

# Intermediary NEWS



October 2004

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## Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update.

The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update list-serv (electronic mailing list) at:

<http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1>.

The Quarterly Provider Update can be accessed at <http://www.cms.gov/providerupdate>. We encourage you to bookmark this Web site and visit it often for this valuable information.

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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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## Provider Education Article: National Participating Physician Directory

The National Participating Physician Directory contains valuable information about Medicare participating physicians for the use of beneficiaries, their families, and their caregivers.

In order to ensure that the Directory includes the most up-to-date information, practicing physicians should check the accuracy of their listings and use the feedback tool on our web site to notify CMS about any information that is incorrect, has changed, or to advise us if you are not listed in the Directory.

### INFORMATION INCLUDED IN THE DIRECTORY

The following information is available regarding Medicare participating physicians (those who have agreed to always accept assignment):

- Name and address (including a mapping feature)
- Medical specialty
- Business telephone number
- Medical school and year of graduation
- Board certification in a medical specialty
- Gender
- Hospital affiliation
- Foreign language
- Residency and internship program (coming soon)
- Sanctions against individual physicians (coming soon)
- Whether accepting new Medicare patients (coming soon)

### HOW TO CHECK ACCURACY OF YOUR INFORMATION

The accuracy of your listing can be checked by clicking on the “Participating Physician Directory” from the home page of <http://www.medicare.gov>. Our feedback tool is available to correct any information that is incorrect, has changed, or to advise us if you are not listed in the Directory. The Directory will be updated on a monthly basis. For additional information about the Directory, click on “Physician Note” at the bottom of the page.

You may also link to the Directory from the CMS web site at: <http://www.cms.hhs.gov/physicians/> (under “Participation”).

**NOTE:** Only participating physicians who have agreed to accept assignment on all Medicare claims and covered services are included in the Directory. Assignment does not apply to Medicare managed care or private fee-for-service plans.

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## “Incident to” Services

### Provider Types Affected

All Medicare providers of professional services

### Provider Action Needed

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

### Background

The intent of this article is to clarify any confusion about billing for “incident to” services. “Incident to” services are defined as those services that are furnished incident to physician professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home. These services are billed to your carrier as if you personally provided them, and are paid at the full physician fee schedule amount.

**Note:** “Incident to” services are also relevant to services supervised by certain non-physician practitioners such as physician’s assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. These services are subject to the same requirements as physician-supervised services. Remember that “incident services” supervised by physician’s assistants, nurse practitioners, clinical nurse specialists, and nurse midwives are reimbursed at 85% of the physician fee schedule when they are supervised by those non-physician practitioners.

For clarity’s sake, this article will refer to “physician” services as inclusive of non-physician practitioners. To qualify as “incident to,” services must be part of your patient’s normal course of treatment, during which a physician **personally performed an initial service, provides direct supervision**, and remains actively involved in the course of treatment. Additionally, the patient record should document the essential requirements for incident to service.

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

- Covered Medicare services (provided by qualified personnel);
- An integral part of the patient’s treatment course;
- Of a type commonly furnished in a physician’s office (not in an institutional setting);
- An expense to you; and
- Of a type commonly rendered without charge (included in your physician’s bills).

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

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

### Your Office

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

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

### Hospital or SNF

For services in a hospital or skilled nursing facility (SNF), the unbundling provision (1862 (a)(14)) provides that all services provided to hospital patients (except for certain professional services personally performed by physicians and other allied health professionals) are only covered as payable hospital services that are billable to the hospital’s intermediary.

Therefore they are not separately billable under the physician fee schedule. Only if the services are provided not physically in the hospital and not located on hospital grounds do they qualify as “incident to” a physician’s services. The same rules that apply to hospitals also apply to SNFs.

### Offices in Institutions

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

One exception to consolidated billing rules in SNFs is that certain chemotherapy “incident to” services are excluded from the bundled SNF payments and may be separately billable to the carrier.

### In Patients’ Homes

In general, you must be present in the patient’s home for the service to qualify as an “incident to” service. There are some exceptions to this direct supervision requirement that apply to homebound patients in medically underserved areas where there are no available home health services, only for certain limited services found in Pub 100-02, Chapter 15 Section 60.4 (B). In these instances, you need not be physically present in the home when the service is performed, although general supervision of the service is required. You must order the services, maintain contact with the nurse or other employee, and retain professional responsibility for the service.

All other incident to requirements must be met. Another exception applies when the service at home is an individual or intermittent service performed by personnel who meet pertinent state requirements (e.g., nurse, technician, or physician extender), and it is an integral part of the physician’s services to the patient. Ambulance Service—neither ambulance services nor EMT services performed under your telephone supervision are billable as “incident to” services.

### Additional Information

To provide additional clarity, we present the following scenarios:

***Must a supervising physician be physically present when flu shots, EKGs, Laboratory tests, or Xrays are performed in an office setting in order to be billed as “incident to” services?***

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

***Can anti-coagulation monitoring be provided “incident to” a physician’s services in an office?***

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

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

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

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

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

Source:

Change Request #: N/A

Medlearn Matters Number: SE0441

# OIG Alert about Charging Extra for Covered Services

## Provider Types Affected

Physicians, suppliers, and providers

## Provider Action Needed

Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees should be mindful that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.

## Background

On March 31, 2004, the Office of the Inspector General (OIG) issued an Alert that focused on physicians charging extra for services covered by Medicare. The Alert noted that these extra contractual charges beyond Medicare's deductible and coinsurance constituted a potential assignment violation. In the Alert, the OIG reminded Medicare participating physicians of the potential liabilities posed by billing Medicare patients for services that are already covered by Medicare. Charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid for by Medicare.

Medicare participating providers can charge Medicare beneficiaries extra for items and services that are not covered by Medicare. In addition, participating providers may charge beneficiaries for any Medicare deductibles and coinsurance without violating the terms of their assignment agreements.

However, when participating providers request added payment for covered services from Medicare patients, they are liable for substantial penalties and exclusion from Medicare and other Federal health care programs. The special services for added payment are known by various names and may include "concierge care," "boutique medicine," "retainer practice," or "platinum practice."

For example, the OIG recently alleged that a physician violated his assignment agreement when he offered his patients, including Medicare beneficiaries, a "Personal Health Care Medical Care Contract" that required payment of an annual \$600 fee. The physician characterized the services to be provided under the contract as "not covered" by Medicare, and the services offered under this contract included:

- Coordination of care with other providers;
- A comprehensive assessment and plan for optimum health; and
- Extra time spent on patient care.

The OIG alleged that based on the specific facts and circumstances of this case, at least some of these contracted services were already covered and reimbursable by Medicare. Therefore, OIG alleged that each contract presented to this physician's Medicare patients constituted a request for payment for already covered services, other than the coinsurance and deductible, and was therefore a violation of the physician's assignment agreement. To resolve these allegations, the physician agreed to pay a settlement amount to the OIG, and to stop offering these contracts to his patients.

Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees are reminded that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.

Note that a participating provider is a provider of Medicare covered items and services who agrees to accept the Medicare-approved charge for all covered services to Medicare patients. A participating provider "accepts assignment" for all Medicare-payable services.



Also note that non-participating providers may also be subject to penalties and exclusion for overcharging beneficiaries for covered services. This is true whether the provider accepts assignment for a given service or not, in which case the provider's charge is limited to the "limiting charge."

### Related Instructions

The Physicians Information Resource for Medicare website is extensive and includes information about Medicare Participation, Participating Physician Directory, Policies and Regulations, including the CMS Quarterly Provider Update, Medicare Coverage Issues Manual, Medicare National Determination Manual, Physician Fee Schedule, Practicing Physician Advisory Council, Medicare Learning Network, and much more.

This website can be found at: <http://www.cms.hhs.gov/physicians/>

### Additional Information

The OIG Alert, dated March 31, 2004 and titled "OIG Alerts Physicians About Added Charges for Covered Services," can be found at the following website: <http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf>

#### Source:

*Related Change Request (CR) #:* N/A

*Medlearn Matters Number:* SE0421

## MMA - CMS to Increase Payments to Hospitals Reclassified Under Medicare Reform Law

### Provider Types Affected

Hospitals

### Provider Action Needed

### Impact to You

This Special Edition concerns the increase of payments to hospitals reclassified geographically under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

### What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) announced that 121 hospitals in 25 states have been geographically reclassified, and each will begin receiving higher payments retroactive to April 1, 2004 for patients who were discharged on or after April 1, 2004.

### What You Need to Do

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

### Background

Medicare pays hospitals for inpatient services provided to Medicare beneficiaries according to the inpatient prospective payment system (IPPS), and payment under the IPPS is based on the average cost of treating patients with a similar diagnosis. However, the actual amount received by a hospital for a particular case depends on a number of factors, including the geographic area in which the hospital is located.

As a general rule, hospitals in urban areas, as defined by the Census Bureau's Metropolitan Statistical Areas (MSAs), are paid at a higher rate than those in rural areas. Under Section 508 of the MMA, Congress directed CMS to create a one-time-only appeals procedure for certain hospitals that were deemed to be in need of financial relief, but fell just outside Medicare's existing criteria for reclassification from their current geographic areas into an adjoining area with higher payment rates.

The MMA was signed by President Bush on December 8, 2003, and CMS published a notice in the January 6, 2004 Federal Register (Vol. 69, No. 3) defining the criteria hospitals must meet to be eligible for the appeals process authorized

by the MMA. In a notice issued in the February 13, 2004 Federal Register (Vol. 69, No. 30), CMS further clarified the criteria hospitals must meet and made technical corrections to the January notice. Nearly 550 hospitals appealed for geographic reclassification by the February 15 deadline based on one or more of the eight criteria established by CMS, and the decision regarding their reclassification was made by the Medicare Geographic Classification Review Board.

Within CMS, this independent panel is responsible for geographic classification appeals under the general criteria in the regulations. On April 20, 2004 CMS announced that 121 of these hospitals (covering 25 states) were geographically reclassified, and each hospital will begin receiving higher payments under the special one-time-only provision in the MMA. The higher payments will be retroactive to April 1, 2004 for patients who were discharged on or after April 1, 2004 and before April 1, 2007.

The list of the hospitals that have been geographically reclassified can be found at the following CMS web site: [http://www.cms.hhs.gov/media/press/files/041904\\_NationalAppendix.asp](http://www.cms.hhs.gov/media/press/files/041904_NationalAppendix.asp).

### **Additional Information**

The CMS press release, "CMS to Increase Payments to Hospitals Reclassified Under Medicare Reform Law," can be found at the following web site: <http://www.cms.hhs.gov/media/press/release.asp?Counter=1015>

Federal Register, Vol. 69, No. 3, CMS Notice "One-Time Appeal Process for Hospital Wage Index Classification," issued Tuesday, January 6, 2004 can be found at: <http://www.cms.hhs.gov/providerupdate/regs/cms1373n.pdf>.

In addition, Federal Register, Vol. 69, No. 30, CMS Notice "Medicare Program; Revisions to the One-Time Appeal Process for Hospital Wage Index Classification," issued February 13, 2004 can be found at: <http://www.cms.hhs.gov/providerupdate/regs/cms1373n2.pdf>.

#### **Source:**

*Related Change Request (CR) #:* N/A

*Medlearn Matters Number:* SE0419

*Effective Date:* April 1, 2004

*Implementation Date:* N/A

## **The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2003 for Inpatient Prospective Payment System (IPPS) Hospitals**

### **Background**

This article provides updated data for determining additional payment amounts for hospitals with a disproportionate share of low-income patients. The SSI/Medicare beneficiary data for IPPS is available electronically and contains the name of the hospital, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. The file is located at the following CMS Web site address:

<http://www.cms.hhs.gov/providers/hipps/dsh.asp>

The data is used for settlement purposes for hospitals with cost reporting periods beginning during FY 2003 (cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003).

### **Policy**

Section 9105 of The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) provides additional payment amounts for hospitals with a disproportionate share of low-income patients. This is done by making adjustments to the prospective payment rate.

#### **Source:**

*Change Request:* 3403

*Effective Date:* October 1, 2004

*Implementation Date:* October 4, 2004

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

In order to fulfill the requirement that a provider make a “reasonable” collection effort with respect to the deductibles and co-insurance amounts owed by dual-eligible patients, our bad debt policy requires the provider to bill the patient or entity legally responsible for the patient’s bill before the provider can be reimbursed for uncollectible amounts. This “must bill” policy was recently upheld by the federal Ninth Circuit Court of Appeals in *Community Hospital of the Monterey Peninsula v Thompson*, 323 F.3d 782 (9th Cir. 2003). The “must bill” policy states that if a patient is determined by the provider to be indigent or medically indigent, the provider does not need to attempt to collect from the patient.

However, the provider must make certain that “no source other than the patient would be legally responsible for the patient’s medical bill; e.g., title XIX, local welfare agency...” ( See, e.g., CMS Provider Reimbursement Manual, sections 312, 322) prior to claiming the bad debt from Medicare.

With respect to “dual-eligibles,” Section 1905(p)(3) of the Social Security Act (“Act”) imposes liability for cost-sharing amounts for Qualified Medicare Beneficiaries on the States, though Section 1902(n)(2) allows the states to limit that amount to the Medicaid rate and essentially pay nothing toward dual eligibles’ cost-sharing if the Medicaid rate is lower than what Medicare would pay for the service.

However, in those instances where the state owes none or only a portion of the dual-eligible patient’s deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State Remittance Advice). Even if the State Plan Amendment limits the liability to the Medicaid rate, by billing the State, a provider can verify the current dual-eligible status of a beneficiary and can determine whether or not the State is liable for any portion thereof.

In November of 1995, language was added in PRM-II Section 1102.3L (the cost report questionnaire) that allowed providers to show other documentation in lieu of billing the states. Unfortunately, that language conflicted with the billing requirements in Chapter 3 of the PRM-I, and the Ninth Circuit panel found Section 1102.3L to be inconsistent with the Secretary’s must-bill policy (323 F.3d at 799). The panel also noted that, effective in August of 1987, Congress had imposed a moratorium on changes in bad-debt-reimbursement policies, and therefore the Secretary lacked authority in November of 1995 to effect a change in policy (Id. At 798, note 9).

As a result of the Ninth Circuit decision, we changed the language in PRM-II Section 1102.3L to revert back to pre-1995 language, which requires providers to bill the individual states for dual-eligibles’ co-pays and deductibles before claiming Medicare bad debt (See Change Request 2796, issued September 12, 2003).

**This article is to serve as a directive to hold harmless providers that can demonstrate that they followed the instructions previously laid out at 1102.3L, for open cost reporting periods beginning prior to January 1, 2004.**

Intermediaries who followed the now-obsolete Section 1102.3L instructions for cost reporting periods prior to January 1, 2004 may reimburse providers they service for dual-eligible bad debts with respect to **unsettled** cost reports that were deemed allowable using other documentation in lieu of billing the state.

Intermediaries that required the provider to file a State Remittance Advice for cost reporting periods prior to January 1, 2004, may NOT reopen providers’ cost reports to accept alternative documentation for such cost reporting periods.

**This “hold harmless” policy affects only those providers with cost reports that were open as of the date of issuance of this memorandum**, relating to cost reporting periods before January 1, 2004, and who relied on the previous language of section 1102.3L in providing documentation.

*Source: JSM 370 dated August 10, 2004*

## Reminder: Hospital Discounts Permitted for Indigent, Uninsured, and Underinsured Patients

### Providers Affected

Hospitals

### Provider Action Needed

This special article serves as a reminder to hospitals of existing Medicare policy that permits hospitals to offer discounts to certain patients so long as a few general guidelines are followed in doing so. This article reflects **no change to existing policy**.

The Centers for Medicare & Medicaid Services (CMS), however, wants to be certain that hospitals understand existing policies that enable hospitals to provide affordable health care to as many of their patients as possible without compromising long-standing Medicare policies or the appropriate use of Medicare's trust funds.

### Background

Recently, several hospital groups and associations raised questions with CMS and some of its fiscal intermediaries (FI) regarding the ability of hospitals to offer discounts to indigent, uninsured, or other low income patients.

In addition, they have raised some questions about Medicare's role in the collection of patient debts owed for hospital services. To address these issues, Secretary Tommy G. Thompson sent a letter to the American Hospital Association on February 19, 2004. A press release was issued by the Department of Health and Human Services containing the text of that letter and may be viewed at:

<http://www.os.dhhs.gov/news/press/2004pres/20040219.html>

Also, CMS has posted a number of questions and answers related to this issue on its Web site. This information may be viewed at:

[http://www.cms.hhs.gov/FAQ\\_Uninsured.pdf](http://www.cms.hhs.gov/FAQ_Uninsured.pdf)

CMS hopes this information will help answer hospitals' questions and permit them to move forward in giving discounts wherever possible for those who need and cannot afford care. At the same time, hospitals and other providers must assure that these discounts are offered in accordance with the Medicare guidelines so as to protect the Medicare trust funds for those who rely on Medicare services.

### Additional Information

For those who would like more detailed information on the Medicare guidelines related to this issue, please refer to the Medicare Provider Reimbursement Manual for this area. The relevant chapter and sections can be found at:

[http://www.cms.hhs.gov/manuals/pub151/PUB\\_15\\_1.asp](http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp)

### Source:

*Medlearn Matters Number:* SE0405

*Effective Date:* Not applicable; this is a reminder of existing policy.



## Update to the Frequency of Billing

### Provider Types Affected

Skilled Nursing Facilities (SNFs), hospitals considered to be Tax Equity and Fiscal Responsibility Act (TEFRA) hospitals, and hospitals paid under the Outpatient Prospective Payment System (OPPS)

### Provider Action Needed

Effective January 1, 2005, Medicare Fiscal Intermediaries (FIs) will accept inpatient bills monthly from SNFs and TEFRA hospitals. Medicare encourages these facilities to bill monthly. In addition, this article clarifies billing of outpatient services under the OPPS on the same day that a repetitive OPPS service is billed on a separate claim.

### Background

On October 1, 2003, The Centers for Medicare & Medicaid Services (CMS) implemented new edits. These edits forced monthly bill submissions for long term care hospitals (LTCHs), SNFs, and inpatient hospitals not subject to the Inpatient Prospective Payment System (IPPS). However, these edits allowed monthly bill submission for periodic interim payment (PIP) providers and inpatient rehabilitation facilities (IRFs).

Inpatient services in TEFRA hospitals (i.e., psychiatric hospital or units, cancer and children's hospitals) and SNFs are to be billed:

- Upon discharge of the beneficiary;
- When the beneficiary's benefits are exhausted;
- When the beneficiary's need for care changes; or
- Monthly.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles. Also, providers subject to the OPPS are reminded that repetitive services to a single individual will be billed monthly.

Where there is an inpatient stay, or outpatient surgery, or outpatient hospital service subject to OPPS, one bill will be submitted for the entire month if the provider uses an occurrence span code 74 to encompass the inpatient stay, day of outpatient surgery, or outpatient service subject to OPPS.

Bills for outpatient services subject to OPPS will contain on a single bill all services provided on the same day except claims containing condition codes 20, 21, or G0 (zero) or kidney dialysis services, which are billed on a 72x bill type. If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service is to be billed on a separate OPPS claim containing the individual service and all packaged and/or related services.

For example, if a chemotherapy drug is administered on a day that a repetitive service is also rendered, then the chemotherapy drug, its administration, its related supplies, etc., are on a separate claim from the monthly repetitive services claim. However, if some of the services are for partial hospitalization, the provider shall place condition code 41 on the claim. For claims containing conditions code 41, all services billed on the same day are to be included on the monthly bill for repetitive services.

Non-repetitive OPPS services, exclusive of partial hospitalization services, are to be put on a single claim along with any packaged services. Repetitive services are billed monthly on a separate claim.

### Additional Information

To view the official instruction and revised manual pages issued to your intermediary on this issue, see CR3382, which may be found at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R239CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R239CP.pdf)

#### Source:

*Related Change Request (CR) #:* 3382

*Medlearn Matters Number:* MM3382

*Related CR Release Date:* August 3, 2004

*Related CR Transmittal #:* 239

*Effective Date:* January 1, 2005

*Implementation Date:* January 3, 2005

## **Elimination of Regulations for Written Statement of Intent**

### **Provider Types Affected**

All Medicare Providers

### **Provider Action Needed**

### **Impact to You**

Effective with the claims filing period ending on December 31, 2004 and thereafter, Medicare will no longer accept Statements of Intent (SOIs) to extend the timely filing limit for filing initial claims.

### **What You Need to Know**

Know the Medicare timely filing requirements for submitting claims. These requirements are in Chapter 1, Section 70 of the Medicare Claims Processing Manual, which may be found at:

[http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp)

### **What You Need to Do**

To ensure accurate claims processing, please submit filings in a timely manner and make certain that you will no longer utilize SOIs.

### **Background**

Medicare regulations at 42 CFR Part 424.45 allowed for the submission of written SOIs to claim Medicare benefits. The purpose of an SOI was to extend the timely filing period for the submission of an initial claim. An SOI, by itself, did not constitute a claim, but rather was used as a placeholder for filing a timely and proper claim.

A Final Rule published in the Federal Register, dated April 23, 2004, Volume 69, Number 79, pages 21963-21966, amended 42 CFR Part 424 by removing the SOI provision at 424.45, effective May 24, 2004. Therefore, for the claims filing period ending on December 31, 2004, and all periods thereafter, Medicare carriers, intermediaries, and Medicare Regional Offices will no longer accept SOIs to extend the timely filing period for claims.



### **Additional Information**

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR 3310, at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### **Source:**

*Related Change Request (CR) #: 3310*

*Medlearn Matters Number: 3310*

*Related CR Release Date: June 18, 2004*

*Related CR Transmittal #: 211*

*Effective Date: May 24, 2004*

*Implementation Date: July 19, 2004*

## New Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (one percent for calendar year 2004) or the private consumer rate as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to 11.75 percent.

Period	Interest Rate
February 7, 2001 – April 25, 2001	14.125%
April 26, 2001 - August 6, 2001	13.75%
August 7, 2001 – October 30, 2001	13.25%
October 31, 2001 – January 31, 2002	13.25%
February 1, 2002 – May 7, 2002	12.625%
May 8, 2002 – August 7, 2002	11.75%
August 8, 2002 – November 18, 2002	12.625%
November 19, 2002 – February 10, 2003	11.25%
February 11, 2003 – April 27, 2003	10.75%
April 28, 2003 – August 10, 2003	11.625%
August 11, 2003 – November 2, 2003	12.125%
November 3, 2003 – February 3, 2004	12.00%
February 4, 2004 – May 6, 2004	12.00%
May 7, 2004 – August 8, 2004	11.875%
August 9, 2004	11.75%

*Effective and Implementation Date: August 9, 2004*

## Chapter 5-Financial Management Manual: Section 420 – Procedures for Reissuance and Stale Dating of Medicare Checks

### Provider Types Affected

Physicians, suppliers, and providers

### Provider Action Needed

### Impact to You

The Centers for Medicare & Medicaid Services (CMS) is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

### What You Need to Know

This instruction updates the Medicare Financial Management Manual (Pub. 100-06) and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding CMS procedures for re-issuance and stale dating of Medicare checks.

### What You Need to Do

Be aware of these instructions in the event you have a problem in the future regarding lost, stolen, defaced, mutilated, destroyed, forged, or uncashed checks from your Medicare carrier/intermediary.

### Background

This instruction updates the *Medicare Financial Management Manual (Pub. 100-06)* and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding the CMS procedures for re-issuance and stale dating of Medicare checks, which expired in September 2002. Legal authority for the CMS re-issuance and stale dated check policy is contained in Medicare regulations published at 42 CFR 424.352.

### Introduction

As part of the CMS effort to improve financial reporting, CMS is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

### Re-issuing Medicare Checks

In December 1993, CMS issued 42 Code of Federal Regulations (CFR) Subpart M – Replacement and Reclamation of Medicare Payments 424.352: Intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. All Medicare contractors must re-issue checks in accordance with 42 CFR 424.352.

The provisions of this regulation require that a Medicare contractor (fiscal intermediary or carrier) perform certain tasks upon notification by a payee that a check has been lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. These tasks are as follows:

- A. The Medicare contractor must contact the financial institution on which the check was drawn to determine whether the check has been negotiated.
- B. If the check **has** been negotiated:
  1. The Medicare contractor will provide the payee with a copy of the check and other pertinent information (such as a claim form, affidavit, or questionnaire to be completed by the payee) required to pursue the claim in accordance with State law and commercial banking regulations.
  2. To pursue the claim, the payee must examine the check and certify (by completing the claim form, affidavit, or questionnaire) that the endorsement is not the payee's.
  3. The claim form and other pertinent information are sent to the Medicare contractor for review and processing of the claim.
  4. The Medicare contractor reviews the payee's claim. If the Medicare contractor determines that the claim appears to be valid, it forwards the claim and a copy of the check to the issuing bank. The Medicare contractor takes further action to recover the proceeds of the check in accordance with State law and regulations.
  5. Once the Medicare contractor recovers the proceeds of the initial check, the Medicare contractor issues a replacement check to the payee.
  6. If the bank of first deposit refuses to settle on the check for good cause, the payee must pursue the claim on his or her own, and the Medicare contractor will not re-issue the check to the payee.
- C. If the check has not been negotiated:
  1. The Medicare contractor arranges with the bank to stop payment on the check; and
  2. Except as provided in paragraph (D) of 42 CFR 424.352, the Medicare contractor re-issues the check to the payee.
- D. No check may be reissued under (C)(2) unless the claim for a replacement check is received by the contractor no later than one year from the date of issuance of the original check, unless State law (including any applicable Federal banking laws or regulations that may affect the relevant State proceeding) provides a longer period, in which case that State law will apply.

Medicare contractors may receive requests for re-issuance of Medicare checks that are older than one year. Based on 42 CFR 424.352 (summarized above), Medicare contractors should inform beneficiaries and providers/ physicians/ suppliers regarding the possibility that State law may provide a more favorable time frame for re-issuance. Requests for re-issuance based on State law should be forwarded by Medicare contractors to their Regional Office. The Regional Office will work with the Regional Office General Counsel to resolve these requests on a case-by-case basis.

Medicare contractors regularly receive requests for re-issuance of Medicare checks that are older than one year. Under 42 CFR 424.352 many of these requests must be denied. However, 42 CFR 424.352 applies **only** to checks that have been lost, stolen, defaced, mutilated, destroyed, or paid on a forged endorsement.

Accordingly, Medicare checks that are in the physical possession of the payee, have not been defaced or mutilated, and have not been negotiated are not subject to the one-year time limit for re-issuance required by 42 CFR 424.352 (d). Therefore, if the below criteria below are met, such checks may be re-issued by the Medicare contractor even if they are older than one year. The criteria are:

1. The payee (beneficiary, physician, supplier, provider, etc.) and/or authorized representative can present the physical check;
2. The Medicare contractor can confirm that the check was not previously reissued; and
3. Re-issuance is not barred by a Federal and/or State statute of limitations.

Any questions that the Medicare contractors have regarding application of the above criteria should be forwarded to their Regional Office. The Regional Office will work with the Regional Office General Counsel to resolve the questions.

### **Stale Dating of Checks**

Medicare contractors are expected to continuously review all outstanding checks, take the appropriate action to stale date checks in conformance with Federal and/or State/local banking regulations, and adjust financial reporting for these actions. Medicare contractors must advise their financial institution of the change in the status of a check.

Outstanding checks are checks that have been issued as payment for Medicare benefits and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Checks are “voided” by rendering them non-negotiable either physically or by placing a stop payment on them.

Stale dated checks are checks that have reached a specific age from date of issue (e.g., one year from the date of issuance) and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds.

Additionally, once a check has been stale dated and is no longer negotiable, the financial institution must be notified in writing.

### **Undeliverable Checks**

Medicare providers, physicians, suppliers, and beneficiaries are responsible for providing their Medicare contractor with their current and accurate mailing address.

The Medicare contractors must comply with the policy established by the “Do Not Forward (DNF) Initiative.” This policy requires Medicare contractors to re-issue the check based on the receipt of updated verified address information per Form CMS-855; and if no updated address information has been submitted, then Medicare contractors must void any returned checks. Checks voided due to DNF may be re-issued in accordance with the instructions in the preceding section titled “Re-issuing Medicare Checks.”

### **Related Instructions**

The Medicare Financial Management Manual, Pub. 100-06, Chapter 5 (Financial Reporting/ Section 420-Procedures for Re-issuance and Stale Dating of Medicare Checks) is new.

These updated manual instructions will be incorporated into the new Internet-only Office of Financial Management Manual, but are available now as part of the official instruction issued to your carrier/intermediary. This instruction (CR2951) can be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

#### **Source:**

*Related Change Request (CR) #: 2951*

*Medlearn Matters Number: MM2951*

*Related CR Release Date: July 16, 2004*

*Related CR Transmittal #: 49*

*Effective Date: August 16, 2004*

*Implementation Date: August 16, 2004*

## CMS Manual System – Payment to Bank

### Provider Types Affected

Providers and suppliers.

### Provider Action Needed

Become familiar with the revised policy regarding Medicare payments to be sent to a bank in the name of a provider/supplier. There is a change in the policy allowing Medicare to send a payment to an individual provider or supplier's bank account for deposit. If certain conditions are met, payments from Medicare to a provider or supplier may be sent to the provider's bank (or similar financial institution) for deposit into the provider's account.

Please refer to the Background section for a review of these conditions. Follow these revised criteria if you want Medicare to deposit payments directly into your bank account.

### Background

Medicare payments may be sent to a bank (or similar financial institution) to be deposited into a provider/supplier's account so long as the following requirements are met:

- The bank may provide financing to the provider/supplier as long as the bank states in writing, in the loan agreement, that it waives its right of offset. (This allows the bank to lend money to the provider as well as deposit money from Medicare into the provider/supplier's account.)
- The bank account is in the provider/supplier's name and only the provider/supplier may issue instructions on that account.
- The bank should only be bound by the provider/supplier's instructions.
- No other agreement that a provider/supplier has with a third party can have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier's account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier's agreement with the financing entity.

Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier's Medicare receivables.

### 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](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #: 3079*

*Medlearn Matters Number: MM3079*

*Related CR Release Date: June 25, 2004*

*Related CR Transmittal #: 213*

*Effective Date: July 25, 2004*

*Implementation Date: July 25, 2004*

## Updated Skilled Nursing Facility Help File Available for CY 2004

### Provider Types Affected

Providers and suppliers of skilled nursing facility (SNF) services

### Provider Action Needed

None. This article provides information only. It alerts you to the CY 2004 SNF Help File that is now available for your use.

### Background

Annually, after the major Healthcare Common Procedure Coding System (HCPCS) updates are completed, CMS also provides you with an SNF Help File, so that you can see which services are included in SNF consolidated billing under Part A, identify the basis of payment for services under Part B, and better understand your fiscal intermediary's (FIs) explanation of edit results on your claims.

This file, a large Microsoft Excel® spreadsheet that specifies the status of over 11,900 HCPCS and CPT codes for SNF billing and payment, is also updated, as necessary, at other times during the year when there are significant changes to the HCPCS file.

### Additional Information

You can find more information about this updated file in Chapters 6 and 7 of the Medicare Claims Processing Manual at:



[http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

The following link will take you directly to the SNF Help File:

[http://www.cms.hhs.gov/manuals/104\\_claims/clm104c06snfhelppdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c06snfhelppdf)

**(This file is directed toward SNFs and suppliers.)**

In addition, you can learn more about SNF consolidated billing at: [www.cms.hhs.gov/medlearn/snfcode.asp](http://www.cms.hhs.gov/medlearn/snfcode.asp)

**(This site is for individuals billing to carriers.)**

#### Source:

*Related Change Request (CR) #:* 3252

*Medlearn Matters Number:* MM3252

*Related CR Release Date:* May 28, 2004

*Related CR Transmittal #:* 189

*Effective Date:* January 1, 2004

*Implementation Date:* June 28, 2004

# **Update to the Common Working File Edits for Skilled Nursing Facility (SNF) Consolidated Billing (CB) to Expand the Bypass for Pharmacy Services**

## **Provider Types Affected**

Hospitals and skilled nursing facilities

## **Provider Action Needed**

This instruction updates the Medicare System Edits for its Common Working File (CWF) for Skilled Nursing Facility (SNF) Consolidated Billing (CB) to expand the bypass for Pharmacy Services, and revises the edit(s) to bypass revenue code 25X when billed with an excluded surgery or emergency room service.

## **Background**

All pharmacy charges are excluded from the Skilled Nursing Facility Consolidated Billing (SNF CB) when related to and billed with an excluded surgery or emergency room visit. SNF CB is required under Section 1888 (e)(2) of the Social Security Act, and SNF CB excludes emergency room services, most surgical procedures, and services related to those exclusions.

Currently, Medicare systems are bypassing the consolidated billing edit on Revenue Code 250 when billed with a line item date of service matching the date of the emergency room service or surgery. Other pharmacy revenue codes are not being bypassed, causing excluded services to be subject to the (SNF CB) rule in error. In addition, some pharmacy charges billed under Revenue Code 250 are also being rejected because the Revenue Code does not require a line item date of service.

This instruction updates the Medicare (CWF) Edits for Skilled Nursing Facility (SNF) Consolidated Billing (CB) to expand the bypass for Pharmacy Services, and it revises the CWF edit(s) to bypass revenue code 25X when billed with an excluded surgery or emergency room service.

## **Additional Information**

The Medicare Claims Processing Manual (Pub 100-04), Chapter 6 (SNF Inpatient Billing) Section 20 (Services Included in Part A PPS Payment Not Billable Separately by the SNF), Subsection 20.1.2 (Other Excluded Services Beyond the Scope of a SNF Part A Benefit), Sub-subsection 20.1.2.1 (Emergency Services) are being revised. The revised pages are attached to the official instruction issued to your intermediary on this change.

To view those instructions, go to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

### **Source:**

*Related Change Request (CR) #:* 3277

*Medlearn Matters Number:* MM3277

*Related CR Release Date:* June 10, 2004

*Related CR Transmittal #:* 200

*Effective Date:* For dates of service on or after April 1, 2001 billed within the timely filing period and received on or after October 4, 2004.

*Implementation Date:* October 4, 2004

# Skilled Nursing Facility Consolidated Billing L Codes – Durable Medical Equipment Regional Carrier and Fiscal Intermediaries

## Provider Types Affected

Skilled Nursing Facilities (SNFs) and suppliers

## Provider Action Needed

### Impact to You

As of April 1, 2004, suppliers cannot get paid for codes L5673 and L5679 for services provided to a beneficiary in a Part A SNF stay.

These codes have replaced codes K0557 and K0558. Codes L5673 and L5679 were inadvertently left off the April 2004 quarterly update edits for SNF consolidated billing.

### What You Need to Know

Once corrected, these codes will allow separate payment by Medicare Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal Intermediaries (FI) outside the perspective payment rate for Medicare beneficiaries in Part A SNF stays. These codes will be added to the October quarterly update.

When claims for L5679 and L5673 are rejected, the following incorrect messages will appear on your statement: Remittance Advice American National Standards Institute (ANSI) Reason code 109, "Claims not covered by this payer/contractor. Claims must be sent to the correct payer/contractor;" and remark code MA101, "A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents."

Since these codes were mistakenly not added to the edits for services that are separately payable outside of consolidated billing and the PPS rate, the provider or supplier should not contact the SNF for payment on these claims.

### What You Need to Do

If your claim for L5679 or L5673 services is not paid from April 1 through September 30, 2004, notify your DMERC or intermediary and request they re-open the claim and use the appropriate override code to process your claim for payment.

### Background

Due to an inadvertent programming error, Medicare systems will not process payments for HCPCS codes L5673 and L5679 as of April 1, 2004. These codes are described as follows:

- **L5673** - Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism, effective January 1, 2004.
- **L5679** - Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism, effective January 1, 2004.
- L5673 and L5679 replaced K0557 and K0558, which were terminated as of December 31, 2003. K0557 and K0558 are defined as follows:
  - ✦ **K0557** - same definition as L5673, terminated December 31, 2003.
  - ✦ **K0558** - Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557), terminated December 31, 2003.

Where appropriate, Medicare has instructed your DMERC or intermediary to pay interest for delayed payments.

### Additional Information

If you have any questions regarding this issue, please contact your DMERC or intermediary at their toll free number. To view the instruction issued to your carrier/intermediary regarding this issue, please visit:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #:* 3295

*Medlearn Matters Number:* MM3295

*Related CR Release Date:* May 28, 2004

*Related CR Transmittal #:* 191

*Effective Date:* June 28, 2004

*Implementation Date:* June 28, 2004

## Additional Clarification of Bill Types 22x and 23x Submitted by Skilled Nursing Facilities with Instruction for Involuntarily Moving a Beneficiary Out of the SNF and Ending a Benefit Period

### Provider Types Affected

Skilled Nursing Facilities (SNFs)

### Provider Action Needed

SNFs should note that this article provides clarification of the difference between bill types 22x, for SNF residents, and 23x, for non-residents. It also provides instruction on when you can and cannot move a beneficiary involuntarily. Note that this clarification replaces CR 2674.

### Background

#### Using the Correct Bill Type

Section 313 of the Benefits Improvement and Protection Act of 2000, P.L. 106-554 revised the “resident” definition to include only individuals who are actually placed in the Medicare-certified part of the SNF. For those residents, bill type 22x should be used. Individuals who are placed in the Medicare non-certified area of the institution will no longer be considered “residents,” and bill type 23x should be used for those nonresidents.

When a SNF limits its Medicare participation to a distinct part unit (DPU) and moves a beneficiary who no longer meets Medicare skilled level of care (required for a covered Part A stay) from the Medicare-certified DPU to a non-certified part of the institution, the beneficiary has technically ceased to reside in the Medicare-certified SNF and, thus, is appropriately billed as a non-resident of the SNF using bill type 23x.

Incorrectly using bill type 22x could inappropriately trigger SNF consolidated billing edits for therapy services that the beneficiary receives in an outpatient setting. However, in the case in which the entire facility qualifies as a Medicare-certified SNF, all Part B therapies must continue to be billed by the SNF on a 22x bill type.

#### Involuntarily Moving a Resident Out of a Medicare-Certified SNF or DPU

The requirements for participation specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU. These circumstances can include the resident’s health improving to the point that he/she no longer requires SNF care.

However, if a resident has exhausted his/her Part A benefits but continues to require SNF care, he/she cannot be moved out of the Medicare-certified SNF or DPU for reasons other than those stated in the regulations. (For example, the resident cannot be moved to avoid consolidated billing requirements, or to establish a new benefit period.)

The determination to move a beneficiary out of the Medicare-certified SNF or DPU must not be made on the basis that the beneficiary has exhausted his/her benefits, but rather on the beneficiary's lack of need for further SNF care. If a resident of a Medicare-certified DPU ceases to require SNF care, he/she may be moved from the DPU to the Medicare non-certified area of the institution. Keep in mind that such a move would end the beneficiary's status as a SNF resident for consolidated billing purposes.

### Ending a Benefit Period

A benefit period ends 60 days after the beneficiary ceased to be an inpatient of a hospital and has not received inpatient skilled care in a SNF during the same 60-day period.

If the SNF resident's health has improved to the point that he/she no longer needs or receives the level of skilled care required for Part A coverage, the SNF must bill one of the two following scenarios:

- 1) For residents who leave the Medicare-certified SNF or DPU:
  - Submit a final discharge bill.
  - Submit on a 23x any services rendered after the discharge and billed by the SNF.
- 2) For residents who remain in the Medicare-certified SNF or DPU after the skilled level of care ends:
  - Submit the last skilled care claim with an occurrence code 22 to indicate the date active care has ended.
  - Submit on a 22x any services rendered and billed by the SNF after the skilled care ended.
  - All therapies must be billed by the SNF on the 22x.

For additional instructions on ending a benefit period, go to the Medicare General Information, Eligibility and Entitlement manual, chapter 3, section 10.4.3.2. The lack of a beneficiary's need for skilled care in a SNF triggers the start of the 60-day count toward ending a benefit period.

However, it is physical location of the beneficiary within the certified part of the facility that confers resident status for the purposes of the SNF Part B consolidated billing rule for therapies. It is possible for a beneficiary to no longer need or receive skilled care resulting in ending a benefit period, but still be a resident of the SNF or Medicare-certified DPU requiring the SNF to bill for all therapies rendered to the resident.

### Additional Information

CR3323 replaces CR2674, which was issued as Transmittal A-03-040 on May 9, 2003. To view the full instruction and the revised Medicare manual changes that are attached to the instruction, visit:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R229CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R229CP.pdf)

**Source:**

- Related Change Request (CR) #:** 3323
- Medlearn Matters Number:** MM3323
- Related CR Release Date:** July 20, 2004
- Related CR Transmittal #:** 229
- Effective Date:** August 19, 2004
- Implementation Date:** August 19, 2004



## Correction to CR 2944, Transmittal 90, Issued on February 6, 2004

### Provider Types Affected

Physicians, suppliers, and providers

### Provider Action Needed

### Impact to You

Change Request (CR) 2944, Transmittal 90, issued on February 6, 2004, entitled “Implementation of Skilled Nursing Facility Consolidated Billing CWF Edit for Therapy Codes Considered Separately Payable Physician Services” incorrectly indicated that services provided in a non-covered skilled nursing facility stay are reimbursed through the prospective payment system.

### What You Need to Know

This instruction corrects the business requirements of CR 2944 and the relevant Internet Only Manual (IOM).

In addition, the associated Medlearn Matters article number MM2944 also was incorrect and will need to be reissued. Though this change is necessary, claims will be processed correctly according to the business requirements established in CR 2944 and CR 3156.

### What You Need to Do

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

### Background

This instruction corrects Section 1B of the Business Requirements of CR 2944, Transmittal 90, issued on February 6, 2004, entitled “Implementation of Skilled Nursing Facility Consolidated Billing CWF Edit for Therapy Codes Considered Separately Payable Physician Services,” which incorrectly indicated that services provided in a non-covered skilled nursing facility stay are reimbursed through the prospective payment system. Language contained in CR 2944 incorrectly indicated that services provided in a non-covered skilled nursing facility stay are both subject to consolidated billing and reimbursed through the prospective payment system.

This instruction 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.”

A complete list of the services affected by SNF consolidated billing can be found on the CMS website at:

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

Lastly, the Medlearn Matters article number MM2944 associated with CR 2944 was incorrect and will need to be reissued.

**Also, note that even though this change is necessary to correct the concept, claims will be processed correctly according to the business requirements established in CR 2944 and CR 3156.**

### Related Instructions

The Medicare Claims Processing Manual (Pub 100-4), Chapter 6 (SNF Inpatient Part A Billing) Section 110 (Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a SNF Part A Stay), Subsection 2.6 (Edit for Therapy Services Separately Payable When Furnished by a Physician) is being revised.

The updated manual instructions are included in the official instruction issued to your carrier, and it can be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

**Source:**

*Related Change Request (CR) #: 3333*

*Medlearn Matters Number: MM3333*

*Related CR Release Date: June 18, 2004*

*Related CR Transmittal #: 209*

*Effective Date: July 1, 2004*

*Implementation Date: July 6, 2004*

## Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2005

This article provides information on the updates to the payment rates used under the PPS for SNFs, for FY 2005, as required by statute.

### Background

Annual updates to the PPS rates are required by §1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), relating to Medicare payments and consolidated billing for SNFs.

### Policy

On July 31, 2002, CMS published an update notice in the Federal Register (67 FR 49798) detailing the schedule of SNF PPS Federal rates applicable for Medicare SNF payments in FY 2003. CMS published the SNF payment rates for FY 2004 (that is, beginning October 1, 2003 through September 30, 2004), in the Federal Register on August 4, 2003 (68 FR 46036).

The methodology used for the update incorporates section 511 of MMA that specifies a separate add on payment for residents with AIDS. The update methodology is identical to that used in the previous year. The statute mandates an update to the Federal rates using the latest SNF full market basket.

*Effective Date: October 1, 2004*

*Implementation Date: October 4, 2004*

## Revised Updated Skilled Nursing Facility NO PAY File for July 2004

### Provider Types Affected

Physicians, suppliers, and providers

### Provider Action Needed

This instruction replaces Change Request (CR) 3275, Transmittal 182, which was issued on May 17, 2004.

### Background

As part of the implementing legislation for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS), the Balanced Budget Act of 1997 requires that all Part B services provided to SNF residents be paid on any existing fee schedule.

Additionally, there are certain services that should not be paid to SNFs. The HCPCS codes for these services are provided to Fiscal Intermediaries (FIs) annually, with quarterly updates as necessary. As part of its support of SNF Consolidated Billing (CB), the Centers for Medicare & Medicaid Services (CMS) has provided the FIs with an SNF NO PAY File. This file, initially released November 1, 2002 for April 1, 2003 implementation, contains Healthcare Common Procedure Coding System (HCPCS) codes that cannot be paid to a SNF.

CMS also provides an SNF Abstract of the Medicare Physician Fee Schedule to FIs to facilitate their pricing of Part B services billed by SNFs. Fee schedule updates are always effective January 1 of the applicable calendar year.

As a result of this instruction, the SNF NO PAY File is updated with two HCPCS code changes effective July 1, 2004 as follows:

- HCPCS code G0104 is now payable to an SNF as a result of a change in Medicare edits for colorectal screening; and
- HCPCS code G0329 has been added to the therapy list in place of HCPCS code G0295, which remains non-covered for Medicare.

### Related Instructions

The official version of this instruction was issued to your FI and it can be found by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #:* 3338

*Medlearn Matters Number:* MM3338

*Related CR Release Date:* June 10, 2004

*Related CR Transmittal #:* 202

*Effective Date:* July 1, 2004

*Implementation Date:* July 6, 2004

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

### Provider Types Affected

Institutional providers billing claims to the Medicare Fiscal Intermediaries (FIs). Physicians, practitioners, and suppliers billing Medicare carriers for services.

### Provider Action Needed

#### Impact to You

HCPCS codes are being added to or removed from the SNF consolidated billing enforcement list.

#### What You Need to Know

Services included on the SNF consolidated billing enforcement list will be paid to SNF Medicare providers only. Services excluded from the SNF consolidated billing enforcement list may be paid to Medicare providers other than SNFs. See *Background* and *Additional Information* sections for further explanation.

#### What You Need to Do

Be aware of the requirements explained below and how they can impact your Medicare payment.

### Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the list of HCPCS codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (SNF PPS).

Services appearing on this list submitted on claims to Medicare Fiscal Intermediaries (FIs) and Carriers, including Durable Medical Equipment Regional Carriers (DMERCs) will not be paid to any Medicare providers, other than a SNF,

when included in SNF consolidated billing. For non-therapy services, the SNF consolidated billing applies only when the services are furnished to a SNF resident during a covered Part A stay.

However, the SNF consolidated billing applies to physical, occupational, or speech-language therapy services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services excluded from the SNF consolidated billing may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Section 1888 of the Social Security Act codifies SNF PPS and consolidated billing.

The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates. New updates are required by changes to the coding system, not because the services subject to the SNF consolidated billing are being redefined.

Other regulatory changes beyond code list updates will be noted when and if they occur. The codes below are listed as being added or removed from the annual update, mentioned above. Deletions from Major Category I F. below, specifically HCPCS code 36489, is being removed because the HCPCS was discontinued as of December 31, 2003. Additions to what is noted as Major Category III below means these services may be provided by any Medicare provider licensed to provide them, **except a SNF**, and are excluded from SNF PPS and consolidated billing.

Additions to therapy inclusions, Major Category V below, mean SNFs alone can bill and be paid for these services when delivered to beneficiaries in a SNF, whereas codes being removed from this therapy inclusion list now can be billed and potentially paid to other types of providers for beneficiaries NOT in a Part A stay or in a SNF bed receiving ancillary services billed on TOB 22x.

**Outpatient Surgery and Related Procedures** (*Major Category I F, FI Annual Update, INCLUSION*) Remove 36489 – placement of cv catheter

Note on Code above: Code discontinued effective December 31, 2003.

**Customized Prosthetic Devices** (*Major Category III, FI Annual Update, EXCLUSION*)

**For FI claims processing**, remove K0556\*, K0557\*, K0558\*, K0559\* - Addition to lower extremity, below knee/above knee, custom fab. **For carrier claims processing**, these codes will remain payable for dates of service prior to January 1, 2004.

Add L5673\*\* - addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism

Add L5679\*\* - addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism

**Chemotherapy Administration** (*Major Category III, FI Annual Update, EXCLUSION*)

Remove 36489\*\*\* - placement of cv catheter

Notes on Codes above:

\* Codes were replaced by L5673, L5679, L5681 and L5683.

\*\* Codes are added to exclusion list retroactive to 1/1/04.

\*\*\* Code discontinued effective 12/31/03.

**Therapies** (*Major Category V, FI Annual Update, for FI billing use revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)*)

Remove G0295^ Electromagnetic stimulation, to one or more areas (Not covered by Medicare) (This code was not previously included on carrier coding files.)

Remove G0237^^ - Therapeutic procd strg endur

Remove G0238^^ - Oth resp proc, indiv

Remove G0239^^ - Oth resp proc, group

Remove G0302^^ - pre-op LVRS service  
Remove G0303^^ - pre-op service LVRS 10-15dos  
Remove G0304^^ - pre-op service LVRS 1-9dos  
Remove G0305^^ - post-op service LVRS min 6dos

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

^ This code was erroneously added to file. Code was not previously included on carrier coding files.

^^ These codes are not considered therapy codes and are not payable to a SNF. They were inadvertently added to the table.

^^^ This code was added to the therapy inclusion list effective July 1, 2004. (Information concerning this code was not received in time to issue a July 2004 update.)

### Additional Information

Each January, separate instructions are published for FIs, Carriers and DMERCs for the annual notice on the SNF consolidated billing. The 2004 Annual Updates for FIs can be found on the CMS web site at:

[www.cms.hhs.gov/manuals/pm\\_trans/R19CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R19CP.pdf)

This instruction is referred to as CR2926.

Overall information regarding SNF CB can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

Quarterly updates now apply to FIs, Carriers and DMERCs. There has been one joint FI/Carrier/DMERC quarterly update published subsequent to the 2004 Annual Updates. This update can be found at:

[www.cms.hhs.gov/manuals/pm\\_trans/R92CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R92CP.pdf)

That instruction is also known as CR3070. The official instruction issued to your carrier regarding this change may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #:* 3348

*Medlearn Matters Number:* MM3348

*Related CR Release Date:* July 9, 2004

*Related CR Transmittal #:* 224

*Effective Date:* October 1, 2004

*Implementation Date:* October 4, 2004

## Skilled Nursing Facility Consolidated Billing

### Provider Types Affected

All Medicare providers, suppliers, physicians, skilled nursing facilities (SNF), and rural swing bed hospitals

### Provider Action Needed

This article is informational only and is intended to remind affected providers that SNFs must submit all Medicare claims for the services its residents receive, except for a short list of specifically excluded services as mentioned in the “Excluded Services” section below. This requirement was established initially as specified in the Balanced Budget Act of 1997 (BBA, P.L. 105-33) and is known as SNF Consolidated Billing (CB).

### Background

Prior to the Balanced Budget Act of 1997 (BBA), a SNF could elect to furnish services to a resident in a covered Part A stay, either:

- Directly, using its own resources;
- Through the SNF's transfer agreement hospital; or
- Under arrangements with an independent therapist (for physical, occupational, and speech therapy services).

In each of these circumstances, the SNF billed Medicare Part A for the services. However, the SNF also had the further option of “unbundling” a service altogether; that is, the SNF could permit an outside supplier to furnish the service directly to the resident, and the outside supplier would submit a bill to Medicare Part B, without any involvement of the SNF itself.

This practice created several problems, including the following:

- A potential for duplicate (Parts A/B) billing if both the SNF and outside supplier billed;
- An increased out-of-pocket liability incurred by the beneficiary for the Part B deductible and coinsurance even if only the supplier billed; and
- A dispersal of responsibility for resident care among various outside suppliers, which adversely affected quality (coordination of care) and program integrity, as documented in several reports by the Office of the Inspector General (OIG) and the General Accounting Office (GAO).

Based on the above-mentioned problems, Congress enacted the Balanced Budget Act of 1997 (BBA), Public Law 105-33, Section 4432(b). This section of the law contains the SNF CB requirements.

Under the CB requirement, **an SNF itself must submit all Medicare claims for the services that its residents receive** (except for specifically excluded services listed below). Conceptually, SNF CB resembles the bundling requirement for inpatient hospital services that's been in effect since the early 1980s—assigning to the facility itself the Medicare billing responsibility for virtually the entire package of services that a facility resident receives, except for certain services that are specifically excluded. CB eliminates the potential for duplicative billings for the same service to the Part A fiscal intermediary by the SNF and the Part B carrier by an outside supplier. It also enhances the SNF's capacity to meet its existing responsibility to oversee and coordinate the total package of care that each of its residents receives.

### Effective Dates

CB became effective as each SNF transitioned to the Prospective Payment System (PPS) at the start of the SNF's first cost reporting period that began on or after July 1, 1998.

The original CB legislation in the BBA applied this provision for services furnished to every resident of an SNF, regardless of whether Part A covered the resident's stay.

However, due to systems modification delays that arose in connection with achieving Year 2000 (Y2K) compliance, the Centers for Medicare & Medicaid Services (CMS) initially postponed implementing the Part B aspect of CB, i.e., its application to services furnished during noncovered SNF stays. The aspect of CB related to services furnished during noncovered SNF stays has now essentially been repealed altogether by Section 313 of the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554, Appendix F).

Thus, with the exception of physical therapy, occupational therapy, and speech language pathology services (which remain subject to CB regardless of whether the resident who receives them is in a covered Part A stay), this provision now applies only to those services that an SNF resident receives during the course of a covered Part A stay.

### Excluded Services

There are a number of services that are excluded from SNF CB. These services are outside the PPS bundle, and they remain separately billable to Part B when furnished to an SNF resident by an outside supplier. However, Section 4432(b)(4) of the BBA (as amended by Section 313(b)(2) of the BIPA) requires that bills for these excluded services, when furnished to SNF residents, must contain the SNF's Medicare provider number.

Services that are categorically excluded from SNF CB are the following:

- Physicians' services furnished to SNF residents. These services are not subject to CB and, thus, are still billed separately to the Part B carrier.
- Certain diagnostic tests include both a professional component (representing the physician's interpretation of the

test) and a technical component (representing the test itself), and the technical component is subject to CB. **The technical component of these services must be billed to and reimbursed by the SNF.** (See Medlearn Matters Special Edition Article SE0440 for a more detailed discussion of billing for these diagnostic tests.)

- Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that **physical therapy, occupational therapy, and speech-language pathology services are subject to CB**, even when they are furnished by (or under the supervision of) a physician.
- Physician assistants working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists;
- Certified registered nurse anesthetists;
- Services described in Section 1861(s)(2)(F) of the Social Security Act (i.e., Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies);
- Services described in Section 1861(s)(2)(O) of the Social Security Act (i.e., Part B coverage of Epoetin Alfa (EPO, trade name Epogen) for certain dialysis patients. Note: Darbepoetin Alfa (DPA, trade name Aranesp) is now excluded on the same basis as EPO);
- Hospice care related to a resident's terminal condition;
- An ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge.

### Physician "Incident To" Services

While CB excludes the types of services described above and applies to the professional services that the practitioner performs personally, **the exclusion does not apply to physician "incident to" services** furnished by someone else as an "incident to" the practitioner's professional service. These "incident to" services furnished by others to SNF residents are subject to CB and, accordingly, must be billed to Medicare by the SNF itself.

Examples of "incident to" services are laboratory tests or x-rays performed in the doctor's office.

### Outpatient Hospital Services

In Program Memorandum (PM) Transmittal # A-98-37 (November 1998, reissued as PM transmittal # A-00-01, January 2000), CMS identified specific types of outpatient hospital services that are so exceptionally intensive or costly that they fall well outside the typical scope of SNF care plans. CMS has excluded these services from SNF CB as well (along with those medically necessary ambulance services that are furnished in conjunction with them).

These excluded service categories are:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnetic resonance imaging services (MRIs);
- Ambulatory surgery that involves the use of an operating room;
- Emergency services;
- Radiation therapy services;
- Angiography; and
- Certain lymphatic and venous procedures.

Effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) has identified certain additional exclusions from CB. The additional exclusions enacted in the BBRA apply only to certain specified, individual services *within* a number of broader service categories that otherwise remain subject to CB. Within the affected service categories the exclusion applies only to those individual services that are specifically identified by HCPCS code in the legislation itself, while all other services within those categories remain subject to CB.

These service categories are:

- Chemotherapy items and their administration;
- Radioisotope services; and
- Customized prosthetic devices.

In addition, effective April 1, 2000, this section of the BBRA has unbundled those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services. Finally, effective January 1, 2004, as provided in the August 4, 2003 final rule (68 Federal Register 46060), two radiopharmaceuticals, Zevalin and Bexxar, were added to the list of chemotherapy drugs that are excluded from CB (and, thus, are separately billable to Part B when furnished to a SNF resident during a covered Part A stay).

### Effects of CB

SNFs can no longer “unbundle” services that are subject to CB in order for an outside supplier to submit a separate bill directly to the Part B carrier. Instead, the SNF itself must furnish the services, either directly, or under an “arrangement” with an outside supplier in which the SNF itself (rather than the supplier) bills Medicare. The outside supplier must look to the SNF (rather than to Medicare Part B) for payment. In addition, SNF CB:

- Provides an essential foundation for the SNF PPS, by bundling into a single facility package all of the services that the PPS payment is intended to capture;
- Spares beneficiaries who are in covered Part A stays from incurring out-of-pocket financial liability for Part B deductibles and coinsurance;
- Eliminates potential for duplicative billings for the same service to the Part A fiscal intermediary (FI) by the SNF and to the Part B carrier by an outside supplier; and
- Enhances the SNF’s capacity to meet its existing responsibility to oversee and coordinate each resident’s overall package of care.

### Additional Information

While this article presents an overview of the SNF CB process, CMS also has a number of articles that provide more specifics on how SNF CB applies to certain services and/or providers.

In addition, the CMS Medlearn Consolidated Billing Website can be found at:

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

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

**Source:**

*Related Change Request (CR) #:* N/A

*Medlearn Matters Number:* SE0431

# Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services

## Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, providers, and imaging centers

## Provider Action Needed

This Special Edition describes SNF Consolidated Billing (CB) as it relates to certain types of exceptionally intensive outpatient hospital services, such as Magnetic Resonance Imaging (MRI) services, Computerized Axial Tomography (CT) Scans, and Radiation Therapy.

## Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB, including a section on services excluded from SNF CB, see Medlearn Matters Special Edition article SE0431 at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The original CB legislation (Section 4432(b) of the Balanced Budget Act of 1997, P. L. 105-33 (BBA 1997)) specified a list of services at Section 1888(e)(2)(A)(ii) of the Social Security Act that were excluded from this provision. As with the inpatient hospital bundling requirement (Section 1862(a)(14) of the Social Security Act) on which it was modeled, the SNF CB provision excluded primarily the services of physicians and certain other practitioners.

Moreover, **these services were excluded categorically, without regard to the specific setting in which they were furnished.** This legislation did not authorize the Department of Health and Human Services (DHHS) to create additional categorical exclusions from CB administratively, thereby reserving this authority for the Congress itself. In fact, the Congress subsequently did enact a number of additional CB exclusions that applied uniformly to services furnished in both hospital and non-hospital settings, in Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA 1999, P.L.106-113, Appendix F). While the original CB legislation did not authorize DHHS to simply carve out entire categories of services from CB without regard to setting, it did define the SNF CB provision in terms of services furnished to a resident of a SNF, and provided a degree of administrative discretion in defining when a beneficiary is considered to be a SNF "resident" for this purpose.

Using this authority, the Centers for Medicare & Medicaid Services (CMS) identified several types of exceptionally intensive outpatient hospital services that were well beyond the general scope of SNF care plans.

These services include:

- Emergency services;
- Cardiac catheterizations;
- Computerized Axial Tomography (CT) scans;
- Magnetic Resonance Imaging (MRI) services;
- Ambulatory surgery;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

CMS established that a beneficiary's receipt of such services in the outpatient hospital setting had the effect of temporarily suspending his/her status as a SNF resident for CB purposes, thus enabling the hospital to bill Part B separately for the services. (See Title 42 of the Code of Federal Regulations (42 CFR), Section 411.15(p)(3)(iii).) The under-

lying rationale for this exclusion was that these services were so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively.

In the legislative history that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress explicitly recognized that this administrative exclusion is specifically limited to "...certain outpatient services **from a Medicare participating hospital or critical access hospital...**" (emphasis added). (See the House Ways and Means Committee Report (H. Rep. No. 108-178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108-391 at 641).) This means that the exclusion does not encompass services that are furnished in other, non-hospital settings (such as freestanding clinics).

As noted previously, in addition to the existing exclusion of certain types of intensive outpatient hospital services under the regulations at 42 CFR 411.15(p)(3)(iii), Congress has elected to exclude several categories of services from CB in the statute itself, at Sections 1888(e)(2)(A)(ii)-(iii) of the Social Security Act.

Unlike the administrative exclusion discussed above, which applies solely to services furnished in the outpatient hospital setting, the statutorily excluded services are separately billable to Part B regardless of the setting (hospital versus free-standing) in which they are furnished. For example, as amended by Section 103 of BBRA 1999, Section 1888(e)(2)(A)(iii)(II) of the Social Security Act excludes certain types of accurate statement of their contents. intensive chemotherapy services, regardless of whether they are furnished in a hospital or freestanding setting. Additional legislation would be required to expand the exemption of CT scans, MRI services, and radiation therapy to apply to services furnished in non-hospital settings.

Chemotherapy and its administration and radioisotopes and their administration are identified in the statute by HCPCS Code. These services are separately billable in all care settings, but the exclusion applies only to the codes specified in the Social Security Act and subsequent regulations. Therefore, other services given in conjunction with an excluded code (e.g., other pharmaceuticals, medical supplies, etc.) remain bundled and should be reimbursed by the SNF to the supplier.

Please note that the professional charge for the physician who performs/interprets the radiological procedure is NOT subject to CB. Since the physician service exclusion applies to the professional component of the diagnostic radiology service, **the physician bills his/her service directly to the Medicare Part B carrier for reimbursement.**

#### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The Centers for Medicare and Medicaid Services (CMS) Medlearn Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

It includes the following relevant information:

- General SNF CB information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

Source:

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0432

## Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Services

### Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, ambulance suppliers, and providers

### Provider Action Needed

This Special Edition article describes SNF Consolidated Billing (CB) as it applies to ambulance services for SNF residents.

### Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e., based on the reason the ambulance service is needed. This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or "bundling" requirement since 1983. Since the law describes CB in terms of services that are furnished to a "resident" of an SNF, the initial ambulance trip that brings a beneficiary to an SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary's SNF "resident" status.

The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.);
- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care;
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below); or
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

### Ambulance Trips to Receive Excluded Outpatient Hospital Services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes.

Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan. Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis.

These services are the following:

- Cardiac catheterization;
- Computerized Axial Tomography Imaging (CT) scans;
- Magnetic Resonance Imaging (MRI) services;
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite);
- Emergency room services;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

Since the receipt of one of these excluded types of outpatient hospital services is considered to end a beneficiary's status as an SNF resident for CB purposes, any associated ambulance trips are, themselves, excluded from CB as well; thus, an ambulance trip furnished in connection with the receipt of such services should be billed separately to Part B by the outside supplier.

### Other Ambulance Trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF.

Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement. However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

### Transfers Between Two SNFs

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)).

Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under §411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2. However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

### Roundtrip to a Physician's Office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate.

The preamble to the July 30, 1999 final rule (64 Federal Register 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing Website is at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

It includes the following relevant information:

- General SNF CB information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

**Source:**

*Related Change Request (CR) #:* N/A

*Medlearn Matters Number:* SE0433

## Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp)

### Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, end-stage renal disease (ESRD) facilities, and hospitals

### Provider Action Needed

This Special Edition is informational only and describes SNF Consolidated Billing (CB) as it applies to Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) and related services.

### Background

The original Balanced Budget Act of 1997 list of exclusions from the prospective payment system (PPS) and consolidated billing (CB) for SNF Part A residents specified the services described in section 1861(s)(2)(O) of the Social Security Act—the Part B erythropoietin (EPO) benefit.

This benefit covers EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secretary for its safe and effective use (see 42 CFR 405.2163(g) and (h)). For an overview of SNF CB and a list of excluded services, see Medlearn Matters article SE0431 at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

Regulations at 42 CFR 414.335 describe payment for EPO and require that EPO be furnished by either a Medicare-approved ESRD facility or a supplier of home dialysis equipment and supplies. The amount that Medicare pays is established by law. Thus, the law and implementing regulations permit a SNF to unbundle the cost of the Epogen drug when it is furnished by an ESRD facility or an outside supplier, which can then bill for it under Part B. A SNF that elects to furnish EPO to a Part A resident itself cannot be separately reimbursed over and above the Part A SNF PPS per diem payment amount for the Epogen drug.

As explained above, the exclusion of EPO from CB and the SNF PPS applies only to those services that meet the requirements for coverage under the separate Part B EPO benefit, i.e., those services that are furnished and billed by an approved ESRD facility or an outside dialysis supplier. By contrast, if the SNF itself elects to furnish EPO services (including furnishing the Epogen drug) to a resident during a covered Part A stay (either directly with its own resources, or under an “arrangement” with an outside supplier in which the SNF itself does the billing), the services are no longer considered Part B EPO services, but rather, become Part A SNF services.

Accordingly, they would no longer qualify for the exclusion of Part B EPO services from CB, and would instead be bundled into the PPS per diem payment that the SNF receives for its Part A services. Note: The Part B coverage rules that apply to EPO are applied in the same manner to Aranesp. (See Medicare Claims Processing Manual, Pub. 100-04, Chapter 8 – Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §60.7.2; see also Medicare Benefit Policy Manual, Pub. 100-02, Chapter 11 – End Stage Renal Disease [ESRD], §90). Accordingly, Aranesp is now excluded on the same basis as EPO. Note: EPO (Epoetin Alfa, trade name Epogen) and DPA (Darbepoetin Alfa, trade name Aranesp) are not separately billable when provided as treatment for any illness other than ESRD. In this case, the SNF is responsible for reimbursing the supplier. The SNF should include the charges on the Part A bill filed for that beneficiary.

**Additional Information**

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The 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](http://www.cms.hhs.gov/manuals/29_rdf/rd200.asp?#_1_17)

You can find the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 11, End Stage Renal Disease (ESRD), at the following CMS Website: [http://www.cms.gov/manuals/102\\_policy/bp102index.asp](http://www.cms.gov/manuals/102_policy/bp102index.asp)

You can find the Medicare Claims Processing Manual, Pub. 100-04, Chapter 8, Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, at the following CMS Website: [http://www.cms.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.gov/manuals/104_claims/clm104index.asp)

The CMS Medlearn Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

Source:

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0434

The image contains two screenshots of the Centers for Medicare & Medicaid Services (CMS) website. The left screenshot shows the 'Chapter II Coverage of Services' page, which lists various codes and their descriptions, such as '200. HEALTH INSURANCE COVERAGE OF PERSONS NEEDING KIDNEY TRANSPLANTATION OR DIALYSIS GENERAL', '201. SPECIFIC MEDICARE APPROVALS REQUIRED BY RENAL DIALYSIS FACILITIES', and '202. COVERAGE OF ANALYSIS SERVICES'. The right screenshot shows the 'Consolidated Billing for Skilled Nursing Facility' page, which includes a 'Highlights' section and a 'Background' section. The background section discusses the Balanced Budget Act of 1997 (BBA) and the impact on SNF billing for services to residents in a covered Part A stay.

## Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage

### Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, end-stage renal disease (ESRD) facilities, and hospitals

### Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to dialysis coverage for SNF residents. See Medlearn Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

### Background

Dialysis furnished to an SNF resident during a covered Part A stay falls within the scope of the SNF benefit under the Social Security Act, Section 1861(h)(7), as long as the SNF elects to provide the dialysis itself, either directly or under an “arrangement” with a qualified outside supplier in which the SNF itself assumes the Medicare billing responsibility. When covered in this manner, the dialysis would be included in the global Medicare Part A per diem payment that the SNF receives under the Prospective Payment System (PPS).

However, the SNF PPS legislation also gives SNFs the option of “unbundling” the dialysis and, thereby, allowing an outside supplier to furnish the dialysis services and submit a bill directly to its Medicare Part B carrier. If the SNF elects this option, dialysis services that meet the requirements for separate coverage under the Part B dialysis benefit (as described in the Social Security Act, Section 1861(s)(2)(F)) are excluded from SNF CB. As such, these services can be furnished and billed directly to the Medicare Part B carrier by the outside dialysis supplier itself. In addition, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive the Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

As noted previously, if the SNF **elects** to provide the dialysis services under Part A, either directly or under an arrangement with an outside supplier, these services would be included in the SNF’s PPS per diem payment (since dialysis services that SNFs furnished in this manner during the PPS base period would have been included on their cost reports and reflected in the PPS base).

Further, since the Social Security Act (Section 1833(d)) expressly prohibits payment under Part B for any service that is covered under Part A, such services would not be excluded from SNF CB, since they would no longer meet the statutory criteria (Section 1888(e)(2)(A)(ii)) of being items and services that meet the requirements for coverage under the separate Part B dialysis benefit of the Social Security Act (Section 1861(s)(2)(F)).

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

It includes the following relevant information:

- General SNF CB information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

*Source:*

*Related Change Request (CR) #: N/A*

*Medlearn Matters Number: SE0435*

## Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services

### Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, and providers

### Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to preventive and screening services provided to SNF residents.

### Background

When the Skilled Nursing Facility (SNF) prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay.

See Medlearn Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's resident (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list preventive and screening services among the services identified for exclusion, these services are included within the scope of the CB provision.

However, reimbursement for covered preventive and screening services, such as vaccines and mammographies, is subject to special billing procedures. As discussed in the May 12, 1998 Federal Register (63 FR 26296), since preventive services (such as vaccinations) and screening services (such as screening mammographies) do not appear on the exclusion list, they are subject to CB. Accordingly, if an SNF resident receives, for example, a flu vaccine during a covered Part A stay, the SNF itself is responsible for billing Medicare for the vaccine, even if it is furnished to the resident by an outside entity.

Nevertheless, even though the CB requirement makes the SNF itself responsible for billing Medicare for a preventive or screening service furnished to its Part A resident, the SNF would not include the service on its Part A bill, but would instead submit a separate bill for the service to Part B. This is because the Part A SNF benefit is limited to coverage of "diagnostic or therapeutic" services (i.e., services that are reasonable and necessary to diagnose or treat **a condition that has already manifested itself**). (See Sections 1861(h) following (7), 1861(b)(3), and 1862(a)(1) of the Social Security Act.)

Accordingly, the Part A SNF benefit does not encompass screening services (which serve to detect the presence of a condition while it is still in an early, asymptomatic stage) or preventive services (which serve to ward off the occurrence of a condition altogether). Such services are always covered under Part B, even when furnished to a beneficiary during the course of a covered Part A SNF stay. Under Section 1888(e)(9) of the Social Security Act, payment for an SNF's Part B services is made in accordance with the applicable fee schedule for the type of service being billed.

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing Website is at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

#### Source:

*Related Change Request (CR) #:* N/A

*Medlearn Matters Number:* SE0436

## Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics

### Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, and providers

### Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to prosthetics and orthotics for SNF residents.

### Background

The SNF CB provision of the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432(b)) is a comprehensive billing requirement under which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. This billing requirement is similar to the billing requirement that has been in effect for inpatient hospital services since 1983.

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's residents (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list prosthetic devices among the services identified for exclusion, such items initially were categorically included within the scope of the CB provision.

However, effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F, Section 103) provided for the exclusion of certain additional types of services from SNF CB. These services are listed in a separate Medlearn Matters article, SE0431, which also provides an overview of SNF CB. This article can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The original statutory exclusions enacted by the BBA consist of a number of broad service categories and encompass all of the individual services that fall within those categories. By contrast, the additional exclusions enacted in the BBRA are more narrowly targeted, and apply only to certain specified, individual services within a number of broader service categories that otherwise remain subject to CB.

For customized prosthetic devices, the exclusion applies only to those individual items that the legislation itself specifically identifies by Healthcare Common Procedure Coding System (HCPCS) code, while all other items within this category remain subject to CB.

The individual HCPCS codes by which the excluded services are identified appear in annual and quarterly CB updates. These CB updates can be found at: [http://www.cms.hhs.gov/providers/snfpps/snfpps\\_pubs.asp](http://www.cms.hhs.gov/providers/snfpps/snfpps_pubs.asp)

The BBRA Conference Committee report (H. Rep. 106-479) characterized the individual services that this legislation targeted for exclusion as "...high-cost, low-probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system..." The BBRA also gives the Centers for Medicare & Medicaid Services (CMS) limited authority to identify additional prosthetic codes for exclusion, in response to developments such as major advances over time in the state of medical technology, or reconfigurations of the HCPCS codes themselves. When new HCPCS codes are established for excluded services, the new codes are communicated through the annual and quarterly CB updates.

Moreover, while Congress elected to exclude from CB certain specific customized prosthetic devices that meet the criteria discussed above regarding high cost and low probability, it declined to exclude other types of prosthetic devices, and also declined to exclude orthotics as a class. In contrast to prosthetics, those items in the orthotics category tend to be more standardized and lower in cost.

Further, even those customized items that fall at the high end of the orthotics category generally are still significantly less expensive and more commonly furnished in SNFs than customized items that fall at the high end of the prosthetics category.

Accordingly, orthotics would not appear to meet the criteria of exceptionally high cost and low probability that served as the basis for the BBRA exclusions. Further, even if certain individual orthotic devices were to be identified as meeting these criteria, excluding them from the CB requirement could not be accomplished administratively, but would require further legislation by Congress to add this service category to the statutory exclusion list.

In addition, CMS notes that in contrast to prosthetics (where the needs of a patient with a missing limb can often be addressed only through the use of a single, particular type of customized device), it is often medically feasible to use a relatively inexpensive orthotic device in place of a more expensive one. Thus, CMS believes that the SNF PPS appropriately places the financial responsibility for such devices (along with the decision-making authority for selecting among them) with the SNF itself, because it may be possible to address a particular SNF resident's condition with equal efficacy by selecting among a broader range of orthotic devices.

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

*Source:*

*Related Change Request (CR) #: N/A*

*Medlearn Matters Number: SE0437*

# MMA-Medicare Prescription Drug, Improvement, and Modernization Act – Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers

## Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, Rural Health Clinics (RHC), and Federally Qualified Health Centers (FQHCs).

## Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to services provided by RHCs and FQHCs.

## Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. Consolidated Billing (CB) places with the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB and a list of the services excluded from SNF CB, see Medlearn Matters Special Edition SE0431 at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

RHC and FQHC services currently do not appear on the list of services that are excluded from the SNF CB requirement. Consequently, when a SNF resident receives RHC or FQHC services during a covered Part A stay, the services are bundled into the SNF's comprehensive per diem payment for the covered stay itself, and are not separately billable to Part B.

This means that rather than submitting a separate bill to Part B for these services, the RHC or FQHC looks to the SNF for its payment. However, Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) has amended the law to specify that when an SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from an RHC or FQHC, those services would not become subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC.

In effect, the amendment enables such services to retain their separate identity as excluded "practitioner" services in this context, rather than being considered bundled "RHC" or "FQHC" services. As such, these services remain separately billable to Part B when furnished to an SNF resident during a covered Part A stay. The MMA specifies that this provision becomes effective with services furnished on or after January 1, 2005.

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

Also, the Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

**Source:**

*Related Change Request (CR) #:* N/A

*Medlearn Matters Number:* SE0438

*Effective Date:* January 1, 2005

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

### Provider Types Affected

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

### Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to CSW services furnished to SNF residents during a Part A covered stay.

### Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns SNFs the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB and a list of the services excluded from SNF CB, see Medlearn Matters Special Edition SE0431 at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

Since CSW services do not currently appear on this excluded list, they are included within the overall package of services that is subject to the SNF CB requirement. Although the inclusion of CSW services under the SNF CB requirement does not preclude Medicare coverage for these services, it makes the SNF responsible for including them in its Part A bill for the resident's covered stay.

In fact, bundling CSW services in the Part A payment rate is not a new concept. The corresponding Medicare comprehensive billing requirement for inpatient hospital services, which similarly includes CSW services while excluding the services of certain other types of mental health professionals, has been in effect since 1983, and served as a model for SNF CB.

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

Also, the Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

It includes the following relevant information:

- General SNF CB information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

#### Source:

*Related Change Request (CR) #:* N/A

*Medlearn Matters Number:* SE0439

## Skilled Nursing Facility Consolidated Billing as It Relates to Certain Diagnostic Tests

### Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, providers, and radiology centers

### Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to certain diagnostic tests that include both a technical component (representing the test itself) and a professional component (representing the physician's interpretation of the test). These tests commonly include diagnostic radiology procedures (such as x-rays) and laboratory tests, but can also include other types of diagnostic procedures (such as audiology services).

### Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB and a list of the services excluded from SNF CB, see Medlearn Matters Special Edition SE0431 at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

However, one of the service categories that the law does exclude from the SNF CB provision is physician services, which are separately billable to the Medicare Part B carrier. See Medlearn Matters Special Edition article SE0445 for a more detailed discussion of SNF CB as it relates to services that are furnished as an “incident to” a physician’s professional services. (This article will be coming soon.) Since many diagnostic tests include both a technical component and a professional component, suppliers need to generate two bills.

For example regarding diagnostic radiology services (such as x-rays), the physician service exclusion applies only to the professional component of the diagnostic radiology service (representing the physician’s interpretation of the diagnostic test). **The physician service is billed directly to the Medicare Part B carrier.** Because the diagnostic radiology service’s technical component is already included within the SNF’s global per diem payment for its resident’s covered Part A stay, the outside supplier that actually furnishes the technical component would look to the SNF (rather than to Medicare Part B) for payment.

As indicated in the preceding discussion, these policies are not new, and have been in effect since the implementation of the SNF PPS in 1998. What has changed, however, is that the Centers for Medicare & Medicaid Services (CMS) installed electronic edits in 2002 that enable the claims processing system to detect automatically any claims that are inappropriately submitted to Part B for those services that are already included within the SNF’s global per diem payment for a resident’s covered Part A stay (such as the technical component of diagnostic tests).

As discussed above, because these services are already included within the SNF’s payment for its resident’s Medicare-covered stay, an outside entity that furnishes the services must look to the SNF, rather than to Medicare Part B, for payment.

#### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>

The CMS Medlearn Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices)

**Source:**

**Related Change Request (CR) #:** N/A

**Medlearn Matters Number:** SE0440

# MMA - July 2004 Update of the Hospital Outpatient Prospective Payment System (OPPS)

**Provider Types Affected**

Hospitals and other providers paid under the OPPS

**Provider Action Needed**

This instruction outlines changes in the Outpatient Prospective Payment System (OPPS) for the July 1, 2004 quarterly update. Unless otherwise noted, all changes in this instruction are effective for services furnished on or after July 1, 2004, unless otherwise noted below.

**Background**

This instruction describes changes announced by the Centers for Medicare & Medicaid Services (CMS) to the Outpatient Prospective Payment System (OPPS) for the July 2004 update.

Also, the July 2004 Outpatient Code Editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) codes and Ambulatory Payment Classification (APC) changes, additions, and other revisions identified in this instruction. Changes in payment for certain drugs, biologicals, and radiopharmaceuticals mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) are being implemented in the July 1, 2004 quarterly OPPS update, under Change Request (CR) 3322 which is being issued separately. CR 3322 addresses OPPS additions, changes, and other revisions for drugs, biologicals and radiopharmaceuticals.

**1. Service Added to New Technology APC**

The following service is assigned for payment in a new technology APC under the OPPS OCE, effective July 1, 2004.

HCPCS	EFFECTIVE DATE	SI	APC	SHORT DESCRIPTOR	LONG DESCRIPTOR	PAYMENT RATE	MINIMUM UNADJUSTED COPAYMENT
C9716*	07/1/04	S	1519	Radiofrequency Energy to Anus	Creation of Thermal Anal Lesions by Radiofrequency Energy	\$1750.00	\$350.00

\*This procedure is used for the treatment of fecal incontinence and involves the application of radiofrequency energy to the internal sphincter complex of the anus.

**2. Drug-Eluting Stents**

In the July 2003 Update of the OPPS, Transmittal A-03-051, Change Request 2771, issued June 13, 2003, CMS provided billing instructions for drug-eluting stents. The Food and Drug Administration (FDA) approved drug-eluting stents effective April 24, 2003. This notification provides updated billing instructions for the placement of drug-eluting stents, especially with the January 1, 2004 reinstatement of device C-codes for cost reporting purposes.

**Effective for services furnished on or after July 1, 2003:**

In Transmittal A-03-051, CR 2771, CMS implemented payment under APC 0656, Transcatheter Placement of Drug-Eluting Coronary Stents, for two HCPCS codes that describe drug-eluting stents and their placement. CMS did not establish new HCPCS codes for the drug eluting coronary stents; however, CMS indicated that hospitals could include the charge for the drug-eluting stent in the charge for G0290 and G0291.

CMS also indicated that, alternatively, hospitals could bill separately for the stent using an appropriate Revenue Code, making certain that the charge for the G0290 and G0291 did not include the charge for the stent. Payment for placement of the stents, and the stents themselves, are made under APC 0656.

As of January 1, 2004, CMS reinstated C-codes for devices for cost reporting and cost tracking purposes. Therefore, hospitals have a third option to report charges for drug eluting stents. That is, hospitals may report HCPCS code C1874, "Stent, coated/covered, with delivery system" with an appropriate Revenue Code to report their charge for drug eluting coronary stents. When using HCPCS code C1874 to bill separately for drug eluting stents, hospitals should make certain

that the charge for G0290 and G0291 for placement of the stents does not include the stent charge. Payment for C1874 is packaged into the payment for APC 656, but reporting a separate charge for the stent(s) provides important data that affects future updates of the OPPS.

**3. Payment Change for CPT code 96567, “Photodynamic tx, skin”**

Effective July 1, 2004, CPT code 96567, “Photodynamic tx, skin” is assigned to APC 1504.

**4. Reporting Line Item Date of Service for Revenue Code without a HCPCS**

In order to accurately determine hospital costs for purposes of updating payment rates for drugs and all other services paid under the hospital OPPS, and in order to package services appropriately, CMS relies on the service line date. Therefore, it is extremely important that the date and charge reported with a revenue code on a line without a HCPCS code represent a single date of service rather than a range of dates.

**5. Reminder Regarding Monthly Reporting of Repetitive Services**

Hospitals shall not bill the following Revenue Codes monthly, as these services are not repetitive Part B services:

<b>TYPE OF SERVICE</b>	<b>REVENUE CODE(S)</b>
Pharmacy	0250-0259
IV Therapy	0260-0269
Medical/Surgical Supplies	0270-0279
Medical/Surgical Supplies	0620-0624
Drugs Requiring Specific ID	0631-0637

**6. Coverage Determinations**

The fact that a drug, device, procedure, or service has a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare fiscal intermediaries shall determine whether a drug, device, procedure, or service meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

**7. Summary of July 2004 Modifications**

The official version of this instruction includes Attachment A which is the OPPS OCE Final Summary of Data Changes Effective July 1, 2004. Appendix A of that instruction 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 OPPS for the July 1, 2004 quarterly release.

To see Appendix A of the actual instruction for all these details, go to:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R195CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R195CP.pdf)

Note that unless otherwise stated, all changes in this instruction are effective for services furnished on or after July 1, 2004.

**Source:**

*Related Change Request (CR) #: 3324*

*Medlearn Matters Number: MM3324*

*Related CR Release Date: June 4, 2004*

*Related CR Transmittal #: 195*

*Effective Date: July 1, 2004*

*Implementation Date: July 6, 2004*

## **July Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 5.2**

### **Provider Types Affected**

Hospitals and other providers paid under the Outpatient Prospective Payment System (OPPS).

### **Provider Action Needed**

Affected hospitals and providers should note that this CR reflects the specifications that were issued for the April release of the OPPS OCE (Version 5.1), as well as changes for the July version (Version 5.2).

### **Background**

Full details regarding the OPPS OCE are contained in CR3314 and providers who bill under the OPPS are likely to be familiar already with the OCE specifications contained in that CR. A key part of CR3314 is Appendix J, which summarizes the modifications being made in Version 5.2 of the OCE. These modifications include the following:

- A new edit (# 65) for revenue codes not recognized by Medicare;
- A new packaging flag related to “Artificial charges for surgical procedure”;
- A new edit (# 66) for codes that will require manual pricing;
- A new edit (# 67) for dates of services for service provided prior to FDA approval;
- Implementation of Version 10.1 of the NCCI file.

### **Additional Information**

For complete details, please see the official instruction issued to fiscal intermediaries regarding this change. That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### *Source:*

*Related Change Request (CR) #: 3314*

*Medlearn Matters Number: MM3314*

*Related CR Release Date: May 28, 2004*

*Related CR Transmittal #: 184*

*Effective Date: July 1, 2004*

*Implementation Date: July 6, 2004*

## **October 2004 Outpatient Prospective Payment System Outpatient Code Editor (OPPS OCE) Specifications Version 5.3**

### **Provider Types Affected**

All outpatient providers with the exception of hospitals not subject to OPPS

### **Provider Action Needed**

Affected hospitals and providers should note that the related CR reflects the specifications that were issued for the July 2004 revision of the OPPS OCE (version 5.2), as well as changes for the October version, which is Version 5.3.

### **Background**

Full details of Version 5.3 of the OPPS OCE are contained in CR3395 and will not be repeated in this article, especially since many of the details are not changing and providers paid under the OPPS are likely familiar with these details.

Key changes in Version 5.3 include the following:

- Edit 67 is amended to reflect that the service was provided *prior to FDA approval or* prior to the date of a National Coverage Determination. Edit 67 is intended to line item reject any line that has a line item date of service that precedes the effective date of FDA approval (Medicare Modernization Act (MMA) Section 621 (a)(1)(15) OR the effective date of a National Coverage Determination(NCD) (MMA Section 731)). If the service is provided prior to the effective date of FDA approval or the effective date of the NCD, then the service is considered not covered by Medicare. Edit 67 was established to comply with MMA. (The italicized language has been added for reason 67.)
- Where submitted charges for HCPCS surgical codes is less than \$1.01 for any line with a packaging flag of 0, the packaging flag will be reset to 3 for that line when there are other surgical procedures on the claim with charges greater than \$1.00. All the modifications are summarized in the following table.

Note: Readers should also read through the specifications and note the highlighted sections, which also indicate change from the prior release of the software. Some OCE/Ambulatory Payment Classifications (APC) modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the “Effective Date” column.

Effective Date	Description
1/1/03	Packaging Flag: 3 “Artificial charges for surgical procedure” Expand the logic as follows: <ul style="list-style-type: none"> <li>■ Apply to all lines with SI = T (or any lines with SI = S in HCPCS range 10000-69999) with charges less than \$1.01 when there are other T procedures (or other S procedure in the same code range, 10000-69999) with charges greater than \$1.00 on the claim. Applicable to all OPSS claims where the APC Return buffer is completed).</li> <li>■ Change effective date for packaging flag 3 to 1/1/03 (previous effective date was 7/1/04).</li> </ul>
8/2000	Change the disposition for edit 27 from RTP to <b>Claim rejection</b> .
10/1/04	Make HCPCS/APC/SI and modifier changes, as specified by CMS.  Implement version <b>10.2</b> of the NCCI file, removing all code pairs which include Anesthesia 00100- 01999), E&M (92002-92014, 99201-99499), MH (90804-90911), CAD (76085, G0236) or G0168.
10/1/04	Update the valid diagnosis code list to add and delete ICD-9-CM diagnosis codes to reflect CMS updates effective 10/1/04, and set appropriate edit flags as indicated by CMS.
10/1/04	Update the valid revenue code list to add revenue codes 0343, 0344; and to delete revenue code 0910. Change description for edit 67 to read “Service provided prior to FDA approval or prior to date of National Coverage Determination (NCD).”

**Additional Information**

For complete details regarding the October version of the OPSS OCE (Version 5.3), please see the official instruction issued to your fiscal intermediary regarding this change. That instruction may be viewed by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

**Source:**

**Related Change Request (CR) #:** 3395

**Medlearn Matters Number:** MM3395

**Related CR Release Date:** July 30, 2004

**Related CR Transmittal #:** 254

**Effective Date:** October 1, 2004

**Implementation Date:** October 4, 2004

# **October Update to the Medicare Outpatient Code Editor (OCE) Version 20.0 for Bills from Hospitals That Are Not Paid Under the Outpatient Prospective Payment System (OPPS)**

## **Provider Types Affected**

Hospitals that are not paid under the OPPS

## **Provider Action Needed**

This change informs hospitals not paid under the OPPS of new additions, changes, and deletions to HCPCS codes, diagnosis codes, and procedure codes. Ensure that your billing staff is aware of these changes and bills accordingly.

## **Background**

The October update of the OCE used for processing hospital claims not paid under the OPPS includes a number of code additions, deletions, and changes.

These are summarized as follows:

- Over 170 new ICD-9-CM diagnosis codes have been added to the list of valid diagnosis codes, **effective October 1, 2004.**
- 25 diagnosis codes have been deleted from the list of valid ICD-9-CM diagnosis codes, **effective October 1, 2004.**
- Over 150 diagnosis codes will have revised short descriptors **effective on October 1, 2004.**
- 100 codes have been deleted from the list of adult diagnosis codes **effective on October 1, 2004.**
- 33 new codes have been added to the list of codes allowed for females only as of **October 1, 2004.**

To view the specific diagnosis codes and their descriptors in the above categories, see the actual CR3396, which may be found at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R255CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R255CP.pdf)

In addition to the extensive list changes mentioned above, the following changes are also noted:

- One code (V8403, Genetic susceptibility to malignant neoplasm of prostate) has been added to the list of diagnoses allowed for males only as of **October 1, 2004.**
- HCPCS code C9219 (Mycophenolic acid, oral) has been added to the list of valid codes, **effective January 1, 2004.**
- HCPCS code C9218 (Injection, azacitidine) has been added to the list of valid codes, effective as of **April 1, 2004.**
- HCPCS code G0336 (PET imaging brain Alzheimer's) has been added to the list of valid codes effective as of **July 1, 2004.**
- Five codes (G0330, PET image initial dx cervcal; G0331, PET image restage ovarian ca; G0341, Percutaneous Islet cell trans; G0342, Laparoscopy Islet cell trans; and G0343, Laparotomy Islet cell transp) have been added to the list of valid codes **effective on October 1, 2004.**
- Three codes (C9408, C9416, and C9434) have been deleted from the list of valid HCPCS, effective January 1, 2004.
- One new diagnosis code (7966, Nonspecific abnormal findings on neonatal screening) has been added to the list of maternity diagnoses, **effective October 1, 2004.**
- C9219 has been added to the list of Non-Reportable procedures, **effective January 1, 2004.**
- C9218 has been added to the list of Non-Reportable procedures, **effective April 1, 2004.**
- Two codes (Q4054 and Q4055) have been removed from the list of Non-Reportable procedures, **effective January 1, 2004.**

## **Additional Information**

For complete details, please see the official instruction issued to your fiscal intermediary, which includes additional details regarding the changes made to version 19.2 of the non-OPPS OCE including:

- New ICD-9-CM Diagnosis Codes
- Deleted ICD-9-CM Diagnosis Codes
- Revised ICD-9-CM Diagnosis Code Descriptions
- New HCPCS/CPT Procedure Codes
- Deleted HCPCS Procedure Codes

- Medicare Outpatient Code Edits
- Non-Reportable Procedures

This instruction may be viewed at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R255CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R255CP.pdf)

**Source:**

*Related Change Request (CR) #: 3396*

*Medlearn Matters Number: MM3396*

*Related CR Release Date: July 30, 2004*

*Related CR Transmittal #: 255*

*Effective Date: Various dates as described below and in the CR*

*Implementation Date: October 4, 2004*

## July Update to the Medicare Outpatient Code Editor (OCE) Specifications Version 19.2 for Bills from Hospitals that are Not Paid Under the Outpatient Prospective Payment System

### Provider Types Affected

Hospitals and other providers that are NOT paid for outpatient services under the Outpatient Prospective Payment System (OPPS).

### Provider Action Needed

This instruction informs fiscal intermediaries that the Outpatient Code Editor (OCE) used to process bills from hospitals not paid under the OPPS has been updated with new additions, changes, and deletions to the Healthcare Common Procedure Coding System (HCPCS) codes to ensure correct billing.

### Background

The non-OPPS OCE has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System/Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) codes. This OCE is used to process bills from hospitals not paid under the OPPS. Affected hospitals and providers should take note of these changes and advise billing staff accordingly.

The following are the changes made to version 19.2 of the non-OPPS OCE:

- The following codes have been deleted from the list of Non-Covered procedures, effective 4/1/02:

1. 44132
2. 44133
3. 44135
4. 44136

- The following codes have been added to the list of Non-Reportable procedures, effective 4/1/02:

1. 44132
2. 44133
3. 44135
4. 44136

- The following new codes have been added to the to the valid HCPCS list, effective 1/1/04:

- |          |          |
|----------|----------|
| 1. C9213 | 5. C9217 |
| 2. C9214 | 6. C9399 |
| 3. C9215 | 7. C9401 |
| 4. C9216 |          |

Note: Transmittal 20 (CR 3155) incorrectly listed C9406 in the valid HCPCS list, effective 1/1/04.

- The following codes have been added to the list of Non-Reportable procedures, effective 1/1/04:

- |          |          |
|----------|----------|
| 1. A9525 | 5. C9216 |
| 2. C9213 | 6. C9217 |
| 3. C9214 | 7. C9399 |
| 4. C9215 | 8. C9401 |

Note: Transmittal 20 (CR 3155) incorrectly listed C9406 in the list of Non-Reportable procedures, effective 1/1/04.

- The following code has been deleted from the valid HCPCS list, effective 4/1/04:

1. E1065

- The following new codes have been added to the list of valid HCPCS, effective 7/1/04:

- |          |           |           |           |           |
|----------|-----------|-----------|-----------|-----------|
| 1. C9716 | 6. K0653  | 11. K0658 | 16. K0663 | 21. K0668 |
| 2. G0329 | 7. K0654  | 12. K0659 | 17. K0664 | 22. K0669 |
| 3. K0650 | 8. K0655  | 13. K0660 | 18. K0665 |           |
| 4. K0651 | 9. K0656  | 14. K0661 | 19. K0666 |           |
| 5. K0652 | 10. K0657 | 15. K0662 | 20. K0667 |           |

- The following codes have been added to the list of Non-Reportable procedures, effective 7/1/04:

- |          |           |           |           |           |
|----------|-----------|-----------|-----------|-----------|
| 1. C9716 | 6. K0654  | 11. K0659 | 16. K0664 | 21. K0669 |
| 2. K0650 | 7. K0655  | 12. K0660 | 17. K0665 |           |
| 3. K0651 | 8. K0656  | 13. K0661 | 18. K0666 |           |
| 4. K0652 | 9. K0657  | 14. K0662 | 19. K0667 |           |
| 5. K0653 | 10. K0658 | 15. K0663 | 20. K0668 |           |

## Additional Information

For complete details please see the official instruction issued to the fiscal intermediary regarding this change.

That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

### Source:

*Related Change Request (CR) #:* 3319

*Medlearn Matters Number:* MM3319

*Related CR Release Date:* May 28, 2004

*Related CR Transmittal #:* 186

*Effective Date:* Various dates as described in this article

*Implementation Date:* July 6, 2004

# Hospital Outpatient Billing and Payment under Outpatient Prospective Payment System for New Drugs or Biologicals After FDA Approval but Before Assignment of a Product-Specific Drug/Biological HCPCS Code

## Provider Types Affected

Providers who bill under the outpatient prospective payment system (OPPS).

## Impact on Providers

Providers should note that beginning January 1, 2004, hospital outpatient departments may bill for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which pass-through status has not been approved, and a product-specific C code and APC payment have not been assigned.

## Background

Section 621(a) of the Medicare Modernization Act (MMA) amends Section 1833(t) of the Social Security Act by adding paragraph (15), "Payment for New Drugs and Biologicals Until HCPCS code are Assigned."

This provision applies only to payments under the OPPS. According to the provision, payment for an outpatient drug or biological that is furnished as part of covered outpatient department services, for which a product-specific Healthcare Common Procedure Coding System (HCPCS) code has not been assigned, shall be paid an amount equal to 95 percent of the Average Wholesale Price (AWP).

Thus, for drugs/biologicals provided on or after January 1, 2004 that are approved by FDA on or after that date and for which pass-through status has not been approved and a product-specific C-code and APC payment have not been assigned, outpatient departments may bill for the drug as follows:

- For drugs receiving FDA approval on or after January 1, 2004, hospitals may bill for the drug/biological using a new "unclassified code of C9399 (unclassified drug or biological).
- For the ANSI ASC X12N 837 I, hospital outpatient departments will report on TOB = 13x, containing revenue code 0636, HCPCS code C9399, and NDC number present in Loop 2400 LIN 03 of the 837 I. Alternatively, the hospital may report in the "Remarks" section of the CMS-1450 or its electronic equivalent (UB-92 flat file version 6.0), the National Drug Code (NDC) for the drug, the quantity of the drug that was administered, expressed in the unit of measure applicable to the drug or biological, and the date the drug was furnished to the beneficiary.

Medicare intermediaries will manually calculate the payment for the drug or biological at 95 per cent of the AWP. The intermediary will pay 80 percent of that calculated payment to the hospital; beneficiaries will be responsible for the 20 percent co-pay after the deductible is met.

Providers should note that drugs or biologicals that are manually priced under these instructions will not be eligible for outlier payment.

Also, the fact that CMS establishes a code and sets a payment rate for a drug or biological does not imply coverage by the Medicare program, but indicates only how the drug or biological may be paid if covered by the program. Fiscal intermediaries determine whether a drug or biological meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Also, beginning January 1, 2004, CMS will assign a drug/biological, product-specific HCPCS C-code and APC payment to a drug or biological approved by the FDA after January 1, 2004 that is approved for pass-through status. The process to apply for pass-through status for a drug or biological is explained on the CMS web site at:

<http://www.cms.hhs.gov/regulations/hopps/d&bfr101002.pdf>

C-codes and APC payments for drugs and biologicals approved for pass-through status are implemented prospectively beginning in July 2004.

CMS will issue further instructions in the future regarding billing and payment under the 2005 OPPTS for drugs and biologicals approved by the FDA after January 1, 2004 for which a product-specific C code has been assigned.

### Additional Information

For further information, see the instruction issued to your intermediary regarding this issue, which can be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #:* 3287

*Medlearn Matters Number:* MM3287

*Related CR Release Date:* May 28, 2004

*Related CR Transmittal #:* 188

*Effective Date:* January 1, 2004

*Implementation Date:* July 6, 2004

# July 2004 Update of the Hospital Outpatient Prospective Payment System (OPPS): Payment for Drugs, Biologicals, and Radiopharmaceuticals

## Provider Types Affected

Hospitals and other providers paid under the OPPTS

## Provider Action Needed

This instruction outlines changes in the Outpatient Prospective Payment System (OPPTS) for the July 1, 2004 quarterly update. Unless otherwise noted, all changes in this instruction are effective for services furnished on or after July 1, 2004.

## Background

This instruction describes changes to the Hospital OPPTS, to be implemented in the July 2004 update. The July 2004 Outpatient Code Editor (OCE) and OPPTS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) codes and ambulatory payment classification (APC) additions, changes, and other revisions identified in this notification.

Unless otherwise noted, all changes addressed in this notification are effective for services furnished on or after July 1, 2004. Certain information provided reflects changes resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) on December 8, 2003.

An Interim Final Rule with comment period describing these changes was published in the Federal Register on January 6, 2004 (69 FR 820). In addition, Change Requests CR3144 and CR3145, issued February 27, 2004, and CR 3154, issued March 30, 2004, also addresses changes resulting from the MMA.

## 1. Payment for Drugs and Biologicals Recently Approved by the FDA

- Beginning in 2004, the MMA requires payment at 95 percent of average wholesale price (AWP) for new drugs and biologicals after FDA approval but before it receives a product-specific HCPCS code.
- For services furnished on or after the designated effective date in Table B1, through June 30, 2004, payment for the drugs and biologicals in Table B1 will be made at 95 percent of AWP.
- For services furnished on or after the designated effective date in Table B1, through June 30, 2004, beneficiary copayment will equal 20 percent of the designated payment rate.
- Effective July 1, 2004, the drugs and biologicals in Table B1 are approved for payment as pass-through drugs and biologicals (see section 2, below).
- Hospitals that used a different HCPCS code to bill for the drugs and biologicals listed in Table B1 that were furnished prior to installation of the July 2004 release may submit adjustment bills.
- The "Effective Date of Payment Rate" listed in Table B1 reflects the date the drug or biological received FDA approval. Claims submitted with dates of service prior to these effective dates will receive OCE edit code 67, "Service provided prior to FDA approval." OCE edits are also addressed in the July 2004 OCE update (CR3314).

**Table B1 - 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
C9213	K	9213	Injection, Pemetrexed	Injection, Pemetrexed, Per 10 mg	\$46.31	\$9.26	2/04/04
C9214	K	9214	Injection, Bevacizumab	Injection, Bevacizumab, Per 10 mg	\$65.31	\$13.06	2/26/04
C9215	K	9215	Injection, Cetuximab	Injection, Cetuximab, Per 10mg	\$54.72	\$10.94	2/12/04
C9216	K	9216	Abarelix, Inject Suspension	Abarelix for Injectable Suspension, Per 10 mg	\$89.72	\$17.94	1/1/04
C9217	K	9300	Injection, Omalizumab	Injection, Omalizumab, Per 5 mg	\$17.14	\$3.43	1/1/04

**2. Drugs and Biologicals Newly-Approved for Pass-Through Payment**

- The drugs and biologicals listed in Table B2 have been designated as eligible for pass-through payment under the OPPS effective July 1, 2004. The effective date of pass-through status for C9213, C9214, C9215, C9216 and C9217 coincides with the date of assignment of product-specific HCPCS codes for each of these drugs.
- Pass-through payment for the drugs and biologicals listed in Table B2 equals 95 percent of AWP.

∑ The minimum unadjusted copayment amounts for the drugs and biologicals listed in Table B2 is calculated in accordance with pass-through payment rules and, therefore, is different from the minimum unadjusted copayment amounts listed in Table B1.

**Table B2 - 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
C9213	G	9213	Injection, Pemetrexed	Injection, Pemetrexed, Per 10 mg	\$46.31	\$6.92	7/1/04
C9214	G	9214	Injection, Bevacizumab	Injection, Bevacizumab, Per 10 mg	\$65.31	\$9.76	7/1/04
C9215	G	9215	Injection, Cetuximab	Injection, Cetuximab, Per 10mg	\$54.72	\$8.18	7/1/04
C9216	G	9216	Abarelix, Inject Suspension	Abarelix for Injectable Suspension, Per 10 mg	\$89.72	\$13.41	7/1/04
C9217	G	9300	Injection, Omalizumab	Injection, Omalizumab, Per 5 mg	\$17.14	\$2.56	7/1/04

**3. Billing and Payment for Fulvestrant, J9395**

Effective January 1, 2004, CMS is correcting the payment rate for J9395, Injection, Fulvestrant, per 25 mg. Medicare fiscal intermediaries shall mass adjust payment for claims with J9395 that were incorrectly paid for services furnished January 1, 2004 through June 30, 2004 and which were processed prior to installation of the July 2004 OPPS PRICER by the fiscal intermediaries. Providers need take no action to effect these adjustments.

HCPCS	SI	APC	Short Descriptor	Payment Rate	Minimum Unadjusted Copayment
J9395	G	9102	Injection, Fulvestrant, per 25 mg	\$81.57	\$13.63

**4. Misclassified Radiopharmaceutical: Billing and Payment for Strontium-89, Chloride, Generic versus Brand Name Form**

In the January 6, 2004 interim final rule, CMS inadvertently misclassified Strontium-89, Chloride as a solesource product. Strontium-89, Chloride should have been listed in CR 3144, “April 2004 Changes to the Hospital Outpatient Prospective Payment System (OPPS): Payment for Drugs, Biologicals and Radiopharmaceuticals, Generic Versus Brand Name.” In this CR, CMS addressed coding and payment for innovator multiple source (brand name) drugs and non-innovator multiple-source (generic) drugs, and implemented HCPCS codes and payment amounts for brand name drugs that CMS was not able to implement in the January 6, 2004 interim final rule.

The new HCPCS codes implemented in the April 2004 OPPS update were required to enable differentiation between the payment amount required under the MMA for a brand name drug and the payment amount required under the MMA for its generic form.

Effective January 1, 2004, Strontium-89, Chloride is classified as a **multi-source product** and is implemented with both a generic and brand name HCPCS code and payment amount.

Fiscal intermediaries shall mass adjust claims with A9600 that were incorrectly paid for services furnished January 1, 2004 through June 30, 2004 and which were processed prior to installation by the intermediaries of the July 2004 OPPS PRICER. Providers need take no action to effect these adjustments.

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date
A9600	K	0701	Strontium-89 Chloride	Supply of Therapeutic Radiopharmaceutical, Strontium-89 Chloride per mCi	\$402.85	\$80.57	1/1/04
C9401	K	9401	Strontium-89 Chloride Brand	Supply of Therapeutic Radiopharmaceutical, Strontium-89 Chloride, Brand Name	\$402.85	\$80.57	1/1/04

**5. Change in Long Descriptor for C9125, Injection, Risperidone, Long Acting, per 12.5 mg**

The Long Descriptor for C9125 is changed, effective July 1, 2004, from “Injection, Risperidone, per 12.5 mg” to “Injection, Risperidone, Long Acting, per 12.5 mg.”

**6. Clarification: Positron Emission Tomography (PET) Scans for Thyroid Cancer and Perfusion of the Heart Using Ammonia N-13**

In the October 2003 update of the Hospital OPPS, Transmittal A-03-076, Change Request 2887, CMS provided instructions concerning PET scans for thyroid cancer and perfusion of the heart using Ammonia N-13.

In the October 2003 instruction, CMS incorrectly stated that Q3000 and Q4078 were reportable with G0296. CMS is clarifying this issue and specifying, according to Transmittal AB-03-092, CR 2687, that Q3000 and Q4078 are not reportable with G0296. Rather, Q3000 and Q4078 are only reportable with HCPCS code series G0030-G0047.

**7. Reporting Line Item Date of Service for Revenue Code without a HCPCS**

In order to accurately determine hospital costs for purposes of updating payment rates for drugs and all other services paid under the hospital OPPS, and in order to package services appropriately, CMS relies on the service line date.

Therefore, it is extremely important that the date and charge reported with a revenue code on a line without a HCPCS code represent a single date of service rather than a range of dates.

## 8. Coverage Determinations

The fact that a drug, device, procedure, or service has a HCPCS code and a payment rate under the OPPS does *not* imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid *if* covered by the program.

Fiscal intermediaries shall determine whether a drug, device, procedure, or service meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

### Additional Information

For complete details, please see the official instruction issued to the intermediary which may be viewed by going to: [http://www.cms.hhs.gov/manuals/pm\\_trans/R194CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R194CP.pdf)

#### Source:

*Related Change Request (CR) #:* 3322

*Medlearn Matters Number:* MM3322

*Related CR Release Date:* June 4, 2004

*Related CR Transmittal #:* 194

*Effective Date:* July 1, 2004

*Implementation Date:* July 6, 2004

## Drug Pricing Update - Payment Limits for J7308 (Levulan Kerastick) and J9395 (Faslodex)

### Provider Types Affected

Physicians, suppliers, and providers

### Provider Action Needed

### Impact to You

New payment limits have been set for HCPCS drug codes J7308 (Levulan Kerastick) and J9395 (Faslodex) when these codes are not paid on a cost or prospective payment basis.

### What You Need to Know

Medicare Carriers are instructed to replace the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) payment limits for HCPCS drug codes J7308 (Levulan Kerastick) and J9395 (Faslodex) with the new rates listed in this instruction for dates of service on or after January 1, 2004.

### What You Need to Do

Be aware of the new payment limits for these two codes.

### Background

This article informs providers that Medicare carriers will apply new payment limits for these HCPCS codes (J7308 (Levulan Kerastick) and J9395 (Faslodex)) for claims processed 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 for the specific HCPCS drug codes listed below (that are not paid on a cost or prospective payment basis) apply.

HCPCS	Short Description	Average Wholesale Price (AWP) %	2004 Payment Limit for Drugs (other than End Stage Renal disease (ESRD) drugs separately billed by independent ESRD Facilities and drugs infused through Durable Medical Equipment (DME))
J7308	Aminolevulinic acid hcl top	85	\$111.47
J9395	Injection, Fulvestrant	85	\$81.57

**Note:** The payment limits listed in the table above supercede the payment limits published in Change Request 3105 (Transmittal 75) dated January 30, 2004, only for these particular HCPCS drug codes for this time period. Also note that the absence or presence of an HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug.

**Implementation**

The implementation date for this instruction is July 25, 2004. The effective date of the change is January 1, 2004. However, Medicare contractors will not adjust any claims previously processed in order to apply these new payment limits unless the provider requests such an adjustment.

- Source:*
- Related Change Request (CR) #: 3312*
- Medlearn Matters Number: MM3312*
- Related CR Release Date: June 25, 2004*
- Related CR Transmittal #: 90*
- Effective Date: January 1, 2004*
- Implementation Date: July 25, 2004*

## **Emergency Hospital Outpatient Billing of Epotein Alfa (EPO) and Darbepoetin Alfa (Aranesp)**

**Provider Types Affected**

Hospitals

**Provider Action Needed**

**Impact to You**

Hospitals are now able to bill End Stage Renal Disease (ESRD)-related anemia on an outpatient visit to the emergency room as described in this article.

**What You Need to Know**

HCPCS codes Q4054 and Q4055 can be billed on a 13X type of bill (TOB) for ESRD patients requiring EPO or Aranesp administration for ESRD-related anemia in association with a hospital outpatient visit related to a medical emergency.

**What You Need to Do**

Keep in mind that the administration for EPO/Aranesp may be required in an outpatient emergency setting and Medicare now pays for that administration. Payment will be limited to unscheduled EPO/Aranesp administrations for ESRD patients with medical emergencies.

**Background**

When ESRD patients come to the hospital for a medical emergency, their dialysis-related anemia may also require treatment. For patients with ESRD who are on a regular schedule of dialysis, EPO, or Aranesp may be administered in a hospital outpatient department with EPO being paid by Medicare using the statutory rate for EPO and with Aranesp being paid based on the MMA (Medicare Modernization Act) Drug Pricing File rate.

### Reporting EPO Charges

Report EPO charges under the revenue code 0634 if less than 10,000 units of EPO are used and use revenue code 0635 if more than 10,000 units are administered. Use HCPCS code Q4055 for EPO, reporting the total number of units as a multiple of 1000 units in the unit field and place the hematocrit value for the hospital outpatient visit in the value code 49.

Example: 40,000 units of EPO administered; Revenue code 635 and 40 placed in units field.

### Reporting Aranesp Charges

For Aranesp, report charges under revenue code 0636 with HCPCS code Q4054. Report the total number of units as a multiple of 1mcg in the unit field and the value code 49 will contain the hematocrit value for hospital outpatient visit.

Note also that Medicare will calculate a coinsurance based on the payment amount for EPO/Aranesp furnished in a hospital outpatient emergency setting and will apply the Medicare deductible as applicable.

### Implementation Dates

While this policy is effective as of January 1, 2004, it will be implemented in Medicare claims processing systems on October 4, 2004.

### Additional Information

To view the actual instruction issued by Medicare on this change, please see:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R197CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R197CP.pdf)

#### Source:

*Related Change Request (CR) #: 3184*

*Medlearn Matters Number: MM3184*

*Related CR Release Date: June 4, 2004*

*Related CR Transmittal #: 197*

*Effective Date: January 1, 2004*

*Implementation Date: October 4, 2004*

## Modification of Requirements in CR 2716, CWF Edits to Ensure Accurate Coding and Payments for Discharge and/or Transfer Policies

### Provider Types Affected

Hospitals

### Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is making emergency revisions to their claims processing systems to modify some edits previously set forth in PM A-03-065 (CR 2716), published on August 1, 2003, regarding inpatient claims and subsequent post-acute claims. **The anticipated date of these revisions is March 15, 2004.**

### Background

As a result of reports from the Office of the Inspector General, CMS had indications that hospitals were incorrectly coding the patient status code field in regards to transfers to post-acute care facilities. In some cases, this resulted in overpayments to the hospital. On January 1, 2004, CMS initiated Common Working File (CWF) edits to identify incorrectly coded hospital claims. CMS also instructed the Medicare intermediaries to automatically cancel hospital claims with an incorrect code in the patient status field.

It has been brought to our attention that the volume of cancellations is causing financial difficulties for many providers. Many of the cancelled claims would not be subject to a reduction in payment even if incorrectly coded. Post-acute claims that might come in out of sequence also caused some hospital claims to be inappropriately canceled. We are now in the process of revising the edit criteria so that only claims with the potential to be overpaid will be cancelled. CMS regrets this adverse impact on the hospital community and is working to modify its edits on March 15, 2004.

The sequencing issue has already been corrected. Obviously, the impact on hospitals has prompted a number of questions regarding this change and the impact of the previous change. Following are some of the most frequently raised questions and CMS answers.

### QUESTIONS AND ANSWERS

#### *What is currently being done by CMS to remedy this problem?*

The Medicare claims processing system has been modified to limit automatic cancellation of inpatient claims only to inpatient hospital claims with a patient status code indicating the patient was sent home upon receipt of a claim from another facility. We have also corrected the issue of canceling claims where a home health claim is received within three days and there may have been an intervening stay (e.g., SNF stay).

#### *What else will be done by CMS?*

CMS has established new criteria for an automatic claim cancellation. Once the CWF edits are revised (expected March 15, 2004), the only claims that will be canceled will be inpatient hospital (IPPS) claims paid under one of the 29 post acute care DRGs, with an actual length of stay (LOS) less than the average length of stay for the assigned DRG, and where CMS has an indication the patient status code is incorrect. This will greatly reduce the volume of cancellations that have no payment implications. CMS is also developing education materials to instruct hospitals on the coding of patient status. Hospitals will be required to code patient status correctly as CMS intends to expand upon these edits for all hospitals at a later date.

#### *Is there a 14-day reference in the inpatient transfer rule?*

No. This reference was incorrectly communicated in CR 2716.

#### *Has the CWF ever edited for the 14-day window for subsequent SNF claims, as referenced in CR 2716?*

The CWF has never edited for such a rule. We only edited for SNF claims if the patient was in a SNF on the same day as their discharge from a hospital.

#### *If the effective date for CR 2716 is January 1, 2004, why are some claims that were paid and/or processed prior to January 1, 2004, being cancelled?*

The effective date is not date of service specific. Any incoming claim that enters the CWF, on or after the effective date, will initiate a history search and potential cancellation of claims. The new edits will only search for and cancel claims with discharges on or after October 1, 2003.

#### *What hospitals are excluded from these edits?*

Hospitals not paid under the Inpatient Prospective Payment System (IPPS) are excluded.

#### *When will these edits take effect?*

The expected date is March 15, 2004.

#### *Does CMS realize that hospitals are out of compliance if they change the patient status code on the claim to a transfer as directed by CMS, even if the medical records or hospital physician orders do not support this? Families and personal physicians often place patients in post-acute settings without the hospital having any knowledge.*

CMS believes that if a patient is receiving post-acute care on the same day as discharge or within three days of discharge in the case of home health care, the post-acute admission is related to the inpatient stay. Physicians and coding staff must be educated on the impact of correct coding.

#### *What should hospitals be doing with canceled claims?*

Hospitals should be correcting the patient status code and resubmitting these claims ASAP to receive the appropriate reimbursement.

#### *Can a hospital receive accelerated payments if the impact of CR 2716's implementation is causing financial difficulties?*

Hospitals should contact their intermediary to determine if they are eligible for accelerated payments.

#### *Can you provide the current list of valid patient status codes?*

Below is the list of Patient Status codes with short Medicare descriptions. This is a required field for all Part A inpatient, SNF, hospice, home health agency (HHA), and outpatient hospital services. This code indicates the patient's status as of the "Through" date of the billing period. It is important to note that the patient status code indicates a destination (as in where the patient is discharged or transferred to) and not a level or type of care received.

Description	Patient Status Code
Home	01
Short term acute hospital	02
Skilled Nursing Facility (SNF)	03
Intermediate Care Facility (ICF) (also nursing facility with neither Medicare nor Medicaid certification)	04
Inpatient Psychiatric Hospital, Inpatient Psychiatric Distinct Part Unit of a Hospital, Children's Hospital, Cancer Hospital	05
Home Health	06
Home IV Provider	08
Admitted as Inpatient to this Hospital (for use only on Medicare outpatient hospital claims)	09
Expired	20
Still Patient	30
Expired at home (for hospice use only)	40
Expired in a medical facility (for hospice use only)	41
Expired-place unknown (for hospice use only)	42
Federal Hospital (such as VA)	43
Hospice-home	51
Hospice-medical facility	52
Medicare Approved Swing Bed *	61
Inpatient Rehabilitation Facility, including rehabilitation distinct part unit of a hospital	62
Long Term Care Hospital	63
Medicaid-only nursing facility	64
Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital	Future 65 (Providers should continue to use 05 until otherwise notified by CMS-expected 2005.) Instructions are forthcoming.

\* There has been some confusion in the provider community regarding the description of 61. CMS advises providers to use 61 for both discharges/transfers to a Medicare approved swing bed within the hospital's approved swing bed arrangement or to another Medicare approved swing bed in another location.

**Source:**

**Medlearn Matters Number:** SE0408

**Effective Date:** January 1, 2004

**Implementation Date:** March 15, 2004

# Revision of Common Working File (CWF) Editing for Same-Day, Same-Provider Acute Care Readmissions

## Provider Types Affected

Inpatient Hospitals

## Provider Action Needed

Effective January 1, 2004:

- When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms **related** to, or for evaluation and management of, the prior stay's medical condition, **hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.** Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.
- When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms **unrelated to**, and/or not for evaluation and management of, the prior stay's medical condition, **hospitals will place condition code (CC) B4 on the readmitting claim for the subsequent readmission.** Please be aware that upon request of the Quality Improvement Organization (QIO), hospitals will be required to submit medical records pertaining to the readmission.

## Background

The Office of the Inspector General (OIG), in a report titled "Review of Medicare Same-Day, Same-Provider Acute Care Readmissions in Pennsylvania During the Calendar Year 1998," recommended the establishment of an edit check in the Medicare claims processing system to identify for review all sameday, same-provider acute care readmissions where the beneficiary was coded as being discharged to another provider before being readmitted. Such an edit was established in the Medicare claims processing system used by your fiscal intermediary (FI) effective January 1, 2004. This is in line with Medicare's policy to make only one diagnosis-related group (DRG) payment for same-day, same-provider admissions.

However, it is possible for a patient to be readmitted on the same day to the same provider for symptoms unrelated to the original condition. As a result, Medicare will allow the use of a condition code (CC) of **B4** on the readmitting claim when a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms **unrelated** to, and/or not for evaluation and management of, the prior stay's medical condition. By December 31, 2005, FIs must receive claims with CC B4 and with discharges before January 1, 2005 to apply interest.

For non-PPS acute care hospitals, such as Maryland waiver hospitals, the readmission bill (if related to original admission) does not have to be combined with the original bill if the stay spans a month. However, the original bill would have to be adjusted to change the patient status code to 30 (still a patient). Subsequent monthly bills for this admission would be billed as interim bills 112, 113, or 114.

## Implementation

The implementation date for this instruction is January 3, 2005. Hospitals with claims that were rejected improperly because of the previous edits (i.e., claims where the readmission was for an unrelated condition) can resubmit those claims with condition code of B4.

## Additional Information

The official instruction issued to your Medicare contractor regarding this change may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

### Source:

*Related Change Request (CR) #: 3389*

*Medlearn Matters Number: MM3389*

*Related CR Release Date: July 30, 2004*

*Related CR Transmittal #: 266*

*Effective Date: January 1, 2004*

*Implementation Date: January 3, 2005*

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

### Provider Types Affected

Physicians, suppliers, and providers

### Provider Action Needed

Physicians, suppliers, and providers should note that this instruction expands the implementation of certain processing rules to all bill types for Automated Multi-Channel Chemistry (AMCC) Tests for End Stage Renal Disease (ESRD) beneficiaries.

### Background

The Office of Inspector General (OIG) conducted several studies that identified Medicare payments for End Stage Renal Disease (ESRD) laboratory related services which were not being paid in compliance with Medicare payment policy.

In response to the payment vulnerabilities identified by the OIG, the claims processing instructions contained in the Medicare Claims Processing Manual (Pub 100-04, Transmittal 79, Chapter 16, Section 40.6.1) directed all contractors to implement changes to ensure that all ESRD laboratory claims are paid in accordance with Medicare payment policy.

This instruction expands the implementation of procedures for reimbursement of Automated Multi-Channel Chemistry (AMCC) Tests to all bill types for ESRD beneficiaries.

### Implementation

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

### Related Instructions

Medicare will apply the rules identified in the Medicare Claims Processing Manual, Pub 100-04, Chapter 16 (Laboratory Services from Independent Labs, Physicians, and Providers), Section 40.6.1 (Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries - FIs) to all bill types for AMCC tests for ESRD beneficiaries.

This chapter can be found at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp)

An extract of Section 40.6.1 is included as follows:

#### 40.6.1 – Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries - FIs

This section will be updated Jul 04 – Visit [http://www.cms.hhs.gov/manuals/pm\\_trans/R79CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R79CP.pdf) to view updated section. (Rev. 1, 10-01-03) A-03-033

Medicare will apply the following rules to Automated Multi-Channel Chemistry (AMCC) tests for ESRD beneficiaries:

- Payment is at the lowest rate for services performed by the same provider, for the same beneficiary, for the same date of service.
- The facility must identify, for a particular date of service, the AMCC tests ordered that are included in the composite rate and those that are not included. See Chapter 8 for the composite rate tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), Hemofiltration, and Continuous Ambulatory Peritoneal Dialysis (CAPD).
- If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.
- If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that Date of Service (DOS) for that beneficiary are separately payable.
- A noncomposite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary. (See §100.6 for details regarding pricing modifiers.)

The FI shared system must calculate the number of AMCC tests provided for any given date of service. The FI sums all AMCC tests with a CD modifier and divides the sum of all tests with a CD, CE, and CF modifier for the same beneficiary and provider for any given date of service. If the result of the calculation for a date of service is 50 percent or greater, the FI does not pay for the tests. If the result of the calculation for a date of service is less than 50 percent, the FI pays for all of the tests. All tests for a date of service must be billed on the monthly ESRD bill.

Providers must send in an adjustment if they identify additional tests that have not been billed. The organ and disease oriented panels (80049, 80051, 80054, and 80058) are subject to the 50 percent rule. Laboratory tests that are not covered under the composite rate and that are furnished to CAPD end stage renal disease (ESRD) patients dialyzing at home are billed in the same way as any other test furnished to home patients.

### 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](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #: 3239*

*Medlearn Matters Number: MM3239*

*Related CR Release Date: May 28, 2004*

*Related CR Transmittal #: 190*

*Effective Date: October 1, 2004*

*Implementation Date: October 4, 2004*

## Long Term Care Hospital Prospective Payment System (LTCH PPS) Annual Update

### Provider Types Affected

Long Term Care Hospitals paid under Medicare's Long Term Care PPS

### Provider Action Needed

This article provides the annual LTCH PPS payment updates and also conveys some Medicare policy changes for the LTCH PPS based on the final rule published on May 7, 2004 for the LTCH PPS (69 FR 25674).

### Background

Long term care hospitals (LTCHs) are certified under Medicare as short-term, acute care hospitals that have been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under section 1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average length of stay of greater than 25 days.

The LTCH PPS replaces the reasonable cost-based payment system under which the LTCHs were paid. The BBRA and BIPA, which mandated the development of a PPS for LTCHs, conferred extremely broad authority on the Secretary in designing the LTCH PPS, specifying only that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.

Payment rates under the LTCH PPS are updated on a July 1 through June 30 cycle, a LTCH rate year (RY). The relative weights for the LTC-DRG patient classification system remain linked to the October 1 through September 30 schedule of the acute inpatient PPS, and are therefore published in the annual IPPS final rule by August 1.

CMS is required to update the payments made under this PPS annually, and for the LTCH PPS Rate Year (RY) 2005, the following applies:

- Standard Federal rate is \$36,833.69;
- Fixed loss amount is \$17,864.00;
- Budget neutrality offset is 0.5%;

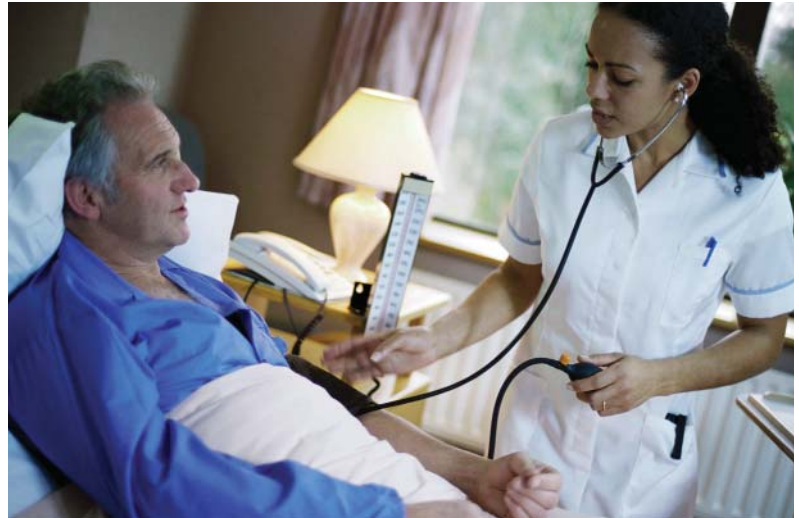
- Wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2004 is 3/5th (60 %);
- Labor-related share is 72.885 %;
- The non-labor related share is 27.115%; and
- The short-stay outlier percentage for “subsection II” LTCHs is 193% for this second transition year.

Other Medicare policy changes include the following:

### 1. Expanding the existing interrupted stay policy

Under the existing interrupted stay policy, implemented at the beginning of the LTCH PPS for cost reporting periods beginning on or after October 1, 2002, if an LTCH patient is discharged to an acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF) and then is readmitted to the LTCH within a fixed period of time, the entire LTCH hospitalization, both before and after the interruption, will be viewed as one episode of care and will generate one LTC-DRG payment.

There has been no such policy with regard to LTCH patients discharged and subsequently readmitted if during the interruption they were not inpatients at one of the above inpatient settings.



Effective July 1, 2004, CMS is expanding its interrupted stay policy to include a discharge and readmission to the LTCH within three days, regardless of where the patient goes upon discharge. This means that if a patient is readmitted to the LTCH within three days of discharge, Medicare will pay only one LTC-DRG.

This policy is intended to cover:

- Discharges and readmissions following an outpatient treatment;
- Three (3) -day or less inpatient stays; and
- Discharge and readmission with an intervening patient-stay at home.

Furthermore, Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the “interruption” would be the responsibility of the LTCH “under arrangements” with one exception RY 2005 (July 1, 2004 – June 30, 2005): if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the Inpatient PPS for that care. (Existing regulations specify that tests or procedures unavailable where a patient is hospitalized should be provided “under arrangement,” and paid for by the original hospital with no additional beneficiary liability.)

Therefore, any tests or procedures that were administered to the patient during that period of time, other than inpatient surgical care at an acute care hospital, will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability.

**NOTE:** CMS will be implementing this policy in a separate CR in January 2005; however, CMS will make these changes retroactive to July 1, 2004.

### 2. Satellite facilities and remote facilities of hospitals that spin off as separate hospitals and seek LTCH status

If a satellite or remote location of multi-campus LTCHs “spins-off” to become an independent LTCH, such a facility must comply with existing requirements for LTCH designation by first being certified as an independent hospital and then presenting discharge data to its fiscal intermediary indicating that once it became a separate and independent hospital, it met the Average Length of Stay (ALOS) requirement for Medicare patients for at least five of the next six months.

CMS is distinguishing “voluntary” separation from a parent LTCH from a separation mandated by the mileage requirement of the provider-based rules. In the latter case, CMS is establishing an exception in situations where the satellite facility or remote location of the hospital is required to become separately certified as a result of failing the mileage requirement of the provider-based regulations.

Under the exception, once these satellite facilities or remote locations become separate independent hospitals, they can immediately be paid as a LTCH if they submit to their fiscal intermediaries discharge data gathered during five months of the immediate six months preceding the facility’s separation from the main hospital. The data must document that they meet the ALOS requirement.

A satellite that is being “voluntarily” spun-off from a parent LTCH, however, will be paid under the IPPS for at least six months. During this time, it must gather data to demonstrate that as a hospital, it complies with the ALOS requirement.

### **3. Determining ALOS based on the number of days of care for only the patients that were discharged during the hospital’s fiscal year**

A LTCH’s ALOS will be calculated by using days and discharge data for only those patients discharged during the cost reporting period. Presently, the days in the hospital and the discharge dates are reported in the cost reporting period when they occurred, as under the TEFRA system.

An example of this change is as follows:

For a hospital on a calendar year cost report, the data for the patient that was admitted on 12/15 and discharged on 1/15 would have no impact on the first cost-reporting period, but would include 31 days and one discharge in calculating the ALOS for the second cost-reporting period.

This change for cases that crosses cost reporting periods would make the methodology for data collection for ALOS purposes consistent with the payment determinations, which under the LTCH PPS are discharged-based.

No LTCH will lose its designation should it fail to meet the ALOS requirement under the new regulations for the first year because of a one-year grandfathering provision that will allow an extra cost reporting period for compliance with the change.

Therefore, for cost reporting periods starting between July 1, 2004 and July 1, 2005, for a LTCH that fails to meet the ALOS requirement under new methodology, the fiscal intermediary has been instructed to calculate the ALOS under the previous methodology in order to determine compliance.

### **Related Instructions**

The Centers for Medicare & Medicaid Services has several fact sheets related to the LTCH PPS and those fact sheets have been revised to reflect this annual update. The fact sheets are available at:

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

The Medicare Claims Processing Manual, Pub 100-04, Chapter 3, Section 150 (Long Term Care Hospitals (LTCHs) PPS), is being updated and the following Sections are being revised. The updated manual instructions are included in the official instruction issued to your carrier which can be found by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### **Source:**

*Related Change Request (CR) #:* 3335

*Medlearn Matters Number:* MM3335

*Related CR Release Date:* June 18, 2004

*Related CR Transmittal #:* 208

*Effective Date:* July 1, 2004

*Implementation Date:* July 6, 2004

## Extension of Interrupted Stay Policy Under Long Term Care Hospital (LTCH) PPS

### Provider Types Affected

Long term care hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Swing Beds and acute care hospitals, both inpatient and outpatient bills

### Provider Action Needed

### Impact to You

Effective July 1, 2004, Medicare will pay only one long term care DRG if one of your patients is discharged from your LTCH and then readmitted within three days (regardless of the discharge venue).

Note: The only exception to this policy is a discharge to an acute care hospital for surgical DRGs.

### What You Need to Know

Effective July 1, 2004, in addition to the in-place LTCH prospective payment system (PPS) interrupted stay policy, there is a new three-day interrupted stay policy that pertains to your patients, regardless of their discharge venue (see note above). This new policy requires that if a patient is readmitted to the LTCH within three days of discharge, Medicare will pay only one LTC DRG.

### What You Need to Do

Make sure that your billing staffs are aware of this new LTCH three-day interrupted stay policy.

### Background

Medicare considers an “interrupted stay” to be part of the first LTCH admission (or, a single discharge from the LTCH). Further, Medicare will only make a **single** LTCH PPS payment for an interrupted patient stay.

For example, if the LTCH discharges the patient on July 1, 2004 and the patient is readmitted to the same LTCH on July 3, 2004, this is an interrupted stay and should be billed as one claim with an occurrence span code 74 from July 1, 2004 through July 2, 2004. The occurrence span code 74 cannot be used for days where other services were performed in another facility, however, because these should be performed under arrangements.

Please keep in mind that Medicare will reject as an interrupted stay LTCH bills where the patient returns to the same LTCH within 3 days of being discharged.

**Reminder:** The Occurrence Span Code 74 (located in field position 36 of the UB-92 or electronic equivalent) reflects the “span code from date” equal to the date of discharge from the LTCH and the “span code through” date equal to the last day the patient was **not** present at midnight.

The following is a short review of the general “interrupted stay” policy. An interruption of stay is defined as an LTCH stay during which a Medicare inpatient is discharged to an acute care hospital, an IRF, or an SNF/swing bed for treatment or services that are not available in the LTCH and returns to the same LTCH within applicable fixed-day periods.

- The day-counts of the applicable fixed-day period begin on the day of discharge from the LTCH (which is also the day of admission to the other site of care) and vary depending on the discharge venue. The applicable fixed-day period for discharge to an acute care hospital is 9 days, 27 days for discharge to an IRF, and 45 days for discharge to an SNF/swing bed.
- Remember that if the patient is readmitted to the LTCH within the fixed-day threshold, the return to the LTCH is considered part of the first admission, and Medicare will make only a single LTCH PPS payment.

**So, the original interrupted stay policy is as follows:**

- When a patient is discharged to an acute care hospital and is readmitted to the same LTCH within 4-9 days (occurrence span code 74 shows 8 days or less);
- When a patient is discharged to an IRF and is readmitted to the same LTCH within 4-27 days (occurrence span code 74 shows 26 days or less);

- When a patient is discharged to an SNF and is readmitted to the same LTCH within 4-45 days (occurrence span code 74 shows 44 days or less); and
- When a patient is discharged to a swing-bed and is readmitted to the same LTCH within 4-45 days (occurrence span code 74 shows 44 days or less).

Medicare will reject inpatient claims (non-surgical DRG acute care hospital, both IPPS and non-IPPS, IRE, SNE, and swing bed) for services during the three day interruption of the LTCH claim with dates of interruption on or after July 1, 2004.

### Implementation

- If a patient's stay qualifies as an interrupted stay, the LTCH should adjust the claim generated by the original LTCH stay and submit one claim for the entire stay (LTCH plus the other site of care) with an occurrence span code 74 demonstrating the interrupted stay days; but
- If the stay does not qualify as an interrupted stay (because the time at another facility before being readmitted to the LTCH exceeds the total fixed-day threshold), you can receive two separate payments.

To summarize again, effective July 1, 2004, in addition to the original policies regarding interrupted stays, there is a special three-day interrupted stay policy that applies regardless of the patient's discharge venue.

This policy requires that if a patient is readmitted to the LTCH within three days of the discharge, Medicare will pay only one LTC DRG. Medicare will not pay separately for claims submitted by other providers (acute hospital, SNF/swing bed, IRE, or any outpatient bill) for the patient's care during this three-day interruption.

This policy will cover readmissions following an outpatient treatment; an inpatient stay at another provider; and a discharge and readmission with an intervening patient-stay at home. Further, payment for any nonsurgical test or procedure procured during the interruption at an outpatient setting or for treatment in an inpatient setting is the LTCH's responsibility and should be considered a service provided "under arrangements."

"Under arrangements" means that the LTCH will bill and be paid for those services performed in another setting and no separate payment will be made to another facility during the three days. The LTCH is responsible for paying the other providers.

There is an exception for surgical DRGs in an acute care hospital. Medicare will issue a separate payment to the acute hospital if the patient stay is grouped to a surgical DRG. A list of surgical DRGs, effective through September 30, 2004, is attached to the instruction issued to your Medicare contractor. That instruction, which is CR3279 can be found at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R240CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R240CP.pdf)

Also, when the interruption exceeds three days, LTCH payment is determined under the original interrupted stay policy (now referred to as a "greater than three-day interruption of stay"), but the day count for purposes of determining the length of stay away from the LTCH begins on the day that the patient was discharged from the LTCH.

Providers should make every effort to bill their claims correctly now, so that their claims are not rejected or cancelled next January when the editing for this is in place.

### Additional Information

You can find more information about the extension of the LTCH interrupted stay policy by reviewing the official instruction issued to your intermediary, which can be found at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R240CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R240CP.pdf)

#### Source:

*Related Change Request (CR) #:* 3279

*Medlearn Matters Number:* MM3279

*Related CR Release Date:* July 23, 2004

*Related CR Transmittal #:* 240

*Effective Date:* July 1, 2004

*Implementation Date:* January 3, 2005

## Availability of Revised Fact Sheets on Long Term Care Hospital Prospective Payment System

Revised fact sheets on Long Term Care Hospital Prospective Payment System are now available on the Medicare Learning Network Web site at [www.cms.hhs.gov/medlearn/lrchpps.asp](http://www.cms.hhs.gov/medlearn/lrchpps.asp).

The fact sheets are:

- [Updated Final Rule Fact Sheet](#) (pdf format 483Kb) Revised: June 2004
- [Short-Stay Outliers Fact Sheet](#) (pdf format 466Kb) Revised: June 2004
- [Interrupted-Stay Fact Sheet](#) (pdf format 828Kb) Revised: June 2004
- [High Cost Outliers Fact Sheet](#) (pdf format 835Kb) Revised: June 2004

*Source: JSM 338 dated July 22, 2004*

## Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2005

This article is to inform you of the changes that will be required as part of the annual IRF PPS update for FY 2005.

### Background

On August 7, 2001, we published in the Federal Register, a final rule that established the PPS for IRFs, as authorized under §1886(j) of the Social Security Act (the Act). In that final rule, we set forth per discharge Federal rates for Federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002.

Annual updates to the IRF PPS rates are required by §1886(j)(3)(C) of the Act. Regulations at 42 CFR §412.624(e)(4) describe the criteria and procedures for determining whether an inpatient rehabilitation facility subject to the inpatient rehabilitation facility prospective payment system (IRF PPS) qualifies for an additional payment for extraordinarily costly cases, known as high-cost outliers.

A final rule, published on August 1, 2003 (68 FR 45674) revised the regulations at §412.624(e)(4) for facilities subject to the IRF PPS. This Change Request (CR) provides instructions for implementing those revisions to the outlier policy for the IRF PPS.

### Policy

On August 1, 2003, we published a final rule in the Federal Register (68 FR 45674) that sets forth the prospective payment rates applicable for IRFs for FY 2004. On July 30, 2004, we published a notice that sets forth the prospective payment rates applicable to IRFs for FY2005. A new IRF PRICER software package will be released prior to October 1, 2004 that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2004 through September 30, 2005.

The new revised Pricer program must be installed timely to ensure accurate payments for the IRF PPS claims with discharges on or after October 1, 2004 through September 30, 2005. Under the existing IRF PPS outlier methodology, the CCR from an IRF's latest settled cost report is used in determining whether a case qualifies for payment as an outlier and the amount of any such payment.

Based on the final rule published in the **Federal Register** on August 1, 2003, this CR provides instructions for applying CCRs for IRFs, including: the use of an alternative CCR when directed by CMS or at the request of the facility and the use of a CCR based on the tentative settlement of the cost report for discharges on or after October 1, 2003; use of the national averages; the criteria for identifying hospitals to be subject to reconciliation; and notification to hospitals about those updates.

*Effective Date:* October 1, 2004

*Implementation Date:* October 4, 2004

# Medicare Inpatient Rehabilitation Facility Classification Requirements

## Provider Types Affected

Rehabilitation Hospitals and Rehabilitation Units: both are referred to as Inpatient Rehabilitation Facilities (IRFs).

## Provider Action Needed

Hospitals and rehabilitation units must meet the criteria specified in regulations 42 CFR 412.23 (b), 412.25, and 412.29 to be eligible for payment under the IRF prospective payment systems. A rehabilitation hospital and rehabilitation unit are both now referred to as an IRF.

The Centers for Medicare & Medicaid Services (CMS) recently issued guidance to Medicare fiscal intermediaries (FIs) regarding the criteria that a facility must meet to be classified as an IRF. This article summarizes some of that guidance.

## Background

Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Social Security Act provide authority for defining which inpatient facilities may be classified as inpatient rehabilitation hospitals and as acute care hospital rehabilitation units. An inpatient rehabilitation hospital and an acute care hospital rehabilitation unit are collectively referred to as an inpatient rehabilitation facility (IRF) under the IRF prospective payment system (PPS).

On January 3, 1984, CMS published a final rule, “Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services” (49 FR 234), which specified that for classification as an IRF, 75 percent of the IRF’s total patient population during the IRF’s cost reporting period must match one or more of the ten medical conditions listed in 42 CFR 405.471. This final rule provision became known as the “75-percent rule.” The IRF’s FI was responsible for verifying whether the IRF’s total patient population met the 75 percent rule.

On March 29, 1985, CMS published a final rule, “Medicare Program; Prospective Payment System for Hospital Inpatient Services: Redesignation of Rules” (50 FR 12740). That rule redesignated the provisions of 42 CFR 405.471 that addressed the 75-percent rule as a provision under 42 CFR 412.23(b) (2). The regulations at 42 CFR 412.25, 412.29, and 412.30 refer to 42 CFR 412.23(b) (2) as one of the criteria a provider must meet to be classified as an IRF. Hospitals and units that met the criterion specified in 42 CFR 412.23(b) (2), as well as other criteria, were eligible to be paid under the IRF PPS.

An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS. The results of the verification procedure are used in determining each facility’s classification status for the next cost reporting period.

IRFs that have already been excluded from the acute care hospital PPS need not reapply to be classified as an IRF. However, on an annual basis, an IRF must self-attest (except for the medical condition criterion specified above and certain other criteria) that it still meets all the criteria for being classified as an IRF. Your FI is always required to verify that your IRF has met the medical condition criterion.

## Changes to the Classification Criteria

On May 7, 2004, CMS published a final rule titled “Medicare Program; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility.” In this final rule CMS changed the:

- Percentage of the IRF’s total patient population that must match one or more of the medical conditions; and
- Medical conditions previously specified in the regulations.

**Percentages**-This final rule specified that during a most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) the IRF treated an inpatient population that met or exceeded the following percentages:

Cost reporting period Minimum percentages of an IRF’s total patient population that must have matched one or more of the medical conditions specified in the “List of Medical Conditions” table below.

Cost Reporting Period	Minimum percentages of an IRF’s total patient population that must have matched one or more of the medical conditions specified in the “List of Medical Conditions” table below
1. Beginning on or after July 1, 2004 and before July 1, 2005	50 percent
2. Beginning on or after July 1, 2005 and before July 1, 2006	60 percent
3. Beginning on or after July 1, 2006 and before July 1, 2007	65 percent
4. Beginning on or after July 1, 2007	75 percent

**List of Medical Conditions**

Medical Condition	Additional comments and requirements pertaining to the condition
1. Stroke	
2. Spinal cord injury	
3. Congenital deformity	
4. Amputation	
5. Major multiple trauma	
6. Femur fracture (hipfracture)	
7. Brain injury	
8. Neurological disorders	Including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson’s disease
9. Burns	
10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies.	<p>The noted conditions must result in significant functional impairment of a mbulation and other activities of daily living that:</p> <ul style="list-style-type: none"> <li>– Have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; or</li> <li>– Result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.</li> </ul> <p>The related CR3334 provides guidance regarding therapy. However, the medical review staff of the FI has the discretion to define:</p> <ul style="list-style-type: none"> <li>– What is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; and</li> <li>– When a systemic disease activation immediately before admission has occurred.</li> </ul>
11. Systemic vasculidities with joint inflammation	<p>The noted condition must result in significant functional impairment of ambulation and other activities of daily living that:</p> <ul style="list-style-type: none"> <li>– Have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; or</li> <li>– Result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. The related CR3334 provides guidance regarding therapy. However, the medical review staff of the FI has the discretion to define:</li> </ul> <ul style="list-style-type: none"> <li>– What is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; and</li> <li>– When a systemic disease activation immediately before admission has occurred.</li> </ul>

Medical Condition	Additional comments and requirements pertaining to the condition
<p>12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint</p>	<p>The noted condition must result in significant functional impairment of ambulation and other activities of daily living that:</p> <ul style="list-style-type: none"> <li>– Have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; or</li> <li>– Result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. The related CR3334 provides guidance on therapy. However, the medical review staff of the FI has the discretion to define:                             <ul style="list-style-type: none"> <li>– What is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; and</li> <li>– When a systemic disease activation immediately before admission has occurred. Please note, a joint replaced by prosthesis is no longer considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.</li> </ul> </li> </ul>
<p>13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay</p>	<p>This condition must also meet one or more of the following specific criteria; the patient:</p> <ul style="list-style-type: none"> <li>– Underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission;</li> <li>– Is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF;</li> <li>– Is age 85 or older at the time of admission to the IRF</li> </ul>

**Written Certification**

A hospital that seeks classification as an IRF for a cost reporting period that occurs after it becomes a Medicare-participating hospital must provide a written certification that the inpatient population it intends to serve meets the medical condition requirement specified above, instead of showing that it has treated an inpatient population that met the medical condition requirement during its most recent cost reporting period.

The written certification is also effective for a cost reporting period of not less than one month and not more than 11 months occurring between the dates the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

If a hospital, hospital unit, or group of beds is paid under the IRF PPS for a cost reporting period based on a written certification that it will meet the medical condition requirement specified above but does not actually meet the requirement for that cost reporting period, CMS adjusts its payments to the hospital retroactively.

The FI effects this payment adjustment to the hospital by calculating the difference between:

- The amount actually paid for services to Medicare patients in the hospital, hospital unit, or beds during the period of provisional exclusion; and
- The amount that would have been paid if the hospital, unit, or beds had not been excluded from the acute care hospital PPS. The FI then takes action to recover the resulting overpayment or corrects the underpayment to the hospital.

**Additional Information**

The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3334, at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

**Source:**

- Related Change Request (CR) #:* 3334
- Medlearn Matters Number:* MM3334
- Related CR Release Date:* June 25, 2005
- Related CR Transmittal #:* 221
- Effective Date:* July 1, 2004
- Implementation Date:* July 1, 2004

## Medical Review Processes

Medical Review is one of the Medicare Program Integrity Units. The primary goal of Program Integrity is to safeguard the Medicare Trust Fund by ensuring that claims billed to Medicare are paid correctly. Medical Review efforts are directed to those areas where there is the greatest risk of inappropriate program payment. It is the goal of Medical Review to ensure that the right amount is paid for covered services which are medically necessary and rendered to eligible beneficiaries by legitimate providers. This goal is accomplished through review of claims utilizing national coverage guidelines, medical knowledge and judgment and the development and implementation of Local Coverage Determinations.

### LCD Development Process

Local Coverage Determination (LCD) is an administrative and educational tool to assist providers, physicians, and suppliers in submitting correct claims for payment. The process for developing the LCD includes developing draft LCDS based on review of medical literature and the contractor's understanding of local practice. In addition, contractors solicit comments from the medical community. Medicare contractors permit interested parties to submit scientific, evidence-based information, professional consensus opinions, or any other relevant information during the draft process.

After a draft LCD has been commented on and revised, it is published in its final form. Subsequently, the LCD Reconsideration process allows an opportunity to request modifications to the policy. The contractor may consider requests from any interested party receiving care or residing in a contractor's jurisdiction.

Requests must be submitted in writing, and must identify the language that the requestor wants added to or deleted from an LCD. Requests must include a justification supported by new evidence, which may materially affect the LCD's content or basis. Copies of published evidence must be included. Any request for LCD reconsideration that, in the judgment of the contractor, does not meet these criteria is invalid.

Within 30 days of the day the request is received, the contractor must determine whether the request is valid or invalid. If the request is invalid, the contractor must respond, in writing, to the requestor explaining why the request was invalid. Within 90 days of the day a valid request was received, the contractor must make a final LCD reconsideration decision and notify the requestor of the decision and its rationale. Decision options include retiring the policy, no revision, revision to a more restrictive policy, or revision to a less restrictive policy.

Requests may be mailed or faxed to:

Patricia Neal, RN Utilization Review Specialist  
CareFirst of MD, INC., Medicare Part A Intermediary  
1946 Greenspring Drive, TBP-11  
Timonium, MD 21093-4141  
FAX: 410-561-7951

### Prepayment Review

Prepayment review is divided into three distinct types of review. These three types are defined as:

#### ■ Automated Review

This review does not involve any human intervention whatsoever. It occurs when a claim/line passes through the claims processing system and is denied in whole or in part because the service(s) is noncovered or incorrectly coded. Automated review parameters are designed utilizing the Local Coverage Determinations.

#### ■ Routine Manual Review

Routine review requires hands on review of the claim and/or any attachment or codes submitted by the provider, excluding the review of complete medical records, for the purpose of preventing payments of noncovered or incorrectly coded services. This review includes any existing documentation such as the claims history file or policy documentation.

#### ■ Complex Medical Review

Complex review goes beyond the routine manual review process and includes review by a nurse of the medical records that are requested by the Intermediary. This review of medical documentation is for the purpose of preventing payment for noncovered or incorrectly coded service.

### Additional Development Requests (ADRs)

During the prepayment review process, a claim will often hit an edit placed in the processing system by Medical Review. This edit will result in the automatic generation of an ADR letter and the claim will suspend in the system pending receipt and complex review of the medical records. Providers have 30 days from the date of the letter to submit the requested medical information. The ADR letter specifically lists the medical information that must be returned for reviewing the pending claim. A copy of the ADR letter must be attached to the front of the medical record sent in by the provider. Failure to submit all of the medical information as requested may result in a partial or full denial of charges. If the medical records are not received within 45 days, the claim will be automatically denied by the system. The failure to submit requested medical records within 45 days will be designated by reason code 56900. Once the claim receives a 56900 denial, the provider's only recourse is to request an appeal of the denial.

Note: Thirty days are allocated for provider processes in submitting the requested record. The remaining fifteen days are allowed for the FI's processing requirements (i.e. mail days required for receipt of the ADR letter, routing the medical records to the correct unit from the mail room, etc.). Providers should make every effort to submit the records within 30 days.

### Important Do's and Don'ts

Do attach the ADR letter to the front of the medical record;

- Do include ALL the medical information as requested on the ADR letter;
- Do submit the medical records per request within 30 days of receipt of ADR letter;
- Do not attempt to expedite claims processing by sending in the medical record prior to receiving the ADR letter based on information in the claims processing system.

### Post Pay Probe Reviews

CareFirst of MD, Inc. Medicare Part A Medical Review conducts medical record reviews on a postpayment basis. A specific group of medical records will be requested; the review of these records is classified as a 'Probe Review'. The probe review process is a data driven process. Paid claims billing data is analyzed and providers are selected for review based on identified aberrancies in comparison with other providers billing the same service(s). A random sample of 20-40 claims is selected from the provider's paid claims data for a specified billing period. In the event of a general probe that is service specific rather than provider specific, a sample of 100 claims will be selected.

Once a provider has been selected for a post pay probe review, a letter is mailed to the provider notifying them that they have been selected for a post-payment probe review. The Special Post-Payment Probe Review Letter indicates the reason for review and includes a list of the claims that have been selected for review. The letter informs the provider that the medical records for the selected claims must be returned to the Fiscal Intermediary within 30 days from the date of the letter. Those claims for which no medical records are received will be reopened for denial due to lack of receipt of medical records.

Once the medical records are received for a specific probe review, the review is assigned to a Probe Nurse. Per CMS standards, Medical Review must complete the reviews within 60 days of record receipt. The probe nurse reviews the claims based on coverage criteria available for the specific service. These sources for criteria may include Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), Medicare Bulletins, Program Memorandums, one-time notifications, as well as specific policies and desk procedures for the type of review.

Once the probe nurse completes the probe review, an error rate is calculated. This error rate is calculated by dividing the total amount of billed charges (associated with the service under review) denied by the total amount of billed charges (associated with the service under review).

Once the denial statistics are obtained, the Probe Nurse develops a "Probe Summary Letter" which is mailed to the attention of the Provider Contact.

This letter outlines the findings of the review by types of denials, an error rate percent, and recommendations for correcting identified errors. Included with the letter is an attachment with a breakdown for each claim that sustained an error.

**Note:** The FI has requested that each facility provide a contact phone number for a designated Provider Point of Contact. The Provider Point of Contact must be someone who has the ability to identify appropriate key personnel (based upon the service under review) for the education and internal planning to resolve the identified issues. In general, the FI has found that the facility Compliance Officer is well suited for this process.

For those providers whose error rate on initial probe review is 10% or less, the Probe Summary Letter commends the provider for the low error rate and informs them that the review of the particular service has been discontinued. Those providers with a greater than 10% error rate on the initial probe review are subjected to a re-probe review after one on one provider education has taken place. This education is usually done by way of a telephone conference call. For those providers with greater than 24% error rate, the usual action is for the provider to be placed on a percentage of prepay review.

### Advance Beneficiary Notice (ABN)

The beneficiary should be notified that a service is non-covered prior to the service being rendered. This notification must be signed and dated by the beneficiary at the time it is received. The ABN should be very specific as to the non-covered services and the effective date of non-coverage.

It is the responsibility of the provider to maintain current knowledge of Medicare coverage guidelines, Local Coverage Determinations (LCDs), and billing guidelines. Once the determination has been made that a service is non-covered and the beneficiary has signed the ABN, the charges may be billed to the beneficiary.

Routinely requesting the beneficiary to sign a letter of non-coverage just in case Medicare does not reimburse for the service is unacceptable. Once a pattern of administering routine ABNs or non specific ABNs is identified, Medicare does not acknowledge the waiver of liability and the provider is held responsible for any denied charges.

### Physician Orders

Medicare requires a legible order for services provided/ordered. Effective 1/1/2004, the method used (e.g. hand written, electronic, or signature stamp) to sign an order or other medical record documentation for medical review purposes in determining coverage is not a relevant factor. However, an indication of a signature in some form needs to be present. A claim will not be denied on the sole basis of type of signature submitted. A MD signature, of some type, is required for orders, therapy plans of treatment, and Certification of Medical Necessity. Additionally, it is requested that the physician orders/prescriptions not only be signed but dated.

**Should you have any questions, contact your provider representative at 1-866-488-0545 or Janice Austin, Utilization Review Specialist at 410 561-4158 or Janice.austin@carefirst.com.**

## Medical Review: Frequently Asked Questions FY 2004, 4th Quarter

1. **Question:** What should the provider place in the blank space on the Advance Beneficiary Notice (ABN) for a possible denial by Medicare?  
**Answer:** The clinical reason the provider thinks the service will be denied (i.e., “Medicare does not pay for services which it considers to be experimental or for research use”). Do NOT put “because Medicare will possibly not pay”. This is not the correct answer.
2. **Question:** How long does it take for Medicare to adjudicate a claim once it is placed in the medical review (MR) location?  
**Answer:** Medical review must review the claim within 60 days after MR receives the documentation and places in their system location. After the claim is adjudicated by MR, the adjudication process will continue through the FISS system for approximately one additional week.
3. **Question:** When a claim is being appealed, does the provider need to submit the documentation again?  
**Answer:** Yes, the MR area will look at all documentation the provider has submitted to compare and update the information. Medical records are the only way to verify services billed were completed properly.

4. **Question:** Why do a lot of my claims get hung up in the FISS system?

**Answer:** There are various reasons why and the following are a few examples:

- Billing incorrectly
- Leaving off the occurrence code when you bill a condition code 20
- Billing drugs with the incorrect type of revenue code
- Using unlisted codes when there are new CPT/HCPCS codes available
- Adding the bill incorrectly
- Billing old CPT/HCPCS codes that have been deleted and no longer recognized by the system
- Using the wrong HIC #
- Using overlapping claim dates

5. **Question:** Why do some claims automatically receive ADRs and others do not?

**Answer:** MR is updating and changing their system edits continuously. These changes may vary with the updates of the HCPCS/CPT codes, changes in CMS instructions, new or altered National Coverage Determinations (NCDs), or new Local Coverage Determinations (LCDs).

6. **Question:** As a provider we are having a problem with denial of claims and the reason is usually because the documentation was incorrect. Is there anyway that a provider could set up a meeting with the Medical Review team?

**Answer:** Yes and we suggest that you do ask for assistance. If you think the problem is a medical review issue please contact Janice Austin, RN at (410) 561-4158.

7. **Question:** What type of documentation is required for J3490 when information is requested?

**Answer:** The following documentation is required: Full name/description of the drug, dosage, route of administration, time, date, physician order, and professional signature. The itemized statement must identify the exact amount billed.

8. **Question:** When a claim is appealed because the ICD-9 CM diagnosis was originally denied – do we need to send in supporting documentation to verify the new ICD-9-CM diagnosis?

**Answer:** Yes. Because the original diagnosis did not support the medical necessity of the service, supporting documentation verifying the new ICD-9 CM code /condition must be submitted. (i.e., H&P or signs and symptoms)

9. **Question:** Therapy progress notes – What do they need to state?

**Answer:** These notes should include the service provided, indication of progress or decline, measurable data (exp. pain scale, ROM, muscle strength, gait deviation, specific gait training, etc.), time spent per modality, and professional signatures all in legible handwriting.

10. **Question:** When can follow-up diabetes self-management training be provided?

**Answer:** Providers cannot bill follow-up diabetes self-management training until the year after the completion of the initial 10 hour training. (The 10 hours of training can be done in a combination of 1/2-hour increments; spread over the 12-month period or less.)

11. **Question:** When ancillary services are furnished in both the emergency room and the observation room setting, is it appropriate to bill for both settings? For example, IV injections administered in the Emergency Room, followed by IV injections administered in the observation room setting?

**Answer:** Yes. Most ancillary services, such as injections, if rendered in both settings would be billable. The provider should bill the appropriate HCPCS code in the revenue center where the service took place. For example, revenue code 450 with HCPCS 90784 with the number of units indicating the number of IV injections given in that setting. Subsequently, if IV injections are rendered in the observation room setting, bill revenue center 760 with HCPCS 90784 with the number of units reflecting the number of IV injections administered.

12. **Question:** Can an anesthesiologist meet the Medicare requirement for direct physician supervision for Phase II cardiac rehabilitation services?

**Answer:** Yes. The coverage criteria for cardiac rehabilitation services located in the Coverage Issues Manual 35-25 (or CMS Online Manual under Publication 100-3, Chapter 1, Section 20-10) states that “services of non-physician personnel must be under the direct supervision of a physician”. The guidelines do not specify a particular physician specialty such as a cardiologist; however the designated physician must be ACLS certified. It is imperative that providers ensure that the physician designated to cover the rehabilitation unit during the Phase II cardiac rehabilita-

tion sessions is aware that she/he is the supervising physician. Direct supervision means that a physician must be in the exercise program area and immediately available and accessible for an emergency at all times the exercise program is conducted.

13. **Question:** Does Medicare pay for therapy treatment performed by technical staff members?

**Answer:** Medicare does not pay for therapy treatment performed by technical staff members. Medicare covers skilled therapy services only when performed by a: qualified physical therapist, qualified physical therapy assistant under the supervision of a qualified physical therapist, qualified speech-language pathologist, qualified occupational therapist, or qualified occupational therapy assistant under the supervision of a qualified occupational therapist. The regulations can be found in the Code of Federal Regulations, 42 CFR 409.44 and 42 CFR 484.

**Skilled Nursing Facility (SNF)**

14. **Question:** Would you explain what information is required when I send in an ADR?

**Answer:** The following medical record documentation should be submitted when responding to an additional development request (ADR).

- Hospital discharge summary or hospital or SNF transfer sheet;
- History and physical;
- Physician signed orders and physician progress notes;
- Signed and dated certification or recertification for skilled care;
- All nurses notes, therapy plan(s) of treatment, therapy evaluations, therapy minutes, therapy notes and progress notes from 30 days prior to the assessment reference date or since admission for each RUG III code billed and through the dates of service;
- Medication, treatment, and wound care records, dietician notes;
- Signed Medicare MDS for each of the RUG III codes billed;
- If this is an adjusted claim and the HIPPS was changed due to an error on a prior claim, submit documentation for the reason for the correction;
- It is important to note that each RUG III code billed must be supported by the information within the medical record. Therefore, you will need to submit medical record documentation to support the MDS “look back” period for each RUG III code billed. For example, the dates of service on a claim are May 1 through May 9, admission date was April 26, and the 5 day MDS has the assessment reference date of April 30. The RUG III code billed is RHA01 for 9 days. The information to support this code would include the information from the admission date of April 30 through the dates of service on the claim, which is May 1 through May 9.

## Local Policy Updates

The following new Local Coverage Determinations (LCDs) were added to the Maryland Medicare website on August 16, 2004 and became effective September 30, 2004:

- Wound Care
- Skin Substitutes

The following LCDs have been revised or updated:

- Bacterial Culture
- Bladder Tumor Antigen
- Botulinum Type A
- Breath Test for *Helicobacter Pylori*
- Cataract Extraction

One policy has been removed from the active policy index and archived as review of data no longer supported the need for this policy:

- Laser Prostatectomy

Active and draft policies may be viewed on the Maryland Medicare website: <http://www.marylandmedicare.com/>

## Local Coverage Determination Updates

The following new policies were added to the Maryland Medicare website:

- Irinotecan (Camptosar)
- Trastuzumab (Herceptin)
- Wound Care
- Skin Substitutes

The following policies have been revised or updated:

- Bacterial Culture
- Bladder Tumor Assays
- Botulinum Type A
- Breath Test for *Helicobacter Pylori*
- Cataract Extraction
- Cryosurgery in Treatment of Liver Tumors
- Intravenous Immune Globulin
- Infliximab (Remicade)
- Modified Barium Swallow

Articles have been added for the following Local Coverage Determinations:

- Cryosurgery in Treatment of Liver Tumors
- Irinotecan
- Modified Barium Swallow

The following policies have been removed from the active policy index and archived:

- Diabetes Outpatient Self-Management Training,” a National Coverage Determination
- Respiratory Therapy in Skilled Nursing Facilities
- Laser Prostatectomy

Active and draft policies may be viewed on the Maryland Medicare website: <http://www.marylandmedicare.com/>



## MMA- Section 937 - Correction of Minor Errors and Omissions Without Appeals

### Provider Types Affected

All Medicare physicians, providers, and suppliers

### Provider Action Needed

Understand the Medicare rules that enable you to correct minor errors and omissions on Medicare claims without having to go through the appeals process. This article will provide information needed to make such minor corrections to Medicare claims within existing procedures.

### Background

Section 937 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-73, requires the Secretary of the Department of Health and Human Services to establish a process for physicians, providers, and suppliers to correct minor errors and omissions in claims without pursuing the formal appeals process.

The Centers for Medicare & Medicaid Services (CMS) currently provides the following ways to make such corrections:

## 1. Correcting Incomplete or Invalid Claims Submissions

Medicare instructions currently provide an opportunity for physicians, suppliers, and providers to correct errors or omissions in a submitted claim without the need to initiate a formal appeal, such as a review or reconsideration. These processes are outlined in the Medicare Claims Processing Manual, Pub. 100-4, Chapter 1 - General Billing Requirements, section 80.3.2 - Handling Incomplete or Invalid Claims and Section 70.2.3.1 - Incomplete or Invalid Submissions. The instructions provide the rationale for determining whether a claim (Forms CMS-1450, CMS-1500 or their electronic equivalent) is considered complete for processing purposes and outlines the actions to be taken by contractors upon receipt of incomplete or invalid claim submissions. Basically, the instructions identify incomplete claims as ones submitted with required information missing, such as the provider's name.

Invalid submissions also are claims that contain complete and required information, but the information is illogical or incorrect (e.g., incorrect HIC# or invalid procedure code) or the information does not conform to required claim formats.

The following definitions may be applied to determine whether data on submitted claims are incomplete or invalid:

- Required – Any data element that is needed in order to process the submission, such as provider name.
- Not Required – Any data element that is optional or is not needed to process the submission, such as the patient's marital status.
- Conditional – Any data element that must be completed if other conditions exist (e.g., if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim). If these conditions exist, the data element becomes required. Based on these instructions, if a claim is submitted with missing or incorrect information for certain specified items, it is considered to be unprocessable and is to be "returned" to the provider. Returning a claim as unprocessable does not mean that every claim is physically returned to the provider.

The terms "return as unprocessable" or "return to provider" refer to the many processes utilized for notifying the provider or supplier of service that their claim cannot be processed, and that it must be corrected or resubmitted. Different contractors use various techniques for returning claims as unprocessable.

Following are just two examples:

- If incomplete or invalid information is detected at the front-end of claims processing, the claim may be returned to the provider identifying the error(s) and explaining how to correct the errors prior to resubmission.
- If incomplete or invalid information is detected at the front-end of the claims processing system, the claim may be suspended and developed; requested corrections and/or medical documentation must be submitted within a 45-day period. After the requested information is received, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the remittance advice.

Under these instructions, carriers and fiscal intermediaries (FIs) typically either suspend claims with defective data for development and correction by the provider or send the claim back to the provider, noting the missing or incorrect items, for correction and resubmission. Claims submissions that are returned to the provider are not considered claims under Medicare regulations.

Therefore, neither of these processes allows for the initiation of an appeal. For more details on these sections, you may view Chapter 1, Sections 70.2.3.1 and 80.3.2, of the Medicare Claims Processing Manual, Pub. 100-04, at:

[http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp)

Once at that site, scroll down to Chapter 1 and click on the file type you wish to download.

## 2. Correcting Mistakes in Previously-Processed Claims

Another process a provider can use is the Adjustment Request Process. Adjustment requests are the most common mechanism for FIs to change a previously accepted bill. The Adjustment Payment Process is outlined in the Medicare Claims Processing Manual, Pub. 100-4, Chapter 3 - Inpatient Hospital Billing, section 50, Adjustment Bills.

Adjustments are required when bills have been accepted and posted in error to a particular record.

You may also view this section of the manual to obtain further details on adjustments by going to: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp)

Once at that page, scroll down to Chapter 3 and click on the type of file you wish to download.

### 3. Reopening Claims

A third process that providers can use is the Reopening Process. Section 1869(b) (1) (G) of the Act provides for the reopening and revision of any initial determination according to guidelines prescribed by the Secretary.

The Medicare Claims Processing Manual, Pub. 100-4, Chapter 29 - Appeals of Claims Decisions, section 60.27 - Reopening and Revision of Claims Determinations and Decisions, distinguishes the reopening process from the appeals process. The purpose for a reopening should be to change the determinations or decisions that result in either overpayments or underpayments. Reopenings have been misconstrued as a level of the appeals process. A reopening is not an appeal right; it is a discretionary action as defined under 42 CFR 405.841.

Requests for adjustments to claims resulting from clerical errors must be handled through the reopening process. The request must be made within one year from the date of the notice of the initial determination. A provider has a four-year timeframe to initiate a reopening after the date of the initial determination if good cause exists.

### 4. Correcting HIPAA Compliance Issues

The fourth process relates to CMS's existing process for evaluating a claim's HIPAA compliance. This process can be found in the Medicare Claims Processing Manual, Pub. 100-4, Chapter 24 - EDI Support Requirements, sections 30.6 - Translators; 70.1 - FI Requirements; and 70.2 - Carrier/DMERC Requirements. Currently, Medicare contractor translators validate the syntax compliance of the X12N 837 standard. The entire file will be rejected when the file is syntactically incorrect.

The contractor will send to the provider the X12N 997 Functional Acknowledgment to report the syntax errors. If the file is syntactically correct, HIPAA implementation guide-compliance validation of the X12N 837 is performed. Compliance validation edits check for required loops and segments, appropriate segments within a loop, valid calendar dates, qualifiers, and so on. Individual claims are rejected to the provider when they contain errors.

The errors are then reported on contractor specific error reports. To view the manual sections on reopening information or for the HIPAA information, use the same Web address as provided above and scroll to Chapters 29 and 24, respectively. Once at each chapter, select the version of the file you wish to review.

#### Source:

*Related Change Request (CR) #:* N/A

*Medlearn Matters Number:* SE0420

*Effective Date:* N/A - Informational Only

## Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2004

### Provider Types Affected

Clinical Diagnostic Laboratories

### Provider Action Needed

### Impact to You

Laboratories must be aware of changes being made to the ICD-9-CM codes as part of the NCD Edit Software Update in October, 2004.

### What You Need to Know

These changes are necessary so that the lab edit module will appropriately process claims using the most current ICD-9-CM codes effective October 1, 2004.

They also implement changes to the list of covered codes developed through the coding analysis public process.

### What You Need to Do

Adopt the new codes in your billing process effective October 2004 and begin using them for services on or after that time to assure prompt and accurate payment of your claim.

### Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Nationally uniform software has been developed by Computer Sciences Corporation and incorporated in the Medicare's claims processing systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003.

The laboratory edit module for the NCDs is being updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. (See Pub. 100-4, Chapter 16, §120.2.)

### Implementation

This article describes upcoming changes to the list of codes associated with the 23 negotiated laboratory NCDs. Most of the changes are a result of new ICD-9-CM codes that become effective on October 1, 2004. A few changes are the result of coding analysis that were conducted through the public process announced in the December 24, 2003 Federal Register.

In accordance with the coding analysis the following laboratory services will have coding changes:

1. Deleting the following diagnosis codes from the list of "ICD-9-CM Codes Covered by Medicare" for the urine culture NCD:

- 584.5 *Acute renal failure with lesion of tubular necrosis;*
- 584.9 *Acute renal failure, unspecified; and*
- 586 *Unspecified renal failure.*

Coverage for these codes will terminate for services furnished on or after October 1, 2004.

2. Adding diagnosis code 729.81 *Swelling of limb*, to the list of "ICD-9-CM Codes Covered by Medicare" for the prothrombin time (PT) and partial thromboplastin time (PTT) NCDs. Coverage for this code will begin for services furnished on or after October 1, 2004.

3. Adding diagnosis code 600.01, *Benign prostate hypertrophy with urinary obstruction*, to the list of "ICD-9-CM Codes Covered by Medicare" for the prostate specific antigen (PSA) test NCD. Coverage for this code will begin for services furnished on or after October 1, 2004.

In order to accommodate the new ICD-9-CM coding changes that become effective on October 1, 2004, the Centers for Medicare & Medicaid Services (CMS) is making the following changes to the edit module.

These changes become effective for services furnished on or after October 1, 2004.

- CMS is adding new ICD-9-CM code 788.38 to the list of ICD-9-CM codes covered by Medicare for urine culture NCD.
- CMS is adding new ICD-9-CM codes 070.70, 070.71, 588.81, 588.89, V01.71, and V01.79 to the list of ICD-9-CM codes covered by Medicare for HIV testing (diagnosis). We are terminating coverage of ICD-9-CM codes V01.7 and 588.8 with services furnished on or after October 1, 2004.
- CMS is adding the following new ICD-9-CM codes to the list of ICD-9-CM codes that do not support medical necessity for the blood counts NCD: 521.06, 521.07, 521.08, 521.10-521.15, 521.20-521.25, 521.30-521.35, 521.40-521.42, 521.49, 524.07, 524.20-524.37, 524.39, 524.50-524.57, 524.59, 524.64, 524.75, 524.76, 524.81, 524.82, 524.89, 525.20-525.26, 618.00-618.05, 618.09, 618.81-618.83, 618.89, 692.84, V72.40, and V72.41.

We are removing the following ICD-9-CM codes that are no longer valid from that list: 521.1, 521.2, 521.3, 521.4, 524.2, 524.3, 524.5, 524.8, 525.2, 618.0, 618.8, and V72.4.

- CMS is adding the following new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time NCD: 070.70, 070.71, 453.40-453.42.

- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the prothrombin time NCD: 070.70, 070.71, 453.40-453.42, 530.86, and 530.87.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the serum iron studies NCD: 070.70 and 070.71.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the collagen crosslinks NCD: 252.00-252.02, and 252.08. We are removing ICD-9-CM code 252.0, which is no longer a valid code, from that list.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the blood glucose testing NCD: 491.22, 707.00-707.07, 707.09, and V58.67. We are removing ICD-9-CM code 707.0, which is no longer a valid code, from that list.
- CMS is adding new ICD-9-CM code V58.67 to the list of covered diagnoses for glycosylated hemoglobin.
- CMS is adding new ICD-9-CM codes to the list of covered diagnoses for the lipid testing NCD: 588.81, and 588.89. We are removing ICD-9-CM code 588.8, which is no longer a valid code, from that list.
- CMS is adding new ICD-9-CM codes to the list of covered diagnoses for the digoxin therapeutic drug assay NCD: 588.81, and 588.89. We are removing ICD-9-CM code 588.8, which is no longer a valid code, from that list.
- CMS is adding new ICD-9-CM code 273.4 to the list of covered diagnoses for alpha-fetoprotein.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the gamma glutamyl transferase NCD: 070.70, 070.71, 252.00-252.02, 252.08, 273.4, 453.40-453.42, 588.81, and 588.89. We are removing ICD-9-CM code 252.0 and 588.8, which are no longer valid codes, from that list.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the hepatitis panel NCD: 070.70 and 070.71.
- CMS is adding new ICD-9-CM code V58.66 to the list of covered diagnoses for the fecal occult blood test.

### Related Instructions

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

### Additional Information

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date-of-service compliant. Since ICD-9-CM is a medical code set, effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims.

The updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems in Table 6 and effective each October 1.

Carriers and DMERCs must eliminate the ICD-9-CM diagnosis code grace period from their system effective with the October 1, 2004 update. Carriers and DMERCs will no longer accept discontinued diagnosis codes for dates of service October 1 through December 31 of the current year.

Claims containing a discontinued ICD-9-CM diagnosis code will be returned as unprocessable.

Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004. After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following Web site: <http://www.cms.hhs.gov/medlearn/icd9code.asp>.

#### Source:

*Related Change Request (CR) #:* 3358

*Medlearn Matters Number:* MM3358

*Related CR Release Date:* July 9, 2004

*Related CR Transmittal #:* 225

*Effective Date:* October 1, 2004

*Implementation Date:* October 4, 2004

# Standardized Responses to Provider Inquiries Regarding the Negotiated National Coverage Determinations (NCDs) Edit Module

## Provider Types Affected

All providers

## Provider Action Needed

This instruction provides responses to commonly asked questions regarding the negotiated laboratory NCDs and the edit module used to implement the NCDs uniformly.

Carriers and fiscal intermediaries (FIs) may elect to use this language in responding to inquiries in their organization to help further standardize action nationally related to clinical diagnostic laboratory services.

## Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Nationally uniform software has been developed by Computer Sciences Corporation (CSC) and incorporated in the Medicare claims processing systems, known as shared systems, so that laboratory claims subject to one of the 23 laboratory NCDs are processed uniformly throughout the nation.

In an effort to further standardize the action of Medicare carriers and intermediaries regarding claims subject to one of the NCDs, CSC has developed language that can be used to respond to inquiries related to the NCDs and the edit module used to implement them.

## Additional Information

The frequently asked questions (FAQs) and their answers are as follows:

### 1) *What is a National Coverage Determination (NCD)?*

The Centers for Medicare & Medicaid Services (CMS) makes NCDs granting, limiting, or excluding Medicare coverage for a specific medical service, procedure, or device. NCDs are made under section 1862(a) (1) of the Social Security Act (the Act) or other applicable provisions of the Act. The national coverage decisions apply nationwide and are binding on all Medicare carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans for purposes of Medicare coverage.

### 2) *What is a Clinical Laboratory Edit Table, and what is its purpose?*

The Clinical Laboratory NCD Edit Table is a diagnosis-to-procedure code edit table used by all Medicare contractors to process Medicare claims. The purpose of the edit table is to ensure that the Medicare claims subject to one of the negotiated laboratory NCDs are processed uniformly throughout the nation.

### 3) *When did the Clinical Laboratory Edit Table become effective?*

The Clinical Laboratory Edit Table became effective January 1, 2003. The negotiated laboratory NCDs became effective on November 25, 2002.

### 4) *How often and why is the Clinical Laboratory NCD Edit Table updated?*

The Clinical Laboratory NCD Edit Table is updated quarterly as necessary to reflect coding updates, ministerial coding changes, and substantive changes to the NCDs developed through the NCD process. Updates to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT) are incorporated into the edit module so as not to substantively change the NCDs.

Codes that flow from the narrative indications of the NCDs, but that were not initially included, may be added through coding analyses that are published on the coverage Internet site for public comment. Substantive policy changes resulting from new or modified NCDs for clinical laboratory services may also be developed and incorporated in the edit module quarterly updates.

**5) Why were the negotiated laboratory NCDs initiated?**

The negotiated laboratory NCDs were initiated to promote program integrity and national uniformity and to simplify administrative requirements for clinical diagnostic services.

**6) Where can I find the list of Clinical Laboratory NCD procedure codes and coverage documentation?**

There is a complete list of procedure codes and coverage information available on the CMS web site. The link to access the NCD Coding Policy Manuals, Federal Register Final Rules, and related CMS Program Memoranda is as follows:

<http://www.cms.hhs.gov/ncd/labindexlist.asp>

**7) How should a laboratory bill for services that are non-covered for reasons other than medical necessity?**

Healthcare Common Procedure Coding System (HCPCS) coding provides for a GY modifier to be used to indicate an item or service that is statutorily excluded or does not meet the definition of any Medicare benefit.

The list of non-covered codes for laboratory procedures subject to the negotiated NCDs can be found in the coding manuals in the “Non-covered ICD-9-CM Codes for All NCD Edits” section. These are the only codes that should be billed with the GY modifier for services subject to the negotiated laboratory NCDs. For information go to:

<http://www.cms.hhs.gov/ncd/labindexlist.asp>

**8) Is there a procedure to follow if I disagree with the coverage policy of any of the negotiated laboratory NCDs?**

If you are requesting a substantive change in an NCD, you must follow the NCD process that requires scientific evidence. Information regarding the NCD process is available on the Internet at: <http://www.cms.hhs.gov/coverage> Click on the coverage process link. CMS has developed a streamlined process for making coding changes that flow from the narrative indication of the negotiated lab NCDs. This was announced in the Federal Register on December 24, 2003 (68 FR 74607).

Under this process, a coding analysis may be performed after a 30-day public comment period to determine if codes are appropriately listed in NCD code lists. Coding analyses do not require scientific evidence, as the substance of the NCD is not altered. To request a coding analysis, you must submit a request identifying the provision in the NCD narrative you believe supports the code. Send the request to the Coverage and Analysis Group, CMS, C1-09 06, 7500 Security Boulevard, Baltimore, MD 21244-1850

**9) What diagnosis codes are used for the negotiated laboratory NCDs?**

Every ICD-9-CM code falls into one of the three possible lists used in the edit module for the negotiated laboratory NCDs. The three code lists include: ICD-9-CM Codes Covered by Medicare, ICD-9-CM Codes Not Covered by Medicare, and ICD-9-CM Codes That Do Not Support Medical Necessity.

**10) What causes an invalid code?**

A code is invalid if it has not been coded to the full number of digits required for that code (Coding Clinic 1995 4th Quarter). Any series of numbers that is not linked to a description in the ICD-9-CM book is an invalid code.

**11) How are probable, suspected, questionable, rule-out, or working diagnoses coded?**

Diagnoses documented as probable, suspected, questionable, rule-out, or working should not be coded as though they exist. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as signs, symptoms, and abnormal test results, exposure to communicable disease or other reasons for the visit.

**12) How can I bill for a preoperative test for patients about to undergo surgery now that the NCDs have removed the V72 series of ICD-9-CM codes?**

Testing prior to any medical intervention associated with a risk of bleeding and thrombosis (other than thrombolytic therapy) will generally be considered medically necessary only when there are signs or symptoms of a bleeding or thrombotic abnormality or a personal history of bleeding, thrombosis, or a condition associated with a coagulopathy. Hospital/clinic-specific policies, protocols, etc., in and of themselves cannot alone justify coverage. Assign the ICD-9-CM codes describing the signs, symptoms, or conditions that justify the need for the test.

If the signs, symptoms or conditions are not on the ICD-9-CM Codes Covered by Medicare list, they can still be submitted with the appropriate medical necessity documentation to substantiate the test. If no underlying signs, symptoms, or conditions are present, a screening code must be used. In this instance, Medicare does not cover the screening code test, and payment will be the responsibility of the beneficiary.

**13) I can't find the list of covered diagnoses for blood counts. Where is it?**

The blood counts policy lists the ICD-9-CM Codes Not Covered by Medicare and the ICD-9-CM Codes That Do Not Support Medical Necessity. The list of ICD-9-CM Codes Covered by Medicare for blood counts is any diagnosis code not listed in either non-covered or not medically necessary lists.

**14) I'm concerned that my claims for sensitivity testing for specimens other than urine will deny as the covered list for codes 87184 and 87186 include only diagnoses that support urine culture sensitivities.**

Claims for sensitivity testing on specimens other than urine will not deny as not medically necessary if they do not have a diagnosis from the ICD-9-CM Codes Covered by Medicare list of covered diagnoses for urine cultures. The edit module does not edit for these CPT codes. Rather, the NCD is intended to educate providers as to the appropriate indications to perform a urine culture sensitivity test.

**15) Why doesn't Medicare cover a Prostate Specific Antigen (PSA) test for my patients with benign prostatic hypertrophy (BPH)?**

The code for BPH, 600.00, is not on the ICD-9-CM Codes Covered by Medicare listing for a diagnostic PSA. Medicare does, however, cover an annual screening PSA test for men over 50. Men with BPH receiving an annual PSA screening should have their claims coded with procedure code G0103 in lieu of CPT code 84153.

This screening procedure code requires a diagnosis code of V76.44 that must appear on the claim form. If the patient has symptoms of prostate carcinoma along with the BPH, such as hematuria, nocturia, urinary frequency, and slow stream, a diagnostic PSA can be covered. More detailed information can be found in Program Memorandum AB-03-132 at: [http://www.cms.hhs.gov/manuals/pm\\_trans/AB03132.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB03132.pdf)

**16) My contractor retired a Local Coverage Determination (LCD) related to one of the NCDs. Can I still get payment for the diagnoses covered in the LCD?**

NCDs are binding on all Medicare claims processing contractors. Carriers and FIs may not have local policies that conflict with an NCD. Since the NCDs for the lab tests that were negotiated are specific to the code level, it is not possible for a local policy to deviate from the ICD-9-CM Codes Covered by Medicare list of diagnoses without being in conflict.

However, contractors are authorized to pay for diagnoses on the ICD-9-CM Codes That Do Not Support Medical Necessity list if the laboratory submits satisfactory documentation along with the claim. In addition, contractors may develop local policies in areas where the NCD is silent.

**Source:**

**Related Change Request (CR) #:** 3374

**Medlearn Matters Number:** MM3374

**Related CR Release Date:** July 23, 2004

**Related CR Transmittal #:** 234

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**Implementation Date:** October 4, 2004

## **NCD: Sensory Nerve Conduction Threshold Test (sNCTs)**

**Provider Types Affected**

Physicians, suppliers, and providers

**Provider Action Needed**

This instruction reaffirms the existing Medicare noncoverage policy on any type of Sensory Nerve Conduction Threshold Test (sNCT), and the device(s) used to perform the test, to diagnose sensory neuropathies or radiculopathies. This instruction constitutes a technical correction to previously issued Change Request (CR) 2988, and CR2988 should be discarded and replaced with this instruction. CR2988 was issued on March 19, 2004.

### Background

As a result of reconsideration, this instruction reaffirms the existing Medicare noncoverage policy on any type of Sensory Nerve Conduction Threshold Test (sNCT), and the device(s) used to perform the test, to diagnose sensory neuropathies or radiculopathies.

The revision to Section 160.23 of Pub. 100-03 is a National Coverage Determination (NCD), and NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. Under 42 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 the Social Security Act, Section 1869(f) (1) (A) (i))

Note that this instruction constitutes a technical correction to previously issued Change Request (CR) 2988. CR2988 should be discarded and replaced with this instruction.

### Related Instructions

The updated manual instructions are also 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](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

From that Website, look for CR3339 in the CR NUM column on the right, and click on the file for that CR.

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

### Additional Information

The following is the revision to the Medicare National Coverage Determinations Manual, Pub. 100-03, Chapter 1 (Coverage Determinations), Section 160 (Nervous System), Subsection 160.23 (Sensory Nerve Conduction Threshold Tests (sNCTs)). Revised sections are ***bolded and italicized***.

#### Medicare National Coverage Determinations Manual

#### Chapter 1 - Coverage Determinations

#### *160 - Nervous System*

#### ***160.23 - Sensory Nerve Conduction Threshold Tests (sNCTs)***

#### ***160.23 - Sensory Nerve Conduction Threshold Tests (sNCTs)***

#### A. General

Sensory Nerve Conduction Threshold Tests (sNCT) is a psychophysical assessment of both central and peripheral nerve functions. It measures the detection threshold of accurately calibrated sensory stimuli. This procedure is intended to evaluate and quantify function in both large and small caliber fibers for the purpose of detecting neurologic disease. Sensory perception and threshold detection are dependent on the integrity of both the peripheral sensory apparatus and peripheral-central sensory pathways. In theory, an abnormality detected by this procedure may signal dysfunction anywhere in the sensory pathway from the receptors, the sensory tracts, the primary sensory cortex, to the association cortex.

This procedure is different and distinct from assessment of nerve conduction velocity, amplitude and latency. It is also different from short-latency somatosensory evoked potentials.

Effective October 1, 2002, CMS initially concluded that there was insufficient scientific or clinical evidence to consider the sNCT test and the device used in performing this test reasonable and necessary within the meaning of section 1862(a)(1)(A) of the law.

Therefore, sNCT was noncovered.

***Effective April 1, 2004***, based on a reconsideration of current Medicare policy for sNCT, CMS concludes that ***the use of any type of sNCT device (e.g. “current output” type device used to perform current perception threshold (CPT), pain perception threshold (PPT), or pain tolerance threshold (PTT) testing or “voltage input” type device used for voltage-nerve conduction threshold (v-NCT) testing) to diagnose sensory neuropathies or radiculopathies in Medicare beneficiaries is not reasonable and necessary.***

**B. Nationally Covered Indications**

Not applicable.

**C. Nationally Noncovered Indications**

***All uses of sNCT to diagnose sensory neuropathies or radiculopathies are noncovered.***

(This NCD last reviewed **June** 2004.)

**Source:**

**Related Change Request (CR) #:** 3339

**Medlearn Matters Number:** MM3339

**Related CR Release Date:** June 18, 2004

**Related CR Transmittal #:** 15

**Effective Date:** April 1, 2004

**Implementation Date:** April 1, 2004

## Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee

**Provider Types Affected**

All Medicare physicians and providers

**Provider Action Needed****Impact to You**

Medicare has issued a national coverage determination (NCD) related to the arthroscopic lavage and arthroscopic debridement for the Osteoarthritic knee.

**What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) has issued an NCD stating that (1) arthroscopic lavage alone for treatment of osteoarthritis of the knee, (2) arthroscopic debridement for presentation of knee pain only, or (3) arthroscopic debridement and lavage with or without debridement, for patients with severe osteoarthritis of the knee are now nationally **non-covered**.

All other indications of debridement for patients without severe osteoarthritis of the knee who present with symptoms other than pain alone are at the discretion of the Medicare contractor (carrier or intermediary).

**What You Need to Do**

Be aware of this NCD and its impact on the services you provide.

**Background**

Arthroscopy is a surgical procedure that allows the direct visualization of the interior joint space. In addition to providing visualization, arthroscopy enables the process of joint cleansing through the use of lavage or irrigation. Lavage alone may involve either large or small volume saline irrigation of the knee by arthroscopy.

Although generally performed to reduce pain and improve function, current practice does not recognize the benefit of lavage alone for the reduction of mechanical symptoms.

Arthroscopy also permits the removal of any loose bodies from the interior joint space, a procedure termed debridement. Debridement, when used alone or not otherwise specified, may include low-volume lavage or washout.

Osteoarthritis is a chronic and painful joint disease caused by degeneration. The American College of Rheumatology defines a patient diagnosis of osteoarthritis of the knee as presenting with pain, and meeting at least five of the following criteria:

- Over 50 year of age;
- Less than 30 minutes of morning stiffness;
- Crepitus (noisy, grating sound) on active motion;
- Bony tenderness;
- Bony enlargement;
- No palpable warmth of synovium;
- ESR <40mm/hr;
- Rheumatoid Factor <1:40; and
- Synovial fluid signs.

Because the clinical effectiveness of arthroscopic lavage and arthroscopic debridement for the severe arthritic knee has not been verified by scientifically controlled studies and after thorough discussions with clinical investigators, the orthopedic community, and other interested parties, CMS issued this NCD. In this NCD, CMS determines that the following procedures are not considered reasonable or necessary in treatment of the osteoarthritic knee and are not covered by the Medicare program:

- Arthroscopic lavage used alone for the osteoarthritic knee;
- Arthroscopic debridement for osteoarthritic patient presenting with knee pain only; or
- Arthroscopic debridement and lavage, with or without debridement, for patients presenting with severe osteoarthritis. Severe osteoarthritis is defined in the Outerbridge classification scale, grades III and IV. Outerbridge is the most commonly used clinical scale that classifies the severity of joint degeneration of the knee by compartments and grade.

Grade I is defined as softening or blistering of joint cartilage.

Grade II is defined as fragmentation or fissuring in an area <1 cm.

Grade III presents clinically with cartilage fragmentation or fissuring in an area >1 cm.

Grade IV refers to cartilage erosion down to the bone.

Grade III and IV are characteristic of severe osteoarthritis.

Other than the above non-covered indications for arthroscopic lavage and/or arthroscopic debridement of the osteoarthritic knee, all other indications of debridement for patients without severe osteoarthritis of the knee who present with symptoms other than pain alone, remain at the discretion of the local carrier or intermediary. In order to determine coverage in such cases, the carrier or intermediary may require submission of one or all of the following documents:

- Operative notes;
- Reports of standing x-rays; and/or
- Arthroscopy results.

### Additional Information

This is a revision of Chapter 1 section 150.9 of Pub. 100-03, the Medicare National Coverage Determination Manual. The NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans.

Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on a Medicare+Choice Organization.

In addition, an administrative law judge may not review an NCD. (See 1869(f) (1) (A) (i) of the Social Security Act). To view the actual NCD issued by CMS, go to: [http://www.cms.hhs.gov/manuals/pm\\_trans/R14NCD.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R14NCD.pdf)

#### Source:

*Related Change Request (CR) #:* 3281

*Medlearn Matters Number:* MM3281

*Related CR Release Date:* June 10, 2004

*Related CR Transmittal #:* 14

*Effective Date:* June 11, 2004

*Implementation Date:* July 11, 2004

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

### Provider Types Affected

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

### Provider Action Needed

### Impact to You

Medicare Advantage (MA) rates were recently adjusted to account for three

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

### What You Need to Know

For services rendered prior to January 1, 2005, payment for services relating to the three NCD services mentioned above are paid by Medicare on a fee-for-service basis for MA plan enrollees.

Note that, prior to January 1, 2005, beneficiaries are not responsible for Part A or Part B deductibles associated with these services, though they are responsible for coinsurance amounts appropriate under Medicare fee-for-service rules.

### What You Need to Do

Be aware that these services will not be paid on a fee-for-service basis on or after

January 1, 2005. Instead, the MA plan will be responsible for making payment.

Note also that MA enrollees receiving services for lung volume reduction surgery services must receive these services in designated hospitals.

### Background

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

### Additional Information

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

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

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

**Source:**

*Related Change Request (CR) #: 3301*

*Related CR Release Date: N/A (CR is not available)*

*Related CR Transmittal #: N/A*

*Effective Date: January 1, 2005*

*Implementation Date: January 3, 2005*

## **Expansion of Policy where Patient is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period, to Include Inpatient Rehabilitation Facilities (IRF) and Long Term Care Hospitals (LTCH) (MMA section 211(e))**

**Provider Types Affected**

Hospitals (specifically Inpatient Rehabilitation Facilities and Long Term Care Hospitals)

**Provider Action Needed**

**Impact to You**

This instruction reflects new policy that applies to coverage of Medicare beneficiaries in an IRF or LTCH who are in a Medicare Advantage organization for a portion of their stay per the Medicare Modernization Act of 2003 (MMA).

**What You Need to Know**

Per the MMA, the terminology “Medicare Advantage” organization will now be used instead of “Medicare + Choice” organization. In addition, the policy regarding coverage when a patient is a member of a Medicare Advantage organization for only a portion of the billing period will now include IRFs and LTCHs.

**What You Need to Do**

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

**Background**

For hospitals paid under the Prospective Payment System (PPS), the Code of Federal Regulation (42 CFR 422.264) outlined a policy for coverage in a Medicare Advantage (MA) organization that begins or ends during an inpatient stay. The rule states that **the patient’s status at admission determines liability**.

For example, a patient is admitted to a hospital on January 28th and is discharged on February 5th. On February 1st the patient enrolls in a MA organization. Medicare Fee-For-Service (FFS) is liable for this inpatient stay because the patient had Medicare FFS at admission. A similar scenario would be true if the patient disenrolled in the MA organization on February 1st.

In this case the MA organization would be responsible for this inpatient stay that started on January 25th. There are no Medicare claims processing system changes needed for this CR because the system was set up to process claims correctly in this fashion since the inception of IRF and LTCH prospective payment.

This instruction notifies Medicare Fiscal Intermediaries (FIs) and providers that the Medicare Modernization Act of 2003 (MMA - Section 211(e)) expanded this policy to include IRFs and LTCHs. Also per the MMA, the terminology “Medicare Advantage” organization will be used instead of “Medicare + Choice” organization.

**Additional Information**

Following is an excerpt of the revised Chapter 1, Section 90 of the Medicare Claims Processing Manual, which reflects these changes. The bold, italicized print shows the changes. “Where a patient either enrolls or disenrolls in an **MA organization** (See the General Information, Eligibility, and Entitlement Manual (Pub. 100-01), Chapter 5, section 80 for definition) during a period of services, two factors determine whether the **MA organization** is liable for the payment.

- Whether the provider is included in inpatient hospital or home health PPS; and
- The date of enrollment.

**Hospital Services**

If the provider is an inpatient acute care hospital, **inpatient rehabilitation facility**, or a **long term care hospital**, and the patient changes **MA** status during an inpatient stay for an inpatient institution, the patient’s status at admission or start of care determines liability.

If the hospital inpatient was not a **MA** enrollee upon admission but enrolls before discharge, the **MA organization** is not responsible for payment.

For **hospitals exempt from PPS (children’s hospitals, cancer hospitals, and psychiatric hospitals/units) and Maryland Waiver hospitals**, if the **MA organization** has processing jurisdiction for the **MA** involved portion of the bill, it will direct the provider to split the bill and send the appropriate portions to the appropriate FI or MA organization. When forwarding a bill to a **MA organization**, the provider must also submit the necessary supporting documents.

If the provider is not a PPS provider, the **MA organization** is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.

The actual instructions issued to your intermediary can be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

**Source:**

**Related Change Request (CR) #:** 3309

**Medlearn Matters Number:** MM3309

**Related CR Release Date:** June 18, 2004

**Related CR Transmittal #:** 207

**Effective Date:** January 1, 2004

**Implementation Date:** July 19, 2004

SIZE	FILE	COMM DATE	MANUAL	SUBJECT	IMPL DATE	CR NUM
53 kb	<a href="#">R24NCD</a>	10/1/2004	PUB 100-03	Update to Chapter 1, Section 220.6 - Dementia and Neurodegenerative Diseases	10/1/2004	3426
56 kb	<a href="#">R24NCD</a>	10/1/2004	PUB 100-04	Treatment of Obesity	10/1/2004	3502
56 kb	<a href="#">R20SCP</a>	10/1/2004	PUB 100-04	Disabling the CWF 57x3 Consistency Error Code	1/3/2005	3470
80 kb	<a href="#">R10BCEP</a>	10/1/2004	PUB 100-01	Two New Medicare Summary Notice (MSN) Messages for Parental Pumps - DMERC Only	10/1/2004	3506
189 kb	<a href="#">R20BCEP</a>	10/1/2004	PUB 100-04	Full Replacement of CR 3415, 3rd Update to the 2004 Medicare Physician Fee Schedule Database	10/1/2004	3505
229 kb	<a href="#">R20BCEP</a>	10/1/2004	PUB 100-04	Fiscal Year (FY) 2005 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) and Other Bill Processing Changes Related to the IPFS Final Rule	10/1/2004	3459
53 kb	<a href="#">R11701N</a>	9/29/2004	PUB 100-02	New Remark Code Message for Use with Claims for Parental Pumps - DMERC Only	10/1/2004	3405
91 kb	<a href="#">R24BCEP</a>	9/24/2004	PUB 100-02	Nurse Practitioners As Attending Physicians in the Medicare Hospice Benefit	6/28/2004	3226

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

## Provider Types Affected

All Medicare providers

## Provider Action Needed

No action is necessary. This article is informational only. The Centers for Medicare & Medicaid Services (CMS) has determined, upon reconsideration of existing policy, that Autologous Blood-Derived Products for Chronic Non-Healing Cutaneous Wounds, both platelet-derived growth factor (PDGF) in platelet-poor plasma and platelet-rich plasma (PRP), will remain non-covered as CMS continues to believe that the clinical effectiveness of these autologous blood-derived products is not adequately proven in scientific literature.

## Background

Patient-donated blood is centrifuged to produce an autologous gel for the treatment of chronic non-healing cutaneous wounds that persist for 30 days or longer and fail to complete the healing process properly. Autologous blood-derived products for chronic non-healing wounds include both PDGF products, such as Procuren and more recent products, and PRP products. PRP differs from previous products because it contains whole cells, including white cells, red cells, plasma, platelets, fibrinogen, stem cells, macrophages, and fibroblasts. PRP is used by physicians in clinical settings. PDGF does not contain cells and was marketed as a product to be used by patients at home.

In 1992 CMS issued a national Medicare non-coverage determination in relation to platelet-derived wound healing formulas containing growth factors in the treatment of non-healing wounds. The determination was based on a lack of sufficient published data to determine the safety and efficacy of such formulas, and a Public Health Service technology assessment. Recently, CMS reconsidered that 1992 decision and concluded that the clinical effectiveness of autologous PDGF products continues to be inadequately proven in scientific literature, and it remains non-covered for treatment of chronic, non-healing cutaneous wounds.

Additionally, the clinical evidence does not support a benefit in the application of autologous PRP for the treatment of chronic, non-healing wounds, and CMS has determined it is not reasonable and necessary and is nationally non-covered. It will remain at the local carrier's discretion whether to pay for Becaplermin, a non-autologous growth factor product approved by the FDA for the treatment of chronic non-healing subcutaneous wounds.

Also, the routine costs of autologous PRP products for the treatment of chronic non-healing wounds associated with Category B Investigational Device Exemption clinical trials are covered by Medicare in accordance with 42 CFR 405.201 – 405.215, 411.15, and 411.406 or section 310.1 of the National Coverage Determinations Manual.

## Additional Information

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

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

### Source:

*Related Change Request (CR) #:* MM3384

*Medlearn Matters Number:* MM3384

*Related CR Release Date:* July 30, 2004

*Related CR Transmittal #:* 19

*Effective Date:* July 23, 2004

*Implementation Date:* July 23, 2004



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

## Provider Types Affected

All providers involved in an NIH sponsored clinical trial

## Provider Action Needed

### Impact to You

In the specific context of an NIH sponsored clinical trial:

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

### What You Need to Know

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

### What You Need to Do

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

## Background

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

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

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

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

## Additional Information

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

### Source:

*Related Change Request (CR) #:* 3385

*Medlearn Matters Number:* MM3385

*Related CR Release Date:* July 30, 2004

*Related CR Transmittal #:* 261

*Effective Date:* October 1, 2004

*Implementation Date:* October 4, 2004

## **MSN Messages for Mammography Claims, Pub 100-04, Chapter 18, Section 20 and Chapter 21, Section 50**

### **Provider Types Affected**

Providers and suppliers who bill for mammography services.

### **Provider Action Needed**

Suppliers and providers should note that this article discusses changes in Medicare Summary Notice (MSN), which are sent to Medicare beneficiaries, and Remittance Advice messages and related situations where both film and digital screening mammography or film and digital diagnostic mammography are performed on the same day.

### **Background**

Screening mammography tests can be performed by both film and digital technology. Because of this, some suppliers/providers have assumed the annual frequency rule did not apply in situations where both a film and digital screening is performed. That is not the case, however; Medicare will only pay for one screening test annually, whether performed by film or digital technology. Additionally, Medicare will pay only once for a screening test for a woman between the ages of 35 and 39. Further, Medicare will only pay for one mammography diagnostic test per day, not two.

The revised manual instructions include Medicare Claims Processing Manual updates regarding which Medicare Summary Notice (MSN) message and ANSI X-12 8351 Adjustment Reason Code will be used on the Remittance Advice when Medicare denies a claim based on film and digital screening or film and digital diagnostic mammography services performed on the same day.

Currently, there are no established comparable MSN messages that can be used to explain why the claim is being denied. Without these new messages, beneficiaries would receive very general messages for denial of claims.

The new MSN Messages are to be used when both film and digital screening mammography or film and digital diagnostic mammography has been performed on the same day. The Spanish translation for each new MSN messages has also been added to the revised manual.

### **Remittance Advice Messages**

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

- If the claim is denied because two screening mammographies were performed on the same day, the claim will be denied with reason code A1 “Claim Denied Charges,” along with remark code M90 “Not covered more than once in a 12 month period.”
- If the claim is denied because two diagnostic mammographies were billed on the same day, the claim is denied with reason code A1 “Claim Denied Charges,” along with remark code M63 “Service denied because payment already made for same/similar procedure within set timeframe.”
- For claims submitted by a facility not certified to perform digital mammographies, the remittance advice will contain reason code B6 “This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty,” along with remark code N92 “This facility is not certified for digital mammography.”
- For claims that were submitted with an invalid or missing FDA identification number, use existing reason code 16 “Claim/service lacks information which is needed for adjudication,” along with remark code MA128 “Missing/incomplete/invalid six digit FDA approved identification number.”

### **Related Instructions**

The Medicare Claims Processing Manual (Pub 100-4), Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services), Subsection 20.8 (Beneficiary and Provider Notices), Subsubsections 20.8.1 (MSN Messages) and 20.8.2 can be found on the CMS Web site at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp)

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

- 1) American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X-12 transactions are part of the Transactions and Code Sets Rule selected by HIPAA

**Source:**

*Related Change Request (CR) #: 2617*

*Medlearn Matters Number: MM2617*

*Related CR Release Date: June 25, 2004*

*Related CR Transmittal #: 214*

*Effective Date: September 25, 2004*

*Implementation Date: September 25, 2004*

## Cryosurgery of the Prostate

### Provider Types Affected

Hospitals and Ambulatory Surgery Centers

### Provider Action Needed

Affected providers should note that this instruction corrects the revenue code for Cryosurgery of the Prostate which was reported previously in CR 1632 as 034X. The revenue code should be **036X**.

This instruction also incorporates changes to Chapter 18 (Preventive and Screening Services), including Section 51 (Cryosurgery of the Prostate Gland), into the Medicare Claims Processing Manual (Pub 100-04).

### Background

This instruction corrects the revenue code; instead of 034X, the revenue code should be **036X**. Medicare will pay for this cryosurgery on an inpatient or outpatient basis.

### Additional Information

The Medicare Claims Processing Manual (Pub 100-4), Chapter 18 (Preventive and Screening Services), Section 51 (Cryosurgery of the Prostate Gland) was revised and the revisions are attached to the official instruction issued to your fiscal intermediary regarding this change. That instruction, CR3168, may be found by going to:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R260CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R260CP.pdf)

**Source:**

*Related Change Request (CR) #: 3168*

*Medlearn Matters Number: MM3168*

*Related CR Release Date: July 30, 2004*

*Related CR Transmittal #: 260*

*Effective Date: January 1, 2005*

*Implementation Date: January 3, 2005*

## Billing for Echocardiography Services

Echocardiography (HCPCS 93303-93350) is a non-invasive technique where pulsed high frequency sound waves are used to locate and study the movements and dimensions of cardiac structures. The sound waves track the motion of the cardiac structures over a period of time.

According to the American College of Cardiology and the American Heart Association (ACC/AHA), while cardiac ultrasound may be applied in different forms (M-mode, two-dimensional, spectral and color flow Doppler imaging), and by two different approaches (transthoracic, transesophageal), all are encompassed in the term echocardiography.

Echocardiography is performed to evaluate specific cardiovascular disorders and for evaluating signs and/or symptoms which may be related to a cardiac disorder. Indications are defined for Transthoracic Echocardiography (TTE) and Transesophageal Echocardiography (TEE).

CareFirst of MD Inc., Medicare Part A Fiscal Intermediary has recently completed data analysis of the use of HCPCS 93303-93350. **A majority of the denials were for noncovered diagnoses** based on our Local Coverage Determination (LCD) Policy Number 03-03. In an effort to reduce the number of denied claims, as well as decrease the intermediary appeal volume, we have included LCDs and coding parameters on our web site. Our web site can be accessed at: [www.marylandmedicare.com](http://www.marylandmedicare.com).

Services billed with a diagnosis code that is not listed in the Covered Diagnosis Codes section of this policy will be denied as not medically necessary. The beneficiary will not be held financially liable unless an Advance Beneficiary Notice (ABN) is obtained.

All of the coverage criteria included in the LCD must be met before echocardiography services can be reimbursed by Medicare. Diagnosis (es) must be present on any claim submitted and must be coded to the highest level of specificity. The diagnosis codes(s) must be representative of the patient's condition.

Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (HCPCS 93320, 93321) and Doppler echocardiography color flow velocity mapping (HCPCS 93325) are frequently billed in addition to the codes for echocardiographic imaging. The documentation in the medical record must reflect the medical necessity for providing these services. Documentation should also include the results of these additional studies, including any measurements of flow velocities, etc.

If you have any questions you can contact Patricia Neal, RN at 410-561-4041.

## Billing for Infusion Therapy Services Using HCPCS Q0081-Q0085

The purpose of this article is to clarify the HCPCS codes used for infusion therapy services. Drug administration codes Q0081, Q0083, Q0084 & Q0085 are defined on a per visit basis.

CareFirst of MD Inc., Medicare Part A Fiscal Intermediary has recently completed data analysis of the use of HCPCS Q0081-Q0085. Coding irregularities were identified with multiple providers resulting in inappropriate reimbursement. Two units of the same code can be billed on the same date, only if two distinct and separate visits to the hospital occur on the same date. The billing of excessive units of HCPCS Q0081-Q0085 results in inappropriate payment to the provider and in increased coinsurance due from the beneficiary. **It is imperative that providers take immediate action to correct this billing practice.**

The complete description for each HCPCS code is as follows:

Q0081 Infusion therapy, using other than chemotherapeutic drugs, per visit. Use this code when infusing intravenous therapy for hydration, or the intravenous administration of antibiotics, anti-emetics, or analgesics.

Q0083 Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit. This code is used for subcutaneous injections, intramuscular injection or IV push medications.

Q0084 Chemotherapy administration by infusion technique only, per visit.

Q0085 Chemotherapy administration by both infusion technique and other technique(s) (e.g., subcutaneous, intramuscular, push), per visit. HCPCS Q0085 is no longer payable under the Hospital Outpatient Prospective Payment System (OPPS) beginning January 1, 2004.

For OPPS providers, hospitals must report both HCPCS Q0083 and HCPCS Q0084 when chemotherapy is administered by both infusion and another route of administration. Claims on which HCPCS Q0085 is billed will be returned to the provider for correction.

For non-OPPS providers, HCPCS Q0085 remains a billable code.

Attention is called to the last phrase in each code; “**per visit**”. Each code describes an episode of care, not hours of infusion, number of medications administered, etc. Correct reporting for each of these codes should indicate Service Units of one (1) for any one date of service.

If the patient receives medication at more than one separate encounter on a single date of service, the medical record should clearly document that the patient was absent from the facility between the administrations. Effectively, there would be two episodes of care.

For example: A patient is receiving intravenous antibiotics twice daily.

The patient presents in the morning, receives the antibiotic and departs the premises. Later in the same day (usually late afternoon or evening) the patient returns for a second antibiotic administration. If the antibiotic is administered by infusion, the correct submission for this date of service would be as follows:

Line 1: Q0081, quantity 01

Line 2: Q0081, quantity 01, Modifier 59

A single line submission to report this date of service is not appropriate. The submission should not report:

Line 1: Q0081, quantity 02, no Modifier

The injection codes HCPCS 90782, 90783, 90784, 90788 are considered separate services from infusion therapy and are separately billable to Medicare. It is important to read the descriptor for each code in order to insure that the proper code has been billed. It is appropriate to bill IV infusion therapy, injection, drugs, and supplies separately. Drugs with a CPT/HCPCS code should be billed under revenue code 636.

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.

## Clarification for Billing Left Ventricular Assist Devices

### Provider Types Affected

All providers who bill Medicare for Left Ventricular Assist Systems (LVAS) and the medically necessary supplies and replacement accessories.

### Provider Action Needed

#### Impact to You

Manufacturer(s) may have erroneously suggested that the Centers for Medicare & Medicaid Services (CMS) instructions on page 8 of Program Memorandum AB-02-152 allow providers to bring a recently discharged patient back for an outpatient visit to replace the Left Ventricular Assist Device (LVAD) equipment that was furnished under Part A in order to receive extra payment under Part B.

#### What You Need to Know

This erroneous suggestion may lead hospitals to believe that they can get extra Part B payment for the LVAD equipment in cases where the replacement or supplies are not medically necessary.

#### What You Need to Do

Please note that Medicare payment is made under Part B for additional **medically necessary** supplies and replacement accessories required after the patient has been discharged from the hospital. Cases without medical need for replacement would be considered double billing. Please also refer to the Background section below.

### Background

The program memorandum described in CR 2378 contains instructions regarding payment for the Left Ventricular Assist System (LVAS) or Left Ventricular Assist Device (LVAD) (page 8 of AB-02-152). The Left Ventricular Assist System (LVAS) is implanted in an inpatient setting and Medicare payment is made under Part A for:

- Hospital inpatient services; and
- Supplies and all necessary accessories for the LVAS (provided in the inpatient setting).

Medicare payment is made under Part B for additional **medically necessary** supplies and replacement accessories required after the patient has been discharged from the hospital. Claims for replacement of supplies and accessories used with the LVAS that are furnished by suppliers should be billed to the local carriers. Claims for replacement of supplies and accessories that are furnished by hospitals should be billed to the intermediary.

It is the responsibility of the local carrier or intermediary to determine whether the replacement supplies and accessories can be covered and to provide instructions, as needed, on how often these items can be replaced. Manufacturer(s) may have erroneously suggested that CMS instructions in AB-02-152 allow providers to bring a recently discharged patient back for an outpatient visit to replace the LVAD equipment that was furnished under Part A in order to receive extra payment under Part B. This erroneous suggestion may lead hospitals to believe that they can get extra Part B payment in cases where the replacement or supplies are not medically necessary.

CMS reminds providers, suppliers, and Medicare intermediaries and carriers that payment under Part B can only be made for replacement of components and accessories that are reasonable and necessary.

If the intermediary or carrier gets claims for replacement of items within a relatively short period of time following discharge from the hospital, they will be aware that this may just be an attempt to obtain additional reimbursement for the LVAD under Part B (in those cases where there is not a true replacement need). For example, the batteries or power sources for these devices require periodic replacement. The manufacturers have indicated that these items should last approximately 6 months to a year, depending on the brand of device.

Therefore, it would not be reasonable and necessary to replace these items anytime before these minimum, expected product lifetimes have expired. For other components and accessories, the product lifetimes will be even longer. Cases without medical need for replacement would be considered double billing.

### Additional Information

To view page 8 of the program memorandum AB-02-152, visit: [http://www.cms.hhs.gov/manuals/pm\\_trans/AB02152.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB02152.pdf)

#### Source:

*Related Change Request (CR) #:* 2378

*Medlearn Matters Number:* SE0424

## Clarification for CR3064 - Medicare Secondary Payer (MSP) Policy for Hospital Reference Lab Services and Independent Reference Lab Services

### Provider Types Affected

Hospitals, Critical Access Hospitals (CAH), and Independent Reference Laboratories

### Provider Action Needed

### Impact to You

Hospitals are no longer required to collect Medicare Secondary Payer (MSP) information where there is no face-to-face encounter with a beneficiary because independent reference laboratories no longer need the information to bill Medicare for reference laboratory services.

### What You Need to Know

This clarification of CR3064 and Medlearn Matters article MM3064 provides additional information regarding preparation of the CMS-1500 claims form. Compliance with this instruction will help assure prompt and correct processing of reference laboratory claims.

### What You Need to Do

Affected providers should ensure that billing staff enter “None” in block 11 of the CMS-1500 when filing claims to Medicare for reference laboratory services when there is not a face-to-face encounter with the Medicare beneficiary.

### Background

Section 943 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that: “The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare Secondary Payer provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.”

Prior to the enactment of MMA, hospitals were required to collect MSP information every 90 days in order to bill Medicare for reference lab services. Further, those providers billing carriers are reminded to enter “None” in Block 11 of the CMS-1500 claims form for reference laboratory services in order to bill Medicare for the reference laboratory services, as described in Section 943(b).

### Additional Information

Due to these policy changes, Medicare intermediaries have been instructed to not include claims for reference laboratory services, as described in Section 943(b) of MMA, in the sample of claims that are reviewed during MSP hospital audits. This is effective for reference laboratory service claims with dates of service of December 8, 2003 and later.

To view the actual instruction issued to your carrier/intermediary, go to:

[http://www.cms.hhs.gov/manuals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #: 3267*

*Medlearn Matters Number: MM3267*

*Related CR Release Date: July 16, 2004*

*Related CR Transmittal #: 17*

*Effective Date: December 8, 2003*

*Implementation Date: August 16, 2004*

## Reporting Medicare Secondary Payer Information on the Health Insurance Portability and Accountability Act of 1996 X12N 837, Created Via the Free Billing Software

### Provider Types Affected

All providers who use free billing software from Medicare for HIPAA 837.

### Provider Action Needed

#### Impact to You

All providers who use free (or low cost) billing software from Medicare for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 837 must receive a software upgrade related to Medicare Secondary Payer (MSP) from their carrier, durable medical equipment regional carrier, or intermediary.

Changes included in the updated software will be required for electronic submission of such claims (when there is one primary payer to Medicare).

**Note that the HIPAA 837 does not accommodate the data Medicare needs when there is more than one primary payer. Providers must submit these types of MSP claims to Medicare on paper.**

### What You Need to Know

Please be sure to submit claims in the correct format to avoid delays in claims processing.

### What You Need to Do

If you use the billing software supplied by a Medicare carrier or intermediary, please obtain the required software upgrade after October 4, 2004 from your carrier/intermediary to ensure accurate electronic claims processing.

### Additional Information

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR NUM 3284, at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #: 3284*

*Medlearn Matters Number: 3284*

*Related CR Release Date: May 28, 2004*

*Related CR Transmittal #: 84*

*Effective Date: October 1, 2004*

*Implementation Date: October 4, 2004*

# Health Insurance Portability and Accountability Act (HIPAA) X12N 837 Institutional Health Care Claim Implementation Guide (IG) Additional Updates

### Provider Types Affected

All Medicare providers who bill Medicare Fiscal Intermediaries (FIs)

### Provider Action Needed

#### Impact to You

On January 3, 2005, the Centers for Medicare & Medicaid Services (CMS) will implement additional edits for institutional claims submitted via direct data entry (DDE).

### What You Need to Know

Please stay current with HIPAA edit instructions related to X12N 837 institutional claims as failure to comply may result in payment delays.

### What You Need to Do

Ensure that your billing practices comply with changes noted below to facilitate accurate and timely claims processing. Specific changes include requirements for a line item date of service for each revenue code on DDE outpatient claims (as defined in CR3031) and that such claims may not contain covered days.

Also, all DDE claims will be edited to ensure they do not contain a UPIN of NPP000.

### Background

HIPAA institutional claim editing business requirements presented in CR 3031, CR3264, and CR3337 are supplemented by additional claim edits contained in Change Request 3321. Medicare claims processing systems used by FIs will be required to:

- Edit outpatient claims submitted via DDE to ensure that a line item date of service is included for each revenue code;
- Edit outpatient claims submitted via DDE to ensure that each does not contain covered days;
- Edit claims submitted via DDE to ensure each does not contain an invalid condition code;
- Edit X12N 837 claims to ensure each does not contain an invalid condition code; and
- Edit all claims submitted via DDE to ensure that each does not contain an NPP000 UPIN.

All claims above submitted via DDE that do not meet the requirements noted will be subject to an appropriate online error message.

**Additional Information**

The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3321, at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

For additional information on HIPAA, please refer to: <http://www.cms.hhs.gov/hipaa/hipaa2/links/default.asp>

**Source:**

*Related Change Request (CR) #: 3321*

*Medlearn Matters Number: MM3321*

*Related CR Release Date: July 23, 2004*

*Related CR Transmittal #: 238*

*Effective Date: January 1, 2005*

*Implementation Date: January 3, 2005*

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

**Provider Types Affected**

All providers

**Provider Action Needed****Impact to You**

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

**What You Need to Know**

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

**What You Need to Do**

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

**Background**

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

At each X12 trimester meeting (generally held in the months of February, June and October) the Committee may update the claims status category codes and health care claim status codes. Included in the code list are specific details, such as the date a code was added, changed, or deleted. Per HIPAA (1996), health plans must be able to conduct the standard electronic transactions mentioned in the regulation.

The named HIPAA transaction for claims status is the ASC X12N 276/277 4010A1 Health Care Claim Status Request and Response. The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes. Medicare contractors are already using these code sets because of prior instructions.

However, recently some new codes and code changes were made with the designation “new as of 2/04.” Medicare carriers and intermediaries will start using the “new as of 2/04” codes as of January 3, 2005.

### Additional Information

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

**Claims status codes communicate information about the status of a claim, i.e., whether it's been received, pending, or paid.** For users who are new to the Claim Status transaction, please review the 276/277 Implementation Guide for using claim status codes.

**The Claim Status transaction is not used as a financial transaction.** Claim Status Category codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-1, STC10-1 and STC11-1 composite elements. They indicate the general category of the status (accepted, rejected, additional information requested, etc.), which is then further detailed in the Claim Status Codes carried in STC01-2, STC10-2 and STC11-2. The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes found at:

<http://www.wpc-edi.com/codes/codes.asp>

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

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

#### Source:

*Related Change Request (CR) #:* 3361

*Medlearn Matters Number:* MM3361

*Related CR Release Date:* July 23, 2004

*Related CR Transmittal #:* 230

*Effective Date:* January 1, 2005

*Implementation Date:* January 3, 2005

## Clarification for Medlearn Matters 3031: Medicare Need for a Specific Line Item Date of Service (LIDOS) for Each Revenue Code on ALL Outpatient and Inpatient Part B Claims

### Provider Types Affected

All providers submitting outpatient and inpatient Part B claims to Medicare

### Provider Action Needed

#### Impact to You

Using a date range instead of a single date in the LIDOS field on outpatient and inpatient Part B claims will not be accepted by Medicare on or after October 1, 2004.

#### What You Need to Know

Medicare business rules rely on a single date in the LIDOS field of these claims in order to ensure accurate payment. Effective October 1, 2004, Medicare will reject claims that use a range of dates in the LIDOS field on these claims.

#### What You Need to Do

Refer to the Background and Additional Information sections below for full details on this requirement and make sure that your billing staffs are aware of this change.

#### Background

Transmittal 107 (CR 3031) issued on February 24, 2004 requires Medicare claims processing systems to make certain changes to implement the HIPAA X12N 837 institutional 837 transaction, see:

([http://www.cms.hhs.gov/manuals/pm\\_trans/R107CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R107CP.pdf).)

These changes are needed to resolve issues with Coordination of Benefits (COB) transactions with third-party payers. Business requirement 3031.1, within CR3031, requires Medicare fiscal intermediaries (FIs) to edit outpatient claims to ensure each contains a line item date or dates of service for each revenue code.

However, effective for claims submitted on or after October 1, 2004, the Centers for Medicare & Medicaid Services (CMS) will require a single date in the LIDOS field on all outpatient claims and inpatient Part B claims.

Medicare fiscal intermediaries will reject any such claims where the LIDOS field contains a range of dates. In determining the national payment rates under the outpatient prospective payment system (OPPS), CMS uses the dates of service in order to correctly attribute the costs of packaged services and items to the procedure for which they are used. This requires the single LIDOS, not a date range.

Also, in order to ensure that CMS does not pay for services on a separate claim that were paid as part of a bundle on another claim, Medicare edits outpatient claims using the LIDOS. This applies to all services on inpatient hospital claims and all but a few specified exceptions on an inpatient SNF claim. This requires separate dates of service as opposed to a date range.

Thus, so that CMS may support these business rules and facilitate recalibration of OPPS payment rates in future years, Medicare FIs will reject as unprocessable all outpatient claims and inpatient Part B claims that contain a range of dates in the LIDOS field.

#### Additional Information

Effective October 1, 2004, all claims submitted on bill types 12x, 13x, 14x, 22x, 23x, 24x, 32x, 33x, 34x, 71x, 72x, 73x, 74x, 75x, 76x, 81x, 82x, 83x, and 85x must contain a single date in the LIDOS field or the claim will be rejected as unprocessable. The complete instruction issued by CMS to your FI may be found at:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R199CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R199CP.pdf)

#### Source:

*Related Change Request (CR) #:* 3337

*Medlearn Matters Number:* MM3337

*Related CR Release Date:* June 10, 2004

*Transmittal #:* 199

*Effective Date:* October 1, 2004

*Implementation Date:* October 4, 2004

## Change to Previous Transmittal Regarding the Discontinued Use of Revenue Code 0910

#### Provider Types Affected

- 1) Comprehensive outpatient rehabilitation facilities (CORFs), rural health clinics (RHCs), and federally qualified health centers (FQHCs); and
- 2) Hospital outpatient departments, community mental health centers (CMHCs), and critical access hospitals (CAHs) billing under the Outpatient Partial Hospitalization Program.

#### Provider Action Needed

Note that the effective date of the discontinuance of revenue code 0910, as mentioned in Medlearn Matters article MM3194 and related CR 3194, has been changed to October 16, 2003.

#### Background

This article contains changes to the effective date of the CR 3194 requirements pertaining to the discontinued use of revenue code 0910. The CR 3194 business requirements document made a revenue code change for claims for certain psychiatric/psychological treatment and services submitted on or after October 1, 2004.

Specifically, it discontinued revenue code 0910 and replaced it with revenue code 0900. This article changes the effective

date of that revenue code change. The revenue code change will now be effective for claims with “dates of service” on or after October 16, 2003.

To briefly review the revenue code change contained in CR 3194: CORFs, RHCs, and FQHCs must use revenue code 0900 to report psychiatric/psychological treatment and services that are subject to the outpatient mental health treatment limitation, just as revenue code 0910 was used in the past.

Similarly, hospital outpatient departments, CMHCs, and CAHs that formerly reported psychiatric/psychological services under the Outpatient Partial Hospitalization Program using revenue code 0910 must now report such treatment under revenue code 0900.

### Additional Information

You can find more information about revenue code 0900 by going to:

[http://www.cms.hhs.gov/manuals/transmittals.comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals.comm_date_dsc.asp)

You can also find the original CR 3194 at that page, and the Medlearn Matters article MM3194 can be found at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3194.pdf>

#### Source:

*Related Change Request (CR) #:* 3343

*Medlearn Matters Number:* MM3343

*Related CR Release Date:* July 23, 2004

*Related CR Transmittal #:* 98

*Effective Date:* October 16, 2003

*Implementation Date:* October 4, 2004

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

### Provider Types Affected

Physicians, suppliers, and providers

### Provider Action Needed

### Impact to You

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

### What You Need to Know

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

### What You Need to Do

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

### Background

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

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

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

- Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on Form CMS-1450.
- On April 1, 1989, the use of ICD-9-CM codes became mandatory for all physician services submitted on Form CMS-1500.
- Effective October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59) (see Change Request (CR) 2725, dated June 6, 2003, at [http://www.cms.hhs.gov/manuals/pm\\_trans/B03045.pdf](http://www.cms.hhs.gov/manuals/pm_trans/B03045.pdf)).
- Effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR 3094 dated February 6, 2004 at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R95CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf)).

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

After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following Website: <http://www.cms.hhs.gov/medlearn/icd9code.asp> The update should be available at this site in June.

**Related Instructions**

The Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service) has been revised.

The updated manual instructions are included in the official instruction issued to your carrier, and it can be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

**Additional Information**

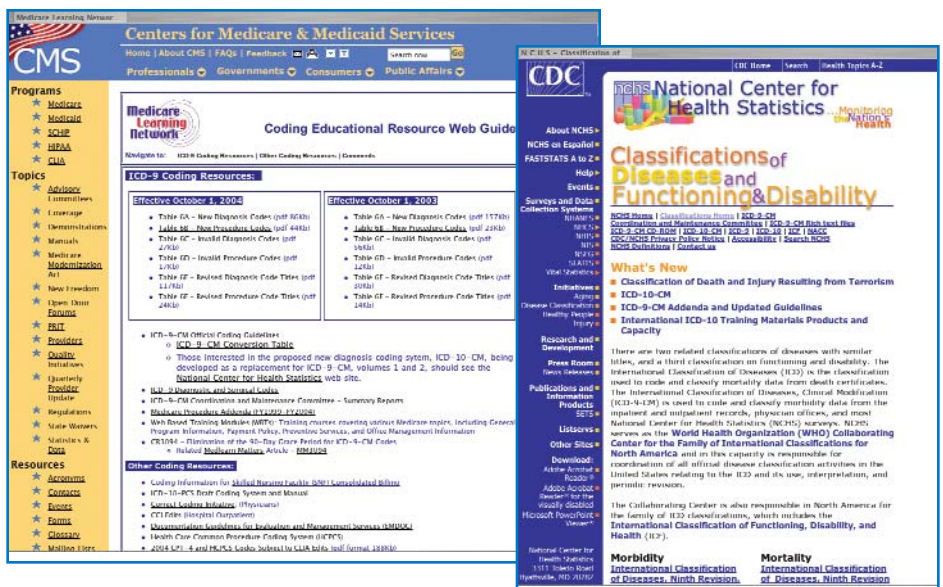
The new, revised, and discontinued ICD-9-CM diagnosis codes are posted annually on the following CMS Website: [www.cms.hhs.gov/medlearn/icd9code.asp](http://www.cms.hhs.gov/medlearn/icd9code.asp)

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

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

**Source:**

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



# 3rd Update to the 2004 Medicare Physician Fee Schedule Database

**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 impact 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 requires that carriers give providers 30 days notice before implementing the revised payment amounts reflected in this instruction. Carriers will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, carriers will adjust claims brought to their attention.

Unless otherwise stated in this instruction, changes will be retroactive to January 1, 2004.

**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 are all included in the table below. You may view the official instruction issued to your carrier by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

From that Web page, look for CR3415 in the CR NUM column on the right, and click on the file for that CR.

**CHANGES TO 3RD UPDATE TO THE 2004 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE**

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

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

CPT/HCPCS	ACTION
	<b>Diagnostic Supervision = 9</b> <b>Note: Effective for services performed on or after October 1, 2004</b>
G0343	<b>Description:</b> Laparotomy for Islet Cell transplant, includes portal vein catheterization and infusion <b>Short Descriptor:</b> Laparotomy Islet cell transp <b>Procedure Status = A</b> <b>WRVU = 19.85</b> <b>Non-Facility PE RVU = 8.82</b> <b>Facility PE RVU = 8.82</b> <b>Malpractice RVU = 2.05</b> <b>PC/TC = 0</b> <b>Site of Service = 1</b> <b>Global Surgery = 090</b> <b>Pre Op = 0.09</b> <b>Intra Op = 0.81</b> <b>Post Op = .10</b> <b>Multiple Procedure Indicator = 2</b> <b>Bilateral Procedure Indicator = 0</b> <b>Assistant at Surgery Indicator = 2</b> <b>Co-Surgery Indicator = 1</b> <b>Team Surgery Indicator = 0</b> <b>Type of Service = 2</b> <b>Diagnostic Supervision = 9</b> <b>Note: Effective for services performed on or after October 1, 2004</b>
23410	<b>Bilateral Status Indicator = 1</b>
33979	<b>Bilateral Status Indicator = 0</b>
33980	<b>Bilateral Status Indicator = 0</b>
52320	<b>Endobase Code = 52000</b>
52325	<b>Endobase Code = 52000</b>
52327	<b>Endobase Code = 52000</b>
52327	<b>Bilateral Status Indicator = 1</b>
52330	<b>Endobase Code = 52000</b>
52332	<b>Endobase Code = 52000</b>
52334	<b>Endobase Code = 52000</b>
52341	<b>Endobase Code = 52000</b>
52342	<b>Endobase Code = 52000</b>
52343	<b>Endobase Code = 52000</b>
52344	<b>Endobase Code = 52000</b>
69440	<b>Bilateral Surgery Indicator = 1</b>
69450	<b>Bilateral Surgery Indicator = 1</b>
69501	<b>Bilateral Surgery Indicator = 1</b>
69502	<b>Bilateral Surgery Indicator = 1</b>
69505	<b>Bilateral Surgery Indicator = 1</b>
69511	<b>Bilateral Surgery Indicator = 1</b>
69530	<b>Bilateral Surgery Indicator = 1</b>
69535	<b>Bilateral Surgery Indicator = 1</b>
69540	<b>Bilateral Surgery Indicator = 1</b>
69550	<b>Bilateral Surgery Indicator = 1</b>
69552	<b>Bilateral Surgery Indicator = 1</b>
69554	<b>Bilateral Surgery Indicator = 1</b>

CPT/HCPCS	ACTION
69601	Bilateral Surgery Indicator = 1
69602	Bilateral Surgery Indicator = 1
69603	Bilateral Surgery Indicator = 1
69604	Bilateral Surgery Indicator = 1
69605	Bilateral Surgery Indicator = 1
69610	Bilateral Surgery Indicator = 1
69620	Bilateral Surgery Indicator = 1
69631	Bilateral Surgery Indicator = 1
69632	Bilateral Surgery Indicator = 1
69633	Bilateral Surgery Indicator = 1
69635	Bilateral Surgery Indicator = 1
69636	Bilateral Surgery Indicator = 1
69637	Bilateral Surgery Indicator = 1
69641	Bilateral Surgery Indicator = 1
69642	Bilateral Surgery Indicator = 1
69643	Bilateral Surgery Indicator = 1
69644	Bilateral Surgery Indicator = 1
69645	Bilateral Surgery Indicator = 1
69646	Bilateral Surgery Indicator = 1
69650	Bilateral Surgery Indicator = 1
69660	Bilateral Surgery Indicator = 1
69661	Bilateral Surgery Indicator = 1
69662	Bilateral Surgery Indicator = 1
69666	Bilateral Surgery Indicator = 1
69667	Bilateral Surgery Indicator = 1
69670	Bilateral Surgery Indicator = 1
69700	Bilateral Surgery Indicator = 1
69711	Bilateral Surgery Indicator = 1
69714	Bilateral Surgery Indicator = 1
69715	Bilateral Surgery Indicator = 1
69717	Bilateral Surgery Indicator = 1
69718	Bilateral Surgery Indicator = 1
69720	Bilateral Surgery Indicator = 1
69725	Bilateral Surgery Indicator = 1
69740	Bilateral Surgery Indicator = 1
69745	Bilateral Surgery Indicator = 1
69799	Bilateral Surgery Indicator = 1
69801	Bilateral Surgery Indicator = 1
69802	Bilateral Surgery Indicator = 1
69805	Bilateral Surgery Indicator = 1
69806	Bilateral Surgery Indicator = 1
69820	Bilateral Surgery Indicator = 1

CPT/HCPCS	ACTION
69840	Bilateral Surgery Indicator = 1
69905	Bilateral Surgery Indicator = 1
69910	Bilateral Surgery Indicator = 1
69915	Bilateral Surgery Indicator = 1
69930	Bilateral Surgery Indicator = 1
69949	Bilateral Surgery Indicator = 1
69950	Bilateral Surgery Indicator = 1
69955	Bilateral Surgery Indicator = 1
69960	Bilateral Surgery Indicator = 1
69970	Bilateral Surgery Indicator = 1
69979	Bilateral Surgery Indicator = 1
96400	PC/TC = 0
96408	PC/TC = 0
96425	PC/TC = 0
96520	PC/TC = 0
96530	PC/TC = 0
0001T	Co-Surgery Indicator = 2

Source:

Related Change Request (CR) #: 3415

Medlearn Matters Number: MM3415

Related CR Release Date: August 13, 2004

Related CR Transmittal #: 278

Effective Date: January 1, 2004

Implementation Date: October 4, 2004

## Medicare Payments for Part B Mental Health Services

The Office of Inspector General (OIG) recently studied the appropriateness of Medicare Part B payments for mental health services and recommended that we promote provider awareness of the requirements for payment of these services. OIG reports can be accessed at <http://www.oig.hhs.gov/oei/oeisearch.html>.

This article explains Medicare’s guidelines for payment of Part B mental health services including qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for evaluation and management (E/M) services involving a general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment.

### QUALIFICATION REQUIREMENTS FOR MENTAL HEALTH PROVIDERS

Providers of mental health services must be qualified to perform the specific mental health services that are billed to Medicare. In order for services to be covered, mental health professionals must be working within their State Scope of Practice Act and licensed or certified to perform mental health services by the State in which the services are performed. Qualification requirements for mental health professionals are listed below.

- A qualified physician must:
  - (1) Be legally authorized to practice by the State in which he/she performs the functions or actions, and
  - (2) Be acting within the scope of his/her license.

■ A clinical psychologist must:

- (1) Hold a doctoral degree in psychology; and
- (2) Be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he/she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Refer to regulations found at 42 CFR §410.71 and the Medicare Carriers Manual Part 3, Chapter II, §2150 for the covered services of a clinical psychologist.

■ A clinical social worker must:

- (1) Possess a master's or doctor's degree in social work;
- (2) After obtaining the degree, have performed at least two years of supervised clinical social work; and
- (3) Be licensed or certified as a clinical social worker by the State in which the services are performed.

In States that do not provide for licensure or certification as a clinical social worker, the individual must:

- (1) Be licensed or certified at the highest level of practice provided by the laws of the State in which the services are performed; and
- (2) Have completed at least two years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, skilled nursing facility, or clinic.

Refer to regulations found at 42 CFR §410.73 and the Medicare Carriers Manual Part 3, Chapter II, §2152 for the covered services of a clinical social worker.

■ A nurse practitioner must:

- (1) Be a registered professional nurse who is authorized to practice as a nurse practitioner delivering mental health services by the laws of the State in which services are furnished; and
- (2) Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners, or be:

- ✦ A registered professional nurse who is authorized to practice as a nurse practitioner by the laws of the State in which the services are furnished, and has been granted a Medicare billing number as a nurse practitioner by December 31, 2000;
- ✦ A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2001; or
- ✦ A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2003, and possesses a master's degree in nursing.

Refer to regulations found at 42 CFR §410.75 and the Medicare Carriers Manual Part 3, Chapter II, §2158 for the covered services of a nurse practitioner.

■ A clinical nurse specialist must:

- (1) Be a registered nurse who is currently licensed to practice in the State where he/she practices and authorized to perform the services of a clinical nurse specialist in accordance with State law;
- (2) Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and
- (3) Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

Refer to regulations found at 42 CFR §410.76 and the Medicare Carriers Manual Part 3, Chapter II, §2160 for the covered services of a certified nurse specialist.

■ A physician assistant must:

- (1) Be a physician assistant who is licensed to practice as a physician assistant by the laws of the State in which services are furnished; and
- (2) Have graduated from a physician assistant educational program accredited by the

Commission on Accreditation of Allied Health Education Programs, or passed the national certification examination administered by the National Commission on Certification of Physician Assistants.

Refer to regulations found at 42 CFR §410.74 and the Medicare Carriers Manual Part 3, Chapter II, §2156 for the covered services of a physician assistant.

### INCIDENT TO SERVICES

Certain nonphysician practitioners such as clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants may have services furnished incident to their professional services. To the extent that they are licensed or authorized by the State to furnish mental health services, these practitioners could have others provide some services as an incident to overall mental health services.

There is no national policy that specifies the qualifications for individuals who may furnish these incidental services. In the absence of national policy, contractors can implement local medical review policies that determine who can furnish mental health services incident to the professional services of these specific nonphysician practitioners. Therefore, inconsistencies may be found in policy in terms of billing and payment to nonphysician practitioners for incident to mental health services.

The requirements found in the Medicare Carriers Manual Part 3, Chapter II, §2050.1 are also applicable to services furnished incident to the professional services of certain nonphysician practitioners. Refer to the following requirements found on the American Psychological Association's (APA) web site at <http://www.apa.org/practice/medincident.html>:

- Qualifications of Ancillary Personnel
- Graduate Medical Education (GME). (Current psychiatric residency programs require the teaching physician to be present during the “key portion” of any service in which a resident is involved. This would require either direct observation of the service, or use of a one-way mirror or video equipment (emphasis added). Thus, if psychiatry interns provide services, they must be observed.)

### REASONABLE AND NECESSARY SERVICES

Section 1862(a)(1)(A) of the Social Security Act states that all Medicare Part B services, including mental health services, must be “reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.” For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service.

Partial hospitalization programs are structured to provide intensive psychiatric care through active treatment for patients who would otherwise require inpatient psychiatric care. These programs are used to prevent psychiatric hospitalization or shorten an inpatient stay and transition the patient to a less intensive level of care.

### REASONABLE EXPECTATION OF IMPROVEMENT

Services must be for the purpose of diagnostic study or be reasonably expected to improve the patient’s condition. The treatment must, at a minimum, be designed to reduce or control the patient’s psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning.

The goal of a course of therapy is not necessarily restoration of the patient to the level of functioning exhibited prior to the onset of illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. “Improvement” in this context is measured by comparing the effect of continuing treatment versus discontinuing it.

Where there is a reasonable expectation that a patient’s condition would deteriorate, relapse further, or require hospitalization if treatment services are withdrawn, this criterion would be met.

### GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

Medical record documentation is required to record pertinent facts, findings, and observations about a patient’s health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient, and is an important element contributing to high quality care. It also facilitates:

- The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time;
- Communication and continuity of care among providers involved in the patient's care;
- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluations; and
- Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of medical and surgical services for Medicare payments include the following, if applicable to the specific setting/encounter:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history;
  - Physical examination findings and prior diagnostic test results;
  - Assessment, clinical impression, and diagnosis;
  - Plan for care; and
  - Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician; Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- CPT and ICD-9-CM codes reported on health insurance claim form should be supported by documentation in the medical record.

#### **DOCUMENTATION GUIDELINES FOR E/M SERVICES INVOLVING A GENERAL PSYCHIATRIC EXAMINATION OR THE SINGLE SYSTEM PSYCHIATRIC EXAMINATION**

Providers should thoroughly familiarize themselves with documentation guidelines for E/M services. These guidelines are available on the Centers for Medicare & Medicaid Services (CMS) web site at:

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

The *Medicare Resident & New Physician Training* manual, Chapter 6, (March 2002 edition) also contains the latest revisions to documentation guidelines for E/M services. Publication is available at <http://www.cms.hhs.gov/medlearn> or upon request from the Medicare Learning Network at <mailto:medlearn@cms.hhs.gov>.

#### **DOCUMENTATION GUIDELINES FOR PSYCHIATRIC DIAGNOSTIC OR EVALUATIVE INTERVIEW PROCEDURES, PSYCHIATRIC THERAPEUTIC PROCEDURES, CENTRAL NERVOUS SYSTEM ASSESSMENT, AND HEALTH AND BEHAVIOR ASSESSMENT**

Providers should follow the documentation guidance for psychiatric diagnostic or evaluative interview procedures and psychiatric therapeutic procedures (CPT codes 90801 – 90802, 90804 – 90899 under the Psychiatry Section), overview and definitions for central nervous system assessment (CPT codes 96100 – 96117), and health and behavior assessment (CPT codes 96150 – 96155) as described in the Physicians' Current Procedural Terminology, which is an annual publication developed by the American Medical Association (AMA). Available from the AMA at:

<http://www.ama-assn.org/ama/pub/category/3113.html>.

Refer to Program Memorandum A-02-129 dated January 3, 2003 for the 2003 update of the Hospital Outpatient Prospective Payment System (OPPS), which provides current revenue and HCPCS codes for the Partial Hospitalization Program. Providers should confer with the local carrier to determine if a local medical review policy has been written regarding documentation requirements.

*Source:*

*Related CR #: N/A*

*Medlearn Matters Number: SE0302*

*Related CR Release Date: N/A*

*Related CR Transmittal #: N/A*

*Effective Date: N/A*

*Implementation Date: N/A*

## Patient Status Code 65 or Implementation of Patient Status Code 65, Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

### Provider Types Affected

Hospitals and other facilities that bill Medicare Fiscal Intermediaries

### Provider Action Needed

This instruction implements Patient Status Code 65, “discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.”

### Background

Field Locator 22 on the UB-92 or electronic equivalent is a **required field** for all Part A inpatient, skilled nursing facility, hospice, home health agency, and outpatient hospital bills. This code indicates a patient’s status as of the “through” date of the billing period.

Currently, hospitals are using patient Status Code 05 for patients discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital, because psychiatric hospitals and psychiatric distinct part units have been included in patient Status Code 05 (previously defined as “discharged/transferred to another type of facility”). This instruction removes these types of hospitals from patient Status Code 05 and assigns them separately identifiable patient Status Code 65.

Also, Medicare identifies psychiatric hospitals by provider number xx-4xxx and psychiatric distinct part units by provider number xx-Sxxx. Payment can be affected when an acute inpatient prospective payment hospital transfers a patient to a psychiatric hospital because psychiatric hospitals are included in the post-acute care transfer policy. Thus, correct coding of this field, which is also a required field, is very important for all providers.

### Implementation

The implementation date for this instruction is January 3, 2005, but the change is effective for claims with a discharge date of April 1, 2004 or later.

### Additional Information

For complete details, please see the official instruction issued to your fiscal intermediary regarding this change. That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #: 3364*

*Medlearn Matters Number: MM3364*

*Related CR Release Date: July 23, 2004*

*Related CR Transmittal #: 237*

*Effective Date: April 1, 2004*

*Implementation Date: January 3, 2005*



# Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003

## Providers Affected

All Ambulance services including volunteer, municipal, private, independent, and institutional providers such as hospitals, critical access hospitals and skilled nursing facilities.

## Provider Action Needed

The new Medicare Prescription Drug, Improvements, and Modernization Act of 2003 (MMA) makes a number of important changes to Medicare payment for ambulance services rendered on or after July 1, 2004.

## What You Need to Know

During the five-year period, July 1, 2004 to December 31, 2009 Fee Schedule will include certain temporary increases in payment.

## What You Need to Do

Make sure your billing staff understands the new changes and bill according to those changes to assure receipt of accurate payment.

## Background

The MMA provides several changes to the payment for ground ambulance services under Section 414 of the Act. Specifically, this section establishes a floor amount for the fee schedule portion of the payment, provides increased payments for urban and rural services, adds an increased payment for ambulance transports originating in certain low density population areas, and provides a 25 percent bonus on the mileage rate for ground transports of 51 miles or greater. These payment changes apply to ground transports only and the air ambulance base and mileage rates remain unchanged. All increases are percentage increases and are cumulative.

More details on these changes are as follows:

### Regional Ambulance FS Payment Rate Floor for Ground Ambulance Transports

To discuss these changes further, we begin with the provision regarding the regional ambulance Fee Schedule (FS) payment rate floor for ground transport services. For services furnished during the period of July 1, 2004, through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground transports is subject to a minimum amount. This minimum depends upon the area of the country in which the service is furnished.

Basically, the country is divided into 9 census divisions and each of those divisions has a regional FS that is constructed using the same methodology as the national FS.

Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national FS rate and the regional rate in accordance with the following schedule:

Year National FS	Percentage	Regional FS Percentage
7/1/04 - 12/31/04	20%	80%
CY 2005	40%	60%
CY 2006	60%	40%
CY 2007 - CY 2009	80%	20%
CY 2010 and thereafter	100%	0%

Where the regional rate is not greater than the national rate, there is no blending and only the national FS amount applies.

**Adjustment to the Ground Mileage Payment Amount for Miles Greater than 50**

For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate for each mile of a transport (both urban and rural points of pickup (POP) that exceeds 50 miles (i.e., 51 miles or greater) when the beneficiary is onboard the ambulance.

The 50 percent increase applied to the rural ambulance FS mileage rate for the first 17 miles of a rural Point of Pickup (POP) continues to apply as it always has under the FS.

For services furnished during the period January 1, 2004 through June 30, 2004, for all ground miles greater than 17 miles, the FS rate equals the urban mileage rate per mile.

**Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports**

For services furnished during the period July 1, 2004 through December 31, 2009, there is a 22.6 percent increase in the FS portion of the base payment for ground ambulance services in low population density rural areas. This increase applies where the POP is in a rural county (or Goldsmith Area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. These rural areas are identified by a zip code with a “B” indicator on the national zip code file.

**Adjustments for FS Payment Rates for Ground Ambulance Transports**

The payment rates under the FS for ground ambulance transports (both the FS base rates and the mileage amounts) are increased for services furnished during the period of July 1, 2004, through December 31, 2006. For services furnished where the POP is urban, the rates are increased by 1 percent and for services furnished where the POP is rural, the rates are increased by 2 percent.

The following chart summarizes the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 payment changes for ground ambulance services that becomes effective on July 1, 2004:

This chart will give you the increase percentage on miles, along with the effective dates of Service

<b>Miles</b>	<b>Effective Dates</b>	<b>Payment Increase*</b>
All rural miles	7/1/04 - 12/31/06	2%
Rural miles 51+	7/1/04 - 12/31/08	25%**
All urban miles	7/1/04 - 12/31/06	1%
Urban miles 51+	7/1/04 - 12/31/08	25%**
All rural base rates	7/1/04 - 12/31/06	2%
Rural base rates (lowest quartile)	7/1/04 - 12/31/09	22.6%**
All urban base rates	7/1/04 - 12/31/06	1%
All base rates (regional fee schedule blend)	7/1/04 - 12/31/09	Floor

Note: \* All payments are percentage increases and all are cumulative.

\*\*Carrier/intermediary systems perform this calculation. All other increases are incorporated into the Medicare Ambulance FS file. However, carriers and intermediaries will continue to apply the applicable FS and reasonable charge/cost blended percentages to determine the payment rates through December 31, 2005, in accordance with the rules of the transition period.

**Additional Information**

Reimbursement for ambulance services will be based on two blended amounts. First, the FS portion of the payment is based on a blend of the national and regional FS amounts. Second, the FS portion is then blended with the reasonable charge/reasonable cost portion during the transition period.

For further information, you may wish to view the actual re-released instruction issued to your Medicare contractor. That instruction can be seen at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R220CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R220CP.pdf).

### Important Dates

These changes will sunset on different dates but all apply beginning with services furnished on July 1, 2004.

*Source:*

*Related Change Request (CR) #: 3099*

*Medlearn Matters Number: MM3099*

*Related CR Release Date: June 25, 2004 re-release date*

*Related CR Transmittal #: 88*

*Note: This is a re-release of this article to reflect the changes made in the re-release of the CR3079.*

*Effective Date: July 1, 2004*

*Implementation Date: July 5, 2004*

## MMA - Medicare Replacement Drug Demonstration

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

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

### Provider Types Affected

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

### Provider Action Needed

#### Impact to You

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

#### What You Need to Know

A signed physician certification will need to be filled out for any of your patients who are applying to participate in this demonstration. By signing this certification, you are certifying that the patient has the condition indicated and you have prescribed or intend to prescribe a coverable drug for this condition in accordance with the demonstration requirements. Your signed certification is necessary for the patient's application to participate in the demonstration to be considered complete.

**For your convenience, physician certification forms may also be faxed to (410) 683-2933.**

**Please note** that nurse practitioners who write prescriptions for these coverable drugs may also sign the certification form.

#### What You Need to Do

Review the list below of coverable conditions and drugs available under this demonstration. If you have any patients you think might be interested and eligible to apply, **let them know.**

Be aware that both Fee-for-Service and Medicare Advantage beneficiaries are eligible to apply for the demonstration. If they would like to request an application or have any questions related to the demonstration, or need assistance completing the application, they can call a toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387). There is also helpful information on our web site ([www.medicare.gov](http://www.medicare.gov)), including an application package that can be downloaded.

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

### Background

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

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

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

For a beneficiary to be eligible for this demonstration, he or she must meet the following criteria:

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

The table below shows the drugs and conditions that will be covered under the demonstration.

### DRUGS COVERED UNDER THE MEDICARE REPLACEMENT DRUG DEMONSTRATION (UPDATED AUGUST 9, 2004)

Demonstration Covered Indication	Drug/Biological— Compound Name (BrandName)
Rheumatoid Arthritis	Adalimumab (Humira) Anakinra (Kineret) Etanercept (Enbrel)
Multiple Sclerosis	Glatiramer acetate (Copaxone) Interferon beta -1a (Rebif, Avonex) Interferon beta -1b (Betaseron)
Osteoporosis (patient must be homebound)	Calcitonin – nasal (Miacalcin – nasal)
Pulmonary Hypertension	Bosentan (Tracleer)
Secondary Hyperparathyroidism	Doxercalciferol (Hectoral)
Paget's Disease	Alendronate (Fosamax) Risedronate (Actonel)
Hepatitis C	Pegylated interferon alfa-2a (Pegasys) Pegylated interferon alfa-2a (PEG-Intron)
CMV Retinitis	Valcyte (Valganciclovir)
Acromegaly Anti-Cancer	Pegvisomant (Somavert)
Cutaneous T-cell Lymphoma	Bexarotene (Targretin)
Non-small cell lung cancer	Gefitinib (Iressa)
Epithelial ovarian cancer	Altretamine (Hexalen)
Chronic Myelogenous Leukemia	Imatinib Mesylate (Gleevec)

Demonstration Covered Indication	Drug/Biological— Compound Name (BrandName)
GI Stromal Tumor	Imatinib Mesylate (Gleevec)
Multiple Myeloma	Thalidomide (Thalomid)
Breast Cancer Stage 2-4 only	Hormonal therapy Anastrozole (Arimidex)
	Exemestane (Aromasin)
	Letrozole (Femara)
	Tamoxifen (Nolvadex)
Prophalactic agent to reduce ifosfamide induced hemorrhagic cystitis	Toremifene (Fareston)
	Mesna-oral tablest (Mesnex)

For more information on this demonstration, please visit [www.medicare.gov](http://www.medicare.gov) or call our toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387) between 8 am and 7:30 pm Eastern time, Monday – Friday. You can also use the toll-free number if you have questions about the demonstration or the application. We also have a beneficiary brochure available that describes the demonstration and its benefits. Copies of the brochure can be requested at: [outreach.mrdd@trailblazerhealth.com](mailto:outreach.mrdd@trailblazerhealth.com)

**Source:**

*Related Change Request (CR) #: N/A*

*Medlearn Matters Number: SE0443 (REVISED)*

*Effective Date: Immediately*

*Implementation Date: Immediately*

## Nurse Practitioners as Attending Physicians in the Medicare Hospice Benefit

**Provider Types Affected**

Nurse practitioners, hospices

**Provider Action Needed**

**Impact to You**

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

**What You Need to Know**

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

**What You Need to Do**

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

**Background**

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

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

A physician will be required to certify the terminal illness and 6 month prognosis. Hospice agencies will bill their Regional Home Health Intermediary for attending physician services performed by a nurse practitioner employed by or under contract to the hospice agency.

Also, nurse practitioners providing attending physician services, who are not employed by or under contract with a hospice agency, will bill the Medicare Local Part B carrier. Medicare Local Part B carriers and intermediaries will pay for these physician services rendered by nurse practitioners on or after December 8, 2003, at the lesser of actual charges or 85% of the physician fee schedule. Instructions for care plan oversight for this provision will be provided under separate instruction.

### Implementation Instructions/Dates

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

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

Regional Home Health Intermediaries (RHHIs) will accept all claims for attending physician services performed by a nurse practitioner in a hospice on or after 12/8/03. Hospice agencies are no longer required to submit copies of Notices of Election (NOEs) to Medicare carriers; **however**, when such agencies bill Regional Home Health Intermediaries (RHHIs), the hospice agency should continue submitting the NOEs to the RHHIs.

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

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

### Related Instructions

The following Internet Only Medicare Manuals (IOM) have been edited with revised and new sections to reflect the requirements to implement section 408 of the Medicare Prescription Drug Improvement and Modernization Act of 2003:

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

### Additional Information

The official instruction (CR3226) 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](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

#### Source:

*Related Change Request (CR) #:* 3226

*Medlearn Matters Number:* MM3226

*Related CR Release Date:* June 15, 2004

*Related CR Transmittal #:* 205

*Effective Date:* December 8, 2003

*Implementation Date:* For providers billing carriers, the implementation date is June 28, 2004; for providers billing intermediaries, use of the GV modifier as described below will be implemented on June 28, 2004 and other intermediary requirements will be implemented on October 4, 2004.

## MMA - Demonstration Project to Clarify the Definition of Homebound

### Provider Types Affected

Home health agencies (HHAs)

### Provider Action Needed

This article is mostly informational, but may be of particular interest to (HHAs) that serve beneficiaries who are taking part in the demonstration effort.

### Background

In accordance with Section 702 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act, or MMA), the Centers for Medicare & Medicaid Services (CMS) will be conducting a two-year demonstration in Massachusetts, Missouri, and Colorado.

The demonstration will be commonly referred to as the Homebound Demonstration. The purpose of the demonstration is to study the efficacy and cost of providing home health services to Medicare beneficiaries with chronic conditions of a specific nature who otherwise would not be deemed homebound under the Medicare program.

HHAs can identify a patient as a demonstration candidate between the period of October 4, 2004 and October 5, 2006. Treatment under this demonstration program is limited to no more than 15,000 beneficiaries. Beneficiaries eligible for this demonstration are those with permanent, severe disabilities who need assistance on a continuing basis with three of five Activities of Daily Living (ADLs), permanent skilled nursing care, and daily attendant visits to monitor, treat, or provide ADL assistance. Beneficiaries must also require technological or personal assistance to leave home, and may not be working outside the home.

The business requirements specified in this article apply only to the Medicare home health benefit and only affect those Regional Home Health Intermediaries (RHHIs) providing payments to HHAs serving Medicare patients within the states covered under the demonstration. In addition, implementation of this demonstration will not require any changes in payments or payment processing under the Home Health Prospective Payment System.

### Additional Information

Upon implementation of the demonstration, providers will be informed that, for the duration of the demonstration in their state, a Medicare patient will be eligible to be considered homebound, without regard to the purpose, frequency, or duration of absences from the home, if the Medicare patient meets all of the following conditions:

1. Is certified by one physician as an individual with a permanent and severe, disabling condition that is not expected to improve;
2. Is dependent upon assistance from another individual with at least three out of the five ADLs specified in the act (eating, toileting, transferring, bathing, and dressing) for the rest of the beneficiary's life;
3. Requires skilled nursing services for the rest of his or her life, and the skilled nursing is more than medication management;
4. Requires an attendant to visit on a daily basis to monitor and treat a medical condition or to assist the beneficiary with ADLs;
5. Requires technological assistance or the assistance of another person to leave the home; and
6. Does not regularly work in a paid position full-time or part-time outside the home.

If a Medicare beneficiary meets these conditions during the demonstration period, providers may refer/enroll this patient for home care whether or not the patient meets the homebound definition.

At enrollment, if the HHA or physician believes that the patient meets the criteria for a demonstration patient, the physician, in signing the Plan of Care (POC), will indicate in the open text remark section that he or she certifies that the patient has a severe and permanent condition and satisfies the requirements of the demonstration.

The HHA and/or physician will enroll and provide services to the patient, inform the patient that he or she is being admitted under a demonstration project of limited duration, and specify the parameters that allow more freedom to leave the home.

The HHA will inform the patient that he or she may take advantage of the more liberal homebound policy only during the demonstration period.

Under the demonstration, the HHA will be encouraged to keep a log of the patients who meet the criteria and were enrolled, and also those who meet the criteria who, for whatever reason, were not enrolled.

For each identified demonstration patient, the HHA will submit to the RHHI a Request for Anticipated Payment (RAP) entering a special code of "HHDEMO" in the remarks field of the claim identifying the patient as part of the demonstration. The HHA will place the same code of "HHDEMO" in the remarks field on any interim claim and end-of-episode claim for that patient as long as the patient meets the demonstration criteria. The HHA will process the RAP and subsequent end-of-episode claim(s) in accordance with standard Medicare claims processing rules.

The RHHI will receive and process the RAP and subsequent claims for payment in accordance with standard Medicare rules. The claim is transmitted to Medicare's Fiscal Intermediary Standard System (FISS), which provides pertinent feedback to the RHHI.

For each identified demonstration patient, the RHHI or FISS will provide the following information on a weekly basis to a designated file address at the CMS data center:

- Home health agency provider number
- Home health agency location
- Patient name
- Medicare health insurance identification number with alphanumeric suffix
- Patient address

Each new weekly file will be appended to the existing file to create a cumulative file on all beneficiaries served under the demonstration.

A CMS Demonstration Support Contractor will access the designated CMS data center file on a regular basis to access information on new demonstration patients. The Support Contractor will notify the patient that he or she has been identified as meeting the requirements of the demonstration, and advise the patient of the opportunity during the demonstration period to leave home frequently and for longer duration than normally allowed while receiving home care under Medicare.

The patient will be encouraged to take advantage of this opportunity and informed that taking advantage of the opportunity will not affect his or her Medicare benefits. The patient will be asked to keep a log of absences from home for the purpose of the evaluation of the demonstration and will be told that he or she may be contacted by the evaluation contractor. The patient will be provided with a toll-free number to answer questions about the demonstration.

After the patient is discharged from home care, the Support Contractor will contact the HHA to request a copy of the plan of care and medical record for each patient. Depending on the evaluation design and number of patients entering the demonstration, the number of records requested may be limited to a number below the 15,000 maximum.

The Support Contractor will monitor enrollment of demonstration patients across the three designated states and will inform CMS when the number of patients nears 15,000. At this point, CMS will inform providers and RHHIs of the cessation of enrollment under the demonstration, if it is before the end of the two-year demonstration period.

The RHHI will provide notification to HHAs in the three states of the cessation of enrollment under the demonstration at the end of the demonstration treatment period, which will be the earlier of the following:

- Notification that the 15,000 enrollment limit has been reached;
- Two years after the start of the demonstration; or
- Such other date as provided by CMS.

Beneficiaries enrolled into the demonstration within 60 days of the 2-year end date of the demonstration (October 5, 2006) will be allowed to continue under the demonstration until the end of that 60-day episode of care.

*Source:*

*Related Change Request #: 3269*

*Medlearn Matters Number: MM3269*

# 2005 DMEPOS Pricing File Record Layout Expansion and New Pricing Procedures for Certain DMEPOS Items based on Modifiers.

## Provider Types Affected

Durable Medical Equipment (DME) Suppliers and Home Health Agencies (HHAs)

## Provider Action Needed

### Impact to You

Medicare will allow for two modifiers effective January 1, 2005 to permit proper payment for DME, prosthetics, and orthotics (DMEPOS).

## What You Need to Know

Please note updated instructions for proper reporting and payment of modifiers AU, AV, and AW when billing for HCPCS codes A4217, A4450, and A4452 and of modifier KF when billing for DME classified as Class III devices.

## What You Need to Do

Ensure that your billing practices comply with changes noted in this article to obtain accurate and timely payment for DMEPOS.

## Background

The following modifiers were added to the HCPCS to identify supplies and equipment that may be covered under more than one DMEPOS benefit category:

Modifiers	Pertaining to:	Relevant HCPCS codes
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply	A4217, A4450 and A4452
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic	A4450 and A4452
AW	Item furnished in conjunction with a surgical dressing	A4450 and A4452

Currently, codes A4217, A4450 and A4452 for tape are the only codes that have been identified that would require use of the modifiers AU, AV, or AW. Providers must report the appropriate modifiers on claims for items identified by codes A4217, A4450, and A4452 that are furnished on or after January 1, 2005.

On January 3, 2005, Medicare systems will have an expanded file format that will allow entry of two modifiers. Until the file is expanded, the complete DMEPOS fee schedule, including modifiers, is available to your intermediary at:

<http://www.cms.hhs.gov/providers/pufdownload/default.asp#dme>

In addition, it provides instructions for proper reporting and payment of modifiers AU, AV, and AW when billing for HCPCS codes A4217, A4450 and A4452, as well as for modifier KF for Class III devices.

Currently, the only situation in which more than one modifier will be used in pricing is when modifier KF is used in conjunction with existing DME modifiers NU, RR, and UE. Elevating/stair climbing power wheelchairs are class III devices. (In previous transmittal 35, dated December 24, 2003). Billing for these devices is as follows:

### HCPCS code K0011

Claims for the base power wheelchair portion of this device are to be billed using HCPCS code K0011 with modifier KF for claims received on or after April 1, 2004, with dates of service on or after January 1, 2004.

### HCPCS code E2300

Claims for the elevation feature for this device should be billed using HCPCS code E2300 for claims with dates of service on or after January 1, 2004.

## HCPCS code A9270

Claims for the stair climbing feature for this device should be billed using HCPCS code A9270 for claims with dates of service on or after January 1, 2004.

Regional Home Health Intermediaries (RHHIs) will not be able to implement the KF modifier until January 1, 2005.

For claims with dates of service prior to January 1, 2005:

- HHAs should note that claims for the base power wheelchair portion of stair-climbing wheelchairs must be submitted with HCPCS code E1399, and RHHIs should pay claims for stair-climbing wheelchair bases billed with code E1399 using the fee schedule amounts for K0011 with the KF modifier.
- All other claims for programmable power wheelchair bases should be paid using the fee schedule amounts for K0011 without the KF modifier.

Effective for claims with dates of service on or after January 1, 2005:

- HHAs must submit modifier KF along with the applicable HCPCS code for all DME items classified by the FDA as class III devices. The fee schedule amounts for K0011, with and without the KF modifier, appear on the online fee schedule file referenced at: [www.cms.hhs.gov/providers/pufdownload/default.asp#dme](http://www.cms.hhs.gov/providers/pufdownload/default.asp#dme)

## Additional Information

The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3300, at:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

### Source:

*Related Change Request (CR) #: 3300*

*Medlearn Matters Number: MM3300*

*Related CR Release Date: July 23, 2004*

*Related CR Transmittal #: 236*

*Effective Date: January 1, 2005*

*Implementation Date: January 3, 2005*

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

## Provider Types Affected

Physicians, providers, and suppliers

## Provider Action Needed

This instruction provides information for updating and implementing the October Quarterly 2004 fee schedule amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). It implements fee schedule amounts for new codes and revises any fee schedule amounts for existing codes that were calculated in error.

## Background

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings (Social Security Act, Sections 1834(a), (h), and (i)). In addition, payment on a fee schedule basis is required for Parenteral and Enteral Nutrition (PEN) by regulations contained in 42 CFR 414.102.

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

- Codes A4363, E1400 thru E1404, K0137 thru K0139, K0168 thru K0181, K0190 thru K0192, K0277 thru K0279, K0284, K0400, K0417, K0419 thru K0439, and K0530 were deleted from the Healthcare Common Procedure Coding System (HCPCS) effective 12/31/1999.

These codes were inadvertently included in the 2004 fee schedule file, and they **are being removed with this update.**

- Codes E1019 and E1021 are also being removed as they are not valid 2004 HCPCS codes.
- The 2004 Puerto Rico schedule amounts for Codes A4351 and A4352 were based on incorrect pricing information. The Durable Medical Equipment Regional Carriers (DMERCs) must revise the base fee schedule amounts for these codes as part of the October quarterly update.
- Codes K0630 thru K0649, representing Lumbar Sacral Orthosis products were added to the HCPCS effective April 1, 2004 and their fee schedule amounts were implemented on July 1, 2004. However, the Centers for Medicare & Medicaid Services has determined that the fee schedule amounts for codes K0630, K0631, K0632, K0634, K0635, K0636, K0637, K0639, K0640, K0642, K0644, K0645, and K0646 were based on incorrect pricing information and has recalculated those fee schedule amounts. The revised amounts will be implemented on October 4, 2004 as part of this update.
- Codes K0650 thru K0669 were added to the HCPCS effective July 1, 2004. Because data is not yet available, implementation of the fee schedule amounts for these items will be delayed until the January 2005 update.



### Implementation

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

### Additional Information

To view the official instruction issued to your DMERC or intermediary on this issue, please see:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R272CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R272CP.pdf)

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

#### Source:

*Related Change Request (CR) #:* 3377

*Medlearn Matters Number:* MM3377

*Related CR Release Date:* August 10, 2004

*Related CR Transmittal #:* 272

*Effective Date:* January 1, 2004 for revised 2004 fee schedule amounts

*Implementation Date:* October 4, 2004

# **October 2004 Quarterly Update of Home Health Common Procedure Coding System (HCPCS) Codes Used For Home Health Consolidated Billing Enforcement**

## **Provider Types Affected**

Physicians, practitioners, and suppliers billing Medicare carriers for services

## **Provider Action Needed**

## **Impact to You**

The HCPCS code **G0329** is being added to Home Health (HH) consolidated billing enforcement.

## **What You Need to Know**

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 reflects the October 2004 update.

## **What You Need to Do**

Affected providers should be aware that **G0329** will not be separately payable for beneficiaries in a Home Health episode as of October 1, 2004.

## **Background**

The Balanced Budget Act of 1997 required consolidated billing of all HH services while a beneficiary is under a HH plan of care authorized by a physician. As a result, billing for all such items and services is to be made to a single HHA overseeing that plan. This HHA is known as the primary agency for Home Health Prospective Payment System (HH PPS) for billing purposes.

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 which Medicare also publishes annually. The lists may also be updated as frequently as quarterly if required by the creation of new HCPCS codes mid-year.

In this update, G0329, Electromagnetic Tx for Ulcers, is being added to enforcement of HH consolidated billing to reflect a mid-year update to the HCPCS lists. Claims for this code for services on or after October 1, 2004, will be subject to this enforcement.

## **Additional Information**

This article provides the quarterly HH consolidated billing update effective October 1, 2004. Quarterly updates were not needed for April or July 2004. This is the only quarterly update for calendar year 2004. The next changes to the HH consolidated billing code list will come with the annual update for calendar year 2005.

The full descriptor for G0329 is as follows:

<b>Code</b>	<b>Description of Code</b>
G0329	Electromagnetic Tx for Ulcers - Electromagnetic therapy to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care.

There is a home health consolidated billing master code list available on the CMS Web site. You may access this list by going to: <http://www.cms.hhs.gov/providers/hhapps/#billing>

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

Source:

Related Change Request (CR) #: 3350

Medlearn Matters Number: MM3350

Related CR Release Date: July 9, 2004

Related CR Transmittal #: 226

Effective Date: October 1, 2004

Implementation Date: October 4, 2004

## Rural Health Fact Sheets

Four new rural health Fact Sheets that contain rural health information, definitions, helpful rural health resources, and Medicare Prescription Drug, Improvement and Modernization Act of 2003 enhancements (if applicable) are now available on the Medicare Learning Network Website at [www.cms.hhs.gov/medlearn/pubs.asp](http://www.cms.hhs.gov/medlearn/pubs.asp).

The Fact Sheets are entitled:

- Rural Health Clinic
- Sole Community Hospital
- Federally Qualified Health Center
- Critical Access Hospital Program

Source: JSM 337 dated July 22, 2004

The screenshot shows the Medicare Learning Network website interface. The header includes the CMS logo and navigation links for Home, About CMS, FAQs, Feedback, and Search. Below the header, there are tabs for Professionals, Governments, Consumers, and Public Affairs. The main content area is titled 'Downloadable Publications' and lists various resources. A sidebar on the left contains a navigation menu with categories like Programs, Topics, and Resources. The main list includes items such as 'General Medicare Program Information', 'What Physicians and Other Suppliers Should Know About Medicare Reimbursement', and 'Reference Guide for Medicare Physician & Supplier Billing'. Each item includes a brief description and a PDF file size.

Section	PDF File Size
SECTION 1: WHO IS MEDICARE	432 KB
SECTION 2: BECOMING A PROVIDER	486 KB
SECTION 3: SUBMITTING CLAIMS	124 MB
SECTION 4: PROVIDER & PATIENT RESPONSIBILITIES IN RHC PROGRAM	171 MB
SECTION 5: PROVIDING QUALITY CARE	127 MB
SECTION 6: PROVIDING QUALITY CARE	175 MB
SECTION 7: WHO IS TRP/CA	125 MB
SECTION 8: PROVIDER SPECIALTY LISTING	21 KB
SECTION 9: FROM CLASSROOM	124 KB
SECTION 10: HONORARY CLERKS	29 KB
SECTION 11: FROM CLASSROOM	228 KB
SECTION 12: CLAIM ASSIGNMENT LISTING	488 KB
SECTION 13: HONORARY CLERKS	119 KB
SECTION 14: CLAIMS	30 KB
SECTION 15: HONORARY CLERKS	14 KB
SECTION 16: HONORARY CLERKS	88 KB

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