

# Intermediary

## NEWS



July 2003

**THIS PUBLICATION  
SHOULD BE SHARED WITH  
ALL HEALTH CARE  
PRACTITIONERS AND  
MANAGERIAL MEMBERS OF  
THE PROVIDER/SUPPLIER  
STAFF.  
BULLETINS AND  
INTERMEDIARY NEWS ISSUED  
AFTER OCTOBER 1, 1999  
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Claims Testing Notification

## Credit Balance

Reporting Update

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Dignity and Peace as Life Nears Its End

## Skilled Nursing Facility

Consolidated Billing Reminders

PROVIDER RELATIONS  
TOLL FREE PHONE NUMBER

866-488-0545

# Intermediary NEWS



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

PROVIDER RELATIONS

**TOLL FREE PHONE NUMBER**

**866-488-0545**



# HIPAA Claims Testing Notification

Between now and October, the health care industry must address the challenge of becoming compliant with the transaction and code set standards under HIPAA. Effective October 16, 2003, administrative transactions (like claims and remittance advice's) that are done electronically must meet new HIPAA regulatory standards for format and content.

Although this is a significant undertaking, the result will greatly enhance electronic communication throughout the health care community. Successful implementation will require the attention and cooperation of all health plans and clearinghouses, and of all providers that conduct electronic transactions.

Communication between trading partners as well as early testing is vitally important. Providers need to make sure their software vendors or billing services have made necessary changes so that they are ready to test with payers in a timely manner. **Experience has shown that testing can take over 1 month.**

Our combined goal must be that on October 17, everyone is using the HIPAA standards and that no one notices any difference. We urge you to focus your attention and resources necessary to make this goal a reality. If testing is not performed timely, provider cash flow could be jeopardized, and, with that, comes the danger of impacting patients' access to health care. That's not an outcome anyone wants to occur.

Some have expressed concern that further changes will be made to the designated formats and therefore they don't want to test until they know changes are final. The current HIPAA standards will be in effect through 2003 and for several more years.



Medicare will only accept and send HIPAA formatted transactions after October 16, 2003. All non-HIPAA formats currently supported by Medicare (such as the National Standard Format for claim and remittance advice, the UB92, the 837 (3051) and 835 (3051)) will not be updated beyond October 16, 2003, nor accepted or sent.

The Companion Guide for CareFirst Medicare Part A is located at [http://www.marylandmedicare.com/pages/mdmedicare/hipaa/hipaa\\_main.htm](http://www.marylandmedicare.com/pages/mdmedicare/hipaa/hipaa_main.htm) This document contains important information required for processing data in the Medicare-FISS system of CareFirst Medicare-A Contractor number 00190.

To begin testing the HIPAA 4010A1 format, please contact the EDI department.

Kenya McEachern	410-561-4299
Debbie Leary	410-561-4122
Wayne Piotrowski	410-561-4145

# Hospice Care Enhances Dignity: Peace as Life Nears Its End

Much of the pain and sense of hopelessness that may accompany terminal illness can be eased by services specifically designed to address these needs. Hospice care, a fully reimbursable Medicare Part A benefits option for beneficiaries and providers since 1983, offers the services designed to address the physical and emotional pain through effective palliative treatment when cure is not possible. In the event that a beneficiary has been advised by his/her physician, that a cure for his/her illness is no longer possible, Medicare beneficiaries may discuss hospice care as an option. Physicians and other health care practitioners can be encouraged that the Medicare program includes a hospice benefit that provides coverage for a variety of services and products designed for those with terminal diagnoses. When properly certified and appropriately managed, hospice care is a supportive and valuable covered treatment option.

Physicians and health care providers in the community, skilled nursing facilities, and hospitals are urged to raise awareness among their patients about the hospice benefit and its availability. Further, a beneficiary may independently elect hospice care. The beneficiary may discuss this option in the event that he or she has a terminal diagnosis; however, in all such cases, a physician must certify that the beneficiary has a terminal diagnosis with a six-month prognosis, if the illness runs its usual course.

Hospice care that is covered by Medicare is chosen for specified amounts of time known as "election periods." Essentially, a physician may certify a patient for hospice care coverage for two initial 90-day election periods, followed by an unlimited number of 60-day election periods. Each election period requires that the physician certify a terminal illness. Payment is made for each day of the election period based on one of four per diem rates set by Medicare, commensurate with the level of care.

Generally speaking, the hospice benefit is intended primarily for use by patients whose prognosis is terminal, with six months or less of life expectancy. The Medicare program recognizes that terminal illnesses do not have entirely predictable courses, therefore, the benefit is available for extended periods of time beyond six months provided that proper certification is made at the start of each coverage period.

Recognizing that prognoses can be uncertain and may change, Medicare's benefit is not limited in terms of time. Hospice care is available as long as the patient's prognosis meets the law's six-month test.

This test is a general one. As the governing statute says: "The certification of terminal illness of an individual who elects hospice shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."

CMS recognizes that making medical prognostication of life expectancy is not always an exact science. Thus, physicians need not be concerned. There is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill.

Many physicians appreciate the fact that hospice care enables family and loved ones to participate in the experience and to get help from the hospice in managing their own feelings and reactions to the illness. The value of hospice care is recognized and advanced by many physicians and other health professionals. One professional organization, the American Academy of Hospice and Palliative Medicine (formerly the Academy of Hospice Physicians) focuses its efforts on the "prevention and relief of suffering among patients and families" through palliative therapy, education and counseling. Among the Academy's objectives are to "bring the hospice approach into mainstream medicine and eliminate the dichotomy whereby patients receive either curative or palliative care."

This distinction is important because despite a growing appreciation for hospice care both as a philosophy and as a fully covered Medicare benefit, there appears to be two perceived barriers to its broader acceptance.

First is an understandable reticence to contemplate the end of life. A 1999 survey conducted by the National Hospice and



Palliative Care Organization (NHPCO) found that Americans generally are reticent to discuss hospice care with their elderly parents. According to the survey, less than one in four of us have put into writing how we wish to be cared for at life's end. About one in five have not contemplated the subject at all, and a slightly smaller number told the surveyors they have thought about it but have not shared their thoughts with others.

The second perceived barrier is a lack of knowledge on the part of both patients and practitioners that the covered hospice benefits are both broad and readily available virtually everywhere in the country. As with other covered services, payments for hospice care generally are made to providers based on prospectively set rates that are updated every year for inflation. Hospice care is primarily a specialized type of home health care, and as is the case with the home health care benefit, hospices are served by regional intermediaries for Medicare billings, payments, cost reports and audits.

Hospice care also is covered by Medicaid in many states. Medicare covers a number of specific services as defined in regulation and in the Medicare Hospice Program Manual. Most of these services are familiar to health care professionals and other practitioners who have worked with skilled nursing facilities (SNFs) and home health services. Covered services include:

- Medical and nursing care
- Medical equipment (such as wheelchairs or walkers)
- Pharmaceutical therapy for



pain relief and symptom control

- Home health aide and home maker services
- Social work services
- Physical and occupational therapy
- Speech therapy
- Diet counseling
- Bereavement and other counseling services
- Case management

In many states, Hospice care also is covered by Medicaid.

In 1999, 474,270 individuals received hospice care at 2,281 certified hospice programs in the United States. In 2000 there were 2,266 certified hospices. In 2001, approximately 580,000 individuals received hospice care at 2,277 (as of August 2001) certified hospice programs. The hospice setting also is appropriate for patients who

suffer from terminal illnesses such as lung disease or end-stage heart ailments, cancer, Alzheimer's disease, and terminally ill AIDS patients. Hospice is not about death, but rather about the quality of life as it nears its end, for all concerned – the patient, family and friends, and the health professional community.

For more information: go online to [www.cms.gov/medicare/hospice/hospice.htm](http://www.cms.gov/medicare/hospice/hospice.htm); check the Medicare Learning Network at [www.cms.gov/medlearn/](http://www.cms.gov/medlearn/); or see a related informational brochure on hospice care at: [www.medicare.gov/publications](http://www.medicare.gov/publications).

*(Source: Program Memorandum AB-03-040; Change Request*

# Peace as Life Nears Its End



# Credit Balance Reporting Update

If we have an overpayment, how much money should we indicate in columns 9 & 10 on the HCFA-838? The credit balance indicates the actual amount paid. It should not include coinsurance, deductible or contractual allowance amounts.

**If you billed an outpatient claim for \$100.00**

Payment-	\$ 75.20
Contractual Allowance-	\$ 6.00
<u>Coinsurance-</u>	<u>\$ 18.80</u>
<b>Total Billed =</b>	<b>\$ 100.00</b>

The amount that needs to be reported in **column 9** is **\$75.20**, which equals the actual amount Medicare paid.

If you have a specific line item that is causing the credit balance, you can find the amount overpaid for that line by accessing DDE and following these steps:

- 1 - Option 01- Inquiries
- 2 - Option- 12- Claims
- 3 - Type HIC # and dates of service
- 4 - Select your claim by entering a " S" or "U" outside of the claim line
- 5 - Go to page 2 of the claim (F8)
- 6 - Key "F11" this page will give you the actual amount paid for a particular line item. The amount will be indicated under the field labeled "REIMB". To find additional revenue lines key "F6" to scroll down.

*(Source: October 2001 Intermediary News)*

# Payment Category Change

**Payment Category Change for HCPCS Codes E1161, Manual Adult Size Wheelchair, Includes Tilt In Space, and E1231 thru E1238, pediatric wheelchairs.**

This is to inform providers of a payment category change for wheelchair codes E1161 and E1231 thru E1238. Codes E1161 and E1231 thru E1238 were added January 1, 2003 and were placed in the capped rental (rental only) payment category. We are moving these items to the payment category for inexpensive/routinely purchased items (purchase or rental), but this change will not be effective in the systems until July 1, 2003. In the meantime, DMERCs must allow suppliers to bill for the purchase of these wheelchairs under code K0009, the code for miscellaneous wheelchairs, and the DMERCs must process these claims under that code. Effective for claims for items furnished on or after July 1, 2003, suppliers must use codes E1161 and E1231 thru E1238 for these items rather than code K0009.



# Reminder:

## Skilled Nursing Facility Consolidated Billing

### Why must billing be consolidated for services for beneficiaries in a SNF?

In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the fiscal intermediary to the SNF. These bundled services had to be billed by the SNF to the FI in a consolidated bill. No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. Medicare beneficiaries can either be in a Part A covered SNF stay which includes medical services as well as room and board, or they can be in a Part B non-covered SNF stay in which the Part A benefits are exhausted, but certain medical services are still covered though room and board.

### What is included in consolidated billing?

The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay. Exception: a limited number of services specifically excluded from consolidated billing and therefore separately payable.

### For Medicare beneficiaries in a covered Part A stay, these separately payable services include:

- physician's professional services;
- certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
- certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
- erythropoietin for certain dialysis patients;
- certain chemotherapy drugs;
- certain chemotherapy administration services;
- radioisotope services; and
- customized prosthetic devices; and
- emergency room services

For a complete list of exclusions to consolidated billing, refer to the SNF manual, section 516, available on [www.cms.hhs.gov](http://www.cms.hhs.gov).

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other covered SNF services for these beneficiaries can be separately billed.

### Examples

1. Mrs. Smith was in a Medicare Part A covered stay in a SNF from 6/01/03 to 6/21/03. Mrs. Smith went to a hospital on 6/15/03, as an outpatient to have a skin abscess drained (HCPCS 10060) she also had a lab test (300-revenue code) with HCPCS 80069 (Renal function). In this example 10060 and 80069 are included in Part A PPS claim and the hospital should bundle bill these charges back to the SNF. The hospital should NOT submit a claim to Medicare.
2. Mr. Jones was in a Medicare Part A covered stay in a SNF from 4/13/03 to 4/30/03. During his stay Mr. Jones went to a outpatient facility on 4/23/03, for a PUNCTURE ASPIRATION OF ABSCESS, HEMATOMA, BULLA, OR CYST, revenue code 361 with HCPCS 10160 supplies were also billed (270). The services are excluded from Part A PPS billing. The outpatient facility should bill Medicare.

# SNF Three Day Qualifying Stay

**I**n order for a skilled stay in an SNF to be covered by Medicare it must be preceded by a 3 day qualifying hospital stay. Three days are defined as 3 billings of room and board, this means that the from and through days actually span 4 calendar days since the discharge or transfer day is not paid. Regulations outlining the providers responsibility are in section 403.5 of the SNF manual and 1870 of the SSA Act. Physicians and health care providers in the community, skilled nursing facilities, and hospitals are urged to raise awareness among their patients about the hospice benefit and its availability. Further, a beneficiary may independently elect hospice care. The beneficiary may discuss this option in the event that he or she has a terminal diagnosis; however, in all such cases, a physician must certify that the beneficiary has a terminal diagnosis with a six-month prognosis, if the illness runs its usual course.

SNF providers are required to indicate the 3-day qualifying stay using Occurrence Span Code (OSC) 70 and the associated dates of the hospital stay.

**Admission Process -** A SNF has no guarantee of payment provision. Therefore, the following guidelines should be adhered to when admitting a beneficiary: (403.5)

- Ask the transferring hospital if the beneficiary had a 3-day qualifying hospital stay and if the transfer meets the 30-day requirement.
- Determine from the transferring hospital if it is aware of the beneficiary's entitlement to Part A benefits.
- When only Part B entitlement is available on admission,

explain to the beneficiary the liability for payment (see §532) for billing instructions for Part B inpatient services.

- If a transfer agreement form is sent from the hospital, use it to determine the qualifying hospital stay dates and entitlement to Medicare.
- When entitlement to Medicare cannot be established from the beneficiary, his representative or your internal records, contact the SSO. (See §406.)
- Determine if the medical appropriateness guidelines are met. (See §212.)

**Three Day Prior Hospitalization --** The hospital discharge must have occurred on or after the first day of the month in which the individual attains age 65 or becomes entitled to health insurance benefits under the disability or chronic renal disease provisions of the law. The 3 consecutive calendar days requirement, can be met by stays totaling 3 consecutive days in one or more hospitals. **In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. (212.1)**

To be covered, the extended care services must be needed for a condition which was treated during the patient's qualifying hospital stay, or by a condition which arose while he was in the facility for treatment of a condition for which he was previously treated in the hospital. In addition, the qualifying hospital stay must have been medically necessary. The intermediary will determine whether this requirement is met; where the situation warrants it, by checking with the attending physician and the hos-

pital

The 3-day hospital stay need not be in a hospital with which the SNF has a transfer agreement. However, the hospital must be: (a) a participating general, psychiatric, or tuberculosis hospital; or (b) an institution which meets at least the conditions of participation for hospitals described in section 203E. and G., i.e., an emergency service hospital. A nonparticipating psychiatric or tuberculosis hospital need not meet the special requirements applicable to psychiatric and tuberculosis hospitals (section 203.1). Stays in Christian Science Sanatoriums (section 202) are excluded for the purpose of satisfying the 3-day period of hospitalization. (See section 410 for prohibition on use of waiver of liability days in meeting 3-day requirement.)

#### Note:

While a 3-day stay in a psychiatric hospital satisfies the prior hospital stay requirement, institutions which primarily provide psychiatric treatment, cannot participate in the program as skilled nursing facilities. Therefore, a patient with only a psychiatric condition who is transferred from a psychiatric hospital to a participating SNF is likely to receive only non-covered care. In the SNF, the term "non-covered care" refers to any level of care which is less intensive and skilled than the SNF level of care which is covered under the program. (See section 214ff). **Three Day Prior Hospitalization : Foreign Hospital.--** A stay of 3 or more days in a hospital outside the United States may satisfy the prior inpatient stay requirement for post-hospital extended care services within the United States if the foreign hospital is qualified as an "emergency hospital." (See section 414, Item 12F, for docu-



mentation requirements. The intermediary will advise the SNF whether the prior inpatient stay requirement is met and whether Part A benefits are payable. (212.2)

**Thirty Day Transfer:**

A. General - Post-hospital extended care services represent an extension of care for a condition for which the individual received inpatient hospital services. Extended care services are "post-hospital" if initiated within 30 days after discharge from a hospital stay which included at least 3 consecutive days of medically necessary inpatient hospital services. (In certain circumstances the 30-day period may be extended, as described in B below). (212.3)

In determining the 30-day transfer period, the day of discharge from the hospital is not counted in the 30 days. For example, a patient discharged from a hospital on August 1 and admitted to an SNF on August 31 was admitted within 30 days. The 30-day period begins to run on the day following actual discharge from the hospital and continues until the individual is admitted to a participating SNF, and requires and receives a covered level of care. Thus, an individual who is admitted to an SNF within 30 days after discharge from a hospital, but does not require a covered level of care until more than 30 days after such discharge, does not meet the 30-day requirement. (See B below for an exception under which such services may be covered.)

**Coverage of Services: (212.3)**

If an individual whose SNF stay was covered upon admission and is thereafter determined not to require a covered level of care, for a period of more than 30 days, payment could not be resumed for any extended care services he may subsequently require. This still holds true even though he has remained in the facility. Such services could not be deemed "post-hospital" extended care services. (For exception, see B below.)

B. Medical Appropriateness

Exception.--An elapsed period of more than 30 days is permitted for SNF admissions where the patient's condition makes it medically inappropriate to begin an active course of treatment in an SNF within 30 days after hospital discharge, and it is medically predictable at the time of the hospital discharge that he will require covered care within a pre determined time period. The fact that a patient enters an SNF within 30 days of discharge from a hospital, for either covered or non-covered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

1. Medical Needs Are Predictable - In determining the type of case which this exception is designed to handle, it is necessary to recognize the intent of the extended care benefit itself. The extended care benefit covers relatively short-term care when a patient requires skilled nursing or skilled rehabilitation services as a continuation of treatment begun in the hospital. The requirement that covered extended care services be provided in an SNF within 30 days after hospital discharge is one means of assuring that the SNF care is related to the prior hospital care.

This exception to the 30-day requirement recognizes that for certain conditions SNF care can serve as a necessary and proper continuation of treatment initiated during the hospital stay, although it would be inappropriate from a medical standpoint to begin such treatment within 30 days after hospital discharge. The exception is intended to apply only where the SNF care constitutes a continuation of care provided in the hospital. Therefore, it will be applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a pre-

determinable time frame. Accordingly, to qualify for this exception it must be medically predictable at the time of hospital discharge that a covered level of skilled nursing facility care will be required within a predictable period of time for the treatment of a condition for which hospital care was received. The patient must begin receiving such care within that time frame.

An example of the type of care for which this provision was designed is a hip fracture case. Under the established pattern of treatment of hip fractures it is known that skilled therapy services will be required subsequent to hospital care, and that they can normally begin within 4-6 weeks after hospital discharge, when weight bearing can be tolerated. Under the exception to the 30-day rule, the admission of a hip fracture patient to an SNF within 4-6 weeks after his hospital discharge for skilled care, which as a practical matter can only be provided on an inpatient basis by an SNF, would be considered a timely admission.



# Benefit Integrity CORNER



## BENEFIT INTEGRITY CORNER

### Program Safeguard Contractor Transition

Program Safeguard Contractors (PSC's) are contractors specifically designated by CMS to handle the program integrity functions of Medicare as mandated in the Health Insurance Portability and Accountability Act (HIPAA).

Effective October 1, 2002, the CMS Program Safeguard Contractor – TriCenturion, LLC took over the Trailblazers Medicare Part B workload for the area of Benefits Integrity. TriCenturion now has oversight of Medicare Part B Benefits Integrity for the Region III states of Maryland, Delaware and Virginia, as well as the District of Columbia. TriCenturion has also recently assumed oversight over the Medicare Part A workload for the states of Maryland and Delaware.

For more information, visit:

- TriCenturion at: [www.tricenturion.com](http://www.tricenturion.com)
- Electronic Data Systems Corporation at: [www.eds.com](http://www.eds.com)

### Recent Reinstatements and Sanctions to the Provider Community

#### Reinstatements

#### **Conrad, Marvin**

Dentist  
6223 Liberty Road  
Baltimore, MD 21207  
Effective Date: June 24, 2003

#### **Herford, Linda**

Owner, DME Company  
219 Kennedy Street NW  
Washington, DC 20011  
Effective Date: March 26, 2003

#### **Harte, Kala**

Nurse/Nurses Aide  
416 S Walnut Street  
Milford, DE 19963  
Effective Date: March 26, 2003

#### **Newlen, Patricia**

Nurse/Nurses Aide  
15 Brandon Ladd Circle  
Waynesboro, VA 22980  
Effective Date: March 10, 2003

#### **Tittermary, Lorraine**

Nurse/Nurses Aide  
15244 King St, Box 204  
Belle Haven, VA 23306  
Effective Date: March 26, 2003

#### **Claney, Jonathon Holt**

Family Physician  
1034 Phoenixville Pike  
West Chester, PA 19380  
Effective Date: March 4, 2003

#### **Jermany, Mertine**

Family Physician  
16078 AE Mullinix Road  
Woodbine, MD 21797  
Effective Date: March 26, 2003

# Benefit Integrity CORNER



## SANCTIONED PROVIDER UPDATE

### ***Baskins, Joanne***

Nurse/Nurses Aide  
1700 Crafton Boulevard  
Pittsburgh, PA 15205  
Effective Date: July 20, 2003  
Type of Action: 1128(b)4

### ***Bole, Elizabeth***

Nurse/Nurses Aide  
119 Villa Drive  
Butler, PA 16001  
Effective Date: July 20, 2003  
Type of Action: 1128(b)4

### ***Bowen, Shirley***

Private Entity  
32 Sassafras Way  
Lewistown, PA 17044  
Effective Date: July 20, 2003  
Type of Action: 1128(a)3

### ***Debose, Serena***

Nurse/Nurses Aide  
5726 Filbert Street  
Philadelphia, PA 19139  
Effective Date: July 20, 2003  
Type of Action: 1128(b)4

### ***George, Karen***

Nurse/Nurses Aide  
291 Thomas Drive  
Gettysburg, PA 17325  
Effective Date: July 20, 2003  
Type of Action: 1128(b)4

### ***Johnson, Margaret***

Nurse/Nurses Aide  
118 Pamela Court  
Levittown, PA 19057  
Effective Date: July 20, 2003  
Type of Action: 1128(b)4

### ***Kitchen, David***

Nurse/Nurses Aide  
15 Sycamore Road  
Ephrata, PA 17522  
Effective Date: July 20, 2003  
Type of Action: 1128(b)4

### ***Levinsky, Ann***

Nurse/Nurses Aide  
4040 Presidential Blvd  
Philadelphia, PA 19131  
Effective Date: July 20, 2003  
Type of Action: 1128(b)4

### ***Manning, Richard***

Surgeon  
1101 Claremont Road  
Carlisle, PA 17013  
Effective Date: July 20, 2003  
Type of Action: 1128(a)2

### ***Mehta, Barry***

Adult Home – Owner  
5551 Oakland Mills Road  
Columbia, MD 21045  
Effective Date: July 20, 2003  
Type of Action: 1128(b)

### ***Oldham, Daniel***

Nurse/Nurses Aide  
P O Box 234  
Duncansville, PA 16635  
Effective Date: July 20, 2003  
Type of Action: 1128(b)4

### ***Panikowski, Lori***

Nurse/Nurses Aide  
2515 South Fairhill Street  
Philadelphia, PA 19148  
Effective Date: July 20, 2003  
Type of Action: 1128(b)4

## Download Files...



The following files can be downloaded from the CMS web site. Visit [www.marylandmedicare.com](http://www.marylandmedicare.com) for the activated links under 'Download Files' on our homepage.

- 👉 Access and download forms on the CMS web site at: [www.cms.gov/forms](http://www.cms.gov/forms)
- 👉 Download CMS files for Medicare Payment Systems at: [www.cms.gov/providers/pufdownload](http://www.cms.gov/providers/pufdownload)
- 👉 Access HCPC files at: [www.cms.gov/paymentsystems](http://www.cms.gov/paymentsystems)
- 👉 Access Medicare Payment Systems and Coding Files at: [www.cms.gov/paymentsystems](http://www.cms.gov/paymentsystems)
- 👉 Download CMS manuals at: [www.cms.gov/manuals/cmstoc.asp](http://www.cms.gov/manuals/cmstoc.asp)
- 👉 Access the Federal Register at: [www.gpoaccess.gov/fr/index/html](http://www.gpoaccess.gov/fr/index/html)
- 👉 Acute Inpatient Prospective Payment System  
*Public Use Files for download for the Prospective Payment System.*  
[www.cms.gov/providers/hipps/ippspufs.asp](http://www.cms.gov/providers/hipps/ippspufs.asp)

## DID YOU KNOW?

*In your claims correction screen (TB9997) the DDE SORT field can sort your claims to be corrected in order?*

### Valid Values

M = Medical Record Number Sort(Ascending Order)

N = Name Sort(Alpha by last name)

H = HIC Number

PROVIDER RELATIONS  
TOLL FREE PHONE NUMBER

866-488-0545

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

Intermediary  
NEWS

