

**TO: All Providers**  
**FROM: CareFirst of Maryland, Inc.**  
**DATE: June 6, 2002**  
**SUBJECT(S): Important Notice to All Providers**  
**New Patient Status Code 64**

**Clarification to Periodic Interim Payments (PIP) For Home Health Providers and Clarification on Extension of Due Dates for Filing Provider Cost Reports**

**Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes**

**Additional Clarification for Medical Nutrition Therapy (MNT) Services**

**Blood Deductible Claims Update**

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### **Important Notice to All Providers**

The Centers for Medicare and Medicaid Services has mandated that all bulletins/newsletters will not be printed and mailed between July and September 2002. However, we will continue to post all bulletins/newsletters on our web site at [www.marylandmedicare.com](http://www.marylandmedicare.com).

We anticipate that we will resume mailing bulletins/newsletters beginning in October 2002.

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### **New Patient Status Code 64**

Effective for discharges on or after October 1, 2002, the National Uniform Billing Committee has approved a new patient status (PS) code for Field Locator (FL) 22 or electronic equivalent of the UB-92.

**64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.**

The FL 22 is a required field for all Part A inpatient, skilled nursing facilities (SNF), hospice, inpatient rehabilitation facilities (IRF), and outpatient hospital services and indicates the patient's status as of the "Through" date of the billing period.

The PS code 64 does not affect payment for acute care hospitals, SNFs, hospices, or outpatient hospitals, but these facilities are still required to use this code when appropriate. For standard system assignment of review codes in the inpatient pricer, 64 should be treated like PS code 04.

When IRFs use PS code 64, their payment will be affected under the transfer provision of IRF PPS. Previously, IRF providers were instructed to code PS code 03, whether the nursing facility was a Medicare or Medicaid certified nursing facility. (See Program Memorandum A-01-110, dated September 14, 2001.) Now, providers will code 03 when discharging/transferring to a SNF and 64 when discharging/transferring to a Medicaid-only nursing facility. The applicable transfer PS codes for IRF PPS are 02, 03, 61, 62, 63, and 64.

**(Source: Program Memorandum A02-041; Change Request 2093)\_**

**The effective date for this instruction is October 1, 2002.**

**The implementation date for this instruction is October 1, 2002.**

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**Clarification to Periodic Interim Payments (PIP) For Home Health Providers and  
Clarification on Extension of Due Dates for Filing Provider Cost Reports**

The purpose of this instruction is to clarify information in Transmittal A-02-007 (Change Request (CR) 1557) and in Transmittal A-01-149 (CR 2012).

**Addendum to PIP for Home Health Providers**

For Transmittal A-02-007 (CR 1557), the as-filed cost reports must reflect all payments received with respect to the cost period, including the one-time PIP provided by the Benefits Improvement Protection Act. Tentative settlements for cost reports containing the one-time PIP should be made no earlier than 45 days and no later than 90 days after the acceptance of a providers cost report.

**Extension of Due Dates for Filing Provider Cost Reports**

For Transmittal A-01-149 (CR 2012), fiscal intermediaries must make tentative settlements within 90 days after the acceptance of a providers cost report. The providers affected are identified in CR 2012 with cost report year ending dates between August 2000 and May 2002. The 90 days is a one-time exception to the 60 day requirement in Transmittal A-01-82 (CR 1468). This exception is for cost report ending dates between August 2000 and May 2002 only.

**(Source: Program Memorandum A-02-042; Change Request 2158)**

**The effective date for this instruction is June 1, 2002.**

**The implementation date for this instruction is June 1, 2002.**

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**Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes**

This is a correction notice to Program Memorandum (PM) AB-02-042, CR 2060, dated April 1, 2002. In the original PM, the applicable bill type included the 23X.

**This bill type is not appropriate for billing of the peripheral neuropathy with loss of protective sensation in people with diabetes.**

All other information and instructions stated in PM AB-02-042, CR 2060 remain in effect.

**(Source: A-02-039; Change Request 2184)**

**The effective date for this instruction is July 1, 2002.**

**The implementation date for this notice is July 1, 2002.**

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**Additional Clarification for Medical Nutrition Therapy (MNT) Services**

No claims for Medical Nutritional Therapy are to be paid by Fiscal Intermediaries. This service is not billable to the Fiscal Intermediary. **All claims for this benefit must be submitted by providers to their local Medicare Carrier on a Form HCFA-1500 or the appropriate electronic format.** There is no separate facility payment for this new benefit. Payment will not be made for HCPCS codes 97802, 97803 or 97804 if billed by a provider on the UB92.

**(Source: Program Memorandum AB-02-059; Change Request 2142)**

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**Blood deductible Claims Update**

There is a problem with the Outpatient Prospective Payment System (OPPS) PRICER software that is resulting in the suspension of all claims for which a blood deductible should be applied. This problem has existed since the implementation of the OPPS. The PRICER is scheduled to be fixed with the January 2003 release, at the earliest. The Centers for Medicare & Medicaid Services (CMS) is therefore approving a work around to allow processing of these claims.

The blood deductibles apply only to whole blood (revenue code 382) and packed red cells (revenue code 381). The other components of blood are not subject to the blood deductible and are covered as biologicals. Fiscal intermediaries will change the revenue code on the affected claims to 389 (other blood). Value codes 37 (pints used) and 39 (pints replaced) will also be removed from the affected claims. The claims will then go through both the standard system and common working file (CWF). **The effect of this action is that CMS will be waiving the beneficiaries' blood deductible on these claims.**

Blood Deductibles will be applied appropriately once the systems fix is implemented.

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

**Questions regarding this bulletin should be directed to the provider relations department at (866) 488-0545.**