Medicare B Resource

FOCUSED INFORMATION for MEDICARE B PROVIDERS in CA, ME, MA, NH, and VT

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This bulletin should be shared with all healthcare practitioners and managerial members of the physician/supplier staff. Bulletins are available at no cost from our website at **www.medicarenhic.com**

CMS CENTERS for MEDICARE & MEDICAID SERVICES

NATIONAL HERITAGE INSURANCE COMPANY

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ALL	**All Specialties**	DRG	**Drugs and Biologicals**	PHY	**Physicians**
AMB	**Ambulance**	DRM	**Dermatology**	PM	**Preventive Medicine**
ANS	**Anesthesia**	ESR	**End Stage Renal Disease**	POD	**Podiatry**
ASC	**Ambulatory Surgery Center**	EYE	**Ophthalmology/Optometry**	PT	**Physical/Occupational Therapy**
CAR	**Cardiology**	LAB	**Laboratory/Pathology**	RAD	**Radiology**
CHI	**Chiropractic**	MH	**Mental Health**	SRG	**Surgery**
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Medicare is Changing: Reconfiguring A/B Contractors

Many of you are aware of the most talked-about changes resulting from the December 2003 "Medicare Modernization Act," such as the "Part D" drug benefit which will be implemented on January 1, 2006. Less on the public radar is a large-scale revamping of the Part A, Part B contractor system, originating in Part 991 of the Act. Between 2006 and 2009, CMS will be phasing in an entirely new program organization for contractors. The United States will be divided into 14 geographies of several adjacent states and one contractor will manage **both** Part A and Part B in each region.

Currently, there are some 20 contractors for Part B and (in almost all geographies) separate contractors for Part A. Under Part B, there are a few single-state contractors (for example, Regence for Utah Part B), and many several-state contractors, including NHIC (California and New England), Noridian (up to 9 states), and others. In the new system, California, Nevada, and Hawaii will constitute "Region 1" for both Part A and Part B. Only some of the regions will transition in a given year. For Region 1 and several other regions, contractors will bid for the new contracts in September 2006 and, allowing for transition mechanics, this set of new contracts will initiate late in 2007.

Several factors motivate this change. Many experts have written that the current configuration of Part A and Part B is a legacy of the configuration of separate Blue Cross and Blue Shield plans in the 1960s. From the beginning, claims processing and medical review functions of Medicare have been run by contractors. In the 1960s, separate Blue Cross and Blue Shield plans could manage Part A and Part B benefits individually. As regions transition to unified Part A/Part B contractors, the new system will provide a more unified face for both providers and beneficiaries. It will be easier to coordinate claims processing issues between Part A and Part B (for example, verifying that a claim for a Part B ambulance trip to a hospital actually occurred with arrival and care at the hospital). The unification should also help support Medicare's plans to create more opportunities for coordination of care between inpatient care, facility care, and office care. There should also be some elimination of administrative redundancies which will lower Medicare's administrative cost.

The CMS home page for the entire Medicare Modernization Act is found at: **http://www.cms.hhs.gov/medicarereform/**

A home page devoted to contractor reform is found at: **http://www.cms.hhs.gov/medicarereform/contractingreform/**

Medicare Myths

Physicians in Southern California may have seen an editorial by the Ventura County Medical Association (VCMA) appearing in the March 2005 issue of *Southern California Physician:* **http://www.socalphys.com/mar05/**

The author described effects of Comparative Billing Reports which are provided by Medicare carriers in most jurisdictions. I will discuss these in more detail below, but in part the author conveyed his viewpoint that:

> Here at the VCMA, we have little doubt that the care provided was necessary. Little doubt that it was well documented. Little doubt that, on average, each encounter met the E&M criteria for the amount billed. And every confidence that *these facts are of no concern to the carrier* or possibly even to the Centers for Medicare and Medicaid Services (CMS).Their focus is strictly on payment reduction in the narrow view and care expansion at no additional cost (to them) in the wide view. [emphasis added]

The topic at issue is Comparative Billing Reports, and NHIC would like to make three points in response.

1. What are CBRs?

Comparative Billing Reports (CBRs) are a required step in CMS's medical review program entitled "Progressive Corrective Action". Providers may be concerned by the term "progressive", implying that something gets bigger or worse. However, the point of the term is "progressive" in the sense that any activity usually starts very small. Congress and CMS want to avoid the scenario where the provider's first contact with Medicare is a substantial overpayment issue.

Now, Medicare contractors are required to undertake data analysis for outlying claims patterns. With very limited staff and some 60 million claims per year, and disbursing over $6 billion of care, the first step in detecting anomalies is statistical. I can assure readers there are a small subset of providers abusing or defrauding the system, sometimes in eye-popping ways, and nearly the only way to detect this is statistical.

However, we are required to take a somewhat broader approach than simply examining (say) an ophthalmologist who suddenly submits $200,000 of claims for anal manometry. For example, if most providers in a certain county and specialty bill care spread across several E/M codes, and a provider bills 90% or 100% of his care with the highest code, he may receive a comparative billing report with bar graphs reflecting this fact. The provider may be unaware of exactly how his care is coded and billed, for example.

I want to emphasize, as Medical Director, that NHIC is fully aware that such a pattern is only a numeric, statistical pattern and the care provided may be fully appropriate and coded correctly. We are also fully aware of the issues under hot discussion for nearly a decade regarding E/M coding principles and practices. In the vast majority of cases, there is no follow-up action other than the CBR. I was told at a recent meeting that "a letter from the government is never good news." However, I can assure providers that the only intention is to inform providers of **data that already exists** in the existing claims patterns; it is not "new" data. Given resources, CMS could simply send CBRs to all providers automatically, to eliminate any sense that outlying patterns were singled out through a metric that was unfair.

Medicare is Changing: Reconfiguring A/B Contractors (Continued)

2. Are CBRs pointless?
That said, an independent standard for E/M evaluations is the national CERT program, in which an independent contractor audits over 100,000 random claims a year across the nation. Among errors on E/M codes cited to California providers in this random national process, some 70% represent the same very small proportion of providers who would qualify for an NHIC-originated CBR.

These two activities are independent (statistical profile of a practice based on claims data, and manual review of a random actual paper medical record by an independent auditor). This suggests that among the several percent of providers who might receive a CBR in California, most would have an anomaly under the external CERT review program if actual paper records were reviewed. **In other cases**, we are fully aware that care and coding underlying the billing pattern could be fully appropriate to the details of the provider's practice, and we have revised our cover letter to state this even more clearly.

3. "Strict focus of the carrier."
Like other government contractors (Boeing, for example), Medicare contractors are responsible for voluminous metrics. These range from call center wait time to enrollment processing accuracy to other diverse metrics. There is no metric whatsoever related to the year-to-year change in Medicare costs in California. There is general guidance to conduct medical review activities in a commonsensical way (for example, not to spend $80 reviewing a $5 claim). There is definitely a metric for claims processing **accuracy**, regarding ongoing random audits which sample from all our paid claims for underpayment or overpayment. Readers should note that broader issues like the annual update to the fee schedule are national issues determined by Congress, whose rules are applied by the Medicare agency.

Medical Director's Bookshelf
Actually, in this case, it is not really a bookshelf but more of a magazine rack. The current director of the agency, Dr. Mark McClellan, is a former Stanford physician with a PhD in economics who has worked at the national level in health policy issues and headed the FDA for several years. In March, Dr. McClellan gave a talk to the American Enterprise Institute on changes in Medicare and the future of Medicare. As of press time, this 15-page talk was available on the AEI website:
http://www.aei.org/docLib/20050329_McClellan.pdf

Also at press time, an article was available on the New Yorker magazine's website by physician-columnist Atul Gawande entitled "Piecework: Medicine's money problem" (New Yorker, April 4, 2005). Dr. Gawande describes at some length his first experience as a resident negotiating his first job and facing the world of insurers and fee schedules:
http://www.newyorker.com/fact/content/articles/050404fa_fact

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Message from the Medical Director for ME, MA, NH, VT

Everyone's time is short and the issue is long, but I wanted to highlight a few topics.

- Expansion of coverage for chiropractic services demonstration (Maine only) - Maine is one of four states in the country included in this 2 year demonstration project.
- CMS seeks provider input on satisfaction with Medicare fee for service contractor services - let CMS know all the good things you think about NHIC!

As always, a number of new, revised, and retired LCDs are published in the *Resource*. There is a new LCD on CPT Category III Codes which requires that documentation clearly supporting the medical necessity of the procedure must be submitted with the claim. When documentation is submitted, the procedure will be reviewed on an individual consideration basis. Five LCDs were revised, Molecular Diagnostics, Skin Substitute, Virtual Colonoscopy, and Intravenous Immunoglobulin.

Although not covered in this *Medicare B Resource*, please remember to respond to requests for documentation associated with the Contractor Error Rate Testing (CERT) program, CMS's process to measure both the paid claims error rate and the provider compliance error rate. Documentation not sent in is counted as an error, resulting in loss of payment and potentially more scrutiny of your specialty. The following table shows those five specialties with the highest annual projected improper payments for NHIC-NE.

Specialty	Projected Improper Payments (millions)	Provider Compliance Error Rate
Internal Medicine	$68.9	26.0%
Cardiology	$37.1	27.1 %
Family Practice	$28.8	40.8 %
Nephrology	$16.0	25.5 %
Emergency Medicine	$12.0	25.0 %

Please feel free to contact me with any questions.

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July is Glaucoma Awareness Month

Glaucoma may cause blindness. Medicare helps pay for a yearly dilated eye exam for people at high risk for Glaucoma. African-American people over 50, and people with diabetes or a family history of glaucoma, are at higher risk. Have patients talk to you to learn if this exam is right for them.

Editor's Note

NHIC Free Electronic Mailing List

NHIC encourages you to join our free electronic mail list for weekly Medicare updates from the NHIC Website. These emails contain information published in the latest *Medicare B Resource* and CMS regulations on coding and billing issues.

To join, go to the NHIC Website: **http://www.medicarenhic.com**, click on "Join our Mailing List", complete the information, and submit.

Ask the Contractor Teleconferences (ACTs)

NHIC - Medicare Part B contractor for California, Maine, Massachusetts, New Hampshire, and Vermont - will host six one-hour ACTs on the following dates:

- June 24 - Billing Tips
- July 22 - Small Providers
- August 11 - Advanced Beneficiary Notices
- August 25 - To Be Announced
- September 16 - To Be Announced
- September 29 - To Be Announced

Medicare providers and staff are encouraged to call in and participate in the conference calls.

Please access the NHIC Website at **http://www.medicarenhic.com**; click on either California or New England Providers, click on Seminars, then click on 'Ask The Contractor Teleconference' for announcements on topics and times, or go to one of the following links: **http://www.medicarenhic.com/ne_prov/seminars_act.shtml** for Maine, Massachusetts, New Hampshire, and Vermont; or **http://www.medicarenhic.com/cal_prov/seminars_act.shtml** for California

At Press Time . . . Future Medlearn Matters . . .

The following CMS Change Requests (CRs) were issued by Centers for Medicare and Medicaid Services for future implementation. The corresponding Medlearn Matters articles were not released for publication at press time but will appear in the next issue of *Medicare B Resource.* If you wish to view the articles when they become available, please check the CMS website at **http://www.cms.hhs.gov/medlearn/matters**

Change Request (CR) Number	CR Issued Date	Subject
CR 3460	9/17/2004	Providing Information for Incident to Services. Full Replacement of CR 3242
CR 3661	2/25/2005	Calculating Payment-to-Cost Ratios for Purposes of Determining Transitional Corrider Payments under the OPPS
CR 3675	1/28/2005	Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients (Supplemental to Change Request 3467)
CR 3741*	4/1/2005	PET for Brain, Cervical, Ovarian, Pancreatic, Small Cell Lung, and Testicular Cancers
CR 3758	3/18/2005	Demonstration for Expanded coverage for chiropractors

***MM3741 - PET for Brain, Cervical, Ovarian, Pancreatic, Small Cell Lung, and Testicular Cancers**
At press time, CMS released Medlearn Matters 3741. For your immediate access, it is posted to the CMS website at: **http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3741.pdf**

The full article will be published in the September 2005 *Medicare B Resource*.

Medlearn Matters Disclaimer

Medlearn Matters articles are prepared as a service to the public and are not intended to grant rights or impose obligations. Medlearn Matters articles may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

1st Update to the 2005 Medicare Physician Fee Schedule Database (CR 3726)

Related Change Request (CR) #: 3726

Related CR Release Date: February 11, 2005

Related CR Transmittal #: 475

Effective Date: January 1, 2005

Implementation Date: April 4, 2005

Medlearn Matters Number: MM3726

Revised

Note: This article was revised on February 24, 2005 to show the correct CR number in the additional information section. All other information in the article remains the same.

Provider Types Affected
Physicians and providers billing Medicare carriers or Fiscal Intermediaries (FIs) for services paid under the Medicare Physician Fee Schedule

Provider Action Needed
Physicians and providers should be aware of the changes to the Medicare Physician Fee Schedule Database, and identify those changes that impact their practice.

Background
CR 3726 amends payment files issued based upon the November 15, 2004, Final Rules for the 2005 Medicare Physician Fee Schedule Database. Many of the changes relate to a National Coverage Determination (NCD) related to G codes and CPT codes for Positron Emission Tomography (PET), which was effective January 30, 2005.

Additional Information
The changes to the fee schedule involve numerous CPT/HCPCS codes. These changes to the 1st Update to the 2005 Medicare Physician Fee Schedule Database are described in an attachment to CR 3726. For complete details, please see the official instruction issued to your carrier/FI regarding this change. That instruction may be viewed at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3726 in the CR NUM column on the right, and click on the file for that CR.

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

The following information is the complete details from the official instruction as mentioned above for the first updates/additions to the 2005 Medicare Physician Fee Schedule Database (MPFSDB). These changes are effective for claims processed on or after January 1, 2005 unless otherwise noted.

Status Code Changes:
Effective for date of service on or after January 30, 2005

- Procedure codes G0030-G0047-TC/26, the status are changed from C (Carrier price the code) to I (Not valid for Medicare purposes. Code not subject to 90 day grace period).
- Procedure codes G0125, G0125-26, G0125-TC, the status is changed from C (Carrier price the code) to I (Not valid for Medicare purposes. Code not subject to 90 day grace period).
- Procedure codes G0210-G0218-T/26, the status is changed from C (Carrier price the code) to I (Not valid for Medicare purposes. Code not subject to 90 day grace period).
- Procedure codes G0220-G0234-TC/26, the status are changed from C (Carrier price the code) to I (Not valid for Medicare purposes. Code not subject to 90 day grace period).
- Procedure codes G0253-G0254- TC/26, the status is changed from C (Carrier price the code) to I (Not valid for Medicare purposes. Code not subject to 90 day grace period).
- Procedure codes G0296,G0296-26, G0296-TC, the status are changed from C (Carrier price the code) to I (Not valid for Medicare purposes. Code not subject to 90 day grace period).
- Procedure codes G0336,G0336-26, G0336-TC, the status are changed from C (Carrier price the code) to I (Not valid for Medicare purposes. Code not subject to 90 day grace period).

1st Update to the 2005 Medicare Physician Fee Schedule Database (CR 3726) (Continued)

- Procedure code 78459-26, the status is changed from R (Restricted coverage) to A (Active Code).
- Procedure codes 78491-78492- TC/26, the status are changed from I (Not valid for Medicare purposes. Code not subject to 90 day grace period) to C (Carrier price the code).
- Procedure codes 78608-78609- TC/26, the status are changed from N (Non covered service) to C (Carrier price the code).
- Procedure codes 78811-78816- TC/26, the status are changed from I (Not valid for Medicare purposes. Code not subject to 90 day grace period) to C (Carrier price the code).

Bilateral Surgery Indicator Changes:

- Procedure code 34900, the Bilateral Surgery Indicator is changed from 0 (Bilateral payment adjustment does not apply) to 1 (Bilateral payment adjust does apply).
- Procedure codes 67950-68135, the Bilateral Surgery Indicator is changed from 0 (Bilateral payment adjustment does not apply) to 1 (Bilateral payment adjust does apply).
- Procedure codes 68320-68750, the Bilateral Surgery Indicator is changed from 0 (Bilateral payment adjustment does not apply) to 1 (Bilateral payment adjust does apply).
- Procedure code 68770, the Bilateral Surgery Indicator is changed from 0 (Bilateral payment adjustment does not apply) to 1 (Bilateral payment adjust does apply).
- Procedure code 68840-68899, the Bilateral Surgery Indicator is changed from 0 (Bilateral payment adjustment does not apply) to 1 (Bilateral payment adjust does apply).

Professional Component (PC) Technical Component (TC) Indicator Changes:

- Procedure Code 0067T, the PC/TC indicator is changed from 0 (Physician service code) to 1 (Diagnostic tests or radiology services. Modifiers 26 and TC can be used with these codes).

Global Surgery Indicator Changes:

- Procedure Codes 54150, the Global Surgery Indicator is changed from XXX (Global concept does not apply) to 000 (Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount).
- Procedure Codes 91034-91040 (TC, 26), the Global Surgery Indicator is changed from XXX (Global concept does not apply) to 000 (Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount).

New Code:

- Procedure Code G0235, Description: PET imaging, any site, not otherwise specified. Short Description: PET not otherwise specified. Procedure code status = N. WRVU= 0.00. Non-Facility PE RVU= 0.00. Malpractice RVU= 0.00. PC/TC indicator = 1. Site of Service = 9. Global = XXX. Multiple Procedure Indicator = 9. Bilateral Procedure Indicator = 9. Assistant at Surgery Indicator = 9. Co-Surgery Indicator = 9. Team Surgery Indicator = 9. Diagnostic Supervision = 9. Effective January 30, 2005.
- Procedure Code G0235-26, Description: PET imaging, any site, not otherwise specified. Short Description: PET not otherwise specified. Procedure code status = N. WRVU= 0.00. Non-Facility PE RVU= 0.00. Malpractice RVU= 0.00. PC/TC indicator = 1. Site of Service = 9. Global = XXX. Multiple Procedure Indicator = 9. Bilateral Procedure Indicator = 9. Assistant at Surgery Indicator = 9. Co-Surgery Indicator = 9. Team Surgery Indicator = 9. Diagnostic Supervision = 9. Effective January 30, 2005.
- Procedure Code G0235-TC, Description: PET imaging, any site, not otherwise specified. Short Description: PET not otherwise specified. Procedure code status = N. WRVU= 0.00. Non-Facility PE RVU= 0.00. Malpractice RVU= 0.00. PC/TC indicator = 1. Site of Service = 9. Global = XXX. Multiple Procedure Indicator = 9. Bilateral Procedure Indicator = 9. Assistant at Surgery Indicator = 9. Co-Surgery Indicator = 9. Team Surgery Indicator = 9. Diagnostic Supervision = 1. Effective January 30, 2005.
- Procedure Code G9033, Description: Amantadine HCL, oral brand, per 100 mg (for use in a Medicare -approved demonstration project). Short Description: Amantadine HCL, oral brand. Procedure code status = X. WRVU= 0.00. Non-Facility PE RVU= 0.00. Malpractice RVU= 0.00. PC/TC indicator = 9. Site of Service = 9. Global = XXX. Multiple Procedure Indicator = 9. Bilateral Procedure Indicator = 9. Assistant at Surgery Indicator = 9. Co-Surgery Indicator = 9. Team Surgery Indicator = 9. Diagnostic Supervision = 9. Effective December 1, 2004.
- Procedure Code G9034, Description: Zanamivir, inhalation powder, administered through inhaler, brand, per 10 mg (for use in a Medicare -approved demonstration project). Short Description: Zanamivir, inh, pwdr, brand. Procedure code status = X. WRVU= 0.00. Non-Facility PE RVU= 0.00. Malpractice RVU= 0.00. PC/TC indicator = 9. Site of Service = 9. Global = XXX. Multiple Procedure Indicator = 9. Bilateral Procedure Indicator = 9. Assistant at Surgery Indicator = 9. Co-Surgery Indicator = 9. Team Surgery Indicator = 9. Diagnostic Supervision = 9. Effective December 1, 2004.

1st Update to the 2005 Medicare Physician Fee Schedule Database (CR 3726) (Continued)

- Procedure Code G9035, Description: Oseltamivir phosphate, oral brand, per 75 mg (for use in a Medicare -approved demonstration project). Short Description: Oseltamivir phosp, brand. Procedure code status = X. WRVU= 0.00. Non-Facility PE RVU= 0.00. Malpractice RVU= 0.00. PC/TC indicator = 9. Site of Service = 9. Global = XXX. Multiple Procedure Indicator = 9. Bilateral Procedure Indicator = 9. Assistant at Surgery Indicator = 9. Co-Surgery Indicator = 9. Team Surgery Indicator = 9. Diagnostic Supervision = 9. Effective December 1, 2004.
- Procedure Code G9036, Description: Rimantadine Hydrochloride, oral brand, per 100 mg (for use in a Medicare -approved demonstration project). Short Description: Rimantadine HCL, brand. Procedure code status = X. WRVU= 0.00. Non-Facility PE RVU= 0.00. Malpractice RVU= 0.00. PC/TC indicator = 9. Site of Service = 9. Global = XXX. Multiple Procedure Indicator = 9. Bilateral Procedure Indicator = 9. Assistant at Surgery Indicator = 9. Co-Surgery Indicator = 9. Team Surgery Indicator = 9. Diagnostic Supervision = 9. Effective December 1, 2004.
- Procedure Code 0067T-26, Short Description: CT colonography; dx. Procedure code status = C. WRVU= 0.00. Non-Facility PE RVU= 0.00. Malpractice RVU= 0.00. PC/TC indicator = 1. Site of Service = 0. Global = XXX. Multiple Procedure Indicator = 0. Bilateral Procedure Indicator = 0. Assistant at Surgery Indicator = 0. Co-Surgery Indicator = 0. Team Surgery Indicator = 9. Diagnostic Supervision = 9.
- Procedure Code 0067T-TC, Short Description: CT colonography; dx. Procedure code status = C. WRVU= 0.00. Non-Facility PE RVU= 0.00. Malpractice RVU= 0.00. PC/TC indicator = 1. Site of Service = 0. Global = XXX. Multiple Procedure Indicator = 0. Bilateral Procedure Indicator = 0. Assistant at Surgery Indicator = 0. Co-Surgery Indicator = 0. Team Surgery Indicator = 9. Diagnostic Supervision = 9.

Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims (CR 3440)

Related Change Request (CR) #: 3440

Related CR Release Date: January 27, 2005 (CR Re-issued)

Related CR Transmittal #: 450

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Medlearn Matters Number: MM3440

Revised

Note: This article was revised on January 31, 2005, to reflect a new CR release date and CR Transmittal number since the CR was reissued. All other information in the article remains the same.

Provider Types Affected
All Medicare Providers

Provider Action Needed

STOP - Impact to You
If you don't submit your Medicare claims electronically, your payments could be affected (unless you meet specific exception criteria mentioned below).

CAUTION - What You Need to Know
ASCA prohibits Medicare from making payments on or after October 16, 2003, for claims that are not submitted electronically. You must submit your claims electronically, unless you meet one of the exceptions listed below.

GO - What You Need to Do
Make sure that your billing staff submits your Medicare claims electronically. Or, if you believe that you meet one of the exception criteria, make sure that you appropriately complete the "Request for Documentation" letter from your carrier or fiscal intermediary to process your claims.

Background
Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires you, with limited exceptions, to submit all your initial claims for reimbursement under Medicare electronically, on or after October 16, 2003.

Further, ASCA amendment to Section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Consequently, unless you fit one of the exceptions listed below, any paper claims that you submit to Medicare will not be paid. In addition, if it is determined that you are in violation of the statute or rule, you may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims (CR 3440) (Continued)

There are some exceptions to this electronic claim submission requirement. They include the following:

- You are a small provider - a provider billing a Medicare fiscal intermediary that has fewer than 25 Full-Time Equivalent employees (FTEs), and a physician, practitioner, or supplier with fewer than 10 FTEs that bills a Medicare carrier;
- A dentist;
- A participant in a Medicare demonstration project in which paper claim filing is required due to the inability of the Applicable Implementation Guide, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to report data essential for the demonstration;
- A provider that conducts mass immunizations, such as flu injections, and may be permitted to submit paper roster bills;
- A provider that submits claims when more than one other payer is responsible for payment prior to Medicare payment;
- A provider that only furnishes services outside of the United States;
- A provider experiencing a disruption in electricity and communication connections that are beyond its control; and
- A provider that can establish an “unusual circumstance” exists that precludes submission of claims electronically.

The process for post-payment based enforcement is as follows:

- Your Medicare contractor will analyze reports displaying the number of paper claims that all providers submitted each quarter.
- By the end of the month following the quarter, selected providers who have submitted the highest numbers of paper claims will be reviewed.
- Medicare contractors will ask these providers to provide information that establishes the exception criteria listed above.

If you, as one such provider, do not respond to this initial “Request for Documentation” letter within 45 days of receipt, your contractor will notify you by mail that Medicare will deny and not pay any paper claims that you submit beginning ninety days after the date of the initial request letter. If you **do** respond to this initial letter, and your response does not establish eligibility to submit paper claims, the contractor will notify you by mail of your ineligibility to submit paper claims. This Medicare decision is not subject to appeal.

In these letters, your Medicare contractor will also tell you how to obtain free and commercially available HIPAA-compliant billing software packages.

If you respond with information that does establish eligibility to submit paper claims, the contractor will notify you by mail that you meet one or more exception criteria to the requirements in Section 3 of the ASCA, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, and you will be permitted to submit paper claims.

However, you will be cautioned that if your situation changes to the point that you no longer meet the exception criteria, you will be required to begin electronic submission of your claims.

If you are permitted to submit paper claims, your carrier/intermediary will not review your eligibility to submit paper claims again for at least two years.

Additional Information

You can learn more about the instructions issued to your carrier/intermediary regarding ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims at: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**

Look for CR 3440 in the CR NUM column on the right, and click on the file for that CR. These instructions provide more detail on what constitutes an “unusual circumstance” that precludes submission of claims electronically.

You might also want to look at the online Manual 100.04, Chapter 24, Section 90, Subsection 5 (Enforcement). You can find this manual at: **http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf**

If you have any questions, please contact your contractor at his toll-free number:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Ambulance - MMA - Medical Review (MR) of Rural Air Ambulance Services (CR 3571)

Related Change Request (CR) #: 3571

Related CR Release Date: February 1, 2005

Related CR Transmittal #: 102

Effective Date: January 1, 2005

Implementation Date: February 14, 2005

Medlearn Matters Number: MM3571

Revised

Note: This article was revised on February 2, 2005 to reflect that CR 3571 was re-issued on February 1, 2005. The CR release date and transmittal number have changed. The article and the related CR3571 were revised to show that the issue applies to rural air ambulance services billing Medicare carriers, as well as those billing Medicare fiscal intermediaries. All other information remains the same.

Provider Types Affected

Providers billing Medicare carriers or fiscal intermediaries (FIs) for rural air ambulance services

Provider Action Needed

STOP - Impact to You

Providers of rural air ambulance services should note that Section 415 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) includes new instructions regarding rural air ambulance services.

CAUTION - What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has revised Chapter 6 "Intermediary MR Guidelines for Specific Services" of the Medicare Program Integrity Manual to include Section 6.4 - Medical Review of Rural Ambulance Services.

GO - What You Need to Do

Be sure to understand these new rules surrounding billing for and medical review of Rural Air Ambulance Services as a result of changes in the MMA.

Background

This article provides information on Medicare's implementation of Section 415 of the MMA, which amends the Social Security Act (SSA) (Section 1834(l)) to provide appropriate coverage of rural air ambulance services. A summary of these changes includes:

Reasonable Requests

When performing a medical review of rural air ambulance claims, your Medicare carrier/ fiscal intermediary must determine if a physician or other qualified medical personnel who reasonably determined or certified that the individual's condition required air transport due to time or geographical factors requested the transport. Medicare considers the following personnel qualified to order air ambulance services:

- Physician,
- Registered nurse practitioner (from the transferring hospital),
- Physician's Assistant (from the transferring hospital),
- Paramedic or Emergency Medical Technician (EMT) (at the scene), and
- Trained first responder (at the scene)

Emergency Medical Services (EMS) Protocols

Please note that the reasonable and necessary requirement for rural air transport can be "deemed" to be met when service is provided pursuant to an established state or regional protocol that has been recognized or approved by the Secretary of the Department of Health and Human Services, which administers Medicare through its Centers for Medicare & Medicaid Services.

Air ambulance providers anticipating transports will be made pursuant to such a state or regional protocol must submit the written protocol to their carrier/FI in advance for review and approval. Your Medicare carrier or intermediary will post instructions for submission of the protocol on its web site.

Your Medicare carrier/intermediary must review the protocol to ensure the contents are consistent with the statutory requirements of 1862(1)(A) directing that all services paid for by Medicare must by reasonable and necessary for the diagnosis or treatment of an illness or injury. The carrier/intermediary will notify you of its protocol review determinations within 30 days of receipt of the protocol. **Remember that you must adhere to all requirements in the Act at 1861 (s) (7) and regulatory requirements at 42CFR 424.10 which directs that all services paid by Medicare must be reasonable and necessary including the requirement that payment can be made only to the closest facility capable of providing the care needed by the beneficiary.**

Ambulance - MMA - Medical Review (MR) of Rural Air Ambulance Services (CR 3571) (Continued)

Prohibited Air Ambulance Relationships
Your carrier/intermediary will not apply the "deemed" reasonable and necessary determination in the following cases:

- If there is a financial or employment relationship between the person requesting the air ambulance service and the entity furnishing the service;
- If an entity is under common ownership with the entity furnishing the service; or
- If there is a financial relationship between an immediate family member of the person requesting the service and the entity furnishing the service.

The only exception to this provision occurs when the referring hospital and the entity furnishing the air ambulance service are under common ownership. Then the above limitation does not apply to remuneration by the hospital for provider based physician services furnished in a hospital reimbursed under Part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.

Reasonable and Necessary Services
Medicare carriers and intermediaries may perform medical review of rural air ambulance claims with "deemed" medical necessity status when there are questions as to whether:

- The decision to transport was reasonably made,
- The transport was made pursuant to an approved protocol, or
- The transport was inconsistent with an approved protocol.

In addition, the carrier/intermediary may conduct a medical review in those instances where there is a financial or employment relationship between the person requesting the air ambulance transport and the person providing the transport.

Additional Information
For purposes of these revised sections of the Medicare Program Integrity Manual, the term "rural air ambulance service" means fixed wing and rotary wing air ambulance services in which the point of pick up of the individual occurs in a rural area (as defined in Section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification published in the *Federal Register* on February 27, 1992 (57 Fed. Reg. 6725).

The official instruction issued to your carrier/intermediary regarding this change, including the revised portion of Chapter 6 of the Medicare Program Integrity Manual may be found at: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**

From that web page, look for CR 3571 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**

Billing for Hemophilia Blood Clotting Factors (Medicare Claims Processing Manual (Pub. 100-04), Chapter 17, Section 80.4) (CR 3755)

Related Change Request (CR) #: 3755 **Medlearn Matters Number:** MM3755

Related CR Release Date: April 8, 2005

Related CR Transmittal #: 521

Effective Date: May 9, 2005

Implementation Date: May 9, 2005

Provider Types Affected
Physicians and providers billing Medicare carriers and intermediaries for blood clotting factors

Provider Action Needed
STOP - Physicians and providers should note that this instruction is based on information contained in Change Request (CR) 3755 which states that **blood clotting factors** not paid on a cost or prospective payment system basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service.

CAUTION - Note: 1) Medicare carriers process claims from noninstitutional providers for blood clotting factors, while 2) blood clotting factor claims from institutional (including claims from hospital-based hemophilia centers) are processed by Medicare Fiscal Intermediaries (FIs).

GO - Be sure billing staff is aware of this requirement.

Billing for Hemophilia Blood Clotting Factors (Medicare Claims Processing Manual (Pub. 100-04), Chapter 17, Section 80.4) (CR 3755) (Continued)

Background
Blood clotting factors not paid on a cost or prospective payment system basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service. As of January 1, 2005, the ASP (average sales price) plus 6% is used.

If a beneficiary is in a covered Part A stay in a Prospective Payment System (PPS) hospital, the clotting factors are paid in addition to the DRG/HIPPS payment (For FY 2005, this payment is based on 95% of Average Wholesale Prices (AWP)). For a Skilled Nursing Facility (SNF) subject to SNF/PPS, the payment is bundled into the SNF/PPS rate.

For hospitals subject to the Outpatient Prospective Payment System (OPPS), the clotting factors, when paid under Part B, are paid based on an Ambulatory Payment Classification, or the APC. For SNFs, the clotting factors, when paid under Part B, are paid based on cost.

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

From that web page, look for CR 3755 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**

Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare Advantage (MA) Plan and Use of the QR Modifier to Identify Patient Registry Participation (CR 3604)

Related Change Request (CR) #: 3604

Related CR Release Date: March 8, 2005

Related CR Transmittal #: 497

Effective Date: January 27, 2005

Implementation Date: January 27, 2005

Implementation Date for QR Modifier: April 4, 2005

Medlearn Matters Number: MM3604

Revised

Note: This article was revised on March 18 to reflect a reissue date and new transmittal number for CR 3604. No other changes were made to the article.

Provider Types Affected
All Medicare providers billing either a Medicare carrier or Fiscal Intermediary (FI) for Implantable Automatic Defibrillators for Medicare beneficiaries who are members of Medicare Advantage plans

Provider Action Needed

STOP - Impact to You
Be aware that CMS is expanding the set of medical indications for the use of implantable automatic defibrillators and this instruction discusses the impact of this change for beneficiaries who are members of a MA plan and receive these services.

CAUTION - What You Need to Know
Effective January 27, 2005, CMS is expanding national coverage for implantable automatic defibrillators by including the following new indications:

1. Patients with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) Class II and III heart failure, and measured left ventricular ejection fraction (LVEF) ≤ 35%;
2. Patients with nonischemic dilated cardiomyopathy (NIDCM) > 9 months, NYHA Class II and III heart failure, and measured LVEF ≤ 35%;
3. Patients who meet all current CMS coverage requirements for a cardiac resynchronization therapy (CRT) device and have NYHA Class IV heart failure;
4. Patients with NIDCM > 3 months, NYHA Class II or III heart failure, and measured LVEF ≤ 35%. (See Note below)

Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare Advantage (MA) Plan and Use of the QR Modifier to Identify Patient Registry Participation (CR 3604) (Continued)

GO - What You Need to Do

Make sure that your billing staffs are aware of these new indications and also the basis for billing Medicare. **Note:** For beneficiaries under a MA plan, payment for defibrillator use effective January 27, 2005 is different for these new indications than it is for previously covered indications. When the beneficiary is under an MA plan, defibrillator use for these new indications is not part of the capitated rates and is to be paid Fee-For-Service (FFS). However, payment for previously covered indications for defibrillators implanted in these beneficiaries will be part of the MA capitated rates and is not to be paid FFS. In addition, data must be collected and reported through an approved data collection mechanism for beneficiaries who receive an implantable automatic defibrillator for the primary prevention (as opposed to secondary prevention) of sudden cardiac death. The above indications are considered primary prevention indications. Additional information regarding the ICD Abstraction Tool is available through a previously issued Special Edition MedLearn Matters Article (SE0517, which is available at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0517.pdf

Background

The Implantable Automatic Defibrillator, consisting of a pulse generator and electrodes for sensing and defibrillating, is an electronic device designed to detect and treat life-threatening tachyarrhythmias. Medicare pays for the use of these defibrillators only for certain clinical indications. Here is a synopsis of the history of indications and payment policies (indicating the effective dates) for implantable defibrillators, leading up to Change Request (CR) 3604:

Indications

July 1, 1991

Documented episode of cardiac arrest due to Ventricular Fibrillation (VF), not due to a transient or reversible cause

July 1, 1999

Documented sustained Ventricular Tachyarrhythmia (VT), either spontaneous or induced by an Electrophysiology (EP) study, not associated with an acute Myocardial Infarction (MI) and not due to a transient or reversible cause Documented familial or inherited conditions with a high risk of life-threatening VT, such as long QT syndrome or hypertrophic cardiomyopathy

October 1, 2003

Coverage was expanded to include coronary artery disease with a documented prior MI, a measured left ventricular ejection fraction ≤ 0.35, and inducible, sustained VT or VF at EP study. (The MI must have occurred more than 4 weeks prior to defibrillator insertion. The EP test must be performed more than 4 weeks after the qualifying MI).

Payment Policies

October 1, 2003 (CRs 2880 & 2992)

For covered defibrillator claims made on behalf of MA (formerly known as M+C) beneficiaries, payment for the expanded coverage (above) would be made on a FFS basis until Medicare capitation rates to MA organizations were adjusted to account for expanded coverage.

Also at this time, system changes were implemented to enable the automatic processing and payment of covered defibrillator claims on a FFS basis when the beneficiary was under a MA plan and the claims included either a KZ modifier attached to the defibrillator procedure codes when billing a carrier or a condition code of 78 when billing a fiscal intermediary.

January 1, 2005 (CR 3301)

Because MA rates have been appropriately adjusted to account for the defibrillator coverage described in CRs 2880 and 2992, covered services for the indications in these CRs will no longer be paid FFS when the beneficiary is under a MA plan.

Now in CR 3604, Medicare announces expanded coverage for implantable defibrillators for additional indications, effective January 27, 2005. These indications are:

- Patients with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) Class II and III heart failure, and measured left ventricular ejectionfraction (LVEF) ≤ 35%;
- Patients with nonischemic dilated cardiomyopathy (NIDCM) > 9 months, NYHA Class II and III heart failure, and measured LVEF ≤ 35%;
- Patients who meet all current CMS coverage requirements for a cardiac resynchronization therapy (CRT) device and have NYHA Class IV heart failure;
- Patients with NIDCM > 3 months, NYHA Class II or III heart failure, and measured LVEF ≤ 35%.

Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare Advantage (MA) Plan and Use of the QR Modifier to Identify Patient Registry Participation (CR 3604) (Continued)

Please note this additional information:

- Since this new coverage exceeds the significant cost threshold for managed care organizations, services related to the newly covered indications will be paid only on a fee-for-service basis for patients enrolled in a managed care plan. To reiterate, for these new indications, Medicare will pay for covered defibrillators on a FFS basis for claims for beneficiaries under MA plans through December 31, 2005. (Coverage guidelines can be found in the National Coverage Determination Manual (NCDM), Section 20.4.). **As a reminder, remember that MA plan beneficiaries are responsible for paying applicable coinsurance, but are not responsible for paying Part A or Part B deductibles (so you should assume that the Part A or Part B deductible has been met). To indicate that the beneficiary is under an MA plan and the services provided are for one of the new indications, providers are to include a KZ modifier for carrier claims and a condition code of 78 for fiscal intermediary claims until the MA capitated rates are adjusted.**
- Payment for previously covered indications for defibrillator use, i.e., those indications approved prior to January 27, 2005, will be part of the MA capitated rates and are not to be paid on a FFS basis for beneficiaries under a MA plan.
- Except for reimbursing for the use of the defibrillators for the new indications, the processing of defibrillator claims for non-MA beneficiaries remains unchanged.
- For indications effective after January 27, 2005, patients must not have:
  - Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;Had a coronary artery bypass graft (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA) within the past 3 months;
  - Had an acute MI within the past 40 days;
  - Clinical symptoms or findings that would make them a candidate for coronary revascularization; or
  - Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year.
  - All patients considered for implantation of a defibrillator must be able to give informed consent.
  - Myocardial infarctions must be documented and defined according to the consensus document of the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction.
  - Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.
  - Providers must be able to justify the medical necessity of devices other than single lead devices. This justification should be available in the medical record.

You should also be aware that Medicare is requiring that patients receiving a defibrillator for the new indications (or for any other indication that is for the primary prevention of sudden cardiac arrest [no history of a previous cardiac arrest]) be enrolled in either a Food and Drug Administration-approved Category B Investigational Device Exemption (IDE) clinical trial, a trial under the Centers for Medicare & Medicaid Services Clinical Trial Policy, or a qualifying data collection system including approved clinical trials and registries to ensure the safety and quality of care.

Initially, CMS will maintain an implantable automatic defibrillator registry using a mechanism that Medicare participating hospitals already use to submit quality data to the Quality Improvement Organizations (QIOs). Hospital staff will fill out the data collection form (supplied by CMS) using the ICD Abstraction Tool and transmit it via QNet (Quality Network Exchange) to the QIO. Iowa Foundation for Medical Care (IFMC) will collect and maintain registry data and the QIOs will be able to ensure the quality of the data by sampling charts. Additional information regarding the ICD Abstraction Tool is available through a previously issued Special Edition MedLearn Article (SE0517), which is available at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0517.pdf

Additional data collection systems (trials or registries) addressing at a minimum the hypotheses specified in this decision must meet the following basic criteria:

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

Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare Advantage (MA) Plan and Use of the QR Modifier to Identify Patient Registry Participation (CR 3604) (Continued)

For purposes of this coverage decision, CMS will determine whether specific registries or clinical trials meet these criteria.

Also, remember that the QR modifier was created for use on Part B claims to identify protocol covered services. The appropriate use of the QR modifier, in defibrillator claims, is to identify patients whose data is being submitted to a registry and to document meeting the coverage requirement for devices implanted for primary prevention of sudden cardiac arrest. Providers should only append the QR modifier on claims submitted on or after April 1, 2005. This modifier is not required when ICD-9-CM codes 427.1 ventricular tachycardia; 427.41 ventricular fibrillation; 427.42 ventricular flutter; 427.5 cardiac arrest; 427.9 cardiac dysrhythmia, unspecified appear on the claim, as these codes identify a patient receiving the device as secondary, not primary prevention, of sudden cardiac arrest.

On the other hand, if none of the above ICD-9 diagnosis codes applies to the device implant, patient data should be submitted to a registry and the QR modiier is required for claims submitted on or after April 1, 2005.

One final note:

- Providers billing Medicare Fiscal Intermediaries should:
- Use the following G codes (payable under OPPS effective October 1, 2003): G0297, G0298, G0299, and G0300. **Note:** These G codes are not payable under the Medicare Physician Fee Schedule and, therefore, should not be billed to Medicare carriers.
- Use the following ICD-9-CM procedure code on 11X type of bills: 37.94
- Providers billing carriers should use procedure code 33249.

Additional Information
You can find more information about Billing for Implantable Automatic Defibrillators for Beneficiaries in an MA Plan by going to: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**

From that web page, look for CR 3604 in the CR NUM column on the right, and click on the file for that CR.

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

CCI - Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 11.1, Effective April 1, 2005 (CR 3688)

Related Change Request (CR) #: 3688

Medlearn Matters Number: MM3688

Related CR Release Date: February 4, 2005

Related CR Transmittal #: 466

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Provider Types Affected
Physicians billing Medicare carriers

Provider Action Needed
This is a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of CCI edits will be effective on April 1, 2005. Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits on the Centers for Medicare & Medicaid Service web site at: **http://www.cms.hhs.gov/physicians/cciedits**

The web site will be updated with the Version 11.1 edits as soon as they are effective.

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

The latest package of CCI edits, Version 11.1, is effective on April 1, 2005. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables: Column 1/Column 2 Correct Coding Edits and MEC Edits.

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

Claims Status Code/Claims Status Category Code Update (CR 3715)

Related Change Request (CR) #: 3715 **Medlearn Matters Number:** MM3715

Related CR Release Date: March 4, 2005

Related CR Transmittal #: 490

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Provider Types Affected
All providers submitting Health Care Claim Status Transactions to Medicare carriers, including Durable Medical Equipment Carriers (DMERCs), and Fiscal Intermediaries (FIs)

Provider Action Needed
This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective July 1, 2005, the Medicare Claims processing system will update its lists of Health Care Claims Status Codes and Health Care Claims Status Category Codes with all applicable code changes posted online with the "new as of 10/04" and prior date designations.

Background
Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets.

Claim Status Category Codes and Claim Status Codes are used in the Health Care Claim Status Response (277) transaction:

- Claim Status Category Codes indicate the general payment status of the claim.
- Claim Status Codes provide more detail about the status communicated in the general Claim Status Category Codes.

These codes are available online at: **http://www.wpc-edi.com/codes/Codes.asp**

Additional Information
The official instruction issued regarding this change can be found at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down the CR NUM column on the right to find the link for CR 3715. Click on the link to open and view the file for the CR.

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

CMS Seeks Provider Input on Satisfaction with Medicare Fee for Service Contractor Services (SE 0513)

Related Change Request (CR) #: N/A **Medlearn Matters Number:** SE0513

Effective Date: N/A

Provider Types Affected
A sample of 8,200 (or 2 percent of) Medicare providers served by 12 Medicare Fee-for-Service contractors (carriers and fiscal intermediaries), including hospitals, Skilled Nursing Facilities (SNFs), rural health clinics, home health clinics, End-Stage Renal Disease (ESRD) facilities, physicians, non-physicians, Durable Medical Equipment (DME) suppliers, and ambulance service providers

Provider Action Needed

STOP - Impact to You
The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your Medicare Fee-for-Service (FFS) contractors (carriers and fiscal intermediaries, including Durable Medical Equipment Regional Carriers (DMERCs) and regional home health intermediaries (RHHIs)). The Medicare Contractor Provider Satisfaction Survey (MCPSS) will be CMS's initial effort to use provider satisfaction as a standard of measurement to evaluate our FFS contractors' performance. CMS values the opinions of the Medicare physician and provider community and understands the important role that FFS contractors play in representing the Medicare program to providers. The MCPSS represents an important opportunity for you to be heard.

CMS Seeks Provider Input on Satisfaction with Medicare Fee for Service Contractor Services (SE 0513) (Continued)

CAUTION - What You Need to Know
The first year of the MCPSS is a pilot. CMS has selected 12 FFS contractors to participate in the pilot: 4 Fiscal Intermediaries (FIs): AdminaStar Federal, Noridian Administrative Services L.L.C., Riverbend GBA, and Empire Medicare Services; 4 Carriers: National Heritage Insurance Company (NHIC), Wisconsin Physician Services (WPS), TrailBlazer Health, and Empire Medicare Services; 2 Durable Medical Equipment Regional Carriers (DMERCs): Health Now New York and AdminaStar Federal; and 2 Regional Home Health Intermediaries (RHHIs): Palmetto GBA and Anthem Health Plans of Maine. A random sample of 8,200 providers (approximately 2% of providers) served by these twelve FFS contractors have been selected to participate in the pilot. If you have been selected, you should have received a notification packet with background information about the pilot, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet web site. The letter also includes a phone number that you can call to request a paper copy of the survey instrument to submit your responses by mail or fax, if you prefer to do so.

GO - What You Need to Do
Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the time to complete and submit your survey responses as soon as possible. The data collection period for the pilot will continue through the end of March.

Background
On January 17, 2005, CMS launched a pilot of the MCPSS. The survey will give providers the opportunity to rate their Medicare contractor on seven administrative functions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider reimbursement.

The survey contains a total of 76 questions and takes approximately 22 minutes to complete. Sampled providers will be able to access the survey on a secure Internet web site or may request a paper copy of the survey and submit via mail or fax. Data collection for the pilot will continue through March 2005. CMS will use the results of the pilot to evaluate and refine the survey instrument, data collection procedures, analysis, and reporting of results for the national survey implementation. The results of the pilot will not be used to evaluate the Medicare contractors' performance. In the future, CMS plans to use the MCPSS to support and assist contractors in using provider feedback to identify and implement "best practices" and quality or process improvement initiatives. CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS.

Additional Information
For questions or additional information about the MCPSS, please visit: **http://www.cms.hhs.gov/providers/mcpss/default.asp**

Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process (CR 3709)

Related Change Request (CR) #: 3709

Medlearn Matters Number: MM3709

Related CR Release Date: February 11, 2005

Related CR Transmittal #: 474

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Provider Types Affected
All physicians, providers, and suppliers billing Medicare Fiscal Intermediaries (FIs) and carriers

Provider Action Needed
This instruction includes information contained in Change Request (CR) 3709 which directs Medicare Contractors (carriers, intermediaries, and Durable Medical Equipment Regional Carriers [DMERCs]) to issue special automated correspondence from their internal systems to physicians, providers, and suppliers informing them that claims that were expected to be crossed over to supplemental payers/insurers (as indicated on a previous Remittance Advice) were not crossed.

Background
Through the national COBA process, Medicare will automatically cross claims over to a supplemental payer/insurer that may pay after Medicare has made its payment decision on the claim. There may be situations (such as claim errors related to HIPPA) that prevent Medicare from crossing a claim over to the supplemental payer/insurer.

In those situations where Medicare is unable to cross the claim, CR 3709 directs Medicare Contractors to issue special automated correspondence to notify physicians, suppliers, and providers when claims previously selected for crossover by Medicare were subsequently unable to be crossed to the supplemental payer/insurer.

Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process (CR 3709) (Continued)

The correspondence sent to the physician, supplier, or provider will contain specific claim information, including the Internal Control Number (ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (if the letter is from an intermediary and the claim was for Part A services), Patient Control Number (if present on the claim), beneficiary name, date of service, and the date the claim was processed. In addition, the letter will include the following message:

"The above claim(s) was/were not crossed over to the patient's supplemental insurer due to claim data errors."

Upon receipt of such correspondence, the physician, supplier, or provider is advised that the claim is not being crossed automatically and the provider may take appropriate action to obtain payment from the supplemental payer/insurer.

Implementation
The implementation date for CR 3709 is July 5, 2005.

Additional Information
Complete details of the COBA Error Notification process are included in the official instruction issued to your carrier/DMERC/intermediary. That instruction may be viewed at: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**

From that web page, look for CR 3709 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/DMERC/intermediary at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

DME - April 2005 Quarterly Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CR 3669)

Related Change Request (CR) #: 3669 **Medlearn Matters Number:** MM3669

Related CR Release Date: January 28, 2005

Related CR Transmittal #: 451

Effective Date: April 1, 2005, for new codes added to the HCPCS, and January 1, 2005, for all other HCPCS codes on the fee schedule

Implementation Date: April 4, 2005

Provider Types Affected
Physicians, providers, and suppliers billing Durable Medical Equipment Regional Carriers (DMERCs) and/or intermediaries

Provider Action Needed
This article is based on Change Request (CR) 3669, and it provides specific information regarding the April quarterly update for the 2005 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

Background
This article provides specific information regarding the April quarterly update for the 2005 DMEPOS fee schedule. The DMEPOS fee schedules are updated on a quarterly basis in order to 1) implement fee schedule amounts for new codes and 2) to revise any fee schedule amounts for existing codes that were calculated in error. Payment on a fee schedule basis is required for:

- Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)), and
- Parenteral and Enteral Nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Note: There are no changes to the PEN fee schedule file for April 2005.

HCPCS code K0670 (addition to lower extremity prosthesis...) is added, effective April 1, 2005 to the list of Healthcare Common Procedural Coding System (HCPCS) accepted by DMERCs and intermediaries.

Also, **HCPCS Code K0671 is being added to the HCPCS effective April 1, 2005** as an accepted code by DMERCs and regional home health intermediaries. This code:

- Describes a rental portable oxygen concentrator system and
- Is to be used when billing Medicare for the portable equipment add-on fee for patients using lightweight oxygen concentrators that can function as both the patient's stationary equipment and portable equipment.

DME - April 2005 Quarterly Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CR 3669) (Continued)

The following HCPCS Codes are to be used to describe combination stationary/portable oxygen concentrators for Medicare billing purposes.

- For claims for combination stationary/portable oxygen concentrators with **dates of service prior to April 1, 2005,** use:
  - HCPCS Code E1390 (stationary oxygen concentrator) with
  - HCPCS Code E0431 (portable gaseous oxygen system).
- For claims with dates of service **on or after April 1, 2005,** use
  - HCPCS Code E1390 (stationary oxygen concentrator) in conjunction **with**
  - HCPCS Code K0671 (portable oxygen concentrator system).

Note: Payment for HCPCS Code K0671 will be based on the current add-on fee schedule amounts for portable oxygen equipment.

Also, the quarterly updates process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual (Pub 100-04, Chapter 23, Section 60). This manual can be accessed at:
http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

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

Additional Information
For complete details, please see the official instruction issued to your DMERC/intermediary regarding this change. That instruction may be viewed at: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**

From that web page, look for CR 3669 in the CR NUM column on the right, and click on the file for that CR.

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

Drugs - Anti-Cancer Chemotherapy for Colorectal Cancer (CR 3742)

Related Change Request (CR) #: 3742

Medlearn Matters Number: MM3742

Related CR Release Date: March 29, 2005

Related CR Transmittal #: 30 and 512

Effective Date: January 28, 2005

Implementation Date: April 18, 2005

Provider Types Affected
Providers and suppliers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs), and fiscal intermediaries (FIs) for anti-cancer chemotherapy

Provider Action Needed
This article is based on information contained in Change Request (CR) 3742, which states that the Centers for Medicare & Medicaid Services (CMS) will cover the off-label use of Oxaliplatin (Eloxatin™), Irinotecan (Camptosar®), Cetuximab (Erbitux™), or Bevacizumab (Avastin™) in clinical trials identified by CMS and sponsored by the National Cancer Institute (NCI).

This national coverage decision does not:
- Modify existing requirements for coverage of these and other anti-cancer chemotherapeutic agents for FDA-approved indications or for off-label indications listed in an approved compendium; or
- Change existing coverage for any off-label uses of these drugs provided outside the clinical trials identified.

Medicare carriers, DMERCs, and intermediaries will continue to make local coverage determinations for medically accepted uses of off-label indications based on guidance provided by the Secretary of the Department of Health and Human Services (DHHS).

Background
On January 28, 2005, CMS announced a National Coverage Determination (NCD) covering the off-label use of certain colorectal anti-cancer drugs in identified clinical trials of colorectal cancer and other cancer types. These clinical trials study the use of one or more off-label uses of these four drugs in colorectal and other cancer types.

Drugs - Anti-Cancer Chemotherapy for Colorectal Cancer (CR 3742) (Continued)

Note: The clinical trials for which these drugs and other items and services are covered appear in Appendix A in the NCD at the following CMS web site: **http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90**

Anti-cancer chemotherapeutic agents are eligible for coverage in a clinical trial setting when the following occurs:
- They are used in accordance with Food and Drug Administration (FDA)-approved labeling;
- Their use is supported in one of the authoritative drug compendia; or
- The Medicare contractor (carriers, Fiscal Intermediaries (FIs), DMERCs) determines an off-label use is medically accepted based on guidance provided by Secretary of DHHS.

Effective for services provided on or after January 28, 2005, CMS covers the following anti-cancer chemotherapeutic agents, which have been approved by the FDA for the treatment of colorectal cancer, when used in clinical trials identified by CMS and sponsored by the National Cancer Institute:
- Oxaliplatin (Eloxatin™)
- Irinotecan (Camptosar®)
- Cetuximab (Erbitux™)
- Bevacizumab (Avastin™)

Under the concept of linking Medicare coverage determinations to clinical studies, the investigational items and services provided in qualified scientific studies are covered (including clinical trials, practical trials, and systematic data collection systems) when:
- They provide for the accrual of supporting evidence of medical necessity; and
- They collect data to support decisions about whether or not a technology is reasonable and necessary.

Note: The list of identified clinical trials for which the routine costs of the items and services are covered appears in the Clinical Trials section of the following CMS web site: **http://www.cms.hhs.gov/coverage**

Non-routine clinical costs include items and services that are provided in either the investigational or the control arms of a clinical trial specified by CMS for coverage. The following non-routine items and services **are not covered** and include items and services:
- Provided solely to satisfy data collection, and that are not used in the direct clinical management of the patient;
- Provided solely to determine trial eligibility;
- Customarily provided by the research sponsors free-of-charge for any enrollee in the trial;
- That are statutorily excluded from Medicare coverage; or
- That do not fall into a benefit category.

This NCD, issued on January 28, 2005, does not withdraw Medicare coverage for items and services that may be covered according to the existing national coverage policy for Routine Costs in a Clinical Trial (See National Coverage Determination Manual, Section 310.1 at the following CMS web site: **http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp)**

Note: The existing requirements for coverage of oxaliplatin, irinotecan, cetuximab, bevacizumab, or other anticancer chemotherapeutic agents for FDA-approved indications or for indications listed in an approved compendium are not modified.

Medicare contractors will continue to make reasonable and necessary coverage determinations under the Social Security Act (Section 1861(t)(2)(B)(ii)(II))based on guidance provided by CMS for medically accepted uses of off-label indications of Oxaliplatin, Irinotecan, Cetuximab, Bevacizumab, or other anticancer chemotherapeutic agents provided outside of the identified clinical trials appearing on the CMS website noted previously.

Some important points to remember when billing Medicare for these anti-cancer drugs are as follows:
- FIs will accept claims for these drugs on types of bill (TOB) 11x, 12x, 13x, 18x, 21x, 22x, 23x, and 85x. Revenue code 0636 should be used.
- When billing carriers, DMERCs and FIs, on a claim other than an inpatient claim, include the QR modifier to show the drug was furnished during a clinical trial.
- Claims submitted to FIs should also contain an ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position to show that the claim involves a clinical trial.
- When using the QR modifier, also be sure to include a HCPCS code of J9035, J9055, J9206, J9263, J8520, J8521, J9190, or J9201, as appropriate for the anti-cancer drug being billed.
- Providers are also to include a QR modifier when billing for nonroutine costs associated with these clinical trials.
- DMERCs will accept claims with HCPCS codes of J8520 and J8521 as clinical trial codes for **oral anticancer** drugs, when accompanied by the QR modifier to show use in a clinical trial.
- When billing for covered routine costs associated with clinical trials as described in section 310 of the NCD Manual, be sure to include a QV modifier on the claim.
- Submit an appropriate cancer diagnosis code for the clinical trial on the claim.

Note: While this NCD is effective as of January 28, 2005, Medicare systems will be unable to process claims containing the QR modifier received before April 1, 2005. For that reason, do not send in claims for drugs or other nonroutine services covered under this NCD until April 1, 2005. Do not hold claims for nonroutine services containing the QV modifier associated with this NCD.

Drugs - Anti-Cancer Chemotherapy for Colorectal Cancer (CR 3742) (Continued)

Additional Information
For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction includes the NCD section 110.17 and it may be viewed by going to:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3742 in the CR NUM column on the right, and click on the file for that CR. You should see two versions of CR 3742 on this web site. The version of CR 3742 with a transmittal number of R30NCD will contain the NCD information and the version with a transmittal number of R512CP will contain the Medicare claims processing instructions.

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

Drugs - MMA - April 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2005, and New January 2005 Quarterly ASP File (CR 3667)

Related Change Request (CR) #: 3667 **Medlearn Matters Number:** MM3667

Related CR Release Date: February 25, 2005

Related CR Transmittal #: 480

Effective Date: January 1, 2005

Implementation Date: April 4, 2005

Provider Types Affected
All Medicare providers

Provider Action Needed

STOP - Impact to You
CR 3667 discusses updates to the new methodology of paying for Medicare Part B covered drugs not paid on the basis of cost or prospective payment.

CAUTION - What You Need to Know
Effective January 1, 2005, Part B covered drugs and biologicals (that are not paid on a cost or prospective payment basis) are paid based on the new Average Sales Price (ASP) drug payment system, described below.

GO - What You Need to Do
Make sure that your billing staffs are aware of these changes.

Background
The Medicare Modernization Act of 2003 (MMA), Section 303(c), revises the methodology of paying for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs are paid based on the new Average Sales Price (ASP) drug payment methodology.

The ASP file, used in the ASP methodology, is based on data CMS receives quarterly from manufacturers. Each quarter, the Centers for Medicare & Medicaid Services (CMS) will update your carrier and Fiscal Intermediary (FI) payment allowance limits with the ASP drug pricing files based on these manufacturers' data.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP, and CMS will update the payment allowance limits quarterly. However, there are exceptions to this general rule as summarized below:

- For **blood and blood products** (with certain exceptions like blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the Average Wholesale Price (AWP) as reflected in the published compendia. **The payment allowance limits will be updated on a quarterly basis.**
- For **infusion drugs** furnished through a covered item of Durable Medical Equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the DME is implanted. **The payment allowance limits will not be updated in 2005.**
- For **influenza, pneumococcal, and hepatitis B vaccines** payment allowance limits are 95 percent of the AWP as reflected in the published compendia. **The payment allowance limits will be updated on a quarterly basis.**

Drugs - MMA - April 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2005, and New January 2005 Quarterly ASP File (CR 3667) (Continued)

- For **drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File** payment allowance limits are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing. In determining the payment limit based on WAC, carriers/FIs will follow the methodology specified in the Medicare Claims Processing Manual for calculating the AWP, but substitute WAC for AWP. Please see Pub. 100-04, Chapter 17 (Drugs and Biologicals) at the following CMS web site: **http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf.** The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting carrier/FI or via posting an MS Excel file on the CMS web site. If the payment limit is available from CMS, carriers/FIs will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File,** payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after December 1, 2004.

The April 2005 and new January 2005 ASP drug pricing files will contain three decimal places in the currency fields. In addition, the new January file contains revised payment limits for some drugs. The codes with a revised payment limit are identified in the column titled "Notes." The absence or presence of a HCPCS code and its associated payment limit in the pricing files do not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier/FI processing your claim will make these determinations.

In addition, your carrier or FI is required to accomplish the following:

- Use the April 2005 ASP and NOC drug pricing files to pay for Medicare Part B drugs effective April 1, 2005. This file shall be used for dates of service from April 1, 2005 through June 30, 2005;
- Determine for any drug or biological not listed in the ASP or NOC drug pricing files, the payment allowance limits in accordance with the policies described in this transmittal, CR3539, dated October 29, 2004 (see **http://www.cms.hhs.gov/manuals/pm_trans/R348CP.pdf),** and CR3232, dated December 16, 2004 (see **http://www.cms.hhs.gov/manuals/pm_trans/R397CP.pdf),** and FIs should seek payment allowances from their local carrier;
- Use the new January 2005 ASP drug pricing file for (1) those claims where the carriers/FIs are asked to retroactively adjust claims processed with the original January 2005 file and (2) those claims with dates of service on or after January 1, 2005 and before April 1, 2005 that are processed after April 4, 2005. **Your carrier or FI shall not search and adjust claims that have already been processed unless brought to their attention;**
- Overlay the old January 2005 file with the new January 2005 file; and
- For any drug or biological for which they (your carrier or FI) calculates a payment allowance limit, forward to CMS the following:
  - The drug name,
  - Dosage,
  - Payment allowance limit, and
  - National Drug Code (if available).

Note: The ASP and NOC drug pricing files will contain the 106 percent ASP, 106 percent WAC or WAC based payment allowance limits; therefore, no additional payment calculation is required by your carrier or FI. The payment limits for the blood clotting factor codes includes the $0.14 per I.U. furnishing fee

Additional Information

The new January 2005 and April 2005 ASP and NOC Pricing Files are available from the following CMS Website on or after March 17, 2005: **http://www.cms.hhs.gov/providers/drugs/asp.asp**

You can find more information about the April 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2005, and New January 2005 Quarterly ASP File at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3667 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

Drugs - New HCPCS Codes for Intravenous Immune Globulin (IVIG) (CR 3745)

Related Change Request (CR) #: 3745 **Medlearn Matters Number:** MM3745

Related CR Release Date: March 18, 2005

Related CR Transmittal #: 507

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Provider Types Affected
Physicians, providers, and suppliers billing Medicare for IVIG

Provider Action Needed

STOP - Impact to You
New HCPCS codes for IVIG will be effective April 1, 2005.

CAUTION - What You Need to Know
Effective April 1, 2005, for dates of service on or after April 1, 2005, codes J1563 and J1564 will no longer be paid by Medicare Fiscal Intermediaries (FIs) and carriers, including Durable Medical Equipment Regional Carriers (DMERCs). Codes J1563 and J1564 will be replaced with HCPCS codes Q9941 - Q9944.

GO - What You Need to Do
These new HCPCS codes are needed to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG. Be sure to bill the new codes when providing these services.

Additional Information
Effective April 1, 2005, the following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG.

HCPCS Code	Short Descriptor	Long Descriptor
Q9941	IVIG lyophil 1G	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED, 1G
Q9942	IVIG lyophil 10 MG	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED, 10 MG
Q9943	IVIG non-lyophil 1G	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, N0N-LYOPHILIZED, 1G
Q9944	IVIG non-lyophil 10 MG	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED, 10 MG

- Based on the above table, providers must bill Q9941 or Q9943, as appropriate, in place of J1563. Similarly, those providers should bill Q9942 or Q9944, as appropriate, instead of J1564.
- Payments for the new Q-codes can be found in the respective quarterly Medicare Part B drug pricing files posted on the CMS web site at: **http://www.cms.hhs.gov/providers/drugs**
- The Medicare Outpatient Code Editor (OCE) will be updated to include these coding changes upon installation of the April 2005 software version 6.1.
- The Outpatient Prospective Payment System (OPPS) for the new Q codes can be found in the April update of OPPS Addendum A and Addendum B on the hospital outpatient web site. OPPS payment is based on the Ambulatory Payment Classification (APC).
- Coverage requirements for IVIG can be found in Chapter 15 of the Medicare Benefit Policy Manual. This manual may be found at: **http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp.** Additional information on IVIG may be found in Chapter 17 (Drugs and Biologicals), Section 80.6 of the Medicare Claims Processing Manual at: **http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp**
- The official instruction issued to your carrier regarding this change may be found at: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**
- From that web page, look for CR 3745 in the CR NUM column on the right, and click on the file for that CR.
- For additional information relating to this issue, please refer to your local carrier or FI. You may find the toll free phone number for your local carrier at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

Drugs - Revisions to January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File (CR 3728)

Related Change Request (CR) #: 3728 **Medlearn Matters Number:** MM3728

Related CR Release Date: February 3, 2005

Related CR Transmittal #: 140

Effective Date: January 1, 2005

Implementation Date: February 5, 2005

Provider Types Affected
All Medicare physicians, providers, and suppliers

Provider Action Needed

STOP - Impact to You
The Centers for Medicare & Medicaid Services (CMS) is revising certain payment limits included in the first quarter 2005 (1Q05) Medicare Part B Drug Pricing File used by Medicare carriers and intermediaries, including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs).

CAUTION - What You Need to Know
Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

GO - What You Need to Do
Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

Background
According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005 drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the new Average Sales Price (ASP) method. The ASP method is based on data submitted to CMS by manufacturers at the 11-digit National Drug Code (NDC) level. CMS then determines the number of billable units per NDC based on published drug pricing information as well as other sources available to CMS.

Through receipt of additional information, CMS has determined certain payment limits in the 1Q05 Medicare Part B Drug Pricing File need revision. Tables 1 and 2 below identify the revised payment limits. The limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. The revised payment limits in this notification supersede the payment limits for these codes in any publication published prior to CR 3728.

Also, note that the ASP-based 1Q05 payment limit for J7510, Q4054, and Q4055 are now provided. The revised payment limit for 90740, a vaccine, is based on 95% of the average wholesale price (AWP). The revised payment limits for the blood clotting factor codes includes the $0.14 per I.U. furnishing fee. The payment limits in Table 2 are for certain new drugs.

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
90740	Hepb vacc, ill pat 3 dose im	3 DOSE SCH	$113.91	$113.91	$113.91
J7190*	Factor viii	I.U.	$0.66	$0.66	
J7191*	Factor viii (porcine)	I.U.	$1.86	$1.86	
J7192*	Factor viii recombinant	I.U.	$1.06	$1.06	
J7193*	Factor ix non-recombinant	I.U.	$0.89	$0.89	
J7194*	Factor ix complex	I.U.	$0.63	$0.63	
J7195*	Factor ix recombinant	I.U.	$0.98	$0.98	
J7197*	Antithrombin iii injection	I.U.	$1.72	$1.72	
J7198*	Anti-inhibitor	I.U.	$1.23	$1.23	
J7510	Prednisone oral per 5 mg	5 MG	$0.05	$0.05	
Q0187*	Factor viia recombinant	1.2 MG	$1,051.45	$1,051.45	
Q2022*	Von Willebrand Factr Cmplx per IU	I.U.	$0.86	$0.86	
Q4054	Darbepoetin alfa, ESRD use	1MCG	$3.54	$3.54	
Q4055	Epoetin alfa, ESRD use	1,000 units	$9.32	$9.76	

* The ASP-based payment allowance limit for blood clotting factors and the furnishing fee for the blood clotting factors do not apply to inpatient claims.

Drugs - Revisions to January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File (CR 3728) (Continued)

HCPCS Code	Drug Name	Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
J3490	Pegaptamib sodium	0.3 MG	$1,054.70	$1,054.70	
J9999	Histrelin implant	5 MG	$530.00	$530.00	
J9999	Natalizumab	5 MG	$31.94	$31.94	

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

Implementation
The implementation date is February 4, 2005.

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

From that web page, look for CR 3728 in the CR NUM column on the right and click on the file for that CR. CMS will also update the Microsoft Excel files on the CMS web site to reflect these revised payment limits. Those files are at:
http://www.cms.hhs.gov/providers/drugs/asp.asp

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

Implementation of the Abstract File for Purchased Diagnostic Tests/Interpretations (Supplemental to CR 3481) (CR 3694)

Related Change Request (CR) #: 3694 **Medlearn Matters Number:** MM3694

Related CR Release Date: February 4, 2005

Related CR Transmittal #: 464

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Provider Types Affected
Physicians and Independent Diagnostic Testing Facilities (IDTFs) billing Medicare carriers for purchased diagnostic tests/interpretations

Provider Action Needed

STOP -
Related CR 3694 **replaces** the requirement in CR 3481 instructing carriers to pay physicians for diagnostic tests and interpretations performed outside of the local carrier's jurisdiction.

CAUTION
All other instructions in CR3481 remain in effect.

GO - What you Need to Do
Medicare carriers will continue to **pay physicians at the local rate, until further notice,** or services purchased outside of the carrier's jurisdiction **when submitted by a physician enrolled in the carrier's jurisdiction.** Physicians should continue to report their name and service facility location on claims for purchased tests/interpretations performed outside of the local carrier's jurisdiction. Physicians use their own PIN to bill for both the purchased portion of the test and the portion of the test that they performed. **Suppliers (laboratories and IDTFs) are to bill local carriers** regardless of where the tests are performed and **carriers are to pay** suppliers **based on ZIP codes.**

NOTE: Physicians should continue to follow the billing instructions provided in Change Request 3630 (Transmittal 415, issued on December 23, 2004) until further notice.

Implementation of the Abstract File for Purchased Diagnostic Tests/Interpretations (Supplemental to CR 3481) (CR 3694) (Continued)

NOTE: This article was revised on March 18, 2005 to include the following message:

Some Medicare carriers use a claims processing system (known as the ViPS Medicare Part B system) to process Medicare claims. These carriers will not implement this change at this time. Those carriers are:

- Empire Medicare Services
- Blue Cross Blue Shield of Kansas
- Triple-S
- GHI

Until further notice, physicians and independent diagnostic testing facilities who bill these carriers should continue to follow the billing instructions provided in CR 3630 issued on December 23, 2004. That CR can be found at:
http://www.cms.hhs.gov/manuals/pm_trans/R415CP.pdf

Also, a corresponding Medlearn Matters article related to CR 3630 may be found at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3630.pdf

Background

CR 3481 instituted a national abstract file of the Medicare Physician Fee Schedule (MPFS) containing Healthcare Common Procedure Coding System (HCPCS) codes billable as purchased diagnostic tests and interpretations for every locality throughout the country. Effective April 1, 2005, suppliers, including laboratories, physicians, and IDTFs, are to bill their local carrier for purchased diagnostics tests and interpretations, regardless of the location where the service was furnished. However, until further notice, CMS is delaying the implementation of the billing instructions specified in CR 3481 for purchased diagnostic service claims **submitted by physicians** due to a locality reporting issue.

Effective April 1, 2005, **carriers should price claims based on the ZIP code of the location where the service was rendered** when submitted by a laboratory or IDTF, using a CMS-supplied abstract file of the MPFS containing the HCPCS codes that are payable under the MPFS as either a purchased test or interpretation for the calendar year. Until further notice, carriers should pay the local rate for purchased interpretation claims when submitted by a physician. **Carriers should accept** and process **claims when billed by suppliers enrolled in the carrier's jurisdiction,** regardless of the location where the service was furnished. **Carriers should allow claims submitted by an IDTF** if the IDTF has previously enrolled to bill for purchased diagnostic test components it performs

Implementation

The implementation date for this instruction is April 4, 2005

Additional Information

To view the official instruction issued to your carrier, visit:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that site, look for CR 3694 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier at their toll-free number, which can be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Importance of Supplying Correct Provider Identification Information Required in Items 17, 17a, 24K, and 33 of the Form CMS-1500, and the Electronic Equivalent (SE 0529)

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0529

Related CR Release Date: N/A

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) would like to remind providers and their billing staffs of the importance of reporting the correct provider identification information in items 17, 17a, 24K, and 33 of the Form CMS-1500, or the electronic equivalent. This information is critical for accurate and timely processing and payment of your claims.

Importance of Supplying Correct Provider Identification Information Required in Items 17, 17a, 24K, and 33 of the Form CMS-1500, and the Electronic Equivalent (SE 0529) (Continued)

Additional Information
Please be aware of the following instructions:

Items 17 and 17a
On the Form CMS-1500, or electronic equivalent, the provider must submit the appropriate referring or ordering physician name in item 17, and the Unique Physician Identification Number (UPIN) of that referring/ordering physician in item 17a. These are required fields when a service was ordered or referred by a physician. When a claim involves multiple referring and/or ordering physicians, you must prepare a separate claim submission for each ordering/referring physician.

Item 17
Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Item 17a
Enter the UPIN of the referring/ordering physician listed in item 17.

- **Referring physician -** is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Oering physician -** is a physician or, when appropriate, a non-physician practitioner who orders nonphysician services for the patient. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name and UPIN. This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services,
- Diagnostic radiology services,
- Portable x-ray services,
- Consultative services, and
- Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list shall also show the ordering/referring physician's name and UPIN. For example, a surgeon shall complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN appear in items 17 and 17a.

When a service is incident to the service of a physician or non-physician practitioner, the name and assigned UPIN of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the local Medicare carrier to obtain the UPIN. A list of toll free numbers of the Medicare carriers is available at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN of the physician supervising the limited licensed practitioner must appear in items 17 and 17a.

When a patient is referred to a physician who also orders **and** performs a diagnostic service, a separate claim form is required for the diagnostic service. Enter the original ordering/referring physician's name and UPIN in items 17 and 17a of the first claim form. Enter the ordering (performing) physician's name and UPIN in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).

Item 24K
Enter the **provider identification number (PIN)** of the performing provider of service/supplier in item 24K if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, or electronic equivalent, show the individual PIN of each performing provider in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in item 24K.

UPINs are not appropriate identifiers for item 24K.

Item 33
Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. **This is a required field.**

For a provider who is **not** a member of a group practice (e.g., private practice), enter the PIN at the bottom of item 33 for paper claims. The PIN should be entered on the **left** side, next to the PIN# field.

Importance of Supplying Correct Provider Identification Information Required in Items 17, 17a, 24K, and 33 of the Form CMS-1500, and the Electronic Equivalent (SE 0529) (Continued)

If a group practice is billing, then the **group PIN** is to be placed in item 33 for paper claims. Enter the group PIN at the bottom of item 33 on the **right** side, next to the GRP# field. Enter the PIN for the performing provider of service/supplier who is a member of that group practice in item 24K.

Suppliers billing a DMERC will use the National Supplier Clearinghouse (NSC) number in this item.

NOTE: When implemented, the National Provider Identification (NPI) number will replace the PIN and UPIN. At that time, you will use the NPI number in items 17a, 24K, and 33.

The above instructions are included Chapter 26 of the Medicare Claims Processing Manual. That manual is available at: **http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp**

The Medicare Benefit Policy Manual may be found at: **http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp**

And, if you have questions, please contact your carrier/DMERC at their toll free number, available at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

Infusion Pumps: C-Peptide Levels as a Criterion for Use (CR 3705)

Related Change Request (CR) #: 3705 **Medlearn Matters Number:** MM3705

Related CR Release Date: February 4, 2005

Related CR Transmittal #: 27 and 471

Effective Date: December 17, 2005

Implementation Date: February 18, 2005

Provider Types Affected
Physicians, suppliers, and providers providing continuous subcutaneous insulin infusion and related drugs/supplies in the treatment of diabetic patients in the home setting and billing Medicare carriers or Fiscal Intermediaries (FIs)

Provider Action Needed

STOP - Impact to You
This article and related CR 3705 adds beta cell autoantibody testing as an alternative diagnostic per the updated C-peptide testing requirement for the use of insulin infusion pumps, effective for services performed on or after December 17, 2004.

CAUTION - What You Need to Know
Providers/suppliers treating Medicare diabetic patients with infusion pumps should be aware of this new Medicare coverage policy.

GO - What You Need to Do
Ensure that your staff is aware of this new coverage and that they bill according to the information in this article.

Background
On August 26, 1999, the Centers for Medicare & Medicaid Services (CMS) issued the first decision memorandum (DM) for continuous subcutaneous insulin infusion pumps (CSII) that utilized a C-peptide testing requirement for Medicare coverage of CSII pump therapy. On May 11, 2001, CMS issued a second DM for insulin pump: "C-Peptide Levels as a Criterion for Use," and on January 1, 2002, CMS revised the laboratory value for the C-peptide testing requirement for Medicare coverage of CSII pump therapy.

Effective for services performed on or after December 17, 2004, in addition to meeting criterion A or B, the beneficiary with diabetes must be insulinopenic per the fasting C-peptide testing requirement or, as an alternative must be beta cell autoantibody positive. Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. For patients with renal insufficiency and a creatinine clearance (actual or calculated from age, gender, weight, and serum creatinine) <50 ml/minute, insulinopenia is defined as a fasting C-peptide level that is less than or equal to 200% of the lower limit of normal of the laboratory's measurement method. CMS establishes that fasting C-peptide levels will only be considered valid when a concurrently obtained fasting glucose is <225 mgdL.

Levels need only be documented once in the patient's medical records.

Coverage of all other uses of CSII that adheres with the Category B IDE clinical trials regulation (42 CFT 405.201) or routine cost under the clinical trials policy (Medicare NCD Manual Chapter 1, Part 4, Section 310.1) will continue.

Those billing for services should note that Medicare carriers will accept, effective for services on or after December 17, 2004, CPT code 84681 (C-peptide) or CPT code 86337 (insulin antibodies) when diagnosis codes 250.00-250.93 are also reported on a claim.

Infusion Pumps: C-Peptide Levels as a Criterion for Use (CR 3705) (Continued)

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

From that web page, look for CR 3705 in the CR NUM column on the right, and click on the file for that CR.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

List of Medicare Telehealth Services (CR 3747)

Related Change Request (CR) #: 3747

Medlearn Matters Number: MM3747

Related CR Release Date: April 1, 2005

Related CR Transmittal #: 31 and 517

Effective Date: January 1, 2005

Implementation Date: May 2, 2005

Providers Affected
Physicians and providers billing Medicare carriers for telehealth services

Provider Action Needed

STOP - Impact to You
Effective for services provided on or after January 1, 2005, the Centers for Medicare & Medicare Services (CMS) added Healthcare Common Procedure Coding System (HCPCS) codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 (for ESRD-related services) to the list of Medicare telehealth services, effective January 1, 2005. Medicare carriers will pay for these ESRD related services when billed with the telehealth modifiers.

CAUTION - What You Need to Know
Providers treating ESRD beneficiaries should also be aware that the above telehealth modifiers “GT” or “GQ” are valid when billed with one of the above mentioned HCPCS codes.

GO - What You Need to Do
Be sure staff is aware of the addition of these ESRD related services to the list of Medicare telehealth services and the appropriate billing procedures.

Background
In the final rule published November 7, 2003, (68 FR 63216) CMS established new G codes for managing patients on dialysis with payments varying based on the number of visits provided within each month. Under this methodology, separate codes are billed for providing one visit per month, two to three visits per month, and four or more visits per month.

The lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would have to provide at least four ESRD-related visits per month. The G codes are reported once per month for services performed in an outpatient setting that are related to the patient’s ESRD.

Since changing the payments for managing patients on dialysis, CMS has received a number of comments from the nephrology community expressing concerns that the change in payments results in hardships for rural and isolated areas, especially in frontier areas where physicians would be required to make multiple long-distance trips during a month to see their patient or vice versa.

To address this issue, CMS added ESRD related services under the monthly capitation payment (MCP) to the list of Medicare telehealth services in the physician fee schedule fine rule published November 15, 2004 (69FR 66276). ESRD related services included in the MCP with 2 or 3 visits per month, and ESRD related services with 4 or more visits per month, may be paid as Medicare telehealth service.

To bill for ESRD related service under the MCP as a telehealth service, at least one visit must be furnished face to face “hands on” to examine the patient’s vascular access site. Examination of the vascular access site must be done by a physician, clinical nurse specialist, nurse practitioner, or physician assistant. Only the facilities, authorized under Section 1834 (m) of the Social Security Act, may serve as a Medicare telehealth-originating site.

Prior to the issuance of CR 3747, the list of Medicare telehealth services only included consultations (CPT codes 99241-99275); office and other outpatient visits (CPT codes 99201-99215); individual psychotherapy (CPT codes 90804 - 90809); pharmacologic management (CPT code 90862); and psychiatric diagnostic interview examination (CPT code 90801), effective for services on or after March 1, 2003.

List of Medicare Telehealth Services (CR 3747) (Continued)

This article and related CR 3747 informs that the ESRD related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) are added to the list of Medicare telehealth services, effective for services furnished on or after January 1, 2005. The telehealth modifier “GT” (providing visits through the use of interactive audio and video telecommunications system) and modifier “GQ” (providing visits through the use of asynchronous telecommunications system) are valid when billed with these ESRD-related service HCPCS codes. The use of the telehealth modifiers indicates that a clinical examination of the vascular access site was furnished face-to-face “hands on” by a physician clinical nurse specialist, nurse practitioner, or physician assistant.

Addition of the above ESRD related services to the list of Medicare telehealth service does not change the eligibility criteria, conditions of payment, payment or billing procedure regarding Medicare telehealth services as established in publication 100-2, Chapter 15, Section 270 and publication 100-4 Chapter 12, Section 190 of the Medicare Benefit Policy Manual. Thus, originating sites only include a physician’s or practitioner’s office, hospital, critical access hospital, rural health clinic, or Federally qualified health center. Originating sites must be in a non-Metropolitans Statistical Area (MSA) county or a rural health professional shortage area. Also, the use of modifier “GQ” is only permitted in Federally funded telemedicine demonstration programs conducted in Alaska or Hawaii.

Clarification for originating sites billing for the telehealth originating site facility fee
With regard to ESRD-related services included in the MCP, the originating site facility fee payment may be made for each visit furnished through an interactive telecommunications system. When the physician or practitioner at the distant site furnishes an ESRD-related patient visit included in the MCP through an interactive telecommunications system, the originating site may bill for a telehealth facility fee.

Example: A 70-year-old ESRD beneficiary receives two ESRD-related visits through an interactive telecommunications system and the required face-to-face visit (to examine the vascular access site) during the month of November. In this scenario, the originating site should bill for two originating site facility fees as described by HCPCS code Q3014, and the MCP physician at the distant site should bill for ESRD-related services with 2 to 3 visits as a telehealth service, e.g., G3018 GT.

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

From that web page, look for CR 3747 in the CR NUM column on the right, and then click on the file for that CR.
If you have questions regarding this issue, contact your carrier on their toll free number, which is available at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Medicare Announces Delay in Processing Certain Claims No Later Than April 18, 2005 (SE 0531)

Related Change Request (CR) #: N/A **Medlearn Matters Number:** SE0531

Effective Date: April 1, 2005

Provider Types Affected
All physicians and providers billing Medicare carriers and all providers billing Medicare fiscal intermediaries (FIs) for services paid under the Outpatient Prospective Payment System (OPPS)

Provider Action Needed
No action is needed. This article is informational only, but affected providers should be aware that this article discusses circumstances that may cause a slight delay in receiving payment from Medicare for some of your claims.

Additional Information
The Centers for Medicare & Medicaid Services (CMS) recently advised Medicare carriers, including durable medical equipment regional carriers (DMERCs) and FIs that certain Medicare systems are being changed on April 18, 2005. Further, CMS advised that certain claims affected by these system changes may not be processed until those system changes are implemented no later than April 18.

Medicare Announces Delay in Processing Certain Claims No Later Than April 18, 2005 (SE 0531) (Continued)

As a result, CMS instructed carriers and FIs to hold these claims and not process them until the system changes are in place. The types of claims affected by this CMS action are as follows:

Claim Types	Medicare will Begin Holding on:	Medicare will Begin Processing the Claims no later than:	Change Request Involved	Provider Types Affected
Claims Affected by Type of Service (TOS) Changes (see note 1. below)	April 1, 2005	April 18, 2005	CR3788 (see Note 2. below)	Those billing Medicare carriers for affected services
Anti-Cancer Chemotherapy for Colorectal Cancer Claims	April 1, 2005	April 18, 2005	CR3742 (See note 2. below)	Those billing Medicare carriers, DMERCs, or FIs for affected services
PET for Brain, Cervical, Ovarian, Pancreatic, Small Cell Lung, and Testicular Cancers Claims	April 1, 2005	April 18, 2005	CR3741 (see note 2. below)	Those billing carriers or FIs for affected services
Holding of Implantable Automatic Defibrillator (IAD) Claims	April 1, 2005	April 18, 2005	N/A	Those billing intermediaries for these services.
Outpatient Prospective Payment System Claims	April 1, 2005	April 18, 2005	N/A	Those providers billing intermediaries for services paid under the OPPS

1. TOS is an indicator that the carrier places on the Form CMS-1500 paper form or electronic format. The indicator is mainly used for data purposes. However, in some instances it affects payment. All HCPCS codes have a corresponding TOS indicator.
2. To view a CR, visit **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp .** Once at that site, scroll down the CR NUM column on the right and click of the file for the CR you are interested in viewing.

If you have any questions related to any of these issues, please contact your carrier, DMERC, or intermediary at their toll free number, which is available at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

MMA - Clarification for Change Request (CR) 3267 (CR 3729)

Related Change Request (CR) #:3729

Medlearn Matters Number: MM3729

Related CR Release Date: March 4, 2005

Related CR Transmittal #: 26

Effective Date: June 6, 2005

Implementation Date: June 6, 2005

Note: This article was revised on March 8, 2005 to show the correct transmittal number.

Provider Types Affected
Hospitals and independent laboratories billing Medicare carriers or fiscal intermediaries (FIs) for laboratory services

Provider Action Needed
This article contains information provided in Change Request (CR) 3729 that clarifies policies previously issued in CR 3267 (Transmittal 228, July 16, 2004). It also informs hospitals and independent labs that 1) they may use collected and retained Medicare Secondary Payer (MSP) information for the billing of nonface-to-face reference lab services, and 2) they are required to collect MSP information from the beneficiary when billing for face-to-face encounters with Medicare patients for lab services.

MMA - Clarification for Change Request (CR) 3267 (CR 3729) (Continued)

Background
Treatment of hospitals for certain services under Medicare Secondary Payer (MSP) Provisions of the Medicare Prescription Drug Improvement & Modernization Act of 2003 (MMA) states:

> "(a) IN GENERAL. - 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 lab services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory."
>
> "(b) REFERENCE LABORATORY SERVICES DESCRIBED. - Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation."

The Centers for Medicare & Medicaid Services (CMS) **will not require independent reference laboratories to collect MSP** information in order to bill Medicare for reference laboratory services as described in subsection (b) above.

Therefore, pursuant to the MMA (Section 943), CMS **will not require hospitals to collect MSP information** in order to bill Medicare for reference laboratory services (as described in subsection (b) above). **This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist.**

Therefore, in situations where hospital and independent labs have already collected and retained MSP information for beneficiaries, they may use the collected and retained MSP information for the billing of non-face-to-face reference lab services.

In addition, **in situations when there is a face-to-face encounter with the beneficiary, hospitals and independent labs are required to collect MSP information from the beneficiary when billing for face-to-face lab services.**

This clarification should have been made as part of CR 3267 (which clarified CR 3064, Transmittal 11, February 27, 2004).

Implementation
The implementation date for this instruction is June 6, 2005.

Additional Information
CR 3267 (Transmittal 228, July 16, 2004) can be reviewed at the following CMS web site:
http://www.cms.hhs.gov/manuals/pm_trans/R228CP.pdf

CR 3064, Transmittal 11, February, 27, 2004) can be reviewed at the following CMS web site:
http://www.cms.hhs.gov/manuals/pm_trans/R11MSP.pdf

The Medicare Secondary Payer Manual (Pub. 100-5) can be found at the following CMS web site:
http://www.cms.hhs.gov/manuals/105_msp/msp105index.asp

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set) provides instructions on how to process reference lab claims submitted on Form CMS-1500, and can be found at the following CMS web site: **http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf**

After you get to Chapter 26, click on Section 10.2 (Items 1-11 - Patient and Insured Information) in the Table of Contents.

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

From that web page, look for CR 3729 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**

Hospitals:
http://cms.hhs.gov/providers/hospital.asp
offers information to providers about hospitals

MMA - Diabetes Screening Tests (CR 3677)

Related Change Request (CR) #: 3677 **Medlearn Matters Number:** MM3677

Related CR Release Date: January 28, 2005

Related CR Transmittal #: 457

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Provider Types Affected
All Medicare providers billing Medicare carriers or fiscal intermediaries for diabetes screening tests for Medicare patients

Provider Action Needed

STOP - Impact to You
This article provides further guidance and clarification of new Medicare coverage rules for diabetes screening tests performed on or after January 1, 2005.

CAUTION - What You Need to Know
The amount of testing covered by Medicare for qualified individuals is changed to one screening test every six months for individuals diagnosed with pre-diabetes and one screening test every twelve months for individuals not diagnosed with pre-diabetes or who were never tested before.

GO - What You Need to Do
Please refer to the Background and Additional Information sections of this article for further details.

Background
This coverage is mandated by Section 613 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA).

Initially, coverage was provided for two screening tests per calendar year for individuals diagnosed with pre-diabetes, and one screening test per year for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested. This article and related CR 3677 clarify that, for individuals diagnosed with pre-diabetes, the two screening tests per year are further limited to one screening test every six months. And, providers should note that these tests for individuals with a pre-diabetes diagnosis must be billed with a V77.1 diagnosis code **and** a "TS" modifier to reflect follow up service.

Any individual with one (1) of the following risk factors for diabetes is eligible for this benefit:

- Hypertension
- Dyslipidemia
- Obesity (with a body mass index greater than or equal to 30 kg/m2), or
- Previous identification of elevated impaired fasting glucose or glucose intolerance

Or, an individual with any two (2) of the following risk factors is also eligible for this benefit:

- Overweight (a body mass index >25, but
- A family history of diabetes
- Age 65 years or older
- A history of gestational diabetes mellitus or giving birth to a baby weighing > 9 lbs.

Effective for services performed on or after January 1, 2005, Medicare will pay for diabetes screening tests under the Medicare Clinical Laboratory Fee Schedule. To indicate that the purpose of the test(s) is for diabetes screening, a screening diagnosis code is required in the diagnosis section of the claim. The following Health Care Common Procedure Coding System (HCPCS) Codes for Diabetes Screening are to be billed for diabetes screening:

- 82947 - Glucose, quantitative, blood (except reagent strip)
- 82950 - Post-glucose dose (includes glucose)
- 82951 - Glucose Tolerance test (GTT), three specimens (includes glucose)

Providers submitting pre-diabetes and diabetes screening claims should note that claims must contain the appropriate HCPCS codes listed above along with a diagnosis code of V77.1.

No coverage is permitted under the MMA benefit for individuals previously diagnosed as diabetic since these individuals do not require screening. Other diabetes screening blood tests for which the Centers for Medicare & Medicaid Services (CMS) has not specifically indicated national coverage continue to be noncovered.

CMS also provides the following definitions for the purpose of this article:
Diabetes: diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on 2 different occasions; a 2-hour post-glucose challenge > 200 mg/dL on 2 different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

MMA - Diabetes Screening Tests (CR 3677) (Continued)

Pre-diabetes: abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to125 mg/dL, or a 2-hour post-glucose challenge of 140 to 199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

Post-glucose challenge test: an oral glucose tolerance test with a glucose challenge of 75 gms. of glucose for non-pregnant adults, or a 2-hour post-glucose challenge test alone.

Implementation
The implementation date for this article is April 4, 2005. It applies to services furnished on or after January 1, 2005.

Additional Information
Updated manual instructions are included in the official instruction issued to your carrier or fiscal intermediary and can be found at: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**

From that web page, look for CR 3677 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, contact your carrier or intermediary at their toll free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

MMA - Expansion of Coverage for Chiropractic Services Demonstration - MAINE ONLY (SE 0514)

Related Change Request (CR) #: NA

Related CR Release Date: N/A

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Medlearn Matters Number: SE0514

Revised

NHIC Note: The original CMS article covers all states listed in the "Provider Types Affected" section below. Only information pertinent to MAINE is demonstrated in this article. To view the complete CMS article, go to the following link:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0514.pdf

Note: This article was revised on March 11 to make several changes, including adding zip codes to Table 2 for Illinois, deleting CPT code 97010, and advising chiropractors that they are subject to local coverage decisions (LCDs) and lab National Coverage Determinations (NCDs)

Provider Types Affected
Chiropractors who practice in the States of Maine and New Mexico, Scott County, Iowa, 26 counties in Illinois (including Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, Will, Boone, Bureau, Carroll, Henry, JoDaviess, Kankakee, Lake, LaSalle, Lee, Marshall, Mercer, Ogle, Putnam, Rock Island, Stark, Stephenson, Whiteside, and Winnebago counties), and 17 counties in central Virginia (including Pittsylvania, Campbell, Appomattox, Nelson, Buckingham, Fluvanna, Louisa, Caroline, Hanover, New Kent, Henrico, Richmond City, Danville City, Goochland, Cumberland, Powhatan, and Amelia counties)

Provider Action Needed

STOP - Impact to You
Under a two-year demonstration project beginning April 1, 2005, doctors of chiropractic will be able to bill Medicare carriers for the Part B medical, radiology, clinical lab, and therapy services that you provide for your Medicare fee-for-service patients. **These services must be billed separately from current services that are covered under Medicare. You must include a demonstration code for all demonstration claims.**

CAUTION - What You Need to Know
Beginning April 1, 2005, CMS is conducting a demonstration to evaluate the feasibility and advisability of expanding the coverage of diagnostic and other chiropractic services under Medicare. This demonstration is required by Section 651 of the Medicare Modernization Act of 2003 (MMA). There is no requirement to enroll in the demonstration in order to bill for the additional demonstration services.

GO - What You Need to Do
If you are a doctor of chiropractic providing services in the geographic areas of this demonstration, make certain that your billing offices are aware of this demonstration and the expanded coverage of chiropractic services that it allows.

MMA - Expansion of Coverage for Chiropractic Services Demonstration - MAINE ONLY (SE 0514) (Continued)

Background

Section 651 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires that the Centers for Medicare & Medicaid Services (CMS) conduct a two-year *Demonstration of Coverage of Chiropractic Services Under Medicare*. Specifically, MMA requires CMS to expand coverage for your services to include "*care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided*."

This means that, under this demonstration, chiropractors will be allowed to bill Medicare Part B for medical, radiology, clinical lab, and certain therapy services related to the treatment of neuromusculoskeletal conditions that you are legally permitted to provide according to your state practice acts, and as allowed within Medicare rules. The diagnostic services that chiropractors will be allowed to perform and bill Medicare for include plain x-rays, EMGs and nerve conduction studies, and clinical lab tests. Chiropractors can order MRIs and CT scans under the demonstration; however they cannot be paid to perform or interpret them. In addition, chiropractors participating in this demonstration will be able to order x-rays and clinical lab services.

The clinical lab services that chiropractors can perform are listed in the clinical lab fee schedule, which can be found at:
http://www.cms.hhs.gov/providers/pufdownload/#labfee

Any chiropractor performing clinical lab tests, and any labs that chiropractors order tests from, must comply with the Clinical Laboratory Improvement Amendments (CLIA) program and the site must be CLIA certified. You will be required to include your practice site's CLIA certification number on the claim form in block 23 on the CMS 1500 form. To submit electronic claims report the CLIA number in: X12N 837P (HIPAA version) loop 2300, REF02. REF01=X4. Medicare will verify that you are eligible to perform the laboratory service. Chiropractors are also subject to clinical laboratory state practice requirements. Chiropractors must also comply with the Stark requirements regarding limitations on physician self-referrals. Information regarding these requirements can be found in Medlearn Matters article number MM3036, which may be found at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2003/MM3036.pdf

Under this demonstration, doctors of chiropractic will also be allowed to bill Medicare for CPT code 98943-extraspinal manipulation. The fee amounts for 98943 per geographic area can be found in Table 1 on page 5 of this article. Coverage will also be expanded to include other ancillary services chiropractors are legally allowed to provide and Medicare currently covers. These procedures include electrotherapy, ultrasound, TENS therapy, and other services that are medically necessary for the treatment of neuromusculoskeletal conditions. Chiropractors will be allowed to provide physical therapy services and to refer patients for therapy under this demonstration.

Chiropractors will also be reimbursed for Evaluation and Management (E&M) services delivered for neuromusculoskeletal conditions. Under the demonstration, chiropractors will be allowed to bill Medicare for both an E&M visit and for treatment the first time you assess a patient, as well as for current patients in such instances as when there is a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Chiropractors should not bill for an E&M service every time they treat a patient. Chiropractors billing Medicare under this demonstration must follow the same documentation guidelines that physicians follow for E&M services. For example, chiropractic manipulation codes include a brief pre-manipulation patient assessment. Additional E&M services may be reported separately using the modifier "-25" if, and only if, the patient's condition requires a significant separately identifiable E&M service. When manipulation and E&M codes are billed for the same visit, it is necessary to attach a "-25" modifier to the E&M code. These guidelines can be found at:
http://www.cms.hhs.gov/medlearn/emdoc.asp

Additional E&M guidance can also be found in the Medicare Claims Processing Manual, publication 10004, Chapter 12, Section 30. This manual may be accessed at: **http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp**

Services provided under this demonstration must be related to acute or active treatment, not maintenance or prevention of neuromusculoskeletal conditions. You must place an AT modifier next to every CPT code on all claims when providing active/corrective treatment to treat acute or chronic subluxation.

You should be aware that while under this demonstration, chiropractors will be subject to the same coverage and payment rules that physicians and physical therapists must follow, such as: 1) rules that apply to physicians regarding billing for the delivery of E&M services and treatment in the same visit; 2) coinsurance or deductible rules; and 3) rules regarding the delivery of physical therapy services, including identifying these services using the GP modifier, and certifying the plan of care every 30 days. Chiropractors must also follow carrier Local Coverage Decisions (LCDs), Laboratory National Coverage Determinations (NCDs), etc. that physicians must follow. These requirements can be found in the Medicare Benefit Policy Manual 100-2 in Chapter 15, Sections 220 and 230 and the Medicare Claims Processing Manual 100-4 in Chapter 5, Section 20 and other manual sections.

The Medicare Benefit Policy Manual may be found at: **http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp**

MMA - Expansion of Coverage for Chiropractic Services Demonstration - MAINE ONLY (SE 0514) (Continued)

Chiropractors must also follow physician requirements for "incident to" services. Information regarding these requirements can be found in a Medlearn Matters article at: **http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0441.pdf**

In addition, chiropractors must follow physician rules for providing therapy services under the incident to provision of the physician regulation. When a physical therapy service is provided incident to the service of a chiropractor, the person who furnishes the service must meet the standards and conditions that apply to physical therapists, except that a license is not required. This means that unless chiropractic students, chiropractic assistants, or sports trainers have graduated from a physical therapy curriculum approved by: 1) the American Physical Therapy Association, or 2) The Committee on Allied Health Education and Accreditation of the American Medical Association, or 3) the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, they cannot provide therapy services incident to a chiropractor. The only exception is that certain persons trained prior to January 1, 1966 may be grandfathered (see 42 CFR 484.4).

Finally, you should check your local Medicare carrier web site for information on local coverage decisions regarding demonstration services.

Other physician approval is not required for your services under this demonstration. Only chiropractors can bill Medicare under this demonstration.

The demonstration will be conducted in four geographic areas-two rural and two urban. One rural and one urban geographic area will be located in a designated Health Professional Shortage Area (HPSA). These areas are the states of Maine and New Mexico, Scott County, Iowa, 26 counties in Illinois (including Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, Will, Boone, Bureau, Carroll, Henry, JoDaviess, Kankakee, Lake, LaSalle, Lee, Marshall, Mercer, Ogle, Putnam, Rock Island, Stark, Stephenson, Whiteside, and Winnebago counties), and 17 counties in central Virginia (including Pittsylvania, Campbell, Appomattox, Nelson, Buckingham, Fluvanna, Louisa, Caroline, Hanover, New Kent, Henrico, Richmond City, Danville City, Goochland, Cumberland, Powhatan, and Amelia counties). Zip codes are provided in Table 2 for Illinois, Table 3 for Virginia, and Table 4 for Iowa.

The demonstration applies to Part B services delivered to all Medicare fee-for-service beneficiaries. The demonstration also applies to Medicare Advantage enrollees of plans who choose to participate in the demonstration; however, the Medicare Advantage requirements are not in this article and these requirements will be addressed separately.

Also, while **you** will only be able to participate if you provide services in the four designated geographic areas, your Medicare patients are not required to live in these areas to receive demonstration services. In addition, chiropractors practicing within the demonstration areas may refer patients to providers that are not located in the demonstration areas. For example, a chiropractor may refer a patient to a radiologist outside of the demonstration area for an MRI.

Chiropractors must apply demonstration code 45 to all demonstration claims. On the 837 professional transaction, chiropractors should report the demonstration number "45" in Loop 2300 REF02 (REF01=P4). If chiropractors are using the CMS-1500 claim form, the demonstration number should be inserted in Box 19 (reserved for local use) along with the word "demo" before the number 45.

You will be required to submit claims for demonstration services separately from claims for CPT codes 98940, 98941, and 98942. For example, if you submit claims for CPT codes 98940 through 98942 with demonstration services and the demonstration code 45, the non-demonstration services will be rejected and you will have to resubmit the non-demonstration services. The demonstration services will be paid. If you submit a claim for CPT codes 98940 through 98942 with demonstration services and the demonstration code 45 is not included, the demonstration services will be rejected and you should resubmit them as a separate claim. The non-demonstration services will be paid in this instance.

Chiropractors should also be aware that they will be subject to the current version of the National Correct Coding Edits (CCI) which can be found at: **http://www.cms.hhs.gov/physicians/cciedits**

Other points of interest to you are as follows:

- CPT codes currently exist for the services that you will provide under this demonstration (See Tables 5 and 6). Your Medicare carrier will develop edits to recognize chiropractors in these four geographic areas and allow you to be reimbursed for your authorized medical, radiology, clinical lab, and therapy services. Information regarding fees for demonstration services (except 98943, which is found in Table 1) can be found at: **http://www.cms.hhs.gov/physicians/mpfsapp/step0.asp**
- Current Medicare coverage for chiropractic services (codes 98940, 98941, and 98942) remains unchanged. The fee schedule for these three codes will continue to apply.
- If you practice in an area that is also classified as a HPSA area, you will be eligible for HPSA bonus payments. Chiropractors are not eligible for incentive payments for Physician Scarcity Area payments.
- You should not bill using any of the osteopathic manipulation codes since these codes are valued specifically for the manipulation services done by osteopaths.

MMA - Expansion of Coverage for Chiropractic Services Demonstration - MAINE ONLY (SE 0514) (Continued)

- You must always place a GP modifier on claims for Physical Therapy services, except for 64550. Chiropractors should place a modifier on claims for 64550, except in cases where it is not part of a therapy plan of care. See Pub. 100-04, chapter 5 section 20 for billing therapy codes. This publication may be found at: **http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp**
- The primary diagnosis at the claim detail must be one of the ICD-9-CM diagnosis codes listed in Table 6 for coverage under this demonstration.

Additional Information

Should you have additional questions, contact your carrier's provider customer toll free line. That number may be found at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

Additional information regarding the demonstration can also be found on the CMS web site at: **http://www.cms.hhs.gov/researchers/demos/eccs/default.asp**

2005 Fee Schedule Amounts for CPT 98943 - Maine Only

State	Carrier	Non-Facility Fee Schedule
Cumberland, York, ME	31142	$24.55
remaining counties in ME	31142	$23.57

Procedure Codes (CPT/HCPCS)

Code	Chiropractic Manipulation Codes
98940	manipulation 1-2 regions
98941	manipulation 3-4 regions
98942	manipulation 5 regions
98943	New for demo—extraspinal manipulation
Code	**Evaluation and Management Codes**
99201	New patient 10 minutes
99202	New patient 20 minutes
99203	New patient 30 minutes
99204	New patient 45 minutes
99205	New patient 60 minutes
99211	Established patient 5 minutes
99212	Established patient 10 minutes
99213	Established patient 15 minutes
99214	Established patient 25 minutes
99215	Established patient 40 minutes
Code	**Diagnostic Codes**
95831	Muscle testing, manual with report; extremity or trunk
95832	Hand, with or without comparison with normal side
95833	Total evaluation of body, excluding hands
95834	Total evaluation of body, including hands
95851	Range of motion measurements and report; each extremity or each trunk section
95852	Hand, with or without comparison with normal side
95857	Tensilon test for myasthenia gravis
95858	With electromyographic recording

MMA - Expansion of Coverage for Chiropractic Services Demonstration - MAINE ONLY (SE 0514) (Continued)

Procedure Codes (CPT/HCPCS) (Continued)

Code	Diagnostic Codes
95860	Needle electromyography; one extremity with or without related paraspinal areas
95861	Two extremities with or without related paraspinal areas
95863	Three extremities with or without related paraspinal areas
95864	Four extremities with or without related paraspinal areas
95867	Cranial nerve supplied muscles, unilateral
95868	Cranial nerve supplied muscles, bilateral
95900	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave Study
95903	Motor, with F-wave study
95904	Sensory
Code	**Therapy Codes**
64550	Application of surface (transcutaneous) neurostimulator
97012	traction, mechanical
97018	paraffin bath
Code	**Chiropractic Manipulation Codes**
97020	Microwave
97024	Diathermy
97026	Infrared
97028	Ultraviolet
97032	electrical stimulation, constant attendance
97034	contrast baths
97035	Ultrasound
97039	unlisted modality
97110	therapeutic exercise
97112	neuromuscular reducation
97113	aquatic therapy with exercise
97116	gait training
97124	Massage
97139	unlisted therapeutic procedure
97140	Manual therapy techniques
97150	therapeutic procedures, group
97504	orthotic fitting and training
97530	Therapeutic activities—dynamic activities to improve functional performance
97703	check out for orthotics and prosthetic use
97750	physical performance test or measurement, with written report
97799	unlisted physical medicine/rehabilitation service
G0283	unattended electrical stimulation for other than wound care
Code	**X rays**
72010	x-ray spine entire
72020	x-ray spine, 1 view
72040	x-ray spine cervical 2-3 views
72050	x-ray, spine cervical 4+ views
72052	x-ray spine cervical complete

MMA - Expansion of Coverage for Chiropractic Services Demonstration - MAINE ONLY (SE 0514) (Continued)

Procedure Codes (CPT/HCPCS) (Continued)

Code	X rays
72069	x-ray spine standing for thoracolumbar
72070	x-ray spine thoracic 2 views
72072	x-ray spine thoracic 3 views
72074	x-ray, spine thoracic 4+ views
72080	x-ray spine thoracolumbar 2 views
72090	x-ray spine thoracolumbar supine and standing
72100	x-ray spine lumbosacral 2-3 views
72110	x-ray spine lumbosacral 4+ views
72114	x-ray spine lumbosacral complete
72120	x-ray spine lumbosacral bending only
Code	**Chiropractic Manipulation Codes**
72170	x-ray pelvis, 1-2 views
72190	x-ray pelvis complete
72200	x-ray sacroiliac joints, up to 3 views
72202	x-sacroiliac joints 3+ views
72220	x-ray sacrum and coccyx 2+ views
73000	x-ray clavicle complete
73010	x-ray scapula compete
73020	x-ray shoulder 1 view
73030	x-ray shoulder 2+ views
73050	x-ray acromioclavicular joint, bilateral
73060	x-ray humerus, 2+ views
73070	x-ray elbow 2 views
73080	x-ray elbow 3+ views
73090	x-ray forearm 2 views
73100	x-ray wrist, 2 views
73110	x-ray wrist, 3+ views
73120	x-ray hand 2 views
73130	x-ray hand 3+ views
73140	x-ray finger(s) 2+ views
73500	x-ray hip unilateral 1 view
73510	x-ray hip unilateral 2+ views
73520	x-ray hip bilateral 2+ views
73550	x-ray femur 2 views
73560	x-ray knee 1-2 views
73562	x-ray knee 3 views
73564	x-ray knee 4+ views
73565	x-ray bilateral knees standing
73590	x-ray tibia fibula 2 views
73600	x-ray ankle 2 views
73610	x-ray ankle 3+ views
73620	x-ray foot, two views

MMA - Expansion of Coverage for Chiropractic Services Demonstration - MAINE ONLY (SE 0514) (Continued)

Procedure Codes (CPT/HCPCS) (Continued)

Code	Chiropractic Manipulation Codes
73630	x-ray foot, 3+ views
73650	x-ray heel 2+ views
73660	x-ray toe—2 or more views
71100	x-ray ribs, unilateral; 2 views
71110	x-ray ribs, bilateral 3 views
71120	x-ray sternum, 2+ views
71130	x-ray, sternum+sc joint

Diagnosis (ICD-9) Codes

Code	Description	Specific Codes Within the Range
307	Special symptoms	307.81
138	Late effects of poliomyelitis	
340	Multiple sclerosis	
346	Migraine	346.00-.01, 346.10-.11, 346.20-.21, 346.80-.81, 346.90-.91
350	Trigeminal neuralgia	350.1, 350.2
352	disorder cranial nerve	352.4
353	disorder, nerve root and plexus	353.0, 353.1, 353.2, 353.4, 353.6
354	Mononeuritis, upper limb and multiple	354.0, 354.1, 354.2, 354.3, 354.4, 354.8, 354.9
355	Mononeuritis, lower limb	355.0, 355.1, 355.2, 355.3, 355.4, 355.5, 355.6, 355.71, 355.79, 355.8, 355.9
356	Neuropathy, hereditary and idoiopathic	356.1, 356.4, 356.8, 356.9
358	disorders myoneural	358.00, 358.01
715	Arthritis, osteoarthritis*	715.0x, 715.1x, 715.2x, 715.3x, 715.8x, 715.9x
716	Arthropathies, NEC/NOS*	716.1x, 716.2x, 716.3x, 716.4x, 716.5x, 716.6x, 716.8x, 716.9x
717	derangement, knee internal	717.0-3, 717.40-43, 717.49, 717.5-7, 717.81-84, 717.85, 717.89, 717.9
718	derangement, other joint*	718.0x, 718.1x, 718.6x, 718.8x, 718.9x, 718.48
719	disorder, joint NEC/NOS*	719.0x, 719.1x, 719.2x, 719.3x, 719.4x, 719.5x, 719.6x, 719.7, 719.8x, 719.9x
720	Spondylitis, ankylosing and other inflammatory spondylopathies	720.0, 720.1, 720.2, 720.81, 720.89, 720.9
721	Spondylosis and allied disorders	721.0, 721.1, 721.2, 721.3, 721.41-.42, 721.5, 721.6, 721.7, 721.8, 721.90, 721.91

MMA - Expansion of Coverage for Chiropractic Services Demonstration - MAINE ONLY (SE 0514) (Continued)

Diagnosis (ICD-9) Codes (Continued)

Code	Description	Specific Codes Within the Range
722	disorder, intervertebral disc	722.0, 722.10-.11, 722.2, 722.30-.32, 722.39-.4, 722.51-.52, 722.6, 722.70-.73, 722.81-.83, 722.91-.93
723 723	disorder cervical spine disorder cervical spine	723.0, 723.1, 723.2, 723.3, 723.4, 723.5, 723.6, 723.7, 723.8, 723.9
724	disorders, back NEC/NOS	724.00-02, 724.1-6, 724.70, 724.71, 724.79, 724.8, 724.9
725	Polymyalgia rheumatica	
726	enthesopathies, peripheral and allied syndromes	726.0, 726.10-.12, .19, 726.2, 726.30-.32, .39, 726.4, .5, 726.60-.65, .69, 726.70-.73,.79, 726.8, .90, .91
727	disorders, synovium tendon and bursa	727.00-.06, 727.09,.1, .2, .3, 727.40-.43, 727.49, 727.50-.51, 727.59, 727.60-.69, 727.81-.83, 727.89-.9
728	disorders, muscle, ligament and fascia	728.10-.12, 728.2, .3, .4, .5, .6, 728.71, 728.79, 728.81, 728.83, 728.85, 728.87, 728.89, 728.9
729	Other disorders of soft tissues	729.0-.2, 729.5, 729.8-.9
733	Other disorders of bone and cartilage	733.6, 733.92
735	deformity, toe acquired	735.0, 735.1, 735.2, 735.4, 735.5, 735.8, 735.9
736	Deformity, limbs acquired	736.00-.07, 736.09-.1, 736.20-.22, 736.29-.32, 736.39, 736.41-.42, 736.6,.70-.76, 736.79, 736.81, 736.89
737	Curvature spine	737.0, 737.10, 737.11, 737.12, 737.19, 737.20-22, 737.29, 737.30-34, 737.40-43, 737.8, 737.9
738	deformity, acquired	738.2-9
739	Lesions, nonallopathic NEC	739.0-9
754	Congenital musculoskeletal deformities	754.1, 754.2, 754.40-44, 754.50-53, 754.59, 754.60-62, 754.69, 754.70, 754.71, 754.79
756	other congenital musculoskeletal abnormalities	756.10-15, 756.17, 756.19, 756.2, 756.3, 756.4, 756.82, 756.83, 756.89
840	Sprains and strains of shoulder and upper arm	840.1-9
841	Sprains and strains of elbow and forearm	841.0-.3,
842	Sprains and strains of wrist and hand	842.00-02, 842.09-13, 842.19
843	Sprains and strains of hip and thigh	843.0, 843.1, 843.8, 843.9
844	Sprains and strains of knee and leg	844.0-844.3, 844.8, 844.9
845	Sprains and strains of ankle and foot	845.00-03, 845.09-13, 845.19
846	Sprains and strains of the sacroiliac region	846.0-3, 846.8, 846.9
847	Sprains and strains of back NEC/NOS	847.0-4, 847.9
848	Sprains and strains, ill-defined, NEC	848.3, 848.40-42, 848.49, 848.8, 848.9

MMA - Expansion of Coverage for Chiropractic Services Demonstration - MAINE ONLY (SE 0514) (Continued)

Diagnosis (ICD-9) Codes (Continued)

Code	Description	Specific Codes Within the Range
905	Late effects, musculoskeletal and connective tissues injuries	905.1-9
907	Late effects, injuries to the nervous system	907.0, 907.1-5, 907.9
922	Contusion, trunk	922.1, 922.31, 922.32, 922.33, 922.8
923	Contusion, upper limb	923.00-03, 923.09-11, 923.20-21, 923.3, 923.8, 923.9
924	Contusion, lower limb	924.00, 924.01, 924.10-11, 924.20-21, 924.3-5, 924.8, 924.9
955	Injury, peripheral nerve(s) of shoulder girdle and upper limb	955.0-9
956	Injury, peripheral nerve(s) of pelvic girdle and lower limb	956.0-5, 956.8, 956.9
958	Certain traumatic complications	958.6
784	Symptoms involving head and neck	784

*** = "x" specifies anatomic site**

MMA - Expansion of Coverage for Chiropractic Services Demonstration-Information Relevant to Outpatient Hospitals and Independent Clinical Laboratories - MAINE ONLY (SE 0521)

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0521

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

NHIC Note: The original CMS article covers all states listed in the "Provider Types Affected" section below. Only information pertinent to MAINE is demonstrated in this article. To view the complete CMS article go to **http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0521.pdf**

Provider Types Affected

Outpatient hospital and independent clinical laboratories that will be able to accept referrals from chiropractors who practice in the States of Maine, New Mexico, Scott County, Iowa, 26 counties in Illinois (including Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, Will, Boone, Bureau, Carroll, Henry, JoDaviess, Kankakee, Lake, LaSalle, Lee, Marshall, Mercer, Ogle, Putnam, Rock Island, Stark, Stephenson, Whiteside, and Winnebago counties), and 17 counties in central Virginia (including Pittsylvania, Campbell, Appomattox, Nelson, Buckingham, Fluvanna, Louisa, Caroline, Hanover, New Kent, Henrico, Richmond City, Danville City, Goochland, Cumberland, Powhatan, and Amelia counties)

Provider Action Needed

STOP - Impact to You

Under a two-year demonstration project beginning April 1, 2005, chiropractors are allowed to order laboratory tests. You will be reimbursed by Medicare for labs that are ordered by chiropractors who practice in the demonstration areas.

CAUTION - What You Need to Know

Beginning April 1, 2005, CMS is conducting a demonstration to evaluate the feasibility and advisability of expanding the coverage of diagnostic and other chiropractic services under Medicare. This demonstration is required by Section 651 of the Medicare Modernization Act of 2003 (MMA).

MMA - Expansion of Coverage for Chiropractic Services Demonstration-Information Relevant to Outpatient Hospitals and Independent Clinical Laboratories - MAINE ONLY (SE 0521) (Continued)

GO - What You Need to Do
If you accept referrals from chiropractors in the geographic areas of this demonstration, make certain that your billing offices are aware of this demonstration and the ability to accept referrals for clinical laboratory services.

Background
Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that the Centers for Medicare & Medicaid Services (CMS) conduct a two-year *Demonstration of Coverage of Chiropractic Services Under Medicare.* Specifically, MMA requires CMS to expand coverage for chiropractic services to include *"care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided."*

This means that, under this demonstration, chiropractors may order clinical laboratory services and you are allowed to accept these orders. These clinical laboratory services are listed in the clinical lab fee schedule, which can be found at **http://www.cms.hhs.gov/providers/pufdownload/#labfee.** You should list the chiropractor's UPIN as the ordering physician for the clinical laboratory service claim.

For private laboratories, on the ASC X12 837P electronic format, you should report the ordering chiropractor's UPIN in loop 2420E. Enter the value 1G in REF01 and the UPIN in REF02. If you are using form 1500, insert the chiropractor's name on line 17 and their UPIN number on line 17a. For outpatient hospital claims, on the ASC X12 837I electronic format, you must report the ordering chiropractor's UPIN (REF02 (REF01=G)) in the 2310C REF (other provider secondary identification) segment.

The demonstration will be conducted in four geographic areas-two rural and two urban. One rural and one urban geographic area will be located in a designated Health Professional Shortage Area (HPSA). These areas are Maine, New Mexico, Scott County, Iowa, 26 counties in Illinois (including Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, Will, Boone, Bureau, Carroll, Henry, JoDaviess, Kankakee, Lake, LaSalle, Lee, Marshall, Mercer, Ogle, Putnam, Rock Island, Stark, Stephenson, Whiteside, and Winnebago counties and Scott County, Iowa), and 17 counties in central Virginia (including Pittsylvania, Campbell, Appomattox, Nelson, Buckingham, Fluvanna, Louisa, Caroline, Hanover, New Kent, Henrico, Richmond City, Danville City, Goochland, Cumberland, Powhatan, and Amelia counties). Zip codes are provided in Table 1 for Illinois, Table 2 for Virginia, and Table 3 for Iowa.

The demonstration applies to Part B services delivered to all Medicare fee-for-service beneficiaries. The demonstration also applies to Medicare Advantage enrollees of plans who choose to participate in the demonstration; however, the Medicare Advantage requirements are not in this article and these requirements will be addressed separately.

Also, while **labs can only accept orders from chiropractors located in the** four designated geographic areas, the Medicare patients are not required to live in these areas to receive demonstration services. In addition, laboratories are not required to be located in the demonstration areas.

Additional Information
If you have additional questions, contact your carrier's provider customer toll free line. That number may be found at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

Additional information regarding the demonstration can also be found on the CMS web site at: **http://www.cms.hhs.gov/researchers/demos/eccs/default.asp**

MMA - Expansion of Coverage for Chiropractic Services Demonstration - Information for Outpatient Hospitals and Radiologists - MAINE ONLY (SE 0522)

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0522

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

NHIC Note: The original CMS article covers all states listed in the "Provider Types Affected" section below. Only information pertinent to MAINE is demonstrated in this article. To view the complete CMS article go to **http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0522.pdf)**

Provider Types Affected
Outpatient hospitals and radiologists that will be able to accept referrals from chiropractors who practice in the States of Maine, New Mexico, Scott County, Iowa, 26 counties in Illinois (including Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry,

MMA - Expansion of Coverage for Chiropractic Services Demonstration - Information for Outpatient Hospitals and Radiologists - MAINE ONLY (SE 0522) (Continued)

Will, Boone, Bureau, Carroll, Henry, JoDaviess, Kankakee, Lake, LaSalle, Lee, Marshall, Mercer, Ogle, Putnam, Rock Island, Stark, Stephenson, Whiteside, and Winnebago counties), and 17 counties in central Virginia (including Pittsylvania, Campbell, Appomattox, Nelson, Buckingham, Fluvanna, Louisa, Caroline, Hanover, New Kent, Henrico, Richmond City, Danville City, Goochland, Cumberland, Powhatan, and Amelia counties)

Provider Action Needed

STOP - Impact to You
Under a two-year demonstration project beginning April 1, 2005, chiropractors are allowed to order x-rays, MRIs, and CT scans. You will be reimbursed by Medicare for radiology services that are ordered by chiropractors who practice in the demonstration areas.

CAUTION - What You Need to Know
Beginning April 1, 2005, CMS is conducting a demonstration to evaluate the feasibility and advisability of expanding the coverage of diagnostic and other chiropractic services under Medicare. This demonstration is required by Section 651 of the Medicare Modernization Act of 2003 (MMA).

GO - What You Need to Do
If you accept referrals from chiropractors in the geographic areas of this demonstration, make certain that your billing offices are aware of this demonstration and the ability to accept referrals for x-rays, MRIs, and CT scans.

Background
Section 651 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires that the Centers for Medicare & Medicaid Services (CMS) conduct a two-year *Demonstration of Coverage of Chiropractic Services Under Medicare.* Specifically, MMA requires CMS to expand coverage for chiropractic services to include *"care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided."*

This means that, under this demonstration, chiropractors are allowed to order x-rays, MRIs, and CT scans and you are allowed to accept these orders. You should list the chiropractor's UPIN as the ordering physician for the radiology service claim. For radiologists, on the ASC X12 837P electronic format, you should report the ordering chiropractor's UPIN in loop 2420E. The value 1G should be entered in REF01 and the UPIN is entered in REF02. If you are using form 1500, the chiropractor's name should be inserted on line 17 and their UPIN number on line 17a. For outpatient hospital claims, on the ASC X12 8371 electronic format, you must report the ordering chiropractor's UPIN (REF02 (REF01=G)) in the 2310C REF (other provider secondary identification) segment.

The demonstration will be conducted in four geographic areas-two rural and two urban. One rural and one urban geographic area will be located in a designated Health Professional Shortage Area (HPSA). These areas are Maine, New Mexico, Scott County, Iowa, 26 counties in Illinois (including Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, Will, Boone, Bureau, Carroll, Henry, JoDaviess, Kankakee, Lake, LaSalle, Lee, Marshall, Mercer, Ogle, Putnam, Rock Island, Stark, Stephenson, Whiteside, and Winnebago counties), and 17 counties in central Virginia (including Pittsylvania, Campbell, Appomattox, Nelson, Buckingham, Fluvanna, Louisa, Caroline, Hanover, New Kent, Henrico, Richmond City, Danville City, Goochland, Cumberland, Powhatan, and Amelia counties). Zip codes are provided in Table 1 for Illinois, Table 2 for Virginia, and Table 3 for Iowa.

Also, while **radiologists can accept orders only from chiropractors located in the** four designated geographic areas, the

Note: The demonstration applies to Part B services delivered to all Medicare fee-for-service beneficiaries. The demonstration also applies to Medicare Advantage enrollees of plans who choose to participate in the demonstration; however, the Medicare Advantage requirements are not in this article and these requirements will be addressed separately.

Medicare patients are not required to live in these areas to receive demonstration services. In addition, radiologists do not need to be located in the demonstration areas.

Additional Information
If you have additional questions, contact your carrier's provider customer toll free line. That number may be found at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

Additional information regarding the demonstration can also be found on the CMS web site at:
http://www.cms.hhs.gov/researchers/demos/eccs/default.asp

MMA- Revisions to Payment for Services Provided Under a Contractual Arrangement (CR 3628)

Related Change Request (CR) #: 3628 **Medlearn Matters Number:** MM3628

Related CR Release Date: February 11, 2005

Related CR Transmittal #:472

Effective Date: January 1, 2005

Implementation Date: March 15, 2005

Provider Types Affected
Physicians, providers, and suppliers billing Medicare carriers provided under a contractual arrangement

Provider Action Needed
This article includes information provided in Change Request (CR) 3628 which makes a slight revision to the language in the Centers for Medicare & Medicaid Services (CMS) Manual System on payment for services provided under a contractual arrangement.

Background
The Medicare Claims Processing Manual (Pub. 100-04, Chapter 1 (General Billing Requirements), Section 30.2.7 (Payment for services provided under a contractual arrangement)) has been revised as a result of the language published in the November 15, 2004 Physician Fee Schedule final rule (CMS-1429F) concerning section 952 of the Medicare Modernization Act (MMA). Instead of stating that the contractual arrangement between an entity and the other physician or provider should include pertinent Medicare program integrity safeguards, CMS is now stating that the entity and the physician or other person are subject to those program integrity safeguards per the following:

- The entity receiving payment and the physician or other person that furnished the service are both subject to the following program integrity safeguard requirements:
  - The entity receiving payment and the person that furnished the service are jointly and severally responsible for any Medicare overpayment to that entity; and,
  - The person furnishing the services has unrestricted access to claims submitted by an entity for services provided by that person.

The entity billing and receiving payment and the person reassigning his or her billing and payment rights are both responsible for compliance with the Medicare program integrity safeguards beginning on January 1, 2005 (the effective date of CMS-1429-F).

Also, a Medicare carrier may make payment to an entity (i.e., a person, group, or facility enrolled in the Medicare program) that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. Thus, the service may be furnished on or off the premises of the entity submitting the bill and receiving payment (excluding billing agents).

Implementation
The implementation date for this instruction is March 15, 2005.

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

From that web page, look for CR 3628 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

MMA - The Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006 (SE 0502)

Related Change Request (CR) #: N/A **Medlearn Matters Number:** SE0502

Related CR Release Date: N/A

The Second in a Series of Medlearn Matters Articles for Providers on Medicare's New Prescription Drug Coverage

Provider Types Affected
All Medicare providers and any staff who have contact with Medicare beneficiaries

MMA - The Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006 (SE 0502) (Continued)

Provider Action Needed

This special edition article provides updated information regarding the Medicare Prescription Drug Plans that will be available to Medicare beneficiaries in 2006. This new benefit was established by the Medicare Modernization Act (MMA), which was enacted in 2003.

This new drug coverage requires **every** Medicare beneficiary to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients. Help can be as simple as referring them to CMS beneficiary educational resources such as 1- 800-MEDICARE and **http://www.medicare.gov.** It is important to encourage your patients to learn more about the new coverage as it may save them money on prescription drug costs.

The Basic Plan

Beginning January 1, 2006, new Medicare prescription drug plans will be available to all people with Medicare. Insurance companies and other private companies will be working with Medicare to offer these drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phase out by May 15, 2006, or when a beneficiary's enrollment in a Medicare prescription drug plan takes effect, if earlier. The cards offered discounts, while the plans offer insurance coverage for prescription drugs.

Medicare prescription drug plans provide insurance coverage for prescription drugs, and like other insurance plans, participating beneficiaries will pay:

- A monthly premium (generally around $37 in 2006); and
- A share of the cost of their prescriptions (with costs varying depending on the drug plan chosen by the beneficiary).

In addition, drug plans can vary depending on the following:

- What prescription drugs are covered;
- How much the beneficiary pays; and
- Which pharmacies the beneficiary can use.

All drug plans will provide a standard level of coverage which Medicare will set. However, for a higher monthly premium, some plans might offer more coverage and additional medications.

When a Medicare beneficiary joins a drug plan, it is important that they choose one that meets their prescription drug needs. The following questions and answers provide key information that might be of interest to you, your staff, or your patient.

When can your patients enroll in this new plan?

If a beneficiary currently has Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), the beneficiary can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. In general, a beneficiary can join or change plans once each year between November 15 and December 31. If they join a Medicare prescription drug plan:

- By December 31, 2005, their coverage will begin on January 1, 2006; and
- After December 31, 2005, their coverage will be effective the first day of the month after the month they join.

Even if a beneficiary does not use many prescription drugs now, they still should consider joining a plan. If they don't join a plan by May 15, 2006, and they don't have a drug plan that covers as much or more than a Medicare prescription drug plan, they will have to pay more each month to join later.

What if the Medicare beneficiary can not pay for a Medicare prescription drug plan?

Some people with an income at or below a set amount and with limited assets (including their savings and stocks, but not counting their home) will qualify for extra help.

The exact income amounts will be set in early 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions.

The type of extra help received will be based on income and assets. In mid-2005, SSA will send people with certain incomes information about how to apply for extra help in paying for their prescription drug costs. If they think they may qualify for extra help, they can sign up with the Social Security Administration (SSA) or their local Medicaid office as early as the summer of 2005.

Will this new plan work with other Medicare coverage that your patients may have?

Yes, Medicare prescription drug plans work with all types of Medicare health plans, and there will be:

- Medicare prescription drug plans that add coverage to the Original Medicare Plan (these plans will be offered by insurance companies and other private companies); and
- Medicare prescription drug plans that are a part of Medicare Advantage Plans (like HMOs), in some areas.

MMA - The Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006 (SE 0502) (Continued)

What if a Medicare beneficiary has a Medigap policy with drug coverage or prescription drug coverage from an employer or union?
The Medicare beneficiary will get a detailed notice from their insurance company or the employer or union informing them whether or not their policy covers as much or more than a Medicare prescription drug plan. This notice will explain their rights and choices.

If a Medicare beneficiary's employer or union plan covers as much as or more than a Medicare prescription drug plan, they can:
- Keep their current drug plan. If they join a Medicare prescription drug plan later, their monthly premium won't be higher; or
- Drop their current drug plan, and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

If a Medicare beneficiary's employer or union plan covers less than a Medicare prescription drug plan, they can:
- Keep their current drug plan, and join a Medicare prescription drug plan to give them more complete prescription drug coverage; or
- Keep their current drug plan. However, if they join a Medicare prescription drug plan later, they will have to pay more for the monthly premium; or
- Drop their current drug plan and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

Additional Information
More information on provider education and outreach regarding drug coverage can be found at:
http://www.cms.hhs.gov/medlearn/drugcoverage.asp

The information contained in this article is based on a fact sheet for beneficiaries. To obtain a copy of this fact sheet for your patients, visit: **http://www.medicare.gov/Publications/Pubs/pdf/11065.pdf**

You can also find additional information regarding prescription drug plans at: **http://www.cms.hhs.gov/pdps/**

Further information on CMS implementation of the MMA can be found at the following CMS web site:
http://www.cms.hhs.gov/medicarereform/

MMA -Your Important Role - #3: Information for Providers, Physicians, Pharmacists and Their Staffs About Medicare Prescription Drug Coverage (SE 0520)

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0520

Related CR Release Date: N/A

Provider Types Affected
Medicare physicians, institutional providers, pharmacists, and any staff who have contact with Medicare beneficiaries

Provider Action Needed

STOP - Impact to You
On January 1, 2006, a new benefit will be available to the 41 million Americans who receive health insurance coverage through the Medicare program. Medicare Prescription Drug Plans will help reduce the cost of prescription drugs. Your patients may ask you about this new benefit.

CAUTION - What You Need to Know
We need your help to make sure Medicare patients know about and understand this new benefit—information is just a click away. Through Medlearn Matters articles, we will give you access to various levels of information. You decide the level of involvement you want to have in helping Medicare patients.

GO- What You Need to Do
Stay informed, visit: **http://www.cms.hhs.gov/medlearn/drugcoverage.asp** on the web. This web site includes links to all articles in this series and information providers need about the new coverage. At a minimum, refer your Medicare patients to 1-800-MEDICARE and **http://www.medicare.gov** on the Web.

Background
You and your staff are trusted sources of information for your patients. You may be the first source of information that Medicare beneficiaries use to explain Medicare Prescription Drug Coverage. Please encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. **If a beneficiary fails to actively choose a prescription drug plan, they may miss out on cost savings for prescription drugs.** Medicare Prescription Drug Coverage will:

MMA -Your Important Role - #3: Information for Providers, Physicians, Pharmacists and Their Staffs About Medicare Prescription Drug Coverage (SE 0520) (Continued)

- Help pay for prescriptions;
- Provide extra help for people with limited income and resources; and
- Cover brand name and generic drugs.

CMS will include Medicare Prescription Drug Coverage details in the *2006 Medicare & You Handbook,* and send it to beneficiaries in October 2005.

Your Role and Involvement - You Choose

Your interest may range from wanting basic to detailed information on this coverage. For example, if you work in a rural locale, or in areas that serve a large population of beneficiaries with limited income and resources, you may have a greater interest in counseling your patients.

- **Basic -** You know that Medicare Prescription Drug Coverage exists and where to send people to learn about benefit details. You may display a poster (available later this spring) in your office or clinic, and make beneficiary-focused materials available in your office.
- **Intermediate -** You know more about Medicare Prescription Drug Coverage, such as:
  - How beneficiaries can enroll;
  - Co-payment amounts;
  - Where to find additional help for people with limited income and resources;
  - Where to find information on the following web sites:
    - **http://www.medicare.gov**
    - **http://www.cms.hhs.gov/medlearn/drugcoverage.asp**
  - How to answer the basic questions.
- **Advanced -** You know detailed information about Medicare Prescription Drug Coverage and the plans available in your area You, or someone on your staff, can answer detailed questions about the drug benefit. In some cases, you or your staff may counsel beneficiaries on their particular situation and the options that will work best for them.

To Stay Updated on New Information and Educational Resources

- Pay attention to correspondence from your national professional associations—-they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listservs and read their newsletters.
- Keep current with information from your Medicare fee-for-service claims processing contractor; bookmark their website, read their bulletins, and register to receive electronic listserv messages.
- Bookmark and visit the provider educational web page on Medicare Prescription Drug Coverage, **http://www.cms.hhs.gov/medlearn/drugcoverage.asp** on the web.
- Register to receive listserv email messages to alert you when new *Medlearn Matters* articles have been released on the new drug benefit (and other Medicare information); register at **http://www.cms.hhs.gov/medlearn/matters on the web.**
- Participate in CMS Open Door Forums, to hear from and ask questions of CMS leadership on topics of interest to your particular provider type; for information about these forums visit **http://www.cms.hhs.gov/opendoor** on the web.

Get Your Staff Involved

In addition, inform members of your staff who interact with Medicare patients every day about the information in this article:

- Physicians - supply this information to nursing and front office staff.
- Hospitals - supply this information to nursing, discharge planning, financial, and emergency room staff.
- Pharmacists - supply this information to your pharmacy technicians and front counter staff.

If you or your staff are willing to further advise and counsel people with Medicare, CMS will have tools to help you do this on **http://www.cms.hhs.gov/partnerships** (toolkit available by April 1, 2005).

Summary

CMS asks you to:

- Respond to questions from your patients in a way that encourages them to seek more information from the Medicare Program;
- Inform members of your staff who interact with Medicare patients about the information resources available to them, and where they may refer patients to learn more about Medicare Prescription Drug Coverage; and
- At a minimum, refer your Medicare patients who are looking for information on Medicare Prescription Drug Coverage to 1-800-MEDICARE or **http://www.medicare.gov** on the web.

Modified Edits for Matching Claims Data to Beneficiary Records (SE 0516)

Related Change Request (CR) #: N/A **Medlearn Matters Number:** SE0516

Effective Date: N/A

Provider Types Affected
All Medicare physicians, providers, and suppliers

Provider Action Needed

STOP - Impact to You
Claims submitted to Medicare must match a Medicare beneficiary record on Health Insurance Claim Number, beneficiary's last name (surname) and the beneficiary's first name.

CAUTION - What You Need to Know
The name reported on the claim should always be the name shown on the beneficiary's Medicare card. If the name submitted does not match the name on Medicare's files for that beneficiary claim number, Medicare will deny the claim.

GO - What You Need to Do
Be aware of this issue and advise your billing staff they should always use the name from the Medicare card when submitting the claim, even if the patient indicates the name on the Medicare card is incorrect.

Background
Over the past several months, the Centers for Medicare & Medicaid Services (CMS) reviewed its personal characteristics editing logic for processing Medicare claims. The review identified a weakness where processed claims were approved for payment under the wrong beneficiary account number. One of Medicare's key claims processing systems, known as the Common Working File (CWF), was approving claims where the beneficiary name and Health Insurance Claim Number did not match the name and number on the Medicare card.

The Office of the Inspector General in the Department of Health and Human Services recommended that CMS implement a modified process for matching the claim information to the beneficiary information on CWF files to eliminate erroneous payments caused by the existing matching criteria.

In October 2004, CMS made a software change to require an exact match on beneficiary First Initial, Surname, and Health Insurance Claim Number submitted on the claim. Since this change was implemented the number of denials because of name/number mismatch tripled.

To resolve these claim denials, providers should bill using the name and number as it appears on the beneficiary Medicare card. If the beneficiary insists the Medicare card is incorrect, advise the beneficiary to contact their local servicing Social Security Field Office to obtain a new Medicare card.

If you have any questions regarding this issue, contact your Medicare carrier, intermediary, or durable medical equipment regional carrier at their toll free number. You can find that number on the web at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

New Contrast Agents Healthcare Common Procedure Coding System (HCPCS) Codes (CR 3748)

Related Change Request (CR) #: 3748 **Medlearn Matters Number:** MM3748

Related CR Release Date: March 11, 2005

Related CR Transmittal #: 502

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Provider Types Affected
All providers, suppliers and physicians billing Medicare fiscal intermediaries (FIs) or carriers for contrast agents.

Provider Action Needed

STOP - Impact to You
As of April 1, 2005, you must use the new "Q" codes that will be added to the HCPCS when you bill for contrast agents.

CAUTION - What You Need to Know
Beginning on April 1, 2005, the new HCPCS codes for contrast agents will become effective, except for hospital outpatient departments, which should continue to use the current "A" codes.

GO - What You Need to Do
Physicians, suppliers, and providers should make sure your billing staff knows that they must use the new codes that have been added to the Healthcare Common Procedure Coding System as of April 1, 2005 in order to bill for contrast agents.

New Contrast Agents Healthcare Common Procedure Coding System (HCPCS) Codes (CR 3748) (Continued)

Background
Effective April 1, 2005, the HCPCS codes for contrast agents in the following table will be added to the HCPCS.

HCPCS Code	Short Descriptor	Long Descriptor
Q9945	LOCM <=149 mg/ml iodine, 1ml	Low osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9946	LOCM 150-199mg/ml iodine,1ml	Low osmolar contrast material, 150 - 199 mg/ml iodine concentration, per ml
Q9947	LOCM 200-249mg/ml iodine,1ml	Low osmolar contrast material, 200 - 249 mg/ml iodine concentration, per ml
Q9948	LOCM 250-299mg/ml iodine,1ml	Low osmolar contrast material, 250 - 299 mg/ml iodine concentration, per ml
Q9949	LOCM 300-349mg/ml iodine,1ml	Low osmolar contrast material, 300 - 349 mg/ml iodine concentration, per ml
Q9950	LOCM 350-399mg/ml iodine,1ml	Low osmolar contrast material, 350 - 399 mg/ml iodine concentration, per ml
Q9951	LOCM >= 400 mg/ml iodine,1ml	Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml
Q9952	Inj Gad-base MR contrast, ml	Injection, gadolinium-based magnetic resonance contrast agent, per ml
Q9953	Inj Fe-based MR contrast, ml	Injection, iron-based magnetic resonance contrast agent, per ml
Q9954	Oral MR contrast, 100 ml	Oral magnetic resonance contrast agent, per 100 ml
Q9955	Inj perflexane lip micros, ml	Injection, perflexane lipid microspheres, per ml
Q9956	Inj octafluoropropane mic,ml	Injection, octafluoropropane microspheres, per ml
Q9957	Inj perflutren lip micros, ml	Injection, perflutren lipid microspheres, per ml

To view payments for these new Q-codes, go to: **http://www.cms.hhs.gov/providers/drugs/default.asp** on the CMS web site and look in the respective quarterly Medicare Part B drug pricing files posted there. In accordance with the standard methodology for drug pricing established by the Medicare Modernization Act of 2003 (MMA), the payment for these contrast agents will be based on the Average Sales Price (ASP) plus 6 percent effective April 1, 2005.

Implementation
This change will be implemented in Medicare claims processing systems on April 4, 2005.

Related Instructions
Please note that:

- HCPCS codes Q9945 - Q9951 will replace codes A4644 - A4646; and
- HCPCS codes Q9952 - Q9954 will replace codes A4643 and A4647; **except that**
- **Hospital outpatient departments shall continue to bill codes A4644 - A4646, A4643, and A4647 and shall not report codes Q9945 - Q9957.**
- Non-institutional providers billing the carriers shall use Q9955 - Q9957 to report specific echocardiography contrast agents.
- All other echocardiography contrast agents not described by Q9955 -Q9957 shall be reported with A9700.

Additional Information
The official instruction issued to your carrier/intermediary regarding this change may be found on the web at: **http://www.cms.hhs.gov/manuals/pm_trans/R502CP.pdf**

Also 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**

New Remittance Advice (RA) Message for Referred Clinical Diagnostic/Purchased Diagnostic Service Duplicate Claims (CR 3679)

Related Change Request (CR) #: 3679

Related CR Release Date: February 25, 2005

Related CR Transmittal #: 484

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Medlearn Matters Number: MM3679

Revised

NOTE: This article was revised on March 17, 2005, to reflect a change to CR 3679, which was reissued on February 25, 2005. The CR 3679 was modified to show that the effective date of this change applies to claims processed on or after July 1, 2005, without regard to the date of service on the claim.

Provider Types Affected

Physicians/suppliers who bill Medicare carriers (excluding DMERCs) for referred clinical diagnostic laboratory and purchased diagnostic services.

Provider Action Needed

STOP - Impact to You

Effective April 1, 2005 a claim for a referred clinical diagnostic/purchased diagnostic service that is identified as duplicate will be denied. For full details of this edit, please see Medlearn Matters article MM3551 at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3551.pdf

CAUTION - What You Need to Know

Effective with claims processed on or after July 1, 2005, CMS will implement a new Remittance Advice (RA) message for such duplicate claims. Carriers will use the following remark code *on remittance advice notices* generated for a referred clinical diagnostic/purchased diagnostic service claim line item denied as a duplicate of a previously paid service: "Your claim for a referred clinical diagnostic/purchased diagnostic service cannot be paid because payment has been made for this service in another carrier jurisdiction."

GO - What You Need to Do

Be ready to accept this new remark code indicating a duplicate claim submission.

Background

Effective April 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will implement a new Common Working File (CWF) edit to check for duplicate claims for referred clinical diagnostic laboratory services and purchased diagnostic services submitted by physicians/suppliers to more than one carrier. (Per Transmittal 124, Change Request 3551, published on October 29, 2004 and described in Medlearn Matters article MM3551)

As a reminder, claims submitted for referred clinical diagnostic/purchased diagnostic services will be considered duplicate when

- The claims contain different carrier numbers;

AND

- All of the data matches on the following claim fields:
  - Beneficiary Name
  - Beneficiary Health Insurance Claim Number (HICN)
  - Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Code
  - Date of Service
  - CPT/HCPCS Code Modifier.

The CWF duplicate claim edit will apply only to:

- Claims containing a CPT code that is included on the clinical laboratory fee schedule (available online at: **http://www.cms.hhs.gov/suppliers/clinlab/default.asp,** Clinical Laboratory Information Resource for Medicare);

OR

- An HCPCS code that is included on the Abstract File for Purchased Diagnostic Tests/Interpretations to be implemented in April 2005.

Effective for claims processed on or after July 1, 2005, CMS will implement a new Remittance Advice (RA) message for claim items denied due to the CWF duplicate claim edit for referred clinical diagnostic/purchased diagnostic service claims:

New Remittance Advice (RA) Message for Referred Clinical Diagnostic/Purchased Diagnostic Service Duplicate Claims (CR 3679) (Continued)

- Carriers will use the following remark code on remittance advice notices generated for a referred clinical diagnostic/purchased diagnostic service claim line item denied as a duplicate of a previously paid service: "Your claim for a referred clinical diagnostic/purchased diagnostic service cannot be paid because payment has been made for this service in another carrier jurisdiction."

Additional Information
The official instruction issued to the carrier regarding this change can be found at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3679. Click on the link to open and view the file for the CR. CR 3551 may be accessed at:
http://www.cms.hhs.gov/manuals/pm_trans/R124OTN.pdf

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

Payment Amounts for the Influenza Virus Vaccine (CPT 90658) and the Pneumoccocal Vaccine (CPT 90732) When Payment is Based on 95 Percent of the Average Wholesale Price (AWP) (CR 3490)

Related Change Request (CR) #: 3490

Medlearn Matters Number: MM3490

Related CR Release Date: September 17, 2004

Related CR Transmittal #:114

Effective Date: September 1, 2004

Implementation Date: October 1, 2004

Provider Types Affected
Physicians, non-physician practitioners, providers, and suppliers

Provider Action Needed

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

CAUTION - What You Need to Know
Annual Part B deductible and coinsurance amounts do not apply

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

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

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

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

Payment Policy Clarification Regarding the Healthcare Common Procedure Coding System (HCPCS) Code Q3001 Performed in an Ambulatory Surgery Center (ASC) (CR 3789)

Related Change Request (CR) #: 3789

Related CR Release Date: April 8, 2005

Related CR Transmittal #: 520

Effective Date: January 1, 2005

Implementation Date: May 9, 2005

Medlearn Matters Number: MM3789

Revised

Note: This article was revised on April 22, 2005, to show that it affects physicians billing for HCPCS code Q3001 and to clarify that the code is carrier priced on the 2005 Medicare Physician Fee Schedule.

Provider Types Affected
Physicians billing Medicare carriers for HCPCS code Q3001 performed in an ASC setting

Provider Action Needed
STOP - Impact to You
HCPCS code Q3001 should be used by providers on claims when billing for radioelements for brachytherapy performed in an ASC setting, instead of the Current Procedural Terminology (CPT) code 79900, effective January 1, 2005.

CAUTION - What You Need to Know
There has been confusion among ASCs and Medicare carriers regarding the use of HCPCS code Q3001. HCPCS Q3001 is carrier priced on the 2005 Medicare Physician Fee Schedule and should be used when billing for prostate brachytherapy procedures when performed in an ASC setting

GO - What You Need to Do
Be aware of the current payment policy for Q3001 and Medicare carriers will process claims containing this code when the services are performed on or after January 1, 2005.

Background
The Centers for Medicare & Medicaid Services (CMS) is aware of confusion among carriers and providers when HCPCS code Q3001 is used to bill for prostate brachytherapy procedures performed in an ASC setting.

Effective January 1, 2005, Q3001 is carrier priced under the 2005 Medicare Physician Fee Schedule Database (MPFSDB) and can be billed to Medicare carriers for Part B services. Previously, Q3001 was only paid under the Outpatient Prospective Payment System (OPPS) and billable only to Medicare fiscal intermediaries.

This instruction and CR 3789 clarify CMS' payment policy decision regarding the use of Q3001 on Medicare claims. HCPCS code Q3001 should be used instead of CPT 79900 when billing for prostate brachytherapy procedures performed in an ASC, on and after January 1, 2005.

Additional Information
For complete details, please see the official instruction issued to your carrier regarding this change which may be found at: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**

From that web page, look for CR 3789 in the CR NUM column on the right, and then click on the file for that CR.

If you have questions regarding this issue, contact your carrier on their toll free number available at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Population-Based Disease Management - Use of Group Health Plan Payment System for Medicare Disease Management Demonstration Serving Medicare Fee For Service Beneficiaries (SE 0519)

Related Change Request (CR) #: N/A

Effective Date: N/A

Medlearn Matters Number: SE0519

Provider Types Affected
All Medicare providers

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) has begun a Medicare Disease Management Demonstration to improve care for chronically ill Fee-For-Service Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The Disease Management Organization, LifeMasters, is currently enrolling beneficiaries in Florida.

Population-Based Disease Management - Use of Group Health Plan Payment System for Medicare Disease Management Demonstration Serving Medicare Fee For Service Beneficiaries (SE 0519) (Continued)

This Disease Management Organization is not an HMO, but is being paid, using the CMS Group Health System/MMCS, to pay a fixed monthly payment for disease management services as an "OPTION 1" cost plan or as an "OPTION 4" plan, which will be a phase in over the next few months. "OPTION 4" means the same as "OPTION 1" but will reference "Chronic Care Organizations" and will also help to differentiate the demonstration enrollees from an HMO enrollee.

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

LifeMasters = H5413 (plan number) in the Medicare systems

Reminder: The Medicare beneficiaries participating in the Medicare Disease Management Demonstration are NOT enrolled in an HMO; they should be treated as traditional Fee-For-Service beneficiaries. No referrals for care are needed and all Fee-For-Service claims will be processed under traditional Medicare payment rules.

Background

This population based demonstration is intended to evaluate how disease management services can improve the health outcomes of Medicare beneficiaries diagnosed with advanced-stage illness from congestive heart failure, diabetes, or coronary heart disease. Up to 30,000 eligible Medicare Fee-For-Service beneficiaries will be enrolled in the treatment arm of the study during the three-year project in Florida.

The project will help Medicare:

- Find better ways to improve the quality of life for people with diabetes and chronic heart disease;
- Determine the benefits of disease management programs for chronically ill persons; and
- Find ways to make these services available to people with Medicare.

The disease management participants will receive disease management services in addition to their usual Medicare benefits. All participants remain in the traditional Fee-For-Service Medicare program under the care of their own doctor. The program is voluntary and the decision whether or not to participate does not affect Medicare benefits.

Demonstration Location

Florida - LifeMasters will be providing services to 30,000 eligible Medicare beneficiaries with congestive heart failure, diabetes, and coronary heart disease in Florida. (Questions? Call 1-888-716-2838).

Medicare Eligibility File Inquiry Screens

When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, Medicare systems screens will display a line item indicating enrollment in an "Option 1" HMO Cost Plan or an "Option 4" plan. The definition of Option 1 means that Medicare is still primary and Fee-For-Service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional Fee-For-Service program. **Even though this demonstration is coded with an HMO plan number, the beneficiaries are not enrolled in an HMO.** Beneficiaries or providers calling to confirm Medicare eligibility should be informed that they/the patient are Medicare eligible and that they are Fee-for-Service beneficiaries, not enrolled in an HMO cost plan.

Prosthetics and Orthotics Ordered in a Hospital or Home Prior to a Skilled Nursing Facility Admission (SE0507)

Related Change Request (CR) #: N/A **Medlearn Matters Number:** SE0507

Effective Date: N/A

Provider Types Affected

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

Provider Action Needed

This article is informational only and describes who is responsible for billing when a customized device is ordered for beneficiary while in the hospital or home but delivered to the beneficiary at a skilled nursing facility.

Background

When a customized device is ordered while a beneficiary is an inpatient at a hospital, and the device is not delivered until after the beneficiary has moved to a Skilled Nursing Facility (SNF), the issue arises as to who is responsible for the billing of the item.

When a beneficiary is going from a hospital stay to a SNF Part A stay and needs an orthotic or prosthetic device, the facility where the medical need occurred is responsible for billing (rather than the supplier or provider of the device, which would bill for

Prosthetics and Orthotics Ordered in a Hospital or Home Prior to a Skilled Nursing Facility Admission (SE0507) (Continued)

instances when need is established while the beneficiary is at home or in the community). Thus, if a prosthetic or orthotic device is medically necessary at the time the beneficiary is in the hospital, in the rare case when the prosthetic or orthotic is not delivered until the beneficiary has arrived at the SNF, the hospital remains responsible for billing for the item.

However, when the medical necessity for the prosthetic or orthotic device occurs after the time the Part A resident enters the SNF; the SNF is responsible for the billing of the prosthesis or orthosis. Given that most prosthetics (and all orthotic devices) are subject to SNF consolidated billing, the cost would be covered in the SNF's global per diem payment unless the item is specifically excluded from SNF consolidated billing. Certain specified customized prosthetics are excluded and if the need for these devices was established in the SNF, the supplier is to bill the Durable Medical Equipment Regional Carrier (DMERC).

When a beneficiary requires a prosthesis or orthosis while in the home and then enters a SNF for a covered Part A stay, the DMERC would be billed by the party which supplied the device (not the SNF). Medical necessity must have been established while the beneficiary was in the home.

If the beneficiary enters a SNF for a non-covered stay and thereafter develops a medical need for a customized device which the SNF orders, the SNF would bill the DMERC for the item, since SNF consolidated billing rules do not apply.

Additional Information
See the Medicare Claims Processing Manual, Pub. 100-4, Chapter 20, §110.3, "Pre-Discharge Delivery of DMEPOS for Fitting and Training," which covers instances in which a beneficiary may take delivery of DME, a prosthetic, or an orthotic for use at home during his or her last two days in an inpatient facility before returning home. This publication can be found at:
http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Also, see Medlearn Matters Special Edition SE0437 for an article that provides specifics on how SNF consolidated billing applies to prosthetics and orthotics. This article can be found at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf

In addition, the CMS Medlearn Consolidated Billing web site 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 web site 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).

Revised Manual Language to Item 24G (Days or Units) CMS-1500 Instructions Regarding the Billing of Oxygen and Oxygen Equipment (CR 3753)

Related Change Request (CR) #: 3753

Medlearn Matters Number: MM3753

Related CR Release Date: March 18, 2005

Related CR Transmittal #: 506

Effective Date: July 1, 2005

Implementation Date: July 1, 2005

Provider Types Affected
Providers and suppliers billing carriers and Durable Medical Equipment Regional Carriers (DMERCs) for oxygen and oxygen equipment

Provider Action Needed

STOP - Impact to You
Suppliers and providers should note that this instruction is based on information contained in Change Request (CR) 3753 regarding revised manual language for oxygen billing instructions for CMS-1500 contained in the Medicare Claims Processing Manual (Pub. 100-04).

Revised Manual Language to Item 24G (Days or Units) CMS-1500 Instructions Regarding the Billing of Oxygen and Oxygen Equipment (CR 3753) (Continued)

CAUTION - What You Need to Know
The language contained in Chapter 26, Section 10.4, Item 24G of the CMS-1500 claim form regarding the billing of oxygen claims is being revised, and the Item 24G billing requirements will include a reference to the actual oxygen billing instructions contained in Chapter 20, Section 130.6 of the Medicare Claims Processing Manual.

GO - What You Need to Do
Please see the Background and Additional Information Sections of this instruction for further details regarding these changes.

Background
The Medicare Claims Processing Manual (Pub. 100-04) language contained in Chapter 26, Section 10.4, Item 24G provides an explanation of how to fill out Item 24G (Days or Units) of the CMS-1500 claim form, and the billing requirements for Item 24G can vary based on the type of service being billed.

The current language explaining the procedures for billing for oxygen is inaccurate and outdated and is removed by CR 3753. The language is being replaced with a direct reference to Chapter 20, Section 130.6 of the same manual that deals with billing for oxygen and oxygen equipment.

The following is the revised wording (bolded and italicized) that is being added to Item 24G (Pub. 100-04, Chapter 26, Section 10.4):

For instructions on submitting units for oxygen claims, see Chapter 20, Section 130.6.

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Section 130 (Billing for Durable Medical Equipment (DME) and Orthotic/ Prosthetic Devices), Subsection 130.6 (Billing for Oxygen and Oxygen Equipment) can be found at:
http://www.cms.hhs.gov/manuals/104_claims/clm104c20.pdf

Implementation
The implementation date for this instruction is July 1, 2005.

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

From that web page, look for CR 3753 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/DMERC at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Skilled Nursing Facility Consolidated Billing as it Relates to Certain Diagnostic Tests (SE 0440)

Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Medlearn Matters Number: SE0440
Revised

NOTE: This article was revised on February 18, 2005. Specifically, line 4 of the "Clarification" statement below was modified to say "These "excluded" services...." instead of "These included services..." We regret this error.

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) as well.

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare Durable Medical Equipment Regional Carrier (DMERC.)

Skilled Nursing Facility Consolidated Billing as it Relates to Certain Diagnostic Tests (SE 0440) (Continued)

Background
When the SNF Prospective Payment System (PPS) was introduced in 1998, it not only changed the way SNFs are paid, but changed 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. See Medlearn Matters Special Edition SE0431 at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

It contains a detailed overview of SNF CB and a list of the services excluded from SNF CB. 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.

Since many diagnostic tests include both a technical component and a professional component, suppliers need to generate two bills. For example, with regard to 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 their Medicare carrier) 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, though, 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 Medicare carriers or intermediaries 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, 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 web site 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.

Also, the SNF PPS Consolidated Billing web site 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)

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS):
http://www.cms.hhs.gov/suppliers/dmepos
contains information pertaining to durable medical equipment and supplies.

Skilled Nursing Facility (SNF) Consolidated Billing as It Relates to Dialysis Coverage (SE 0435)

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0435

Effective Date: N/A

Revised

Implementation Date: N/A

Note: This article was revised on February 2, 2005, to include clarifying language, but no substantive changes were made.

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**

Clarification
The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These excluded services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare Durable Medical Equipment Regional Carrier (DMERC))

Background
Dialysis furnished to a 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 and 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, Section103) excluded from SNF CB those ambulance services that are necessary to transport a 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 web site may 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 versions.

Skilled Nursing Facility (SNF) Consolidated Billing as It Relates to Dialysis Coverage (SE 0435) (Continued)

The SNF PPS Consolidated Billing web site 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).

Skilled Nursing Facility (SNF) Consolidated Billing (CB) as It Relates to Therapy Services (SE 0518)

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0518

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected
Skilled Nursing Facilities (SNFs), physicians, practitioners, physical and occupational therapists, speech-language pathologists, rehabilitation agencies, hospitals, home health agencies

Provider Action Needed
This article is informational only and describes SNF Consolidated Billing (CB) as it applies to physical and occupational therapies and speech-language pathology services furnished to SNF residents during a Part A covered stay, residents of a Medicare-certified SNF who are not eligible for Part A care, and beneficiaries who reside in the non-certified portion of a nursing home.

Note: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier (DMERC.)

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 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. A covered Part A stay occurs when a beneficiary meets all of the requirements for coverage under Part A's extended care benefit, and resides in an institution or part thereof that is Medicare-certified as an SNF. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are services specifically excluded from this consolidated billing provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service.

The law specifically provides that physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services are not excluded from consolidated billing (Section 1888(e)(2)(A)(ii) of the Social Security Act and regulations at 42 CFR 411.15(p)(1)(i)). (References in this article to therapy cover only PT, OT, and SLP services.)

(See Medlearn Matters Special Edition article SE0431 for a detailed overview of SNF consolidated billing, including a section on services excluded from the SNF consolidated billing.) This article can be found at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

The consolidated billing legislation is very emphatic that PT, OT, and SLP services furnished to SNF residents are always subject to consolidated billing. This applies even when a resident receives the therapy during a non-covered stay in which a beneficiary who is not eligible for Part A extended care benefits still resides in an institution (or part thereof) that is Medicare-certified as a SNF. The legislation also applies regardless of whether or not the services are performed by, or under the supervision of, a practitioner (such as a physician) whose services would otherwise be excluded from consolidated billing.

Therapy services that are furnished to residents of a Medicare-certified SNF are subject to the SNF consolidated billing provision. Payment for therapy services furnished during a covered Part A stay is included in the SNF's global per diem PPS rate.

Skilled Nursing Facility (SNF) Consolidated Billing (CB) as It Relates to Therapy Services (SE 0518) (Continued)

In a non-covered SNF stay, the beneficiary may be eligible for coverage of individual medical and other health services under Part B. Since the beneficiary still resides in a Medicare-certified institution (or part thereof) the therapy services are subject to the SNF consolidated billing provision. Under this provision, the claims for therapy services furnished during a non-covered SNF stay must be submitted to Medicare by the SNF itself. The SNF is responsible for reimbursing the provider. The SNF would bill its fiscal intermediary and be reimbursed under the Medicare fee schedule.

When a beneficiary resides in a nursing home (or part thereof) that is not certified as an SNF by Medicare, the Part A extended care benefit cannot cover the beneficiary's stay. However, the beneficiary may still be eligible for Part B coverage of certain individual services, including therapy. In this case, the beneficiary is not considered an SNF resident for Medicare billing purposes, and the therapy services are not subject to consolidated billing. Either the therapy provider or the facility may bill the Medicare carrier for Part B directly.

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 Web site 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 web site 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).

The Centers for Medicare & Medicaid Services (CMS) Consolidation of the Claims Crossover Process (SE 0504)

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0504

Related CR Release Date: N/A

Provider Types Affected
All Medicare physicians, providers, and suppliers

Provider Action Needed
Physicians, providers, and suppliers should note that this special edition article is to inform you of system changes to implement a switch from 1) Medicare intermediaries, carriers, and Durable Medical Equipment Regional Carriers (DMERCs) crossing supplemental claims to supplemental insurers to 2) a single entity, the Coordination of Benefits Contractor (COBC), doing the same from one location.

Background
The Centers for Medicare & Medicaid Services (CMS) is consolidating the Medicare claims crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA) initiative.

Currently, supplemental payers/insurers (including eligibility-file-based Medigap, Medicaid and employer plans) **must sign multiple crossover agreements** with Part A intermediaries and Part B carriers and Durable Medical Equipment Regional Carriers (DMERCs) to accomplish an automatic, or eligibility-file based, crossover to other insurers that pay after Medicare has made its payment decision on a claim.

The Centers for Medicare & Medicaid Services (CMS) Consolidation of the Claims Crossover Process (SE 0504) (Continued)

In the future (under the new consolidated claims crossover process) **supplemental payers/insurers will sign one national crossover agreement** and work directly with the COBC (which represents CMS). The supplemental payer/insurer will:

- Send eligibility files to identify its covered members, and
- Receive outbound HIPAA ANSI X-12N 837 Coordination of Benefits (COB) claims and National Council for Prescription Drug Programs (NCPDP) claims for use in calculating their secondary payment liability.
- On July 6, 2004, CMS began testing the consolidated crossover process with approximately ten supplemental payers/insurers. Note the following:
  - Testing is focused on the outbound HIPAA ANSI X-12 837N COB claims that are translated from Medicare's Part A intermediary, Part B carrier, and DMERC processed claims.
  - Initial -implementation will take place after successful testing is completed, and the 10 supplemental payers/insurers will be moved to full COBA crossover production through one entity, the COBC.
  - Throughout the course of fiscal year 2005, CMS will begin transitioning all supplemental payers/insurers from the existing eligibility file-based crossover process to the national COBA process.

Detailed requirements for 1) eligibility file-based crossover and 2) claim-based (mandatory Medigap) crossover were previously issued by CMS in Change Request (CR) 3109 (Transmittal 98), and CMS subsequently issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. Transmittal 138 may be accessed at: **http://www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf**

CR 3218 (Transmittal 138) provided:

- Major changes to many of the requirements previously published in CR 3109 (Transmittal 98) and
- Moved the implementation of claim-based crossover to a future date.

Physician, Provider, and Supplier Action

NOTE: Physicians, providers, and suppliers will not need to take any new actions with respect to the COBA automatic (or eligibility-file-based) crossover process.

The key difference between the existing automatic crossover process and the new COBA automatic crossover process is that, when a supplemental payer/insurer provides CMS with specific claim types and member information for those claims they wish to receive, **the claims will be crossed over to the supplemental payers/insurers only after the claims have left the Medicare claims payment floor.**

Thus, **physician, provider, and supplier offices should receive payment and/or processing information** from a patient's supplemental payer/insurer **after the Medicare payment has been received** (once the supplemental payer/insurer has transitioned to the COBA crossover process).

Physicians, providers, and suppliers will be able to reference a listing of eligibility file-based COBA trading partners on the COBA portion of the following CMS COB web site as supplemental payers/insurers are scheduled to move to full eligibility-file-based crossover production under the COBC: **http://www.cms.hhs.gov/medicare/cob/coba/coba.asp.** (This listing is not currently available but will be available after supplemental payers/insurers have moved to full production with the COBC.)

Physicians, providers, and suppliers should note that the following important information will require your attention when a supplemental payer/insurer 1) has transitioned to the COBA eligibility-file-based crossover process and 2) is listed on the web site noted in the previous paragraph.

- Although the claim may cross to multiple supplemental payers/insurers, only one will print on your remittance advice. In this situation, if one of the supplemental payers/insurers is Medigap, the Medigap insurer will always print.
- Since payment from the supplemental payer/insurer should occur only after the Medicare payment has been issued, it is advised that you do not bill the supplemental payer/insurer for a minimum of 15 work days after receiving the Medicare payment. This will allow sufficient time for the claim to cross to the supplemental payer/insurer and the subsequent actions necessary to issue payment from the supplemental payer/insurer.
- In addition, prior to submitting a claim to the supplemental payer/insurer, it is advised that you use available self-service tools to research the status of your supplemental payment, e.g., the supplemental payer/insurer's website, claims automated "hot line," etc.
- There may be situations (such as claim errors related to HIPAA) that prevent the automatic crossover from occurring after you have received a Medicare remittance advice (electronic or supplemental paper) notifying you that the claim has crossed to the supplemental payer/insurer.
- Again, it is advised that you allow a minimum of 15 work days after Medicare payment has been issued before billing the supplemental payer/insurer to ensure that an automatic supplemental payment will not be issued. In addition, it is advised that you use the self-service tools of the supplemental payer/insurer to research the status of your supplemental claim prior to submitting it for supplemental payment.
- As a reminder, only the "official" Medicare remittance advice or HIPAA 835 Electronic Remittance Advice should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:

The Centers for Medicare & Medicaid Services (CMS) Consolidation of the Claims Crossover Process (SE 0504) (Continued)

- You are billing the supplemental payer/insurer after the 15 work days from the Medicare- issued payment have expired, and
- You have used the available self-service tools to research the status of your supplemental payment,

Special Note for Physicians and Suppliers

Currently, Part B carriers and DMERCs assign identification numbers (known as In-key or OCNA numbers) to Medigap insurers that do **not** participate in the automatic, or eligibility-file-based, crossover process.

There are no current changes to this process and no current action is required of physicians, providers, and suppliers to change internal procedures related to Medigap claim-based crossovers. Participating physicians and suppliers that bill Part B carriers and DMERCs for claim-based crossover will be informed approximately 90 days prior to implementing any changes to the claim based crossover process. CMS expects this method of crossover to decrease sharply under the consolidated COBA crossover process, since most Medigap insurers will now have a single entity to which they can submit eligibility files to identify their covered members.

Related Instructions

On April 9, 2004, CMS issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. CR 3218 (Transmittal 138), may be viewed at: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**

From that web page, look for CR 3218 in the CR NUM column on the right, and click on the file for that CR.

Additional Information

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

Therapy - Update to 100-04 and Therapy Code Lists (CR 3647)

Related Change Request (CR) #: 3647

Related CR Release Date: April 1, 2005

Related CR Transmittal #: 515

Effective Date: January 3, 2005

Implementation Date: July 5, 2005

Medlearn Matters Number: MM3647

Revised

Note: This instruction was revised on April 4, 2005, because CR 3647 was reissued. This instruction reflects the revised release date and transmittal number for CR 3647. No other changes were made to the instruction.

Provider Types Affected

Providers billing intermediaries and carriers for Part A inpatient and Part B outpatient services

Provider Action Needed

Providers should note that this instruction provides details from Change Request (CR) 3647 which updates the list of Healthcare Common Procedure Coding System (HCPCS) codes describing therapy services including physical therapy, occupational therapy, and speech-language pathology. It also clarifies the term "always therapy" codes. The term "therapy" as used in this instruction refers only to physical therapy, occupational therapy, and speech-language pathology. The term "therapists" refers to physical therapists, occupational therapists, speech-language pathologists, and, in some cases, to physicians, clinical nurse specialists, nurse practitioners, and physician assistants who may provide therapy services.

Background

Change Request (CR) 3647 updates the list of HCPCS codes that describe therapy services for physical therapy, occupational therapy, and speech-language pathology. Some of these changes are required to prevent conflicts with OPPS codes, which were effective January 1, 2005, and others are updates to the current list.

Financial limitations on therapy services were mandated by the Balanced Budget Act (BBA), and in order to limit the services, a list of the services to which limits would apply was developed and published as AB-03-018 in February 7, 2003. The original list may be viewed at: **http://www.cms.hhs.gov/manuals/pm_trans/AB03018.pdf**

Specialty codes 73 and 74 were incorrectly noted in Transmittal AB-03-018 and have since been reassigned to specialties that are not therapy services.

This list is being updated due to new codes and new information about the codes listed. The limitations are not in effect in the year 2005, but are mandated to be implemented on January 1, 2006 unless new legislation is passed. Regardless of whether financial limitations are in effect, CMS uses this list to identify therapy services for policy purposes.

Therapy - Update to 100-04 and Therapy Code Lists (CR 3647) (Continued)

Applicable Outpatient Rehabilitation HCPCS Codes

CMS identifies the following codes as therapy services. See the notes below the table for details about each code.

The financial limits (when in effect) apply to services represented by the following codes, except as noted below.

Note: Listing of the following codes does not imply that services are covered.

Table 1: HCPCS Codes Identified as Therapy Services

64550+	90901+	*92506*	*92507*	*92508*	*92526*
92597	*92605*** **	*92606*** **	*92607*	*92608*	*92609*
92610+	92611+	92612+	92614+	92616+	95831+
95832+	95833+	95834+	95851+	95852+	96105+
96110+@#	96111+#	96115+#	*97001*	*97002*	*97003*
97004	*97010*** **	*97012*	*97016*	*97018*	*97020*
97022	*97024*	*97026*	*97028*	*97032*	*97033*
97034	*97035*	*97036*	*97039*	*97110*	*97112*
97113	*97116*	*97124*	*97139*	*97140*	*97150*
*97504***	*97520*	*97530*	97532+	*97533*	*97535*
97537	*97542*	97597+	97598+	*97602*** **	*97605*** **
*97606*** **	*97703*	*97750*	*97755*	*97799**	G0779+***
G0280+***	*G0281*	*G0283*	*G0289*	0029T+***	

* The physician fee schedule abstract file does not contain a price for codes 96110, or 97799, since the carrier prices them. Therefore, the Fiscal Intermediary (FI) must contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

@ Effective January 1, 2004, 96110 will be an active code on the physician fee schedule. Carriers shall no longer price this code.

** Code 97504 should not be reported with code 97116. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed; both codes may be billed with modifier 59 to denote a separate anatomic site.

*** The physician fee schedule abstract file does not contain a price for codes G0279, G0280, 0020T, or 0029T since they are priced by the carrier. In addition, the carrier determines coverage for these codes. Therefore, the FI contacts the carrier to obtain the appropriate fee schedule amount.

****Codes are bundled. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, Medicare does not pay separately for these codes. If billed alone, either code will be denied using group code CO on the remittance advice notice with claim adjustment reason code 97 that says: “Payment is included in the allowance for another service/procedure.” Medicare will use reason code 97 to deny a procedure code that should have been bundled. Alternatively, reason code B15, which has the same intent, may also be used.

 # If billed by an outpatient hospital department, these are paid using the Outpatient Prospective Payment system (OPPS).

Underlined codes are always therapy services, regardless of the circumstances or who performs them. These codes always require therapy modifiers whenever they are billed.

+ Codes sometimes represent therapy services. These codes and all codes on the above list always represent therapy services when performed by therapists.

There are some circumstances when these codes will not be considered representative of therapy services and therapy limits (when they are in effect) will not apply. Codes marked + are not therapy services when:

- It is not appropriate to bill the service under a therapy plan of care, and
- They are billed by providers of services who are not therapists, i.e., physicians, clinical nurse specialists, nurse practitioners and psychologists.

The Codes marked + on the above list may not be used by therapists, or by physicians, or by non-physician practitioners who are not therapists without a therapy modifier in situations where the service provided is integral to an outpatient rehabilitation therapy service. It is not the +code itself, but the circumstance under which a +code is billed that determines whether a modifier is required. Physicians and non-physician practitioners who can appropriately provide the services represented by the codes marked ‘+’ on the above list should only use therapy modifiers (GP, GN, GO) with the above codes when the services are outpatient rehabilitation therapy services provided under a therapy plan of care. **Do not use the modifier when it is not needed.**

Therapy services, whether represented by “always therapy” codes, or “sometimes therapy codes in the above list performed as outpatient rehabilitation therapy services, must follow all the policies for therapy services (see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 5, and the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 15).

Therapy - Update to 100-04 and Therapy Code Lists (CR 3647) (Continued)

Additional HCPCS Codes
Codes that are not on the list of therapy services should not be billed with a modifier. There are thousands of such codes; but, for example, the following outpatient non-rehabilitation HCPCS codes should be billed without modifiers:

Table 2: Outpatient Non-Rehabilitation HCPCS Codes

95860	95861	95863	95864	95867	95869	95870
95900	95903	95904	95934	G0237	G0238	G0239

Note: The above codes are intended to facilitate the contractor's ability to pay claims under the Medicare Physician Fee Schedule (MPFS). They are not intended to be a list of all covered OPT services and they do not assure coverage of these services.

Implementation
The implementation date for this instruction is July 5, 2005.

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

From that web page, look for CR 3647 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**

Tool Available for Registering Patients with Implantable Cardioverter Defibrillators (SE 0517)

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0517

Effective Date: N/A

Provider Types Affected
Physicians and other providers needing to register Medicare patients receiving the Implantable Cardioverter Defibrillator (ICD) as primary prevention of sudden cardiac death

Provider Action Needed

STOP - Impact to You
The Centers for Medicare & Medicaid Services (CMS) requires that any Medicare patient receiving an ICD as primary prevention of sudden cardiac death be enrolled in a data collection system. CMS has an electronic tool available to Medicare participating hospitals to assist in submitting this data to the data collection system, also referred to as the registry.

CAUTION - What You Need to Know
CMS identifies Medicare patients receiving an ICD for primary prevention indications and requiring participation in a registry in the coverage policy at: **http://www.cms.hhs.gov/mcd/viewimplementation.asp?id=148.**

GO - What You Need to Do
Review this article for more details and work closely with your hospital to ensure it is participating in data collection and you are providing necessary data.

Background
CMS has released an Implantable Cardioverter Defibrillator Abstraction (ICDA) tool to facilitate the collection of information related to ICDs. The tool is available for download by each hospital's QualityNet Exchange Administrator from the following Internet location: **http://www.qnetexchange.org/icda**

Please note that users must utilize this direct link to access the ICDA information. Once at this page, you will see a brief overview of the tool and then click on "ICDA Tools" to begin the download process for the tool and associated guides for using the tool. Also available on the web site is a "paper" tool. This is a one-page, printable version of the ICDA and contains a list of all data elements collected in the tool.

Providers are not required to use the paper tool. In addition, Frequently Asked Questions are available at the same web location.

CMS has already notified many providers of the availability of this tool through the Hospital Data Collection auto-notification public list and the Inpatient Point of Contact ListServe.

Tool Available for Registering Patients with Implantable Cardioverter Defibrillators (SE 0517) (Continued)

CMS covers ICDs for certain populations of patients as both primary and secondary prevention of sudden cardiac arrest. However, Medicare requires that any Medicare patient receiving an ICD or replacement ICD as primary prevention be enrolled in a data collection system. Submitting patient information through the ICDA tool satisfies the coverage requirement. The complete document describing the coverage policy and data submission requirements is located on the CMS web site at:
http://www.cms.hhs.gov/mcd/viewimplementation.asp?id=148

Beneficiaries receiving an ICD for primary prevention can be identified through the absence of ICD-9-CM diagnosis codes for secondary prevention from the claim. A patient claim for which at least one of the following codes does not appear for secondary prevention could signify that the patient should be enrolled in a registry. Medicare Part B claims submitted on or after April 1, 2005 for implantation of an ICD for primary prevention should include a QR modifier to signify that the patient is enrolled in a registry.

Although CMS does not have a coding mechanism for Part A claims that is similar to the function of modifier QR on Part B claims, CMS will have the ability to match inpatient claims to identify and review registry participation through other mechanisms.

Because coding practices may vary slightly, providers should rely primarily on the coverage guidance provided at **http://www.cms.hhs.gov/mcd/viewimplementation.asp?id=148** to determine whether data submission is required. The following codes serve to assist in identifying patients with previous arrhythmias (secondary prevention) however depending on coding practices may not accurately reflect the requirements for coverage:

- 427.1 Ventricular tachycardia
- 427.41 Ventricular fibrillation
- 427.42 Ventricular flutter
- 427.5 Cardiac arrest
- 427.9 Cardiac dysrhythmia, unspecified

The ICDA tool allows for on-line collection of registry information, including patient identifiers, history and clinical characteristics, medications, ICD indications, device information, complications, and facility and provider information. The ICDA tool allows for the ability to import and export data utilizing existing XML standards.

Using the ICDA tool to collect standardized data assists CMS in making a reasonable and necessary determination for Medicare patients. At this time, users are encouraged to utilize the tool for data collection activities as it is a requirement of Medicare coverage for patients who receive the device for primary prevention of sudden cardiac arrest (patients without history of an arrest or arrhythmia).

Three individually recorded ICDA training sessions will be available for viewing and/or downloading from the ICDA site in the near future. Physicians and providers with dial-up Internet connections can download the recordings for viewing. QIOs can also download the recordings and transfer them to a CD for distribution to providers.

The three individual recorded sessions, which allow for subject matter-specific viewing, are as follows:

- ICDA 1.0 Installation and Setup
- ICDA 1.0 Abstraction Processes (New, Edit)
- ICDA 1.0 Import and Export

In addition, the ICDA User's Guide, available from the ICDA site, provides detailed instructions on the installation, set-up, and utilization of the tool.

Location of Software and Documents
The following software and associated documents are accessed from the "Tools" option available from the ICDA Overview page at **http://www.qnetexchange.org/icda:**

- Access the ICDA Version 1.0 Installation Instructions (pdf)
- Access the ICDA Installation (exe)
- User's Guide Download Instructions (pdf)
- ICDA User's Guide (exe)
- Using the ICDA User's Guide (pdf)

Complete, detailed installation instructions, including screen prints, are also provided in Chapter 2 of the ICDA Version 1.0 User's Guide.

Launching the ICDA Application
Users must launch the ICDA application using the shortcut/icon provided on their desktop, or through the ICDA Program Group in the Windows Start menu. Please refer to the ICDA User's Guide for instructions on setting up providers and users within the tool.

Please notify your internal point of contact if you have any questions. They may contact the QualityNet Help Desk if additional information and/or assistance are needed.

Update to the Healthcare Provider Taxonomy Codes (HPTC) Version 5.0 (CR 3716)

Related Change Request (CR) #: 3716 **Medlearn Matters Number:** MM3716

Related CR Release Date: February 18, 2005

Related CR Transmittal #: 479

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Provider Types Affected
Providers who bill Carriers including Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

STOP - Impact to You
CMS has released the summary of changes reflected in the Health Care Provider Taxonomy Code (HCPT) list version 5.0. Medicare carriers and DMERCs will update their HPTC tables with this new version effective on April 1, 2005.

CAUTION - What You Need to Know
The Health Insurance Portability and Accountability Act (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims accepted with invalid data are non-compliant.

GO - What You Need to Do
Please review the information included here and stay current on all HIPAA requirements to assure timely processing of your claims.

Background
Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets. The Provider Taxonomy code set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care transaction.

HIPAA requires that submitted data, which is part of a named code set, must be valid data from that code set. The health care provider taxonomy is a named code set in the 837 professional implementation guide, thus carriers must validate the inbound taxonomy codes against their internal HPTC tables.

The HPTCs are updated twice per year, in April and October. The summary of changes for Version 5.0 is noted in the table below:

TYPE OF CHANGE	PROVIDER TAXONOMY VALUE CODE
Additions	•390200000X •261QM1103X •291900000X •332000000X •341800000X •3418M1120X •3418M1110X •3418M1130X
Revisions	•261QM1101X •261QM1100X •261QM1102X •2865M2000X •2865X1600X •3416A0800X •3416L0300X •3416S0300X
Inactivation (will be deleted in future version)	•2865C1500X

Update to the Healthcare Provider Taxonomy Codes (HPTC) Version 5.0 (CR 3716) (Continued)

The HPTC code list is available in two forms from the Washington Publishing Company:
http://www.wpc-edi.com/codes/taxonomy

- A free Adobe PDF download or
- An electronic representation of the list which will facilitate automatic loading of the code set. This version is available for purchase.

Additional Information
The official instruction issued regarding this change can be found at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp
On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3716. Click on the link to open and view the file for the CR.

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

Updated/Revised Medlearn Matters Articles

The following articles were published in a previous *Medicare B Resource* and have been revised recently by CMS. The revisions include no substantive changes or clarifying language. They are listed here for your reference.

CR#	Revised Date	Article Title	Change Made	Web Link
CR3481	03/18/05	Implementation of the Medicare Physician Fee Schedule (MPFS) National Abstract File for Purchased Diagnostic Tests and Interpretations	This article was revised to include the following message: Some Medicare carriers use a claims processing system (known as the ViPS Medicare Part B system) to process Medicare claims. These carriers will not implement this change at this time. Those carriers are: • Empire Medicare Services • Blue Cross Blue Shield of \Kansas • Triple-S • GHI Until further notice, physicians, laboratories, and independent diagnostic testing facilities who bill these carriers should continue to follow the billing instructions provided in CR3630 issued on December 23, 2004.	**http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3481.pdf**

Updated/Revised Medlearn Matters Articles (Continued)

CR#	Revised Date	Article Title	Change Made	Web Link
CR3500	03/18/05	Unprocessable Unassigned Form CMS-1500 Claims	This article was revised because CR 3500 was reissued. The only changes to the article are to show the new CR release date and transmittal number. No other changes were made to the article.	**http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3500.pdf**
CR3585	03/25/05	MMA - Hospice Pre-Election Evaluation and Counseling Services	This article was revised to emphasize that the medical director referenced in this article must be an employee of the hospice agency.	**http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3585.pdf**
CR3592	02/08/05	Skilled Nursing Facility (SNF) Consolidated Billing Service Furnished Under an "Arrangement" with an Outside Entity	This article was revised to provide some clarifying language, but no substantive changes were made.	**http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3592.pdf**
CR3683	02/08/05	April Quarterly Update to 2005 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement	This article was revised to provide some clarifying language, but no substantive changes were made.	**http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3683.pdf**
SE0431	02/18/05	Skilled Nursing Facility Consolidated Billing	This article was revised as follows: Specifically, line 4 of the "Clarification" statement below was modified to say "These excluded services...." instead of "These included services..."	**http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf**

Updated/Revised Medlearn Matters Articles (Continued)

CR#	Revised Date	Article Title	Change Made	Web Link
SE0432	02/18/05	Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services	This article was revised to include clarifying language but no substantive changes were made.	**http://www.cms.hhs.gov/medlearn /matters/mmarticles/2004/SE0432.pdf**
SE0433	02/18/05	Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services	This instruction was revised to include clarifying language, but no substantive changes were made.	**http://www.cms.hhs.gov/medlearn /matters/mmarticles/2004/SE0433.pdf**
SE0434	03/01/05	Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp)	This article was revised to delete the reference to Chapter 17 of the Medicare Benefit Policy Manual in the Additional Information section of the article.	**http://www.cms.hhs.gov/medlearn /matters/mmarticles/2004/SE0434.pdf**
SE0436	02/18/05	Skilled Nursing Facility Consolidated Billing and Preventive/ Screening Services	This article was revised as follows: Specifically, line 4 of the “Clarification” statement below was modified to say “These “excluded” services....” instead of “These included services...”	**http://www.cms.hhs.gov/medlearn /matters/mmarticles/2004/SE0436.pdf**
SE0437	02/18/05	Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics	This article was revised as follows: Specifically, line 4 of the “Clarification” statement below was modified to say “These “excluded” services....” instead of “These included services...”	**http://www.cms.hhs.gov/medlearn /matters/mmarticles/2004/SE0437.pdf**

Updated/Revised Medlearn Matters Articles (Continued)

CR#	Revised Date	Article Title	Change Made	Web Link
SE0438	02/18/05	Medicare Prescription Drug, Improvement, and Modernization Act (MMA) - Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers	This article was revised as follows: Specifically, line 4 of the "Clarification" statement below was modified to say "These "excluded" services...." instead of "These included services..."	**http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0438.pdf**
SE0439	02/18/05	Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers	This article was revised as follows: Specifically, line 4 of the "Clarification" statement below was modified to say "These "excluded" services...." instead of "These included services..."	**http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0439.pdf**

August is National Immunization Awareness Month

Have your patients get a pneumococcal shot. Patients may only need it one in a lifetime. Patients should contact their health care provider about getting this shot. Medicare beneficiaries pay nothing if their health care provider accepts what Medicare pays.

Charge Limit Violations for Non-Participating Physicians

Non-participating physicians are subject to a limiting charge equal to 115% of the approved amount on nonassigned claims.

As instructed by CMS, Medicare Part B contractors do not mail limiting charge reports (specifically the Limiting Charge Exception Report (LCER) and Limiting Charge Monitoring Report (LCMR)) to physicians, other practitioners, and suppliers.

Instead, physicians, other practitioners, and suppliers may use remittance advice information to calculate limiting charge amounts for nonassigned services. Charges exceeding limiting charge amounts are identified on the provider Remittance Advice with message CO-45 (charges exceed your contracted/legislated fee arrangement). The amount immediately following CO-45 is the actual dollar amount over the limiting charge. **If that amount is collected from the beneficiary, then that amount is to be refunded to the patient.** Refunds of overcharges are required and the remittance form will serve as provider notice that a refund is necessary.

Example:
SUMMARY OF NONASSIGNED CLAIMS (on Provider Remittance Advice)

PROC	BILLED	ALLOWED	DEDUCT	COINS		GRP/RC
99212	**50.00**	**24.66**	**24.66**	**0.00**	**CO-45**	**21.64**

The Limiting Charge for 99212 is $28.36 (115% of the approved charge $24.66). The billed amount should not exceed $28.36, therefore, the overcharge is $21.64 (difference between $50 and $28.36 due the beneficiary).

Reference: Medicare Program Integrity Manual (Pub100-08) Chapter 4, Sections 4.20.5.2 and 4.25.

CLIA New Waived Tests - April 1, 2005 (CR 3650)

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test.

CPT Code/Modifier	Effective Date	Description
86703QW	6-25-2004	OraSure OraQuick Advance Rapid HIV-1/2 Antibody Test {Oral Fluid, Fingerstick Whole Blood and Venipuncture Whole Blood}
84443QW	8-18-2004	ThyroTec, Inc. ThryoTest Whole Blood TSH Test
87880QW	10-29-2004	Beckman Coulter ICON DS Strep A Test
87880QW	10-29-2004	Laboratory Supply Company (LSC) PEP Strep A Cassette Test
87880QW	10-29-2004	Laboratory Supply Company (LSC) PEP Strep A Dipstick Test
87880QW	10-29-2004	Stanbio Laboratory EZ-Well Strep A Rapid Device Test
83036QW	11-9-2004	Provalis Diagnostics In2it In-Office Analyzer (II) A1C Prescription Home Use Test System

New waived code, 86703QW, has been assigned for the HIV-1 and HIV-2 antibody test performed using the OraSure OraQuick Advance Rapid HIV-1/2 Antibody Test {Oral Fluid, Fingerstick Whole Blood and Venipuncture Whole Blood}.

New waived code, 84443QW, has been assigned for the thyroid stimulating hormone (TSH) test performed using the ThyroTec, Inc. ThryoTest Whole Blood TSH Test.

CPT code 87807 (infectious agent antigen detection by immunoassay with direct optical observation: respiratory syncytial virus) is a new code for 2005. Hence, CPT code 87807QW replaces the CPT code 87899QW for the Binax NOW RSV Test and the Integrated Biotechnology Quick Lab RSV Test.

A complete list of the waived tests can be found on the CMS website at: **http://www.cms.hhs.gov/clia/waivetbl.pdf**

Do Not Forward Initiative

Medicare Publication 100-04 Chapter 1, Section 80.5.1 instructs carriers and DMERCs (hereafter called “contractors”) to use “return service requested” envelopes when mailing checks to providers and suppliers (hereafter called “providers”). The use of these envelopes allows the U.S. Postal Service to return Medicare checks to contractors free of charge.

When the post office returns a “return service requested” envelope to the contractor, the contractor applies a Do Not Forward (DNF) flag to the provider’s Medicare number. The contractor will not generate any additional checks for that provider until the provider sends a properly completed change of address form back to the contractor. Upon verifying the new address, the contractor removes the DNF flag and can again generate checks for the provider.

Because some providers get paid through electronic funds transfer (EFT), there may be cases where a provider does not have a correct address on file, but the contractor continues to pay the provider through EFT.

Effective October 1, 2002, contractors began using “return service requested” envelopes for hardcopy remittance advices, in addition to using them for hardcopy checks, with respect to providers that have elected to receive hardcopy remittance advices.

Hospice Physician Services

Overview
Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner. If the attending physician is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the hospice.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient’s attending physician (if there is one), and the Medical Director (or the physician member of the Interdisciplinary Group (IDG)). *Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness*. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician’s or medical director’s clinical judgment regarding the normal course of an individual’s illness. ***It should be noted that predicting life expectancy is not always exact.***

Administrative Activities
Payment for physicians’ administrative and general supervisory activities is included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.

These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group (IDG). *Nurse practitioners may not serve as or replace the medical director or physician member of the IDG.*

Payment for physicians or *nurse practitioner serving as the attending physician, who provide direct* patient care services *and who are* hospice employees or under arrangement with the hospice, is made through Part A Medicare.

Attending Physician Services
When a Medicare beneficiary elects hospice coverage he/she may designate an attending physician, *who may be a nurse practitioner,* not employed by the hospice, in addition to receiving care from hospice-employed physicians. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient’s terminal illness are not considered “hospice services.” These attending physician services are billed to the carrier, provided they were not furnished under a payment arrangement with the hospice.

Where the service is considered a hospice service (i.e., a service related to the hospice patient’s terminal illness that was furnished by someone other than the designated “attending physician” [or a physician substituting for the attending physician]) the physician or other provider must look to the hospice for payment.

Only **professional** services related to the hospice patient’s terminal condition that were furnished by the “attending physician”, are billed to carriers. When the attending physician furnishes a terminal illness related service that includes both a professional and technical component (e.g., x-rays), he/she bills the professional component of such services to the carrier and looks to the hospice for payment for the technical component. Likewise, the attending physician would look to the hospice for payment for terminal illness related services furnished that have no professional component (e.g., clinical lab tests).

Hospice Physician Services (Continued)

The attending physician should code services with the **GV** modifier "Attending physician not employed or paid under agreement by the patient's hospice provider" when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition. Carriers make payment to the attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service.

If another physician covers for a hospice patient's designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or *locum tenens* billing instructions. In such instances, the attending physician bills using the GV modifier in conjunction with either the Q5 or Q6 modifier.

Billing and Payment for Services Unrelated to Terminal Illness
Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider to the carrier for non-hospice Medicare payment. These services are coded with the **GW** modifier (service not related to the hospice patient's terminal condition) when submitted to a carrier.

Care Plan Oversight
The attending physician may bill for care plan oversight services for a hospice enrollee. The physician must bill for these services using Form CMS-1500. These services are not to be included on the hospice bill.

Care plan oversight (CPO) exists where there is physician supervision of patients under care of hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the hospice during the month for which CPO services were billed.

Claims for CPO must be submitted with no other services billed on that claim and may be billed only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months. One unit of service is shown for the month.

Services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to, time associated with discussions with the patient, his or her family or friends to adjust medication or treatment, time spent by staff getting or filing charts, travel time, and/or physician's time spent telephoning prescriptions in to the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.

For CPO claims physicians must enter the 6-character Medicare provider number of the hospice providing Medicare covered services to the beneficiary for the period during which CPO services were furnished and for which the physician signed the plan of care. Physicians are responsible for obtaining the hospice Medicare provider numbers.

For additional hospice information go to the CMS Online Manual at
http://www.cms.hhs.gov/manuals/104_claims/clm104c11.pdf

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by Centers for Medicare and 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 listserv (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 website and visit it often for this valuable information.

Reference: CMS Program Memorandum Change Request 2686; Transmittal AB-03-075
See the complete transmittal on the CMS website at **http://cms.hhs.gov/manuals/pm_trans/AB03075.pdf**

Resubmission of Claim Denials (CR 3622)

Providers should **NOT resubmit** procedures or claims that were denied or are in the process of being reviewed. If a provider **rebills** a procedure that was denied as a result of a medical review, the provider may not appeal the denial decision on the resubmitted claim line. Appeal rights are only allowed the first time that NHIC adjudicates the claim.

Effective July 5, 2005, the Medicare system will be revised to deny, as duplicate, a newly- submitted claim if the previous claim was denied, medically reviewed, or where documentation was requested but not received. The "Duplicate Non-Paid" denial message will read:

"We denied this service because it is a duplicate of a service denied on a previous claim. This denial is not appealable unless the provider can document that the service was not a duplicate because it was performed more often than indicated in the original (claim) line."

Providers should submit their appeal only after the **initial** determination has been completed by NHIC on a claim. A redetermination (first level of appeal - formerly known as review and reconsideration) should be requested if the provider is dissatisfied with the initial determination of the claim. A provider has 120 days from the date of the initial claim determination to request a redetermination.

REMINDER: The Telephone Appeals (now called Redeterminations) process is changing, please refer to the following articles for more information:

NE: http://www.medicarenhic.com/ne_prov/updates/2005/nephoneappeal_0105.htm
SCA & NCA: http://www.medicarenhic.com/cal_prov/updates/2005/phoneappealreduce_0205.htm

Reference: Change Request 3622

Practice Administration Information Resource for Medicare:
http://www.cms.hhs.gov/providers/pair
is designed with recommendations from the Medicare Group Management Association (MGMA), and contains information for private practice providers and their administrative staffs.

Ask the Contractor Teleconferences (ACTs)

NHIC - Medicare Part B contractor for California, Maine, Massachusetts, New Hampshire, and Vermont - will host six one-hour ACTs on the following dates:

- June 24 - Billing Tips
- July 22 - Small Providers
- August 11 - Advanced Beneficiary Notices
- August 25 - To Be Announced
- September 16 - To Be Announced
- September 29 - To Be Announced

Medicare providers and staff are encouraged to call in and participate in the conference calls.

Please access the NHIC Website at **http://www.medicarenhic.com**; click on either California or New England Providers, click on Seminars, then click on 'Ask The Contractor Teleconference' for announcements on topics and times, or go to one of the following links: **http://www.medicarenhic.com/ne_prov/seminars_act.shtml** for Maine, Massachusetts, New Hampshire, and Vermont; or **http://www.medicarenhic.com/cal_prov/seminars_act.shtml** for California

Independent Diagnostic Testing Facilities (IDTFs) - Level of Supervision

This article is a reminder to IDTFs on the level of physician supervision (personal, direct, or general) required for specific diagnostic tests payable under the Medicare physician fee schedule. The levels of specific physician supervision for diagnostic tests are:

1. **General Supervision -** procedure must be performed under the general supervision of a physician, furnished under the physician's overall direction and control, but the physician's presence is not required.
2. **Direct Supervision -** procedure must be performed under the direct supervision of a physician. Physician must be present in the office suite and immediately available to furnish assistance and direction throughout the procedure.
3. **Personal Supervision -** procedure must be performed under the personal supervision of a physician. Physician must be in attendance in the room during the performance of the procedure.

To obtain provider certification, a new individual provider or group goes through an enrollment process by submitting a completed form CMS-855B Enrollment Application and Attachment 2 to NHIC Provider Enrollment. The provider must list all procedure codes to be billed to Medicare. Once NHIC Provider Enrollment is satisfied the requirements for physician supervision, technician competence and equipment are met, the IDTF provider is enrolled in Medicare to perform the specified services.

The provider who is already certified with Medicare and wants to add additional codes must complete and submit form CMS-855B Enrollment Application section 1, 15, and Attachment 2, section 1 to the Provider Enrollment.

If an IDTF bills for a service not indicated on the initial or revised application, payment for those services will be denied. These denied services do have appeal rights., however, appealing these denials will not resolve the issue of meeting certification requirements for the level of supervision. This issue must be resolved through NHIC Provider Enrollment.

For additional information regarding provider enrollment, how to access enrollment forms or locate NHIC Provider Enrollment address go to: **http://www.cms.hhs.gov/providers/enrollment/default.asp**

For website information on NHIC Provider Enrollment, visit:
California: **http://www.medicarenhic.com/cal_prov/enroll.shtml**
Maine, Massachusetts, New Hampshire, and Vermont: **http://www.medicarenhic.com/ne_prov/enroll.shtml**

Preventive - New Medicare Preventive Services

Please post this for your Medicare patients: Message brought to you by US Department of Health and Human Services

New Preventive Services from Medicare Available Now!

Living a healthy lifestyle is important and Medicare wants to help you stay healthy. New preventive benefits are available now. People with Medicare can start taking advantage of the following new preventive services:

Cardiovascular Screening
Medicare covers cardiovascular screening tests for early detection of, or to identify a high risk for developing, heart disease.

Diabetes Screening
Medicare covers diabetes screening to test blood sugar levels to find out if you have diabetes or if you are at high risk for it.

A One-Time "Welcome to Medicare" Physical Exam

Medicare will cover a one-time "Welcome to Medicare" physical exam within the first six months after you have Medicare Part B.

For more information about these important preventive services, call **1-800-MEDICARE (1-800-633-4227).** We are available 24 hours a day, seven days a week to answer your Medicare questions. TTY users should call 1-877-486-2048. Information is also available at **http://www.medicare.gov** on the web.

Correction to Intravenous Iron Therapy Article - CA

A CMS publication number is incorrect on the Intravenous Iron Therapy Article for California in the September 2004 *Medicare B Resource,* page 79. The last line of the first paragraph should change the CMS publication number from 100-8 to 100-04.

Health Professional Shortage Area (HPSA) - CA

Federal law permits special payment for professional services provided by physicians in federal designated Health Professional Shortage Areas (HPSA). Physicians who provide covered services in rural or urban HPSAs are entitled to a ten percent additional payment.

The US Department of Health and Human Services determines which areas are considered to be qualified for designation as a HPSA. Those that qualify and are of the approved specialties for HPSA are eligible to receive an additional ten percent incentive of the paid amount for Medicare claims.

The following specialties are eligible for the HPSA program: 01-30, 33-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, and 98-99. For a key to what the specialty codes mean, visit **http://www.cms.hhs.gov/providers/enrollment/taxonomy.pdf**

The rendering provider must be one of the approved specialties to be eligible for the HPSA incentive payment. If the billing group is one of the eligible specialties listed above, however the rendering provider is not, the incentive for that rendering provider will not be paid the HPSA bonus.

HPSA boundaries are based on census tracts and in many cases do not coincide with routinely used boundaries such as ZIP codes or streets. You can find out what census tract an address is located in by going to: **http://www.ffiec.gov/geocode/default.htm**

Below are additions, reinstatements and withdrawal to the current geographic areas entitled to HPSA incentive payment. **These are changes to Northern California and Southern California.** For additional information on HPSA, please see the complete listing on our website at: **http://www.medicarenhic.com/cal_prov/hpsa.shtml**

Northern California

HPSA Updates
Effective Date: January 1, 2005
County: El Dorado
City: Pollock Pines
Census Tract: 313.01, 313.02, 314.04, 314.05, 314.06
Modifier: QU

HPSA Withdrawals
Effective Date: January 1, 2005
County: El Dorado
City: Pollock Pines
Census Tract: 314.01, 316.98
Modifier: QU

Effective Date: January 1, 2005
County: Stanislaus
City:
Census Tract: 32.01, 32.02, 34.00, 35.00
Modifier: QU

Southern California

HPSA Update

* No changes for Southern California

Telephone Redeterminations Reduced - CA

In preparation for the upcoming changes under Section 521 of the BIPA implementation, posted to the Federal Register on March 8, 2005, NHIC Northern and Southern California will implement the following:

- Effective June 1, 2005 the number of ICNs processed per call will be reduced from 5 to 3.

Providers using the telephone redeterninations process are encouraged to begin submitting their redetermination appeal requests in writing in preparation for the elimination of telephone appeals anticipated to occur on January 1, 2006.

Additional details will be provided in future newsletters regarding changes to the second-level appeals process with the implementation of the Qualified Independent Contractors (QIC) on January 1, 2006.

Written requests for first level appeals/redeterminations should be sent to:

NHIC Medicare Redeterminations
PO BOX 272854
Chico CA 95927-2854

Medicare Health Plans: http://www.cms.hhs.gov/healthplans

Medicare Home Health: http://www.cms.hhs.gov/providers/hha

Medicare Hospice: http://www.cms.hhs.gov/providers/hospiceps

Medicare Ambulance: http://www.cms.hhs.gov/suppliers/ambulance

Aging with Dignity Conference - MA

SAVE THE DATE
Tuesday, June 7, 2005

THE AGING WITH DIGNITY CONFERENCE:

Preventing and Responding to Substance Use Problems Among Older People

A conference for health and human service professionals

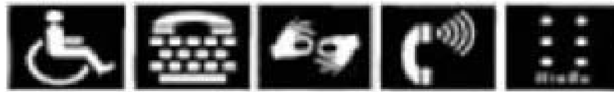
Holiday Inn, Worcester, MA

Registration brochure will be mailed six weeks before the conference.

If you would like additional information, please contact

AdCare Educational Institute, Inc.

at 508-752-7313; TTY: 508-754-0039



Co-Sponsored by:

The MA Department of Public Health, The MA Geriatric Substance Abuse Task Force, The MA Association of Councils on Aging and Senior Center Directors & AdCare Educational Institute, Inc.

Seminar Schedule - ME, MA, NH, VT

MEDICARE B FREE SEMINARS

NHIC

Provider Education & Training

Seminar Schedule for
Maine, Massachusetts, New Hampshire, and Vermont

June - September 2005

NHIC Medicare Education and Outreach invites you to attend our seminars - designed to provide you with the information needed to bill and receive Medicare payments correctly. Please take the opportunity to learn more about Medicare and the changes that may affect you.

Please make sure you register two (2) days prior to the event, as space may be limited.

2.0 Continuing Education Units will be issued for the General Billing Seminars.

You can register for any of these seminars by visiting our website at: **http://www.medicarenhic.com/ne_prov/seminars.shtml**

Seminar Schedule - ME, MA, NH, VT (Continued)

Maine Seminars

Event	Date	Location	Times & Rooms
Podiatry	6-20	St. Josephs Hospital 900 Broadway Bangor, ME	8:00-10:00 Willette Room
Podiatry	6-23	Maine Medical Center Bramhall St. Portland, ME	9:00-11:00 Dana Center, Class Room 2
Physical and Occupational Therapy	8-9	Maine General North St. Waterville, ME	8:00-10:00 Dean Auditorium
Physical and Occupational Therapy	8-23	Maine Medical Center Bramhall St. Portland, ME	8:00-10:00 Dana Center Auditorium
General Billing	9-12	Central Maine Medical 12 High St. Lewiston, ME	9:00-11:00 Conference Rooms A & B
General Billing	9-16	Maine General North St. Waterville, ME	8:00-10:00 Dean Auditorium
Physical and Occupational Therapy	9-19	St. Josephs Hospital 900 Broadway Bangor, ME	8:00-10:00 Willette Room
General Billing	9-22	Maine Medical Center Bramhall St. Portland, ME	9:00-11:00 Dana Center, Class Room 9

Inform your Medicare patients of the new Medicare 800 number:

1-800-MEDICARE

(1-800-633-4227)

Seminar Schedule - ME, MA, NH, VT (Continued)

Massachusetts Seminars

Event	Date	Location	Times & Rooms
General Billing	6-16	Cape Cod Hospital 27 Park St. Hyannis, MA	1:00-3:00 Mashpee Health Ctr., Board Room
General Billing	7-12	Morton Hospital & Medical 88 Washington St. Taunton, MA	10:00-12:00 Margret Stone Room
General Billing	7-20	Saints Memorial Medical Center 1 Hospital Drive Lowell, MA	9:30-11:30 First Floor Conference Room
Physical and Occupational Therapy	8-17	Quincy Medical Center 114 Whitwell St. Quincy, MA	9:00-11:00 Conference Rooms A & B
Physical and Occupational Therapy	8-18	Anna Jacques Hospital 25 Highland Ave Newburyport, MA	1:00-3:00 Higgins Room
General Billing	9-22	Baystate Health Partners 338 Birnie Ave. Springfield, MA	8:30-10:30 Board Room

New Hampshire Seminars

Event	Date	Location	Times & Rooms
Podiatry	6-17	Holiday Inn 172 North Main St. Concord, NH	1:30-3:30 The Capital Room
Physical and Occupational Therapy	8-4	Frisbie Medical Center 11 Whitehall Rd. Rochester, NH	8:30-10:30 Conference Center, Strafford Rm.
General Billing	8-17	Citizens Bank 20 Highland St. Plymouth, NH	8:30-10:30 The Community Room
Physical and Occupational Therapy	8-29	Valley Regional Hospital 243 Elm St. Claremont, NH	12:30-2:30 Buckley Room
General Billing	8-31	Littleton Regional Hospital 600 St. Johnsbury Rd. Littleton, NH	8:30-10:30 Conference rooms 1 & 2
General Billing	9-19	Frisbie Medical Center 11 Whitehall Rd. Rochester, NH	8:30-10:30 Conference Center, Strafford Rm.

Seminar Schedule - ME, MA, NH, VT (Continued)

Vermont Seminars			
Event	**Date**	**Location**	**Times & Rooms**
Physical and Occupational Therapy	8-17	Brattleboro Memorial Hospital 17 Belmont Ave. Brattleboro, VT	10:30-12:30 Brewbarry Conference Room
Physical and Occupational Therapy	8-19	Northwest Medical Center Fairfield St. St. Albans, VT	10:30-12:30 Cobblestone Building
General Billing	9-16	Veterans Administration 100 Veterans Drive White River Jct., VT	10:30-12:30 Yasinski Research & Education Bldg.
General Billing	9-23	NHIC Office 312 Hurricane Lane Williston, VT	10:30-12:30 EDS Conference Room

Telephone Appeals Changes - ME, MA, NH, VT

In preparation for the upcoming changes under Section 521 of the BIPA implementation posted to the Federal Register on March 8, 2005, NHIC in Maine, Massachusetts, New Hampshire, and Vermont will implement the following changes to its telephone appeals process:

- The toll-free line for the Massachusetts providers is eliminated effective May 1, 2005. Massachusetts providers must call **1-207-294-4322.**
- The number of ICNs processed per call to NHIC telephone appeals call will be reduced from 5 to 3, effective June 1, 2005.

Providers using the telephone appeals process are encouraged to begin submitting their redetermination appeal requests in writing in preparation for the elimination of telephone redeterminations January 1, 2006. Send written redetermination appeals requests to:

NHIC
PO Box 1000
Hingham, MA 02044
Attention: Redetermination

Additional details will be provided in future newsletters regarding changes to the second-level appeals process with the implementation of the Qualified Independent Contractors (QIC) on January 1, 2006.

For providers in ME, MA, NH, and VT-
All unclassified drugs (J3490, J3590 and J9999)
should be submitted with the total amount of the drug dispensed to the patient in Item 19 of the CMS 1500 claim form, or electronic equivalent, in addition to the name and route of admission of the drug.

Evaluation and Management Codes - CA, ME, MA, NH, VT

Medical Review is sharing the information below to promote awareness of potential billing problems identified through NHIC medical review of claims. Please review this information carefully and ensure your practice is compliant with Medicare Program regulations to avoid receiving Medicare Program payments in error.

Throughout the course of the year, Evaluation and Management (E/M) service codes were the primary focus of medical review. Since E/M service codes are widely used by physicians and practitioners, we prepared this comprehensive resource detailing the issues, trends, and patterns identified through the review of documentation and coding. Findings for each E/M key component and specific E/M services categories are detailed in the following article.

NHIC strongly encourages providers reporting these services to evaluate coding and documentation methods/tools used within their own practice organization to ensure compliance with Centers for Medicare and Medicaid Services (CMS), and AMA CPT Coding Manuals and 1995 and 1997 Evaluation and Management Documentation Guidelines. For the complete guidelines, published by CMS, please visit **http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf** page 27. (Pub 100-04, Ch 12, Sec 30.6 ff)

General Documentation Issues - Office or Other Outpatient Visit - 99212 - 99215

- Services not supported by documentation
- Illegible handwriting
- Rendering/Performing provider not indicated accurately
- Legible identity of the Physician/Practitioner missing
- Documentation submitted reflects incorrect date of service
- Patient history elements (past, family and/or social history (PFSH)) were not documented.
- Inconsistently documented Chief Complaint (CC), History of Present Illness (HPI), Review of Systems, and Past, Family and Social History (PFSH).
- Review of systems routinely lacked required number of elements required by CPT/CMS (e.g. comprehensive history requires a review of 10 body systems).
- Documentation reflected performance of medical decision making, however, specific information is not indicated in the medical records.
- Details of physician medical decision making was difficult to discern due to illegibility.
- Name of patient was not identified in the medical record.
- Medical record(s) did not support the level of service.

Findings - Office or Outpatient Consultations 99241-99242

Services Documented Supported A Follow-Up Visit

As stated in the Current Procedural Terminology (CPT) 2005, **"If subsequent to the completion of a consultation, the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the follow-up consultation codes should not be used. In the hospital setting, the consulting physician should use the appropriate inpatient hospital consultation code for the initial encounter and then subsequent hospital care codes (not follow-up consultation codes). In the office setting, the appropriate established patient code should be used."**

No Request For Office Or Outpatient Consultation Services

A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.

No Report Of Consultation Findings Documented

A written report must be furnished to the requesting physician. In an emergency department or inpatient or outpatient setting where the medical record is shared between the referring physician and the consultant, the request may be documented as part of a plan written in the requesting physician's progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report may consist of an appropriate entry in the common medical record. In an office setting, the documentation requirement may be met by a specific written request for the consultation from the requesting physician or if the consultant's records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the requesting physician.

Consultation Initiated By Patient And/Or Family

As stated in the Current Procedural Terminology (CPT) 2005, **"A "consultation" initiated by a patient and/or family, and not requested by a physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultation or office visits, as appropriate."** (See CPT codes 99271-99275, and 99201-99215)

Office Consultation Services (99241 - 99245)

Procedure codes 99241-99245 are used to report consultations provided in the physician's office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care, or emergency room.

Evaluation and Management Codes - CA, ME, MA, NH, VT (Continued)

- A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.
- A physician consultant may initiate diagnostic and/or therapeutic services at the same time or subsequent visit.
- The written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient's medical record.
- The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

No Examination Documented Only Counseling
If counseling and coordination of care time accounts for more than 50% of the encounter, time is a key factor in determining the level of E/M service. Medical record documentation should reflect the length of time (face-to-face or floor time) of the encounter. The record should reflect the content of the overall need for the coordination of care and counseling. NHIC suggests recording the total length of time spent counseling the patient, in addition to the overall length of encounter.

Services Not Supported By Documentation
All services reported to the Medicare program must be substantiated by information documented within the patient's medical record and the medical record must be made available upon request. Services that are not documented in the medical record should not be billed to the Medicare program. For the review determination, the undocumented services were not allowed.

Filing claims for services that are not substantiated by medical record documentation could be perceived as a false claims submission. NHIC asks that you evaluate the availability of medical record documentation for all services reported to the Medicare program for reimbursement to ensure services are consistently documented.

Illegible Handwriting
It is important that providers document patient services legibly and sufficiently. If we are unable to read the medical records due to indecipherable handwriting, the reviewer may not be able to determine that services were medically necessary. In such instances medical review staff must deny the services, or allow payment for the level of care that can be determined from the legible portion(s) of the medical record. Medical record documentation must be complete and legible and clearly indicate:

- The reason for the encounter, and
- The rendered service(s),
- The extent of the service(s) performed and
- Include information that supports the medical necessity of the service(s) provided.

Illegible medical record documentation makes it difficult to substantiate the level of the service billed and to establish the medical necessity of the care rendered.

Rendering/Performing Provider Not Indicated
Our review identified providers reporting services under their **personal** Medicare Provider Identification Number (PIN) for services rendered by **other** physicians or health care practitioners.

CMS billing instructions clearly indicate the PIN of performing provider must be indicated in Item 24K of the CMS Form-1500 claim form or electronic claim field equivalent. Information contained in the patient's medical record should support this information. Billing under another professional's PIN number could result in:

- Claim data which indicates performance of excessive services compared to the professional's peer group.
- Beneficiary reports of fraud because the rendering provider is not known to them.

There are limited situations in which services of another physician or healthcare professional may be reported under another physician's Medicare PIN. They are:

- Services provided by a *locum tenens* physician;
- Services of a substitute physician are reported under the regular physician's Medicare PIN. Modifier Q6 must be reported with each service rendered by a *locum tenens* physician and Q5 reported for a substitute physician. The physician or group must keep a record of each service provided by the substitute or *locum tenens* physician, and make this record available to NHIC upon request; and
- Services rendered by an ancillary staff member 'incident to' a physician's service. It is appropriate to report the supervising physician's name in Item 24K of the CMS Form-1500 claim form. Medical record documentation must provide the name and legible identity of the professional rendering the service.

Physician/Practitioner Signature Missing
Medical record documentation must provide the name and legible identity of the professional rendering the service. Medical reviewers identified that the name of the professional rendering the service(s) is frequently omitted.

Evaluation and Management Codes - CA, ME, MA, NH, VT (Continued)

Documentation Submitted Reflects Incorrect Date Of Service

The correct progress note or medical record for the date(s) under review should be provided upon request.

History Findings

The following issues pertaining to documentation of patient history were identified during review:

- Patient history elements History of Past Illness (HPI), Review of Systems (ROS) and Past, family and/or social history (PFSH) were not documented.
- Inconsistently documented Chief Complaint, History of Present Illness, Review of Systems, and Past, Family and Social History.
- Review of Systems routinely lacked required number of elements required by CPT/CMS (e.g., comprehensive history requires a review of 10 body systems).

Examination Findings

The following issues were identified regarding the documentation of patient physical exam:

- The number of body areas examined did not meet specific level required by CPT code.

Medical Decision Making Findings

The Medical Decision Making (Mdm) sometimes reflected a **low level.**

- Often during review the Mdm documentation indicated the presenting problem was known to the provider, and in many cases there were multiple visits per patient in a span of time related to the same diagnosis. In many cases the documentation was based upon a limited diagnosis, limited data and low risk.

Patient Not identified in Notes

Every page in the medical record should contain the patient's name.

Selecting Appropriate Level of Care

Review of documentation identified that the medical record did not support the level of care identified by CPT codes reported to Medicare. Providers must take care in selecting the CPT code that accurately reflects the extent of services rendered during a patient encounter. Providers should choose the level of CPT code that meets the requirements stated in CPT code description. Please keep the following in mind when choosing a CPT code:

- Patient history (Hx), examination (Ex) and medical decision making (Mdm) are the three key components in selecting the level of E/M service. Physicians and healthcare practitioners should review and determine the extent of each component (Hx, Ex, Mdm) rendered during the E/M encounter.
- Specific categories of evaluation and management services require performance of all E/M components or 2 out of 3 key components. The following describes the E/M categories:
  - o 2 of 3 components (Hx, Ex, or Mdm) must be performed for established patient services in the office, home, subsequent nursing facility services, domiciliary care, subsequent hospital care, follow up inpatient consultations.
  - o All 3 key components (Hx, Ex, Mdm) must be performed for new patient services in the office, home or domiciliary care setting; and hospital observation; initial hospital care; consultations; confirmatory consultation; Emergency Room services; and comprehensive nursing facility assessment services.

Note: Medical necessity and reasonableness continues to be the hierarchy for payment. The documentation may reflect a 99215 service, however, the 99215 service may not be medically necessary and reasonable. (i.e., patient seen monthly by same provider).

NHIC continues to use both the 1995 and 1997 E/M Guidelines. Copies of these guidelines may be obtained through Customer Service or CMS's website **http://www.cms.hhs.gov/medlearn/emdoc.asp.**

Join the NHIC Mailing List!

Go to http://www.medicarenhic.com, click on 'Join Our Mailing List', complete the information and submit. We will automatically send you Medicare Part B, and CMS, updates via E-mail.

Billing Beneficiaries Upfront

Problem: NHIC Compliance indicates many providers continue to bill beneficiaries before services are rendered. If beneficiaries receive the Medicare Summary Notice, and realize that they overpaid the provider, they call NHIC to complain about the problem.

Tip: Upon submission of the Medicare Participating Physician or Supplier Agreement Contract, providers agree to bill for and accept assignment of the Medicare beneficiary services. Therefore, if a participating provider collects more than the applicable deductible and coinsurance for covered services, it is considered an assignment violation even if the amount collected is shown on the claim form (Item 32) and/or the excess is promptly refunded once the provider receives the Part B payment. Since the beneficiary's deductible status or the position of an individual claim among other approved charges is not determined until the claim is processed, it is advisable for you not to collect your portion of the claim until the Medicare Summary Notice (MSN) is received.

Reference: Medicare Claims Processing Manual (CMS Pub. 100-04) Chapter 4, Section 30 - 30.3.
http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Anesthesia Billed by Surgeon

Problem: Some providers continue to report the following conscious sedation codes with diagnostic and therapeutic injection procedures:

01905 - Anesthesia for myelography, discography, vertebroplasty
00620 - Anesthesia for procedures on thoracic spine and cord; not otherwise specified
00630 - Anesthesia for procedures in lumbar region; not otherwise specified
99141 - Sedation with or without analgesia

Tip: Please note: Medicare does not allow separate payment for an anesthesia service performed by the physician who also renders the medical or surgical service. In that case, payment for the anesthesia service is made through the payment for the medical or surgical service. No charge can be made to the patient.

Reference: IOM Publication 100.4 Chapter 12, Section 50 - Payment for Anesthesiology Services (Rev. 1, 10-01-03)
http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Visit the CMS national quarterly newsletter website for the Quarterly Provider Update at: http://cms.hhs.gov/providerupdate

TMP-EDO-0001 Version 3.0

Service Specific Prepayment Reviews - ME, MA, NH, VT

Service specific prepayment reviews are conducted when potential billing problems exist amongst providers reporting claims to NHIC. Service specific prepayment reviews are conducted with a sample of a minimum of 100 claims. Results of claims review are shared with each individual provider from whom medical records are requested, via Remittance Notice. If an issue is identified, education will be developed and communicated to a specific provider, or an article in *Medicare B Resource* will be written to address widespread issues and to ensure that all providers are reporting the services correctly.

The following highlights code specific reviews.

Findings - Injection, adenosine for therapeutic use, 6 mg - J0150

Dosage not provided
The number of milligrams administered must be documented in the patient's chart and be available to the carrier upon request.

Incorrect HCPCS coding
Report Adenosine used for cardiovascular stress testing using the following codes:

- **For services performed prior to January 1, 2004,** report HCPCS code J0151, Adenosine 90 mg in a unit of one (1).
- **For services on or after January 1, 2004,** report HCPCS code J0152, Adenosine 30 mg. Report the number of vials that were medically necessary in Item 24D, Days or Units, on the CMS-1500 claim form, or electronic equivalent. Do not use the number of milligrams or cc's administered.

EXAMPLE: If administering 58mg of Adenosine (J0152), report **2** in the units box-not 58.

Findings - Incision and drainage of abscess - 10060

Supporting documentation for the services not provided.

Services not supported by documentation.

Findings - Critical Care - 99291
Supporting documentation for critical care services not provided
Medicare contractors are authorized to request medical records to establish if program funds are being paid correctly. These requests may be initiated for any claim in process or on a post-payment basis. Failure to provide documentation may result in downcoding, denial, or recoupment of Medicare payment.

Medical records did not indicate the duration of time spent providing critical care services
The time spent with the individual patient and the service rendered must be recorded in the patient's record to support the claim for critical care services.

Inaccurate Coding of Critical Care Services
The Medical Decision Making records sometimes reflect a **low level**. For example, a majority of services documented indicated providers were utilizing critical care procedure codes when office or emergency room procedure codes were more appropriate. Critical care includes the care of critically ill and unstable patients who require constant physician attention, whether the patient is in the course of a medical emergency or not. It involves decision making of high complexity to assess, manipulate, and support circulatory, respiratory, central nervous, metabolic, or other vital system function to prevent or treat single or multiple vital organ system failure.

Teaching Physicians GC Modifier Not Reported on the Claim
All teaching physician services must be identified with modifier GC when submitting the claim on the CMS Form-1500. {See CMS Publication 100-4, Chapter 12 §100} It is expected the medical record contain the teaching physician's level of participation in the service.

For the complete guidelines, published by CMS, please visit **http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf, page 47**

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We will automatically send you Medicare Part B updates via E-mail

CABBS Mailbox Reports

Are you submitting claims electronically, and you think the claims are being accepted into the NHIC CABBS system, yet you're not getting paid?

Maybe you're **not** reading the mail in your CABBS mailbox.

When submitting claims through CABBS there are 3 acknowledgements the system will supply:

- **Initial acknowledgment:** This is put into the CABBS mailbox right after submission of the claim file is complete. This acknowledgement is like a 'hand shake', just acknowledging that your system has connected to the CABBS system and your computer has talked to our computer. This is not an acknowledgement that the claims have been received and accepted.
- **997 Acknowledgement:** This acknowledges the file has either passed or failed the edits at the 997 level
- **ESR (Error Summary Report):** If the file has passed the edits at the 997 level it then will go through the pre-pass edit level. At this level the ESR will be generated, and advise how many claims were received, accepted and deleted (if applicable). If an edit sets there will be an error message advising of the error, a message advising the patient connected with the failing claim (e.g. message will say "HIC Number in Error") and advise of the severity (claim delete, batch delete or file delete). All claims that make it past the pre-pass edit level will then go onto processing to be worked, out the door for payment or auto-denial. If a claim makes it past the pre-pass level and then is denied at the processing level (or auto-denied), this is a 'billing issue' **not** an EDI issue.

If you are unable to access your CABBS mailbox or unable to download your reports, contact your software vendor for assistance, as it their responsibility to assist with the downloading and interpretation of these reports.

Please refer to the Medlearn Matters article titled:
Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims (CR 3440) for more Electronic Data Interchange Information (EDI).
Visit: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3440.pdf

For information about NHIC electronic billing, please call your local NHIC office:

Northern California	**1.530.879.2662**
Southern California	**1.213.593.6052**
ME, MA, NH, VT	**1.781.749.7745**

Local Coverage Determination (LCD) Changes - CA

This article provides updates to the Local Coverage Determinations. **Please access revised LCDs via http://www.medicarenhic.com/cal_prov/policies.shtml**

When a Local Medical Review Policy (LMRP) is converted to an LCD, some information is no longer included (coding information, reason for denial, etc.). LCDs consist of only "reasonable and necessary" information. If appropriate, articles related to the LCD will be published. These articles will include additional information regarding coding, requirements, etc.

The following LMRPs were converted to LCDs between January 1, 2005 and March 31, 2005:

- Clinical Use of Hepatitis C Virus (HCV) Molecular Tests
- Coverage Criteria for Treatment of Pathologic Symptomatic Toenails
- Cytogenetic Studies
- Electrodiagnostic Studies
- "Free" Prostate Specific Antigen
- Gonadotropin-Releasing Hormone Analogs (Lupron, Leuprolide Acetate, Goserelin, Zoladex, Viadur)
- Implantable Loop Recorder
- Intracoronary Brachytherapy With Stent
- Kyphoplasty
- Level 3 Sleep Studies; Home, Unattended
- Lumbar MRI
- Magnetic Resonance Angiography of the Abdomen, Pelvis and Chest
- Pulmonary Services
- Retroperitoneal Ultrasound
- Sedimentation Rate
- Syphilis Test
- Troponin
- Urodynamics
- Vision Rehabilitation for Low Vision Patients
- Vitamin B12 Injection

Revised LCDs

The following LCDs were updated :

- **Erythropoietin Analogs for the Treatment of Anemia Unrelated to Dialysis Therapy**

  Added HCPCS code J0880 back into the LCD, since it was deleted in error. *(effective for dates of service on or after 1/1/05)*

- **Implantable Infusion Pump for Treatment of Chronic Intractable Pain**
  - o Revised the effective date from 01/01/05 to 01/01/04 based on the effective date of CR 3022.
  - o Removed reference to CPT code J2275 at the beginning of the CPT section, and clarified the use of J codes for medications with and without their own J code.
  - o Removed fentanyl and hydromorphone from the list of off-label drugs, as CMS now classifies them as infusible per CR 3105.
  - o Added reference to the "KD" modifier in the Documentation Requirements section. *(effective for dates of service on or after 1/1/04)*

- **Intravenous Immune Globulin**
  - o Per Change Request 3745:

    Added CPT codes Q9941, Q9942, Q9943, and Q9944

    Deleted CPT codes J1563 and J1564 *(effective for dates of service on or after 4/1/05)*

- **Psychiatric Pharmacology**
  - o Removed asterisks from ICD-9 codes 294.10 and 294.11 in the ICD-9 Codes that Support Medical Necessity section. Reference to secondary codes is no longer applicable, as the allowance of the procedures will be based on the primary codes.
  - o Converted policy from LMRP to LCD template. *(effective for dates of service on or after 2/15/2005)*

Local Coverage Determination (LCD) Changes - CA (Continued)

- **Radiologic Examination, Chest**
  - o Deleted truncated codes 093.2, 093.8, 342.9, 795.3, 902.1, and 903.0.
  - o Expanded the following codes to their highest level of specificity: 093.20-093.24, 093.81, 093.82, 093.89, 342.90, 342.91, 342.92, 795.31, 795.39, 902.10, 902.11, 902.19, 903.00-903.02, and 903.9. *(The above changes are retroactive to 07/15/2003)*
  - o Converted policy from LMRP to LCD template.

New LCD Drafts

- Independent Diagnostic Testing Facilities (IDTF)
- Upper Gastrointestinal Endoscopy
- Vestibular Function Testing

Pending LCDs

- Allergy Testing
- Anorectal Manometry, Anal Electromyography, and Biofeedback Training for Perineal Muscles and Anorectal or Urethral Sphincters
- Bariatric Surgery
- Category III CPT Codes
- Chiropractic Services (Manual Spinal Manipulation)
- Gait Analysis
- Psychotherapy
- Virtual Colonoscopy (CT Colonoscopy)

Please access Draft LCDs via http://www.medicarenhic.com/cal_prov/policies_draft_index.shtml

New Articles Published

- Alcohol Septal Ablation for Hypertrophic Obstructive Cardiomyopathy
- Virtual Colonoscopy (CT Colonoscopy)
- Implantable Infusion Pump for Treatment of Chronic Intractable Pain
- Independent Diagnostic Testing Facilities - Supervision and Medical Responsibility Requirements
- Macugen® Treatment of Wet Age-Related Macular Degeneration
- Non-Coverage of Anodyne® Therapy for Peripheral Neuropathy or any condition
- Self-Administered Drug Exclusion List

Please access Articles via http://www.medicarenhic.com/cal_prov/med_review.shtml#3

Paper Copies and E-Mailing List

You may subscribe to the LCD mailing list for NHIC by going to **http://www.medicarenhic.com,** clicking on ‘Join our Mailing List’ and completing the form making sure to request General NHIC Website Updates or California LCD/LMRP in order to receive weekly electronic Medicare B updates. To obtain a hard copy of any of the LCDs for NHIC you may contact Customer Service at the telephone numbers identified on the inside back cover or by writing to Customer Service at:

Northern California:
Medicare Written Inquiries
P O Box 2006
Chico, CA 95927-2006

Southern California:
Correspondence
PO Box 272857
Chico, CA 95927-2857

Local Coverage Determination (LCD) Changes - ME, MA, NH, VT

This article provides updates to Local Medical Policies. Please make corrections to your appropriate policy.

Please access revised LCDs via http://www.medicarenhic.com/ne_prov/policies.shtml

Revised LCDs

The following LCDs were updated.

- **Molecular Diagnostics:** Added CPT codes 88367 and 88368 *(effective for dates of service on or after 4/1/05)*
- **Skin Substitute:** Added HCPCS code J7344 *(effective for dates of service on or after 1/1/05- technical update due to annual HCPCS update).*
- **Virtual Colonoscopy:** Technically corrected language under "ICD9 CM codes that do not support medical necessity" and removed ICD-9-CM codes that were duplicative *(effective for dates of service on or after 1/15/05).*
- **Intravenous Immunoglobulin:** Added new HCPCS codes Q9941 and Q9943 *(effective for services on or after 4/1/05)*

New LCD

- **CPT Category III Codes** *(effective for dates of service on or after 5/31/05)*
  The Category III codes are temporary codes created to track the utilization of emerging technologies, services, and procedures.
  Please access the complete LCD via **http://www.medicarenhic.com/ne_prov/policies.shtml**

Paper Copies and E-Mailing List

You may subscribe to the LCD mailing list for NHIC by going to **http://www.medicarenhic.com,** clicking on 'Join our Mailing List', and completing the form making sure to request 'General NHIC Website Updates' or 'New England LCD/LMRP' in order to receive weekly electronic Medicare B updates. To obtain a hard copy of any of the LCDs for NHIC you may contact Customer Service at the phone numbers identified on the inside back cover or by writing to Customer Service at:

MA, ME, NH, VT:
Written Correspondence/Overpayments
PO Box 1000
Hingham, MA 02044

To see new National Coverage Determinations visit the CMS website at

http://cms.hhs.gov/coverage

or

http://www.cms.hhs.gov/mcd/indexes.asp

Drugs

See the NHIC website for Drug and Injection pricing files at:

April - **http://www.medicarenhic.com/providers/fees/drugallowlimits_apr05.htm**
January - **http://www.medicarenhic.com/providers/fees/drugallowlimits_jan05.htm**
Injection article - **http://www.medicarenhic.com/providers/fees/injcodeupdt_0405.htm**

Drugs - January 2005 Payment Allowance Limits For Medicare Part B Drugs (CR 3728)

Effective January 1, 2005

HCPCS	Short Description	HCPCS Code Dosage	1st Quarter 05 Payment Limit	1st Quarter Independent ESRD Limit
90740	Hepb vacc, ill pat 3 dose im	3 Dose Schedule	$113.91	$113.91
J7190*	Factor viii	I.U.	$0.66	$0.66
J7191*	Factor viii (porcine)	I.U.	$1.86	$1.86
J7192*	Factor viii recombinant	I.U.	$1.06	$1.06
J7193*	Factor ix non-recombinant	I.U.	$0.89	$0.89
J7194*	Factor ix complex	I.U.	$0.63	$0.63
J7195*	Factor ix recombinant	I.U.	$0.98	$0.98
J7197*	Antithrombin iii injections	I.U.	$1.72	$1.72
J7198*	Anti-inhibitor	I.U.	$1.23	$1.23
J7510	Prednisolone oral per 5 mg	5 MG	$0.05	$0.05
Q0187*	Factor viia recombinant	1.2 MG	$1,051.45	$1,051.45
Q2022*	VonWillebrand Factor Complex per IU	I.U.	$0.86	$0.86
Q4054	Darbepoetin alfa, ESRD use	1 MCG	$3.54	$3.54
Q4055	Epoetin alfa, ESRD use	1000 UNITS	$9.32	$9.76

* The ASP-based payment allowance limit for blood clotting factors and the furnishing fee for blood clotting factors do not apply to inpatient claims.

CR 3728

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - CA Only

Effective January 1, 2005

Area 03 Marin, Napa, and Solano Counties
Area 05 San Francisco
Area 06 San Mateo County
Area 07 Alameda and Contra Costa Counties
Area 09 Santa Clara County
Area 17 Ventura County
Area 18 Los Angeles County
Area 26 Orange County
Area 99 Rest of State

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
	03	58356	$3,279.77	$ 3,115.78	$ 3,583.15
#	03	58356	$ 399.20	$ 379.24	$ 436.13
	03	62367	$ 49.30	$ 46.84	$ 53.87
#	03	62367	$ 24.29	$ 23.08	$ 26.54
	03	62368	$ 64.45	$ 61.23	$ 70.41
#	03	62368	$ 38.95	$ 37.00	$ 42.55
	03	88125	$ 23.83	$ 22.64	$ 26.04
#	03	88125	$ 23.83	$ 22.64	$ 26.04
	03	88125 TC	$ 8.09	$ 7.69	$ 8.84
#	03	88125 TC	$ 8.09	$ 7.69	$ 8.84
	03	88367	$ 251.09	$ 238.54	$ 274.32
#	03	88367	$ 251.09	$ 238.54	$ 274.32
	03	88367 TC	$ 172.63	$ 164.00	$ 188.60
#	03	88367 TC	$ 172.63	$ 164.00	$ 188.60
	03	88368	$ 174.55	$ 165.82	$ 190.69
#	03	88368	$ 174.55	$ 165.82	$ 190.69
	03	88368 TC	$ 89.26	$ 84.80	$ 97.52
#	03	88368 TC	$ 89.26	$ 84.80	$ 97.52
	03	89220	$ 21.58	$ 20.50	$ 23.58
#	03	89220	$ 21.58	$ 20.50	$ 23.58
	03	96567	$ 96.61	$ 91.78	$ 105.55
#	03	96567	$ 96.61	$ 91.78	$ 105.55
	05	58356	$3,771.08	$ 3,582.53	$ 4,119.91
#	05	58356	$ 429.70	$ 408.22	$ 469.45
	05	62367	$ 54.79	$ 52.05	$ 59.86
#	05	62367	$ 25.78	$ 24.49	$ 28.16
	05	62368	$ 70.97	$ 67.42	$ 77.53
#	05	62368	$ 41.39	$ 39.32	$ 45.22
	05	88125	$ 26.34	$ 25.02	$ 28.77
#	05	88125	$ 26.34	$ 25.02	$ 28.77
	05	88125 TC	$ 9.35	$ 8.88	$ 10.21
#	05	88125 TC	$ 9.35	$ 8.88	$ 10.21

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - CA Only (Continued)

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
	05	88367	$ 284.62	$ 270.39	$ 310.95
#	05	88367	$ 284.62	$ 270.39	$ 310.95
	05	88367 TC	$ 200.01	$ 190.01	$ 218.51
#	05	88367 TC	$ 200.01	$ 190.01	$ 218.51
	05	88368	$ 195.37	$ 185.60	$ 213.44
#	05	88368	$ 195.37	$ 185.60	$ 213.44
	05	88368 TC	$ 103.30	$ 98.14	$ 112.86
#	05	88368 TC	$ 103.30	$ 98.14	$ 112.86
	05	89220	$ 24.95	$ 23.70	$ 27.26
#	05	89220	$ 24.95	$ 23.70	$ 27.26
	05	96567	$ 111.91	$ 106.31	$ 122.26
#	05	96567	$ 111.91	$ 106.31	$ 122.26
	06	58356	$3,730.40	$ 3,543.88	$ 4,075.46
#	06	58356	$ 426.87	$ 405.53	$ 466.36
	06	62367	$ 54.33	$ 51.61	$ 59.35
#	06	62367	$ 25.65	$ 24.37	$ 28.03
	06	62368	$ 70.42	$ 66.90	$ 76.94
#	06	62368	$ 41.17	$ 39.11	$ 44.98
	06	88125	$ 26.12	$ 24.81	$ 28.53
#	06	88125	$ 26.12	$ 24.81	$ 28.53
	06	88125 TC	$ 9.24	$ 8.78	$ 10.10
#	06	88125 TC	$ 9.24	$ 8.78	$ 10.10
	06	88367	$ 281.82	$ 267.73	$ 307.89
#	06	88367	$ 281.82	$ 267.73	$ 307.89
	06	88367 TC	$ 197.73	$ 187.84	$ 216.02
#	06	88367 TC	$ 197.73	$ 187.84	$ 216.02
	06	88368	$ 193.61	$ 183.93	$ 211.52
#	06	88368	$ 193.61	$ 183.93	$ 211.52
	06	88368 TC	$ 102.12	$ 97.01	$ 111.56
#	06	88368 TC	$ 102.12	$ 97.01	$ 111.56
	06	89220	$ 24.67	$ 23.44	$ 26.96
#	06	89220	$ 24.67	$ 23.44	$ 26.96
	06	96567	$ 110.64	$ 105.11	$ 120.88
#	06	96567	$ 110.64	$ 105.11	$ 120.88
	07	58356	$3,306.27	$ 3,140.96	$ 3,612.10
#	07	58356	$ 405.66	$ 385.38	$ 443.19
	07	62367	$ 49.93	$ 47.43	$ 54.54
#	07	62367	$ 24.74	$ 23.50	$ 27.03
	07	62368	$ 65.34	$ 62.07	$ 71.38

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - CA Only (Continued)

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
#	07	62368	$ 39.66	$ 37.68	$ 43.33
	07	88125	$ 24.15	$ 22.94	$ 26.38
#	07	88125	$ 24.15	$ 22.94	$ 26.38
	07	88125 TC	$ 8.15	$ 7.74	$ 8.90
#	07	88125 TC	$ 8.15	$ 7.74	$ 8.90
	07	88367	$ 253.60	$ 240.92	$ 277.06
#	07	88367	$ 253.60	$ 240.92	$ 277.06
	07	88367 TC	$ 173.82	$ 165.13	$ 189.90
#	07	88367 TC	$ 173.82	$ 165.13	$ 189.90
	07	88368	$ 176.58	$ 167.75	$ 192.91
#	07	88368	$ 176.58	$ 167.75	$ 192.91
	07	88368 TC	$ 89.87	$ 85.38	$ 98.19
#	07	88368 TC	$ 89.87	$ 85.38	$ 98.19
	07	89220	$ 21.73	$ 20.64	$ 23.74
#	07	89220	$ 21.73	$ 20.64	$ 23.74
	07	96567	$ 97.28	$ 92.42	$ 106.28
#	07	96567	$ 97.28	$ 92.42	$ 106.28
	09	58356	$3,676.34	$ 3,492.52	$ 4,016.40
#	09	58356	$ 426.23	$ 404.92	$ 465.66
	09	62367	$ 53.96	$ 51.26	$ 58.95
#	09	62367	$ 25.74	$ 24.45	$ 28.12
	09	62368	$ 70.05	$ 66.55	$ 76.53
#	09	62368	$ 41.28	$ 39.22	$ 45.10
	09	88125	$ 25.97	$ 24.67	$ 28.37
#	09	88125	$ 25.97	$ 24.67	$ 28.37
	09	88125 TC	$ 9.08	$ 8.63	$ 9.92
#	09	88125 TC	$ 9.08	$ 8.63	$ 9.92
	09	88367	$ 278.59	$ 264.66	$ 304.36
#	09	88367	$ 278.59	$ 264.66	$ 304.36
	09	88367 TC	$ 194.48	$ 184.76	$ 212.47
#	09	88367 TC	$ 194.48	$ 184.76	$ 212.47
	09	88368	$ 191.92	$ 182.32	$ 209.67
#	09	88368	$ 191.92	$ 182.32	$ 209.67
	09	88368 TC	$ 100.41	$ 95.39	$ 109.70
#	09	88368 TC	$ 100.41	$ 95.39	$ 109.70
	09	89220	$ 24.25	$ 23.04	$ 26.50
#	09	89220	$ 24.25	$ 23.04	$ 26.50
	09	96567	$ 108.81	$ 103.37	$ 118.88
#	09	96567	$ 108.81	$ 103.37	$ 118.88

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - CA Only (Continued)

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
	17	58356	$2,952.80	$ 2,805.16	$ 3,225.93
#	17	58356	$ 388.34	$ 368.92	$ 424.26
	17	62367	$ 46.18	$ 43.87	$ 50.45
#	17	62367	$ 23.91	$ 22.71	$ 26.12
	17	62368	$ 61.03	$ 57.98	$ 66.68
#	17	62368	$ 38.33	$ 36.41	$ 41.87
	17	88125	$ 22.48	$ 21.36	$ 24.56
#	17	88125	$ 22.48	$ 21.36	$ 24.56
	17	88125 TC	$ 7.27	$ 6.91	$ 7.95
#	17	88125 TC	$ 7.27	$ 6.91	$ 7.95
	17	88367	$ 229.97	$ 218.47	$ 251.24
#	17	88367	$ 229.97	$ 218.47	$ 251.24
	17	88367 TC	$ 154.06	$ 146.36	$ 168.31
#	17	88367 TC	$ 154.06	$ 146.36	$ 168.31
	17	88368	$ 162.27	$ 154.16	$ 177.28
#	17	88368	$ 162.27	$ 154.16	$ 177.28
	17	88368 TC	$ 79.84	$ 75.85	$ 87.23
#	17	88368 TC	$ 79.84	$ 75.85	$ 87.23
	17	89220	$ 19.34	$ 18.37	$ 21.13
#	17	89220	$ 19.34	$ 18.37	$ 21.13
	17	96567	$ 86.26	$ 81.95	$ 94.24
#	17	96567	$ 86.26	$ 81.95	$ 94.24
	18	58356	$2,952.75	$ 2,805.11	$ 3,225.88
#	18	58356	$ 399.42	$ 379.45	$ 436.37
	18	62367	$ 46.68	$ 44.35	$ 51.00
#	18	62367	$ 24.51	$ 23.28	$ 26.77
	18	62368	$ 61.98	$ 58.88	$ 67.71
#	18	62368	$ 39.37	$ 37.40	$ 43.01
	18	88125	$ 22.80	$ 21.66	$ 24.91
#	18	88125	$ 22.80	$ 21.66	$ 24.91
	18	88125 TC	$ 7.32	$ 6.95	$ 7.99
#	18	88125 TC	$ 7.32	$ 6.95	$ 7.99
	18	88367	$ 231.20	$ 219.64	$ 252.59
#	18	88367	$ 231.20	$ 219.64	$ 252.59
	18	88367 TC	$ 153.87	$ 146.18	$ 168.11
#	18	88367 TC	$ 153.87	$ 146.18	$ 168.11
	18	88368	$ 163.88	$ 155.69	$ 179.04
#	18	88368	$ 163.88	$ 155.69	$ 179.04
	18	88368 TC	$ 79.98	$ 75.98	$ 87.38

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - CA Only (Continued)

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
#	18	88368 TC	$ 79.98	$ 75.98	$ 87.38
	18	89220	$ 19.41	$ 18.44	$ 21.21
#	18	89220	$ 19.41	$ 18.44	$ 21.21
	18	96567	$ 86.21	$ 81.90	$ 94.19
#	18	96567	$ 86.21	$ 81.90	$ 94.19
	26	58356	$3,096.28	$ 2,941.47	$ 3,382.69
#	26	58356	$ 402.70	$ 382.57	$ 439.96
	26	62367	$ 47.90	$ 45.51	$ 52.34
#	26	62367	$ 24.52	$ 23.29	$ 26.78
	26	62368	$ 63.26	$ 60.10	$ 69.12
#	26	62368	$ 39.41	$ 37.44	$ 43.06
	26	88125	$ 23.31	$ 22.14	$ 25.46
#	26	88125	$ 23.31	$ 22.14	$ 25.46
	26	88125 TC	$ 7.70	$ 7.32	$ 8.42
#	26	88125 TC	$ 7.70	$ 7.32	$ 8.42
	26	88367	$ 240.18	$ 228.17	$ 262.40
#	26	88367	$ 240.18	$ 228.17	$ 262.40
	26	88367 TC	$ 162.21	$ 154.10	$ 177.22
#	26	88367 TC	$ 162.21	$ 154.10	$ 177.22
	26	88368	$ 168.90	$ 160.46	$ 184.53
#	26	88368	$ 168.90	$ 160.46	$ 184.53
	26	88368 TC	$ 84.25	$ 80.04	$ 92.05
#	26	88368 TC	$ 84.25	$ 80.04	$ 92.05
	26	89220	$ 20.44	$ 19.42	$ 22.33
#	26	89220	$ 20.44	$ 19.42	$ 22.33
	26	96567	$ 90.87	$ 86.33	$ 99.28
#	26	96567	$ 90.87	$ 86.33	$ 99.28
	99	58356	$2,693.64	$ 2,558.96	$ 2,942.80
#	99	58356	$ 371.82	$ 353.23	$ 406.21
	99	62367	$ 43.26	$ 41.10	$ 47.27
#	99	62367	$ 23.10	$ 21.95	$ 25.24
	99	62368	$ 57.56	$ 54.68	$ 62.88
#	99	62368	$ 37.01	$ 35.16	$ 40.43
	99	88125	$ 21.15	$ 20.09	$ 23.10
#	99	88125	$ 21.15	$ 20.09	$ 23.10
	99	88125 TC	$ 6.60	$ 6.27	$ 7.21
#	99	88125 TC	$ 6.60	$ 6.27	$ 7.21
	99	88367	$ 212.24	$ 201.63	$ 231.87
#	99	88367	$ 212.24	$ 201.63	$ 231.87
	99	88367 TC	$ 139.62	$ 132.64	$ 152.54

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - CA Only (Continued)

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
#	99	88367 TC	$ 139.62	$ 132.64	$ 152.54
	99	88368	$ 151.23	$ 143.67	$ 165.22
#	99	88368	$ 151.23	$ 143.67	$ 165.22
	99	88368 TC	$ 72.42	$ 68.80	$ 79.12
#	99	88368 TC	$ 72.42	$ 68.80	$ 79.12
	99	89220	$ 17.55	$ 16.67	$ 19.17
#	99	89220	$ 17.55	$ 16.67	$ 19.17
	99	96567	$ 78.19	$ 74.28	$ 85.42
#	99	96567	$ 78.19	$ 74.28	$ 85.42

Reference: **CR 3726**

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - ME, MA, NH, VT

Maine
Locality 03 **York & Cumberland Counties**
Locality 99 **Rest of State**

Massachusetts
Locality 01 **Middlesex, Norfolk, Suffolk Counties**
Locality 99 **Rest of State**

New Hampshire
Locality 40 **Entire State**

Vermont
Locality 50 **Entire State**

Effective January 1, 2005

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
			Maine		
	03	58356	$2,602.84	$ 2,472.70	$ 2,843.61
#	03	58356	$ 363.38	$ 345.21	$ 396.99
	03	62367	$ 42.17	$ 40.06	$ 46.07
#	03	62367	$ 22.73	$ 21.59	$ 24.83
	03	62368	$ 56.18	$ 53.37	$ 61.38
#	03	62368	$ 36.35	$ 34.53	$ 39.71
	03	88125	$ 20.63	$ 19.60	$ 22.54
#	03	88125	$ 20.63	$ 19.60	$ 22.54
	03	88125-TC	$ 6.34	$ 6.02	$ 6.92
#	03	88125-TC	$ 6.34	$ 6.02	$ 6.92
	03	88367	$ 205.81	$ 195.52	$ 224.85
#	03	88367	$ 205.81	$ 195.52	$ 224.85

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - ME, MA, NH, VT (Continued)

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
			Maine		
	03	88367-TC	$ 134.50	$ 127.78	$ 146.95
#	03	88367-TC	$ 134.50	$ 127.78	$ 146.95
	03	88368	$ 147.07	$ 139.72	$ 160.68
#	03	88368	$ 147.07	$ 139.72	$ 160.68
	03	88368-TC	$ 69.69	$ 66.21	$ 76.14
#	03	88368-TC	$ 69.69	$ 66.21	$ 76.14
	03	89220	$ 16.88	$ 16.04	$ 18.45
#	03	89220	$ 16.88	$ 16.04	$ 18.45
	03	96567	$ 75.31	$ 71.54	$ 82.27
#	03	96567	$ 75.31	$ 71.54	$ 82.27
	99	58356	$2,351.41	$ 2,233.84	$ 2,568.92
#	99	58356	$ 352.37	$ 334.75	$ 384.96
	99	62367	$ 39.67	$ 37.69	$ 43.34
#	99	62367	$ 22.32	$ 21.20	$ 24.38
	99	62368	$ 53.35	$ 50.68	$ 58.28
#	99	62368	$ 35.66	$ 33.88	$ 38.96
	99	88125	$ 19.52	$ 18.54	$ 21.32
#	99	88125	$ 19.52	$ 18.54	$ 21.32
	99	88125-TC	$ 5.69	$ 5.41	$ 6.22
#	99	88125-TC	$ 5.69	$ 5.41	$ 6.22
	99	88367	$ 189.31	$ 179.84	$ 206.82
#	99	88367	$ 189.31	$ 179.84	$ 206.82
	99	88367-TC	$ 120.22	$ 114.21	$ 131.34
#	99	88367-TC	$ 120.22	$ 114.21	$ 131.34
	99	88368	$ 137.29	$ 130.43	$ 149.99
#	99	88368	$ 137.29	$ 130.43	$ 149.99
	99	88368-TC	$ 62.37	$ 59.25	$ 68.14
#	99	88368-TC	$ 62.37	$ 59.25	$ 68.14
	99	89220	$ 15.12	$ 14.36	$ 16.51
#	99	89220	$ 15.12	$ 14.36	$ 16.51
	99	96567	$ 67.33	$ 63.96	$ 73.55
#	99	96567	$ 67.33	$ 63.96	$ 73.55
			Massachusetts		
	01	58356	$3,264.49	$ 3,101.27	$ 3,566.46
#	01	58356	$ 406.18	$ 385.87	$ 443.75
	01	62367	$ 49.46	$ 46.99	$ 54.04
#	01	62367	$ 24.65	$ 23.42	$ 26.93
	01	62368	$ 64.89	$ 61.65	$ 70.90

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - ME, MA, NH, VT (Continued)

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
			Massachusetts		
#	01	62368	$ 39.59	$ 37.61	$ 43.25
	01	88125	$ 23.97	$ 22.77	$ 26.19
#	01	88125	$ 23.97	$ 22.77	$ 26.19
	01	88125-TC	$ 8.10	$ 7.70	$ 8.86
#	01	88125-TC	$ 8.10	$ 7.70	$ 8.86
	01	88367	$ 250.88	$ 238.34	$ 274.09
#	01	88367	$ 250.88	$ 238.34	$ 274.09
	01	88367-TC	$ 171.70	$ 163.12	$ 187.59
#	01	88367-TC	$ 171.70	$ 163.12	$ 187.59
	01	88368	$ 175.01	$ 166.26	$ 191.20
#	01	88368	$ 175.01	$ 166.26	$ 191.20
	01	88368-TC	$ 88.97	$ 84.52	$ 97.20
#	01	88368-TC	$ 88.97	$ 84.52	$ 97.20
	01	89220	$ 21.55	$ 20.47	$ 23.54
#	01	89220	$ 21.55	$ 20.47	$ 23.54
	01	96567	$ 96.14	$ 91.33	$ 105.03
#	01	96567	$ 96.14	$ 91.33	$ 105.03
	99	58356	$2,866.87	$ 2,723.53	$ 3,132.06
#	99	58356	$ 382.54	$ 363.41	$ 417.92
	99	62367	$ 45.09	$ 42.84	$ 49.27
#	99	62367	$ 23.52	$ 22.34	$ 25.69
	99	62368	$ 59.73	$ 56.74	$ 65.25
#	99	62368	$ 37.74	$ 35.85	$ 41.23
	99	88125	$ 21.99	$ 20.89	$ 24.02
#	99	88125	$ 21.99	$ 20.89	$ 24.02
	99	88125-TC	$ 7.08	$ 6.73	$ 7.74
#	99	88125-TC	$ 7.08	$ 6.73	$ 7.74
	99	88367	$ 223.90	$ 212.71	$ 244.62
#	99	88367	$ 223.90	$ 212.71	$ 244.62
	99	88367-TC	$ 149.48	$ 142.01	$ 163.31
#	99	88367-TC	$ 149.48	$ 142.01	$ 163.31
	99	88368	$ 158.36	$ 150.44	$ 173.01
#	99	88368	$ 158.36	$ 150.44	$ 173.01
	99	88368-TC	$ 77.58	$ 73.70	$ 84.76
#	99	88368-TC	$ 77.58	$ 73.70	$ 84.76
	99	89220	$ 18.81	$ 17.87	$ 20.55
#	99	89220	$ 18.81	$ 17.87	$ 20.55
	99	96567	$ 83.72	$ 79.53	$ 91.46
#	99	96567	$ 83.72	$ 79.53	$ 91.46

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - ME, MA, NH, VT (Continued)

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
		New Hampshire & Vermont			
	40	58356	$2,665.86	$ 2,532.57	$ 2,912.46
#	40	58356	$ 375.20	$ 356.44	$ 409.91
	40	62367	$ 43.05	$ 40.90	$ 47.04
#	40	62367	$ 23.16	$ 22.00	$ 25.30
	40	62368	$ 57.47	$ 54.60	$ 62.79
#	40	62368	$ 37.19	$ 35.33	$ 40.63
	40	88125	$ 21.10	$ 20.05	$ 23.06
#	40	88125	$ 21.10	$ 20.05	$ 23.06
	40	88125-TC	$ 6.60	$ 6.27	$ 7.21
#	40	88125-TC	$ 6.60	$ 6.27	$ 7.21
	40	88367	$ 210.71	$ 200.17	$ 230.20
#	40	88367	$ 210.71	$ 200.17	$ 230.20
	40	88367-TC	$ 138.24	$ 131.33	$ 151.03
#	40	88367-TC	$ 138.24	$ 131.33	$ 151.03
	40	88368	$ 150.54	$ 143.01	$ 164.46
#	40	88368	$ 150.54	$ 143.01	$ 164.46
	40	88368-TC	$ 71.95	$ 68.35	$ 78.60
#	40	88368-TC	$ 71.95	$ 68.35	$ 78.60
	40	89220	$ 17.48	$ 16.61	$ 19.10
#	40	89220	$ 17.48	$ 16.61	$ 19.10
	40	96567	$ 77.47	$ 73.60	$ 84.64
#	40	96567	$ 77.47	$ 73.60	$ 84.64
	50	58356	$2,531.50	$ 2,404.93	$ 2,765.67
#	50	58356	$ 356.60	$ 338.77	$ 389.59
	50	62367	$ 41.36	$ 39.29	$ 45.18
#	50	62367	$ 22.48	$ 21.36	$ 24.56
	50	62368	$ 55.14	$ 52.38	$ 60.24
#	50	62368	$ 35.89	$ 34.10	$ 39.22
	50	88125	$ 20.24	$ 19.23	$ 22.11
#	50	88125	$ 20.24	$ 19.23	$ 22.11
	50	88125-TC	$ 6.12	$ 5.81	$ 6.68
#	50	88125-TC	$ 6.12	$ 5.81	$ 6.68
	50	88367	$ 200.82	$ 190.78	$ 219.40
#	50	88367	$ 200.82	$ 190.78	$ 219.40
	50	88367-TC	$ 130.39	$ 123.87	$ 142.45
#	50	88367-TC	$ 130.39	$ 123.87	$ 142.45
	50	88368	$ 143.89	$ 136.70	$ 157.21
#	50	88368	$ 143.89	$ 136.70	$ 157.21
	50	88368-TC	$ 67.45	$ 64.08	$ 73.69

Fee Schedule - April 2005 Corrections/Additions to the Medicare Physician Fee Schedule - ME, MA, NH, VT (Continued)

	AREA	CODE/ MOD	PAR FEE	NON-PAR FEE	LIMIT CHARGE
		New Hampshire & Vermont			
#	50	88368-TC	$ 67.45	$ 64.08	$ 73.69
	50	89220	$ 16.31	$ 15.49	$ 17.81
#	50	89220	$ 16.31	$ 15.49	$ 17.81
	50	96567	$ 72.98	$ 69.33	$ 79.73
#	50	96567	$ 72.98	$ 69.33	$ 79.73

Reference: **CR 3726**

X-Ray - 2005 Portable X-Ray Transportation Fees (CR 3280)

2005 Portable X-Ray Transportation Fees for California	
R0070 (One Patients)	$174.06
R0075 UN (Two Patients)	$87.03
R0075 UP (Three Patients)	$58.01
R0075 UQ (Four Patients)	$43.52
R0075 UR (Five Patients)	$34.81
R0075 US (Six or more)	$29.02

2005 Portable X-Ray Transportation Fees for Maine	
R0070 (One Patients)	$138.72
R0075 UN (Two Patients)	$69.36
R0075 UP (Three Patients)	$46.24
R0075 UQ (Four Patients)	$34.68
R0075 UR (Five Patients)	$27.74
R0075 US (Six or more)	$23.12

2005 Portable X-Ray Transportation Fees for Massachusetts	
R0070 (One Patients)	$156.98
R0075 UN (Two Patients)	$78.49
R0075 UP (Three Patients)	$52.32
R0075 UQ (Four Patients)	$39.25
R0075 UR (Five Patients)	$31.40
R0075 US (Six or more)	$26.17

X-Ray - 2005 Portable X-Ray Transportation Fees (CR 3280) (Continued)

2005 Portable X-Ray Transportation Fees for New Hampshire and Vermont	
R0070 (One Patients)	$108.59
R0075 UN (Two Patients)	$54.30
R0075 UP (Three Patients)	$36.19
R0075 UQ (Four Patients)	$27.15
R0075 UR (Five Patients)	$21.72
R0075 US (Six or more)	$18.10

Reference: **CR 3280**

NOTES

NHIC Contacts

	Provider IVR	Provider Telephone Review	Provider Customer Service	Report Fraud and Abuse
Northern California	1-877-591-1587	1-888-656-3212	1-877-527-6613	1-877-591-1587
Southern California	1-866-502-9054	1-866-539-5597	1-877-527-6613	1-866-502-9054
Maine	1-877-567-3129	1-207-294-4322	1-877-258-4442	1-877-567-3129
Massachusetts	1-877-567-3130	1-207-294-4322	1-877-527-6594	1-877-567-3130
New Hampshire	1-866-539-5595	1-207-294-4322	1-877-258-4442	1-866-539-5595
Vermont	1-866-539-5595	1-207-294-4322	1-877-258-4442	1-866-539-5595

NHIC EDI Contacts

	EDI Customer Service	ECS Claim Submission
Northern California	1-530-896-7024	1-530-892-6550 or 1-213-593-6948 (local # for southern counties)
Southern California	1-213-593-6950	1-530-879-1774 or 1-213-593-5943 (local # for southern counties)
Maine	1-781-749-7745	
Massachusetts	1-781-749-7745	
New Hampshire	1-781-749-7745	
Vermont	1-781-749-7745	

Other Contacts

American Medical Association	1-800-621-8335
CMS-1500 forms order line	1-800-621-8335
Associated Hospital Service, Inc. - Part A	1-877-567-9250
CIGNA - Region D- DMERC	
General Information	1-877-320-0390
Government Printing Office	1-866-512-1800
HealthNow New York, Inc. - Region A - DMERC	1-866-419-9458
MassHealth	1-800-322-2909
MaineCare	1-800-452-4694
Medi-Cal	1-800-541-5555
Mutual of Omaha (Part A)	1-866-580-5945
New Hampshire Medicaid	1-800-423-8303
Office of Vermont Health Access	1-800-925-1306
Railroad Retirement - Palmetto Government Benefits	1-877-288-7600
United Government Services (Part A)	1-866-380-4745

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