hospital Outpatient Setting

The purpose of this bulletin is to clarify proper billing of HCPCS codes used for outpatient Evaluation/Management (E/M) services. CareFirst of MD Inc., Medicare Part A Fiscal Intermediary has an active medical policy parameter in place to review E/M services billed with units greater than one. Medical review denials are primarily due to failure to support separate and distinct visits on the same date of service. Report condition code G0 when **distinct and independent visits** on the same day in the same revenue center occur (e.g., seen in Emergency Room twice in one day).

We recently completed data analysis of the use of HCPCS 99201-99215 and HCPCS 99281-99285 (revenue codes 450/451/452/510). Coding irregularities were identified with multiple providers resulting in a significant error rate. Appropriate coding of E/M services involves the assessment of all services provided during that visit. In an effort to arrive at the correct level of service, the most common practice is to **report a *single visit code*** per day, assessing all E/M services provided to arrive at the correct level of service. Visits with more than one health professional and multiple visits with the same health professional that take place during the same session and at a single location within the hospital constitute a *single visit* (CMS Pub 100-4, 25-\$60,FL46).

Our overall goal is to ensure proper billing practices so that claims will be submitted and paid correctly.

Any questions should be addressed to your Provider Representative at 1-866-488-0545. Medical Review will closely monitor submission of these codes for correct format.

Override of Medicare System Edit for Observation Services Exceeding 48 Hours

Provider Types Affected

Hospitals

Provider Action Needed

Stop – Impact to You

Medicare system edits do not allow claims to be paid for observation services greater than 48 hours.

Caution – What You Need to Know

When the hours are found to be reasonable and necessary, Fiscal Intermediaries (FIs) will be able to override the Medicare system edits on affected hospital outpatient claims submitted with units of services for observation greater than 48 hours.

Go-What You Need to Do

You must give the beneficiary an Advance Beneficiary Notice (ABN) per the Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections, 40.3.1, if you submit claims for observation services greater than 48 hours.

Background

Currently, Medicare edits do not allow claims greater than 48 hours that are submitted showing the units of service for observation (Revenue Code 0762) for processing. The FI suspends the claim and will request complete medical documentation to review the medical necessity of all observation services billed.

If additional hours are not found to be reasonable and necessary, all hours beyond 48 hours are denied and shown as a non-covered service on the claim. However, if the hours are found to be reasonable and necessary the claims can not be processed at this time for payment due to the Medicare system edit. Changes will be made by Medicare to allow the edit to be overridden to allow payment of these claims as of April 1, 2005.

Additional Information

For details on policy see Section 70.4 of the Medicare Benefit Policy Manual.

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

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

Related Change Request (CR) #: 3311

Medlearn Matters Number: MM3311

Related CR Release Date: October 22, 2004

Related CR Transmittal #: 120

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

MMA - Payment for Emergency Medical Treatment and Labor Act (EMTALA)-Mandated Screening and Stabilization Services

Provider Types Affected

Hospitals, including critical access hospitals (CAHs)

Provider Action Needed

While voluntary, it is to the provider's benefit to bill presenting symptoms or complaints in addition to the principal diagnosis. To ensure you are paid appropriately for your services, you may use Form Locator 76 of the UB-92 claim form to bill for the ICD-9-CM code that represents the patient's reason for the visit. Although only one diagnosis code for the reason for the visit may be recorded in Form Locator 76, at the provider's discretion additional diagnoses not inherent in the final diagnosis may be reported in Form Locators 68 through 75. Providers may use these fields when billing for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with Revenue Codes 45X, 0516, or 0526 to ensure appropriate payment. We support hospitals' efforts to educate physicians on documentation to support correct coding, and contractors should assist hospitals in providing this education when requested.

This instruction is pursuant to Section 1867 of the Social Security Act (EMTALA) for services provided on or after January 1, 2004.

Background

This instruction addresses implementation of provisions contained in the Medicare Modernization Act (MMA) regarding payment for EMTALA-mandated screening and stabilization services.

The MMA (Section 944(a)) requires that determinations of whether items and services provided in emergency departments (EDs) are reasonable and necessary 1) be made on the basis of information available to the treating physician or practitioner at the time the item or service was ordered or furnished by the physician or practitioner, and 2) take into consideration the patient's presenting symptoms or complaint, and not only on the patient's principal diagnosis. The frequency with which a patient receives a service may not be considered.

To ensure that current Local Medical Review Policies (LMRPs)/Local Coverage Determinations (LCDs) do not inappropriately deny ED claims, fiscal intermediaries (FIs) have been instructed as a result of the related change request to discontinue LMRP/LCD frequency edits for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with Revenue Codes 45X, 0516, or 0526 to ensure appropriate payment.

While the frequency with which a patient receives a service before and after admission may not be considered, medical review can be targeted at potentially aberrant ED billing, but decisions must be based on the information available to the ED physician, including the patient's presenting conditions, as required by the MMA provision.

In the past some hospitals have been hesitant to submit the full array of diagnosis codes, believing they conflict with existing coverage policies. Consistent with the law, hospitals may now submit the codes related to the patient's presenting symptoms or complaints. For further discussion of when a claim would be considered fraudulent, see http://www.cms.hhs.gov/manuals/108_pim/pim83c04.pdf.

In summary, providers should be aware that Medicare FIs will, as of the implementation date of the related instruction:

- Consider the diagnoses in Form Locator 76 and Form Locators 68-75 for payment decisions and may target medical review at ED billing, when data indicates there may be a problem
- Make decisions based on the information available to the ED physician or practitioner, including the patient's presenting conditions, when performing medical review
- Discontinue automated frequency edits resulting from LMRPs/LCDs with a 45X, 0516, or 0526 Revenue Code, or for items or services, including diagnostic tests, performed under EMTALA, to ensure that current LMRPs/LCDs do not inappropriately deny ED claims
- Reopen claims for ED services provided on or after January 1, 2004 that were denied prior to the issuance of this instruction if the provider so requests.

Implementation

The implementation date for this instruction is November 22, 2004.

Additional Information

Hospitals should be aware that the Medicare Program Integrity Manual (Pub 100-08), Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 5.1.1 (Prepayment Edits), is being revised. The updated manual instructions are attached to the official instruction released to your intermediary. You may view that instruction at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3437 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, contact your intermediary at their toll-free number, which may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>

Related Change Request (CR) #: 3437

Medlearn Matters Number: MM3437

Related CR Release Date: October 22, 2004

Related CR Transmittal #: 84

Effective Date: November 22, 2004

Implementation Date: November 22, 2004

Percutaneous Transluminal Angioplasty (PTA)

Provider Types Affected

Hospitals, physicians, and suppliers.

Provider Action Needed

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

Background

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

PTA is covered to treat atherosclerotic obstructive lesions:

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

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

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

Additional Information

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

In addition, providers billing carriers:

- Place no more than one Pre-Market Approval (PMA) number (that begins with a “P”) in either item 23 of the CMS-1500 paper claim format or in the 2300 Investigational Device Exemption (IDE) Number Ref Segment, data element REF02 (REF01=LX) of the 837p claim format
- Use the QA modifier to reflect PTA post-approval study devices claim
- Use 37799, unlisted procedure, vascular surgery, as the procedure code
- Use 433.10 as the diagnostic code For providers billing FIs:
- Place no more than one PMA number (that begins with a “P”) in form locator 43 of the CMS-1450 paper form or in 2300 IDE Number Ref Segment, data element REF02 (REF01=LX) of the 837i
- Use revenue code 0624 for post-approval study devices in form locator 42 of the CMS-1450 paper claim form or 2400 Institutional Service Line SV201 Segment, data element 234 of the 837i
- Use 433.10 as the diagnostic code
- Use the inpatient procedure codes of 39.50 (angioplasty or atherectomy of non-coronary vessel) and 39.90 (insertion of non-coronary artery stent or stents) The official instruction issued to your carrier regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals.comm_date_dsc.asp.

From that web page, look for CR 3489 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please call your carrier/intermediary at their toll free number at:

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

Related Change Request (CR) #: 3489

Medlearn Matters Number: MM3489

Related CR Release Date: October 15, 2004

Related CR Transmittal #: 314 and 25

Effective Date: October 12, 2004

Implementation Date: October 12, 2004

Treatment of Obesity

Provider Types Affected

All Providers.

Provider Action Needed

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

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

Background

Nationally Covered Indications

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

Nationally Noncovered Indications

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

Other

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

Implementation

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

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3502 in the CR NUM column on the right and click on the file for that CR. Attached to CR 3502 is the actual revised language for the Medicare NCD Manual.

If you have any questions, please contact your Medicare contractor at:

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

Related Change Request (CR) #: 3502

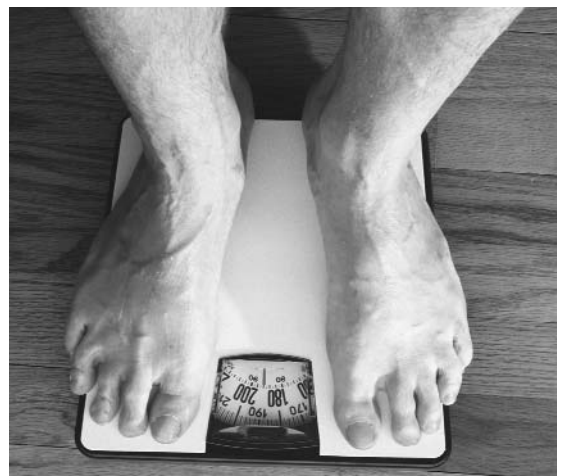
Medlearn Matters Number: MM3502

Related CR Release Date: October 1, 2004

Related CR Transmittal #: 23

Effective Date: October 1, 2004

Implementation Date: October 1, 2004



Expanded Coverage for PET Scans

Provider Types Affected

Physicians

Provider Action Needed

On April 16, 2003, the Centers for Medicare & Medicaid Services (CMS) announced its intent to expand coverage of positron emission tomography (PET) for Medicare beneficiaries with thyroid cancer and heart disease. This expanded coverage enhances physicians' current evaluative options, and is an example of CMS's commitment to making new medical technologies available to its beneficiaries when evidence is adequate to conclude that the technology is reasonable and necessary for diagnosis or treatment of an illness.

Background

Thyroid Cancer

Thyroid cancer constitutes less than one percent of all human malignant tumors. In a small number of these patients, the usually accurate Iodine-131 whole body scan is not helpful in identifying recurrent disease following initial treatment. In these patients, CMS determined that the evidence is adequate to conclude that PET is reasonable and necessary, with certain limitations, for management of patients with recurrent thyroid cancer.

Cardiac Disease

Cardiovascular disease is a broad term encompassing such conditions as hypertension, coronary artery disease, and congestive heart failure. These conditions cause significant morbidity and mortality in the Medicare population. CMS determined that the evidence is adequate to conclude that cardiac imaging with PET, using the radiopharmaceutical ammonia N-13, is reasonable and necessary, with certain limitations, for the diagnosis and management of patients with known or suspected coronary artery disease.

PET Coverage Not Expanded

Alzheimer's Disease

Alzheimer's disease (AD) is an age-related and irreversible brain disorder that occurs gradually and results in memory loss, behavior and personality changes, and a decline in thinking abilities. AD is the most common cause of dementia, representing approximately two-thirds of cases. PET has been proposed as a diagnostic tool in the management of patients with AD. CMS's review of the evidence concluded that PET did not improve patient outcomes in this group of beneficiaries and, therefore, CMS will continue its present noncoverage policy. The clinical benefit of using PET for patients with AD has not been demonstrated. To provide the best of emerging medical technology for Medicare beneficiaries, Medicare covers clinical evaluation of cognitive impairment, as recommended by the American Academy of Neurology. At present, the available scientific evidence indicates that clinical evaluation remains the most appropriate approach for diagnosis and management of AD. CMS will design a demonstration to evaluate the appropriate role of PET for patients with suspected dementia. CMS will work with the National Institutes of Health to convene a multidisciplinary expert meeting with geriatricians, neurologists, radiologists, PET experts, and patient advocates to fully explore the value of PET for AD.

Soft Tissue Sarcoma

CMS has decided against expanding coverage of PET for soft tissue sarcoma, a rare type of cancer for which current imaging techniques have good diagnostic capabilities. CMS determined that the evidence was not adequate to conclude that PET for soft tissue sarcoma was reasonable and necessary and, therefore, CMS will continue its current noncoverage policy.

Additional Information

Other Coverage

Medicare covers PET, with certain limitations, for the diagnosis, staging and restaging of various cancers, including lung, esophageal, colorectal, lymphoma, head and neck, and breast along with myocardial viability and presurgery evaluation of refractory seizures.

Source:

Medlearn Matters Number: SE0319

Magnetic Resonance Spectroscopy (MRS) for Diagnosing Brain Tumors

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

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

Background

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

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

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

Implementation

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

Additional Information

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

From that Web page, look for CR3425 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3425

Medlearn Matters Number: MM3425

Related CR Release Date: September 10, 2004

Related CR Transmittal #: 21

Effective Date: September 10, 2004

Implementation Date: September 10, 2004

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

Provider Types Affected

Physicians and providers.

Provider Action Needed

This instruction notifies physicians and providers that Medicare will provide coverage for 2-deoxy-2- [F-18] fluoro-D-glucose (FDG)-PET scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least 6 months duration. This service may be covered:

- When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and Alzheimer's disease (AD) under specific requirements, **or**
- For use in a Centers for Medicare & Medicaid Services (CMS)-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

Background

Effective for dates of service on or after September 15, 2004, Medicare will provide coverage for FDG Positron Emission Tomography PET for one of the following:

- When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and Alzheimer's disease; **or**
- When used in a CMS-approved practical neurodegenerative disease clinical trial.

Clinical trial results are expected to help in determining if PET scans contribute to the effective diagnosis and treatment of Medicare beneficiaries with mild cognitive impairment or early dementia, and add information that will help monitor, evaluate, and improve clinical outcomes of patients with this disease.

Refer to the Medicare Claims Processing Manual, Publication 100-04, Chapter 13, Section 60, for general Medicare coverage and billing requirements for PET scans for dementia and neurodegenerative diseases.

Also, refer to the Medicare National Coverage Determinations (NCD) Manual, Publication 100-03, Section 220.6 for complete coverage policy and clinical trial requirements. The revision to the NCD Manual, Pub. 100-03, Section 220.6 is an NCD. NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans.

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

Key portions of these revised manuals are as follows:

FDG-PET Requirements for Use in the Differential Diagnosis of AD and FTD

According to the NCD on this issue, Medicare covers FDG-PET scans for either a) the differential diagnosis of both FTD and Alzheimer's disease AD under specific requirements or, b) its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

For use in the differential diagnosis of FTD and AD, an FDG-PET scan is considered reasonable and necessary for patients with a recent diagnosis of dementia and documented cognitive decline of at least 6 months, who meet diagnostic criteria for both AD and FTD. These patients have been evaluated for specific alternative neurodegenerative diseases or causative factors, but the cause of the clinical symptoms remains uncertain.

The following additional conditions must be met before an FDG-PET scan can be ordered:

- a. The patient's onset, clinical presentation, or course of cognitive impairment is such that FTD is suspected as an alternative neurodegenerative cause of the cognitive decline. Specifically, symptoms such as social disinhibition, awkwardness, difficulties with language, or loss of executive function are more prominent early in the course of FTD than the memory loss typical of AD;

- b. The patient has had a comprehensive clinical evaluation (as defined by the American Academy of Neurology (AAN)) encompassing a medical history from the patient and a well-acquainted informant (including assessment of activities of daily living), physical and mental status examination (including formal documentation of cognitive decline occurring over at least 6 months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging (MRI) or computed tomography (CT);
- c. The evaluation of the patient has been conducted by a physician experienced in the diagnosis and assessment of dementia;
- d. The evaluation of the patient did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment;
- e. The FDG-PET scan is performed in a facility that has all the accreditation necessary to operate nuclear medicine equipment. The reading of the scan should be done by an expert in nuclear medicine, radiology, neurology, or psychiatry, with experience interpreting such scans in the presence of dementia;
- f. A brain single photon emission computed tomography (SPECT) or FDG-PET scan has not been obtained for the same indication.

The indication can be considered to be different in patients who exhibit important changes in scope or severity of cognitive decline, and meet all other qualifying criteria listed above and below (including the judgment that the likely diagnosis remains uncertain). The results of a prior SPECT or FDG-PET scan must have been inconclusive or, in the case of SPECT, difficult to interpret due to immature or inadequate technology. In these instances, an FDG-PET scan may be covered after 1 year has passed from the time the first SPECT or FDG-PET scan was performed.

- g. The referring and billing provider(s) have documented the appropriate evaluation of the Medicare beneficiary. Providers should establish the medical necessity of an FDG-PET scan by ensuring that the following information has been collected and is maintained in the beneficiary medical record:
 - Date of onset of symptoms;
 - Diagnosis of clinical syndrome (normal aging; mild cognitive impairment or MCI; mild, moderate or severe dementia);
 - Mini mental status exam (MMSE) or similar test score;
 - Presumptive cause (possible, probable, uncertain AD);
 - Any neuropsychological testing performed;
 - Results of any structural imaging (MRI or CT) performed;
 - Relevant laboratory tests (B12, thyroid hormone); and,

Number and name of prescribed medications.

- The billing provider must furnish a copy of the FDG-PET scan result for use by CMS and its contractors upon request.

These services should be billed with HCPCS code of G0336 (Pet imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. FTD).

FDG-PET Requirements for Use in the Context of a CMS-Approved Neurodegenerative Disease Practical Clinical Trial Utilizing Specific Protocol

With regard to use of the FDG-PET in the context of a CMS-approved clinical trial, the clinical trial must compare patients who do and those who do not receive an FDG-PET scan and have as its goal to monitor, evaluate, and improve clinical outcomes. In addition, it must meet the following basic criteria:

- Written protocol on file;
- Institutional Review Board review and approval;
- Scientific review and approval by two or more qualified individuals who are not part of the research team; and
- Certification that investigators have not been disqualified.

Physicians should note that a **QV** modifier must be used when billing Medicare carriers for a CMS-approved neurodegenerative disease practical clinical trial. In addition, on such claims from trials that are billed to Medicare intermediaries, a second diagnosis code (ICD-9) of **V70, 7**, along with the appropriate principal diagnosis code and **HCPCS code G0336** must be entered on the CMS-1450 or its electronic equivalent. There will be a link on the cms.hhs.gov/coverage website that will have a list of all the participating trial facilities once they have been selected.

Implementation Date

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

Additional Information

As previously mentioned, the Medicare Claims Processing Manual (Pub. 100-04), Chapter 13 (Radiology Services), Section 60 (Positron Emission Tomography (PET) Scans) is being updated by this instruction. It includes billing and claims processing requirements for PET Scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least 6 months duration who meet diagnostic criteria for both FTD and AD, or its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

In addition, the Medicare NCD Manual (Pub. 100-03), Chapter 1 (Coverage Determinations) Section 220 (Radiology), Subsection 6 (Positron Emission Tomography (PET)) Scans, is being updated by this instruction to include complete coverage policy and requirements for related clinical trials. These updated manual instructions are included in the official instruction issued to your carrier/intermediary, which can be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR 3426 in the CR NUM column on the right, and click on the file for that CR.

If you have questions, please contact your intermediary at their toll-free number, which may be found at:

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

Related Change Request (CR) #: 3426

Medlearn Matters Number: MM3426

Related CR Release Date: October 1, 2004

Related CR Transmittal #: 24

Effective Date: September 15, 2004

Implementation Date: October 4, 2004

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

Provider Types Affected

Hospitals, Providers, and Independent ESRD Facilities

Provider Action Needed

Stop – Impact to You

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

Caution – What You Need to Know

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

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

Background

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

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

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

Implementation Date

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

Additional Information

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

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

For hospital Outpatient Prospective Payment System (OPPS), the payment rate for Advate can be found in the latest quarterly update of the OPPS Outpatient Code Editor that is posted on the CMS OPPS website. The CMS Hospital Outpatient Prospective Payment System website can be found at: <http://www.cms.hhs.gov/providers/hopps/>

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

Related Change Request (CR) #: 3426

Medlearn Matters Number: MM3426

Related CR Release Date: October 1, 2004

Related CR Transmittal #: 24

Effective Date: September 15, 2004

Implementation Date: October 4, 2004

Tubing and Other Supplies Used for the Administration of Separately Payable Drugs

This information applies to freestanding ESRD facilities only. If you are infusing a separately payable drug, the supplies to infuse the drug should be billed under the appropriate HCPCS or A4913 "Miscellaneous Dialysis Supplies, not otherwise specified".

If you are billing A4913 a detailed description of the tubing is required, including size and manufacturer. You must also provide the amount paid for the tubing from the supplier. The description and the price of the tubing needs to be keyed into the remarks field on page 4 of direct data entry.

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

Implementation Date

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

Related Instructions

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

Additional Information

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

From that web page, look for CR 3418 in the CR NUM column on the right, and then click on the file for that CR.

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

Related Change Request (CR) #: 3418

Medlearn Matters Number: MM3418

Related CR Release Date: August 27, 2004

Related CR Transmittal #: 110

Effective Date: January 1, 2004

Implementation Date: September 27, 2004

MMA Drug Pricing Update – Payment Limit for J9045 (Carboplatin Injection) and J9310 (Rituximab Cancer Treatment)

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

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

Background

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

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

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

Implementation Date

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

Additional Information

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

From that Web page, look for CR3419 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier at their toll-free number, which may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>

Related Change Request (CR) #: 3419

Medlearn Matters Number: MM3419

Related CR Release Date: August 24, 2004

Related CR Transmittal #: 106

Effective Date: April 1, 2004

Implementation Date: September 24, 2004

MMA - Drugs Paid by Average Selling Price Beginning January 1, 2005

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

Physicians, suppliers, and providers should note that beginning January 1, 2005, the payment limit for Part B drugs and biologicals, not paid on a cost or prospective payment basis, will be paid based on the Average Sales Price (ASP) plus 6 percent. Drugs will be paid based on date of service and the lower of:

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

Background

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

This instruction notifies contractors (Part B Local Carriers and Durable Medical Equipment Carriers (DMERCs)) that the MMA mandates that drugs and biologicals not paid on a cost or prospective payment basis are to be paid based on the ASP beginning January 1, 2005.

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

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

Finally, contractors will:

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

Implementation

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

Related Instructions

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

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

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

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

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3232 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>

Related Change Request (CR) #: 3232

Medlearn Matters Number: MM3232

Related CR Release Date: July 23, 2004

Related CR Transmittal #: 248

Effective Date: August 23, 2004

Implementation Date: January 3, 2005

MMA - January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2005

Provider Types Affected

All providers

Provider Action Needed

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

Background

According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005 drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the Average Sales Price (ASP) plus six (6) percent. The Centers for Medicare & Medicaid Services (CMS) will supply its carriers/intermediaries with the ASP drug pricing file for Medicare Part B drugs. The ASP is based on quarterly drug information supplied to CMS by drug manufacturers.

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

Exceptions

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

1. The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
2. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted. The payment allowance limits will not be updated in 2005.
3. The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
4. The payment allowance limits for drugs not included in the ASP Medicare Part B Drug Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing.

Note that the absence or presence of a HCPCS code and its associated payment limit in the ASP files does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Implementation

The implementation date is January 3, 2005.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3539 in the CR NUM column on the right and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:

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

Related Change Request (CR) #:3539

Medlearn Matters Number: MM3539

Related CR Release Date: October 29, 2004

Related CR Transmittal #: 348

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

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

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

Background

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

The alpha-numeric index and the table of drugs will be posted to the CMS web site by the end of October. The CMS web site address for that posting will be: <http://www.cms.hhs.gov/providers/pufdownload/default.asp#alphanu>

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

Implementation

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

Additional Information

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

From that Web page, look for CR3422 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:

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

Related Change Request (CR) #: 3422
Medlearn Matters Number: MM3422
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 283
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Full Replacement of CR 3415, 3rd Update to the 2004 Medicare Physician Fee Schedule Database. CR 3415 Is Rescinded

Provider Types Affected

Physicians, providers, and suppliers.

Provider Action Needed

Physicians, providers, and suppliers should note the changes to the Medicare Physician Fee Schedule Database and identify those changes that affect their practice.

Background

Payment files were issued to carriers based upon the November 7, 2003 and January 7, 2004 Final Rules. This instruction amends those payment files and replaces CR 3415.

Changes to the PC/TC indicator for these codes should not have been included.

CR 3415 included changes to the Professional Component/Technical Component (PC/TC) indicator for Current Procedural Terminology (CPT) codes 96400, 96408, 96425, 96520, and 96530 from a 5 to 0.

Implementation

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

Additional Information

The actual changes to the fee schedule involve numerous CPT/HCPCS codes and the actual effective dates vary. These changes to the revised 3rd Update to the 2004 Medicare Physician Fee Schedule Database are described in the following table.

Changes to Revised 3rd Update to the 2004 Medicare Physician Fee Schedule Database

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

CPT/HCPCS	ACTION
	<p>Assistant at Surgery Indicator =9 Co-Surgery Indicator = 0 Team Surgery Indicator = 0 Type of Service = 4 Diagnostic Supervision = 9 Note: Effective for services performed on or after September 15, 2004</p>
G0336 - 26	<p>Description: PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. fronto-temporal dementia Short Descriptor: PET imaging brain Alzheimer's Procedure Status = A WRVU = 1.50 Non-Facility PE RVU = .51 Facility PE RVU = .51 Malpractice RVU = .05 PC/TC = 1 Site of Service = 1 Global Surgery = XXX Multiple Procedure Indicator = 0 Bilateral Procedure Indicator = 0 Assistant at Surgery Indicator = 9 Co-Surgery Indicator = 0 Team Surgery Indicator = 0 Type of Service = 4 Diagnostic Supervision = 9 Note: Effective for services performed on or after September 15, 2004</p>
G0341	<p>Description: Percutaneous islet cell transplant, includes portal vein catheterization and infusion (To report imaging bill 75887 or 75885) Short Descriptor: Percutaneous islet cell trans Procedure Status = A WRVU = 6.98 Non-Facility PE RVU = 2.73 Facility PE RVU = 2.73 Malpractice RVU = 0.48 PC/TC = 0 Site of Service = 1 Global Surgery = 000 Multiple Procedure Indicator = 2 Bilateral Procedure Indicator = 0 Assistant at Surgery Indicator = 9 Co-Surgery Indicator = 1 Team Surgery Indicator = 0 Type of Service = 2 Diagnostic Supervision = 9 Note: Effective for services performed on or after October 1, 2004</p>
G0342	<p>Description: Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion Short Descriptor: Laparoscopy Islet cell Trans Procedure Status = A WRVU = 11.92 Non-Facility PE RVU = 5.32 Facility PE RVU = 5.32 Malpractice RVU = 1.46 PC/TC = 0 Site of Service = 1 Global Surgery = 090 Pre Op = 0.09 Intra Op = 0.81 Post Op = 0.10 Multiple Procedure Indicator = 2 Bilateral Procedure Indicator = 0 Assistant at Surgery Indicator = 2 Co-Surgery Indicator = 1 Team Surgery Indicator = 0 Type of Service = 2 Diagnostic Supervision = 9 Note: Effective for services performed on or after October 1, 2004</p>
G0343	<p>Description: Laparotomy for islet cell transplant, includes portal vein catheterization and infusion Short Descriptor: Laparotomy Islet cell transp Procedure Status = A WRVU = 19.85 Non-Facility PE RVU = 8.82 Facility PE RVU = 8.82 Malpractice RVU = 2.05 PC/TC = 0 Site of Service = 1 Global Surgery = 090 Pre Op = 0.09 Intra Op = 0.81 Post Op = .10 Multiple Procedure Indicator = 2</p>

CPT/HCPCS	ACTION
	Bilateral Procedure Indicator = 0 Assistant at Surgery Indicator = 2 Co-Surgery Indicator = 1 Team Surgery Indicator = 0 Type of Service = 2 Diagnostic Supervision = 9 Note: Effective for services performed on or after October 1, 2004
23410	Bilateral Status Indicator = 1
33979	Bilateral Status Indicator = 0
33980	Bilateral Status Indicator = 0
52320	Endobase Code = 52000
52325	Endobase Code = 52000
52327	Endobase Code = 52000
52327	Bilateral Status Indicator = 1
52330	Endobase Code = 52000
52332	Endobase Code = 52000
52334	Endobase Code = 52000
52341	Endobase Code = 52000
52342	Endobase Code = 52000
52343	Endobase Code = 52000
52344	Endobase Code = 52000
69440	Bilateral Surgery Indicator = 1
69450	Bilateral Surgery Indicator = 1
69501	Bilateral Surgery Indicator = 1
69502	Bilateral Surgery Indicator = 1
69505	Bilateral Surgery Indicator = 1
69511	Bilateral Surgery Indicator = 1
69530	Bilateral Surgery Indicator = 1
69535	Bilateral Surgery Indicator = 1
69540	Bilateral Surgery Indicator = 1
69550	Bilateral Surgery Indicator = 1
69552	Bilateral Surgery Indicator = 1
69554	Bilateral Surgery Indicator = 1
69601	Bilateral Surgery Indicator = 1
69602	Bilateral Surgery Indicator = 1
69603	Bilateral Surgery Indicator = 1
69604	Bilateral Surgery Indicator = 1
69605	Bilateral Surgery Indicator = 1
69610	Bilateral Surgery Indicator = 1
69620	Bilateral Surgery Indicator = 1
69631	Bilateral Surgery Indicator = 1
69632	Bilateral Surgery Indicator = 1
69633	Bilateral Surgery Indicator = 1
69635	Bilateral Surgery Indicator = 1
69636	Bilateral Surgery Indicator = 1
69637	Bilateral Surgery Indicator = 1
69641	Bilateral Surgery Indicator = 1
69642	Bilateral Surgery Indicator = 1
69643	Bilateral Surgery Indicator = 1
69644	Bilateral Surgery Indicator = 1

Maryland Medicare Part A

CPT/HCPCS	ACTION
69645	Bilateral Surgery Indicator = 1
69646	Bilateral Surgery Indicator = 1
69650	Bilateral Surgery Indicator = 1
69660	Bilateral Surgery Indicator = 1
69661	Bilateral Surgery Indicator = 1
69662	Bilateral Surgery Indicator = 1
69666	Bilateral Surgery Indicator = 1
69667	Bilateral Surgery Indicator = 1
69670	Bilateral Surgery Indicator = 1
69700	Bilateral Surgery Indicator = 1
69711	Bilateral Surgery Indicator = 1
69714	Bilateral Surgery Indicator = 1
69715	Bilateral Surgery Indicator = 1
69717	Bilateral Surgery Indicator = 1
69718	Bilateral Surgery Indicator = 1
69720	Bilateral Surgery Indicator = 1
69725	Bilateral Surgery Indicator = 1
69740	Bilateral Surgery Indicator = 1
69745	Bilateral Surgery Indicator = 1
69799	Bilateral Surgery Indicator = 1
69801	Bilateral Surgery Indicator = 1
69802	Bilateral Surgery Indicator = 1
69805	Bilateral Surgery Indicator = 1
69806	Bilateral Surgery Indicator = 1
69820	Bilateral Surgery Indicator = 1
69840	Bilateral Surgery Indicator = 1
69905	Bilateral Surgery Indicator = 1
69910	Bilateral Surgery Indicator = 1
69915	Bilateral Surgery Indicator = 1
69930	Bilateral Surgery Indicator = 1
69949	Bilateral Surgery Indicator = 1
69950	Bilateral Surgery Indicator = 1
69955	Bilateral Surgery Indicator = 1
69960	Bilateral Surgery Indicator = 1
69970	Bilateral Surgery Indicator = 1
69979	Bilateral Surgery Indicator = 1
0001T	Co-Surgery Indicator = 2

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

From that Web page, look for CR3505 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3505

Medlearn Matters Number: MM3505

Related CR Release Date: October 1, 2004

Related CR Transmittal #: 306

Effective Date: January 1, 2004

Implementation Date: October 4, 2004

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

Provider Types Affected

Physicians

Provider Action Needed

This is a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of CCI edits will be effective on January 1, 2005. Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits on the Centers for Medicare & Medicaid (CMS) web site at:

<http://www.cms.hhs.gov/physicians/cciedits>

The web site will be updated with the Version 11.0 edits as soon as they are effective.

Background

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

The latest package of CCI edits, Version 11.0, is effective on January 1, 2005. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables: Column 1/Column 2 Correct Coding Edits and MEC Edits.

Additional Information

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

Related Change Request (CR) #: 3491

Medlearn Matters Number: MM3491

Related CR Release Date: October 22, 2004

Related CR Transmittal #: 324

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

New Diagnosis Code for Influenza Virus Vaccine Claims

All Medicare institutional providers, Part B physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccine must use the new diagnosis code ICD-9-CM, V04.81 for claims with dates of service on and after October 1, 2003.

Related CR #: N/A

Medlearn Matters Number: SE0312

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Effective Date: N/A

Implementation Date: N/A



Change in the Type of Bill for Billing Diagnostic and Screening Mammographies

Provider Types Affected

Hospitals

Provider Action Needed

Stop – Impact to You

Effective April 1, 2005, the correct Type of Bill (TOB) for billing Medicare for diagnostic and screening mammographies is the 13x.

Caution – What You Need to Know

Effective for dates of service of April 1, 2005 and later, diagnostic screening and mammographies should no longer be billed using the 14x TOB. Payment will not be made for such services if billed with a 14x TOB for services on or after April 1, 2005.

Go-What You Need to Do

Make sure that billing staffs are aware of this change to avoid payment delays.

Additional Information

This change applies to hospitals billing on TOB 13x for HCPCS codes of 76082, 76083, 76090, 76091, 76092, G0202, G0204, and G0206.

The 22x, 23x and 85x remain as appropriate TOBs for providers other than hospitals.

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

Related Change Request (CR) #: 3469

Medlearn Matters Number: MM3469

Related CR Release Date: October 29, 2004

Related CR Transmittal #: 337

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Pneumococcal Vaccine Payment increase Effective October 1, 2003

Effective October 1, 2003, the Medicare Part B payment for the pneumococcal vaccine will be increased to the lower of the charge billed to Medicare or \$18.62. Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the pneumococcal vaccination must take assignment on the claim for the vaccine.

For additional information about immunizations, refer to the Immunizations Quick Reference Guide at <http://www.cms.hhs.gov/medlearn/refimmu.asp>

Related CR #: N/A

Medlearn Matters Number: SE0311

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Effective Date: 10/01/2003

Implementation Date: N/A

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

Provider Types Affected

Physicians, non-physician practitioners, providers, and suppliers

Provider Action Needed

Stop – Impact to You

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

Caution – What You Need to Know

Annual Part B deductible and coinsurance amounts do not apply

Go-What You Need to Do

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

Additional Information

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

On the above online page, scroll down while referring to the CR column on the right to find the link for CR 3490. Click on the link to open and view the file for the CR.

Related Change Request (CR) #: 3490

Medlearn Matters Number: MM3490

Related CR Release Date: September 17, 2004

Related CR Transmittal #:114

Effective Date: September 1, 2004

Implementation Date: October 1, 2004

Important News about Flu Shots for Medicare Beneficiaries

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

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

Background

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

Because of the limited availability of flu vaccines this season, the Centers for Disease Control and Prevention (CDC) is recommending that individuals be given priority for getting the flu vaccine who are 1) at high risk for serious flu compli-

cations; or 2) in contact with people at high risk for serious flu complications. Individuals in the following groups are included in the high-risk category, and they should receive a flu vaccination this season:

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

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

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

Medicare Billing for Flu Vaccines

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

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

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

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

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

If you are not a Medicare-enrolled physician or provider who gives a flu vaccine to a Medicare beneficiary, you can ask the beneficiary for payment at the time of service. The beneficiary can then request Medicare reimbursement. Medicare reimbursement will be approximately \$18 for each flu vaccine. To request reimbursement, the beneficiary will need to obtain and complete form CMS 1490S by calling 1-800-MEDICARE, or they may access and download the form at <http://www.cms.hhs.gov/forms> on the web.

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

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

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

Additional Information

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

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

Source:

Medlearn Matters Number: SE0464

October 2004 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Provider Types Affected

Hospitals and other providers paid under the OPSS

Provider Action Needed

This instruction provides changes to the OPSS for the October 2004 quarterly update. Unless otherwise noted, all changes in this article are effective for services furnished on or after October 1, 2004.

Background

This article describes changes to the Hospital Outpatient Prospective Payment System (OPSS) to be implemented in the October 2004 update. The October 2004 Outpatient Code Editor (OCE) and OPSS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) codes and Ambulatory Payment Classification (APC) additions, changes, and deletions, identified in this article.

Details regarding OPSS changes for the October 2004 quarterly update, including Attachment A, Summary of Data Modifications, OCE/APC v5.3, effective October 1, 2004, are contained in the official instruction issued to your intermediary. That instruction may be viewed by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On that web site, look for CR3420 in the CR NUM column on the right, and click on the file for that CR. A summary of key changes follows:

1. New Service

The following new service is assigned for payment under the OPSS OCE, effective October 1, 2004.

Table 1. Payment for New Service

HCPCS	EFFECTIVE DATE	SI	APC	SHORT DESCRIPTOR	LONG DESCRIPTOR	PAYMENT RATE	MINIMUM UNADJUSTED COPAYMENT
C9717	10/01/04	T	0150	Stapled Hemorrhoidopexy	Hemorrhoidopexy, Complex or Extensive, by a Circular Stapler	\$1,210.81	\$242.16

2. Payment for Drugs and Biologicals Recently Approved by the FDA

Transmittal 188 (CR 3287) explains how hospitals may report new drugs and biologicals after Food and Drug Administration (FDA) approval but before assignment of product-specific HCPCS codes. Beginning in 2004, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) requires that payment for new drugs and biologicals after FDA approval but before assignment of product-specific HCPCS codes be equal to 95 percent of AWP.

- For services furnished on or after the designated effective date in Table 2, through September 30, 2004, but prior to the effective date of pass-through status and assignment of a product-specific HCPCS code, payment for the drugs and biologicals in Table 2 will be made at 95 percent of AWP.
- For services furnished on or after the designated effective date in Table 2, through September 30, 2004, beneficiary copayment will equal 20 percent of the designated payment rate.
- Effective October 1, 2004, the drugs and biologicals in Table 2 are approved for payment as pass-through drugs and biologicals (see section 3, below).
- Hospitals that used a code other than C9399 to bill for drugs and biologicals listed in Table 2 that were furnished prior to installation of the July 2004 release may submit adjustment bills.
- The “Effective Date of Payment Rate” listed in Table 2 reflects the date the drug or biological received FDA approval. Claims that are submitted using these HCPCS codes with dates of service prior to the specified “Effective Date of Payment Rate” found in Table 2 will receive OCE edit 67, “Service provided prior to FDA approval.” OCE edits are addressed in the October 2004 OCE Specifications Recurring Update Notification, CR 3395.

Note: The Medlearn Matters article for CR3395 may found at:
<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3395.pdf>

Table 2. Payment for Drugs and Biologicals Recently Approved by the FDA

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date of Payment Rate
C9218	K	9218	Injection, Azacitidine	Injection, Azacitidine, per 1 mg	\$4.52	\$0.90	05/19/04
C9219	K	9219	Mycophenolic Acid, Oral	Mycophenolic Acid, Oral, per 180 mg	\$2.67	\$0.53	02/27/04

3. Drugs and Biologicals Newly Approved for Pass-Through Payment

- The drugs and biologicals listed in Table 3 have been designated as eligible for pass-through payment under the OPPS, effective October 1, 2004. The effective date of pass-through status for C9218 and C9219 coincides with the date of assignment of product-specific HCPCS codes for each of these drugs.
- Payment for the drugs and biologicals listed in Table 3 equals 95 percent of AWP. Effective October 1, 2004, beneficiary copayment for C9218 and C9219 is recalculated consistent with coinsurance rules that apply to drugs and biologicals with pass-through status.
- “Injection, Azacitidine, per 1 mg” and “Mycophenolic Acid, Oral, per 180 mg” were originally approved by the FDA effective 05/19/04 and 02/27/04, respectively (see Table 2). These drugs both received product-specific HCPCS codes and were assigned pass-through status effective 10/01/04. Therefore, for claims with dates of service from the effective date of FDA approval to September 30, 2004, these drugs may be appropriately billed using C9399. Effective October 1, 2004, these drugs are no longer billable using C9399 and must be billed using the appropriate HCPCS identified in this article.

Table 3. Drugs and Biologicals Newly Approved for Pass-Through Payment

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date of Pass-Through Status
C9218	G	9218	Injection, Azacitidine	Injection, Azacitidine, per 1 mg	\$4.52	\$0.68	10/01/04
C9219	G	9219	Mycophenolic Acid, Oral	Mycophenolic Acid, Oral, per 180 mg	\$2.67	\$0.40	10/01/04

4. Misclassified Drugs and Biologicals: Billing and Payment for “Ganciclovir Long Act Implant,” “Bcg Live Intravesical Vac,” and “Gallium ga 67”

In the January 6, 2004 interim final rule, the Centers for Medicare & Medicaid Services (CMS) inadvertently misclassified “Ganciclovir Long Act Implant,” “Bcg Live Intravesical Vac,” and “Gallium ga 67” as multiple-source products and, therefore, incorrectly established new HCPCS for brand name forms of these drugs. These three drugs should not have been listed as multiple source drugs in CR3144, “April 2004 Changes to the Hospital Outpatient Prospective Payment System (OPPS): Payment for Drugs, Biologicals, and Radiopharmaceuticals, Generic Versus Brand Name,” in which CMS addresses coding and payment for innovator multiple-source (brand name) drugs and non-innovator multiple-source (generic) drugs, and in which CMS implements HCPCS codes and payment amounts for brand name drugs that CMS was not able to previously implement in the January 1, 2004 update.

CMS is modifying the OCE and PRICER to reflect the reclassification of “Ganciclovir Long Act Implant,” “Bcg Live Intravesical Vac,” and “Gallium ga 67” as sole source products, effective January 1, 2004. As mandated by the MMA, the payment amounts for these products are between 88 and 95 percent of their May 1, 2003 AWP.

For claims that are submitted on or after implementation of the October 2004 update, for services furnished on or after January 1, 2004, hospitals should use the sole source codes identified in Table 4, below, for reporting “Ganciclovir Long Act Implant,” “Bcg Live Intravesical Vac,” and “Gallium ga 67.”

HCPCS C9416 and C9434, representing “Bcg Live Intravesical, brand,” and “Gallium ga 67, brand,” are deleted from the OPSS OCE effective January 1, 2004. Because of release deadlines, CMS was unable to delete HCPCS C9412, representing “Ganciclovir Implant, brand,” in the October update of the OCE. Because PRICER was appropriately updated, however, hospitals should use the sole source code identified in Table 4, below, for reporting “Ganciclovir Long Act Implant.” C9412 will be appropriately deleted in the January 1, 2005 OPSS update.

Separate instruction will be issued to address billing and payment for claims for “Ganciclovir Long Act Implant,” “Bcg Live Intravesical Vac,” and “Gallium ga 67” that were processed prior to implementation of the October 2004 update.

Table 4. Reclassified Drugs and Biologicals

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date
J7310	K	0913	Ganciclovir Long Act Implant	Ganciclovir, 4.5 mg, Long-Acting Implant	\$4,400.00	\$880.00	01/01/04
J9031	K	0809	Bcg live intravesical vac	BCG (Intravesical) per Instillation	\$148.33	\$29.67	01/01/04
Q3002	K	1619	Gallium ga 67	Supply of Radiopharmaceutical diagnostic Imaging Agent, Gallium GA 67, per mCi	\$28.73	\$5.75	01/01/04

5. Billing for “FDG, per Dose (4-40 mCi/ml),” C9408 and APC 9408

In the October 2004 update of the OPSS OCE, CMS inadvertently deleted HCPCS code C9408 and its associated APC, 9408, effective January 1, 2004. For claims with dates of service on or after January 1, 2004, that are submitted after implementation of the October 2004 update, hospitals should bill for “FDG, per Dose (4-40 mCi/ml)” using HCPCS code C1775.

For claims submitted prior to implementation of the October 2004 update, hospitals may still use C9408 to bill for the brand name form of “FDG, per Dose (4-40 mCi/ml).”

6. October 2004 OCE Modifications

Attachment A of CR3420 is the OPPTS OCE Summary of Data Modifications, effective October 1, 2004. This document summarizes all of the modifications made to APCs, HCPCS and CPT procedure codes, APC assignments, status indicators, modifiers, revenue codes, and edits to update the OPPTS OCE for the October 1, 2004 quarterly release. CR3420 may be found at: http://www.cms.hhs.gov/manuals/pm_trans/R290CP.pdf

Implementation

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

Additional Information

For further details, please see the official instruction issued to your intermediary. That instruction may be viewed by going to: http://www.cms.hhs.gov/manuals/pm_trans/R290CP.pdf

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

Related Change Request (CR) #: 3420

Medlearn Matters Number: MM3420

Related CR Release Date: August 27, 2004

Related CR Transmittal #: 290

Effective Date: October 1, 2004

Implementation Date: October 4, 2004

MMA-Changes in Transitional Outpatient Payment (TOP) for 2004

Provider Types Affected

Hospitals subject to the Outpatient Prospective Payment System (OPPS); Community Mental Health Centers (CMHCs)

Provider Action Needed

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) discontinues TOPs payments for 2004 for many facilities paid under the Hospital Outpatient Prospective Payment System (OPPS).

Background

The information in this One Time Notification supersedes Transmittal 15 (CR 2908) that was issued on poOctober 31, 2003. It reflects changes resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 on December 8, 2003.

As of January 1, 2004, TOPs are being discontinued for:

- All community mental health centers (CHMCs); and
- All hospitals **except** rural hospitals having 100 or fewer beds, sole community hospitals that are located in rural areas, and cancer hospitals and children's hospitals as described in sections 1886(d)(1)(B) (iii) and (v).

Also, where TOPs payments **are being discontinued**, one last interim TOP will be paid in January 2004 for services furnished thru December 31, 2003.

Fiscal intermediaries (FIs) have been directed to permanently continue to hold harmless TOP interim payments for cancer hospitals and children's hospitals in accordance with the provisions of the Statute.

Also, hold harmless TOPs will continue through December 31, 2005 for rural hospitals having 100 or fewer beds, in accordance with the provisions of the MMA.

In addition, hold harmless TOPs will apply to sole community hospitals which are located in rural areas, with respect to services furnished during cost reporting periods beginning on or after January 1, 2004, and will continue through December 31, 2005, in accordance with the provisions of the MMA.

Implementation

Targeted for January 1, 2004.

Related Instructions

To view the actual program transmittal for this article, please visit:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that site, look for CR number 3015, scroll down, and then click on the file number for that CR.

For additional information on the OPPI and TOPs payments, please refer to Chapter 4 of the Medicare Claims Processing Manual (Pub 100-04). This chapter may be found at:

http://www.cms.hhs.gov/manuals/104_claims/clm104c04.pdf

Should you have additional questions, please contact your fiscal intermediary at their toll free number. If you do not know that number, you may retrieve it from: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

Important Note: MM3214 clarifies the policy and business requirements in this instruction relating to changes in the hospital Outpatient Prospective Payment System (OPPS) for services furnished during calendar years 2004 and 2005 and revises the method for determining whether a hospital is considered rural for purposes of Transitional Outpatient Payments (TOPs). It is very important to read the bold printed portions of MM3214 to see the clarifications. To see MM3214, go to: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3214.pdf>

Related Change Request (CR) #: 3015

Medlearn Matters Number: MM3015

Related CR Release Date: December 19, 2003

Related CR Transmittal #: R30OTN

Effective Date: January 1, 2004

Implementation Date: Targeted for January 1, 2004

Fiscal Year (FY) 2005 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) and Other Bill Processing Changes Related to the IPPS Final Rule

Provider Types Affected

Hospitals (IPPS and LTCH).

Provider Action Needed

This instruction outlines important policies in the IPPS Final Rule. These include New Tech Add-ons, Postacute Care Diagnosis Related Groups (DRGs), Core-Based Statistical Areas (CBSAs), Hospital Quality Initiative, Low Volume Hospitals, LTCH hospitals within hospitals (HwH), and other changes related to capital payments.

Background

This instruction outlines changes for IPPS hospitals for FY 2005. The changes for FY 2005 were published in the Federal Register on August 11, 2004. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2004, unless otherwise noted.

This instruction also addresses new Grouper and DRG changes that are effective October 1, 2004 for hospitals paid under the LTCH Prospective Payment System (PPS) as well as information on the HwH provision. LTCH PPS rate changes occurred on July 1, 2004. For other LTCH policy changes, please also refer to:

- Transmittal 208, Change Request (CR) 3335, published on June 18, 2004, Long Term Care Hospital Prospective Payment System (LTCH PPS) Fiscal Year 2005-Update, at: http://www.cms.hhs.gov/manuals/pm_trans/R208CP.pdf
- Transmittal 240, CR 3279, published on July 23, 2004, Expansion of the Existing Interrupted Stay Policy Under Long Term Care Hospital (LTCH) Prospective Payment System, at http://www.cms.hhs.gov/manuals/pm_trans/R240CP.pdf

- Transmittal 267, CR 3391, published on July 30, 2004, Crossover Patients in New Long Term Care Hospitals, at http://www.cms.hhs.gov/manuals/pm_trans/R267CP.pdf

Key changes are as follows:

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Changes

ICD-9-CM coding changes are effective October 1, 2004, and the new ICD-9-CM codes are listed, along with their DRG classifications in Tables 6a and 6b of the August 11, 2004 Federal Register. The ICD-9-CM codes that have been replaced by expanded codes or other codes or that have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f. The August 11, 2004 Federal Register can be found at the following CMS web site: <http://www.cms.hhs.gov/providerupdate/regs/cms1428f.pdf>

Furnished Software Changes

The following software programs were issued to Medicare claims processing system maintainers for FY 2005:

Grouper 22.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2004.

Medicare Code Editor (MCE) 21.0 and Outpatient Code Editor (OCE) versions 20.0 and 5.3 use the new ICD-9-CM codes to validate coding for hospital discharges and outpatient services effective October 1, 2004.

IPPS Pricer 05.0

IPPS Pricer 05.0 is for discharges occurring on or after October 1, 2004.

1. Rates:

Standardized Amount Update Factor	1.033
Hospital Specific Update Factor	1.033
Common Fixed Loss Cost Outlier Threshold	\$25800.00
Federal Capital Rate	\$416.53
Puerto Rico Capital Rate	\$199.01
Outlier Offset-Operating National	0.948978
Outlier Offset-Operating Puerto Rico	0.973183
Outlier Offset-Operating National PR blend	0.955029
IME Formula	1.42*[1 + resident-to-bed ratio]**.405-1]
MDH/SCH Budget Neutrality Factor *	0.999876

* Replace the 2004 update with 1.002608 (average of FY 2004).

Quality = 1 / Wage Index > 1	Full Update and .711 Labor Share	
	Labor Share	Non-Labor Share
National	3238.07	1316.18
PR National	3238.07	1316.18
PR Specific	1554.79	625.84
Quality <= 1 / Wage Index > 1	Lower Update and .711 Labor Share	
	Labor Share	Non-Labor Share
National	3225.53	1311.08
PR National	3225.53	1311.08
PR Specific	1548.77	623.42

Quality = 1 / Wage Index <= 1	Full Update and .62 Labor Share
Labor Share	Non-Labor Share
National	2823.64 1730.62
PR National	2823.64 1730.62
PR Specific	1351.99 828.64
Quality < 1 / Wage Index <= 1	Lower Update and .62 Labor Share
Labor Share	Non-Labor Share
National	2812.70 1723.91
PR National	2812.70 1723.91
PR Specific	1346.76 825.43

Please be advised that the numbers in the above two tables do not match the August 11, 2004 Federal Register, however these are the most current numbers.

The revised hospital wage indices and geographic adjustment factors are contained in Tables 4a2 (urban areas), 4b2 (rural areas), and 4c2 (redesignated hospitals) of the August 11, 2004 Federal Register. These tables can be found at the following CMS web site: <http://www.cms.hhs.gov/providers/hipps/ippswage.asp>

The August 11, 2004 Federal Register can be found at: <http://www.cms.hhs.gov/providerupdate/regs/cms1428f.pdf>

2. Postacute Care Transfer Policy

On October 1, 1998, CMS established a postacute care transfer policy that paid as transfers all cases assigned to one of 10 DRGs if the patient is discharged to a psychiatric hospital or unit, an inpatient rehabilitation hospital or unit, a LTCH, a children’s hospital, a cancer hospital, a skilled nursing facility, or a home health agency. On October 1, 2003, that list was expanded to 29 DRGs.

Effective for discharges on or after October 1, 2004, CMS is adding two more DRGs to this list (541 and 542) and removing 483 from the list.

3. New Technology Add-On Payment

Effective for discharges on or after October 1, 2004, there are three “new” new technology add-on payments, 1) the OP-1 Implant, 2) CRT-D and 3) Kinetra®, in addition to InFUSE™, which was effective October 1, 2003. Xigris is no longer included.

The maximum add-on payment for InFUSE™ (ICD-9-CM procedures of 84.51 and 84.52 must both be present AND codes 81.05, 81.08, 81.35, and 81.38 MUST NOT be present) is \$1,955.00. The maximum add-on payment for OP-1 (ICD-9_CM code of 84.52 MUST be present and at least one of 81.05, 81.08, 81.35, or 81.38 must also be present) is also \$1,955.00. For both of these add-ons, the DRG must also be 497 or 498. The maximum add-on payment for CRT-D (ICD-9-CM code of 00.51 or 00.54 must be present) is \$16,262.50 and the maximum for Kinetra® (ICD-9-CM codes 02.93 AND 86.95 must be present) is \$8,285.00.

It is possible to have multiple new technologies on the same claim. Should multiple new technologies be present, Pricer will calculate each separately and then total the new technology payments.

Low Volume Hospitals

Hospitals considered low volume shall receive a 25% bonus to the operating final payment. To be considered “low volume” the hospital must have fewer than 200 discharges and be located at least 25 miles from another hospital. The discharges are determined from the latest cost report. The final rule identifies the process for determining which hospitals are low volume on page 49101 and 49244. Please contact your FI if you think you are a “low volume” hospital.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following web site: <http://www.qnetexchange.org>. Please select ‘HDC’, then ‘List of Providers’ under the heading ‘Reporting Hospital Quality

Data for Annual Payment Update' or 'What's New'. The actual CR contains a list of the providers (by provider number) that are not receiving the quality initiative bonus.

Core-Based Statistical Area (CBSA)

Effective October 1, 2004, inpatient acute hospitals are no longer classified into a Metropolitan Statistical Area (MSA). A CBSA is now used. The CR includes two attachments. These attachments will assist your FI in determining the correct CBSA.

Disproportionate Share (DSH) Adjustment for Urban to Rural Providers

42 CFR 412.102 provides for a transition to a rural payment amount from an urban payment amount under the operating PPS over two years. There are a few hospitals with a DSH adjustment near or greater than 12 (the cap on the operating DSH adjustment for certain groups of providers) that were considered urban under the MSA definition, but are now considered rural under the CBSA definition. These providers shall receive an adjustment to their operating DSH payment over the next two years and have been coded into the Pricer in an attempt to most closely approximate the DSH payment they will receive upon cost report settlement. The adjustment gives these hospitals 2/3 of the difference between the urban and rural operating DSH for FY 05 and 1/3 of the difference between the urban and rural operating DSH for FY 06 Based on the best available data, CMS has identified the following providers:

Medicare Provider Identification Numbers

180049	190044	190144
190191	330047	340085
370016	370149	420043

Capital PPS Payments to Hospitals Located in Puerto Rico

Currently, §412.374 of the regulations provide that capital PPS payments to hospitals located in Puerto Rico are based on a blend of 50 percent of the capital Federal rate (derived from the costs of all acute care hospitals participating in the IPPS, including those located in Puerto Rico) and 50 percent of the Puerto Rico capital rate (derived from the costs of Puerto Rico acute care hospitals only). In the August 11, 2004 IPPS final rule, CMS revised §412.374 of the regulations to provide that, for discharges occurring on or after October 1, 2004, capital PPS payments to hospitals located in Puerto Rico will be based on a blend of 75 percent of the capital Federal rate and 25 percent of the Puerto Rico capital rate. This change parallels the change in payments to Puerto Rico hospitals under the operating PPS provided for by section 504 of Pub. L. 108-173 for discharges occurring on or after October 1, 2004 which increases the national portion of the operating PPS payment for Puerto Rico hospitals from 50 percent to 75 percent and decreases the Puerto Rico portion of the operating PPS payments from 50 percent to 25 percent.

Capital PPS Payments to Hospitals Previously Reclassified for the Operating PPS Standardized Amounts

Previously, the standardized amounts varied under the operating PPS based on a hospital's geographic location (large urban versus other urban and rural areas). In addition, previously, a hospital could be reclassified to a large urban area by the Medicare Geographic Classification Review Board (MGCRB) for the purpose of the standardized amount if certain criteria were met. Also, in the past, if a rural or other urban hospital was reclassified to a large urban area for purposes of the operating PPS standardized amount, under the capital PPS the hospital was also eligible for a large urban add-on payment under §421.316, as well as a DSH payment adjustment under §412.320.

With the permanent equalization of the operating PPS standardized amounts provided for by various pieces of legislation (Public Laws 108-7, 108-89 and 108-173), all hospitals are now paid based on the large urban standardized amount, regardless of geographic location or MGCRB redesignation. Because there are no longer differences in standardized amounts due to geographic classification as a result of this legislation, hospitals are not eligible to reclassify solely for standardized amount purposes. Accordingly, the MGCRB denied all FY 2005 standardized amount reclassification requests.

In the August 11, 2004 IPPS final rule, CMS explained that because of the changes to the operating PPS described above, rural and other urban hospitals that were previously eligible to receive the large urban add-on and DSH payments under the capital PPS because they reclassified to a large urban area for the purpose of the standardized amount under the operating PPS, are no longer able to reclassify, and therefore, will not be eligible to receive those additional capital PPS payment adjustments beginning in FY 2005. For discharges occurring on or after October 1, 2004, only hospitals

geographically located in a large urban area (as defined in §412.63(c)(6)) are eligible for large urban add-on payments provided for under §412.312(b)(2)(ii) and §412.316(b). Similarly, for discharges occurring on or after October 1, 2004, only hospitals serving low-income patients that are geographically located in an urban area (as defined in §412.64) and that meet all other requirements of §412.320 will be eligible for capital PPS DSH payments provided for under §412.320.

Geographic Classification and Definition of Large Urban Area under the Capital PPS

Currently, under the capital PPS the large urban location adjustment provided for under §412.316(b) and the DSH payment adjustment for certain urban hospitals provided for under §412.320 are based on the existing geographic classifications set forth at §412.63. Beginning in FY 2005 and thereafter, a hospital's geographic classification (MSA) will be based on OMB's new CBSA designations, as set forth under new §412.64. Because of this change in the MSA definitions (under new §412.64), CMS has revised §412.316(b) and §412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the large urban location adjustment (§412.316(b)) and the DSH payment adjustment (§412.320) will be based on the geographic classifications at §412.64.

A large urban area is defined at §412.63(c)(6) as an MSA with a population of more than 1,000,000 or a NECMA with a population of more than 970,000 based on the most recent available population data published by the Bureau of the Census. Beginning in FY 2005, based on the new MSA definitions established under §412.64 and the 2000 Census data, there are a total of 62 large urban areas, which are denoted in Tables 4A2 and 4B2 in the Addendum of the August 11, 2004 IPPS final rule. In that same final rule, CMS revised §§412.312(b)(2)(ii) and 412.316(b) to clarify that for discharges occurring on or after October 1, 2004, the definition of large urban area set forth at §412.63(c)(6) continues to be in effect under the capital PPS for the large urban add-on adjustment

LTCH Changes

LTCH PPS Cost-To-Charge Ratios

To ensure that the distribution of outlier payments remains equitable, for FY 2005 a LTCH's overall Medicare cost-to-charge ratio is considered not to be reasonable if the value exceeds the combined (operating plus capital) upper (ceiling) cost-to-charge ratio thresholds calculated annually by CMS under the Hospital Inpatient PPS and published in the Federal Register. Effective for discharges occurring on or after October 1, 2004, the combined operating and capital upper limit (ceiling) on cost-to-charge ratios is 1.409 (1.240 plus 0.169). The appropriate (combined) statewide average cost-to-charge ratios for FY 2005 can be found in Tables 8A and 8B of the IPPS Final Rule.

LTCH Pricer, DRGs, and Relative Weights

The annual update of the LTC-DRGs, relative weights and Grouper software for FY 2005 are published in the annual IPPS final rule. The same Grouper software developed for the Hospital Inpatient PPS will be used for the LTCH PPS.

Version 22.0 of the Hospital Inpatient PPS Grouper will be used for FY 2005, but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients.

The annual update of the LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay (for short-stay outlier cases) for FY 2005 was determined using the most recent available LTCH claims data (FY 2003).

The LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay effective for discharges on or after October 1, 2004 can be found in Table 11 of this final rule and are in the LTCH PPS PRICER program.

LTCH Hospital Within Hospital (HwH) Provision

Effective for discharges from LTCHs as described in §412.23(e)(2)(i) meeting the criteria in §412.22(e)(2), or satellite facilities of long-term care hospitals that meet the criteria in §412.22(h), CMS has finalized the following revisions to separateness and control regulations at 412.22(e) and added new payment policy regulation at 412.534 for cost reporting periods beginning on or after October 1, 2004.

- The policies will also be applicable if the host hospital is a hospital other than an acute care hospital but only applicable if the HwH is a LTCH.
- For existing LTCH HwHs, the 3 performance of basic hospital functions qualifications for HwHs at 412.22(e)(5) (i), (ii), and (iii) are eliminated for cost reporting periods beginning on or after October 1, 2004. (Note provisions of "hold harmless year 10/1/04 – 10/1/05 below)

- If a LTCH HwH meets existing separateness and control of administrative and medical governance provisions at 412.22(e)(1) through (e)(4), payment will be made under the LTCH PPS as specified in 412.534.

Basic Payment Formula

Please note the new regulations at 42 CFR 412.534 limit the relevant percentage of patients to only Medicare patients.

- Under 412.534, if a LTCH HwH's admissions from its host hospital exceed 25 percent (or the applicable percentage) of its discharges for the HwH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise pay under the IPPS (including capital, DSH, IME, outliers, etc.).
- In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

Specific Circumstances

- For rural acute care hospitals with HwHs, instead of the 25 percent criterion, the majority, (i.e., at least 51 percent) of the patients would have to be from the hospitals other than the host. In addition, in determining the percentage of patients admitted from the host, any patient that had been Medicare outliers at the host and then transferred to the HwH would be considered as if they were admitted from a non-host hospital.
- For urban single or MSA dominant hospitals, CMS would allow the HwH to admit from the host up to the host's percentage of total Medicare discharges in the MSA. CMS would apply a floor of 25 percent and a ceiling of 51 percent to this variation.

Transition Period

CMS has established a 4-year phase-in of this policy for existing LTCH HwHs and also for LTCHs-under-formation that satisfy the following two-prong requirement:

- On or before October 1, 2004 they have certification as acute care hospitals, under Part 489; and
- Before October 1, 2005 designation as a LTCH.

For purposes of full payment under the LTCH PPS during the transition period, the percentage of discharges from the LTCH HwH originating from the host hospital for each applicable cost reporting period, may not exceed the percentage of discharges during the provider's 2004 cost reporting period that were admitted from the host hospital.

Payments under this policy will be based on reconciliation at cost report submission in order to determine the total number of discharges from the LTCH in a cost reporting period.

- **Year 1** – (cost reporting periods beginning on or after October 1, 2004 through September 30, 2005) a “hold harmless”
 - * If the percentage of LTCH HwH discharges originating from the host does not exceed the percentage for such patients established the provider's 2004 cost reporting period, payments will be made under the LTCH PPS.
 - * If the percentage of such discharges exceeds the number of such discharges from the host hospital in its 2004 cost report period, for those discharges in excess of that percentage, Medicare will pay under the basic payment formula specified above.
- **Year 2** – (cost reporting periods beginning on or after October 1, 2005 through September 30, 2006)
 - * LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their 2004 cost reporting period or 75 percent.
 - * For discharges in excess of that threshold, the payments will be determined under “the basic payment formula” specified above.
- **Year 3** – (cost reporting periods beginning on or after October 1, 2006 through September 30, 2007)
 - * LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their 2004 cost reporting period or 50 percent.

- * For discharges in excess of that threshold, the payments will be determined under “the basic payment formula” specified above.
- **Year 4** – (cost reporting periods beginning on or after October 1, 2007 (full phase-in)
 - * LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the 25 percent of the applicable percentage described for “specific circumstances above.”
 - * For discharges in excess of that threshold, the payments will be determined under “the basic payment formula” specified above.

Implementation

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

Additional Information

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

From that Web page, look for CR 3459 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your FI at their toll-free number, which may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>

Related Change Request (CR) #: 3459

Medlearn Matters Number: MM3459

Related CR Release Date: October 1, 2004

Related CR Transmittal #: 309

Effective Date: October 1, 2004

Implementation Date: October 4, 2004

Crossover Patients in New Long Term Care Hospitals (LTCH)

Provider Types Affected

New Long Term Care Facilities

Provider Action Needed

Stop – Impact to You

Previously, when a facility operating as an acute care hospital was converted to a LTCH, patients were discharged under the IPPS (acute care) provider number and readmitted under the LTCH provider number, although the patient never left the facility.

Caution – What You Need to Know

This new policy will pay one discharge payment to the discharging LTCH for patients that were admitted prior to the effective date of a hospital’s transition to a LTCH. Such patients are referred to as “crossover patients.”

Go-What You Need to Do

You must bill the patient’s entire stay under the new LTCH provider number. You must cancel any bills paid under the acute hospital provider number for patients that are still in your facility.

Background

When a hospital changes designation and provider number, the policy has been to discharge the patient under the “old” provider number and readmit the patient under the “new” provider number (Pub. 100-04, Chapter 3, section 100.4.1 and 150.14.1). This has resulted in two payments to a facility for the same patient.

When a hospital undergoes a change in ownership or a change in classification from an acute care hospital to an LTCH, payment issues arise for “crossover” patients who were admitted prior to the change in classification and who are still hospitalized under the new provider number. Since all LTCHs are required to be certified as acute hospitals and generally be paid under the IPPS for six months prior to designation as a LTCH, in 42 CFR 412.23(e), there are “crossover patients”

who were admitted to the facility when it was an acute care hospital and are still patients when the conversion to the LTCH occurs. Medicare pays twice in those cases for what was really one episode of care since separate payments are made to both the acute hospital and the LTCH.

The Centers for Medicare & Medicaid Services (CMS) is establishing a consistent policy for such situations to avoid this situation. Therefore, Medicare will issue one discharge-based payment to the hospital that discharges the patient under the applicable payment system. The payment methodology used will consider all the days of the patient stay in the facility (both prior to and following the date of LTCH designation) to be a single episode of LTCH care.

Payment for this single episode of care will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under the LTCH PPS. Further, the days of the patient's stay both prior to and following designation as a LTCH are counted in determining the patient's total length of stay at the LTCH, both for payment purposes as well as for the LTCH's average length of stay (ALOS) calculation under 42 CFR 412.23(e)(2) and (3).

This policy applies only to a patient stay in an acute care hospital that is designated as a LTCH on or after October 1, 2004.

Implementation

These instructions will be implemented on January 3, 2005.

Additional Information

The revised section of the Medicare Claims Processing Manual (Pub. 100-04, Chapter 3, section 100.4.1 and 150.14.1) are attached to the instruction issued by CMS to your intermediary. That instruction may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that page, scroll down the CR NUM column on the right to CR3391 and click on the file for that CR.

If you should have questions, contact your intermediary on their toll free number, which may be found at:

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

Request (CR) #: 3391

Medlearn Matters Number: MM3391

Related CR Release Date: July 30, 2004

Related CR Transmittal #: 267

Effective Date: October 1, 2004

Implementation Date: January 3, 2005

Guidelines for Medicare Part B Laboratory Testing

Provider Types Affected

Clinical diagnostic laboratories

Provider Action Needed

This article explains the Centers for Medicare & Medicaid Services (CMS) coverage policies for diagnostic and screening prostate specific antigen (PSA) laboratory tests under Medicare Part B. It also explains the importance of including the date of service on orders for laboratory testing.

Background

Diagnostic PSA Laboratory Testing

Under §4554(b)(1) of the Balanced Budget Act (BBA), Public Law 105-33 mandated the use of negotiated rulemaking with interested parties in the laboratory community to promote uniformity, administrative simplicity, and program integrity regarding coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B. As a result of this negotiated rulemaking, a National Coverage Decision (NCD) was developed for the diagnostic PSA test, which is a tumor marker for adenocarcinoma of the prostate and may be useful in the differential diagnosis of men presenting with as-yet undiagnosed disseminated metastatic disease. When used in conjunction with other prostate

cancer tests, such as digital rectal examination, the PSA test may assist in the decision-making process for diagnosing prostate cancer. PSA also serves as a marker in following the progress of most prostate tumors once a diagnosis has been established, as an aid in the management of prostate cancer patients, and in detecting metastatic or persistent disease in patients following treatment.

The test is of proven value in differentiating benign from malignant disease in men with lower urinary tract signs and symptoms (i.e., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia, and incontinence) as well as patients with palpably abnormal prostate glands on physical exam, and in patients with other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder. The NCD for diagnostic PSA tests does not apply to screening PSA tests. Also, use CPT/HCPCS code 84153 for diagnostic PSA testing.

Screening PSA Laboratory Testing

Screening PSA testing measures the level of prostate specific antigen in the patient's blood for the early detection of the marker for adenocarcinoma of the prostate subject to coverage, frequency, and payment limitations as follows:

- Covered at a frequency of once every 12 months for men who have attained age 50 if at least 11 months have passed following the month in which the last Medicare-covered screening PSA test was performed; and
- Must be ordered by the patient's physician, physician's assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is authorized under State law to perform the examination, fully knowledgeable about the patient's medical condition, and who would be responsible for using the results of any examination (test) performed in the overall management of the patient's specific medical problem, which includes explaining the results of the test to the patient. Use HCPCS code G0103 for the screening PSA test.

Date of Service for Laboratory Testing

During the clinical diagnostic laboratory services negotiated rulemaking, CMS learned that there was considerable variability regarding the date of service on laboratory claims. To promote uniformity, the committee recommended a national policy related to the date of service on laboratory claims. CMS published a proposed rule for public comment on March 10, 2000 (65 FR 13082) and published the final rule on November 23, 2001 (66 FR 58788). The final rule states that:

- The date of service for laboratory tests that is reported on the claim is to be the date the tested specimen was collected; and
- The person obtaining the specimen must furnish the date of collection of the specimen to the entity billing Medicare. Physicians or their staff who draw specimens for testing **must** report the date of collection of the specimen on orders for laboratory tests. Laboratories may refuse to perform tests on orders for laboratory tests that do not include the information they need in order to seek payment for services performed, i.e., the date of collection of the specimen.

Additional Information

Source:

Medlearn Matters Number: SE0317

Editing of Hospital and Skilled Nursing Facility (SNFs) Part B Inpatient Services (Full Replacement of Change Request 3366)

Provider Types Affected

Hospitals and Skilled Nursing Facilities (SNFs)

Provider Action Needed

Stop – Impact to You

This CR (CR3531) replaces CR 3366, changing the payable/non-payable status of some revenue codes billed as Part B services. These updates to these revenue codes are reflected in the discussion below.

Caution – What You Need to Know

Medicare is requiring your Fiscal Intermediaries (FI) to install an edit to assure that payment is made on 12x and 22x TOBs for claims with revenue codes listed in the non-payable table for SNFs and hospitals. CR3531 also updates some edits regarding revenue codes 024x (all inclusive ancillary), 0634 (EPO under 10,000 units), 0635 (EPO over 10,000 units), 0379 (Other anesthesia), 096x (professional fees), and 0948 (not a valid code). This article explains the changes. It also adds 22x as an applicable TOB for Diabetes Self Management Training services (DSMT).

Go-What You Need to Do

Make sure that your billing staffs are aware these to assure prompt and accurate claims processing.

Background

As communicated in CR 3366 (released on July 23, 2004), Medicare will pay, under Part B, for certain physician and for certain non-physician medical and other health services that a participating hospital or SNF furnishes to their inpatients. This is done when these patients are not eligible or entitled to, or have exhausted, their Part A benefits.

However, CMS identified that some FIs are paying for services under the 12X and 22X TOBs that do not meet the definition of these inpatient Part B services. Therefore, CR 3366 required the standard Medicare systems to include an edit to assure payment is made on 12X and 22X TOBs only for those services defined in section 10, Chapter 6, of the Medicare Benefit Policy Manual, as an inpatient Part B service. This manual may be found at:

http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp

This CR updates edits as follows:

- Removes revenue code 024x from the non-payable table for hospital Part B inpatient services (12x type of bill (TOB));
- Removes revenue code 0379 from the non-payable table for SNFs (22x TOB) and hospitals (012x TOB) inpatient Part B services;
- Removes revenue code 096x from the non-payable table and replaces it with 0960, 0961, 0962, and 0969 for SNFs and hospitals inpatient Part B services;
- Removes revenue code 0948 from the non-payable table for SNFs (22x TOB) and hospitals (12x TOB); and
- Updates Section 300.5.1, Chapter 15 of the Medicare Benefit Policy Manual to include 22x TOB as an applicable TOB for Diabetes Self-Management Training.

Additional Information

Specific revenue codes that will never be paid are listed in the related CR3531, which may be found at:

http://www.cms.hhs.gov/manuals/transmittals.comm_date_dsc.asp

From that web page, look for CR 3531 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at the revised pages of the Medicare Claims Processing Manual, Chapter 4, Section 240.1 (Editing Hospital Part B Inpatient Services) and Chapter 7, Section 10.1.1 (Editing of Skilled Nursing Facilities Part B Inpatient Services). These revised sections are attached to CR3531.

If you have any questions, please contact your intermediary at their toll free number which may be found at:

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

Related Change Request (CR) #: 3531

Medlearn Matters Number: MM3531 Related CR Release Date: October 29, 2004

Related CR Transmittal #: 351

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

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

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

Important Note: MM3333 corrects MM2944, which incorrectly indicates that services provided in a non-covered SNF stay are both subject to consolidated billing and reimbursed through the prospective payment system. MM3333 provides the corrected language (by removing the language indicating that the services are subject to the prospective payment system when provided to beneficiaries in a noncovered SNF stay) as follows:

“Physical, occupational, and speech therapy services are subject to consolidated billing when provided to beneficiaries in either a Part A covered skilled nursing facility (SNF) stay or during a non-covered stay. A small number of these services are considered surgery when performed by a physician and may be separately paid by the carrier. They are considered therapy when performed by a physical and occupational therapist and continue to be subject to consolidated billing.”

To see MM3333, go to: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3333.pdf>

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

Implementation

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

Related Instructions

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

“A number of therapy services are considered separately payable when provided by a physician and shall be paid separately by the Medicare carrier. However, these services are considered therapy when provided by a physical or occupational therapist; will be subject to consolidated billing; and payment for them is included in the prospective payment rate provided to the SNF by the FI (Medicare fiscal intermediary).”

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

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

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

Related Change Request (CR) #: 2944

Medlearn Matters Number: MM2944 Related CR Release Date: February 6, 2004

Related CR Transmittal #: R90CP

Effective Date: July 1, 2004

Implementation Date: July 6, 2004

Psychotropic Drug Use in Skilled Nursing Facilities (SNFs)

Provider Types Affected

Skilled nursing facilities (SNFs)

Provider Action Needed

This article explains Medicare’s guidelines for psychotropic drug use in SNFs, including the definition of an unnecessary drug, justification for drug use outside guidelines, and antipsychotic drugs.

Background

In response to concerns expressed by the Senate Special Committee on Aging, the Office of Inspector General (OIG) studied the extent to which psychotropic drugs are being used in nursing homes as inappropriate chemical restraints. The OIG found that, in general, these drugs are being used appropriately. Where there are problems, they are related to inappropriate dosage, chronic use, lack of documented benefit to the resident, and unnecessary duplicate drug therapy.

Definition of an Unnecessary Drug

Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug used:

- In excessive dose (including duplicate drug therapy);
- For excessive duration;
- Without adequate monitoring;
- Without adequate indications for its use;
- In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the above reasons.

Note: When a resident receives duplicate drug therapy, an evaluation should be completed for accumulation of the adverse effects.

Note: Adequate indications for use means that there is a valid clinical reason for the resident to receive the drug based on some, but not necessarily all, of the following:

- Resident assessment;
- Plan of care;
- Reports of significant change;
- Progress notes;
- Laboratory reports;
- Professional consults;
- Drug orders; or
- Observation and interview of the resident.

Justification for Drug Use Outside Guidelines

A drug used outside these guidelines must be based on sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug. Some examples of evidence that would support a justification as to why a drug is being used outside these guidelines, but in the best interest of the resident, may include:

- A physician's note indicating that the dosage, duration, indication, and monitoring are clinically appropriate and the reasons as to why they are clinically appropriate. The note should demonstrate that the physician has carefully considered the risk/benefit to the resident in using a drug outside the guidelines.
- A medical or psychiatric consultation or evaluation (e.g., Geriatric Depression Scale) confirming the physician's judgment that use of a drug outside the guidelines is in the best interest of the resident.
- Documentation of a physician, nursing, or other health professional indicating that the resident is being monitored for adverse consequences or complications of the drug therapy;
- Documentation confirming that previous attempts at dosage reduction have been unsuccessful;
- Documentation (including MDS documentation) showing the resident's subjective or objective improvement or maintenance of function while taking the medication;
- Documentation showing that the resident's decline or deterioration has been evaluated by the interdisciplinary team to determine whether a particular drug, a particular dose, or duration of therapy may be the cause; and
- Documentation showing why the resident's age, weight, or other factors would require a unique drug dose or drug duration, indication, or monitoring.

Guidelines for Use of Antipsychotic Drugs

SNFs must ensure, based on a comprehensive assessment of the resident, the following:

I. When an antipsychotic drug has not been used in the past, it is not given unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following specific conditions:

- Schizophrenia;
- Schizo-affective disorder;
- Delusional disorder;
- Psychotic mood disorders (including mania and depression with psychotic features);
- Acute psychotic episodes;
- Brief reactive psychosis;
- Schizophreniform disorder;
- Atypical psychosis;
- Tourette's disorder;
- Huntington's disease;
- Organic mental syndromes (now called delirium, dementia, and amnestic and other cognitive disorders by DSM-IV) with associated psychotic and/or agitated behaviors that have been quantitatively and objectively documented. This documentation is necessary to assist in:
 - Assessing whether the resident's behavioral symptom requires some form of intervention.
 - Determining whether the behavioral symptom is transitory or permanent.
 - Relating the behavioral symptom to other events in the resident's life to learn about potential causes (e.g., death in the family, adhering to the resident's customary daily routine).
 - Ruling out environmental causes (e.g., excessive heat, noise, overcrowding).
 - Ruling out medical causes (e.g., pain, constipation, fever, infection).

- Are persistent;
- Are not caused by preventable reasons; and
- Cause the resident to:
 - Present a danger to himself/herself or to others;
 - Continuously scream, yell, or pace and results in an impairment of functional capacity, or
 - Experience psychotic symptoms (e.g., hallucinations, paranoia, delusions) that are not exhibited as dangerous behaviors or as screaming, yelling, or pacing but result in distress or impairment of functional capacity.

Note: Short-term (7-day) symptomatic treatment of hiccups, nausea, vomiting, or pruritus. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can be treated for longer periods of time. Antipsychotics should not be used if the only indication is one or more of the following:

- Wandering;
- Poor self care;
- Restlessness;
- Impaired memory;
- Anxiety;
- Depression (without psychotic features);
- Insomnia;
- Unsociability;
- Indifference to surroundings;
- Fidgeting;
- Nervousness;
- Uncooperativeness; or
- Agitated behaviors that do not represent danger to the resident or others.

II. Unless clinically contraindicated, gradual dose reductions of the antipsychotic drug and behavioral interventions are considered in an effort to discontinue the drug. Close supervision should be provided when gradual dose reductions are carried out. If the gradual dose reduction causes an adverse effect on the resident and is discontinued, documentation of this decision and the reasons for it should be included in the clinical record. Gradual dose reductions consist of tapering the daily dose to determine whether symptoms can be controlled by a lower dose or the drug can be altogether eliminated.

Note: Behavior intervention is a modification of the resident's behavior or environment, including staff approaches to care, to the largest degree possible to accommodate the behavioral symptoms.

Note: Clinically contraindicated means that gradual dose reductions or behavioral interventions need not be undertaken if:

- The resident has a history of recurrence of psychotic symptoms (e.g., delusions, hallucinations) that have been stabilized with a maintenance dose of an antipsychotic drug without incurring significant side effects and has one of the following specific conditions:
 - Schizophrenia;
 - Schizo-affective disorder;
 - Delusional disorder;
 - Psychotic mood disorders (including mania and depression with psychotic features);
 - Acute psychotic episodes;
 - Brief reactive psychosis;
 - Schizophreniform disorder;
 - Atypical psychosis;
 - Tourette's disorder; or
 - Huntington's disease
- The resident has organic mental syndrome, and gradual dose reductions have been attempted twice in one year that resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction or a return to previous dose reduction was necessary; or

- The resident's physician provides a justification as to why the continued use of the drug and the dose of the drug are clinically appropriate. This justification should include:
- A diagnosis that includes a description of the symptoms (not simply a diagnostic label or code);
- A discussion of the differential psychiatric and medical diagnosis (e.g., why the resident's behavioral symptom is thought to be the result of a dementia with associated psychosis and/or agitated behaviors and not the result of an unrecognized painful medical condition or a psychosocial or environmental stressor);
- A description of the justification for the choice of a particular treatment or treatments; and
- A discussion of why the present dose is necessary to manage the resident's symptoms.

Additional Information

Source:

Medlearn Matters Number: SE0316

Change to the Common Working File Skilled Nursing Facility Consolidated Billing Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site

Provider Types Affected

Skilled nursing facilities (SNFs), suppliers of ambulance services, and therapists

Provider Action Needed**Stop – Impact to You**

Effective on or after April 1, 2005, you must not separately bill your Fiscal Intermediary (FI) for transporting, by ambulance, a Medicare beneficiary in a covered Part A SNF stay, to or from an Independent Diagnostic Testing Facility (IDTF). If you do submit this ambulance transport as a Part B bill, it will be denied. Also, the SNF must submit Medicare claims for all physical and occupational therapies, and speech-language pathology services its residents received under inpatient Part B.

Caution – What You Need to Know

Medicare considers the ambulance transport of a beneficiary in a covered Part A SNF stay, to or from an IDTF, to be part of SNF Consolidated Billing (CB). Therefore, this transport is to be paid in the SNF Prospective Payment System (PPS) rate and may not be paid separately as Part B services. Therefore, on or after April 1, 2005, any such Part B ambulance claims that you bill to your FI will be denied.

Go-What You Need to Do

Make sure that your billing staffs are aware that the ambulance transport of any beneficiary in a Part A covered SNF stay to or from an IDTF cannot be separately billed under Part B. Also, be sure they are aware of the requirements to bill for the therapies mentioned in the STOP section above.

Background

Section 4432(b) of the Balanced Budget Act (BBA) requires CB for SNFs. Under CB requirements, the SNF must submit under Part A, except for certain excluded services, all Medicare claims for all the services its residents receive. Also, the SNF must submit Medicare claims for all physical and occupational therapies and speech-language pathology services its residents received under inpatient Part B. In addition, all Medicare-covered Part A services that are deemed to be within a SNF's scope or capability are considered paid in the SNF PPS rate.

Except for specific exclusions, SNF CB includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay, including those to and from IDTFs.

This instruction clarifies the current SNF CB rules for ambulance transports to or from IDTFs, and implements a change to the processing of institutional provider claims for ambulance transports of a SNF Part A stay beneficiary to or from an IDTF, when billed separately as a Part B service to the FI.

Specifically, Change Request (CR) 3196, which was released earlier this year, included new edits to be installed in the Common Working File (CWF) to deny ambulance suppliers' Part B claims to their carriers (on or after October 4, 2004) for ambulance transports of SNF Part A stay beneficiaries to or from an IDTF. This instruction requires the CWF to apply the same edits to these ambulance services when billed to the FI by institutional providers.

This means that ambulance transports to or from IDTFs are considered paid in the SNF PPS rate and may **not** be billed as Part B services. More specifically, ambulance transports are included in the SNF PPS rate if:

- The first or second character (origin or destination) of any Healthcare Common Procedure Coding System (HCPCS) code ambulance modifier is "D" (diagnostic or therapeutic site other than P or H); and
- The other modifier (origin or destination) is "N" (SNF).

The "D" origin/destination modifier includes cancer treatment centers, wound care centers, radiation therapy centers, and all other diagnostic or therapeutic sites.

Ambulance transports to or from renal dialysis facilities for the purpose of receiving dialysis and related services are excluded from SNF CB. In this case, the first or second character (origin or destination) of any HCPCS code ambulance modifier is a "G" (hospital-based ESRD facility) or "J" (freestanding ESRD facility), and the other modifier (origin or destination) is "N" (SNF).

SNFs are not responsible for the costs of these transports.

Under this instruction, when Medicare denies a claim for services that are covered under SNF CB, your intermediary will reflect reason code 97, "Payment is included in the allowance for another service/procedure" on the remittance advice.

Implementation

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

Related Instructions

Updated manual instructions are attached to the official instruction released to your intermediary. You may view that instruction by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3427 in the CR NUM column on the right, and click on the file for that CR.

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

Request (CR) #: 3427

Medlearn Matters Number: MM3427

Related CR Release Date: October 29, 2004

Related CR Transmittal #: 342

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Reminder Notice of the Implementation of the Ambulance Transition Schedule

Provider Types Affected

Ambulance providers and suppliers

Provider Action Needed

Stop – Impact to You

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

payable under the ambulance fee schedule for CY2005 will consist of 80 percent of the fee schedule amount and 20 percent of providers' reasonable cost or suppliers' reasonable charge amount for the service.

Caution – What You Need to Know

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

Go-What You Need to Do

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

Background

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

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

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

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

**Previous and current year percentages*

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

Implementation

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

Related Instructions

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

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

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

Additional Information

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

From that web page, look for CR 3473 in the CR NUM column on the right, and click on the file for the desired CR.

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

Request (CR) #: 3473

Medlearn Matters Number: MM3473

Related CR Release Date: October 22, 2004

Related CR Transmittal #: 320

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

Medicare Comprehensive Outpatient Rehabilitation Facility Coverage

Provider Types Affected

Medicare Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Provider Action Needed

Stop – Impact to You

The Medicare Benefit Policy Manual, Chapter 12 (Comprehensive Outpatient Rehabilitation Facility (CORF)), has been updated to clarify general requirements, covered and non-covered services, provisions of services, and specific CORF services.

Caution – What You Need to Know

Medicare defines a CORF as a facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of the injured and disabled or to patients recovering from illness. Policy changes in the CORF manual touch on the following topics: Rules for Provision of Services; Place of Treatment; Personnel Qualification Requirements; and Services Furnished Under Arrangements (including Physicians, Physical Therapy, Occupational Therapy, Speech-Language Pathology, Respiratory Therapy, Social, Psychological, and Nursing Services). Policy changes were additionally made regarding: Referral for Treatment; Plan of Treatment; Prosthetic and Orthotic Devices and Supplies; Drugs and Biologicals; Home Environment Evaluation; and Outpatient Mental Health Treatment Limitation.

Go-What You Need to Do

The most pertinent changes are outlined below in the Additional Information section; however, to see all the changes, please refer to, Chapter 12 of Publication 100-2, which is attached to CR 3315. (Instructions for accessing that CR are found later in this article.)

Background

A service may be covered as a CORF service only if it would be covered as an inpatient hospital service provided to a hospital patient. This does not mean that the beneficiary must require a hospital level of care or meet other requirements unique to hospital care. This provision merely requires that the service, if otherwise covered, would be covered if provided in a hospital.

Additional Information

Key policy changes made in the CORF portion of the Medicare Benefit Policy Manual include the following:

Physicians

CORF physician services are services such as a consultation, home, office, and institutional evaluation and management

services rendered by a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he/she performs services. Examinations for the purpose of establishing and reviewing the plan of care that do not result in a billable service are also considered to be CORF physician services.

CORF facility physicians must have completed at least one year of training, subsequent to completion of a one-year hospital internship, in the medical management of patients requiring rehabilitative services or they must have completed at least one year of full-time or part-time experience in a rehabilitation setting, providing physician services similar to those required in a rehabilitation facility.

The facility physician must be present in the facility long enough to provide medical direction, medical care services, and consultation services within acceptable professional standards and practice.

Physicians are expected to work together with physical therapists, occupational therapists or speech-language pathologists who will provide the actual therapy when establishing patient care plans, although the respiratory therapy plan of treatment is expected to be established entirely by the physician.

A physician specializing only in pulmonary rehabilitation is not considered to have the experience needed to medically manage patients who need skilled rehabilitation services.

Therapists/Social Services

Qualified physical or occupational therapists are required to evaluate and reevaluate the patient's level of function and to consult in the development of the plan of treatment. A qualified physical or occupational therapist assistant functioning under the general supervision of the qualified physical or occupational therapist may also carry out the implementation of the plan, in accordance with applicable State laws.

Social services are covered CORF services, if they are part of a coordinated, comprehensive skilled rehabilitation program and are included in the plan of treatment established and signed by the referring physician and contribute to the improvement of the individual's condition.

Respiratory Therapy

Respiratory therapy (respiratory care) services are services prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with respiratory deficiencies and abnormalities of function as part of a coordinated comprehensive skilled rehabilitation program. These services are covered CORF services if they are part of a coordinated, comprehensive, skilled rehabilitation program and included in the plan of treatment established and signed by the referring physician, and considered reasonable and necessary for the diagnosis or treatment of an illness or injury.

Respiratory services must be performed in conjunction with core CORF services by respiratory therapists, physical therapists, occupational therapists, or registered nurses, as recognized by applicable State law.

Prosthetics and Orthotics

Prosthetics and orthotics are considered covered CORF services if they are part of a comprehensive, coordinated, skilled rehabilitation program established and signed by the referring physician, and furnished in conjunction with a physician's service or on a physician's order. These devices are covered CORF services if they are part of a comprehensive, coordinated, skilled rehabilitation program.

Drugs and Biologicals

Drugs and biologicals are covered if they are part of a coordinated, comprehensive, skilled rehabilitation program and are included in the plan of treatment established and signed by the physician.

Home Visits

A single home environment evaluation visit is covered as a CORF service if it is a part of a coordinated, comprehensive, skilled rehabilitation program and is included in the plan of treatment established and signed by the referring physician. Coverage is limited to the services of one professional, i.e., either a physical or occupational therapist selected by the CORF (whose services are covered by the CORF benefit).

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

From that web page, look for CR 3315 in the CR NUM column on the right, and click on the file for that CR.

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

The most pertinent changes are outlined in this Additional Information section; however, to see all the changes, please refer to the CORF manual, Chapter 12 of Pub 100-2, that is attached to CR 3315.

Note: This article was revised on October 14, 2004, to provide references to the correct Medicare manual and to clarify coverage for home visits on page 3.

Request (CR) #: 3315

Medlearn Matters Number: MM3315

Related CR Release Date: September 24, 2004 Revised

Related CR Transmittal #: 21

Effective Date: June 30, 2004

Implementation Date: October 25, 2004

Comprehensive Outpatient Rehabilitation Facilities/Outpatient Physical Therapy (CORF/OPT) Edit for Billing Inappropriate Supplies

Provider Types Affected

Comprehensive outpatient rehabilitation facilities and outpatient physical therapy facilities

Provider Action Needed

Stop – Impact to You

A system edit is being established to return claims to CORFs/OPTs when billing for supplies with revenue code 270 without an appropriate Healthcare Common Procedure Code System (HCPCS) code.

Caution – What You Need to Know

Supplies furnished by CORFs/OPTs are considered part of the practice expense. CORFs/OPTs should not bill for the supplies they furnish except for the splint and cast, level II HCPCS Q codes associated with the level I HCPCS in the 29000 series.

Go-What You Need to Do

Make sure the appropriate HCPCS code is used to avoid returned claims and delayed payment when billing for certain supplies furnished by CORFs/OPTs.

Background

This instruction requires Medicare fiscal intermediaries (FIs) to return claims to CORFs/OPTs when billing for supplies without an appropriate HCPCS. Supplies are considered part of the practice expense and are not separately payable under the Medicare Physician Fee Schedule (MPFS) except for the splint and cast, level II HCPCS Q codes associated with the level I HCPCS in the 29000 series.

Thus, CORFs/OPTs should not bill for the supplies they furnish except for the splint and cast, level II HCPCS Q codes associated with the level I HCPCS in the 29000 series. The appropriate Level II HCPCS “Q” codes to be used are Q4001 thru Q4049. The appropriate Level I HCPCS codes associated with the Level II HCPCS “Q” codes are 29000 thru 29085; 29105 thru 29131; and 29305 thru 29515.

The splint and cast supplies are to be billed on a bill type of 74X or 75X with a supplies revenue code of 270 and the appropriate HCPCS codes.

Note that your intermediary will not search their files for claims already processed to make adjustments. However, the

intermediary will adjust any claims brought to their attention.

Additional Information

The official instruction issued to your intermediary may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3468 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your intermediary at their toll free number, which may be found at:

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

Request (CR) #: 3468

Medlearn Matters Number: MM3468

Related CR Release Date: October 22, 2004

Related CR Transmittal #: 319

Effective Date: July 1, 2001

Implementation Date: April 4, 2005

Medicare Termination of Beneficiaries With End Stage Renal Disease (ESRD)

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

Physicians, suppliers, and providers should note that this instruction provides information to Medicare intermediaries, including regional home health intermediaries, on handling overpayment issues related to End Stage Renal Disease (ESRD) beneficiaries whose Medicare Part A coverage should have ended prior to December 1999.

It also tells contractors what to do if another third-party payer has voluntarily made or voluntarily makes a primary payment to the individual or entity when Medicare also paid for the services.

Background

Entitlement for individuals with End Stage Renal Disease (ESRD) is governed under the Social Security Act (Section 226A). In addition, under the Social Security Act (Section 226A(b)(2)), Medicare Part A benefits based on ESRD will be terminated:

- Thirty-six (36) months after the month the individual receives a kidney transplant; or
- Twelve (12) months after the month in which the individual who has not received a kidney transplant no longer requires a regular course of dialysis.

However, when Part A entitlement is not terminated in a timely manner, the Social Security Act (Section 1837(h)) permits Part A entitlement to extend up through the month the individual is notified that Part A coverage has been terminated.

Generally, this means that no attempt will be made to recover any payments that Medicare previously made for Part A covered items and services. However, Medicare payments should be accepted in instances where another third-party payer has voluntarily made or voluntarily makes a primary payment for the items and services to the individual or other entity that Medicare paid, if the third party payer voluntarily repays Medicare its primary payment

In November 2003 the Social Security Administration (SSA) terminated the Medicare coverage of approximately 8,000 individuals for Part A services and issued a notice to each beneficiary.

The notice provided the date(s) that Medicare coverage ends and gave the beneficiary the right to file an appeal. Also, neither beneficiaries nor providers are being held financially liable for items and services received prior to the formal notice of Medicare termination to the extent that another third party payer has not voluntarily made or does not voluntarily make a primary payment for any items and services.

Medicare intermediaries have been instructed not to issue demand letters or recoup Part A payments made to fee-for-service providers who have received payments on behalf of these individuals. The period for not issuing the demand letters or recouping Part A payments is the period on or after the date of Part A termination up to the final notice of termination of coverage from the Social Security Administration, which is November 2003.

In addition, Medicare intermediaries shall not reopen any cost reports or claims paid for recouping these payments for services made to fee-for-service providers for these beneficiaries during the timeframes defined in the preceding paragraph.

This instruction relates to this subset of Medicare beneficiaries and does not revise Medicare policies.

Implementation

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

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR2923 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your intermediary at their toll-free number, which may be found at:

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

Request (CR) #: 2923

Medlearn Matters Number: MM2923

Related CR Release Date: October 29, 2004

Related CR Transmittal #: 13

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Clarification of Epoetin Alfa (EPO) Billing Procedures and Codes in ESRD

Provider Types Affected

Physicians, suppliers, and renal dialysis facilities (RDFs) caring for patients with End Stage Renal Disease (ESRD)

Provider Action Needed

Physicians, suppliers, and RDFs should note that this Special Edition provides an overview of the differences between Medicare's billing procedures and codes for End Stage Renal Disease (ESRD) usage of EPO/DPA.

Background

Epoetin Alfa (EPO) Billing Procedures and Codes

The Centers for Medicare & Medicaid Services (CMS) has assigned a new HCPCS code (Q4055) for EPO, and the new Healthcare Common Procedure Coding System (HCPCS) code (Q4055) is provided for ESRD EPO usage only. Also, CMS has deleted all the current "Q" codes (Q9920 through Q9940) established for ESRD patients on EPO.

All other rules still apply for billing EPO for ESRD related anemia.

Intermediaries pay for EPO to ESRD facilities as a separately billable drug to the composite rate. No additional payment is made to administer EPO, whether in a facility or a home. Medicare beneficiaries dialyzing from home may choose between two methods of payment.

EPO payment is in addition to the composite rate and the following billing procedures are to be used for EPO administered in your facility. Identify EPO and the number of injections by:

- Revenue Code 634: EPO administration of less than 10,000 units; and
- Revenue Code 635: EPO administration of equal to or more than 10,000 units.

The following value codes should be used for reporting Hemoglobin and Hematocrit readings:

- Hemoglobin (Hgb) Reading: Value Code 48; and
- Hematocrit (Hct) Reading: Value Code 49.

In addition, use value code **68** for reporting the number of EPO units administered during the billing period. And, remember to include the HCPCS code Q4055 on the claim.

Summarizing for EPO

For dates of service on and after January 1, 2004, claims include the following:

- Bill Type = 721 (Clinic ESRD First Service to Last Service) or other bill type as applicable
- Revenue Code = 634 or 635 (according to units administered)
- HCPCS Codes = Q4055 (Required)
- Units = number of administrations (not to exceed 13 for a 30-day month or 14 for a 31-day month)
- Value Codes = 48 (hemoglobin reading) or 49 (hematocrit reading)
- Value Code = 68 (number of units of EPO administered) Reimbursement remains the same at \$10.00 per 1,000 units. (Reference: CMS Pub. 100-4, Chapter 8, Section 60.4)

Example 1: The following numbers of EPO units were administered during the billing period 2/1/04 – 2/28/04:

Date	EPO Units	Date	EPO Units
2/1	3000	2/15	2500
2/4	3000	2/18	2500
2/6	3000	2/10	2560
2/8	3000	2/22	2500
2/11	2500	2/25	2000
2/13	2500	2/27	2000

Total: 31,060 units

For value code 68, enter 31,060.

Your intermediary uses 31,100 to determine the rate payable. This is 31,060 rounded to the nearest 100 units. The rate payable is \$311.00 (31.1 * \$10).

Hgb=10.2

Revenue Code: 634 – 12

Value Code: 68 – 31,060

HCPCS: Q4055

VC 48: 10.2

Example 2: The following number of EPO units was administered during the billing period 5/1/04 – 5/30/04:

Date	EPO Units	Date	EPO Units
5/10	20,000	5/24	9,500
5/12	9,000	5/26	10,000
5/14	11,000	5/28	10,000
5/19	8,000	5/30	10,000
5/22	15,000		

Total: 102,500 units

HCPCS code: Q4055

Revenue Code: 634, 3 (number of administration dates)

HCPCS code: Q4055

Revenue Code: 635, 6 (number of administration dates)

Value Code: 68, 102,500

Value Code: 49, 30.9 (Hct)

(See ESRD Manual Section 60.)

If an electronic submitter has additional documentation, which Medicare may require, they can indicate “DOCUMENTATION AVAILABLE UPON REQUEST” in the narrative (NTE02) segment. If the additional documentation you have is needed for Medicare to make its payment determination, a development letter will be sent requesting the information.

If the NTE02 segment does not indicate the availability of the additional documentation or the information is not returned in a timely manner, the claim will be returned as unprocessable.

Related Instructions

Change Request (CR) 2963, Transmittal 39, January 6, 2004 can be found at the following CMS website:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

CR 3037; Transmittal 36, December 24, 2003 can be found at the following CMS website:

http://cms.hhs.gov/manuals/pm_trans/R36OTN.pdf

CR 2984, Transmittal 118, March 5, 2004 can be found at the following CMS website:

http://www.cms.hhs.gov/manuals/transmittals/cr_num_asc.asp

Additional Information

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

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

Lastly, see the Medicare Claims Process Manual, Pub. 100-04, Chapter 8, Section 60.4 at the following CMS Website:

http://www.cms/manuals/104_claims/clm104c08.pdf

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0406

Related CR Release Date: N/A

Use Condition Code 59 When an ESRD Beneficiary Receives Non-Scheduled or Emergency Dialysis Services at a Non-Primary ESRD Dialysis Facility

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This special instruction describes the use of Condition Code 59 when billing for ESRD beneficiaries receiving dialysis services at non-primary ESRD dialysis facilities

Background

Condition code 59 was created to help track treatments given at non-primary ESRD facilities.

The responsibility for the care plan and treatments remains with the patients’ “home” facility even though arrangements are made to perform dialysis treatments at the other certified facility.

Condition Code for Dialysis Services Provided at a Facility That Is Not the Home Facility

ESRD facilities should note that:

- When a beneficiary receives dialysis services at a non-primary ESRD dialysis facility, Condition Code 59 should be used in completing Form CMS-1450 (Form Locators (FLs) 24-30) for Billing, and
- When a patient (who is traveling or transient) receives scheduled services at a non-primary ESRD dialysis facility, Condition Code 59 should be used.

Related Instructions

You are also referred to Change Request (CR) 3183, Transmittal# 149, titled New Condition Code for ESRD Facilities and Patient Status Code Changes, dated April 23, 2004, which can be found at the following CMS web site:

http://www.cms.hhs.gov/manuals/pm_trans?R149CP.pdf

The associated Medlearn Matters article can be found at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3183.pdf>

Additional Information

An excellent booklet is also available titled Preparing for Medical Emergencies: A Guide for People on Dialysis that can be found at the following CMS web site: <http://www.medicare.gov/publications/pubs/pdf/10150.pdf>

If you have any questions, please call your fiscal intermediary at their toll-free number, which may be found at:

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

Request (CR) #: N/A

Medlearn Matters Number: SE0452

Related CR Release Date: N/A

Should Condition Codes 20, 21 or Occurrence Code 32 be Used?

Beneficiaries are assumed to be liable on claims using condition code 21, since these claims, sometimes called “no-pay bills” and having all non-covered charges, are submitted to Medicare to obtain a denial that can be passed to subsequent payers. An advance beneficiary notice (ABN) is not required in these cases. If an ABN is given, condition code 21 cannot be used.

Claims with condition code 20 may be submitted with both covered and non-covered charges. An ABN should not be employed when condition code 20 is used. Claims are billed with condition code 20 at the beneficiary's request, where the provider has already advised the beneficiary that Medicare is not likely to cover the service (s) in question. Providers may directly collect payment from beneficiaries in such cases for non-covered charges, but if, upon review, Medicare decides a service in question is actually covered and pays, providers must return any payment collected from beneficiaries for these services.

Occurrence code 32 on a claim signifies that an ABN was given to a beneficiary on a specific date. This code must be employed if this specific ABN is given, and condition code 20 will not be used on the subsequent claim (i.e., **no charges will be billed as non-covered**). All services on such claims with occurrence code 32 must be covered charges, even if the result of full adjudication of these claims is expected to be that services will be found to be non-covered. If such services are non-covered after full adjudication, the beneficiary remains liable for the services. If instead, as a result of medical review, Medicare finds services are covered, the Medicare Program becomes liable since the provider will receive payment direct from Medicare.

Only services for which the ABN was given should be shown on the claim with occurrence code 32, since the code pertains to every service on the claim. Providers must give separate ABNs for different procedures if performed on different dates, and show the services and the dates ABNs were given on separate bills for each date involved.

If a service not pertaining to an ABN was rendered in the same period as service(s) requiring an ABN, such services must be submitted on separate claims, and the statement dates of these claims cannot overlap. If the time periods cannot be separated (i.e., a service requiring an ABN is given on the same day a service not requiring an ABN), a single claim must be submitted, just for the overlapping period, using occurrence code 32, showing all services as covered, and placing

modifier GA on the HCPCS code to identify the service (revenue code) line for which the ABN was given. Since this is an exception process, providers are reminded to use this mechanism only when it is impossible to separate the billing periods.

The final instance in which beneficiaries are liable for non-covered charges is for services they request be billed to Medicare, but Medicare does not cover by statute. Examples of services not covered by statute include personal comfort items, hearing aides and hearing examinations, routine eye and dental care. Providers should advise beneficiaries each time they are aware services not covered by statute are being requested before Medicare is billed, but ABNs are not to be used in these cases.

If, in a situation in which giving an ABN is not appropriate, and the beneficiary demands a Medicare determination for any line(s) for other than Home Health (HH) PPS services, the provider is instructed to put those line(s) on a separate claim showing the charges as non-covered and put condition code 20 on the bill. If a beneficiary wants an MSN for denial reasons on any line(s), providers are instructed to put those lines(s) on a separate claim and show condition code 21 on that bill. If the provider gives the beneficiary an ABN under any other circumstances, the provider must show the charges as covered and also put occurrence code 32 on the claim to affix beneficiary liability. There are no provider billing requirements for billing services excluded by statute other than billing such items as non-covered.

(See Change Request 3115, Transmittal 133 for complete billing instructions related to the billing of non-covered charges).

Questions regarding this bulletin should be directed to the Provider Relations Department at 1-866-488-0545.

New Policy and Refinements on Billing Non-Covered Charges to Fiscal Intermediaries (FIs)

Provider Types Affected

Providers who bill Medicare FIs

Provider Action Needed

This instruction refines guidance in Chapter 1, Section 60 of Medicare's On-Line Publication 100-04, Medicare Claims Processing Manual. It serves to effect compliance with the Health Insurance Portability and Accountability Act (HIPAA) in ensuring all services not covered by Medicare may be submitted and accepted on Medicare claims, which in turn can be crossed over to subsequent payers.

Background

Basic comprehensive instructions on billing non-covered charges to FIs are found in Chapter 1, Section 60 of Medicare's On-line Publication 100-4 on Claims Processing, and summarizes several prior program memoranda.

(See Transmittal R25CP, Change Request (CR) 2634, October 31, 2003, Billing Non-Covered Charges to Fiscal Intermediaries – Summary and New Instructions, at: http://www.cms.hhs.gov/manuals/pm_trans/R25CP.pdf.)

The scope of these instructions is limited to institutional fee-for-service claims and not other types of transactions using claim formats.

Since publication of the summary instructions and one clarification (see Transmittal R133CP, CR 3115, April 2, 2004, Billing Non-Covered Charges to Fiscal Intermediaries – Summary and New Instructions – Clarification, at http://www.cms.hhs.gov/manuals/pm_trans/R133CP.pdf), the Centers for Medicare & Medicaid Services (CMS) has become aware of other required refinements and new need(s) including the following:

- Allowing totally non-covered provider-liable outpatient claims without either condition codes 20 or 21 – **NEW NEED**; your FI will accept and process to completion totally non-covered outpatient claims as long as either: (1) condition code 20 or 21 appears on the claim; (2) no other indicators appear at the claim or line level to indicate possibility of beneficiary liability; or (3) all indicators at the claim or line level indicate provider, not beneficiary, liability.
- Providing additional guidance on billing bundled services related to an Advance Beneficiary Notice (ABN) with

specific examples for rural health clinics (RHCs), federally qualified health clinics (FQHCs) and laboratory panel tests billed on institutional claims – **REFINEMENT**;

- Bypassing of some edits related to non-covered ambulance line items billed as non-covered using the QM or QN modifiers so those claims/line items can process to completion – **REFINEMENT**; and
- Other updates to web site addresses, conforming text, and comparable administrative changes.

Finally, although the basic principles of billing non-covered charges are static, there will be some ongoing adjustments required because of changes in related policy areas, which is the case with any type of billing.

For example, as CMS refines its beneficiary financial protection notices, such as the ABNs and Notices of Exclusion from Medicare Benefits (NEMBs), the policies on billing non-covered charges will also be subject to review and potentially change, because they are intertwined with these notices in terms of determination of liability. (See NEMBs listed on CMS web site <http://www.cms.hhs.gov/medicare/bni/>).

Policy related to ABNs and similar notices has been evolving rapidly since 2000 and the ramifications of changes in this policy area for billing are likely to continue into 2005.

Implementation

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

Additional Information

Revisions to the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01) and the Medicare Claims Processing Manual (Pub. 100-04) are attached to the official instruction issued to your FI. You may view that instruction by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR 3416 in the CR NUM column on the right, and click on the file for that CR.

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

Request (CR) #: 3416

Medlearn Matters Number: MM3416

Related CR Release Date: October 22, 2004

Related CR Transmittal #: 12

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

MMA - Use of Group Health Plan Payment System to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries Under Section 721 of the MMA

Providers Affected

Physicians, providers, and suppliers

Provider Action Needed

Stop – Impact to You

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

Caution – What You Need to Know

With the exception of how CMS is paying these private organizations, beneficiaries enrolled in these programs will be considered covered under the traditional Medicare FFS program for all other purposes. Beneficiaries will only receive coordinated care/disease management services from these chronic care organizations and they are not restricted in any way on how they receive their other Medicare services.

Go-What You Need to Do

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

Background

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

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

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

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

With the exception of how CMS is paying these organizations, beneficiaries enrolled in these programs will be considered covered under the traditional Medicare FFS program for all other purposes. Beneficiaries will only receive coordinated care/disease management services from these chronic care organizations. They are not restricted in any way on how they receive their other Medicare services.

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

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

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

Implementation

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

Additional Information

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

From that Web page, look for CR3410 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier at their toll-free number, which may be found at:

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

Request (CR) #: 3410

Medlearn Matters Number: MM3410

Related CR Release Date: July 30, 2004

Related CR Transmittal #: 256

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

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

Provider Types Affected

All providers.

Provider Action Needed

Stop – Impact to You

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

Caution – What You Need to Know

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

Go-What You Need to Do

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

Background

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

Additional Information

You may also refer to the revised Publication 100-05, Chapter 1, Section 50B, which is part of the official instruction issued to your carrier/intermediary regarding this change. That instruction may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3447. Click on the link to open and view the file for the CR.

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

Request (CR) #: 3447

Medlearn Matters Number: MM3447

Related CR Release Date: September 24, 2004

Related CR Transmittal #: 19

Effective Date: October 25, 2004

Implementation Date: October 25, 2004



Application of the Medicare Secondary Payer for the Working Aged Provision to Former Spouses and the Medicare Secondary Payer for the Disabled Provision to Former Spouses and Certain Family Members with Coverage Under the Federal Employees Health Benefits (FEHB) Program

Provider Types Affected

All Medicare providers

Provider Action Needed

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

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

Background

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

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

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

Additional Information

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

From that web page, look for CR 3120 in the CR NUM column on the right, and click on the file for that CR.

Request (CR) #: 3120

Medlearn Matters Number: MM3120

Related CR Release Date: August 27, 2004

Related CR Transmittal #: 18

Effective Date: November 29, 2004

Implementation Date: November 29, 2004

Inappropriate Access to or Use of Electronic Data Interchange (EDI) Transaction Data by Third Party Entities

Provider Types Affected

All physicians, suppliers, and providers.

Provider Action Needed

Stop – Impact to You

Failure to abide by Medicare security requirements for EDI access could lead to suspension of EDI capabilities.

Caution – What You Need to Know

This article clarifies and reminds affected physicians, providers, and suppliers of existing Medicare requirements and prohibitions concerning use of EDI numbers and passwords.

Go-What You Need to Do

Be sure you and your third party partners are aware of and abide by these requirements to protect your EDI access and to maintain your ability to submit timely claims to Medicare.

Background

Medicare contractors (carriers and intermediaries) support electronic data interchange (EDI) to enable providers, either directly or through third party agents to:

- Verify patient eligibility to determine if a claim should be submitted to Medicare;
- Submit claims to Medicare electronically;
- Determine the status of a previously submitted claim; and
- Post adjudication decisions and payments to patient accounts.

It is important to note that these functions are the only functions for which a provider or a third party entity is entitled to send EDI transactions directly to Medicare contractors (carriers, DMERCs, or fiscal intermediaries) or receive EDI transactions directly from Medicare contractors.

Third-party entities that request permission to access Medicare EDI records directly generally fall into one of the following categories:

1. A clearinghouse as defined by the Health Insurance Portability and Accountability Act (HIPAA) that transfers and may translate claim, eligibility, claim status, and/or payment and remittance advice data for EDI transactions being transmitted between providers and one or more Medicare contractors;
2. An agent a provider has hired to prepare claims and possibly other EDI transactions for submission to one or more Medicare contractors, and possible posting to patient records/provider accounts of eligibility, claim status, and adjudication/payment data issued by one or more Medicare contractors;
3. A clearinghouse as in #1 above that also performs agent services as in #2 above; and
4. A third party that does not perform clearinghouse or agent services as described in #1-3, but that may want direct access to outbound Medicare EDI transactions for alternate functions. Entities included in this category include collection agents in pursuit of delinquent beneficiary payments to providers and vendors that market payment data analysis services to providers that serve Medicare patients.

Third parties in categories 1, 2, and 3 perform functions that qualify them for direct access to Medicare contractor EDI systems. If a provider elects to use the services of a third party to perform permitted Medicare EDI functions, the provider must complete an EDI Agreement and furnish the Medicare contractor with a signed authorization specifying the EDI services each third party may perform on their behalf. The third party must comply with existing requirements to obtain their own EDI number and password from the Medicare contractor that services each provider being represented.

Medicare contractors can issue EDI numbers and passwords to category 1, 2, and 3 entities and permit them to submit and/or obtain EDI data directly to/from the Medicare contractor EDI systems. Third parties in category 4 do not

perform functions that qualify them for direct access to Medicare systems, and may not be issued EDI numbers or passwords.

Medicare requires that providers and third party entities to which EDI numbers and passwords are issued protect the security of those numbers and passwords to prevent use by unauthorized individuals. Furthermore, providers and third party entities of any category are prohibited from accessing Medicare systems using an EDI number or password not directly issued to them by a Medicare contractor.

This instruction is being issued to clarify and remind affected parties of existing CMS requirements and prohibitions concerning access to and use of EDI numbers and passwords.

Issues

Although they may qualify for direct access to Medicare contractor EDI systems, the read, write and use rights vary for entities in categories 1, 2, and 3. Third parties in categories 2 or 3 are allowed to review data within transactions, whereas category 1 entities are limited to review of “electronic envelope” data that contains routing information for the transactions. Some category 1 entities may be confused regarding this limitation.

The Centers for Medicare & Medicaid Services (CMS) recently discovered that at least one third-party entity in category 4 has been using EDI numbers and passwords furnished them by providers to download electronic remittance advice (ERA) transactions for those providers. The data **was not being used** to post

adjudication and payment data to patient accounts, but was being used solely for automated analysis to detect information such as payment patterns and to generate reports. The providers were using the paper remittance advice notices they received, and not the ERAs, to post their accounts. CMS has been advised that other companies may also be marketing similar services and may be using EDI numbers and passwords issued to providers to obtain outbound EDI transactions from Medicare contractor systems for use in ways other than intended by Medicare.

CMS Policy

The following manual instructions contain CMS requirements that apply to these issues:

- The Medicare Claims Processing Manual (Pub. 100-04, Chapter 24 (EDI Support Requirements) contains CMS requirements for EDI access. This can be accessed at: http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf
- The Business Partners Systems Security Manual (BPSSM) (Appendix A, Section 2.9.10 of the Core Security Requirements (CSR)) contains further requirements applicable to use of passwords issued to permit system access. These can be found at: http://www.cms.hhs.gov/manuals/117_systems_security/117_systems_security_atcA.pdf

These password requirements apply to entities to which Medicare contractors issue passwords, as well as to Medicare contractors themselves.

- The Medicare Claims Processing Manual (Pub. 100-04), Chapter 24 (EDI Support Requirements), Section 90 contains instructions concerning mandatory electronic submission of claims to Medicare as required by ASCA. This information is available at: http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf
- The Medicare Claims Processing Manual (Pub.100-04), Chapter 1 (General Billing Requirements), Section 80 (Carrier and FI Claims Processing Timeliness) contains Medicare’s payment floor requirements at: http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf

In regard to access policies for entities in categories 1-4:

- Category 1 third parties that transfer EDI data to and/or from providers, but do not translate that data into or from a format that complies with the HIPAA requirements are **not permitted** to:
 - * Open the electronic envelope of the transmitted data; or
 - * Generate reports that include data from within those transmission envelopes.
- Category 2 and 3 agents **are permitted** to:
 - * Open the electronic envelopes of the transmitted data; and
 - * Use the data for analysis and generation of reports for the providers they serve, in addition to use of that data to prepare beneficiary claims, determine claim status or Medicare eligibility, and/or to post adjudication and payment data to patient accounts.

- Category 4 third parties may use data prepared by Medicare, but the following requirements must be met as conditions for use:
 - * The data must be forwarded to the entity by the provider;
 - * A signed agreement must be in effect between the provider and the entity in which the provider authorizes the entity to use the data and specifying how the data may and may not be used;
 - * The entity has furnished the provider with a signed confidentiality agreement that meets Medicare's and HIPAA's privacy and security requirements for protection of personally identifiable beneficiary health data;
 - * The provider has notified the patients that their personally identifiable health data will be shared with the entity and how it will be used; and
 - * The provider agrees not to furnish data to the entity for any patients who object.
- A category 4 entity:
 - * May not be given an EDI number or password for direct access to Medicare data; and
 - * Is never permitted to use a provider's EDI number or password for that or any other purpose.
As stated in the CSRs in BPSSM section 2.9.10, passwords (1) are "unique for specific individuals," (2) must be "controlled by the assigned user and [are] not subject to disclosure."

Contractor Actions if Improper Access is Identified

In the event a Medicare contractor becomes aware that improper access has been given, appropriate termination of EDI capabilities and notification must occur. For example:

- If an entity, previously issued an EDI number and password, falls under category 4, the Medicare contractor must immediately disable the EDI number and password of that entity, and then notify the entity and the provider why this has been done.
- If a third party entity is using a provider's EDI number and password to access Medicare systems, the Medicare contractor must immediately disable the EDI number and password, and then contact that provider by mail or phone to make them aware of Medicare's requirements and prohibitions.

During this contact, and while the EDI number and password are disabled, the Medicare contractor will remind the provider that:

- Loss of EDI privileges could result in termination of Medicare payment since the Administrative Simplification Compliance Act (ASCA) prohibits payment of claims submitted on paper that should have been submitted to Medicare electronically; and
- In those cases when ASCA permits claims to be submitted on paper, payment is delayed as result of the lengthier payment floor that applies to paper claims.

Additional Information

Providers can review appropriate requirements by checking the Web sites mentioned above.

Remember: The law requires most providers to bill Medicare electronically and EDI access is crucial to that process. Protect your access and protect your patients' confidentiality by abiding by Medicare's privacy and security requirements.

If you have any questions regarding this issue, contact the EDI department of your carrier/intermediary at their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, that number may be found at: <http://www.cms.hhs.gov/providers/edi/anum.asp>

If you bill for Medicare Part B services, that number may be found at: <http://www.cms.hhs.gov/providers/edi/bnum.asp>

Additional Information

Providers can review appropriate requirements by checking the Web sites mentioned above.

Remember: The law requires most providers to bill Medicare electronically and EDI access is crucial to that process. Protect your access and protect your patients' confidentiality by abiding by Medicare's privacy and security requirements.

If you have any questions regarding this issue, contact the EDI department of your carrier/intermediary at their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, that number may be found at: <http://www.cms.hhs.gov/providers/edi/anum.asp>

If you bill for Medicare Part B services, that number may be found at: <http://www.cms.hhs.gov/providers/edi/bnum.asp>

Related Change *Request (CR) #*: N/A

Medlearn Matters Number: SE0461

Related CR Release Date: N/A

Fiscal Intermediary 835 Flat File and Companion Document Change

Provider Types Affected

Providers who bill Fiscal Intermediaries (FI)

Provider Action Needed

Be advised that a new field has been added to the FI Part A 835 flat file to accommodate the forced balancing amount in the standard paper remittance (SPR). In addition, the FI companion document has been changed to show that the total HCPCS reported charges amount in TS317 equals the sum of all reported charges with the HC qualifier.

Background

HIPAA transactions must comply with the implementation guides. CMS policy is to make the standard paper remittance advice mimic the electronic remittance advice for those data elements contained in both the standard paper remittance (SPR) and the electronic remittance advice (ERA).

Changes in the Fiscal Intermediary Flat File to Accommodate the Forced Balancing Amount in the SPR

The forced balancing amount that is sometimes used to balance the SPR is reported in the electronic remittance advice (ERA), and the SPR needs to expand to create the appropriate space for this information. Thus, the SPR report format will be modified to include a new field; the presumptive payment adjustment (PRE PAY ADJ) field will be added below the interest field in Part A and Part B claim detail sections.

FIs will place A7 (Presumptive Payment Adjustment) in the Reason code field to reflect the forced balancing amount in the SPR.

Changes in the FI Companion Document

The FIs will ensure that the total HCPCS reported charge amount in TS317 is equal to the sum of reported charge amount(s) when the qualifier is HC.

Additional Information

The official instruction issued to the intermediary regarding this change can be found online at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above online page, scroll down while referring to the CR NUM column on the right to find the link for CR 3344. Click on the link to open and view the file for the CR. A sample of the SPR is attached to the CR to illustrate these changes.

You may also refer to related CRs 1522, 1828, 1959, and 2233.

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

Request (CR) #: 3344

Medlearn Matters Number: MM3344

Related CR Release Date: July 23, 2004

Related CR Transmittal #: 252

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

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

Background

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

CMS has issued a memorandum to all Medicare carriers and fiscal intermediaries, including Durable Medical Equipment Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs), stating that effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the SPRs; no other format for SPRs will be used.

Additional Information

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

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

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

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

Note: This article was revised on November 19, 2004, to correct a typographical error in the third line of the Background section. Specifically, the phrase “date elements” was corrected to read “data elements.”

Request (CR) #: N/A

Medlearn Matters Number: SE0451

Effective Date: N/A Revised

Implementation Date: January 1, 2005

Guidance for Part A Providers Switching to Electronic Remittance Advices (ERAs)

Provider Types Affected

Providers who bill Fiscal Intermediaries (FIs).

Provider Action Needed

This Special Edition reminds providers that FIs are prohibited from sending providers Standard Paper Remittance (SPR) Advices if the providers have switched to receiving electronic remittance advices (ERAs). This is effective the 31st day after providers switch to the ERAs.

Background

The Centers for Medicare & Medicaid Services (CMS) issued the Medicare Part A Implementation Guide 4A.01 for the ANSI ASC X12 835 Version 003051 Electronic Remittance Advice as a tool to provide assistance in the development and

execution of the electronic transfer of remittance advice data and/or payment. The purpose of implementing the electronic RA is to expedite the goal of achieving a totally paperless claims processing and payment system.

The Medicare Claims Processing Manual, Publication 100-4, Chapter 22, Section 40.1, states that FIs can allow providers to receive a hard copy remittance in addition to the ERAs during the first 30 days of receiving the ERAs and during other testing. After that time, FIs cannot send an SPR to providers in addition to the electronic transmission. This same requirement was included in the Medicare Intermediary Manual, the predecessor of the current manual, for more than five years.

CMS recently issued a memorandum to its FIs when it came to their attention that FIs were not adhering to these requirements. The memorandum states that by January 1, 2005, FIs must terminate the issuance of SPRs to those providers (or billing agents, clearinghouses, or other entities representing providers) currently receiving ERAs and begin enforcing the termination of SPRs effective with the 31st day after providers switch to the ERA.

Additional Information

For more information on ERAs, refer to the Medicare Part A Implementation Guide 4A.01 for the ANSI ASC X12 835 Version 003051 Electronic Remittance Advice, which can be found at: <http://www.cms.hhs.gov/providers/edi/introset.pdf>

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

If you have any questions regarding this issue, you may also contact your FI at their toll free number, which is available at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>

To speak to your FI's contact regarding a switch to ERAs, contact your FI's Electronic Data Interchange coordinator. Their phone number may be found at: <http://www.cms.hhs.gov/providers/edi/anum.asp>

Request (CR) #: N/A Medlearn Matters Number: SE0447

Effective Date: N/A

Implementation Date: January 1, 2005

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Provider Types Affected

All providers

Provider Action Needed

Stop – Impact to You

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

Caution – What You Need to Know

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

Please note that in case of a discrepancy, the code text included on the Washington Publishing Company (WPC) web site will supersede any corresponding text in a CR.

In addition, with respect to Health Care Claim Adjustment Reason Codes, few temporary reason codes (D16-D20) were added for the cases where commercial payers do not make use of the available remark codes when the reason code used is too generic to help providers decide on the follow-up action. **Medicare will not use these new temporary reason codes but rather will continue the current use of the combination of reason and appropriate remark codes.**

Go-What You Need to Do

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

Background

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

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

<http://www.wpc-edi.com/codes/Codes.asp>

Additional Information

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

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

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

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

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

Request (CR) #: 3466 Medlearn Matters Number: MM3466

Related CR Release Date: October 15, 2004

Related CR Transmittal #: 313

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

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

Provider Types Affected

Physicians and other health care professionals

Provider Action Needed

This instruction provides important information on a new initiative to automatically enroll certain Medicare beneficiaries in the Medicare-Approved Drug Discount Card program.

Background

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

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

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

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

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

Transitional Assistance Program

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

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

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

Under the Medicare-Approved Drug Discount Card Program, Medicare beneficiaries are deemed to meet the income requirement for the \$600 credit in 2004 and 2005 if they are:

- Enrolled in Medicare Savings Programs as Qualified Medicare Beneficiaries (QMBs);
- Specified Low-income Medicare Beneficiaries (SLMBs); or
- Qualifying Individuals (QI-1s).

Current Initiative

The Centers for Medicare & Medicaid Services (CMS) has launched a new initiative to facilitate enrollment and provide a streamlined process for the \$600 credit. Under this initiative, participating national Medicare-approved drug discount card sponsors will agree to follow simple procedures to facilitate the \$600 credit enrollment for about 1.1 million Medicare Savings Programs beneficiaries.

- On September 14, 2004, CMS issued interim guidance to all Medicare-approved drug discount card sponsors outlining the process for Medicare Savings Programs auto-enrollment. National sponsors have notified CMS of their intention to participate.
- If these beneficiaries have not already enrolled in this card program, CMS will randomly assign those eligible Medicare Savings Programs beneficiaries to participating Medicare-approved drug discount card sponsors.
- Starting in mid-October, card sponsors will mail an enrollment kit to each Medicare Savings Programs enrolled individual. The enrollment kit will contain the following information:
- Pre-enrollment materials: Card Program, Member Handbook, Membership Card, Discount Drug List, Pharmacy Directory.
- A notice advising the Medicare Savings Programs beneficiary of the automatic assignment, effective date of enrollment, eligibility for the \$600 credit, information about their right to decline and/or switch to another Medicare-approved drug discount card, and a toll-free number.

- The card begins providing discounts on November 1. To activate the \$600 credit, the beneficiary makes one call to 1-800-MEDICARE or to the card sponsor's 800 number. On the call, the beneficiary answers two questions to confirm they are eligible for the credit:
- Does the beneficiary have other health insurance with any outpatient prescription drug coverage?; and
- Does the beneficiary have annual income (including spouse, if married) above or below \$12,569 for singles and \$16,862 for couples?
- Medicare Savings Programs beneficiaries who wish to choose another card can call 1-800- MEDICARE to learn about their other choices.
- If a beneficiary is not eligible for the \$600 credit because of other drug coverage, they will still be able to use the drug card they received and benefit from any associated discounts.
- Medicare Savings Programs beneficiaries who wish to cancel enrollment in a card must call the drug card sponsor at the toll free number provided and request their enrollment be canceled. As a result of this new program for enrollment in the drug card program, all beneficiaries in Medicare Savings Programs can start getting large savings on their drug costs.

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

For More Information

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

- Download a free patient-education brochure at: <http://www.medicare.gov> (or call 1-800-MEDICARE to order a limited number of free copies).

- Read the materials on the Medicare-Approved Drug Discount Cards and Transitional Assistance Program web page, at <http://www.cms.hhs.gov/medlearn/drugcard.asp>. This page includes a variety of useful publications.
- Attend CMS Open Door Forums in person or by telephone (toll-free). These forums address concerns and issues of physicians, nurses, and allied health professionals. Visit: <http://www.cms.hhs.gov/opendoor> for further details.
- Visit: <http://www.cms.hhs.gov/medicarereform> for the latest information on MMA.
- Contact your carrier for information by using the toll-free provider lines. Visit <http://www.cms.hhs.gov/medlearn/tollnums.asp> for your carrier's toll-free number.

Note: This article was revised on October 22 to correct the Web address for State Health Insurance Counseling and Assistance Programs.

Request (CR) #: N/A

Medlearn Matters Number: SE0457

Related CR Release Date: N/A Revised

MMA - Medicare-Approved Drug Discount Cards and Transitional Assistance Program: A Summary of New Initiative of Interest to Pharmacists and Pharmacy Professionals

Provider Types Affected

Pharmacists and other pharmacy professionals

Provider Action Needed

This instruction provides important information on a new initiative to automatically enroll certain Medicare beneficiaries in the Medicare-Approved Drug Discount Card program.

Background

In an earlier Medlearn Matters article (SE 0422), an overview of the Medicare-approved Drug Discount Card Program was provided.

(See SE0423 at: <http://www.cms.hhs.gov/medlearn/matters/mmarticle/2004/SE0423.pdf>.)

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

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

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

Transitional Assistance Program

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

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

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

Under the Medicare-Approved Drug Discount Card Program, Medicare beneficiaries are deemed to meet the income requirement for the \$600 credit in 2004 and 2005 if they are:

- Enrolled in Medicare Savings Programs as Qualified Medicare Beneficiaries (QMBs);
- Specified Low-income Medicare Beneficiaries (SLMBs); or
- Qualifying Individuals (QI-1s).

Current Initiative

The Centers for Medicare & Medicaid Services (CMS) current initiative facilitates enrollment and provides a streamlined process for the \$600 credit. Participating national Medicare-approved drug discount card sponsors will agree to follow simple procedures to facilitate the \$600 credit enrollment for about 1.1 million Medicare Savings Programs beneficiaries.

- On September 14, 2004, CMS issued interim guidance to all Medicare-approved drug discount card sponsors outlining the process for Medicare Savings Programs auto-enrollment. National sponsors have notified CMS of their intention to participate.
- CMS will randomly assign those eligible Medicare Savings Programs beneficiaries who have not already enrolled in a card to participating Medicare-approved drug discount card sponsors.
- Starting in mid-October, card sponsors will mail an enrollment kit to each Medicare Savings Programs enrolled individual. The enrollment kit will contain the following information:
 - * Pre-enrollment materials: (Card Program, Member Handbook, Membership Card, Discount Drug List, Pharmacy Directory).
 - * A notice advising the Medicare Savings Programs beneficiary of the automatic assignment, effective date of enrollment, eligibility for the \$600 credit, information about their right to decline and/or switch to another Medicare-approved drug discount card, and a toll-free number.
- The card begins providing discounts on November 1. To activate the \$600 credit, the beneficiary makes one call to 1-800-MEDICARE or to the card sponsor's 800 number. On the call, the beneficiary answers two questions to confirm they are eligible for the credit:
 - * Does the beneficiary have other health insurance with any outpatient prescription drug coverage?; and
 - * Does the beneficiary have annual income (including spouse, if married) above or below \$12,569 for singles and \$16,862 for couples?
- Medicare Savings Programs beneficiaries who wish to choose another card can call 1-800- MEDICARE to learn about their other choices.
- If a beneficiary is not eligible for the \$600 credit because of other drug coverage, they will still be able to use the drug card they received and benefit from any associated discounts.
- Medicare Savings Programs beneficiaries who wish to cancel enrollment in a card must call the drug card sponsor at the toll free number provided and request their enrollment be canceled. As a result of this new program for enrollment in the drug card program, all beneficiaries in Medicare Savings Programs can start getting large savings on their drug costs.

Additional Information

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

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

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

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

This Call Center is available 24 hours per day, 7 days per week, and it connects beneficiaries with customer service representatives who can answer questions and perform price comparisons for discount cards and other assistance programs. Beneficiaries should prepare a list of current prescription drugs and dosages prior to contacting the Call Center. Also, beneficiaries may request a copy of their individualized price comparison results. Customer service representatives will also be able to refer to appropriate sponsor or other resources (such as, make appropriate referrals for eligibility determination or to their State Pharmacy Assistance Program).

■ The Prescription Drug and Other Assistance Programs Website at:

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

At this site, beneficiaries can find eligibility, enrollment, and price comparison information for each available discount card in a particular area, as well as their state pharmacy assistance programs. It also has a tool that helps beneficiaries determine the best savings program based on their prescription drug needs. The negotiated prices displayed will be a drug's maximum price for an approved sponsor's service area. Actual prices may vary, but will not be more than the posted prices.

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

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

■ State Health Insurance Counseling and Assistance Programs (SHIP):

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

For More Information

The following information resources are available for pharmacists and other pharmacy professionals:

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

Note: This article was revised on October 22 to correct the Web address for State Health Insurance Counseling and Assistance Programs.

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0458

Related CR Release Date: N/A Revised

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

Provider Types Affected

Ambulatory surgical centers

Provider Action Needed

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

Background

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

Until further notice, carriers will continue to use the FY 2004 wage index to calculate payments to ASCs and the payment rates that were effective for services furnished on or after April 1, 2004.

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

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

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

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

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

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

Additional Information

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

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

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

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

Related Change Request (CR) #: 3394

Medlearn Matters Number: MM3394

Related CR Release Date: August 27, 2004

Related CR Transmittal #: 288

Effective Date: October 1, 2004

Implementation Date: October 1, 2004

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

Provider Types Affected

Ambulatory Surgical Centers

Provider Action Needed

Be aware that HCPCS codes 50559, 50959, and 50978 are being deleted from the ASC list effective for services performed on or after January 1, 2005.

Background

The Centers for Medicare & Medicaid Services (CMS) is updating the ASC HCPCS codes list as a result of changes in the American Medical Association (AMA) Physician's Current Procedural Terminology (CPT). The deletions of the HCPCS codes described in this notification are the results of changes in the CPT for 2005. There are no additions or replacement codes.

Additional Information

The link to your Carrier's website may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>

Should you have any additional questions, please feel free to call your carrier/intermediary at their toll free number, which may also be found at that same Web site.

Related Change Request (CR) #: N/A Medlearn Matters Number: SE0463

Related CR Release Date: N/A Effective Date: January 1, 2005

Implementation Date: January 5, 2005

Durable Medical Equipment Carrier – Revision to CR 2631 for Durable Medical Equipment Carriers Only

Provider Types Affected

Durable medical equipment suppliers

Provider Action Needed

Stop – Impact to You

Effective April 1, 2005, instead of the 2010AA Billing Provider loop to document place of service (POS) in your Durable Medical Equipment Carrier (DMERC) claims, you must use the 2420C Service Facility loop (line level) or 2310D (claim level). If you use the 2010AA loop and not one of these latter two loops, your claims will be returned as unprocessable when the place of service is other than home.

Caution – What You Need to Know

In your DMERC claims, if the place of service reported in either the 2300.CLM05 or the 2400.SV105 is anything other than Home - 12 (or CMS equivalent POS codes of 4-homeless shelter, 13-assisted living, and 14-group home), the Medicare claims processing system will only use the 2420C and 2310D loops to make the appropriate place of service determination. The Medicare System will not use the 2010AA loop to determine the valid place of service in these instances. Likewise, optical Character Reader and Keyshop claims submitted in the ANSI 4010A1 format must utilize the 2310D to report the facility.

Go-What You Need to Do

Make sure that your billing staff knows that, on your DMERC claims, they must use the 2420C and 2310D loops (and not

the 2010AA Billing Provider loop) to document the place of service when that place is other than the home of the beneficiary.

Background

This article addresses Change Request 3261 that revises an earlier one (CR 2631). CR 2631 (Transmittal 1813B3, dated August 1, 2003) implemented procedures to follow when the POS on your claim is other than home (Code – 12 or equivalent as mentioned earlier).

It required that, on version 4010/4010A of the ASC X12N 837 electronic claim format, you provide the name, address, and zip code of the location where the service was performed, for all claims received on or after April 1, 2004. More specifically, it required that Billing Provider loop 2010AA always be completed, and was to be heavily relied on to serve as the documentation of a valid place of service.

The problem with this requirement in CR 2361 is that if the POS is not actually “home,” the 2010AA loop billing may not be where the service was provided. It could actually be supplier information and not the place of service.

Although all claims must have a completed 2010AA Billing Provider loop, beginning April 1, 2004, this does not ensure that your claim has been properly submitted, because the Billing or Pay To Provider’s location may not be where the services were rendered.

Therefore, in order to process claims correctly, the following change must be made for DMERC claims only:

- The Medicare system will not use the 2010AA loop to make the appropriate facility determination. It will only use the 2420C and 2310D loops to determine POS. Requirements for the required information for these two loops are not being changed with these instructions.
- The Medicare system will provide edits that require you to supply complete facility information at either the 2310D or the 2420C loops if the place of service reported in either the 2300.CLM05 or the 2400.SV105 is other than Home – 12 (or the equivalent POS codes as determined by CMS). If you don’t, the claim will be returned to you with the appropriate remarks code as stated in CR2631.
- Likewise, OCR and Keyshop claims submitted in the ANSI 4010A1 format must utilize the 2310D to report the facility information from block 32 because line level facility information is not readily available on a 1500 form. Medicare will edit these claims accordingly.

Note: The Medicare Standard System first looks to the line item/2420C and then looks to the claim item/2310D for POS information. Currently, it then looks to the Header Information at 2010AA.

Implementation Date

The implementation date for these changes will be April 4, 2005.

Additional Information

You can find CR 3261 by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3261 in the CR NUM column on the right, and click on the file for that CR number. The revised pages of the online manual Pub 100-4, Chapter 1, Section 10 are attached to that CR. In addition you can find CR 2631 at: http://www.cms.hhs.gov/manuals/pm_trans/R1813B3.pdf

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

Related Change Request (CR) #: 3261 Medlearn Matters Number: MM3261

Related CR Release Date: November 3, 2004

Related CR Transmittal #: 353

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

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

Provider Types Affected

Physicians, providers, and suppliers.

Provider Action Needed

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

Background

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

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

- For **therapeutic shoe HCPCS codes A5500, A5501, A5503-A5507, K0628, and K0629** the Medicare Modernization Act of 2003 (MMA, Section 627) changes the payment methodology from reasonable charge to the prosthetic and orthotic fee schedule. Further information on the pricing update for therapeutic shoes will be provided in a separate article for the 2005 update of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule.

For splints and casts the following applies:

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

Implementation

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

Additional Information

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

From that Web page, look for CR3430 in the CR NUM column on the right, and click on the file for that CR. That CR has a detailed list of HCPCS codes for splints and casts with associated gap-filled payment amounts that your carrier will use in making payment in 2005 based on the lower of the actual charge or the gap-filled payment amount.

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

Related Change Request (CR) #: 3430

Medlearn Matters Number: MM3430

Related CR Release Date: September 10, 2004

Related CR Transmittal #: 297

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

Durable Medical Equipment Ordered with Surrogate Unique Physician Identification Number (UPIN)

Provider Types Affected

Physicians

Provider Action Needed

This special edition is intended primarily for informational purposes, but physicians should ensure that they are meeting the requirements for Medicare in order to receive a UPIN.

Background

Section 1833(q) of the Social Security Act (SSA) requires that all physicians who meet the §1861(r) definition of a physician must have a UPIN. All claims for services ordered or referred by a physician must include the name and UPIN of the ordering/referring physician. A physician or supplier who bills Medicare for a service or item must show the name and UPIN of the ordering/referring physician on the claim form, if that service or item was the result of an order or referral from a physician. If the ordering physician is also the performing physician, the physician must enter his/her name and assigned UPIN as the ordering physician. If the ordering/referring physician is not assigned a UPIN, the biller may use a surrogate UPIN. A physician or supplier who submits a claim for a service or item is responsible for ensuring that the name and UPIN of the ordering/referring physician is obtained and submitted on Form HCFA-1500. Physician names and UPINs can be found in the UPIN directory. If the physician's UPIN has not yet been issued, a surrogate UPIN is to be used only until an individual UPIN has been assigned. Surrogate UPINs are used under the following conditions:

- OTH000: To be used when the ordering/referring physician has not yet been assigned and does not qualify for one of the other surrogate UPINs. When OTH000 is used, ensure that it is not being over utilized. Notify the suppliers, physicians, or billers if their use of surrogates is excessive. If surrogate UPINs are over utilized, the Part B contractor via the UPIN Registry will confirm that a UPIN has not been assigned to the ordering/referring physician. If a UPIN has been assigned, the physician will be notified of the assigned UPIN. If a UPIN has not been assigned, the physician will be notified of the need to file an application for a UPIN and sent an application form.
- RES000: To be used by physicians meeting the description of "intern," "resident," or "fellow."
- VAD000: To be used by physicians serving on active duty in the United States military and those employed by the Department of Veterans Affairs.
- PHS000: To be used by physicians serving in the Public Health Service, including the Indian Health Service.
- RET000: To be used by retired physicians who have not been issued a UPIN. (Retired physicians who have been assigned a UPIN must use the assigned UPIN.)

It is CMS's goal to assign a UPIN to every physician/health care practitioner and group practice that meets the Medicare definition.

Source:

Medlearn Matters Number: SE0315



MMA - Section 706_ Implementation of Coverage of Religious Nonmedical Health Care Institution (RNHCI) Items and Services Furnished in the Home

Provider Types Affected

RNHCI and Durable Medical Equipment (DME) Suppliers who may make arrangements with RNHCIs

Provider Action Needed

Effective January 1, 2005, RNHCIs may choose to provide certain Medicare items and RNHCI nursing services in a beneficiary's home. This RNHCI home service benefit is time-limited and will expire on December 31, 2006. Details of those services and how to bill Medicare for them are included in this article. RNHCIs should be familiar with these requirements in order to receive accurate and timely payment for these services.

Background

Section 706 of the MMA extends coverage to certain RNHCI items and services that are provided in a beneficiary's home.

Previously, beneficiaries with a RNHCI election only received coverage for inpatient services in a RNHCI. Those beneficiaries whose religious beliefs prevent them from receiving most medical services and who have an effective election are now eligible for specified home health benefits from a RNHCI.

Beginning April 4, 2005, RNHCIs may submit claims for specified DME and RNHCI nursing visits in the home, although coverage is available from January 1, 2005. Coverage is extended to specified DME items such as: canes, crutches, walkers, commodes, a standard wheelchair, hospital beds, bedpans, and urinals. The DME items are specified by Healthcare Common Procedure Coding System (HCPCS) code numbers and substitute codes may not be billed.

Total Medicare payments to all RNHCI providers nationwide for these items are limited to \$700,000 per calendar year.

When RNHCIs offer home services to RNHCI beneficiaries they may order items and services without a physician order, but with the concurrence of the RNHCI utilization review committee. Receipt of these items and services from a RNHCI do not compromise the beneficiary's election for RNHCI care.

The RNHCI may establish a payment arrangement with one or more DME supplier to obtain any of the specified DME items. Items provided by a DME supplier dealing directly with the beneficiary are excluded. The RNHCI may provide RNHCI nursing services directly using their own staff or under an arrangement using independent RNHCI nurses. These services comprise the RNHCI home benefit. The RNHCI home benefit must exclude the same services that are excluded from home health benefit as defined in 42 CFR 409.49 and 42 CFR 403.768. Services provided by independent RNHCI nurses while working directly for the beneficiary are excluded.

Specific Billing Guidance

The specific billing guidance that RNHCIs need to follow to bill for these items and services are:

- RNHCIs should submit claims for specified DME items from the DME supplier only to the fiscal intermediary for the RNHCI, using type of bill (TOB) 43x.
It is crucial that the RNHCI stress to the DME supplier that the DME supplier must not bill these items to the DME regional carrier; such an action could terminate the beneficiary's election of RNHCI services.
- RNHCIs must submit claims for DME items using revenue codes 291 (rental), 292 (purchase- new) or 293 (purchase- used) only, reporting a HCPCS code, service units, and a date of service for each line item.
- RNHCIs may only provide DME items as specified by the following list of HCPCS:

Canes	<ul style="list-style-type: none"> ■ E0100 Cane, includes canes of all materials, adjustable or fixed, with tip ■ E0105 Cane, quad or three prong, includes canes of all materials, adjustable or fixed with tip
Crutches	<ul style="list-style-type: none"> ■ E0112 Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips ■ E0113 Crutch underarm, wood, adjustable or fixed, pair, with pad, tip and handgrip ■ E0114 Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips ■ E0116 Crutch underarm, other than wood, adjustable or fixed, with pad, tip and handgrip

Walkers	<ul style="list-style-type: none"> ■ E0130 Walker, rigid (pickup), adjustable or fixed height ■ E0135 Walker, folding (pickup), adjustable or fixed height ■ E0141 Walker, rigid, wheeled, adjustable or fixed height ■ E0143 Walker, folding, wheeled, adjustable or fixed height
Commodes	<ul style="list-style-type: none"> ■ E0163 Commode chair, stationary, with fixed arms ■ E0167 Pail or pan for use with commode chair
Wheelchairs	<ul style="list-style-type: none"> ■ K0001 Standard wheelchair
Hospital Beds & Accessories	<ul style="list-style-type: none"> ■ E0250 Hospital bed, fixed height, with any type side rails, with mattress ■ E0255 Hospital bed, variable height, hi-lo, with any type side rails, with mattress ■ E0260 Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress ■ E0275 Bed pan, standard, metal or plastic ■ E0276 Bed pan, fracture, metal or plastic ■ E0290 Hospital bed, fixed height, without side rails, with mattress ■ E0292 Hospital bed, variable height, hi-lo, without side rails, with mattress ■ E0325 Urinal; male, jug-type, any material ■ E0326 Urinal; female, jug-type, any material

- Payment to RNHCIs for these specified DME items will be made based on the DME fee schedule.
- Coinsurance applies to these items. Deductible does not apply to these items.
- RNHCIs must submit claims for RNHCI nursing visits on type of bill 43x using revenue code 57x, reporting each visit as a separate line item using HCPCS code G0156, service units, and a date of service for each line item.
- RNHCIs must report the nursing services in increments of 15 minutes, as defined by HCPCS code G0156.
- Payment to RNHCIs for nursing visits will be made using the table of Metropolitan Statistical Area (MSA)-specific per-visit rates, which is shown in the Additional Information section below.

Additional Information

Payments made for nursing services are shown in the following table:

Facility Specific Per-Visit Rates for RNHCI Nursing Services for Services Provided in Calendar Year 2005

FacilityMSA Area	2005 Wage Index Value	Facility Wage-Adjusted Labor Portion	Facility Non-Labor Portion	Total Facility Per-Visit Rate
1123	1.1290	31.04	8.32	39.36
1600	1.0851	29.83	8.32	38.16
1680	0.9626	26.46	8.32	34.78
1840	0.9753	26.81	8.32	35.13
1920	1.0054	27.63	8.32	35.95
2080	1.0904	29.98	8.32	38.30
3480	1.0039	27.60	8.32	35.92
4480	1.1732	32.25	8.32	40.57
5080	1.0076	27.70	8.32	36.02
5600	1.3586	37.36	8.32	45.68
5960	0.9742	26.78	8.32	35.10
7320	1.1267	30.98	8.32	39.30
7360	1.4712	40.45	8.32	48.77
8200	1.1078	30.46	8.32	38.78
8840	1.0971	30.16	8.32	38.48

Notes:

- National base RNHCI nursing rate is \$35.81.
- Labor portions are calculated as follows: $\$35.81 \times .76775 \times \text{facility's wage index value}$.
- Non-labor portions are calculated as follows: $\$35.81 \times .23225 = \8.32 .
- Facility per-visits rates are the sum of the labor and non-labor portions.

The official instructions issued to your RNHCI fiscal intermediary are in two parts, one reflecting changes to the Medicare Claims Processing Manual and the other reflecting changes to the Medicare Benefit Policy Manual.

The actual manual changes are attached to these instructions. To view the changes to the Medicare Claims Processing Manual, you may see CR3529, transmittal 357 at: http://www.cms.hhs.gov/manual/pm_trans/R357CP.pdf

View the changes to the Medicare Benefit Policy Manual, Transmittal 25 of CR 3529 at: http://www.cms.hhs.gov/manuals/pm_trans/R25BP.pdf

For additional information relating to this issue, please call your RNHCI intermediary at their toll free number.

Related Change Request (CR) #: 3529

Medlearn Matters Number: MM3529

Related CR Release Date: November 5, 2004

Related CR Transmittal #: 25 and 357

Effective Date: January 1, 2005

Implementation Date: April 4, 2005

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

Additional Information

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

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

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

The official instruction issued to your carrier/intermediary (including Durable Medical Equipment Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs)) regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3525 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 3525 Medlearn Matters Number: MM3525

Related CR Release Date: October 29, 2004

Related CR Transmittal #: 340

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

MMA - Medicare Program: Update to the Prospective Payment System (PPS) for Home Health Agencies for Calendar Year 2005

Provider Types Affected

Home health agencies

Provider Action Needed

This article provides information on the annual update of:

- Home Health Prospective Payment System (HH PPS) rates for Calendar Year (CY) 2005; and
- The wage index values and labor percentages to be used in HH PPS payment calculations.

It also modifies the fixed-dollar loss ratio used in determining outlier payments.

Background

The related CR3446 directs Regional Home Health Intermediaries (RHHIs) to implement the CY 2005 annual update for the home health prospective payment system (HH PPS). The HH PPS rates are the national 60-day episode and the national per-visit amounts by discipline used to calculate the low utilization payment adjustment and the outlier payment.

For CY 2005, Medicare will continue to apply the design and case mix methodology described in section III.G of the home health PPS July 3, 2000 Final Rule (65 FR 41192 through 41203).

The labor adjustment to the PPS rates will continue to be based on the site of service of the beneficiary as set forth in the Code of Federal Regulations (42 CFR 484.220 and 484.230), and this labor adjustment is applied to both per-episode and per-visit payment calculations.

MMA Changes

Effective January 1, 2005, the Medicare Modernization Act of 2003 (MMA) required the Centers for Medicare & Medicaid Services (CMS) to change the annual home health update from a fiscal year basis to a calendar year basis. Additionally, the MMA provided for a payment update based on the home health market basket percentage increase, minus 0.8 percent, beginning with the last three calendar quarters of 2004 and continuing through 2006.

For CY2005, the final update to the HH PPS rates is 2.3 percent (3.1% HH market basket – 0.8%). In addition to these MMA changes, the labor and non-labor percentages applied in wage-index adjustment are being revised effective for episodes with a “Through” date on or after January 1, 2005 as follows:

- The labor portion applied for this year will be 0.76775 percent; and
- The non-labor portion applied will be 0.23225 percent.

These percentages will be used in the wage adjustment of all of the payment calculations mentioned above.

Also, for episodes with claim statement “Through” dates on or after January 1, 2005, the fixed-dollar loss (FDL) ratio used in the determination of outlier payments is being re-estimated, based on the most recent available data with the loss-sharing ratio (LSR) remaining unchanged, as follows:

- The FDL ratio is now 0.70.
- The LSR remains unchanged at 0.80.

Updated Metropolitan Statistical Area Table

An updated Metropolitan Statistical Area (MSA) table will be used by Medicare systems that will reflect the 2005 pre-reclassified pre-floor hospital wage index. Effective April 1, 2004, the MMA provided for a five-percent payment increase for one year for services furnished in a rural area.

For episodes with claim statement “Through” dates on or after January 1, 2005 and on or before March 31, 2005, the updated MSA table will be used in applying this five-percent rural add-on to HH PPS payment rates. Medicare systems will identify episodes in these timeframes that qualify for the five-percent add-on using MSA codes that begin with “99.”

Note that claim statement “Through” dates are reported in FL6 of the UB-92 claim form or its electronic equivalent.

Implementation

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

Related Instructions

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 10 (Home Health Agency Billing), Section 70.5 (Annual Updates to the HH Pricer) has been revised.

The updated manual instructions are attached to the official instruction released to your RHHI, and you may view that instruction by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3556 in the CR NUM column on the right, and click on the file for that CR.

Additional Information

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

Related Change Request (CR) #: 3556 Medlearn Matters Number: MM3556

Related CR Release Date: November 5, 2004

Related CR Transmittal #:362

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

Indian Health Service (IHS) or Tribal Hospitals Including Critical Access Hospitals (CAHs) Payment Methodology for Inpatient Social Admissions and Outpatient Services Rendered at a Separate Facility

Provider Types Affected

IHS or Tribal Hospitals, including CAHs

Provider Action Needed

This instruction clarifies the IHS or Tribal Hospitals', including CAHs', payment methodology for social admissions and outpatient services rendered at separate facilities.

Background

IHS or Tribal Hospitals (including CAHs) often submit a Type of Bill (TOB) 12X for social admissions. This TOB is denied by the designated fiscal intermediary (FI) if a separate facility subsequently bills TOB 13X for outpatient services or TOB 72X for dialysis services rendered during a social admission at an IHS/Tribal/CAH Hospital.

It should be noted that:

- There may be situations when a beneficiary is admitted to an IHS/ Tribal facility for social reasons. If these social admissions are for patient and family convenience, they are not billable to Medicare.
- Social admission stays do not qualify for any payment on either an 11X or 12X TOB.
- For admissions before surgery, only the scheduled surgery and related services may be:
 - * Billed on a 13X TOB, if the surgery is performed on an outpatient basis; and
 - * Billed on an 11X TOB, if the surgery is performed on an inpatient basis.
- Social admissions occurring after an inpatient discharge may not be billed to Medicare.
- For patients in a social admission status requiring outpatient services at another facility, the 12X TOB, if submitted, will be rejected by Medicare's FI.

- A duplicate payment would be created if a 12X TOB from the admitting facility occurred with 1) a 13X TOB from another hospital, or 2) a 72X TOB from a Renal Dialysis Facility. This is inappropriate.

Because there is a significant number of social admissions in IHS/ Tribal facilities, Medicare has decided to disallow payment for inpatient Part B services during a social admission stay when there is another bill from a different facility for an outpatient service.

The following represents the Centers for Medicare & Medicaid Services (CMS) policy:

- When a 12X TOB from an IHS/ Tribal facility (including CAHs) covers the same time period as 1) a 13X TOB received from another hospital, or 2) a 72X TOB received from a Renal Dialysis Facility:
 - ✦ The 12X TOB is presumed to represent a social admission and is disallowed; and
 - ✦ The 13X TOB/ 72X TOB will be paid.
- A social admission stay does not qualify for any payment for the TOBs 11X or 12X.
- A social admission cannot be used to satisfy the three-day prior stay for Skilled Nursing Facilities.

Implementation

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

Related Instructions

The official instruction issued to your FI may be viewed at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3452 in the CR NUM column on the right, and click on the file for that CR.

Additional Information

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

Request (CR) #: 3452 Medlearn Matters Number: MM3452

Related CR Release Date: October 29, 2004

Related CR Transmittal #: 336

Effective Date: April 1, 2005

Implementation Date: April 4, 2005



MMA-Addition of Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists as Emergency On-Call Providers for Critical Access Hospitals

Provider Types Affected

Critical Access Hospitals (CAHs)

Provider Action Needed

Be aware of the changes, introduced by Section 405 of the Medicare Modernization Act (MMA), that allow CAHs to include physician assistants, nurse practitioners, and clinical nurse specialists as CAH emergency room on-call providers, effective with dates of service on or after January 1, 2005.

Background

Section 405 of the MMA introduces the following changes for CAHs beginning with cost reporting periods that start on or after January 1, 2005:

- CAHs may include physician assistants, nurse practitioners and clinical nurse specialists as CAH emergency room on-call providers.
- CAHs may include amounts for reasonable compensation and related costs of these non-physician practitioners who are on call, and payment will be made via the cost report settlement process.
- Non-physician practitioners who are on call do not have to be present on the premises of the CAH involved.
- Non-physicians practitioners who are on call cannot be furnishing physician services at another site while on call.
- Non-physician practitioners who are on call cannot be on call at any other provider or facility while on call.

The Medicare Claims Processing Manual is being revised as a result of the Change Request (CR3228), on which this article is based. Section 30.1.3 of Chapter 3 of that manual is revised and CAHs should note that the revision requires that, for the costs associated with these non-physician practitioners to be allowable, the costs must be incurred under a written contract that requires the on-call provider to come to the CAH when the provider's presence is medically required.

Additional Information

To view the entire instruction issued to your intermediary, go to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that site, look for CR3228 in the CR NUM column on the right and click on the file for that CR.

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

Related Change Request (CR) #: 3228

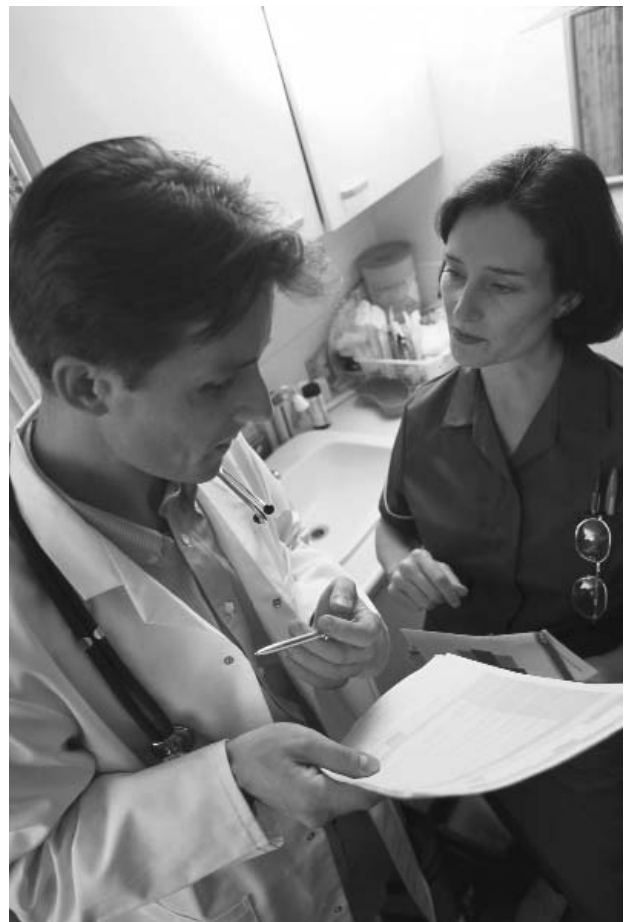
Medlearn Matters Number: MM3228

Related CR Release Date: August 27, 2004

Related CR Transmittal #: 285

Effective Date: January 1, 2005

Implementation Date: January 3, 2005



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Voluntary Refund Disclosure

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