Medicare Informa
División Medicare / Parte B

¡Qué Bueno Que Preguntó!

¿DE QUÉ SE TRATA LA LIMITACIÓN QUE SE APLICA A LOS SERVICIOS AMBULATORIOS DE SALUD MENTAL?

La sección 2470 del *Medicare Carrier Manual* establece que independientemente de los gastos reales en que un beneficiario incurra por el tratamiento de algún desorden mental, psiconeurótico o de personalidad, mientras éste no se encuentre hospitalizado al momento en que incurrió en dichos gastos, se le aplicará una limitación de un 62.5 porciento a la cantidad que Medicare apruebe, ya sea para ser aplicada al deducible o con propósitos de pago por parte de Medicare.

El término "desorden mental, psiconeurótico o de personalidad" se define como las condiciones psiquiátricas específicas descritas en el "American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, Third Edition – Revised (DSM-III-R).

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We Are Glad You Asked!

WHAT IS THE OUTPATIENT MENTAL HEALTH SERVICES LIMITATION?

Section 2470 of the Medicare Carrier Manual states that regardless of the actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare allowed amount for those services.

The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric conditions described in the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM-III-R).

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Este boletín debe ser compartido con todos los profesionales de la salud y administrativos que formen parte de su oficina. Copias adicionales del boletín están disponibles en nuestra página de internet a la siguiente dirección: www.triples-med.org

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Additional no-cost copies are available on our website at www.triples-med.org

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¡Qué Bueno Que Preguntó!

Desde la portada...

El término "hospital" en este contexto significa una institución que se encuentra comprometida primordialmente en proveer a los pacientes hospitalizados, por o bajo supervisión médica:

- Servicios diagnósticos y terapéuticos para diagnóstico médico, tratamiento y cuidado de personas lesionadas, incapacitadas o enfermas;
- Servicios de rehabilitación para personas lesionadas, incapacitadas o enfermas; o
- Servicios siquiátricos para el diagnóstico y tratamiento de pacientes enfermos mentalmente.

Los gastos por concepto de servicios diagnósticos (ej. Pruebas psiquiátricas y evaluación para diagnosticar la enfermedad del paciente) no se encuentran sujetos a esta limitación. La misma aplica solamente a servicios terapéuticos y a servicios efectuados para evaluar el progreso del curso del tratamiento de una condición diagnosticada.

El siguiente es un ejemplo de cómo Medicare aplica esta limitación:

Servicio rendido por un médico en una facilidad ambulatoria: **90805**

Tarifa para este servicio ambulatorio para el año 2001 en Puerto Rico: **$61.74**

$61.74 x 62.5%* = $38.59 x 80% = $30.87**

* Limitación a los servicios ambulatorios de salud mental

** Después de que la limitación ha sido aplicada, y el deducible ha sido satisfecho, Medicare paga el 80% de dicha cantidad o el remanente de dicha tarifa

En reclamaciones asignadas, el proveedor puede facturar al beneficiario por la diferencia entre la tarifa asignada por Medicare a dicho servicio y la cantidad permitida después de haber sido aplicada la limitación. En efecto, Medicare paga 50 porciento de la tarifa asignada y el beneficiario es responsable del otro 50 porciento.

We Are Glad You Asked!

From the cover...

The term "hospital" in this context means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physician(s):

- *Diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons;*
- *Rehabilitation services for injured, disabled, or sick persons; or*
- *Psychiatric services for the diagnosis and treatment of mentally ill patients.*

Expenses for diagnostic services (e.g., psychiatric testing and evaluation to diagnose the patient's illness) are not subject to this limitation. This limitation applies only to therapeutic services and to services performed to evaluate the progress of a course of treatment for a diagnosed condition.

The following is an example of how this limitation is applied by Medicare:

Service rendered by a physician in an outpatient setting: ***90805***

2001 Medicare Fee for this outpatient service in Puerto Rico: ***$61.74***

$61.74 x 62.5%* = $38.59 x 80%** = $30.87

***** *Outpatient Mental Health Limitation*

****** *After the limitation has been applied, and the annual deductible has been satisfied, Medicare pays 80% of that amount or the remainder of that rate.*

On assigned claims, the provider may bill the beneficiary for the difference between the fee schedule amount for that service and the amount allowed after the outpatient psychiatric limitation has been applied. In effect, Medicare pays 50 percent of the fee schedule amount and the beneficiary is responsible for the other 50 percent.

Sections 2470 –2472.2 MCM/10-01/LV

TRICARE For Life

CONOZCA A *TRICARE FOR LIFE*

¿Qué es *TRICARE For Life*?

TRICARE For Life es una nueva cubierta expandida de *TRICARE,* el sistema de cuidado de la salud del Departamento de la Defensa de los Estados Unidos, el cual sustituye a CHAMPUS (*Civilian Health and Medical Program of the Uniformed Services*). Esta cubierta comenzó el 1 de octubre de 2001.

¿En qué consiste esta nueva cubierta?

TRICARE For Life es una amplia cubierta que actúa como un plan suplementario a Medicare. Medicare será el pagador primario en los servicios que cubre. *TRICARE For Life* pagará deducibles y coaseguros.

¿Quiénes pueden tener esta cubierta?

TRICARE For Life fue creado para militares retirados, sus cónyuges y otros dependientes que cualifiquen. Éstos deben tener 65 años o más y poseer Parte A y Parte B de Medicare. También los viudos (as) y ciertas categorías de ex cónyuges que no se hayan vuelto a casar son elegibles. Los portadores de la Medalla de Honor también tienen derecho a esta cubierta. Otras personas que no sean elegibles a Medicare tendrán otros modelos de cubiertas bajo el sistema *TRICARE.*

¿Cuál será la tarjeta de identificación del beneficiario de *TRICARE For Life*?

El beneficiario de Medicare que es elegible a *TRICARE For Life* presentará su tarjeta de Medicare con cubierta de la parte A y parte B y también presentará su identificación como militar. Medicare actuará como primario y *TRICARE For Life* como suplementario. Un dato importante es que el Departamento de la Defensa decidió no emitir tarjetas nuevas a los militares retirados. Esto significa que aunque la identificación militar presente una fecha expirada, la misma resulta activa.

¿Qué tiene que hacer un proveedor de Medicare cuando presta servicios a un beneficiario de Medicare que también posee *TRICARE For Life*?

KNOW TRICARE FOR LIFE

What is TRICARE For Life?

TRICARE For Life is an expanded new coverage of TRICARE, the Department of the Defense's healthcare system, which substituted CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). This coverage began in October 1, 2001.

What does this new coverage consist of?

TRICARE For Life is an extensive coverage that acts like a Medicare supplementary plan. Medicare will be the primary payer for the covered services. TRICARE For Life will pay deductibles and coinsurances.

Who are elegible for this coverage?

TRICARE For Life was created for military retirees, spouses, and other Medicare-elegible family members. These should be 65 years old or older and have both Medicare Part A and Part B. Also the widow(ers) and certain categories of former spouses who have not remarried are elegible. Bearers of the Medal of Honor have the right to this coverage too. Other persons that are not Medicare-elegible will have other coverage models under the TRICARE system.

What identification card will TRICARE For Life beneficiaries use?

The TRICARE For Life-eligible Medicare beneficiary will present his/her Medicare identification card (with Part A and Part B) and his/her military I.D. Medicare will act as primary payer and TRICARE For Life as supplementary. An important fact is that the Department of the Defense decided not to emit new cards to the military retirees. This means that although the military identification presents an expirated date, the same is valid.

What does a Medicare provider do when he renders services to a Medicare beneficiary that also have TRICARE For Life?

TRICARE For Life

En general, un proveedor no tiene que ser "Proveedor autorizado por *TRICARE*" o "Proveedor Participante de *TRICARE*" para recibir pagos por reclamaciones a *TRICARE For Life*. **El único requisito es que el proveedor sea participante de Medicare o acepte pacientes de dicho programa.** El Departamento de Defensa trabajó con Medicare para la coordinación de beneficios necesarios entre ambos y así facilitar el sistema de facturación. Esto significa que una vez un proveedor preste servicios de salud a un paciente que posee Medicare y también *TRICARE For Life*, deberá someter la factura por dichos servicios a Medicare. Tan pronto Medicare adjudique dicha factura, automáticamente enviará la misma al contratista encargado de procesar las facturas de *TRICARE For Life*. Éste pagará el deducible y el coaseguro de Medicare. *TRICARE For Life* podrá pagar otros beneficios no cubiertos por Medicare, siempre que se definan en su cubierta. El contratista de *TRICARE For Life* enviará el pago al proveedor y también una Explicación de Beneficios al beneficiario.

¿Cómo actuará *TRICARE For Life* en la situación en que el servicio sea prestado por un proveedor no participante del programa Medicare que no acepte asignación?

TRICARE For Life pagará directamente al beneficiario la porción que le corresponda, tan pronto como Medicare adjudique la reclamación no asignada que recibió del proveedor de los servicios (es ley que todo proveedor que preste servicios a beneficiarios de Medicare, participante o no, someta al programa Medicare la factura por sus servicios)

¿Cuál es la entidad encargada del proceso de los pagos de *TRICARE For Life*?

El pago de la parte de la factura que corresponde a *TRICARE For Life* será procesado por la compañía *Wisconsin Physicians Services Insurance Corporation.*

In general, a provider does not have to be "TRICARE-authorized" or "TRICARE-participating" to receive payments for claims to TRICARE For Life. ***The only requirement is that the supplier must be participant of Medicare or accept Medicare patients of said program****. The Department of Defense worked with Medicare for the necessary coordination of benefits among both programs and thus facilitate the claims submission process. This means that once suppliers render health services to patients that possesses Medicare and also TRICARE For Life, they should submit a claim for those services to Medicare. As soon as Medicare adjudicates the claim, it will automatically send the information to the contractor responsible for processing TRICARE For Life claims. This contractor will pay the Medicare deductible and coinsurance. TRICARE For Life could pay other benefits not covered by Medicare, as long as defined in their coverage. The contractor of TRICARE For Life will send the payment to the provider and an Explanation of Benefits to the beneficiary.*

How will TRICARE For Life act when the service is rendered by a non-participating provider of the Medicare Program that did not accept assignment?

TRICARE For Life will pay the beneficiary the corresponding portion, as soon as Medicare adjudicates the non-assigned claim submitted by the provider (it is the law that every provider that renders services to Medicare beneficiaries, participates or not, should submit Medicare the claim for his/her services).

Which is the entity responsible for the process of TRICARE For Life payments?

The payment of the part of the claim that corresponds to TRICARE For Life will be processed by Wisconsin Physicians Services Insurance Corporation.

Colaboración especial de QIPRO "Quality Improvement Professional Research Organization, Inc."

MÉDICOS Y BENEFICIARIAS EN PIE DE LUCHA CONTRA EL CÁNCER DE MAMA

Estimado doctor:

Los médicos desempeñamos un rol muy importante e influyente en motivar a las mujeres, particularmente a las de mayor edad, a participar en programas de detección temprana de cáncer. El diálogo y la relación médico-paciente sobre la mamografía de cernimiento y su importancia, es un indicador esencial en el uso inicial y subsiguiente de la mamografía. La orden médica y el consejo del médico de confianza de la paciente son factores claves para que las mujeres se realicen las mamografías.

Nos dirijimos a usted con el propósito que se una a la estrategia desarrollada por QIPRO y su Alianza Puertorriqueña para la Promoción de la Mamografía. La Alianza es un esfuerzo de agencias públicas y privadas convocadas y coordinadas por QIPRO/MEDICARE en respuesta a uno de los problemas de salud más significativo identificado en la mujer puertorriqueña: **el cáncer de mama.**

En Puerto Rico, el cáncer de mama es la segunda causa de muerte por cáncer en nuestras mujeres. QIPRO y su Alianza está participando en el proyecto nacional de cáncer de mama cuyo objetivo persigue lograr que por lo menos el 70% de las féminas en Puerto Rico de 50 años en adelante, se realicen una mamografía anual. Así se contribuirá a reducir las muertes prematuras, mejorar la salud y calidad de vida de nuestro pueblo.

El riesgo de desarrollar cáncer de mama aumenta significativamente con la edad. El 75% de los casos se desarrollan en mujeres mayores de 50 años. A pesar de la evidencia científica que existe sobre la utilización de la mamografía, como herramienta principal para reducir la mortalidad de cáncer de mamas, la tasa anual de mamografía en mujeres beneficiarias de Medicare de 50 a 67 años en Puerto Rico, es solamente de 45%. **Este es el porcentaje más bajo entre todas las beneficiarias de Medicare de Estados Unidos y Puerto Rico.**

La buena noticia es que existe una posible solución : ***que usted ordene a sus pacientes una mamografía.***

El impacto positivo que tiene el consejo del médico a sus pacientes sobre la mamografía anual ha sido bien evidenciado en un estudio realizado por la Dra. Melba Sánchez de la Escuela de Salud Pública de la UPR con el título "Conocimientos y Creencias sobre Cáncer de Mama en Mujeres de Edad Avanzada en Puerto Rico". **El estudio demuestra, entre otros hallazgos, que si el médico ordena la mamografía, la mujer se la hace.** Por lo tanto, dependemos de médicos comprometidos como usted para que participen voluntariamente en esta causa.

Actualmente, contamos con el apoyo y activa participación en la Alianza de agencias relacionadas al campo de la salud como CMS, Departamento de Salud, ASES, Humana, Triple C, Triple-S, MCS, Cruz Azul, COSVI, Pharmacia Upjohn, FDA, Hospital Oncológico de Ponce, entre otros, quienes se han unido con el firme propósito de mejorar la tasa de utilización de mamografía de Puerto Rico.

Esperamos contar con su colaboración en esta encomiable gestión. Si tiene preguntas o necesita más información, favor de comunicarse con el Dr. Luis A. López, Coordinador Clínico Principal de Proyectos de Mejoramiento de Calidad de Servicios o la Sra. Brenda Agosto, Coordinadora del Proyecto Nacional de Cáncer de Mama en QIPRO al 641-1240. En QIPRO agradecemos su atención al respecto y le deseamos todo éxito en su quehacer profesional.

Este proyecto cuenta con el endoso de la Asociación Médica de Puerto Rico y su presidente el Dr. Eladio Santos Aponte.

Noviembre, 2001/QIPRO

Health Insurance Portability and Accountability Act (HIPAA)

X12N 837 PROFESSIONAL COMPANION DOCUMENT

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 837 implementation guides. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the VMS system of Triple-S Inc. Contractor number 00973. The information in this document is subject to change. Changes will be communicated in the standard Medicare Bulletin monthly news bulletin and on Triple-S Inc. / Medicare Division Web site: www.triples-med.org. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

- Negative values submitted in the following fields may not be processed and may result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), Service Unit Count (2400 Loop, SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102).
- The only valid values for CLM05-3 (Claim Frequency Type Code) are '1' (ORIGINAL) and '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and may result in duplicate claim rejection. The claims processing system does not process electronic replacements.
- The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 will be rejected.
- Claims that contain percentage amounts submitted with values in excess of 99.99 will be rejected.
- Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal will be rejected.
- Data submitted in CLM20 (Delay Reason Code) may not be used for processing.
- Triple-S will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
- You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set may cause the interchange (transmission) to be rejected at the carrier translator.

- The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
- Currency code (CUR02) must equal 'USA'.
- Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.
- Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).
- Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).
- Service unit counts (units or minutes) cannot exceed 999.9 (SV104).
- For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.
- The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^, |, and: Submitting delimiters not supported within this list will cause an interchange (transmission) to be rejected.
- Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
- Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Non-implementation guide data may not be sent for processing consideration.
- Any data submitted in the PWK (Paperwork) segment may not be considered for processing.
- Purchased diagnostic tests (PDT) amounts should be submitted at the detail line level (Loop 2400), not at the header claim level (Loop 2300). PDT amounts submitted at the header claim level (Loop 2300) may be ignored.
- Peer Review Organization (PRO) information should be submitted at the header claim level (Loop 2300). PRO information submitted at the detail line level (Loop 2400) will be ignored.
- All dates that are submitted on an incoming 837-claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).
- Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).
- Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).
- Triple-S will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).

- Triple-S may edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Institutional or Professional Implementation Guides.
- Triple-S will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
- Triple-S may reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.
- Triple-S may reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
- Triple-S may reject an interchange (transmission) that is not submitted with a valid carrier code. Each individual Contractor determines this code.
- Triple-S will reject an interchange (transmission) submitted with more than 9,999 loops.
- Triple-S will reject an interchange (transmission) submitted with more than 9,999 segments per loop.
- Triple-S will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.
- Triple-S will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).
- Triple-S will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
- You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes may not be considered in processing.
- Only valid qualifiers for Medicare should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing may cause the claim or the transaction to be rejected.
- You may send up to four modifiers; however, the last modifier may not be considered. The Triple-S processing system may only use the first three modifiers for adjudication and payment determination of claims.
- Triple-S will return the version of the 837 inbound transaction in GS08 (Version/Release/ Industry Identifier Code) of the 997.
- We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.
- Compression of files is not supported for transmissions between the submitter and Triple-S.

CR1809-Nov. 08, 2001/JS

Health Insurance Portability and Accountability Act (HIPAA)

LAS DISPOSICIONES SOBRE ADMINISTRACIÓN SIMPLIFICADA (AS) CONTENIDAS EN EL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)"

1. **¿Qué es HIPAA?**

Su nombre es *Health Insurance Portability and Accountability Act of 1996.* Es una ley creada por solicitud de la industria de la salud. Los estándares adoptados por la Secretaría de Salud y Servicios Humanos aplican a toda la industria, no solamente a Medicare y Medicaid.

2. **¿Quiénes deben cumplir con esta ley?**

Las entidades cubiertas por esta ley lo son todos los planes médicos, los pagadores y los *clearinghouses* (*third party administrators*) que procesan datos electrónicamente. La ley aplica a todas las transacciones electrónicas que estas organizaciones llevan a cabo y para las cuales exista un estándar. HIPAA le confiere la autoridad a la Secretaría de Salud de imponer penalidades de hasta $100.00 por violación a cualquiera que falle en cumplir con algún estándar. La penalidad monetaria total en una persona por año no debe exceder los $25,000 por violación de cada requisito.

3. **¿Qué es la Administración Simplificada?**

Las disposiciones de Administración Simplificada contenidas en HIPAA han sido creadas para reducir las cargas administrativas y los costos en la industria de la salud. La Administración Simplificada hace posible la uniformidad en las transmisiones electrónicas.

4. **¿Cuáles son las transacciones que están cubiertas por la Administración Simplificada?**

La ley HIPAA le requiere a la Secretaría de Salud y Servicios Humanos el adoptar estándares para las transacciones administrativas y financieras relacionadas al cuidado de la salud que mencionamos a continuación:

ADMINISTRATIVE SIMPLIFICATION PROVISIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

1. ***What is HIPAA?***

Health Insurance Portability and Accountability Act of 1996 better known, as HIPAA is a law created upon request of the health industry. The standards adopted by the Department of Health and Human Services apply to the entire industry, not only to Medicare and Medicaid.

2. ***Who should comply with this law?***

All health insurance plans, payees and clearinghouses (third party administrators) that process data electronically are entities covered by this law. The legislation applies to all electronic transactions that these entities carry out and for which a standard exist. HIPAA confers the Secretary of Health and Human the authority to impose penalties of $100.00 to those that fail in complying with a standard. Monetary penalty per person per year should not exceed the $25,000 for the violation of each requirement.

3. ***What are the Provisions of Administrative Simplification?***

The Administrative Simplification provisions contained in HIPAA are aimed at reducing administrative cost and burdens in the health care industry. Administrative Simplification makes uniform electronic transmission possible.

4. ***What transactions are covered by Administrative Simplification?***

HIPAA requires that the Secretary of the Department of Health and Human Services adopt standards for all the following administrative and financial transactions related to health care:

- Solicitudes de ingreso o de baja de un plan médico
- Reclamaciones a planes
- Primas de planes de salud
- Informe inicial de lesiones relacionadas al trabajo
- Coordinación de Beneficios y remesas
- Estatus de reclamaciones a planes de salud
- Referidos

5. **¿Qué transmisiones deben cumplir con los estándares?**

Toda transmisión electrónica que sea realizada de una computadora a otra, debe cumplir con los estándares. Estas transmisiones electrónicas incluyen aquellas que utilizan cualesquiera de los siguientes medios: cintas magnéticas, diskettes o discos compactos. Los estándares igualmente aplican a Internet, *intranets*, líneas arrendadas,*dial-up lines*, redes de comunicación privadas, y otros.

6.**¿Qué agencia es responsable del desarrollo de las guías de implantación de los estándares adoptados por el Departamento de Salud y Servicios Humanos?**

Las guías de implantación y los estándares fueron desarrollados por el *American National Standards Institute* (ANSI) *Acredited Standards Committee (ASC) X12N.*

7.**¿Cuándo serán efectivos los estándares?**

La industria de la salud tiene 24 meses para implantar los estándares. Los planes de salud pequeños tendrán 36 meses para implantarlos. Las demoras en la adopción de los estándares no alargará estos periodos de implantación.

8.**¿Se les requerirá a los médicos que adquieran computadoras?**

No, no existe tal requisito.

- *Health insurance enrollment and eligibility*
- *Health insurance claims*
- *Health insurance premiums*
- *First Injury Report*
- *Coordination of benefits and remittance advice*
- *Status of health insurance claims*
- *Referrals*

5. ***What transmissions should comply with the standards?***

All electronic transmission conducted from a computer to another should comply with the standards. These electronic transmissions include those that use any of the following means: magnetic tape, diskettes or compact disks. The standards likewise apply to Internet, Intranets, leased lines, dial-up lines, private networks of communication, and other.

6. ***What agency is responsible for the development of the guidelines for the standards adopted by the Department of Health and Human Services?***

These guidelines were developed by the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N.

7. ***When will these standards become effective?***

The health care industry has 24 months to implement the standards. Small insurance plans will have 36 months to implement the standards. Delays in the adoption of the standards will not lengthen these implementation periods.

8. ***Will physicians be required to acquire computers?***

No, such requirement does not exist.

Health Insurance Portability and Accountability Act (HIPAA)

9. **¿Se verán afectadas las transacciones en papel?**

No. Las transacciones en papel continuarán sin cambios por el momento.

10. **¿Está el gobierno creando un banco de datos centralizado con la información de todo individuo?**

No. No hay disposiciones en la ley HIPAA que cree o proponga crear dicho banco de datos. El gobierno no tendrá acceso a los récords de cuidado médico transmitidas entre los planes médicos y los proveedores de servicios de cuidado de la salud.

11. **¿Cuán protegida estará la información de salud?**

La ley instruye a la Secretaría de Salud y Servicios Humanos a adoptar estándares de seguridad y privacidad para que todos los planes médicos, *clearinghouses*, y proveedores los sigan. Estos estándares serán requeridos en todas las etapas de transmisión y almacenaje de información relacionada al cuidado de salud. Se requerirá proteger la información sobre salud antes, durante y después de las transmisiones electrónicas. La legislación y reglamentaciones concernientes a privacidad definirán en el futuro lo que serán divulgaciones apropiadas o inapropiadas de la información sobre salud y de cómo los derechos de los pacientes serán protegidos.

9. ***Will paper transactions be affected?***

No, paper transactions will continue without any changes for the moment.

10. ***Is government creating a centralized bank of data with the information of all individual?***

No. There are no provisions in the law that creates or proposes the creation of said data bank. Government will not have access to records of medical care transmitted from insurance plans to health care providers.

11. ***How protected will health information be?***

The law instructs the Secretary of Health and Human Services to adopt security and privacy standards so that the health insurance plans, clearinghouses, and suppliers follow them. These standards will be required in all the phases of transmission and storage of health care information. Protection of health information will be required before, during and after the electronic transmissions. The legislation and regulations on privacy will define in the future what will be appropriate or inappropriate disclosures of the information and of how the rights of patients will be protected.

LV/DG/11-2001

Gonzalo V. González, MD FACP

MEDICARE COVERAGE OF NON-INVASIVE VASCULAR STUDIES FOR END STAGE RENAL DISEASE (ESRD) PATIENTS

Medicare pays for outpatient maintenance dialysis services furnished by ESRD facilities based on a composite payment rate. This rate is a comprehensive payment and includes all services, equipment, supplies, and certain laboratory tests and drugs that are necessary to furnish a dialysis treatment.

For dialysis to take place there must be a means of access so that the exchange of waste products may occur. As part of the dialysis treatment, ESRD facilities are responsible for monitoring access, and when occlusions occur, either declot the access or refer the patient for appropriate treatment. Procedure associated with monitoring access involve taking venous pressure, aspirating thrombus, observing elevated recirculation time, reduced urea reduction ratios, or collapsed shunt, etc. All such procedures are covered under the composite rate.

A number of ESRD facilities are monitoring access through non-invasive vascular studies such as duplex and doppler flow scans and billing separately for these procedures. Non-invasive vascular studies are not covered as a separately billable service if used to monitor a patient's vascular access site. Medicare pays for the technical component of the procedure in the composite payment rate.

An ESRD facility must furnish all necessary services, equipment and supplies associated with a dialysis treatment, either directly or under arrangements that make the facility financially responsible for the service. If an ESRD facility or a renal physician decides to monitor the patient's access site with a non-invasive vascular study and does not have the equipment to perform the procedure, the facility or physician may arrange for the service to be furnished by another source. The alternative source, such as an independent diagnostic testing facility must look to the ESRD facility for payment. No separate payment for non-invasive vascular studies for monitoring the access site of an ESRD patient, whether coded as the access site or peripheral site, is permitted to any entity.

Where there are signs and symptoms of vascular access problems, doppler flow studies may be used as a means to obtain diagnostic information to permit medical intervention to address the problem. Doppler flow studies may be considered medically necessary in the presence of signs or symptoms of possible failure of the ESRD patient's vascular access site, and when the results are used in determining the clinical course of the treatment for the patient.

The only Current Procedural Terminology (CPT) billing code for non-invasive vascular testing of a hemodialysis access site is 93990. Medicare will deny separate billing of the technical component of this code if it is performed on any patient for whom the ESRD composite rate for dialysis is being paid, unless there is appropriate medical indication of the need for a doppler flow study.

When a dialysis patient exhibits signs and symptoms of compromise to the vascular access site, doppler flow studies may provide diagnostic information that will determine the appropriate medical intervention. Medicare considers a doppler flow study medically necessary when the beneficiary's dialysis access site manifests signs or symptoms associated with vascular compromise and when the results of this test are necessary to determine the clinical course of treatment.

Examples supporting the medical necessity for doppler flow studies include:

a. Elevated dynamic venous pressure > 200mm HG when measured during dialysis with the blood pump set on a 200cc/min.,

b. Access recirculation of 12 percent or greater,

c. An otherwise unexplained urea reduction ratio < 60 percent, and

d. An access with a palpable "water hammer" pulse on examination (which implies venous outflow obstruction).

Unless the documentation is provided supporting the necessity of more than one study, Medicare will limit payment to either a doppler flow study or an arteriogram (fistulogram, venogram), but not both.

An example of when both studies may be clinically necessary is when a doppler flow study demonstrates reduced flow (blood flow rate less than 800cc/min or a decreased flow of 25% or greater from previous study) and the physician requires an arteriogram to further define the extent of the problem. The patient's medical record(s) must provide documentation supporting the need for more than one imaging study.

This policy is applicable to claims from ESRD facilities and all other sources, such as independent diagnostic testing facilities and hospital outpatient departments.

The professional components of the procedure are included in the monthly capitation payment (MCP) (see 15060.1 of Medicare Carriers Manual, Part 3). The professional component should be denied for code 93990 if billed by the MCP physician. Medically necessary services that are included or bundled into the MCP (e.g., test interpretations) are separately payable when furnished by physicians other than the MCP physician (see 15060.1 and 15060.2 of the Medicare Carriers Manual, Part 3).

If the claim is denied, it will be reported on a remittance advice with group code "CO" and claim adjustment reason code 24, "Payment for charges denied. Charges are covered under a capitation agreement."

Billing for monitoring of hemodialysis access using CPT codes for non-invasive vascular studies other than 93990 is considered a misrepresentation of the service actually provided and should be considered for fraud investigation.

GGL-1638
CR#1855/AB-01-129/September 2001

EXTERNAL COUNTERPULSATION (ECP) FOR SEVERE ANGINA

External counterpulsation (ECP), commonly referred to as enhanced external counterpulsation, is a non-invasive outpatient treatment for coronary artery disease refractory to medical and/or surgical therapy. Although ECP devices are cleared by the Food and Drug Administration (FDA) for use in treating a variety of cardiac conditions, including stable or unstable angina pectoris, acute myocardial infarction and cardiogenic shock, the use of this device to treat cardiac conditions other than stable angina pectoris is not covered, since only that use has developed sufficient evidence to demonstrate its medical effectiveness. Non-coverage of hydraulic versions of these types of devices remains in force.

Coverage is provided for the use of ECP for patients who have been diagnosed with disabling angina (Class III or Class IV, Canadian Cardiovascular Society Classification or equivalent classification) who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical intervention, such as PTCA or cardiac bypass because:

1. their condition is inoperable, or at high risk of operative complications or post-operative failure
2. their coronary anatomy is not readily amenable to such procedures; or
3. they have co-morbid states which create excessive risk.

A full course of therapy usually consists of 35 one-hour treatments, which may be offered once or twice daily, usually 5 days per week. The patient is placed on a treatment table where their lower trunk and lower extremities are wrapped in a series of three compressive air cuffs which inflate and deflate in synchronization with the patient's cardiac cycle.

GGL-1637
CR#1884/CIM TR.146/October 2001

PREOPERATIVE SERVICES

On page 6 of our October through December 2000 Medicare Informa bulletin, we published HCFA's (now CMS) ruling regarding coverage of routine, screening and preoperative services. It states that services in absence of symptoms, signs or diseases status as represented by covered ICD-9 codes will not be reimbursed (Section 1862 (a)(1)(A) of the Social Security Act).

CMS has revised this ruling to allow payment for services represented by the following preoperative ICD-9 range of codes:

- V72.81 (pre-operative cardiovascular examination)
- V72.82 (pre-operative respiratory examination)
- V72.83 (other specified pre-operative examination)
- V72.84 (pre-operative examination, unspecified).

All claims for preoperative medical examination and preoperative diagnostic test must be accompanied by the appropriate ICD-9 code for preoperative examination (V72.81 through V72.84). Other diagnoses and conditions justifying the medical necessity must be reported in the order form from the physician to the laboratory. The physician must also document in the medical record the medical necessity for the test. Example: aminophiline levels for a patient on aminophiline therapy.

Medicare will periodically evaluate the medical order to assess the medical necessity and if needed request the medical record for the same purpose.

GGL-1636
CR#1815/MCM TR. 1719/ August 2001

MEDICAL REVIEW OF SERVICES FOR PATIENTS WITH DEMENTIA

Dementia is the general loss of cognitive abilities, including an impairment of memory and may include one or more of the following: aphasia, apraxia, agnosia or disturbed planning, organizing and abstract thinking abilities. Dementia excludes the loss of intellectual functioning caused by clouding of consciousness. Advances in diagnostic techniques, including neuropsychiatric testing, currently enable physicians and psychologists to diagnose some dementias when the patient's disease is at its earliest stages. Throughout the course of their disease, patients with dementia may benefit from pharmacologic, physical, occupational, speech-language, and other therapies.

Providers may not use ICD-9 codes for dementia alone as a basis for determining whether a Medicare covered benefit was reasonable and necessary because these codes do not define the extent of a beneficiary's cognitive impairment. For example, a claim submitted with only a diagnosis of Alzheimer's Disease (ICD-9 code 331.0) may entitle a beneficiary to evaluation and management visits and therapies if the contractor determines that these therapies are reasonable and necessary when reviewed in the context of a beneficiary's overall medical condition.

Because dementia is a diagnostic term with broad clinical implications, it may not support the medical necessity of a Medicare covered benefit when used alone. Providers should enter the primary diagnosis or condition as well as secondary diagnoses or conditions that most closely reflect the medical necessity of the billed service on line 21 of Form HCFA-1500. For example, a provider using physical therapy to treat a patient with an unsteady gait due to Alzheimer's dementia may enter either ICD-9 code 331.0 (Alzheimer's Disease) or ICD-9 code 781.2 (Abnormality of Gait) as the primary diagnosis. If the provider enters ICD-9 code 331.0 as the primary diagnosis, then he or she should include ICD-9 code 781.2 as the secondary diagnosis to support the medical necessity of the physical therapy service.

When a beneficiary with dementia experiences an illness or injury unrelated to their dementia, the provider should submit a claim with a primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer's Disease, a physical therapy provider should submit a claim using ICD-9 code V63.64 (Hip joint replacement by artificial or mechanical device or prosthesis) as the primary diagnosis, not ICD-9 code 331.0 (Alzheimer's Disease).

MEDICARE COVERAGE AND CODING FOR SERVICES RELATED TO ANTHRAX

A number of questions have recently arisen regarding Medicare's coverage and coding rules for services related to anthrax testing and treatment. The purpose of this article is to remind you of the existing policy regarding Medicare coverage for screening services and coding policies relative to these services. In essence, Medicare covers anthrax testing when reasonable and necessary and ordered by a physician.

Medicare beneficiaries who believe they may have been exposed to anthrax may present to a physician's office, emergency room, clinic or other Medicare provider, even in the absence of signs or symptoms of infection, to request testing to determine if they have the disease or have been exposed to it. After examining such a patient, a physician or other qualified practitioner may determine that a diagnostic test should be performed to ascertain whether the patient has been exposed to, or is infected with, anthrax. In this specific clinical situation, Medicare will cover the test and related services. All usual rules regarding documentation for the reason for the test and the need for a written order apply. As always, Medicare covers only testing necessary to diagnose and treat the patient.

The culture should be coded using HCPCS code 87081 (culture, presumptive, pathogenic organisms, screening only). The payment for obtaining the specimen is included in the evaluation and management payment. Other medically necessary tests should be coded with the appropriate HCPCS codes.

When the reason for performing the test is because the patient has had contact with or exposure to a communicable disease or biological agent, the appropriate ICD-9-CM code, V01.8 (Contact with or exposure to communicable diseases, other communicable diseases) should be used, whether or not the patient has signs or symptoms of a disease. When submitting claims for a patient with a nasal swab positive for *B. anthracis* (anthrax), who will be treated with antibiotics, code 795.3 (nonspecific positive culture findings) should be used. If prophylactic antibiotics are prescribed, code V07.39 (other prophylactic chemotherapy) should be used. Only if the patient is confirmed to have disease caused by anthrax bacillus should codes from the anthrax series be used.

022.0 cutaneous anthrax

022.1 pulmonary anthrax

022.3 anthrax septicemia

022.8 other specified manifestations of anthrax

022.9 anthrax, unspecified

We note that Medicare coverage of anthrax testing (as with other public health sponsored testing) does not extend to mass testing performed by public health officials in response to a confirmed anthrax exposure. However, Medicare will cover any subsequent medically appropriate and necessary diagnosis and treatment consistent with existing policy.

FAQ on Anthrax available from CMS on: http://questions.cms.hhs.gov

Click on "Find Answers"

In the "Search Text (Optional)" box, type in "anthrax"

GGL-1632

REVISIÓN MÉDICA

REVISIÓN POST PAGO DE RECLAMACIONES

Como parte del *Medical Review Progressive Corrective Action*, este Contratista está revisando a nivel post pago reclamaciones por servicios de laboratorios clínicos y diagnósticos, entre otros.

Durante dichas revisiones hemos identificado varias situaciones que deseamos compartir con la comunidad de proveedores de Medicare con el fin de que se corrijan las mismas de manera que las reclamaciones puedan pagarse correctamente y reducir el margen de error. Estas son:

1. Referidos médicos en los cuales el médico que ordena el servicio escribe el diagnóstico en palabras pero no incluye el ICD-9. Esta situación ocasiona que el proveedor que presta los servicios pueda cometer errores al momento de codificarlo y por consiguiente indique un diagnóstico erróneo o que no represente la condición del paciente.
2. Servicios facturados que incluyen diagnósticos que no son los indicados en el referido médico, aún cuando la orden contenía el diagnóstico númerico (ICD-9) debidamente indicado.
3. Referidos médicos que no tienen la fecha en que el médico ordenó las pruebas. Medicare sólo considerará válidos, para efecto de pago, aquellas ordenes médicas que contengan, por lo menos, la siguiente información:
   a. Fecha en que el médico ordena la(s) prueba(s)
   b. Pruebas o estudios ordenados de forma legible
   c. Firma y número de licencia del médico que ordena el/los servicios
   d. UPIN del médico que ordena el/los servicios
   e. Diagnóstico, preferiblemente númerico.

Del referido no incluir esta información, será motivo suficiente para que cualquier servicio pagado por Medicare sea recuperado ya que no se estarían cumpliendo con los criterios establecidos por el Programa.

Agradeceremos tomen nota de la información antes indicada, ya que la misma ayudará al procesamiento de la reclamación.

MEDICAL REVIEW

POST PAYMENT CLAIMS REVIEW

As part of the Medical Review Progressive Corrective Action, this Contractor is performing post payment reviews of diagnostic and clinical services, among others.

During this review, we have identified several situations that we would like to share with our provider community in order that these can be corrected and that claims submitted are paid correctly, reducing the margin of error. These are:

1. *Referrals in which the doctor that orders the service only includes a narrative of the diagnosis. This situation can cause that the supplier that lends the services err when he/she tries to code the diagnostic and consequently indicate an erroneous diagnosis that does not represent the condition of the patient.*
2. *Services billed that include diagnoses that are not the one indicated in the order form. Even though, the order contained the diagnostic code (ICD-9) properly indicated.*
3. *Referrals that do not have the date in which the doctor ordered the tests. Medicare will only consider valid, for effects of payment, those medical orders that contain, at least, the following information:*
   a. Date in which the doctor orders the test (s)
   b. Tests or studies ordered in a legible form
   c. Referrals must contains the signature, name and license number of the doctor that orders the services
   d. UPIN of the doctor that orders the services
   e. Diagnostic, preferably codified numerically using the ICD-9.

If the above information is not in the order form, it does not comply with the criteria established by Medicare, which therefore justifies the recoupment of payment made for the service.

Please be sure that the above instructions are followed, since it will help that your claim be processed correctly.

REVISIÓN MÉDICA

A TODOS LOS CENTROS DE DIAGNÓSTICO Y TRATAMIENTO (CDTs) Y MÉDICOS QUE PRESTAN SERVICIOS EN ESTOS CENTROS

Hacemos referencia al artículo titulado *Emergency Department,* publicado en la página 14 del volumen 56 (octubre, noviembre y diciembre de 1999 de nuestro boletín Medicare Informa y a la política médica para servicios en salas de emergencia (*Emergency Department Services*), publicada en la página 30 del volumen 59 (julio 2000).

Deseamos aclarar que actualmente en Puerto Rico los Centros de Diagnóstico y Tratamiento que pertenecen o están afiliados a hospitales son los siguientes:

- CDTs de Canóvanas y Trujillo Alto afiliados al Hospital de Carolina
- CDT de San Lorenzo afiliado al Hospital Ryder Memorial
- CDTs afiliados al Hospital Municipal de San Juan

De acuerdo con los informes de reclamaciones procesadas y pagadas en los últimos meses, hemos encontrado varios CDTs y médicos que prestan servicios en éstos facturando los códigos de procedimiento 99281 al 99285 (servicios en sala de emergencia) cuando lo correcto es facturar los códigos de procedimiento de evaluación y manejo correspondiente a oficina y lugar de servicio 11 (oficina).

Enfatizamos que los servicios facturados bajo los códigos de procedimiento 99281 al 99285 no se pagarán en CDTs que no cumplan con la definición de Sala de Emergencia según establecido en el Manual del Contratista de Medicare y por el Gobierno de Puerto Rico. Sin embargo, la prestación de estos servicios puede facturarse, como mencionamos, con los códigos de procedimiento de oficina en lugar de servicio 11.

Esta instrucción entrará en vigor 10 días a partir de la fecha de emisión de este boletín.

MEDICAL REVIEW

TO ALL CENTERS FOR DIAGNOSTIC AND TREATMENT (CDT's) AND PROVIDERS RENDERING SERVICES IN THESE CENTERS

We make reference to the article Emergency Department, published on page 14 of volume 56 (October, November, December 1999) of our bulletin and to the Local Medical Review Policy for Emergency Department Services published on page 30 of volume 59 (July 2000).

We would like to clarify that currently in Puerto Rico the Centers for Diagnostic and Treatment (CDT) that are affiliated or belonging to hospitals are the following:

- *Canóvanas and Trujillo Alto CDTs affiliated to the Carolina Hospital*
- *San Lorenzo CDT affiliated to the Ryder Memorial Hospital*
- *All CDTs affiliated to the San Juan Municipal Hospital*

According to past months processed and paid claims reports, we have found that various CDTs and providers that render services in these centers are billing procedure codes 99281 through 99285 (Emergency Room Services). The correct billing should be evaluation and management procedure codes for office visit and place of service 11 (office).

We want to emphasize that CDTs billing services using procedure codes 99281 through 99285 that do not comply with the definition of an emergency room as established in the Medicare Carrier Manual and the Government of Puerto Rico will not be paid. Nevertheless, and as mentioned before, the rendering of these services can be billed with the office visit procedure code and place of service 11.

This will be effective 10 days after the emission date of this bulletin.

EVRE-11.02/JR/11-01

ICD-9-CM CODING FOR DIAGNOSTIC TESTS

As required by the Health Insurance Portability and Accountability Act (HIPAA), the Secretary published a rule designating the ICD-9-CM and its *Official ICD-9-CM Guidelines for Coding and Reporting* as one of the approved code sets for use in reporting diagnoses and inpatient procedures. This final rule requires the use of ICD-9-CM and its official coding and reporting guidelines by most health plans (including Medicare) by October 16, 2002.

The *Official ICD-9-CM Guidelines for Coding and Reporting* provides guidance on coding. The ICD-9-CM Coding Guidelines for Outpatient Services, which is part of the *Official ICD-9-CM Guidelines for Coding and Reporting,* provides guidance on diagnoses coding specifically for outpatient facilities and physician offices.

The ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office) have instructed physicians to report diagnoses based on test results. The Coding Clinic for ICD-9-CM confirms this longstanding coding guideline. CMS agrees with these long standing official coding and reporting guidelines.

Following are instructions for contractors, physicians, hospitals, and other health care providers to use in determining the use of ICD-9-CM codes for coding diagnostic test results. The instructions below provide guidance on the appropriate assignment of ICD-9-CM diagnoses codes to simplify coding for diagnostic tests consistent with the ICD-9-CM Guidelines for Outpatient Services (hospital-based and physician office). Note that physicians are responsible for the accuracy of the information submitted on a bill.

A. **Determining the Appropriate Primary ICD-9-CM Diagnosis Code For Diagnostic Tests Ordered Due to Signs and/or Symptoms**

1. If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis.

2. If the diagnostic test did not provide a diagnosis or was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

3. If the results of the diagnostic test are normal or non-diagnostic, and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probable, suspected, questionable, rule out, or working), then the interpreting physician should not code the referring diagnosis. Rather, the interpreting physician should report the sign(s) or symptom(s) that prompted the study. Diagnoses labeled as uncertain are considered by the ICD-9-CM Coding Guidelines as unconfirmed and should not be reported. This is consistent with the requirement to code the diagnosis to the highest degree of certainty.

B. **Instruction to Determine the Reason for the Test**

As specified in §4317(b) of the Balanced Budget Act (BBA), referring physicians are required to provide diagnostic information to the testing entity at the time the test is ordered. As further indicated in 42 CFR 410.32 all diagnostic tests "must be ordered by the physician who is treating the beneficiary." As defined in §15021 of the Medicare Carrier Manual (MCM), an "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. An order may include the following forms of communication:

a. A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility;

b. A telephone call by the treating physician/practitioner or his/her office to the testing facility; and

c. An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

NOTE: If the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient's medical record if it is available. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

D. **Unrelated/Co-Existing Conditions/Diagnoses**

Unrelated and co-existing conditions/diagnoses may be reported as additional diagnoses by the physician interpreting the diagnostic test.

E. **Diagnostic Tests Ordered in the Absence of Signs and/or Symptoms (e. g. screening tests)**

When a diagnostic test is ordered in the absence of signs/symptoms or other evidence of illness or injury, the physician interpreting the diagnostic test should report the reason for the test (e. g. screening) as the primary ICD-9-CM diagnosis code. The results of the test, if reported, may be recorded as additional diagnoses.

F. **Use of ICD-9-CM To The Greatest Degree of Accuracy and Completeness**

NOTE: This section explains certain coding guidelines that address diagnoses coding. These guidelines are longstanding coding guidelines that have been part of the *Official ICD-9-CM Guidelines for Coding and Reporting.*

The interpreting physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness for the diagnosis resulting from test, or for the sign(s)/ symptom(s) that prompted the ordering of the test.

In the past, there has been some confusion about the meaning of "highest degree of specificity," and in "reporting the correct number of digits." In the context of ICD-9-CM coding, the "highest degree of specificity refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis.

In order to report the correct number of digits when using ICD-9-CM, refer to the following instructions:

ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with 3 digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits to provide greater specificity. Assign three-digit codes only if there are no four-digit codes within that code category. Assign four-digit codes only if there is no fifth-digit subclassification for that category. Assign the fifth-digit subclassification code for those categories where it exists.

For the latest ICD-9-CM coding guidelines, please refer to the following website: http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guide.

Evaluation

Refer to the attachment for further guidance on determining the appropriate ICD-9-CM diagnoses codes. The attachment is a listing of questions and answers that appeared in the American Hospital Association's (AHA) Coding Clinic for ICD-9-CM (1st Qtr 2000).

ATTACHMENT

QUESTION 1:

A skin lesion of the cheek is surgically removed and submitted to the pathologist for analysis. The surgeon writes on the pathology order, "skin lesion." The pathology report comes back with the diagnosis of "basal cell carcinoma." A laboratory-billing consultant is recommending that the ordering physician's diagnosis be reported instead of the final diagnosis obtained by the pathologist. Also, an insurance carrier is also suggesting this case be coded to "skin lesion" since the surgeon did not know the nature of the lesion at the time the tissue was sent to pathology. Which code should the pathologist use to report his claim?

ANSWER 1:

The pathologist is a physician and if a diagnosis is made it can be coded. It is appropriate for the pathologist to code what is known at the time of code assignment. For example, if the pathologist has made a diagnosis of basal cell carcinoma, assign code 173.3, Other malignant neoplasm of skin, skin of other and unspecified parts of face. If the pathologist had not come up with a definitive diagnosis, it would be appropriate to code the reason why the specimen was submitted, in this instance, the skin lesion of the cheek.

QUESTION 2:

A patient presents to the hospital for outpatient x-rays with a diagnosis on the physician's orders of questionable stone. The abdominal x-ray diagnosis per the Radiologist is "bilateral nephrolithiasis with staghorn calculi." No other documentation is available. Is it correct to code this as 592.0, Calculus of kidney, based on the radiologist's diagnosis?

ANSWER 2:

The radiologist is a physician and he/she diagnosed the nephrolithiasis. Therefore, it is appropriate to code this case as 592.0, Calculus of kidney.

QUESTION 3:

A patient undergoes outpatient surgery for removal of a breast mass. The pre- and post-operative diagnosis is reported as "breast mass." The pathological diagnosis is fibroadenoma. How should the hospital outpatient coder code this? Previous *Coding Clinic* advice has precluded us from assigning codes on the basis of laboratory findings. Does the same advice apply to pathological reports?

ANSWER 3:

Previously published advice has warned against coding from laboratory results alone, without physician interpretation. However, the pathologist is a physician and the pathology report serves as the pathologist's interpretation and a microscopic confirmatory report regarding the morphology of the tissue excised. Therefore, a pathology report provides greater specificity. Assign code 217, Benign neoplasm of breast, for the fibroadenoma of the breast. It is appropriate for coders to code based on the physician documentation available at the time of code assignment.

QUESTION 4:

A referring physician sent a urine specimen to the cytology lab for analysis with a diagnosis of "hematuria" (code 599.7). However, a cytology report authenticated by the pathologist revealed abnormal cells consistent with transitional cell carcinoma of the bladder. Although the referring physician assigned code 599.7, Hematuria, the laboratory reported code 188.9, Malignant neoplasm of bladder, Bladder, part unspecified. For reporting purposes, what would be the appropriate diagnosis code for the laboratory and the referring physician?

ANSWER 4:

The laboratory should report code 188.9, Malignant neoplasm of bladder, Bladder, part unspecified. It is appropriate to code the carcinoma, in this instance, because the cytology report was authenticated by the pathologist and serves as confirmation of the cell type, similar to a pathology report. The referring physician should report code 599.7, Hematuria, if the result of the cytological analysis is not known at the time of code assignment.

QUESTION 5:

A patient presents to the physician's office with complaints of urinary frequency and burning. The physician ordered a urinalysis and the findings were positive for bacteria and increased WBCs in the urine. Based on these findings a urine culture was ordered and was positive for urinary tract infection. Should the lab report the "definitive diagnosis," urinary tract infection, or is it more appropriate for the lab to report the signs and symptoms when submitting the claim?

ANSWER 5:

Since this test does not have physician interpretation, the laboratory (independent or hospital-based) should code the symptoms (i.e., urinary frequency and burning).

QUESTION 6:

The physician refers a patient for chest x-ray to outpatient radiology with a diagnosis of weakness and chronic myelogenous leukemia (CML). The radiology report demonstrated no acute disease and moderate hiatal hernia. For reporting purposes, which codes are appropriate for the facility to assign?

ANSWER 6:

Assign code 780.79, Other malaise and fatigue, and code 205.10, Myeloid leukemia, without mention of remission, for this encounter. It is not necessary to report code 553.3, Diaphragmatic hernia, for the hiatal hernia, because it is an incidental finding.

[For CMS purposes, the primary diagnosis would be reported as 780.79 (Other malaise and fatigue), and the secondary diagnosis as 205.10 (Myeloid leukemia, without mention of remission, for this encounter).

QUESTION 7:

A patient presents to the doctor's office with a complaint of fatigue. The physician orders a complete blood count (CBC). The CBC reveals a low hemoglobin and hematocrit. Should the lab report the presenting symptom fatigue (code 780.79) or the finding of anemia (code 285.9)?

ANSWER 7:

The laboratory (independent or hospital-based) should code the symptoms, because no physician has interpreted the results. Assign code 780.79, Other malaise and fatigue, unless the lab calls the physician to confirm the diagnosis of anemia.

CLAIMS FOR GLAUCOMA SCREENING SERVICES

The Centers for Medicare and Medicaid Services (CMS) would like to remind our providers that the effective date for the Glaucoma Screening Services is January 1, 2002. This article was published in our Medicare Informa, Vol.67, page 45.

Conditions of Coverage. - The Benefits Improvements and Protection Act of 2000, §102, provides annual coverage for glaucoma screening for eligible Medicare beneficiaries, i.e., those with diabetes mellitus or a family history of glaucoma, and certain other individuals found to be at high risk for glaucoma as determined by CMS through rulemaking later this year. Medicare will pay for glaucoma screening examinations where they are furnished by or under the direct supervision of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law. Coverage applies to glaucoma screening examination services performed on eligible beneficiaries on or after January 1, 2002.

Screening for glaucoma is defined to include:

- A dilated eye examination with an intraocular pressure measurement
- A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination.

Payment may be made for a glaucoma screening examination that is performed on an eligible beneficiary after at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed.

Following are the HCPCS codes to bill for glaucoma screening:

G0117 - Glaucoma screening for high risk patients furnished by a physician.

G0118 - Glaucoma screening for high risk patients furnished under the direct supervision of a physician.

Frequency. - Once a beneficiary has received a covered glaucoma screening procedure, the beneficiary may receive another procedure after 11 full months have passed. To determine the 11-month period, start your count beginning with the month after the month in which the previous covered screening procedure was performed.

Diagnosis Coding Requirements. - Bill glaucoma screening using screening ("V") code V80.1 (Special Screening for Neurological, Eye, and Ear Diseases, Glaucoma). Claims submitted without a screening diagnosis code will be returned to the provider as unprocessable.

Payment Methodology. – Payment for glaucoma screening will be based on the Medicare physician fee schedule. Deductible and coinsurance apply.

Reembolso

ESTIMULACIÓN DEL NERVIO SACRO PARA LA INCONTINENCIA URINARIA

El estimulador del nervio sacro es un generador de pulsaciones que transmite impulsos eléctricos a los nervios sacros mediante la implantación de un alambre. Estos impulsos logran la contracción de los músculos de la vejiga y le permiten al paciente el evacuar más apropriadamente.

Sección 65-18 del Manual de Medicare

De acuerdo a esta sección 65-18 y efectivo el 1 de enero de 2002, la estimulación del nervio sacro estará cubierta para el tratamiento de la incontinencia urinaria, síndrome de urgencia-frecuencia y retención urinaria. La estimulación del nervio sacro envuelve la prueba temporera para determinar si un estimulador implantable es efectivo y la implantación permamente en candidatos apropriados. Ambos servicios están cubiertos.

Las siguientes limitaciones para la cubierta aplican a todas las indicaciones:

- El paciente debe ser refractario a la terapia convencial (conducta documentada, farmacológica y/o terapia quirúrgica correctiva) y que sea un candidato a la implantación quirúrgica de manera que se pueda administrar anestesia.
- Pacientes con incontinencia acentuada, obstrucción urinaria, y condiciones neurológicas (tales como la diabetes con envolvimiento nervioso periferal) las cuales están asociadas con manifestaciones secundarias están excluídas.
- El paciente debe haber pasado por la prueba de estimulación exitosamente para poder resistir la implantación. Antes de que un paciente sea elegible para la implantación permanente el/ella debe

Reimbursement

SACRAL NERVE STIMULATION FOR URINARY INCONTINENCE

A sacral nerve stimulator is a pulse generator which transmits electrical impulses to the sacral nerves through an implanted wire. These impulses cause the bladder muscles to contract, which gives the patient ability to void more properly.

Section 65-18 of the Medicare Carrier Manual

This section establishes that effective January 1, 2002, sacral nerve stimulation is covered for the treatment of urinary urge incontinence, urgency-frequency syndrome and urinary retention. Sacral nerve stimulation involves both a temporary test stimulation to determine if an implantable stimulator would be effective and a permanent implantation in appropriate candidates. Both the test and the permanent implantation are covered.

The following limitations for coverage apply to all indications:

- *Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.*
- *Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.*
- *Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must*

demostrar una mejoría de 50% o más en las pruebas de estimulación. El progreso de la mejoría se mide llevando récord diario de las evacuaciones.

- El paciente debe demostrar la habilidad de poder llevar el record de las evacuaciones diarias de manera que los resultados clínicos del procedimiento de implantación puedan ser evaluados apropiadamente.

demonstrate a 50% or greater improvement through test stimulation. Improvement is measured through voiding diaries.

- *Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.*

Trans.144 and 1881/AB-01-143/October 4, 2001/MM/MB

PHYSICIAN SUPERVISION OF DIAGNOSTIC TESTS

CMS revised levels of physician supervision required for diagnostic tests payable under the Medicare physician fee schedule. The regulation defines these levels of physician supervision for diagnostic tests as follows:

- **General supervision** means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel that actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.
- **Direct supervision** in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
- **Personal supervision** means a physician must be in attendance in the room during the performance of the procedure.

NOTE: PHYSICAL THERAPY SPECIALTIES

Effective July 1, 2001, a physical therapist that is presently certified by the American Board of Physical Therapy Specialties can perform procedures assigned a level of 21, 22, 66, 6a, 77, or 77a without supervision.

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LEVEL OF PHYSICIAN SUPERVISION OF SPECIFIC DIAGNOSTIC TESTS

CODE	LEVEL	CODE	LEVEL	CODE	LEVEL
URODYNAMICS					
51725 & TC	2	51726 & TC	2	51736 & TC	2
51741 & TC	2	51772 & TC	2	51784 & TC	2
51785 & TC	3	51792 & TC	2	51795 & TC	2
51797 & TC	2				
MALE GENITAL SYSTEM					
54240 & TC	2	54250 & TC	1		
ANTEPARTUM SERVICES					
59020 & TC	2	59025 & TC	1		
RESERVOIR/PUMP IMPLANTATION					
62367 & TC	2	62368 & TC	2		
DIAGNOSTIC RADIOLOGY					
HEAD AND NECK					
70010 & TC	3	70015 & TC	3	70030 & TC	1
70100 & TC	1	70110 & TC	1	70120 & TC	1
70130 & TC	1	70134 & TC	1	70140 & TC	1
70150 & TC	1	70160 & TC	1	70170 & TC	3
70190 & TC	1	70200 & TC	1	70210 & TC	1
70220 & TC	1	70240 & TC	1	70250 & TC	1
70260 & TC	1	70300 & TC	1	70310 & TC	1
70320 & TC	1	70328 & TC	1	70330 & TC	1
70332 & TC	3	70336 & TC	2	70350 & TC	1
70355 & TC	1	70360 & TC	1	70370 & TC	3
70371 & TC	3	70373 & TC	3	70380 & TC	1
70390 & TC	3	70450 & TC	1	70460 & TC	2
70470 & TC	2	70480 & TC	1	70481 & TC	2
70482 & TC	2	70486 & TC	1	70487 & TC	2
70488 & TC	2	70490 & TC	1	70491 & TC	2
70492 & TC	2	70540 & TC	1	70541 & TC	2
70551 & TC	1	70552 & TC	2	70553 & TC	2
CHEST					
71010 & TC	1	71015 & TC	1	71020 & TC	1
71021 & TC	1	71022 & TC	1	71023 & TC	3
71030 & TC	1	71034 & TC	3	71035 & TC	1
71036 & TC	3	71040 & TC	3	71060 & TC	3
71090 & TC	3	71100 & TC	1	71101 & TC	1
71110 & TC	1	71111 & TC	1	71120 & TC	1
71130 & TC	1	71250 & TC	1	71260 & TC	2
71270 & TC	2	71550 & TC	1	71555 & TC	2

SPINE AND PELVIS

72010 & TC	1	72020 & TC	1	72040 & TC	1
72050 & TC	1	72052 & TC	1	72069 & TC	1
72070 & TC	1	72072 & TC	1	72074 & TC	1
72080 & TC	1	72090 & TC	1	72100 & TC	1
72110 & TC	1	72114 & TC	1	72120 & TC	1
72125 & TC	1	72126 & TC	2	72127 & TC	2
72128 & TC	1	72129 & TC	2	72130 & TC	2
72131 & TC	1	72132 & TC	2	72133 & TC	2
72141 & TC	1	72142 & TC	2	72146 & TC	1
72147 & TC	2	72148 & TC	1	72149 & TC	2
72156 & TC	2	72157 & TC	2	72158 & TC	2
72170 & TC	1	72190 & TC	1	72192 & TC	1
72193 & TC	2	72194 & TC	2	72196 & TC	1
72200 & TC	1	72202 & TC	1	72220 & TC	1
72240 & TC	3	72255 & TC	3	72265 & TC	3
72270 & TC	3	72285 & TC	3	72295 & TC	3

UPPER EXTREMITIES

73000 & TC	1	73010 & TC	1	73020 & TC	1
73030 & TC	1	73040 & TC	3	73050 & TC	1
73060 & TC	1	73070 & TC	1	73080 & TC	1
73085 & TC	3	73090 & TC	1	73092 & TC	1
73100 & TC	1	73110 & TC	1	73115 & TC	3
73120 & TC	1	73130 & TC	1	73140 & TC	1
73200 & TC	1	73201 & TC	2	73202 & TC	2
73220 & TC	1	73221 & TC	1		

LOWER EXTREMITIES

73500 & TC	1	73510 & TC	1	73520 & TC	1
73525 & TC	3	73530 & TC	3	73540 & TC	1
73550 & TC	1	73560 & TC	1	73562 & TC	1
73564 & TC	1	73565 & TC	1	73580 & TC	3
73590 & TC	1	73592 & TC	1	73600 & TC	1
73610 & TC	1	73615 & TC	3	73620 & TC	1
73630 & TC	1	73650 & TC	1	73660 & TC	1
73700 & TC	1	73701 & TC	2	73702 & TC	2
73720 & TC	1	73721 & TC	1	73725 & TC	2

ABDOMEN

74000 & TC	1	74010 & TC	1	74020 & TC	1
74022 & TC	1	74150 & TC	1	74160 & TC	2
74170 & TC	2	74181 & TC	1	74185 & TC	2
74190 & TC	3				

GASTROINTESTINAL TRACT

74210 & TC	3	74220 & TC	3	74230 & TC	3
74235 & TC	3	74240 & TC	3	74241 & TC	3
74245 & TC	3	74246 & TC	3	74247 & TC	3
74249 & TC	3	74250 & TC	2	74251 & TC	3
74260 & TC	3	74270 & TC	3	74280 & TC	3
74283 & TC	3	74290 & TC	1	74291 & TC	1
74300 & TC	3	74301 & TC	3	74305 & TC	3
74320 & TC	3	74327 & TC	3	74328 & TC	3
74329 & TC	3	74330 & TC	3	74340 & TC	3
74350 & TC	3	74355 & TC	3	74360 & TC	3
74363 & TC	3				

URINARY TRACT

74400 & TC	2	74410 & TC	2	74415 & TC	2
74420 & TC	3	74425 & TC	3	74430 & TC	3
74440 & TC	3	74445 & TC	3	74450 & TC	3
74455 & TC	3	74470 & TC	3	74475 & TC	3
74480 & TC	3	74485 & TC	3		

GYNECOLOGICAL AND OBSTETRICAL

74710 & TC	1	74740 & TC	3	74742 & TC	3
74775 & TC	3				

HEART

75552 & TC	1	75553 & TC	2	75554 & TC	1
75555 & TC	1				

AORTA AND ARTERIES

75600 & TC	3	75605 & TC	3	75625 & TC	3
75630 & TC	3	75650 & TC	3	75658 & TC	3
75660 & TC	3	75662 & TC	3	75665 & TC	3
75671 & TC	3	75676 & TC	3	75680 & TC	3
75685 & TC	3	75705 & TC	3	75710 & TC	3
75716 & TC	3	75722 & TC	3	75724 & TC	3
75726 & TC	3	75731 & TC	3	75733 & TC	3
75736 & TC	3	75741 & TC	3	75743 & TC	3
75746 & TC	3	75756 & TC	3	75774 & TC	3
75790 & TC	3				

VEINS AND LYMPHATICS

75801 & TC	3	75803 & TC	3	75805 & TC	3
75807 & TC	3	75809 & TC	3	75810 & TC	3
75820 & TC	3	75822 & TC	3	75825 & TC	3
75827 & TC	3	75831 & TC	3	75833 & TC	3
75840 & TC	3	75842 & TC	3	75860 & TC	3
75870 & TC	3	75872 & TC	3	75880 & TC	3
75885 & TC	3	75887 & TC	3	75889 & TC	3
75891 & TC	3	75893 & TC	3		

TRANSCATHETER PROCEDURES

75894 & TC	3	75896 & TC	3	75898 & TC	3
75900 & TC	3	75940 & TC	3	75945 & TC	3
75946 & TC	3	75960 & TC	3	75961 & TC	3
75962 & TC	3	75964 & TC	3	75966 & TC	3
75968 & TC	3	75970 & TC	3	75978 & TC	3
75980 & TC	3	75982 & TC	3	75984 & TC	3
75989 & TC	3				

TRANSLUMINAL ATHERECTOMY

75992 & TC	3	75993 & TC	3	75994 & TC	3
75995 & TC	3	75996 & TC	3		

OTHER PROCEDURES

76000 & TC 3	76001 & TC 3	76003 & TC 3
76010 & TC 1	76020 & TC 1	76040 & TC 1
76061 & TC 1	76062 & TC 1	76065 & TC 1
76066 & TC 1	76070 & TC 1	76075 & TC 1
76076 & TC 1	76078 & TC 1	76080 & TC 3
76086 & TC 3	76088 & TC 3	76093 & TC 1
76094 & TC 1	76095 & TC 3	76096 & TC 3
76098 & TC 1	76100 & TC 2	76101 & TC 2
76102 & TC 2	76120 & TC 2	76125 & TC 2
76150 1	76350 2	76355 & TC 3
76360 & TC 3	76365 & TC 3	76370 & TC 2
76375 & TC 1	76380 & TC 1	76400 & TC 1

DIAGNOSTIC ULTRASOUND

HEAD AND NECK

76506 & TC 1	76511 & TC 2	76512 & TC 2
76513 & TC 2	76516 & TC 1	76519 & TC 1
76529 & TC 1	76536 & TC 1	

CHEST

76604 & TC 1	76645 & TC 1

ABDOMEN AND RETROPERITONEUM

76700 & TC 1	76705 & TC 1	76770 & TC 1
76775 & TC 1	76778 & TC 1	

SPINAL CANAL

76800 & TC 1

PELVIS

76805 & TC 1	76810 & TC 1	76815 & TC 1
76816 & TC 1	76818 & TC 1	76825 & TC 1
76826 & TC 1	76827 & TC 1	76828 & TC 1
76830 & TC 1	76831 & TC 3	76856 & TC 1
76857 & TC 1	76870 & TC 1	76872 & TC 1

EXTREMITIES

76880 & TC 1	76885 & TC 1	76886 & TC 1

VASCULAR STUDIES

ULTRASONIC GUIDANCE PROCEDURES

76930 & TC 3	76932 & TC 3	76934 & TC 3
76936 & TC 3	76938 & TC 3	76941 & TC 3
76942 & TC 3	76945 & TC 3	76946 & TC 3
76948 & TC 3	76950 & TC 3	76960 & TC 3
76965 & TC 3		

OTHER PROCEDURES

76970 & TC 1	76975 & TC 3	76977 & TC 1
76986 & TC 3		

RADIATION ONCOLOGY

77417	1				

DIAGNOSTIC NUCLEAR MEDICINE

ENDOCRINE SYSTEM

78000 & TC	1	78001 & TC	1	78003 & TC	1
78006 & TC	1	78007 & TC	1	78010 & TC	1
78011 & TC	1	78015 & TC	1	78016 & TC	1
78018 & TC	1	78070 & TC	1	78075 & TC	1

HEMATOPOIETIC, RETICULOENDOTHELIAL, AND LYMPHATIC SYSTEM

78102 & TC	1	78103 & TC	1	78104 & TC	1
78110 & TC	1	78111 & TC	1	78120 & TC	1
78121 & TC	1	78122 & TC	1	78130 & TC	1
78135 & TC	1	78140 & TC	1	78160 & TC	1
78162 & TC	1	78170 & TC	1	78172 & TC	1
78185 & TC	1	78190 & TC	1	78191 & TC	1
78195 & TC	1				

GASTROINTESTINAL SYSTEM

78201 & TC	1	78202 & TC	1	78205 & TC	1
78206 & TC	1	78215 & TC	1	78216 & TC	1
78220 & TC	1	78223 & TC	1	78230 & TC	1
78231 & TC	1	78232 & TC	1	78258 & TC	1
78261 & TC	1	78262 & TC	1	78264 & TC	1
78270 & TC	1	78271 & TC	1	78272 & TC	1
78278 & TC	1	78282 & TC	1	78290 & TC	1
78291 & TC	1				

MUSCULOSKELETAL SYSTEM

78300 & TC	1	78305 & TC	1	78306 & TC	1
78315 & TC	1	78320 & TC	1	78350 & TC	1

CARDIOVASCULAR SYSTEM

78414 & TC	1	78428 & TC	1	78445 & TC	1
78455 & TC	1	78457 & TC	1	78458 & TC	1
78460 & TC	1	78461 & TC	1	78464 & TC	1
78465 & TC	1	78466 & TC	1	78468 & TC	1
78469 & TC	1	78472 & TC`	1	78473 & TC	1
78478 & TC	1	78480 & TC	1	78481 & TC	1
78483 & TC	1	78494 & TC	1	78496 & TC	1

RESPIRATORY SYSTEM

78580 & TC	1	78584 & TC	1	78585 & TC	1
78586 & TC	1	78587 & TC	1	78588 & TC	1
78591 & TC	1	78593 & TC	1	78594 & TC	1
78596 & TC	1				

NERVOUS SYSTEM

78600 & TC	1	78601 & TC	1	78605 & TC	1
78606 & TC	1	78607 & TC	1	78610 & TC	1
78615 & TC	1	78630 & TC	1	78635 & TC	1
78645 & TC	1	78647 & TC	1	78650 & TC	1

GENITOURINARY SYSTEM

78700 & TC	1	78701 & TC	1	78704 & TC	1
78707 & TC	1	78708 & TC	1	78709 & TC	1
78710 & TC	1	78715 & TC	1	78725 & TC	1
78730 & TC	1	78740 & TC	1	78760 & TC	1
78761 & TC	1				

OTHER DIAGNOSTIC NUCLEAR MEDICINE PROCEDURES

78800 & TC	1	78801 & TC	1	78802 & TC	1
78803 & TC	1	78805 & TC	1	78806 & TC	1
78807 & TC	1	78990	1		

MEDICINE

GASTROINTESTINAL

91000 & TC	3	91010 & TC	3	91011 & TC	3
91012 & TC	3	91020 & TC	3	91030 & TC	3
91032 & TC	3	91033 & TC	3	91052 & TC	3
91055 & TC	3	91060 & TC	3	91065 & TC	1
91122 & TC	3				

SPECIAL OPHTHALMOLOGICAL SERVICES

92060 & TC	1	92065 & TC	1	92081 & TC	1
92082 & TC	1	92083 & TC	1	92135 & TC	1
92235 & TC	2	92240 & TC	2	92250 & TC	1

OTHER SPECIALIZED SERVICES

92265 & TC	3	92270 & TC	3	92275 & TC	3
92283 & TC	1	92284 & TC	1	92285 & TC	2
92286 & TC	3				

VESTIBULAR FUNCTION TESTS WITH RECORDING

92541 & TC	5	92542 & TC	5	92543 & TC	5
92544 & TC	5	92545 & TC	5	92546 & TC	5
92547	5	92548 & TC	5		

AUDIOLOGIC FUNCTION TESTS

92552	5	92553	5	92555	5
92556	5	92557	5	92561	5
92562	5	92563	5	92564	5
92565	5	92567	5	92568	5
92569	5	92571	5	92572	5
92573	5	92575	5	92576	5
92577	5	92579	5	92582	5
92583	5	92584	5	92585 & TC	5
92587 & TC	5	92588 & TC	5	92589	5
92596	5				

CARDIOGRAPHY

93000	1	93005	1	93012	1
93015	2	93016	2	93017	2
93024 & TC	3	93040	1	93041	1
93224	1	93225	1	93226	1
93230	1	93231	1	93232	1
93235	1	93236	1	93268	1
93270	1	93271	1	93278 & TC	1

ECHOCARDIOGRAPHY

93303 & TC	1	93304 & TC	1	93307& TC	1
93308 & TC	1	93312 & TC	3	93313	3
93314	3	93315 & TC	3	93316	3
93317	3	93320 & TC	1	93321 & TC	1
93325 & TC	1	93350 & TC	1		

CARDIAC CATHETERIZATION

93501 & TC	3	93505 & TC	3	93508 & TC	3
93510 & TC	3	93511 & TC	3	93514 & TC	3
93524 & TC	3	93526 & TC	3	93527 & TC	3
93528 & TC	3	93529 & TC	3	93530 & TC	3
93531 & TC	3	93532 & TC	3	93533 & TC	3
93555 & TC	3	93556 & TC	3	93561 & TC	3
93562 & TC	3	93571 & TC	3	93572 & TC	3

INTRACARDIAC ELECTROPHYSIOLOGICAL PROCEDURES

93600 & TC	3	93602 & TC	3	93603 & TC	3
93607 & TC	3	93609 & TC	3	93610 & TC	3
93612 & TC	3	93615 & TC	3	93616 & TC	3
93618 & TC	3	93619 & TC	3	93620 & TC	3
93621 & TC	3	93622 & TC	3	93623 & TC	3
93624 & TC	3	93631 & TC	3	93640 & TC	3
93641 & TC	3	93642 & TC	3	93660 & TC	3

OTHER VASCULAR STUDIES

93720	1	93721	1	93724 & TC	3
93731 & TC	2	93732 & TC	2	93733 & TC	1
93734 & TC	2	93735 & TC	2	93736 & TC	1
93737 & TC	2	93738 & TC	2		
93740 & TC	1	93770 & TC	1		

CEREBROVASCULAR ARTERIAL STUDIES

93875 & TC	1	93880 & TC	1	93882 & TC	1
93886 & TC	1	93888 & TC	1		

EXTREMITY ARTERIAL STUDIES

93922 & TC	1	93923 & TC	1	93924 & TC	1
93925 & TC	1	93926 & TC	1	93930 & TC	1
93931 & TC	1				

EXTREMITY VENOUS STUDIES

93965 & TC	1	93970 & TC	1	93971 & TC	1

VISCERAL AND PENILE VASCULAR STUDIES

93975 & TC	1	93976 & TC	1	93978 & TC	1
93979 & TC	1	93980 & TC	1	93981 & TC	1

EXTREMITY ARTERIAL-VENOUS STUDIES

93990 & TC	1

PULMONARY

94010 & TC	1	94014	1	94015	1
94060 & TC	2	94070 & TC	2		
94200 & TC	1	94240 & TC	1		
94250 & TC	1	94260 & TC	1	94350 & TC	1
94360 & TC	1	94370 & TC	1	94375 & TC	1
94400 & TC	2	94450 & TC	2	94620 & TC	1
94621 & TC	2	94664	2	94665	2
94680 & TC	2	94681 & TC	2	94690 & TC	1
94720 & TC	1	94725 & TC	1	94750 & TC	1
94760	1	94761	1	94762	1
94770 & TC	1	94772 & TC	1		

ALLERGY

95004	2	95024	2	95027	2
95028	2	95044	2	95052	2
95056	2	95060	3	95065	3
95070	2	95071	2		
95078	3				

FOR CERTAIN CODES WITHIN THE RANGE OF CPT 95860 THROUGH 95937, THE FOLLOWING ADDITIONAL CRITERIA APPLY.

NOTE: a All level of supervision standards for the lead number (“6” or “7”) apply; in addition, the PT with ABPTS certification may personally supervise another PT but only the PT with ABPTS certification may bill.

66 May be performed only by PTs with ABPTS certification and certification in this specific procedure, or performed personally by the physician.

77 PT with ABPTS certification (TC & PC), or direct supervision of physician (TC & PC), or technician with certification and general supervision of physician (TC only; PC physician) procedure.

22 May be performed by a technician with on-line real-time contact with physician

21 Procedure may be performed by technician with certification and under general supervision of a physician; otherwise under direct supervision of physician. (TC only; PC always physician).

NEUROLOGY AND NEUROMUSCULAR PROCEDURES
SLEEP TESTING

95805 & TC	1	95806 & TC	1	95807 & TC	1
95808 & TC	1	95810 & TC	1	95811 & TC	1
95812 & TC	1	95813 & TC	1	95816 & TC	1
95819 & TC	1	95822 & TC	1	95824 & TC	1
95827 & TC	1	95829 & TC	1	95858 & TC	3
95860 & TC	6a	95861 & TC	6a	95863 & TC	6a
95864 & TC	6a	95867 & TC	6a	95868 & TC	6a
95869 & TC	6a	95870 & TC	6a	95872 & TC	66
95875 & TC	3	95900 & TC	77a	95903 & TC	77a
95904 & TC	77a	95920 & TC	22	95921 & TC	2
95922 & TC	3	95923 & TC	3	95925 & TC	21
95926 & TC	21	95927 & TC	21	95930 & TC	21
95933 & TC	77a	95934 & TC	77a	95936 & TC	77a
59937 & TC	77a	95950 & TC	1	95951 & TC	1
95953 & TC	1	95954 & TC	3	95955 & TC	2
95956 & TC	1	95957 & TC	1	95958 & TC	3
95961 & TC	3	95962 & TC	3		

CENTRAL NERVOUS SYSTEM ASSESSMENT

96100	4	96105	4	96110	4
96111	4	96115	4	96117	4

ALPHA-NUMERICS

G0004	1	G0005	1	G0006	1
G0015	1	G0030 & TC	1	G0031 & TC	1
G0032 & TC	1	G0033 & TC	1	G0034 & TC	1
G0035 & TC	1	G0036 & TC	1	G0037 & TC	1
G0038 & TC	1	G0039 & TC	1	G0040 & TC	1
G0041 & TC	1	G0042 & TC	1	G0043 & TC	1
G0044 & TC	1	G0045 & TC	1	G0046 & TC	1
G0047 & TC	1	G0050	1	G0106 & TC	3
G0125 & TC	1	G0126 & TC	1	G0130 & TC	1
G0131 & TC	1	G0132 & TC	1	G0163 & TC	1
G0164 & TC	1	G0165 & TC	1	M0302 & TC	1
Q0035 & TC	1	V5362	1	V5363	1
V5364	1				

MAMOGRAFÍA EXPLORATORIA Y DE DIAGNÓSTICO

El Centro de Servicios Medicare & Medicaid (CMS) notificó actualizaciones a las siguientes secciones.

La Sección 4601, Mamografía exploratoria y Mamografía de Diagnóstico ha sido actualizada de acuerdo a la §104 del «Benefits Improvement and Protection Act» (BIPA) del año 2000 el cual enmienda la §1848(j)(3) del Acta para incluir la mamografía exploratoria como un servicio para el cual se paga según el Medicare Physician Fee Schedule (MPFS). El límite de pago para la mamografía exploratoria no aplicará a las reclamaciones con fecha de servicio del 1 de enero de 2002 en adelante. Ambas mamografías exploratorias y de diagnóstico pueden ser pagadas cuando se realizan el mismo día para el mismo beneficiario.

Sección 4601.2, Identificación de una Reclamación con Mamografía exploratoria y Mamografía de Diagnóstico. Se ha creado el código 76085 "Digitalization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening

SCREENING AND DIAGNOSTIC MAMMOGRAPHY

The Centers for Medicare & Medicaid Services (CMS) notified the updates on the following sections.

Section 4601, Screening Mammography and Diagnostic Mammography is updated based on §104 of the Benefits Improvement and Protection Act (BIPA) of 2000 which amends §1848(j)(3) of the Act to include screening mammography as a physician service for which payment is made under the Medicare Physician Fee Schedule (MPFS). The payment limitation for screening mammography no longer applies for claims with dates of service on or after January 1, 2002. Diagnostic mammography and screening mammography can both be paid when performed on the same day when provided to the same beneficiary.

Section 4601.2, Identifying a Screening Mammography Claim and a Diagnostic Mammography Claim. In addition, a new code 76085 "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in

Reembolso

mammography (List separately in addition to code for primary procedure)“ para la conversión de película estándar a imágenes digitales en la detección computadorizada (CAD por sus siglas en Inglés) que debe ser utilizado en conjunto con el código 76092 de una mamografía exploratoria regular. En adición se ha creado el código G0236, “Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure)“ el cual debe ser utilizado en conjunto con el código 76090 ó 76091 de mamografía de diagnóstico regular.

Subsección A, incluye la lista de los códigos específicos a utilizarse en reclamaciones de mamografía comenzando el 1 de enero de 2002.

Subsección B, Códigos de Detección Computadorizada - incluye los nuevos códigos de la detección computadorizada (CAD por sus siglas en Inglés).

Subsección C, Códigos de Mamografía Eliminados - incluye todos los códigos de mamografía que serán eliminados efectivo el 1 de enero de 2002.

Subsección D, Centros de Evaluación Autorizados - se ha modificado para incluir lo siguiente, ya no es necesario que los contratistas mantengan rastro de los proveedores que están asociados a las facilidades de mamografía certificados a menos que haya una razón específica para mantener el rastro.

Subsección E, Reclamaciones con fecha de servicio antes del 1 de enero de 2002 - se revisa para incluir las Limitaciones de Pago para el 2001 para la Mamografía exploratoria.

Subsección F , Las Tarifas Fijas para Médicos serán utilizadas para el pago de todas las pruebas de mamografía comenzando con las reclamaciones con fecha de servicio del 1 de enero de 2002 en adelante.

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addition to code for primary procedure)” for computer-aided detection (CAD) conversion of standard film images to digital images has been created as an add-on code to be billed in conjunction with a regular screening mammography (code 76092); and new code G0236, “Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure)”, has been created as an add on code to be billed in conjunction with a regular diagnostic mammography (codes 76090 or 76091).

***Subsection A**, Specific Codes used with mammography claims on or after January 1, 2002, lists-codes that will be used beginning January 1, 2002.*

***Subsection B**, New Computer-aided Detection (CAD) Codes Used as Add-On Codes, has been added to define the new CAD codes.*

***Subsection C**, Deleted Mammography Codes, has been added to define those codes deleted as of January 1, 2002.*

***Subsection D**, Certified Screening Centers/Suppliers, has been modified to add a sentence that contractors are no longer required to keep track of physicians who are associated with the certified mammography facilities unless there is a specific reason for doing so.*

***Subsection E,** Claims with dates of service prior to January 1, 2002, is being revised to include the 2001 Screening Mammography Payment Limitations as stated in Program Memorandum AB-00-91.*

***Subsection F**, Medicare Physician Fee Schedule will be used for payment for all mammography tests beginning with claims with dates of service on or after January 1, 2002.*

Reembolso

Subsección G, Códigos Nuevos de Detección Computadorizada (CAD por sus siglas en Inglés) como códigos adicionales para la mamografía exploratoria y de diagnóstico.

Subsección H, Instrucciones de facturación especiales para reclamaciones con fecha de servicio del 1 de octubre de 1998 **hasta el 31 de diciembre de 2001**, cuando un radiólogo interpreta los resultados en radiografías adicionales.

Subsección I, Instrucciones de Facturación Especiales Cuando el Radiólogo Interpreta los Resultados en Película Adicional - se cambia para reflejar la nueva política. Efectivo el 1 de enero de 2002, cuando el resultado de la interpretación de un mamograma exploratorio resulta en la ejecución de un mamograma de diagnóstico el mismo día para el mismo beneficiario, Medicare pagará ambas pruebas. Se utilizará el modificador nuevo GG con el código de diagnóstico para demostrar que la prueba de exploración resultó en pruebas de diagnóstico adicionales. Este modificador se utilizará para propósitos de rastreo.

Sección 4601.2 Como Identificar una Reclamación de Mamografía exploratoria y una de Mamografía de Diagnóstico

A. Los códigos específicos utilizados en las reclamaciones de mamografía en o después del 1 de enero de 2002 son los siguientes. Los códigos CPT y los códigos G se pagarán de acuerdo a las Tarifas Fijas para Médicos.

Reimbursement

***Subsection G**, New Computer-aided detection (CAD) codes as add-on codes for screening and diagnostic mammography.*

***Subsection H**, Special Billing Instructions When Radiologist Interpretation Results inAdditional Films (For claims with dates of service October1, 1998 **through December 31, 2001**).*

***Subsection I**, Special Billing Instructions When Radiologist Interpretation Results in Additional Films, is changed to effectuate new policy. When radiologist interpretation of screening mammogram results in performance of diagnostic mammogram on same day for the same beneficiary, beginning January 1, 2002, both tests will be paid by Medicare. A new modifier (GG) will be used with the diagnostic code to show that the screening test turned to additional diagnostic tests. This modifier is for tracking purposes.*

***4601.2 Identifying a Screening Mammography Claim and a Diagnostic Mammography Claim**.*

A. Specific Codes used with mammography claims on or after January 1, 2002 are listed below. CPT codes and G codes will be paid under the Medicare Physician Fee Schedule.

CPT Code 76092	- Screening mammography, bilateral (two view film study of each breast).
CPT Code 76090	- Diagnostic mammography, unilateral.
CPT Code 76091	- Diagnostic mammography, bilateral.
HCPCS Code G0202	- Screening mammography, direct digital image, bilateral, all views.
HCPCS Code G0204	- Diagnostic mammography, direct digital image, bilateral, all views.

Reembolso

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HCPCS Code G0206 - Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views.

CPT Code 76085 - Computer-aided detection add-on code for screening mammography (use with CPT code 76092)

HCPCS Code G0236 - Computer-aided detection add-on code for diagnostic mammography (use with CPT Codes 76090 or 76091)

New Modifier GG - Performance and payment of a screening mammography and diagnostic mammography on same patient same day. Attach to Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test; contractors will pay both the screening and diagnostic mammography tests. This modifier is for tracking purposes only.

ICD-9 Code V76.12 - Diagnosis code for screening mammography

ICD-9 codes for diagnostic mammography will vary according to diagnosis.

B. Códigos nuevos de Detección Computadorizada (CAD por sus siglas en ingles) utilizados como códigos *Add-On*:

Se ha creado como código *add-on*, el código 76085 «Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure)» para la conversión de película estándar a imágenes digitales que debe ser utilizado en conjunto con el código 76092 de una mamografía exploratoria regular. El pago se realizará de acuerdo a las Tarifas Fijas para Médicos.

Por separado, se ha creado el código G0236, «Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure)» para la detección computadorizada. Este código es también un código *add-on* y como tal debe ser utilizado en conjunto con los códigos de mamografía de diagnóstico, 76090 ó 76091.

B. New Computer-aided Detection (CAD) codes used as Add-On Codes:

A new CPT code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure)", for computer-aided detection conversion of standard film images to digital images has been established as an add-on code that can be billed only in conjunction with the primary service screening mammography code 76092. Payment will be made under the Medicare Physician Fee Schedule.

A separate code, G0236, has been created for "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure)" for computer aided detection. This code is also an add-on code and must be used with diagnostic mammography codes (76090 and 76091).

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C. Códigos de mamografías que serán eliminados a partir del 1 de enero de 2002:

HCPCS Code G0203-Screening mammography film processed to produce digital image, bilateral all views;

HCPCS Code G0205-Diagnostic mammography, film processed to produce digital image, bilateral, all views;

HCPCS Code G0207-Diagnostic mammography, film processed to produce digital image, unilateral

D. Centros de Evaluación Certificados – La ley provee ciertos estándares para aquellos centros cualificados para prestar este servicio y cómo éstos deben ser certificados. Efectivo el 1 de octubre de 1994 el Mammography Quality Standards Act (MQSA) requiere que todos los centros de mamografías que facturen al programa Medicare sean certificados por el Food and Drug and Administration (FDA). La información de la certificación es enviada directamente del FDA a CMS. CMS luego le provee la información de certificación a los contratistas. Medicare solamente pagará a los centros de mamografía que estén certificados por el FDA. El proveedor debe informar a sus pacientes cuáles son los centros que posee esta certificación.

Los centros de mamografía exploratoria no deben divulgar las radiografías para interpretación a proveedores que no estén debidamente aprobados bajo el número de certificación del centro a menos que el paciente haya solicitado la transferencia de las radiografías de una facilidad a otra para una segunda opinión o por motivo de mudanza a otra parte del país donde se estará realizando la próxima mamografía exploratoria. Las interpretaciones deben ser realizadas por profesionales que estén asociados con el centro de mamografía certificado.

E. En enero 1 de cada año desde el 1991 hasta el 2001 CMS actualizaba el límite general por el porciento de aumento en el Medicare Economic Index.

Reimbursement

C. Deleted mammography codes as of January 1, 2002:

D. Certified Screening Centers/Suppliers.— The law provides specific standards regarding those qualified to perform this service and how they should be certified. As of October 1, 1994, the Mammography Quality Standards Act (MQSA) requires that all mammography centers who bill Medicare get certification from the Food and Drug Administration (FDA). Certification information from FDA is then forwarded to CMS. CMS then provides certification information to carriers. Medicare will only reimburse FDA-certified mammography centers. Physicians should inform their patients about centers that are certified.

The mammography facilities which perform screening mammographies are not to release screening mammography X-rays for interpretation to physicians who are not approved under the facility's certification number unless the patient has requested a transfer of the films from one facility to another for a second opinion, or because the patient has moved to another part of the country where the next screening mammography will be performed. Interpretations are to be performed only by physicians who are associated with the certified mammography facility.

E. On January 1 of each year after 1991 through 2001, CMS updated the overall limit by the percentage increase in the Medicare Economic Index.

Reembolso

Existe un cargo límite especial para los servicios de mamografías prestados por proveedores no participantes.

NOTA: Los cálculos desglosados anteriormente no aplican para reclamaciones con fecha de servicio de 1 de enero de 2002 en adelante.

F. La §104 del Benefits Improvement and Protection Act (BIPA) del 2000 establece que toda reclamación con fecha de servicio del 1 de enero de 2002 en adelante donde se indique cualquier prueba de mamografía (exploración o diagnóstico) se pagará de acuerdo a las Tarifas Fijas para Médicos. El componente técnico, profesional y el servicio global serán incluídos en las Tarifas Fijas para Médico. El cargo permito por Medicare es el menor del cargo actual o de la cantidad en la Tarifa Fija. El pago por el servicio es de 80 porciento del cargo permitido. El coaseguro es al 20 porciento del menor del cargo actual o de la cantidad en la Tarifa Fija. El deducible de la Parte B es descartado y no aplica a la mamografía exploratoria.

   Como con otros servicios de Tarifas Fijas para Médicos de Medicare, las provisiones de la reducción para el proveedor no participante y el cargo límite aplica a todas las pruebas de mamografía incluyendo la mamografía exploratoria.

G. El código HCPCS 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography», for computer-aided detection conversion of standard film images to digital images», se ha añadido como *add-on*. Este puede ser facturado únicamente con el código primario para mamografía exploratoria, 76092. El pago se hará de acuerdo a las Tarifas Fijas para Médicos de Medicare.

Reimbursement

If mammography services are furnished by nonparticipating physicians and suppliers, there is a special limiting charge. (See MCM §5256)

***NOTE**: The above calculations do not apply to claims with dates of service on or after January 1, 2002.*

F. For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of all mammography tests (including screening mammography) under the Medicare Physician Fee Schedule (MPFS). The technical component, the professional component and the Global service will all be included on the Medicare Physician Fee Schedule. The Medicare allowed charge is the lower of the actual charge or the MPFS amount. The Medicare payment for the service is 80 percent of the allowed charge. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. Part B deductible is waived and does not apply to screening mammography.

As with other MPFS services, the non-participation provider reduction and the limiting charge provisions apply to all mammography tests (including screening mammography).

G. In addition, a new HCPCS code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography", for computer-aided detection conversion of standard film images to digital images", has been established as an add-on code that can be billed only in conjunction with the primary service screening mammography code 76092. Payment will be made under the MPFS.

Reembolso

En adición se ha creado el código G0236 como *add-on*, «Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography for computer aided detection (CAD) el cual debe ser facturado en conjunto con el código de mamografía de diagnóstico regular, 76090 ó 76091.

H. Instrucciones de facturación especiales para reclamaciones con fecha de servicio del 1 de octubre de 1998 **hasta el 31 de diciembre de 2001**, cuando un radiólogo interpreta los resultados en radiografías adicionales - Cuando una mamografía exploratoria presenta problemas potenciales, Medicare permite a los radiólogos ordenar perspectivas adicionales. Cuando la interpretación de un radiólogo resulta en radiografías adicionales, la mamografía deja de considerarse como una prueba de exploración por edad de la mujer y estandar de frecuencia o para propósitos de pago. Esto se puede realizar sin una orden adicional del proveedor del servicio. En estos casos solamente se facturará las radiografías de diagnóstico. La prueba de exploración original no será facturada. No obstante, como la prueba original era como prueba de exploración, para propósitos estadísticos, la reclamación se consideraría como de exploración.

Para facturar una mamografía de diagnóstico que originalmente era una de exploración se debe utilizar el Modificador GH con el código apropriado para el mamograma de diagnóstico. Este modificador debe ser reportardo de manera que Medicare pueda recolectar data estadística.

NOTA: No obstante, la prueba de diagnóstico luego de que una prueba de exploración arrojara posibles problemas no tiene que tener la misma fecha de servicio.

Reimbursement

Also, a new code G0236 - "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography" for computer aided detection (CAD), which has been created as an add-on code to be billed in conjunction with a regular diagnostic mammogram (codes 76090 or 76091).

H. *Special Billing Instructions When Radiologist Interpretation Results in Additional Films (For claims with dates of service October 1, 1998* ***through December 31, 2001)*** *—Medicare allows a radiologist to order additional mammography views when a screening mammography shows a potential problem. When a radiologist interpretation results in additional films, the mammography is no longer considered a screening exam for application of age and frequency standards or payment purposes. This can be done without an additional order from the treating physician. In this case, only the diagnostic x-ray(s) will be billed. The original screening test will not be billed. However, since the original intent for the exam was for a screening, for statistical purposes, the claim would be considered a screening.*

When billing a diagnostic mammogram that had been converted from a screening mammogram, use Modifier GH with the code for the appropriate diagnostic mammogram. This modifier must be reported to enable us to collect statistical data.

***NOTE**: However, the ordering of a diagnostic test by a radiologist following a screening test that shows a potential problem need not be on the same date of service.*

Reembolso

Se debe utilizar el código CPT 76092 (mamografía exploratoria lateral) y Tipo de Servicio = 1 para someter un mamograma exploratorio. Si la mamografía exploratoria resulta ser un mamograma de diagnóstico se debe utilizar el código CPT 76090 (unilateral) o el 76091 (bilateral), TOS = 4, y utilizar el modificador GH. En este caso se pagará la reclamación como mamografía de diagnóstico en vez de exploración.

En los casos donde se realizan pruebas de diágnostico adicionales para el mismo beneficiario en la misma visita y el mismo día se necesitará el UPIN del proveedor en la reclamación. Es de suma importancia que el radiólogo incluya el UPIN del proveedor del servicio y la condición del paciente de lo contrario la reclamación será rechazada.

I. Nuevas instrucciones de facturación aplican para fechas de servicio del 1 de enero de 2002 en adelante. Medicare permitirá que se ordenen radiografías adicionales sin tener la orden del proveedor primario. Se debe incluir el Modificador GG con el código de la mamografía de diagnóstico cuando se sometan reclamaciones para mamografía exploratoria y mamografía de diágnostico para el mismo paciente en el mismo día. El Modificador GG se utilizará para propósitos estadísticos. Ambas pruebas serán pagadas por Medicare.

Reimbursement

When submitting a claim for a screening mammogram, use CPT code 76092 (screening mammography, bilateral) and Type of Service =1. But, if the screening mammogram turns into a diagnostic mammogram, use CPT code 76090 (unilateral) or 76091 (bilateral), TOS=4, and use the GH modifier. The claim will be paid as a diagnostic mammography instead of a screening mammography.

Where additional diagnostic tests are performed for the same beneficiary, same visit on the same day, the UPIN of the treating physician is needed on the claim. The radiologist must refer back to the treating physician for his/her UPIN and also report to the treating physician the condition of the patient.

I. For dates of service on or after January 1, 2002 – New billing instructions apply. Medicare allows additional films to be done without an additional order from the treating physician. When submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach Modifier GG to the diagnostic mammography. We are requiring Modifier GG be appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Both the screening mammography and the diagnostic mammography will be reimbursed by Medicare.

CR 1837/Trans.1724/Sept. 27,2001/MM/MB

Reembolso

FACTOR DE INFLACIÓN PARA AMBULANCIAS PARA EL 2002

TRANSFONDO

La Sección 1834(l)(3)(A) del "Social Security Act" provee la base para actualizar los límites de pago para los servicios de ambulancia. Específicamente, esta sección provee la actualización para los pagos en el 2002 los cuales se calculan de acuerdo al aumento porcentual del índice de precios al consumidor para los consumidores urbanos (CPI-U por sus siglas en Inglés) para el período de 12 meses terminado en junio del año anterior y reducido por 1.0 punto porcentual. El porciento resultante se conoce como el **factor de inflación de ambulancia** (AIF por sus siglas en Inglés.)

Como es de costumbre el AIF es aplicado al cargo razonable o al límite de costo razonable del año anterior. No obstante, en el año fiscal 2001 hubo dos límites de pago en efecto debido al mandato en la sección 423 del " Benefits Improvement and Protection Act " el cual requería dos AIFs para el 2001. Hubo un AIF para el período del 1 de enero de 2001 hasta el 30 de junio de 2001 y un segundo AIF para el período del 1 de julio de 2001 hasta el 31 de diciembre de 2001. Debido a la existencia de esos dos AIFs durante el 2001 no existe un cargo razonable para el cual se pueda aplicar el AIF para el 2002. Por consiguiente, se requiere de un ajuste al método convencional para determinar los límites de pago para el 2002.

Utilizando el AIF estatutorio para el 2002, CMS computó un ajuste en el AIF del 2002, de manera tal que al aplicarse al último límite de pago (tarifas en efecto para el periodo del de julio de 2001 al 31 de diciembre de 2001) el efecto sea igual a la aplicación del AIF estatutorio para el 2002 al promedio de los límites de pago para los dos periodos del 2001.

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AMBULANCE INFLATION FACTOR FOR 2002

BACKGROUND

Section 1834(l)(3)(A) of the Act provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2002 that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year, reduced by 1.0 percentage point. The resulting percentage is referred to as the ambulance inflation factor (AIF).

Customarily, the AIF is applied to prior year's reasonable charge limit. However, in 2001 there were two payment limits in effect because section 423 of the Benefits Improvement and Protection Act of 2000 mandated two AIFs for 2001. There was one AIF for the period January 1, 2001 through June 30, 2001 and a second AIF for the period July 1, 2001 through December 31, 2001. Because there were two AIFs in 2001, there is no single 2001 reasonable charge limit to which the 2002 AIF may be applied. Accordingly, an adjustment to the usual method is required to determine 2002 payment limits.

Using the statutory AIF for 2002, CMS calculated an adjusted 2002 AIF so that when applied to the latest payment limits available (that is, the rates in effect for the period July 1, 2001 through December 31, 2001) the effect is the same as if the 2002 statutory AIF were applied to the average of the payment limits for both 2001 periods.

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POLÍTICA

El AIF para el año calendario de 2002 es de **1.2 porciento.**

IMPLANTACIÓN

Este porciento aplica a los límites de pago efectivos durante el período del 1 de julio de 2001 hasta el 31 de diciembre de 2001.

PM AB-01-148/CR 1875/October 18,2001/mm/mb

Reimbursement

POLICY

*The AIF for calendar year 2002 is **1.2 percent**.*

IMPLEMENTATION

This percent apply to the payment limits in effect during July 1, 2001 through December 31, 2001.

FACTORES DE ACTUALIZACIÓN A DMEPOS PARA EL 2002

Conforme al "Benefits Improvement and Protection Act (BIPA) of 2000", al "Balanced Budget Refinement Act of 1999" y al "Balanced Budget Act of 1997", los siguientes porcentajes representan el aumento que CMS realizó a las tarifas para "DMEPOS" a partir del 1 de enero de 2002.

DMEPOS UPDATE FACTORS FOR 2002

According to the Benefits Improvement and Protection Act (BIPA) of 2000, the Balanced Budget Refinement Act of 1999 and the Balanced Budget Act of 1997, the following percentages represent the increase made by CMS for DMEPOS pricing beginning January 1, 2002.

Categoría/Category	January 1, 2002
DME	0.6*
Prosthetics & Orthotics	1.0
Other Reasonable Charge Items**	CPI-U

***** Temporary increase not to be carried over into future periods

****** Other than ambulance services

AB-01-26/CR1500/02-07-01/AB-01-40/CR1577/03-09-01/MRM
AB-01-126/CR1856/09-14-01

Reembolso

TARIFAS FIJAS DE CÓDIGOS DMEPOS SUJETOS A JURISDICCIÓN LOCAL

A continuación indicamos las tarifas de los códigos DMEPOS con jurisdicción local. Estas tarifas serán efectivas al 1 de enero de 2002.

Reimbursement

FEE SCHEDULE FOR DMEPOS CODES SUBJECT TO LOCAL CARRIER JURISDICTION

The following is the fee schedule for DMEPOS codes subject to local carrier jurisdiction. The fees will become effective January 1, 2002.

CODIGO HCPCS *HCPCS CODE*	CATEGORIA *CATEGORY*	TARIFAS FIJAS PR *PR FEE SCHEDULE*	TARIFAS FIJAS VI *VI FEE SCHEDULE*
E0749RR	Capped Rental	$ 453.35	$ 235.70
E0616	Inexpensive or Routinely Purchased DME	$ 2,301.93	$ 2,716.28
E0753	Prosthetic / Orthotic	$ 1,746.84	$ 1,176.05
E0782NU	Inexpensive or Routinely Purchased DME	$ 3,952.58	$ 4,066.20
E0782UE	Inexpensive or Routinely Purchased DME	$ 2,964.42	$ 3,049.65
E0782RR	Inexpensive or Routinely Purchased DME	$ 395.27	$ 406.64
E0783NU	Inexpensive or Routinely Purchased DME	$ 7,050.22	$ 7,676.89
E0783RR	Inexpensive or Routinely Purchased DME	$ 705.02	$ 767.71
E0785	Inexpensive or Routinely Purchased DME	$ 399.71	$ 399.71
L8600	Prosthetic / Orthotic	$ 258.60	$ 440.96
L8603	Prosthetic / Orthotic	$ 360.69	$ 358.97
L8610	Prosthetic / Orthotic	$ 527.74	$ 477.09
L8612	Prosthetic / Orthotic	$ 527.74	$ 461.01
L8613	Prosthetic / Orthotic	$ 274.41	$ 216.49
L8614	Prosthetic / Orthotic	$ 16,461.27	$ 13,075.98
L8619	Prosthetic / Orthotic	$ 7,066.73	$ 5,190.37
L8630	Prosthetic / Orthotic	$ 232.22	$ 219.55
L8641	Prosthetic / Orthotic	$ 221.66	$ 227.06
L8642	Prosthetic / Orthotic	$ 221.66	$ 209.33
L8658	Prosthetic / Orthotic	$ 131.93	$ 203.17
L8670	Prosthetic / Orthotic	$ 316.64	$ 246.45

**** La inclusión o exclusión de una tarifa fija para un articulo o servicio no implica cubierta de algún seguro de salud.**

**** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.**

AB-01-26/CR1500/02-07-01/AB-01-40/CR1577/03-09-01/MRM
AB-01-126/CR1856/09-14-01

Reembolso

A TODOS LOS CENTROS DE CIRUGÍA AMBULATORIA

ACTUALIZACIÓN DE TARIFAS

Conforme a la Sección 1833 (1)(2)(C) del Acta del Seguro Social, el Centro de Servicios Medicare & Medicaid (CMS) ha autorizado la actualización de tarifas de pago a los Centros de Cirugía Ambulatoria. Estas nuevas tarifas son efectivas para los servicios prestados en o después del 1 de octubre de 2001. El índice de los valores utilizado en áreas urbanas y rurales es parte de la actualización para el año fiscal 2002 del Sistema de Pagos Prospectivos de Hospitales (Hospital Prospective Payment System).

En la primera tabla identificada como **TARIFAS DE PAGO ASC 2001-2002** se incluyen las nuevas tarifas por categoría y área geográfica. Los números romanos presentados en la tabla de tarifas indican las áreas y los cargos que aplicarán a cada una de éstas. Dichas áreas se incluyen en la segunda tabla identificada como **Áreas Urbanas**.

Reimbursement

TO ALL AMBULATORY SURGICAL CENTERS

PAYMENT RATES UPDATES

As stated in Section 1833 (1)(2)(C) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has authorized the update payment rates to the Ambulatory Surgical Centers. These new fees are effective for services rendered on or after October 1, 2001. The wage index values used for urban and rural areas are part of the Fiscal Year 2002 update of the hospital inpatient prospective payment system (PPS).

*The first table identified as **ASC PAYMENT RATES 2001-2002** includes the new payment rates arranged by category and geographic areas. The roman numerals presented in the payment rate table indicate the areas and the charge that will apply to each one of these. These areas are detailed in the second table identified as **Urban Areas**.*

Trans.AB-01-121/ CR 1763/September 7, 2001

GROUP/ GRUPO	FEE / TARIFA	I 0.4832	II 0.4832	III 0.4832	IV 0.486	V 0.5218	VI 0.4832	VII 0.4832
1	$ 323.00	$ 265.49	$ 265.49	$ 265.49	$ 265.81	$ 269.79	$ 265.49	$ 265.49
2	$ 433.00	$ 355.91	$ 355.91	$ 355.91	$ 356.33	$ 361.67	$ 355.91	$ 355.91
3	$ 495.00	$ 406.87	$ 406.87	$ 406.87	$ 407.35	$ 413.45	$ 406.87	$ 406.87
4	$ 612.00	$ 503.04	$ 503.04	$ 503.04	$ 503.63	$ 511.18	$ 503.04	$ 503.04
5	$ 696.00	$ 572.09	$ 572.09	$ 572.09	$ 572.76	$ 581.34	$ 572.09	$ 572.09
*6	$ 806.00	$ 689.21	$ 689.21	$ 689.21	$ 689.84	$ 697.93	$ 689.21	$ 689.21
7	$ 966.00	$ 794.02	$ 794.02	$ 794.02	$ 794.95	$ 806.86	$ 794.02	$ 794.02
*8	$ 949.00	$ 806.75	$ 806.75	$ 806.75	$ 807.52	$ 817.37	$ 806.75	$ 806.75

***INCLUYE $150.00 POR LENTE INTRAOCULAR (IOL's)/ INCLUDES $150.00 FOR INTRAOCULAR LENS (IOL's)**

ÁREAS URBANAS/URBAN AREAS						
I. AGUADILLA	Aguada	Aguadilla	Moca			
II. ARECIBO	Arecibo	Camuy	Hatillo			
III. CAGUAS	Caguas	Cayey	Cidra	Gurabo	San Lorenzo	
IV. MAYAGUEZ	Añasco	Cabo Rojo	Hormigueros	Mayaguez	Sabana Grande	San Germán
V. PONCE	Guayanilla	Juana Díaz	Peñuelas	Ponce	Villalba	Yauco
VI. SAN JUAN / BAYAMÓN	Aguas Buenas	Barceloneta	Bayamón	Canóvanas	Carolina	Cataño
	Ceiba	Comerío	Corozal	Dorado	Fajardo	Florida
	Guaynabo	Humacao	Juncos	Las Piedras	Loíza	Luquillo
	Manatí	Morovis	Naguabo	Naranjito	Río Grande	San Juan
	Toa Alta	Toa Baja	Trujillo Alto	Vega Alta	Vega Baja	Yabucoa
VII. AREAS RURALES /						

Reembolso

ACTUALIZACIÓN A LOS CARGOS RAZONABLES PARA EL 2002 PARA SERVICIOS DIFERENTES A AMBULANCIA Y SERVICIOS DE LABORATORIO

Los siguientes códigos están sujetos a la actualización de cargo razonable:

Entablillados y Enyesados (Jurisdicción local)*

A4565 Q4001 Q4002 Q4003 Q4004 Q4005 Q4006 Q4007 Q4008 Q4009 Q4010
Q4011 Q4012 Q4013 Q4014 Q4015 Q4016 Q4017 Q4018 Q4019 Q4020 Q4021
Q4022 Q4023 Q4024 Q4025 Q4026 Q4027 Q4028 Q4029 Q4030 Q4031 Q4032
Q4033 Q4034 Q4035 Q4036 Q4037 Q4038 Q4039 Q4040 Q4041 Q4042 Q4043
Q4044 Q4045 Q4046 Q4047 Q4048 Q4049

*Los códigos para entablillados y yesos deben ser utilizados **sólo** para facturar servicios **para reducir una fractura o dislocación**. Estas tarifas fueron aumentadas por el factor de actualización de 3.2 porciento del IIC del 2002.

Reimbursement

REASONABLE CHARGE UPDATE FOR 2002 FOR ITEMS AND SERVICES, OTHER THAN AMBULANCE AND LABORATORY SERVICES

The following codes are subject to the reasonable charge update:

*Splints and Casts (Local Carrier Jurisdiction)**

*The codes for splints and casts are **only** to be used for splints and casts **used to reduce a fracture or dislocation**. These gap-filled amounts have been increased by the 2002 IIC update factor of 3.2 percent.*

PAGOS PARA ENTABLILLADOS Y YESOS PARA EL 2002
2002 PAYMENT AMOUNTS FOR SPLINTS AND CASTS

A4565	$ 6.30	Q4018	$ 10.65	Q4036	$ 24.59
Q4001	$ 35.89	Q4019	$ 3.34	Q4037	$ 12.06
Q4002	$ 135.65	Q4020	$ 5.33	Q4038	$ 30.21
Q4003	$ 25.78	Q4021	$ 4.94	Q4039	$ 6.04
Q4004	$ 89.25	Q4022	$ 8.92	Q4040	$ 15.11
Q4005	$ 9.50	Q4023	$ 2.48	Q4041	$ 14.66
Q4006	$ 21.42	Q4024	$ 4.46	Q4042	$ 25.03
Q4007	$ 4.76	Q4025	$ 27.72	Q4043	$ 7.33
Q4008	$ 10.71	Q4026	$ 86.53	Q4044	$ 12.52
Q4009	$ 6.34	Q4027	$ 13.86	Q4045	$ 8.51
Q4010	$ 14.28	Q4028	$ 43.27	Q4046	$ 13.69
Q4011	$ 3.17	Q4029	$ 21.19	Q4047	$ 4.25
Q4012	$ 7.14	Q4030	$ 55.78	Q4048	$ 6.85
Q4013	$ 11.54	Q4031	$ 10.60	Q4049	$ 1.55
Q4014	$ 19.48	Q4032	$ 27.89		
Q4015	$ 5.77	Q4033	$ 19.76		
Q4016	$ 9.74	Q4034	$ 49.17		
Q4017	$ 6.68	Q4035	$ 9.89		

Trans.AB-01-118/CR 1803/09-31-01
MM/MB

Reembolso

ACTUALIZACIÓN DE LOS CÓDIGOS Y PAGOS PARA CENTROS DE CIRUGÍA AMBULATORIA (ASCs)

El Centro de Servicios Medicare & Medicaid (CMS por sus siglas en inglés) notificó los códigos nuevos y los que serán eliminados de la lista de códigos de procedimientos de los Centros de Cirugía Ambulatoria. Esta lista es el resultado de los cambios en la *American Medical Association Physician's Current Procedural Terminology (CPT) for 2002.*

CMS permite el pago de la facilidad cuando los procedimientos quirúrgicos son prestados en Centros de Cirugía Ambulatoria certificados por Medicare.

Estos códigos y grupos de pago se encuentran en el *2002 Health Care Procedure Coding System (HCPCS).*

Los siguientes códigos eliminados y nuevos serán efectivos para servicios prestados en o después del 1 de enero de 2002.

Reimbursement

CODES AND PAYMENT UPDATES FOR AMBULATORY SURGICAL CENTERS (ASC's)

The Centers for Medicare & Medicaid (CMS) notified the deletions from and additions to the Ambulatory Surgical Center (ASCs) procedure codes list. The ASC list is the result of changes in the American Medical Association Physician's Current Procedural Terminology (CPT) for 2002.

CMS provides a facility payment fee for the surgical procedures when they are performed in Medicare certified ASCs.

These codes and payment groups are reflected in the 2002 Health Care Procedure Coding System (HCPCS).

The following deleted or added codes will be effective for services performed on or after January 1, 2002:

Trans.AB-01-141/CR 1860/October 2, 2001/MM

Códigos Eliminados *Deleted Codes*	**Códigos Añadidos** *Added Codes*	**Grupo de Pago** *Payment Group*
26585	25024	3
26597	25025	3
29815	25275	4
54510	25671	1
	29805	3
	29806	3
	29807	3
	29824	5
	29900	3
	29901	3
	29902	3
	36819	3
	36820	3
	46020	3
	52001	2
	53431	2
	53444	2
	53445	1
	53446	1
	54162	2
	54163	2
	54164	2
	54512	2

Reembolso

CODIFICACIÓN PARA SERVICIOS NO CUBIERTOS Y PARA SERVICIOS NO RAZONABLES Y NECESARIOS

Este artículo sustituye la información publicada en el Medicare Informa, Vol. 67, páginas 54-56.

Los modificadores GY y GZ serán efectivos el 1 de enero de 2002 con la actualización anual del HCPCS. Estos modificadores fueron creados para permitir la facturación a Medicare de servicios considerados como estatutorios no cubiertos o que no cumplen con la definición de un beneficio de Medicare y servicios considerados como no razonables y necesarios por Medicare.

Los códigos Q3015 y Q3016 presentados en el Medicare Informa, Vol. 67, no serán implantados.

Códigos y Modificadores Descontinuados

A9160 - Non-covered service by podiatrist

A9170 - Non-covered service by chiropractor

A9190 - Personal comfort item, (non-covered by Medicare statute)

GX - Service not covered by Medicare

Modificadores Nuevos

GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit.

GZ - Item or service expected to be denied as not reasonable and necessary.

Aclaración en el uso del código A9270

El código HCPSCS A9270, Servicio no cubierto, se mantendrá como un código activo y válido para Medicare. El código A9270 no será aceptado como código de servicio cuando sea facturado a los carriers. Este código es para los suplidores de equipo médico.

Uso de los Modificadores GA, GY y GZ

El modificador GY debe utilizarse cuando el proveedor o suplidor quiere indicar que el servicio es considerado como estatutorio no cubierto o no es un beneficio de Medicare.

Reimbursement

CODING FOR NON-COVERED SERVICES AND SERVICES NOT REASONABLE AND NECESSARY

This article supersedes the information published on volume 67 pages 54-56 of our bulletin.

The modifiers GY and GZ will be effective on January 1, 2002 with the annual HCPCS update. These modifiers were developed to allow practitioners and suppliers to bill Medicare for items and services that are statutorily non-covered or do not meet the definition of a Medicare benefit and items and services not considered reasonable and necessary by Medicare.

The Q3015 and Q3016 described on volume 67 of the Medicare Informa, will not be implemented.

Discontinued Codes/Modifier

A9160-Non-covered service by podiatrist

A9170-Non-covered service by chiropractor

A9190 - Personal comfort item, (non-covered by Medicare statute)

GX - Service not covered by Medicare

New Modifiers

GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit.

GZ - Item or service expected to be denied as not reasonable and necessary.

Clarification on Use of A9270

HCPCS code A9270, Non-covered item or service, will remain an active code and valid for Medicare. Code A9270 will no longer be accepted for services or items billed to carriers. This code is for use only by DMEPOS suppliers.

Use of the GA, GY, and GZ Modifiers

The new GY modifier must be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered or is not a Medicare benefit.

Reembolso

El modificador GZ debe utilizarse cuando el proveedor o suplidor no tiene un "Advance Beneficiary Notification (ABN) firmado por el beneficiario y quiere indicar que Medicare denegará el servicio como no razonable y necesario.

El modificador GA debe utilizarse cuando el proveedor o suplidor tiene en archivo un "Advance Beneficiary Notification (ABN) firmado por el beneficiario y quiere indicar que el servicio será denegado como no razonable y necesario.

Los modificadores GY y GZ deben ser utilizados con los códigos HCPCS apropiados En el caso donde no exista un código de procedimiento para describir estos servicios se debe utilizar el "not otherwise classified code" (NOC) con el modificador correspondiente.

Reclamaciones con modificadores GY, GZ y GA

Toda reclamación sometida con los modificadores GZ y GY podrá ser denegada automáticamente.

Toda reclamación que tenga el modificador GZ y GA para un mismo servicio será rechazada.

Información Explicativa a Incluir en las reclamaciones

Cada vez que se utilize el código NOC, la reclamación debe incluir una descripción de los servicios prestados. En el caso de reclamaciones en papel esta información debe ser incluida en el campo 19 de la forma HCFA-1500 o sometida como un anejo a la reclamación. Para las reclamaciones en forma electrónica la explicación del servicio prestado debe ser sometida en el campo de nivel de nota de la reclamación. Si se necesita espacio adicional para la narrativa se deberá entrar el "ADD" adecuado en el campo NTE01 y entrar la narrativa adicional en el campo NTE02.

Reimbursement

The new GZ modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.

The GA modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they do have on file an ABN signed by the beneficiary.

The GY and GZ modifiers should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe services, a "not otherwise classified code" (NOC) must be used with the corresponding modifier.

Claims with GY, GZ and GA modifier

Claims submitted using GY and GZ modifiers can be auto-denied.

If the GZ and GA modifiers are submitted for the same item or service, will be rejected.

Explanatory Information To Be Included on Claims

Anytime a NOC code is used, providers and suppliers must include a description of the services or items provided. This information must be entered in item 19 on the Form HCFA-1500 or submitted as an attachment. For electronic claims, providers and suppliers must report this information in the claims level note. If space for additional narrative is needed, the provider or supplier must enter the qualifier "ADD" in NTE01 then enter the additional narrative in NTE02.

Trans.B-01-58/CR 1820/September 25, 2001/mm/mb

Reembolso

NUEVAS PRUEBAS AL CERTIFICADO DE DISPENSA

Las siguentes pruebas han sido aprobadas por la Admnistración Federal de Drogas y Alimentos como pruebas de dispensa bajo el *Clinical Laboratory Improvement Amendments (CLIA).* Los códigos CPT (Current Procedural Terminology) deben tener el modificador QW para de esta manera ser reconocidos como pruebas de dispensa.

Reimbursement

NEW TESTS TO THE WAIVED CERTIFICATE

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

NOMBRE DE LA PRUEBA ***TEST NAME***	**MANUFACTURERO** ***MANUFACTURER***	**CODIGO(S) CPT** ***CPT CODE(S)***
*Wyntek OSOM Ultra Strep A Test	Wyntek Diagnostics, Inc.	87880QW
*Beckman Coulter Primary Care V Immunochemical Strep A Test	Beckman Coulter	87880QW
*Phamatech At Home Drug Test	Phamatech	80101QW (This test may not be covered in all instances. Contact your Medicare carrier for claims instructions)
*Beckman Coulter Primary Care Diagnostics Flexsure HP Test for IgG Antibodies to H. Pylori in Whole Blood	Beckman Coulter, Inc.	86318QW
*Wampole PreVue B. burgdorferi Antibody Detection Assay	Wampole Laboratories	86618QW
*Phamatech At Home Drug Test (Model 9150T)	Phamatech	80101QW (This test may not be covered in all instances. Contact your Medicare carrier for claims instructions)
*Phamatech At Home Drug Test (Model 9078T)	Phamatech	80101QW (This test may not be covered in all instances. Contact your Medicare carrier for claims instructions)

*** Newly added waived test system**

Reembolso

Reimbursement

NOMBRE DE LA PRUEBA *TEST NAME*	MANUFACTURERO *MANUFACTURER*	CODIGO(S) CPT *CPT CODE(S)*
*KDK Corporation Lactate Pro System	KDK Corporation	83605QW
*QuickVue Dipstick Strep A	Quidel Corporation	87880QW
*Bayer Multisitck Pro 10 LS Reagent Strips	Bayer Diagnostics	81002 82570QW
*Bayer Multisitck Pro 11 Reagent Strips	Bayer Diagnostics	81002 82570QW
*Bayer Multisitck Pro 7G Reagent Strips	Bayer Diagnostics	81002 82570QW
*Advantage Diagnostics Advantage Marijuana (THC) and Cocaine Home Drug Test	Advantage Diagnostics Corporation	80101QW (This test may not be covered in all instances. Contact your Medicare carrier for claims instructions)
*Beckman Coulter Primary Care Diagnostics Gastrocult	Beckman Coulter, Inc.	82273QW
*Medical Instruments Corporation Pronto Dry H. pylori	Medical Instruments Corporation	87077QW

*** Newly added waived test system**

El código CPT para la prueba *Bion Diagnostic Sciences BTA stat test (for home use),* ha sido cambiado al 86294QW, efectivo el 13 de septiembre de 2001.

Nuevos códigos CPT han sido asignados para las siguientes pruebas:

86294QW for the Bion Diagnostic Sciences BTA stat test (for home use);

86618QW for the Wampole PreVueÔ *B. burgdorferi* Antibody Detection Assay; and

83605QW for the KDK Corporation Lactate Pro System.

Trans.AB-01-145/CR 1877/October 10, 2001/MM

The CPT code has been changed to 86294QW for the Bion Diagnostic Sciences BTA stat test (for home use), Effective: September 13, 2001.

New waived CPT codes have been assigned for the following tests:

***86294QW** for the Bion Diagnostic Sciences BTA stat test (for home use);*

***86618QW** for the Wampole PreVueÔ* B. burgdorferi *Antibody Detection Assay; and*

***83605QW** for the KDK Corporation Lactate Pro System.*

Contrato

PROVEEDORES SANCIONADOS

Proveedores sancionados son aquellos que han violado las obligaciones de su contrato con Medicare o Medicaid. A estos proveedores no se les permite facturar al Programa Medicare. Los "carriers" reciben mensualmente una lista de parte de CMS, que contiene las exclusiones y reintegraciones efectuadas por la Oficina del Inspector General (OIG). Las exclusiones son efectivas a los 20 días de la fecha de la notificación al proveedor. Estas exclusiones y reintegraciones serán efectivas a la fecha indicada. Las instrucciones para el manejo de los proveedores sancionados fueron establecidas por CMS en las secciones 14030.5 a la 14030.13 en el *Medicare Carrier Manual*.

La sección 4304 del "Balanced Budget Act" (BBA) modificó la sección 128A(a) del "Social Security Act". Específicamente, el "BBA" añadió nuevas penalidades monetarias civiles de hasta $10,000 por cada artículo o servicio provisto y hasta tres veces la cantidad reclamada en casos en que una persona se contrata con un proveedor excluído, con el propósito de proveer servicios o artículos para el cuidado de la salud, y dicha persona sabe o debería saber que el proveedor estaba excluído de Medicare.

La sección 1128A del "SSA" define el término "persona" incluyendo "una organización, una agencia u otra entidad, pero excluyendo al beneficiario." Esta provisión aplica a contratos o acuerdos efectuados después del 5 de agosto de 1997.

Para cumplir con nuestro compromiso de educar a los proveedores de Medicare, a continuación presentamos en la siguiente página la lista de los proveedores que han sido excluídos o reintegrados al programa Medicare:

Contract

SANCTIONED PROVIDERS

Sanctioned providers are practitioners who violate their obligations under the "Medicare and Medicaid Programs Protection Act". They are excluded from billing the Medicare Program. Carriers receive a monthly listing from CMS containing exclusion and reinstatement or withdrawal actions taken by the Office of Inspector General (OIG). Exclusion actions are effective 20 days from the date of the notice to the provider. Reinstatements / withdrawals are effective as of the date indicated. CMS established the instructions for the handling of sanctioned providers on MCM sections 14030.5 to 14030.13.

Section 4304 of the Balanced Budget Act (BBA) modified Section 1128A(a) of the Social Security Act. Specifically, the BBA added new civil monetary penalties of up to $10,000 for each item or service provided, and triple the claimed amount in cases in which a person contracts with an excluded provider for the provision of health care items or services and the person knows or should have known that the provider was excluded from participation in the Medicare program.

Section 1128A of the Social Security Act defines the term "person" to include "organization, agency, or other entity, but excluding a beneficiary". This provision applies to arrangements or contracts entered into after August 5, 1997.

To comply with our commitment to educate and inform our medical community we have included on next page the most recent list of excluded and/or reinstated providers:

Proveedores Excluídos del Programa Medicare

Providers Excluded from the Medicare Program

NOMBRE *NAME*	DIRECCION *ADDRESS*	PERIODO DE EXCLUSION *PERIOD OF EXCLUSION*	FECHA EFECTIVIDAD *EFFECTIVE DATE*
Ramírez Santoni, David	Cervantes Apt. Santurce, PR 00907	Permanent	March 1, 1991
Bailey, Colin D H	227 Golden Rock Dev Est Christiansted St. Croix, VI 008204	Indefinite	April 1, 1992
Escalante Santos, Gilberto	Urb. Summit Hills 596 Torrecillas St. Rio Piedras, PR 00920	Indefinite	June 10, 1994
Alvarado Sánchez, Mayda C.	56 Georgetti St. Comerío, PR 00782	Indefinite	September 3, 1997
Ortíz Ramos, Jorge L.	17St. - 3D1 Covadonga Toa Baja, PR 00949	Indefinite	December 20, 1999
Atocha Sánchez, José M.	720 Ponce De León Ave. San Juan, PR 00918	Indefinite	April 29, 1996
Capó Fernández, Yolanda	Plaza Vega Baja Pearle Vision Express Vega Baja, PR 00693	Indefinite	April 16, 1997
Soto Vázquez, Julio M.	Villa Rosa III B27 - 1St. Guayama, PR 00784	Indefinite	May 17, 1991
Rosado Montalvo, Héctor	Ponce Plaza Alfonso XII - Int. Isabel St. Ponce, PR 00731	Indefinite	May 22, 1997
Stella, Edgar	513 Street Tintillo Hills Bayamón, PR 00966	20 years	January 29, 1986
Rivera Cruz, Carlos	205 Lauro Piñero Ave. Ceiba, PR 00735	Indefinite	December 20, 1999
Moreno Torres, Edwin	134 Calle José I. Quinton Coamo, PR 00769	5 years	December 20, 1998
Mercado Franci, José A.	Villa Clarita 2 6 St. # 46 Fajardo, PR 00738	Indefinite	August 20, 2000
Texidor Sánchez, Carmen I.	25 St. - Z-19 Rio Verde Caguas, PR 00725	Indefinite	August 20, 2000
Rutkowski Whitehead, Morris E.	371 San Jorge St. Santurce, PR 00912	Indefinite	July 14, 1993
Arce Forestier, Nestor	3 Muñoz Rivera St. Camuy, PR 00627	Indefinite	August 20, 1998
Francis Ambulance	99 Manolo Flores St. Fajardo, PR 00738	Indefinite	August 20, 2000
Rivera López, Aixa	Pearl Vision 52-E José De Diego St. Cayey, PR 00736	Indefinite	September 20, 2000
Pérez Cuevas, Reynaldo	Centro Visual de Florida Florida, PR 00650	Indefinite	October 19, 2000
Arrillaga, Abenamar	Ext. Hermanas Davila 23 - J St. Bayamón, PR 00959	20 years	May 18, 2000
Kutcher Olivo, Roberto	Calle Betances 80 Canóvanas, PR 00629	Indefinite	March 20, 2001
Grana Díaz, Roberto	Urb Sagrado Corazón 1616 Calle Sta Eduviges San Juan, PR 00926	Indefinite	May 20, 2001
Maisonet Correa, Carlos	61 Marginal Sta. Rosa Bayamón, PR 00960	Indefinite	September 20,2001

Contrato

NUEVO CÓDIGO DE ESPECIALIDAD PARA EL MANEJO DE DOLOR

CMS ha establecido una nueva especialidad médica para Manejo de Dolor. El nuevo código es "72". Los médicos que escojan esta especialidad no están obligados a aceptar la asignación a menos que él/ella entre en un acuerdo de participación. Si el médico no está inscrito, él/ella debe completar la forma de inscripción CMS 855I (para solicitante individual) o CMS 855B (para grupos), con copia de la certificación de la especialidad de la Junta Médica de Examinadores.

Los médicos ya inscritos en el Programa de Medicare que deseen cambiar su especialidad actual deberán completar la forma de inscripción CMS 855I (para proveedor individual) o CM 855B (para grupos), y enviarla con copia de la certificación de la especialidad de la Junta Médica de Examinadores. Al completar la forma CMS 855, el proveedor deberá indicar que él/ella desea cambiar su especialidad actual.

Trans. B-01-57/CR1872/Sept. 21, 2001/SES

Contract

NEW SPECIALTY CODE FOR PAIN MANAGEMENT

CMS has established a new physician specialty code for Pain Management. The new code is "72". Physicians choosing this specialty code are not required to accept assignment unless he/she enters into a participating supplier agreement. If the physician is not already enrolled, he/she must complete the general enrollment form CMS 855I (for individual applicant) or CMS 855B (for groups), with copy of the certification of specialty from the Medical Board of Examiners.

Those physicians already enrolled in the Medicare Program that wish to change their current specialty code must complete the general enrollment form CMS 855I (for individual applicant) or CMS 855B (for groups), with copy of the certification of specialty from the Medical Board of Examiners. In completing the CMS 855 the provider must indicate that he/she wish to change their current specialty.

HCFA 855 FORMS

With the implementation of the November 1, 2001, versions of Form CMS-855, effective October 31, 2001, the version of Form HCFA-855 (1/98) will be obsolete. This Carrier will continue to accept and process all 1/98 versions of Form HCFA-855 through December 31, 2001. All 1/98 versions of Form HCFA-855 postmarked after and received in our office for the first time after December 31, 2001, will be returned to the applicant with the appropriate November 1, 2001, Form CMS-855.

Also with this implementation, the **1/98 Form HCFA-855C** (Change of Information Request) will be obsolete. All change requests postmarked after December 31, 2001 must be submitted on the appropriate Form CMS-855 with a signed and dated certification statement.

Electronic copies of all CMS Medicare Enrollment forms can be found at the Medicare web site at (http://www.hcfa.gov/medicare/enrollment/forms/). Also copies can be obtained through 1-877-715-1921.

Trans. AB-01-146/CR 1835/October 12, 2001/SES

Facturación por Medios Electrónicos (EMC)

PROGRAMA DE FACTURACIÓN ELECTRÓNICA PARA MEDICARE

A partir de enero de 2002 el programa de facturación Medifast será reemplazado por el programa de SES Profesional. El programa de SES Profesional tendrá la capacidad de generar reclamaciones Medicare en el formato X12 (837). Los proveedores que soliciten el programa de facturación de enero del 2002 en adelante recibirán el programa de SES Profesional. Habrá un cargo nominal de $25.00 anuales por el programa SES Profesional para generar reclamaciones Medicare. Si el proveedor va a utilizar el programa de SES Profesional para generar reclamaciones Medicare y reclamaciones Triple-S entonces aplica el cargo establecido por Triple-S. Aquellos proveedores que sean usuarios de Medifast deberán cambiar el programa de facturación a uno que genere las reclamaciones en el formato X12 (837) antes del 16 de octubre de 2002. En las próximas publicaciones incluiremos una lista de los "Vendors" de EMC que estén certificados con Triple S/Medicare para enviar reclamaciones Medicare en el formato X12 (837).

Requisitos Minimos para programa SES Profesional:

Procesador Pentium 200Mhz
Resolución Video 800 X 600
32MB de Memoria
Disco duro de 1GB
Modem 14.4kbps
CD-ROM
Internet Explorer 4.0

Configuración recomendada para programa SES Profesional:

Procesador Pentium III
Resolución Video 800 X 600
128MB Memoria
Disco duro de 4GB
Modem 56kbps
CD-ROM
Internet Explorer 5.5

Desde el 2 de enero de 2002 estaremos disponibles para hacer pruebas de reclamaciones en el formato 837 con los proveedores que así lo deseen. Los proveedores que pasen las pruebas satisfactoriamente podrán utilizar el formato X12 (837) en producción. A partir del 16 de octubre de 2002 será obligatorio utilizar el formato 837 para enviar reclamaciones electrónicas, toda reclamación recibida en formato NSF luego del 15 de octubre de 2002 se rechazará.

Electronic Media Claims (EMC)

MEDICARE ELECTRONIC BILLING SOFTWARE

Starting on January 2002 the Medifast electronic billing software will be replaced with the SES Professional electronic billing software. The SES Professional software will be capable of creating Medicare electronic claims using the X12 (837) format. Medicare providers that request our billing software after December 31, 2001 will receive the SES Professional software. There will be a nominal charge of $25.00 annually for the use of the SES Professional software for Medicare billing only. If the provider uses SES Professional for Triple-S billing then the charges established by Triple-S will apply.

Current Medifast users must change their billing software to a HIPAA compliant electronic billing software no later than October 16, 2002. In future publications we will include a list of EMC Vendors certified with Triple-S / Medicare as HIPAA compliant vendors.

Minimum requirements for SES Professional:

Pentium 200Mhz CPU
800 x 600 Video resolution
32MB RAM
1Gb Hard Drive
14.4Kbps modem
CD-ROM
Internet Explorer 4.0

Recommended configuration for SES Professional:

Pentium III CPU
800 x 600 Video resolution
128MB RAM
4Gb Hard Drive
56Kbps modem
CD-ROM
Internet Explorer 5.5

Triple-S / Medicare will be available for X12 837 testing with providers starting on January 2, 2002. Providers that test successfully can then use the X12 837 format on the production environment. As required by HIPAA all claims received after October 15, 2002 on an electronic format other than the X12 837 will be rejected.

PLANES DE CUIDADO COORDINADO EN PUERTO RICO

En 1997 el Congreso de los Estados Unidos bajo la Ley de Balance Presupuestario, aprobó nuevas opciones para la prestación de servicios de cuidado de la salud a los beneficiarios de Medicare. Dichas opciones se conocen como la parte C de Medicare o *Medicare Plus Choice Plans*. Una de esas opciones lo son los Modelos de Cuidado Coordinado.

No es hasta este año que en Puerto Rico incursiona el primer *Medicare Plus Choice Plan* bajo el nombre de MMM Healthcare, Inc. . CMS (anteriormente conocido como HCFA) aprobó este contrato el 18 de julio de 2001 con fecha de efectividad del 1 de septiembre de 2001 para los pueblos de Adjuntas, Arecibo, Barceloneta, Ciales, Coamo, Florida, Guayanilla, Jayuya, Juana Díaz, Manatí, Morovis, Peñuelas, Ponce, Santa Isabel, Vega Alta, Vega Baja, Villalba, Utuado y Yauco.

A partir de diciembre de 2001 su área de cobertura se extenderá a otros 14 municipios que son: Bayamón, Canóvanas, Carolina, Cataño, Corozal, Dorado, Guaynabo, Loíza, Luquillo, Rio Grande, San Juan, Toa Alta, Toa Baja y Trujillo Alto.

Las personas que deseen afiliarse a este modelo de cuidado coordinado deben poseer las Partes A y B de Medicare, ya sea por edad o por incapacidad (no deben tener fallo renal en etapa terminal) y deben residir en el área de servicio de MMM Healthcare, Inc. Éste tendrá un periodo de inscripción abierto hasta el 31 de diciembre de 2001.

Durante los próximos dos años habrá cambios en las reglas sobre cuándo y cuan frecuentemente puede un beneficiario cambiar de plan, incluyendo el plan original de Medicare. Comenzando el 1 de enero de 2002 hasta el 30 de junio de 2002 los beneficiarios podrán, por una vez solamente, desafiliarse de un plan e ingresar en otro. Después de este periodo, en noviembre de 2002 habrá otra oportunidad para efectuar cambios que serán efectivos el 1 de enero de 2003. En el año 2003 este periodo será durante los meses de enero a marzo. A esto se le conoce como periodos de enlace.

Los interesados en obtener información adicional sobre los periodos de enlace pueden visitar la siguiente

MANAGED CARE PLANS IN PUERTO RICO

In 1997 the Congress of the of the United States, under the Federal Balanced Budget Act of 1997, approved new options for the rendering of health care services to Medicare beneficiaries. The new program that brings those options is known as Medicare Part C or Medicare + Choice. One of these options is the Managed Care Model.

It is not until this year, that the first Medicare + Choice product, a managed care model, enters in Puerto Rico under the name MMM Healthcare, Inc. CMS (formerly HCFA) approved this contract on July 18, 2001 with an effective date of September 1, 2001, for the following towns on the island: Adjuntas, Arecibo, Barceloneta, Ciales, Coamo, Florida, Guayanilla, Jayuya, Juana Díaz, Manatí, Morovis, Peñuelas, Ponce, Santa Isabel, Vega Alta, Vega Baja, Villalba, Utuado and Yauco.

As of December 2001 its coverage area will be expanded through other 14 municipalities: Bayamón, Canóvanas, Carolina, Cataño, Corozal, Dorado, Guaynabo, Loíza, Luquillo, Rio Grande, San Juan, Toa Alta, Toa Baja and Trujillo Alto.

Those Medicare beneficiaries interested in this managed care model must possess Medicare Part A and Part B, elegibility based on age or disability (not as an ESRD benefit) and must reside in MMM Healthcare Inc. service area. There will be an open enrollment period until December 31, 2001.

Over the next two years, the rules for when and how often can a beneficiary switch Medicare health plans, including the original Medicare plan, will change. Starting January 1, 2002 through June 30, 2002 beneficiaries will have the opportunity to leave a Medicare health plan and join another plan once. After this period, in November 2002, they will have another chance to switch plans. The change will be effective January 1, 2003. In 2003, this period will take place from January through March. These periods are called linking periods.

Those persons interested in obtaining additional information regarding linking periods may visit

Relaciones con la Comunidad

dirección en Internet:www.medicare.gov/Publications/Search/View/ViewPubList.asp?Language=English.

Además, para cualquier otra información pueden llamar a los teléfonos 1-866-333-5470 ó al 1-866-333-5469 (TTY) para personas con impedimentos auditivos.

Los pacientes que se acojan a MMM Healthcare Inc., deberán tener un referido de su médico de cabecera participante de la red de esta compañía para poder recibir servicios de médicos especialistas. Si por alguna razón en el área cubierta por la red de proveedores a la que el beneficiario pertenece, no hay contrato firmado para una especialidad dada, MMM Healthcare Inc. hará los arreglos necesarios para proveer dichos servicios y el beneficiario acudirá al médico con el cual se hizo ese arreglo particular. MMM Healthcare Inc. pagará al especialista por los servicios brindados al paciente acogido a su programa.

El plan original de Medicare no pagará por los servicios prestados a pacientes acogidos a MMM Healthcare Inc. que le sean facturados. Los pacientes acogidos a modelos de cuidado coordinado se encuentran identificados en los sistemas de procesamiento del carrier. El procedimiento establece que el plan original de Medicare denegará las facturas por dichos servicios y referirá las reclamaciones denegadas al plan de cuidado coordinado.

Los proveedores de servicios que deseen cotejar la elegibilidad de un beneficiario acogido a MMM Healthcare Inc., pueden llamar a los siguientes teléfonos: 1-866-333-5470 ó al 1-866-333-5469 (TTY) para personas con impedimentos auditivos.

Community Relations

www.medicare.gov/Publications/Search/View/ViewPubList.asp?Language=English.

For any other information, you may call 1-866-333-5470 or 1-866-333-5469 (TTY) for hearing impaired persons.

In order to receive services from specialists, patients that enroll with MMM Healthcare Inc. should have a referral from their network's primary care physician. If for any reason an arrangement with a specific medical specialty does not exist in that geographical area, MMM will do the necessary arrangements to provide the services. The beneficiary will attend to the specialist with whom the special arrangement was made. MMM will pay the specialist for the services rendered to the beneficiary enrolled in the managed care program.

Traditional Medicare will not pay services rendered to patients enrolled in MMM Healthcare Inc. Patients enrolled in managed care models are identified in traditional Medicare processing systems. The procedure establishes that traditional Medicare will deny claims for services rendered to said patients and will refer all denied claims to the managed care plan.

To obtain eligibility information about a MMM Healthcare Inc. beneficiaries, providers may call 1-866-333-5470 or 1-866-333-5469 (TTY) for hearing impaired persons.

GL/11-2001

MEDPARD 2002

Deseamos recordarles que el MEDPARD, el directorio de médicos y suplidores participantes del programa Medicare correspondiente al 2002, se encuentra disponible a través de nuestra página en Internet en la siguiente dirección: **http:\\www.triples-med.org**.

2002 MEDPARD

*We would like to remind you that the 2002 Medicare Directory of Participating Physicians/Suppliers, the MEDPARD, is available in our web site at **http:\\www.triples-med.org**.*

Mensaje especial para los Beneficiarios Medicare de QIPRO
"Quality Improvement Professional Research Organization, Inc."

CÁNCER DE MAMA

El cáncer de mama, mejor conocido como cáncer de seno, es una de las principales causas de muerte entre las mujeres. Es considerado como la primera causa de muerte en mujeres de 35 a 54 años y la segunda causa entre las edades de 55 a 74. En Puerto Rico se estima que una de cada 18 mujeres es diagnosticada con éste en alguna etapa de su vida. Más de la mitad de las muertes por cáncer de seno ocurre en mujeres mayores de 50 años.

Aunque es importante notar que la mayoría de las mujeres con cáncer de seno no tienen factores de riesgo conocidos, se mencionan entre los más importantes los siguientes:

a) Sexo femenino: aunque 1 de cada 100 hombres pueden padecerlo también
b) Edad: a mayor edad, mayor el riesgo
c) Historial personal y/o Historial familiar de cáncer de mama
d) Factor genético
e) Haber tenido el primer hijo después de los 30 años o no haber tenido hijos nunca
f) Primera menstruación o regla antes de los 12 años / Menopausia después de los 55 años
g) Biopsias previas del seno, especialmente si fueron diagnosticadas condiciones precancerosas.
h) Sobrepeso, dieta alta en grasas y consumo de alcohol

Te preguntarás qué podemos hacer ó qué hacemos para disminuir las muertes por esta condición. Este tipo de cáncer suele infiltrar tejidos y órganos vecinos o metastatizar en forma temprana, por ello la importancia de detectarlo oportunamente. Diversos estudios han demostrado que la detección y el diagnóstico temprano pueden hacer la diferencia. Al diagnosticar tempranamente aumentan las alternativas de tratamiento y la efectividad de los mismos y lo más importante reduce o disminuye las muertes.

La detección temprana del cáncer de seno se realiza por tres métodos, los cuales son complementarios. Éstos son: Mamografía, Examen clínico y Auto-examen de los senos.

La mamografía es el método más efectivo para la detección temprana del cáncer de seno, cuando mejor puede responder a tratamientos. Mediante la mamografía se puede detectar el cáncer hasta un promedio de dos años antes de la mujer poder palpar una lesión o masa. También puede localizar cáncer no palpable durante el examen clínico del seno. La mamografía puede detectar un 90% del cáncer de seno en mujeres sin síntomas.

La mamografía de cernimiento ha comprobado que reduce las muertes por cáncer de seno un 63% en mujeres de 40 a 69 años que se someten a examenes clínicos.

La Sociedad Americana del Cáncer y el Colegio Americano de Radiología recomiendan realizar mamografías todos los años a mujeres mayores de 40 años. Además la Sociedad Americana del Cáncer recomienda la realización de un examen clínico del seno antes de las mamografías anuales en mujeres de 40 años o mas. En aquellas mujeres entre las edades de 20 a 39 años se recomienda realizar el examen clínico del seno cada tres años.

No seas parte de las estadísticas de muerte por este cáncer. Consulta con tu médico sobre los beneficios de la detección temprana.

¡Tu Familia y Puerto Rico te Necesitan!

Special Message from "QIPRO "Quality Improvement Professional Research Organization, Inc." for Medicare Beneficiaries

BREAST CANCER

Breast cancer is one of the principal causes of deaths in women. It is considered as the second leading cause of death for women in the United States. In United States 1 in 8 women will develop breast cancer in her lifetime. More than 180,000 women are diagnosed with breast cancer each year.

Even though it is important to note that the majority of women with breast cancer have no known risk factors, we will mention some of the most important:

a) Gender: Being a female is one of the most important risk factors, although 1 on every 100 men could have it.

b) Age: Risk increases as you get older.

c) Personal history of breast cancer/ Family history of breast cancer

d) Genetic factors

e) Women who have their first child late (after about age 30)

f) Women who never had children

g) Menstruation at an early age (before age 12) / Late menopause (after age 55)

h) Previous breast biopsies, especially if precancerous tissue was found.

i) Overweight, high fat diets, alcohol intake

You will be asking what we can do or what we are doing toward the reduction of deaths from this condition. This type of cancer invade tissues and nearby organs, or spread outside the breast early; that is why the importance of early detection. Many studies had demonstrated that early detection and diagnosis could make the difference. When this cancer is detected and diagnosed early, treatment alternatives and their effectiveness are higher, and more important deaths are reduced.

There are three methods for early detection on Breast Cancer, and they are complimentary for each other. These are Mammography, Clinical Breast Exam, and the Breast self-exam.

Mammography is the best method of detecting breast cancer in its earliest, most treatable stage. Through mammography cancer can be detected an average of nearly two years before a woman can feel the lump by Breast self-exam. It also locates cancer that can not be felt during a clinical breast examination. Mammography detects about 90% of breast cancers in women who do not present symptoms.

Screening mammography has been shown to reduce mortality from breast cancer by 63% among women aged 40-69 years who undergo screening.

The American College of Radiology and the American Cancer Society recommend annual mammograms for women older than 40 years. Also the American Cancer Society recommends that women aged 40 and older have an annual clinical breast exam prior to mammography. For women aged 20-39, Clinical Breast Exam is recommended every three years.

Don't be part of the death statistics of this cancer. Talk to your doctor about the benefits of early detection.

Your Family and your Country Need You!

NOTA AL BENEFICIARIO

PRIMAS, DEDUCIBLES Y COASEGUROS DE MEDICARE PARA EL AÑO 2002

SEGURO DE HOSPITAL (PARTE A)

Deducible - $812.00 (los primeros 60 días)

Coaseguros - $203.00 (diarios por los días 61 al 90 (en cada periodo de beneficios)

- $406.00 (diarios por los días 91 al 150)

FACILIDAD DE ENFERMERÍA ESPECIALIZADA (SKILLED NURSING FACILITY)

- 100% por los primeros 20 días de la estadía
- $101.50 diarios por los días 21 al 100 (en cada periodo de beneficios)

SEGURO MÉDICO (PARTE B)

Deducible - $100.00 Anuales

Coaseguro - 20% de la cantidad aprobada por Medicare para algunos servicios, una vez completado el deducible anual

PRIMA MENSUAL DE LA PARTE B:

- $54.00

AB-01-154/CR1906/10-31-01/LV

MESSAGE TO THE BENEFICIARY

PREMIUMS, DEDUCTIBLES, AND COINSURANCES OF MEDICARE FOR 2002

HOSPITAL INSURANCE (PART A)

Deductible - $812.00 (first 60 days)

Co-Insurance- $203.00 (day 61 to 90 each benefit period)

- $406.00 (daily for days 91-150)

SKILLED NURSING FACILITY

- 100% (for the first 20 day of stay)

- $101.50 (each day for days 21 to 100 - each benefit period)

MEDICAL INSURANCE (PART B)

Deducible - $100.00 Annual

Co-Insurance - 20% of the amount approved by Medicare covered services, once the deductible has been completed.

PART B PREMIUM:

$54.00

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