Medicare Informa
División Medicare / Parte B

¡Qué Bueno Que Preguntó!

PREGUNTAS MÁS FRECUENTES SOBRE FACTURACIÓN POR SERVICIO DE AMBULANCIA

¿Cómo voy a facturar el millaje?

Se utilizará el código A0425 más el modificador que identifica el punto de origen y destino del servicio.

¿Cómo se calculará el pago por el servicio de ambulancia?

La nueva metodología de pago fijo por los servicios de ambulancia que comenzó el 1 de abril de 2002 establece que durante el periodo de transición, del 1 de abril de 2002 al 31 de diciembre de 2002, se pagará una tarifa combinada. La tarifa combinada será el 80 porciento del cargo razonable del código de ambulancia y el 20 porciento de la tarifa fija por código de servicio establecida por CMS para estos servicios.

Continua en la página 4

We Are Glad You Asked!

MOST FREQUENTLY ASKED QUESTIONS ON THE BILLING OF AMBULANCE SERVICES

How do we bill for mileage?

You will be using code A0425 and the modifier that identifies the starting point and the final destination of the service.

How will the payment for ambulance service be computed?

On April 1, 2002 the new ambulance fee schedule methodology was implemented and it established that the payment would be a blended charge. The blended fee is computed by taking a percentage of the reasonable charge and a percentage of the fee schedule established by CMS for the service. During the transition period beginning on April 1, 2002 until December 31, 2002 the combined fee will be 80% of the reasonable charge and 20% of the fee schedule per ambulance code.

Continue on page 4

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

Emission Date: June 15, 2002 **Volume 70 / April, May, June 2002**

http://www.cms.hhs.gov
http://www.triples-med.org

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TABLA DE CONTENIDO

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¡Qué Bueno Que Preguntó!

¿Cuál es la tarifa fija por código de servicio de ambulancia?

La tarifa fija por código para los servicios de ambulancia para el periodo del 1 de abril de 2002 al 31 de diciembre de 2002 es:

Código / *Code* A0426 - $163.39

Código / *Code* A0427 - $258.70

Código / *Code* A0428 - $136.16

Código / *Code* A0429 - $217.85

¿Dónde puedo conseguir una tabla de millas entre pueblos para poder facturar el millaje?

Se puede dirigir a:

Autoridad de Carreteras
Oficina de Proyectos
Centro Gubernamental Minillas
Piso 15
Santurce, PR 00907

O a la siguiente dirección de internet: www.DTOP.GOV.PR

We Are Glad You Asked!

What is the fee schedule per ambulance code?

The fee schedule per ambulance code during the transition period of April 1, 2002 until December 31, 2002 is:

Where can we get a mileage chart that establishes the miles between cities and towns?

Or you can go to the following web address: www.DTOP.GOV.PR

PARTE B DE MEDICARE DE LOS RETIRADOS DEL FERROCARRIL

La Junta de Retiro del Ferrocarril de los Estados Unidos, otorgó a *Palmetto Government Benefits Administrators* un contrato para servir como carrier de la parte B del Programa Medicare para los retirados del ferrocarril. Bajo este contrato, Palmetto GBA administra los beneficios de la Parte B de Medicare de los retirados del ferrocarril en toda la nación.

La Junta de Retiro del Ferrocarril administra *Railroad Retirement and Unemployment Insurance Acts*, que cubre a la fuerza laboral del ferrocarril y a sus familias. Losbeneficiarios

RAILROAD MEDICARE PART B

Palmetto Government Benefits Administrator was awarded a contract by the U.S. Railroad Retirement Board to serve as Part B Carrier for Railroad Medicare. Under the contract, Palmetto GBA administers the Part B Medicare benefits for Railroad Medicare beneficiaries nationwide.

The Railroad Retirement Board administers the Railroad Retirement and Unemployment Insurance Acts covering the nation's railroad workforce and their families. Railroad retirement beneficiaries are covered by Medicare on the same basis as social security beneficiaries are; however, the Railroad

¡Qué Bueno Que Preguntó!

del sistema de retiro del ferrocarril están cubiertos por Medicare al igual que lo están los beneficiarios del seguro social; sin embargo, la Junta de Retiro del Ferrocarril inscribe a sus beneficiarios, cobra las primas, y tiene la autoridad de seleccionar al carrier de la parte B. Al ser el carrier nacional del Programa Medicare para los retirados del ferrocarril, Palmetto GBA procesa las facturas por concepto de servicios médicos a los beneficiarios de dicho programa. Para preguntas relacionadas a reclamaciones, pagos y cubierta, puede llamar al teléfono libre de cargo del Centro de Servicio al Cliente: 1-877-288-7600, lunes a viernes de 9:00 a.m. a 5:15 p.m. (EST). El Sistema de Respuesta Automática posee un horario extendido de lunes a viernes de 7:00 a.m. a 9:00 p.m. (EST) para cotejar estatus de reclamaciones.

Si desea escribir a Palmetto GBA con relación a su reclamación al Programa Medicare para los retirados del ferrocarril, puede hacerlo a la siguiente dirección:

Palmetto GBA
Railroad Medicare Part B
P.O. Box 10066
Augusta, GA 30999

Para obtener información general sobre el Programa Medicare para los retirados del ferrocarril puede comunicarse a través de la siguiente dirección electrónica:

http://www.palmettogba.com/palmetto/palmetto.nsf/Contact+Us/Providers+Railroad+Medicare?OpenDocument

Palmetto GBA Web Page

We Are Glad You Asked!

Retirement Board enrolls railroad retirement beneficiaries for Part B medical coverage, collects their premiums, and has the authority to select a Part B carrier.

Railroad Retirement Medicare claims for physician services are processed by Palmetto GBA, the national Medicare Part B carrier for railroad retirement annuitants. For questions about claims, payments, coverage, contact the Railroad Medicare Customer Service Center toll-free at 1-877-288-7600, Monday-Friday, 9 a.m. until 5:15 p.m. (EST). The Automated Response Unit has extended hours for claim status inquiries and is accessible Monday – Friday, 7 a.m. until 9 p.m. (EST).

Should you like to contact Palmetto GBA in writing about your Railroad Medicare claim, send your inquiry to:

You can get your general Railroad Medicare Part B inquiries answered at:

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA MODEL COMPLIANCE EXTENSION PLAN AND INSTRUCTIONS NOW AVAILABLE

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law. It requires, among other things, that the Department of Health and Human Services establish national standards for electronic health care transactions and code sets. October 16, 2002 is the deadline for covered entities such as health plans, clearinghouses and providers (such as physicians, dentists, hospitals, nursing homes and others) to comply with these new standards. However, in December 2001, the Administrative Simplification Compliance Act (ASCA, Public Law 107-105) gave covered entities not compliant by October 16, 2002 the opportunity to extend their compliance deadline by 1 year – to October 16, 2003. This extension opportunity is applicable to all HIPAA covered entities other than small health plans (those with less than $5 million in annual receipts whose compliance date is already set for October 16, 2003). In order to qualify for this extension, covered entities must submit a compliance plan by October 15, 2002.

A model compliance plan and instructions on how to complete and submit it is available at the Centers for Medicare & Medicaid Services (CMS) Web site, www.cms.hhs.gov/hipaa. You can submit this on-line model plan electronically through the Web site or print and mail it. You can submit your own paper version of the plan as long as it provides equivalent information (covered entity and contact information; reasons for filing for the extension; HIPAA implementation budget information; and where you are in implementing and testing including whether or not you plan to use a vendor). The CMS strongly encourages electronic filing but if you must file on paper, you should send your form to Attention: Model Compliance Plans, Centers for Medicare & Medicaid Services (CMS), P.O. Box 8040, Baltimore, MD. 21244-8040. The deadline for both electronic and paper submissions is October 15, 2002.

If you file electronically through the Web site, you will receive an electronic confirmation number acknowledging and granting your extension. If you file a paper version, you won't receive a confirmation, but if your paper plan consists of the required equivalent information, you may consider your extension granted.

The instructions give more details on how to complete the form; explanation of whom should file for an extension; data you need to include; and where to get more information on definitions, frequently asked questions, etc.

For more information, please contact our Community Relations area at 787-749- 4232 or toll free at 1-877-715-1921.

Providers Using Medicare Supplied Billing Software

Triple -S will continue to provide electronic billing software for providers' to submit their Medicare claims. The HIPAA compliant version of this software will be available as of October 1, 2002 from the SES Help Desk at 787-793-5223. Providers who will continue to use the non-HIPAA version Medicare billing software at any time between October 16, 2002 and October 16, 2003 must submit a Compliance Extension Plan as described above.

AB-02-071/CR2168/05-10-02/DG

Health Insurance Portability and Accountability Act (HIPAA)

REVISED TIMELINES FOR HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) REQUIREMENTS

CMS revised the timeline for HIPAA related activities including provider / trading partner testing. The revised testing schedule is as follows:

TRANSACTION	Testing Available From	Testing End Date
Electronic Claim - 837 Professional	4/16/2002	10/16/2003
Electronic Remittance - 835	5/16/2002	10/16/2003
Electronic Claim 837 Coordination of Benefits	6/16/2002	10/16/2003
Claim Status - 276/277	7/16/2002	10/16/2003

Note: The 10/16/2003 date applies to those trading partners approved for delay. For all others the original HIPAA implementation date of 10/16/2002 will apply.

CR#2039/Transmittal AB-02-020/js

MEJORAS A LA REMESA ESTÁNDAR EN PAPEL Y COMPARACIÓN CON LA REMESA EN EL FORMATO X12 DE LA TRANSACCIÓN 835V4010

Como resultado de los esfuerzos para programar la Remesa Estándar en Papel (SPR, por sus siglas en inglés) conforme al formato electrónico X12 835 de HIPAA, esta se mejoró. Estos cambios serán vigentes el 1 de julio de 2002.

Los dos anejos que se incluyen proveen instrucciones para incluir las revisiones al formato e información sobre cómo reconciliar los datos financieros de la Remesa Estándar en Papel. Se provee además, para ayudar en la programación, la relación de los campos de la Remesa Estándar en Papel con los campos del formato X12 de la transacción 835V4010.

Remesa Estándar en Papel y el Formato X12 de la Transacción 835V4010

En el primer anejo proveemos los campos en la Remesa Estándar en Papel y el campo correspondiente en el formato X12 de la transacción 835V4010. Además, incluye algunos campos computados para uso del proveedor/suplidor que no están presente en la remesa electrónica (ERA, por sus siglas en inglés). En la columna de comentarios se proveen aclaraciones e instrucciones para algunos casos especiales.

IMPROVEMENT OF THE STANDARD PAPER REMITTANCE (SPR) ADVICE NOTICES AND SPR-X12 835V4010 CROSSWALK

As a result of efforts to reprogram SPRs to correspond to the X12 835 changes for HIPAA, there are a number of improvements in the SPR format. These changes will become effective on July 1, 2002.

Included are two attachments providing instructions for revisions to the SPR format to incorporate those improvements and information on balancing financial amounts in an SPR. In addition, a crosswalk of the SPR data fields to the 835V4010 data fields is provided to assist with programming.

SPR and X12 835V4010 Crosswalk

The crosswalk (Attachment 1) provides a systematic presentation of SPR data fields and the corresponding fields in an 835V4010. It also includes some computed fields for provider use that are not present in an ERA. The comment column in the crosswalk provides clarification and instruction in some special cases.

Continue on next page

Remittance Field	835V4010 Field	LOOP ID	NSF V 2.01 Field #	COMMENT
CARRIER NAME	N102	1000A	100-07	
CARRIER ADDRESS 1	N301	1000A		
CARRIER ADDRESS 2	N302	1000A		
CARRIER CITY	N401	1000A		
CARRIER STATE	N402	1000A		
CARRIER ZIP	N403	1000A		
PROVIDER NAME	N102	1000B	200-06	
PROVIDER ADDRESS 1	N301	1000B		
PROVIDER ADDRESS 2	N302	1000B		
PROVIDER CITY	N401	1000B		
PROVIDER STATE	N402	1000B		
PROVIDER ZIP	N403	1000B		
PROVIDER #	REF02 when IC IN REF01	1000B	200-07	
DATE (CHECK/EFT ISSUE DATE)	BPR16		200-09	
CHECK/EFT TRACE #	TRN02		200-08	
REMITTANCE #				This is not a required field
BENEFICIARY LAST NAME (PATIENT LAST NAME)	NM103	2100	400-13	
BENEFICIARY FIRST NAME (PATIENT FIRST NAME)	NM104	2100	400-14	
HIC (INSURED IDENTIFICATION #)	NM109	2100	400-07	
ACNT (PATIENT CONTROL #)	CLP01	2100	400-03	Use a single 0 if not received on 837 (CLM01)
ICN (PAYOR CLAIM CONTROL #)	CLP07	2100	400-22	
ASG(ASSIGNMENT)	LX01	2000	500-24	
MOA CODES (CLAIM REMARK CODES)	MOA	2100	400-23 THRU 400-27	
PERF PROVIDER (PERFORMNG PROVIDER IDENTIFICATION)	REF02 when IC IN REF01	2110	450-37	If more than 1 performig provider, insert # of 1st
SERVICE DATE (FROM)	DTM02 when 150 in DTM01	2110	450-07	
SERVICE DATE (THROUGH)	DTM02 when 151 in DTM01	2110	450-08	
POS (PLACE OF SERVICE)	REF02 when LU IN REF01	2110	450-11	
NUM (UNITS OF SERVICE)	SVC05	2110	450-17	
PROC (PROCEDURE CODE - PAID)	SVC01-2	2110	450-13	
MODS (MODIFIERS)	SVC01-3 THRU SVC01-6	2110	450-14 THRU 450-16	aabbccdd in the sample
SUBMITTED PROCEDURE CODE	SVC06-2	2110	451-09	(ppppp) in the sample format
BILLED (SUBMITTED LINE CHARGE)	SVC02	2110	450-18	
ALLOWED (ALLOWED/CONTRACT AMT)	AMT02 when B6 in AMT01	2110	450-21	
DEDUCT (DEDUCTIBLE AMT)	CAS03, 06, 09,12,15, 18 when 1 in CAS 02, 05, 08, 11, 14 or 17	2110	450-22	

Remittance Field	835V4010 Field	LOOP ID	NSF V 2.01 Field #	COMMENT
COINS (COINSURANCE AMT)	CAS03, 06, 09,12,15, 18 when 2 in CAS 02, 05, 08, 11, 14 or 17	2110	450-23	
PROV PD (CALCULATED PMT TO PROVIDER)	SVC03	2110	450-28	
RC (GROUP AND REASON CODES)	CAS01+ CAS02 05/08/11/14/17	2110	450-38 THRU 450-44	
RC-AMT (REASON CODE AMTS)	CAS03, 06, 09,12,15, 18 when no 1 or 2 in CAS 02, 05, 08, 11, 14 or 17	2110	451-10 THRU 451-14	
REM (LINE REMARK CODES)	LQ02	2110	451-16 THRU 451-20	
PT RESP (PATIENT RESPONSIBILITY)	CLP05	2100	500-23	
BILLED (SUBMITTED CLAIM LEVEL CHARGES)	CLP03	2100	500-05	
ALLOWED (ALLOWED/CONTRACT AMT-CLAIM LEVEL)		2100	500-08	
DEDUCT (DEDUCTIBLE AMT-CLAIM LEVEL))		2100	500-09	
COINS (COINSURANCE AMT-CLAIM LEVEL)		2100	500-10	
TOTAL RC AMOUNT				Computed. Excludes Interset, Late Filing Charges, Deductible, Coinsurance and Prev. Pd.
PROV PD (CALCULATED PMT TO PROVIDER - CLAIM LEVEL)	CLP04	2100	500-15	
NET (ACTUAL PMT TO PROVIDER FOR CLAIM)		2100	500-19	This is a computed field including Interest, Late Filing Charge and Prev. Pd.
PREVIOUSLY PAID			500-17 THRU 500-18	
INT (INTEREST PAID)	AMT02 when I in AMT01	2100	500-11	
LATE FILING CHARGE	AMT02 WHEN KH IN AMT01	2110	451-07	
INSURER TO WHOM CLAIM IS FORWARDED	NM103 when TT in NM101& 2 in NM102	2100	500-25	CRSSOVER CARRIER NAME
# OF CLAIMS			800-06	
TOAL BILLED AMT(BT SUBMITTED CHARGES)			800-08	
TOTAL ALLOWED AMT			800-11	
TOTAL DEDUCT AMT			800-12	
TOTAL COINS AMT			800-13	

Remittance Field	835V4010 Field	LOOP ID	NSF V 2.01 Field #	COMMENT
TOTAL RC AMOUNT				Sum of all RC adjustments. Excludes interest, late filing charge, deductible, coinsurance, and prev. pd.
PROV PD AMT			800-18	
PROVIDER ADJ AMT			COMPUTED	
CHECK AMT	BPR02		800-22	
PROVIDER LEVEL ADJUSTMENT REASON CODE	50 OR AP OR B2 OR CS OR FB OR IR OR J1 OR L6 OR LE OR SL OR WO IN PLB03 1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB13-1		700-06	This and the next three lines explain the provider level adjustments.
FCN OR ADJ REASON (FINANCIAL CONROL #/PROV ADJ REASON)	PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, PLB13-2. POSITION 3-19		700-08	
HIC	PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, PLB13-2 POSITION 20-30		700-04	
PROVIDER LEVEL ADJUSTMENT AMOUNT	PLB04, PLB06, PLB 08, PLB10, PLB12, PLB14 WHEN 50 OR AP OR B2 OR CS OR FB OR IR OR J1 OR L6 OR LE OR SL OR WO IN PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB13-1		700-07	Includes Interest, Late Filing Charge, Previously Paid and other adjustments as applicable

Ejemplo del Formato de la Remesa de Pago

El segundo anejo incluye el formato revisado de la Remesa Estándar en Papel. Esta muestra provee un ejemplo del formato en general pero la Remesa Estándar en Papel real podría comprender mayor (o menor) número de líneas. A continuación los cambios en el formato incluídos en esta revisión:

1. Los campos de "Cantidad Pagada al Beneficiario" y "Cantidad de Pago MSP" utilizados para computar el pago al proveedor, serán informados ahora como Códigos de Razón de Ajustes.

Sample SPR Format

Attachment 2 contains the revised format for the SPR. This sample provides an example of the general format but the actual SPR may contain additional (or fewer) lines. The following format changes are included in this revision:

1. *"Amount paid to beneficiary," and "MSP amount" fields used to compute provider payment will now be reported as reason code adjustments, rather than in separate fields.*

2. Habrá un nuevo campo en el nivel de reclamación para informar las reducciones por someter tardíamente la reclamación.
3. Habrá además, un espacio para proveer el código HCPCS sometido y el código HCPCS pagado en cada línea de servicio.
4. El campo de "Total Offset" ahora se llamará "Provider Adj.".
5. Se eliminaron los campos de "Total Pagado al Beneficiario" y "Total de Otros Ajustes" en el nivel de proveedor.

2. *There is a new claim level field for the informational reporting of late filing reductions.*
3. *There is also space to provide the submitted HCPCS code and the paid HCPCS code at each service line.*
4. *The " Total Offset " field has been renamed as "Provider Adj."*
5. *The " total paid to beneficiary," and "total other adjustments" fields have been deleted at the provider level.*

ATTACHMENT 2

CARRIER NAME
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP
(9099) 111-2222

MEDICARE
REMITTANCE
NOTICE

PROVIDER NAME
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP

PROVIDER #: 1234567890
PAGE #: 1 OF 999
CHECK/EFT #: 123456789012345678 90
REMITTANCE # 123456789012345678 90 (NOT A REQUIRED FIELD)

```
*LINE 1                                                                                                                *
*LINE 2                                                                                                                *
*LINE 3                                                                                                                *
*LINE 4                                                                                                                *
*LINE 5                                                                                                                *
*LINE 6                                                                                                                *
*LINE 7                                                                                                                *
*LINE 8                                                                                                                *
*LINE 9                                                                                                                *
*LINE 10                                                                                                               *
*LINE 11                                                                                                               *
*LINE 12                                                                                                               *
*LINE 13                                                                                                               *
*LINE 14                                                                                                               *
*LINE 15                                                                                                               *
```

PERF PROV SERVDATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD

NAME LLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 123456789012345678 90 ICN 123456789012345 ASG X MOA 11111 22222 33333 44444 55555

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) RBM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) RBM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) RBM: RRRRR RRRRR RRRRR RRRRR RRRRR

PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12

ADJ TO TOTALS: PREV PD 1234567.12 INTEREST 1234567.12 LATE FILING CHARGE 1234567.12 NET 1234567.12

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXX

Health Insurance Portability and Accountability Act (HIPAA)

CARRIER NAME YYYYMMDD (999) 111-2222
MEDICARE
PROVIDER #: 1234567890 PROVIDER NAME
REMITTANCE
CHECK/EFT #:12345678901234567890 PAGE#: 999 OF 999 NOTICE
REMITTANCE# 12345678901234567890 (NOT A REQUIRED FIELD)

PERF PROV SERVDATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS RC-AMT PROV PD

NAME LLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222
33333 44444 55555

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12
1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12
1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR

PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12
1234567.12

ADJ TO TOTALS: PREV PD 1234567.12 INTEREST 1234567.12 LATE FILING CHARGE 1234567.12 NET 1234567.12

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXX

TOTALS: # OF CLAIMS BILLED AMT ALLOWED AMT DEDUCT AMT COINS AMT TOTAL AMT PROV PD RC-AMT PROV AMT PROV ADJ AMT CHECK AMT
99999 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12

PROVIDER ADJ DETAILS: PLB REASON CODE FCN HIC AMOUNT
1111 12345678901234567 123456789012 1234567.12
2222 12345678901234567 123456789012 1234567.12
3333 12345678901234567 123456789012
1234567.12
4444 12345678901234567 123456789012
1234567.12
5555 12345678901234567 123456789012
1234567.12

GLOSSARY: GROUP, REASON, MOA, REMARK AND REASON CODES

XX TTT.....
XXX TTT.....
MXX TTT.....
XX TTT.....

Health Insurance Portability and Accountability Act (HIPAA)

```
CARRIER NAME                                  YYYY/MM/DD                      (999) 111-2222
        MEDICARE
PROVIDER #: 1234567890                                                        PROVIDER NAME
        REMITTANCE
CHECK/EFT #:12345678901234567890                                              PAGE#: 999 OF 999            NOTICE
REMITTANCE# 12345678901234567890 (NOT A REQUIRED FIELD)

                              SUMMARY OF NON-ASSIGNED CLAIMS

PERF PROV SERVDATE     POS NOS PROC  MODS       BILLED   ALLOWED   DEDUCT    COINS      GRP/RC-AMT       PROV PD
----------------------------------------------------------------------------------------------------------------
NAME LLLLLLLLLLLL, FFFFFFFF  HIC 123456789012  ACNT 12345678901234567890  ICN 123456789012345  ASG X   MOA 11111 22222
                                                                                                33333 44444 55555

1234567890 MMDD MMDDYY  12 123  PPPPP aabbccdd   1234567.12 1234567.12 1234567.12 1234567.12  GPRRR 1234567.12
1234567.12
                               (PPPPP)    REM:     RRRRR      RRRRR      RRRRR      RRRRR      RRRRR
1234567890 MMDD MMDDYY  12 123  PPPPP aabbccdd   1234567.12 1234567.12 1234567.12 1234567.12  GPRRR 1234567.12
1234567.12
                               (PPPPP)    REM:     RRRRR      RRRRR      RRRRR      RRRRR      RRRRR
1234567890 MMDD MMDDYY  12 123  PPPPP aabbccdd   1234567.12 1234567.12 1234567.12 1234567.12  GPRRR 1234567.12  1234567.12
                               (PPPPP)    REM:     RRRRR      RRRRR      RRRRR      RRRRR      RRRRR

PT RESP 1234567.12                   CLAIM TOTAL    1234567.12 1234567.12 1234567.12 1234567.12  1234567.12     1234567.12

CLAIM INFORATION FORWARDED TO:  XXXXXXXXXXXXXXXXXXXXXXXX
```

Reconciliación de la remesa de pago

Como en la transacción 835, las cantidades indicadas en una remesa en papel deben estar reconciliadas en los niveles de transacción, reclamación y línea de servicio, utilizando las siguientes fórmulas:

- **Reconciliación de la línea de servicio:**

  Cargo de línea de servicio sometido – la suma de las cantidades RC del servicio = *Prov Pd* (pago calculado al proveedor/ suplidor)

- **Reconciliación de la reclamación:**

  Billed (cargo sometido en el nivel de la reclamación) – la suma de todas las cantidades RC del nivel de servicio = Prov Pd (pago calculado al proveedor y/o suplidor en el nivel de la reclamación)

- **Reconciliación de la transacción:**

  Sumar todas las cantidades pagadas al proveedor/suplidor (Prov. Pd) en los segmentos de la reclamación – Ajustes totales al proveedor y/o suplidor = Cantidad del cheque

SPR Balancing

As with an 835, the amounts reported in a paper remittance advice must balance at the transaction, the claim and the service line levels, following these formulas:

- ***Service line balancing**:*

  Submitted line charge – Sum of service level RC amounts = Prov Pd (Calculated pmt to provider)

- ***Claim level balancing:***

  Billed (submitted claim level charge) – Sum of all service level RC amounts = Prov Pd (calculated pmt to provider at the claim level)

- ***Transaction level balancing:***

  Sum of all Prov. Pd amounts in the claim segments – Total provider adj. = Amount of check

Requisitos generales para una remesa de pago completa

Las reglas de la transacción 835 para completar los campos y para llevar a cabo cálculos también aplican a los campos correspondientes en la Remesa Estándar en Papel.

- Cualquier ajuste que aplique al cargo sometido, o que aplique a las unidades o ambas situaciones deben informarse en la reclamación o en los segmentos de ajuste de servicio con el grupo, razón y código de comentario correspondiente con la explicación. Todo ajuste en el nivel de proveedor/suplidor debe informarse en la sección de ajustes del nivel de proveedor/suplidor de la remesa de pago.
- El cómputo del campo "Net" debe incluir "Prov Pd" (Cálculo de pago al proveedor/ suplidor, en la transacción 835 es CLP04) e interes, cargos por atrasos y pagos previos.
- Indicar en la Remesa Estándar en Papel sólo el nombre de la primera compañía a la que se transfiere la reclamación por "crossover" aun cuando la información sobre coordinación de beneficios (COB) sea enviada a más de una compañía.
- La cantidad del cheque es la suma de todos los pagos en las reclamaciones menos cualquier ajuste al proveedor/ suplidor.
- Cantidades positivas de ajuste reducen la cantidad del pago y cantidades negativas de ajuste lo aumentan.
- No se generará una Remesa Estándar en Papel para una reclamación cancelada. Se generará una remesa en papel para reclamaciones ajustadas que han sido pagadas previamente apareciendo la cantidad pagada en la reclamación cancelada.

General SPR Completion Requirements

Field completion and calculation rules in the 835 also apply to the corresponding fields in the SPR, including the following:

- *Any adjustment applied to the submitted charge and/or units must be reported in the claim and/or service adjustment segments with the appropriate group, reason and remark codes explaining the adjustments. Every provider level adjustment must likewise be reported in the provider level adjustment section of the SPR.*
- *The computed field "Net" must include "Prov Pd "(Calculated Pmt to Provider, CLP04 in the 835) and interest, late filing charges and previously paid.*
- *Report the first crossover carrier name on the SPR, even if COB information is sent to more than one payer.*
- *The amount of the check is the sum of all claim level payments less any provider level adjustments.*
- *Positive adjustment amounts reduce the amount of the payment and negative adjustment amounts increase it.*
- *An SPR for a voided claim will not be issued. Issue SPR for the adjusted claim with "Previously Paid" showing the amount paid for the voided claim.*

B-01-76/CR1953/12-11-01/IC

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT (ASCA)

Preguntas Más Frecuentes

P1: ¿Qué es una entidad cubierta?

R1: Para propósitos de HIPAA, son aquellas personas o entidades sujetas a los requisitos de cumplimiento que la ley establece. Esta categoría la componen, entre otros, 1) los planes de salud, 2) los *healthcare clearinghouses* y 3) los proveedores de servicios de salud que transmiten información de salud electrónicamente.

P2: ¿Qué es un *healthcare clearinghouse*?

R2: Bajo la reglamentación de *Administrative Simplification*, es una entidad pública o privada que procesa o facilita el intercambio y procesamiento de elementos de información no estandarizados de información de salud a elementos estandarizados. Un *healthcare clearinghouse* puede ser también un socio de negocio, aplicándole los requisitos establecidos por HIPAA. Por ejemplo, las compañías facturadoras o las compañías que procesan reclamaciones pueden ser consideradas *healthcare clearinghouses*.

P3: ¿Qué es un socio de negocio?

R3: Persona o entidad a la que, por necesidades administrativas o de negocio, se le autoriza a recibir, manejar o crear información de salud protegida. En el contexto de HIPAA, es toda aquella entidad (contratista independiente) que efectúa una función o actividad en beneficio o en nombre de una entidad cubierta que requiere el uso o divulgación de información demográfica o de salud que permite identificar a un individuo en particular.

P4: ¿Qué es información de salud protegida?

R4: Es toda aquella información que identifica a un individuo en específico y que se transmite por cualquier medio de comunicación electrónica; se mantiene en cualquier medio de comunicación electrónica según HIPAA los define; se transmite o mantiene en cualquier otro medio.

HIPAA ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT (ASCA)

Frequently Asked Questions

Q1: *What is a covered entity?*

A1: *A covered entity is one of the following; 1) health plan, 2) healthcare clearinghouse, 3) healthcare provider who transmits any health information in electronic form.*

Q2: *What is a healthcare clearinghouse?*

A2: *A healthcare clearinghouse is a public or private entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction. For example, billing agencies or companies that process claims could be considered healthcare clearing houses.*

Q3: *What is a business partner?*

A3: *A business partner with respect to a covered entity, is a person to whom the covered entity discloses protected health information so that person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the covered entity. This includes contractors or other persons who receive protected health information from the covered entity (or from another business partner of the covered entity) for the purposes described in the previous sentence, including lawyers, auditors, consultants, third-party administrators, healthcare clearinghouses, data processing firms, billing firms, and other covered entities. This excludes persons who are within the covered entity's workforce.*

Q4: *What is protected health information?*

A4: *Protected health information is an individually identifiable health information that is or has been electronically transmitted or electronically maintained by a covered entity and includes such information in any other form.*

Health Insurance Portability and Accountability Act (HIPAA)

P5: A finales de 2001, el Congreso aprobó una extensión de un año para el estándar de Códigos y Transacciones ¿Qué impacto tendrá ésta extensión?

R5: La extensión proveerá a las entidades cubiertas más tiempo para llevar a cabo las alteraciones en sus sistemas de información, realizar pruebas e implantar los cambios requeridos por la Reglamentación de Códigos y Transacciones necesarios para HIPAA.

P6: ¿Pueden los planes de salud pequeños solicitar la extensión a su fecha límite para cumplir con el estándar de Códigos y Transacciones?

R6: No. La fecha de cumplimiento para los planes de salud pequeños es el 16 de octubre de 2004.

P7: ¿La fecha límite para cumplir con los requisitos de Privacidad de HIPAA se ve afectada por la extensión otorgada?

R7: No. La fecha de cumplimiento del estándar de Privacidad es abril de 2003 o abril de 2004 para los planes de salud pequeños.

P8: ¿Todas las entidades cubiertas obtienen la extensión automáticamente?

R8: No. Aquella entidad cubierta que desee acogerse al beneficio de la extensión del año debe solicitarla al Departamento de Salud Federal (HHS por sus siglas en inglés) antes del 16 de octubre de 2002.

P9: ¿Tiene el Departamento de Salud Federal la responsabilidad de revisar y aprobar el plan de cumplimiento previo a la otorgación de la extensión?

R9: La ley no requiere que el Departamento de Salud Federal apruebe o rechace el plan de trabajo. El simple hecho de solicitar la extensión y someter el plan de trabajo es suficiente para obtener la extensión del año.

P10: ¿Dónde puedo obtener una copia del formulario modelo? ¿Tengo que utilizar el formulario modelo o puedo usar otro formato?

R10: El formulario modelo para solicitar la extensión y las instrucciones de como completar el mismo están disponibles en la página de Internet de los *Centers for Medicare & Medicaid Services (CMS)*, www.cms.hhs.gov/hipaa. Aunque la solicitud de extensión y el plan de trabajo pueden enviarse en un formato distinto al publicado, se recomienda el uso del formulario modelo.

Q5: *What will be the impact of the one-year compliance extension?*

A5: *The delay will give covered entities more time to build, test, and successfully implement the new Final Electronic Transactions and Code Sets required by HIPAA.*

Q6: *Can small health plans apply for the October, 2003 extension?*

A6: *No. The compliance date for small health plans does not change.*

Q7: *Does the extension affect the compliance date for the HIPAA privacy standards?*

A7: *No. The compliance date for the privacy standards is still April 2003, or for small health plans, April 2004.*

Q8: *Do all covered entities automatically get an extension?*

A8: *No. Covered entities must submit a compliance extension plan to the Department of Health and Human Services (HHS) before October 16, 2002 to get an extension.*

Q9: *Is HHS going to actually review and approve all these compliance extension plans? Will some be denied?*

A9: *The law does not require approval or disapproval of plans. Submission of an extension plan is sufficient to secure the one-year extension.*

Q10: *Where can I get a copy of the compliance extension form? Do I have to use the form, or can I submit a compliance plan in another format?*

A10: *A model compliance plan and instructions on how to complete and submit it is available in the Centers for Medicare & Medicaid Services (CMS) Website, www.cms.hhs.gov/hipaa. The compliance extension form developed by CMS is a model. While CMS strongly recommend its use, covered entities may submit compliance plans using other formats.*

P11: ¿Cuán extenso debe ser el modelo a utilizarse para solicitar la extensión?

R11: Si usted decide utilizar su propio formato para solicitar la extensión, el mismo debe incluir la siguiente información: 1) presupuesto del proyecto, itinerario de trabajo (*schedule*), plan de trabajo, estrategia de implantación para garantizar su cumplimiento; 2) contratistas o *vendors* a utilizarse durante el proyecto; 3) evaluación de los problemas; 4) itinerario para iniciar pruebas, las cuales deben comenzar no más tarde del 16 de abril de 2003.

P12: El plan de trabajo de mi organización es bastante extenso y voluminoso, ¿debo enviarlo todo?

R12: No. El formulario modelo para solicitar la extensión sólo requiere que se incluya un resumen del plan de trabajo.

P13: ¿Puedo enviar la solicitud de extensión electrónicamente?

R13: Si. El Departamento de Salud Federal prefiere que la solicitud de extensión se envíe electrónicamente. Sin embargo, aquellas entidades que así lo deseen, pueden enviarla en papel.

P14: ¿Cuál es la fecha límite para solicitar la extensión?

R14: Toda entidad cubierta que desee acogerse a la extensión debe solicitar la misma no más tarde del 15 de octubre de 2002.

P15: ¿Dónde debo enviar la solicitud de extensión cuando este completa?

R15: La solicitud de extensión debe enviarse a *Attention: Model Compliance Plans, Centers for Medicare & Medicaid Services (CMS), P.O. Box 8040, Baltimore, MD 21244-8040.*

P16: ¿Cómo una entidad cubierta puede saber si aquellos con los que hace negocio han solicitado la extensión?

R16: Cada entidad cubierta tiene la responsabilidad de comunicarse con sus socios de negocio para indagar si han solicitado la extensión. Esta información debe ser incluida como parte del itinerario de prueba que debe comenzar no más tarde del 16 de abril de 2003.

Q11: *How extensive is the model compliance extension form?*

A11: *The model compliance extension form is simple and easy to complete. ASCA requires the compliance plan to have summary information regarding compliance activities, including: 1) budget, schedule, work plan and implementation strategy for achieving compliance; 2) planned use of contractors or vendors; 3) assessment of compliance problems; and 4) a timeframe for testing to begin no later than April 16, 2003.*

Q12: *My organization has a very detailed, voluminous compliance plan - are we supposed to submit the whole thing?*

A12: *No. The compliance extension form only asks for summary information from your detailed plan. You do not need to send other information.*

Q13: *Can I file the compliance extension form electronically?*

A13: *Yes. We encourage electronic filing of compliance extension plans although, we will also accept compliance plans submitted on paper.*

Q14: *When is the application deadline for the compliance extension?*

A14: *Covered entities must submit their compliance extension plan by October 15, 2002.*

Q15: *Where should I send my completed compliance extension form?*

A15: The completed compliance extension form should be sent to Attention: Model Compliance Plans, Centers for Medicare & Medicaid Services (CMS), P.O. Box 8040, Baltimore, MD 21244-8040.

Q16: *How will one covered entity know whether another covered entity with which it does business has submitted a compliance plan?*

A16: *Each covered entity should communicate directly with its own trading partners to determine which ones have submitted compliance plans. This information could be included in establishing schedules for the testing activities that are to begin by April 16, 2003, culminating in a migration to the new standards that meets the needs of all trading partners.*

P17: Entiendo que yo cumpliré con los requisitos de la Ley para octubre de 2002. Sin embargo, sé que algunos de mis socios de negocio no estarán listos para esa fecha. ¿Debo solicitar la extensión de manera que pueda utilizar formatos no estándares para comunicarme con mis socios de negocios?

R17: No. Una entidad cubierta se considerará en cumplimiento una vez pueda recibir y transmitir información en los formatos estándares. Por lo que no tendrá que enviar la solicitud de extensión.

P18: ¿Puede una entidad cubierta requerir que sus proveedores de servicio utilicen las transacciones estándares antes del 16 de octubre de 2003?

R18: Esta es una decisión de negocios entre la entidad cubierta y sus proveedores de servicios. HIPAA o la *Administrative Simplification Compliance Act* (ASCA por sus siglas en inglés) no impide que los planes requieran a sus proveedores el uso de las transacciones estándares antes de la fecha límite. Sin embargo, las penalidades que establece la Ley no podrán aplicarse hasta el 2003.

P19: ¿Qué harán con la información que yo proveo?

R19: ASCA requiere que se tome una muestra de los planes de trabajo sometidos y se provean al *National Committee on Vital and Health Statistics* (NCVHS por sus siglas en inglés), comité que provee asesoramiento al Secretario de Salud Federal. El NCVHS tendrá la responsabilidad de evaluar la muestra seleccionada para identificar problemas comunes que afecten el cumplimiento con los estándares y periódicamente publicará recomendaciones para solucionar dichos problemas.

P20: La información provista por mi ¿podrá hacerse pública?

R20: Bajo el *Freedom of Information Act* el Gobierno Federal podrá proveer al público toda información que posea excepto aquella que este exenta por ley. El formulario modelo ha sido diseñado de manera que la información provista no sea información exenta.

Q17: *I believe I will be fully compliant by October 2002. However, I know that some of my trading partners are requesting extensions and will continue to use nonstandard formats after that date. Do I need to submit a compliance extension plan so that I can continue to communicate with these partners using nonstandard transactions?*

A17: *No. A covered entity will be considered compliant if it can send and receive compliant transactions, and therefore does not need to submit a compliance extension plan.*

Q18: *Can a plan require its network providers to move to standard transactions before October 16, 2003?*

A18: *This is a business decision between the plan and its provider network. Neither HIPAA nor ASCA preclude plans from requiring that their providers use standard transactions in advance of the compliance deadline, but HIPAA non-compliance penalties will not apply to a provider that has submitted a compliance plan until 2003.*

Q19: *What will be done with the information I provide?*

A19*: ASCA requires that a sample of the compliance plans will be provided to the National Committee on Vital and Health Statistics (NCVHS), an advisory committee to the Secretary of Health and Human Services. The NCVHS will review the sample to identify common problems that are complicating compliance activities, and will periodically publish recommendations for solving the problems.*

Q20: *Will the information I provide be made public?*

A20*: Under the Freedom of Information Act (FOIA), information held by the federal government is available to the public on request, unless it falls within one of several exemptions. The model compliance extension form was designed to avoid collection of any information that would be subject to exemption, such as confidential personal or proprietary information. If such information is submitted, both FOIA and ASCA require that it be edited before the files are released either to the NCVHS or to the public.*

P21: ¿De qué forma la extensión afecta las actividades de implantación de Medicare?

R21: La extensión no afectará las actividades de implantación ya que Medicare continuará con la implementación de las transacciones electrónicas de forma escalonada. Una vez el proveedor realice pruebas de las transacciones y obtenga resultados exitosos, podrá comenzar a utilizar las mismas en el ambiente de producción.

P22: ¿Tiene un vendedor de programas de facturación que solicitar la extensión?

R22: No. Sólo las entidades cubiertas, planes de salud, *clearinghouses* y proveedores deben solicitar la extensión.

P23: ¿Deben las entidades cubiertas detener sus pruebas hasta el 2003?

R23: Recomendamos que toda entidad cubierta comience a realizar pruebas tan pronto estén listos. De esta forma tendrán tiempo para corregir cualquier situación que pudiese surgir.

P24: ASCA otorga autoridad al Secretario de Salud Federal para excluir entidades cubiertas del Programa Medicare si éstas no envían la solicitud de extensión o no cumplen con la fecha de implantación de octubre de 2002. ¿Serán excluidas aquellas entidades que no cumplan?

R24: El Departamento de Salud Federal publicará la reglamentación propuesta para manejar esta nueva excepción.

CMS/HIPAA website/5-20-02/RG/ELS

Q21: *How does the delay affect Medicare implementation activities?*

A21: Medicare will continue to implement the HIPAA transaction standards on a sequenced basis. Once a provider has successfully tested a transaction with us, it will be able to use the standard in our production environment.

Q22: *Do software vendors need to file for a compliance extension?*

A22: *No. Only covered entities - plans, clearinghouses and providers - must file. In fact, vendors will need to maintain their current delivery schedules for compliant software in order for covered entities to make use of the additional implementation time.*

Q23: *Should covered entities discontinue testing until 2003?*

A23: We recommend that all covered entities begin to test as soon as they are ready in order to allow adequate time to address and correct problems.

Q24: *ASCA allows the Secretary of HHS to exclude covered entities from the Medicare program if they do not submit a compliance extension plan or achieve compliance by October, 2002. Will every covered entity be excluded?*

A24: *HHS will be publishing proposed regulations to address this new exclusion authority.*

Health Insurance Portability and Accountability Act (HIPAA)

PROGRAMA DE FACTURACIÓN LIBRE DE COSTO

Desde finales de la década de 1980 CMS le exige a los contratistas de Medicare que ofrezcan a los proveedores un programa de facturación electrónica libre de costo o por un costo nominal de un máximo de $25.00 anuales. Hasta el momento hemos cumplido con este requisito ofreciendo el programa de facturación electrónica Medifast.

Medifast genera reclamaciones electrónicas en el formato National Standard Format (NSF). La implementación de HIPAA en octubre del 2002 traerá grandes cambios en los procesos de facturación electrónica. HIPAA establece como requisito el formato X12 para transacciones electrónicas cubiertas por la ley. Entre las transacciones incluidas se encuentran la reclamación y explicacion de pago electrónica.

En lugar de modificar Medifast ofreceremos a un costo nominal de $25.00 anuales un programa de facturación electrónica que cumple con los requisitos de HIPAA. El programa que ofreceremos será SES Profesional. SES Profesional es un programa de facturación electrónica desarrollado por Interactive Systems. La próxima versión de SES Profesional cumplirá con los requisitos de HIPAA y además tendrá la capacidad de generar reclamaciones Medicare. Esta versión del programa estará disponible a partir del 1 de octubre de 2002.

CMS eliminará el requisito de ofrecer un programa de facturación electrónica libre de costo el 1 de octubre de 2003. Luego de esta fecha los proveedores de Medicare podrá utilizar cualquier programa de facturación electrónica del mercado que cumpla con los requisitos de HIPAA.

FREE BILLING SOFTWARE

Since the late 1980s CMS has required Medicare contractors to offer free billing software to our Providers upon request. Until now we have been complying with this requirement by offering Medifast as our free billing software.

The latest Medifast version creates Medicare electronic claims using the National Standard Format (NSF). HIPAA implementation on October 2002 will bring significant changes to the electronic billing process. HIPAA establishes that every covered transaction must be in the X12 format. Covered transactions include the electronic claim and remittance advice.

Instead of making changes to Medifast we will offer a HIPAA compliant software for the nominal fee of $25.00 per year. Our HIPAA compliant electronic billing software will be SES Professional. SES Professional is an electronic billing system developed and serviced by Interactive Systems Inc. The next SES Professional release will comply with HIPAA requirements and will be capable of creating Medicare claims. This program will be available on October 1, 2002.

By October 2003 CMS will no longer require contractors to offer free billing software. After October 2003 Medicare providers will have the option of using the HIPAA compliant electronic billing software of their preference among the ones available on the market.

Ref. HIPAA/May 24, 2002/JS

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

IMPORTANT REMINDER FROM THE CARRIER MEDICAL DIRECTOR

Education

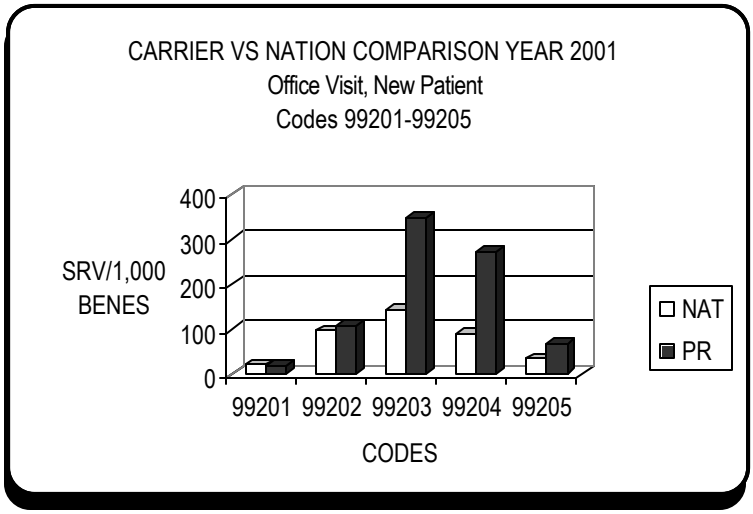
Encyclopedia Britanica relates that "analytical philosophers would say that the philosophy of education should end with the attempt to clarify and justify educational statements".

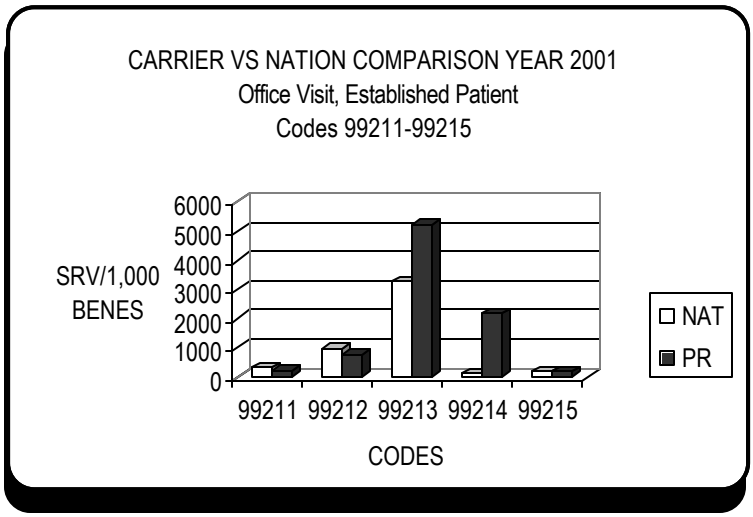
In practice the field includes repetition of concepts to anchor in our neurological system, notions, ideas and governing rules on a specific subject.

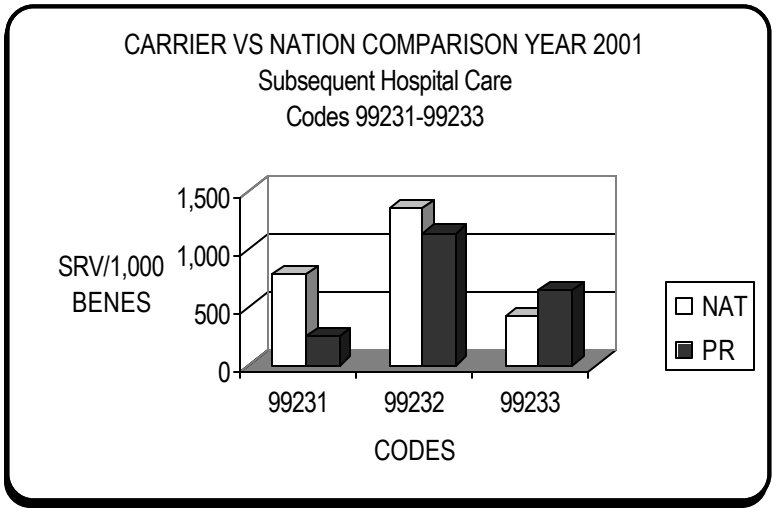
In spite of repeated articles and conferences addressing Evaluation and Management (E & M) rules, we have noticed the persistence of overbilling for the highest levels of these codes. Aberrancies in our area (PR) were over the normal when compared with the Nation.

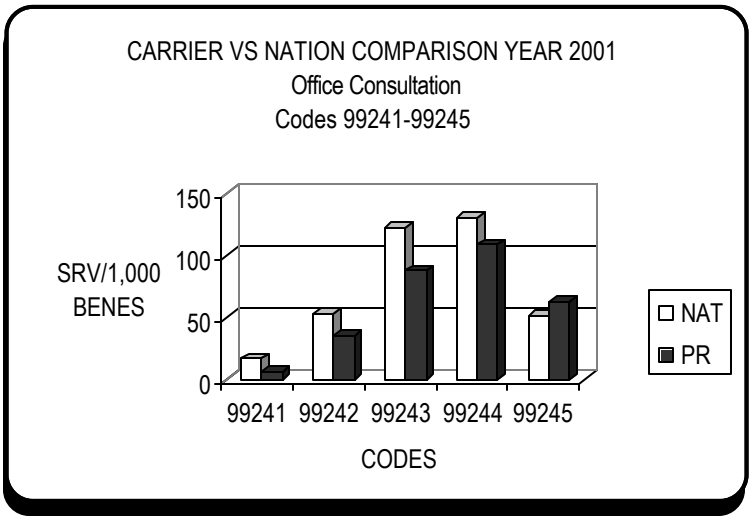
Statistics

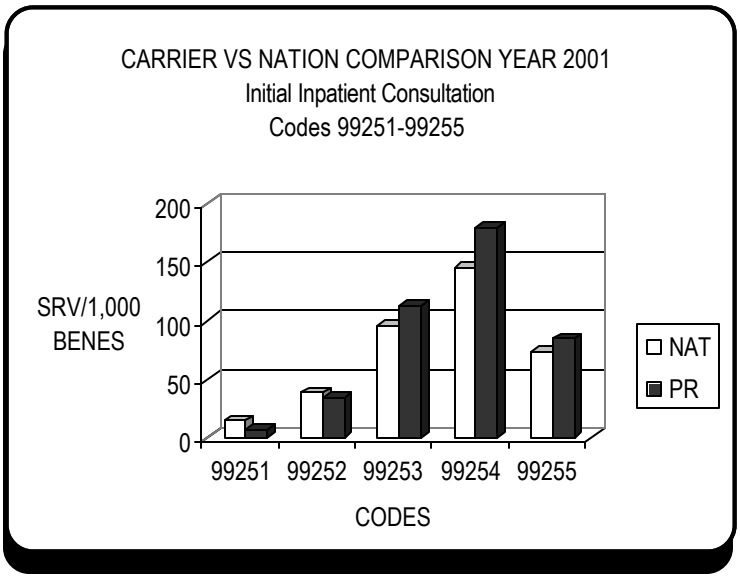
The following are relation of aberrancies and the codes involved:

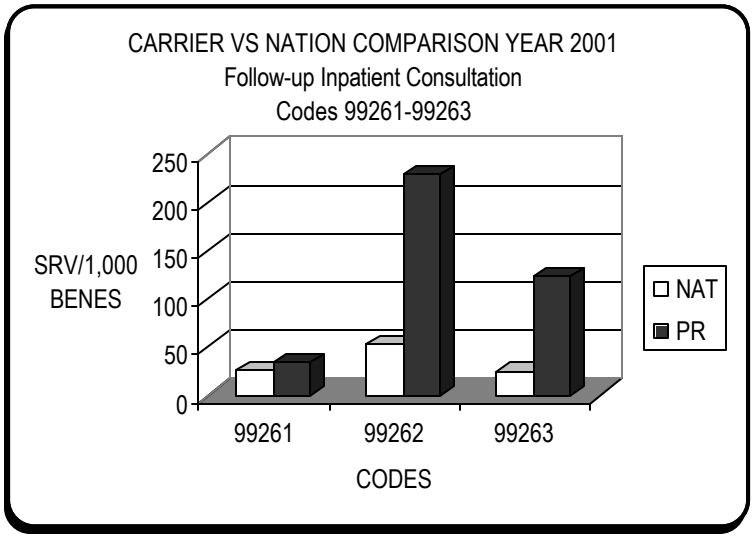


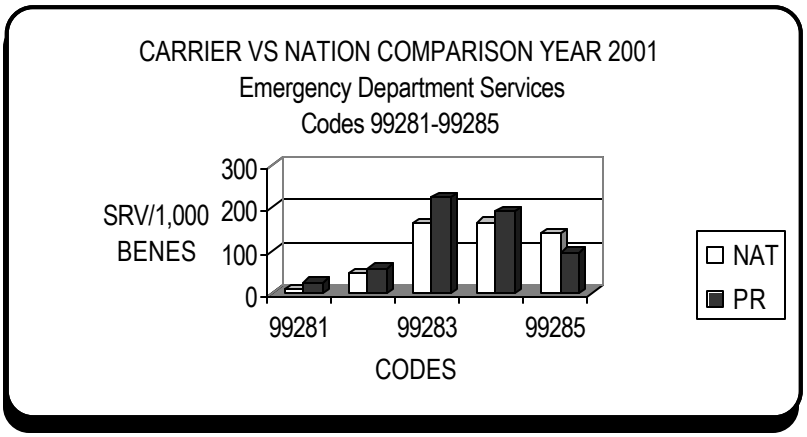


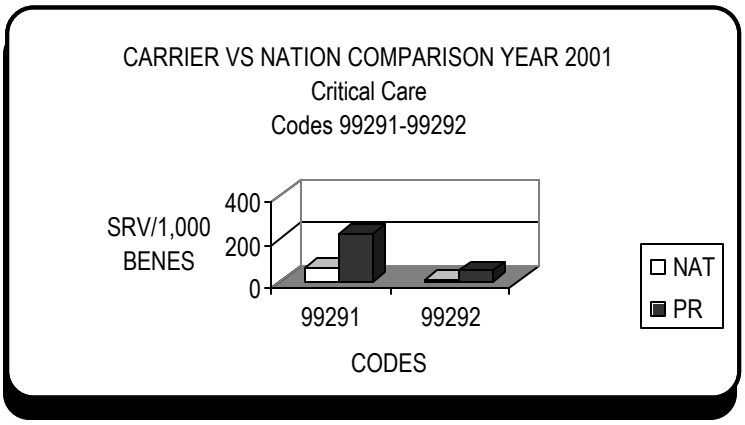

CARRIER VS NATION COMPARISON YEAR 2001
Subsequent Hospital Care
Codes 99231-99233
SRV/1,000 BENES
1,500
1,000
500
0
99231
99232
99233
CODES
NAT
PR

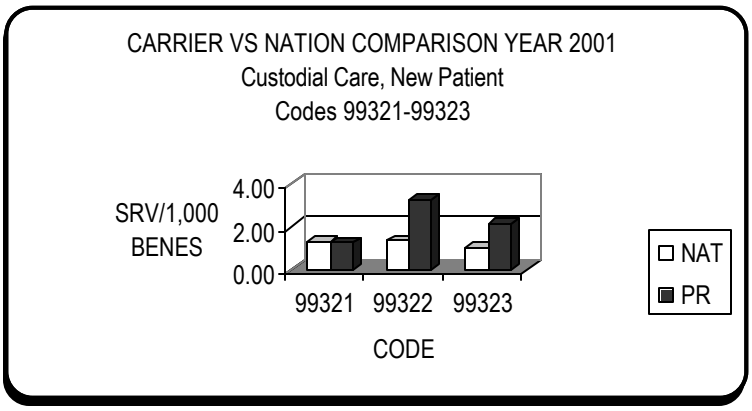

CARRIER VS NATION COMPARISON YEAR 2001
Office Consultation
Codes 99241-99245
SRV/1,000 BENES
150
100
50
0
99241 99242 99243 99244 99245
CODES
NAT
PR

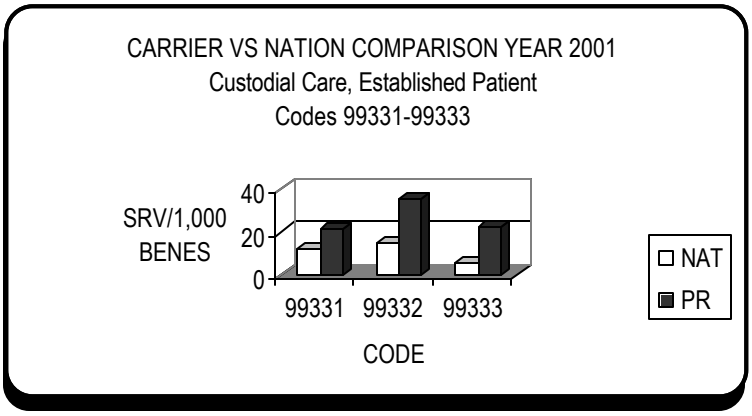

CARRIER VS NATION COMPARISON YEAR 2001
Initial Inpatient Consultation
Codes 99251-99255
SRV/1,000 BENES
200
150
100
50
0
99251 99252 99253 99254 99255
CODES
NAT
PR

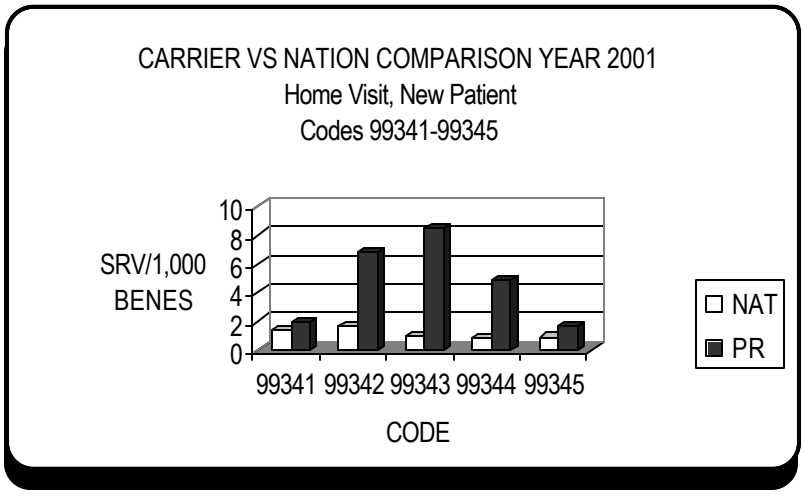

CARRIER VS NATION COMPARISON YEAR 2001
Follow-up Inpatient Consultation
Codes 99261-99263
SRV/1,000 BENES
250
200
150
100
50
0
99261
99262
99263
CODES
NAT
PR


CARRIER VS NATION COMPARISON YEAR 2001
Emergency Department Services
Codes 99281-99285
SRV/1,000 BENES
300
200
100
0
99281
99283
99285
CODES
NAT
PR


CARRIER VS NATION COMPARISON YEAR 2001
Critical Care
Codes 99291-99292
SRV/1,000 BENES
400
200
0
99291
99292
CODES
NAT
PR

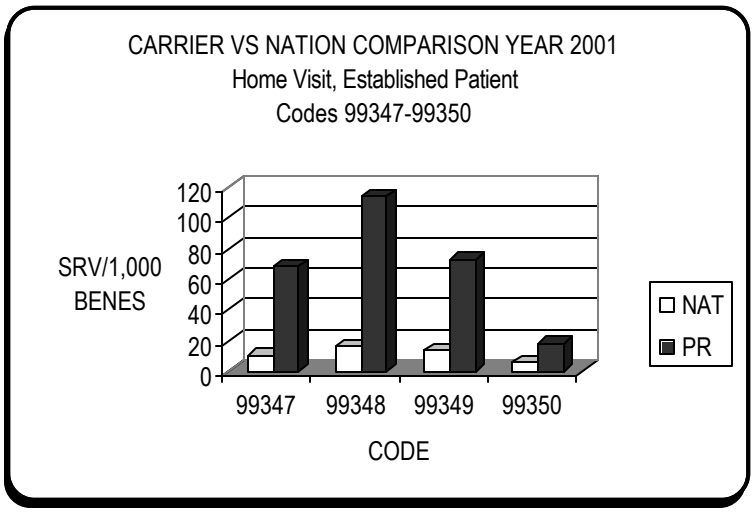

CARRIER VS NATION COMPARISON YEAR 2001
Custodial Care, New Patient
Codes 99321-99323
SRV/1,000 BENES
4.00
2.00
0.00
99321 99322 99323
CODE
NAT
PR


CARRIER VS NATION COMPARISON YEAR 2001
Custodial Care, Established Patient
Codes 99331-99333
SRV/1,000 BENES
40
20
0
99331 99332 99333
CODE
NAT
PR


CARRIER VS NATION COMPARISON YEAR 2001
Home Visit, New Patient
Codes 99341-99345
SRV/1,000 BENES
10
8
6
4
2
0
99341 99342 99343 99344 99345
CODE
NAT
PR

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP



From the publication in our Medicare Informa and data obtained by the American Medical Association adapted by the Center for Medicare and Medicaid Services (CMS), we reproduce the following information. This information was published in the Medicare Informa, Volume 23 November/December 1994-January 1995, pages 4-5.

Documentation guidelines

I. Introduction

What is Documentation and Why is it Important?

Medical record documentation is required to record pertinent facts, findings and observations about an individual's health history including past and present illnesses, examinations, tests, treatments and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time.
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluation; and
- Collection of data that may be useful for research and education

An appropriately documented medical record can reduce many of the "hassies" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What do Payers Want and Why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services provided have been accurately reported

II. General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - Assessment, clinical impression or diagnosis;
   - Plan for care; and
   - Date and legible identity of the observer
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The following is an article published in our Medicare Informa, Volume 12, September 1993, page 3 about the adequate documentation of medical records based on principles from several national medical institutions in Continental USA (CONUS):

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

Adequate Documentation

We are constantly asked for guidelines pertaining to adequate documentation. The information listed below was exerpted from information developed to help physicians and other medical care givers to properly record pertinent facts and observations about an individual's health history including past and present illnesses, treatments and outcomes.

The following principles of medical record documentation has been developed jointly by representatives of the American Health Information Management Association, The American Hospital Association, The American Manage Care and Review Association, The American Medical Association, The American Medical Review Association, The Blue Cross and Blue Shield Association and the Health Insurance of America.

These are some of the things that should present when supplying information to be reviewed for medical necessity purposes.

How does the documentation in your records measures up?

1. Is the reason for the patient encounter documented in the medical record?
2. Are the services that were provided documented?
3. Does the medical record clearly explain why support services, procedures and supplies were provided?
4. Is the assessment of patient's conditions apparent in the medical record?
5. Does the medical record contain information of the patient's progress and the result of treatment?
6. Does the medical record include the patient's plan for care?
7. Does the information in the medical record describing the patient's condition, provide a reasonable medical rationale for the services and the choice of setting that are to be billed?
8. Does the information in the medical record supports the care given in the case, when another health care professional must assume or perform medical review?

Principles of documentation

1. The medical record should be complete and legible.
2. Documentation of each patient encounter should include: the date; the reason for the encounter, appropriate history and physical examination; review of lab, x-ray and other ancillary services, when appropriate; assessment and plan for care (including discharge plan, if appropriate).
3. Past and present diagnosis should be accessible to the treating and/or consulting physician.
4. The reasons and results of x-ray, lab test and other ancillary services should be documented or included in the medical record.
5. Relevants health risk factors should be identified.

6. Patient's progress, including response to treatment, changes in treatment, changes in diagnosis and patient's non-compliance, should be documented.
7. The written plan for care should include, when appropriate: treatment and medications, specifying frequency and dosage; any referral consultations; patients/family education; and specific instructions for follow-up.
8. The documentation should support the intensity of the patient evaluation and/or the treatment, including though process and the complexity of the medical decision making.
9. All entries to the medical record should be dated and authenticated.
10. The CPT/ICD-9 codes reported on the health insurance claims for or billing statements should reflect the documentation in the medical record.

GGL-1759

NONCONTACT NORMOTHERMIC WOUND THERAPY (NNWT)

NNWT is a device reported to promote wound healing by warming a wound to a predetermined temperature. The device consists of a non-contact wound cover into which a flexible, battery powered, infrared heating card is inserted. There is insufficient scientific or clinical evidence to consider this device as reasonable and necessary for the treatment of wounds within the the meaning of §1862(a)(1)(A) of the Social Security Act and will not be covered by Medicare.

PM-AB-02-025/CR2027/02-15-02Trans.152/CIM/02-15-02/LV

FE DE ERRATA

Deseamos aclarar que por razones de origen técnico, en el 4to párrafo del artículo ***"Continuous Positive Airway Pressure"*** publicado en la página 8 del volumen 69 de nuestro boletín (enero, febrero y marzo 2002), los símbolos utilizados debieron ser los que aquí se representan y no los publicados entonces:

ERRATA

We would like to clarify that due to technical reasons, the symbols used in the fourth paragraph of article ***"Continuous Positive Airway Pressure"*** *published on page 8 of volume 69 of our bulletin (January, February, March 2002), should have be those represented below and not those published then:*

Effective for services furnished on or after April 1, 2002:

The use of CPAP devices are covered under Medicare when ordered and prescribed by the licensed treating physician to be used in adult patients with OSA if either of the following criteria using the Apnea-Hyopopnea Index (AHI) are met:
AHI $\geq$ 15 events per hour, or
AHI $\geq$ 5 and $\leq$ 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia or documented hypertension, ischemic heart disease or history of stroke.

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

OPEN LMRP DEVELOPMENT/OPEN CAC

In order to assure that the development of Local Medical Review Policies (LMRP) occur through a public and open process, Medicare will permit the submission of information from members of the general public. Medicare will permit interested parties to submit scientific evidence-based information, professional consensus opinion or any relevant information.

Medicare will allow interested parties (generally those that would be affected by the LMRP), including providers, physicians, vendors, manufacturers, beneficiaries or their caretakers, to make presentations of information related to draft policies. Medicare Carrier Medical Director (CMD) will accept written (or e-mail) comments and give them full and equal considerations as if presented at the meeting.

Members of the CAC (Carrier Advisory Committee) may attend these public meetings.

PIM T09/CR1021/07-30-01

CONSULTS VERSUS VISITS

The next section contains a run-down from the Medicare Carriers Manual's section 15506 on what a consult is and isn't to help you choose the right path.

Consultation versus visit

- Consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by physician or other appropriate source (unless it is a patient-generated confirmatory consultation).
- A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.
- After the consultation is provided, the consultant prepares a written report of his/her findings which is provided to the referring physician.

Consultation followed by treatment

A transfer of care occurs when the referring physician transfers the responsibility for the patient's care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. The receiving physician would report a new or established patient visit depending on the situation (a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years and setting (e.g., office or inpatient).

A physician consultant may initiate diagnostic and/or therapeutic services at an initial or subsequent visit. Subsequent visits (not performed to complete the initial consultation) to manage a portion or all of the patient's condition should be reported as established patient office visit or subsequent hospital care, depending on the setting.

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

LOCAL MEDICAL REVIEW POLICIES VS. NATIONAL COVERAGE DECISIONS

There are two types of medical review decisions under which the Medicare Part B offices operate. They are National Coverage Decisions (NCD) and Local Medical Review Policies (LMRP). The national decisions generally are mandates by CMS.

The NCDs and LMRPs can be differentiated by reading the Medicare Informa. LMRPs will generally state that it is an LMRP at the beginning of the policy. There is also a statement at the end of the policy that states "This policy does not reflect the sole opinion of the carrier. This policy was developed considering comments from the medical community via the Carrier Advisory Committee...)." NCDs will state that they are NCDs and often cite the *Medicare Carriers Manual or Coverage Issues Manual* as the source.

New LMRPs are developed on the basis of need as determined from review of data and/or internal and external sources. Internal sources may include reviewers, claims examiners, program integrity analysts, appeals staff, and hearing staff. External sources can include CMS Program Memoranda and Change Requests, the provider community, and other carriers/ intermediaries.

The criteria for implementing a new LMRP includes but is not limited to:

1. An aberrance of focused review data compared to national statistics and other carriers;
2. The potential savings based on the volume of services and dollars paid;
3. The potential for misuse that may result in inappropriate payments;
4. A new technology that is projected to be widely used with significant payment potential;
5. A unique service that would make coverage determinations inconsistent without clear guidelines.

Once a new LMRP is drafted, the Carrier's Medical Director presents it to the Carrier's Advisory Committee, which is made up of medical practitioners. Please note that a copy of the draft policy is available for review on the Medicare Part B web-site at **www.triples-med.org**. The Provider community then has a minimum of 45 days to give their comments and feedback to the proposed policy. In order to assure that the development of local medical review policies occurs through an open process, Medicare encourages submission of information from members of the general public. Interested parties may submit scientific evidence based information, professional consensus opinions, anecdotal evidence or any other relevant information. Information obtained will be made available to the Carrier Advisory Committees. A new policy is then instituted and is published in the Medicare Informa along with the effective date of the new policy.

GGL-1781/Medicare Informa Vol. 64 (Jan., Feb., March, 2001), Page 3

COVERAGE AND BILLING OF THE DIAGNOSIS AND TREATMENT OF PERIPHERAL NEUROPATHY WITH LOSS OF PROTECTIVE SENSATION IN PEOPLE WITH DIABETES

Coverage

Peripheral neuropathy is the most common factor leading to amputation in people with diabetes. In diabetes, peripheral neuropathy is an anatomically diffuse process primarily affecting sensory and automatic fibers; however, distal motor findings may be present in advanced cases. Long nerves are affected first, with symptoms typically beginning insidiously in the toes and then advancing proximally. This leads to loss of protective sensation (LOPS), whereby a person is unable to feel minor trauma from mechanical, thermal or chemical sources. When foot lesions are present, the reduction in automatic nerve function may also inhibit wound healing.

Peripheral neuropathy with LOPS, secondary to diabetes, is a localized illness of the feet and falls within the regulation's exception to the general exclusionary rule. Foot exams for people with diabetic peripheral neuropathy with LOPS are reasonable and necessary to allow for early intervention in serious complications that typically afflict diabetics with the disease.

Effective for services furnished on or after July 1, 2002, Medicare covers, as a physician service, an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. Five sites should be tested on the plantar surface of each foot, according to the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. The areas must be tested randomly since the loss of protective sensation may be patchy in distribution and the patient may get clues if the test is done rhythmically. Heavily callused areas should be avoided. As suggested by the American Podiatric Medicine Association, an absence of sensation at two or more sites out of 5 tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament must be present and documented to diagnose peripheral neuropathy with loss of protective sensation.

Applicable HCPCS Codes

- G0245 – Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include:
  1. the diagnosis of LOPS;
  2. a patient history;
  3. a physical examination that consists of at least the following elements:
     (a) visual inspection of the forefoot, hindfoot and toe web spaces,
     (b) evaluation of a protective sensation,
     (c) evaluation of foot structure and biomechanics
     (d) evaluation of vascular status and skin integrity,
     (e) evaluation and recommendation of footwear, and
  4. patient education

- G0246 – Follow-up evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following:

  1. a patient history;
  2. a physical examination that includes:
     (a) visual inspection of the forefoot, hindfoot and toe web spaces,
     (b) evaluation of protective sensation,
     (c) evaluation of foot structure and biomechanics,
     (d) evaluation of vascular status and skin integrity,
     (e) evaluation and recommendation of footwear, and
  3. patient education

- G0247 – routine foot care of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following:

  (1) local care of superficial wounds,
  (2) debridement of corns and calluses, and
  (3) trimming and debridement of nails.

  NOTE: Code G0247 must be billed on the same date of service with either G0245 or G0246 in order to be considered for payment.

Short Descriptors

G0245 – INITIAL FOOT EXAM PT LOPS

G0246 – FOLLOW-UP EVAL OF FOOT PT LOPS

G0247 – ROUTINE FOOTCARE PT W LOPS

Diagnosis Codes

Providers should report one of the following diagnosis codes in conjunction with this benefit: 250.60, 250.61, 250.62, 250.63 and 357.2.

Payment Requirements

These services, G0245-G0247, may be furnished and billed by any Medicare provider licensed to provide such services. Deductible and coinsurance apply. These codes all have a type of service of 1.

The effective date is July 1, 2002.

PM AB-02-042 / CR2060 - April 1, 2002
GGL-1771

Contractor's Policy Number
VI/PR-02-025

Contractor Name
Triple-S, Inc.

Contractor Number
00973

Contractor Type
Carrier

LMRP Title
Electrocardiographic Monitoring for 24 hours (Holter Monitoring)

AMA CPT Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 50-15

Primary Geographic Jurisdiction
Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
October 21, 1994

Original Policy Ending Date
June 30, 2002

Revision Effective Date
July 1, 2002

Revision Ending Date
N/A

LMRP Description
Electrocardiographic monitoring can be performed on ambulatory patients over a set period of time (usually twentyfour hours). The monitoring device (holter monitor) allows the patient to resume their normal lifestyle and activities while recording episodes of arrhythmia. This gives the physician documented episodes of arrhythmias or absence of arrhythmias to correlate with the patient's symptoms.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare will consider twenty-four hour electrocardiographic monitoring to be medically necessary in any of the following circumstances (see Covered ICD-9 Codes):

The patient complains of palpitations, and physical examination and standard EKG have not satisfactorily explained the patient's complaints.

The patient has experienced an unexplained syncopal episode or the patient has experienced a transient episode of cerebral ischemia which is felt to possibly be secondary to a cardiac rhythm disturbance.

The patient has been found to have a significant cardiac arrhythmia or conduction disorder (see list below) and Holter monitoring is necessary as part of the evaluation and management of the patient:

Complete Heart Block
Second Degree AV Block
New Left Bundle Branch Block
New Right Bundle Branch Block
Bifasicular Block
Paroxysmal SVT
Paroxysmal VT
Atrial Fib/Flutter
Ventricular Fib/Flutter
Cardiac Arrest
SA Node Dysfunction
Frequent PAC's
Frequent PVC's
Wandering Atrial Pacemaker
Unspecified Cardiac Arrhythmia
The patient has a heart condition (see list below) associated with a high incidence of serious cardiac arrhythmia and/or myocardial ischemia, and holter monitoring is being done as part of the evaluation and management of the patient:
Dressler's Syndrome
History of Myocardial Infarction
Angina Pectoris
Prinzmetals's Angina
Aneurysm of Heart Wall
Chronic Ischemic Heart Disease
Pericarditis
Mitral Valve Disease
Cardiomyopathy
Anomalus AV Excitation

Cardiomegaly
Post Heart Surgery
Prolonged QT Interval

The patient has a cardiac arrhythmia or other cardiac condition and a cardiac medication which affects the electrical conduction system of the heart has been prescribed, and Holter monitoring is necessary to evaluate the effect of the cardiac medication on the patient's cardiac rhythm and/or conduction system.

The patient has a pacemaker and clinical findings (history or physical examination) suggest possible pacemaker malfunction.

Claims submitted for holter studies performed at unusually frequent intervals will be reviewed by Medicare to make certain that the services were medically reasonable and necessary.

CPT/HCPCS Section & Benefit Category
Medicine/Cardiovascular

CPT/HCPCS Codes
93224-93237 ECG monitoring for 24 hours

Not Otherwise Classified Codes (NOC)
N/A

ICD-9 Codes that Support Medical Necessity

410.00-410.02	Acute myocardial infarction of anterolateral wall
410.10-410.12	Acute myocardial infarction of other anterior wall
410.20-410.22	Acute myocardial infarction of inferolateral wall
410.30-410.32	Acute myocardial infarction of inferoposterior wall
410.40-410.42	Acute myocardial infarction of inferior wall
410.50-410.52	Acute myocardial infarction of other lateral wall infarction
410.60-410.62	Acute myocardial infarction of true posterior wall infarction
410.70-410.72	Acute myocardial infarction of subendocardial infarction
410.80-410.82	Acute myocardial infarction of other specified sites
410.90-410.92	Acute myocardial infarction of unspecified site
411	Postmyocardial infarction syndrome
411.1	Intermediate coronary syndrome
411.81	Acute coronary occlusion without myocardial infarction
411.89	Other acute and subacute forms of ischemic heart disease
412	Old myocardial infarction
413.0-413.9	Angina pectoris
414	Coronary atherosclerosis of unspecified vessel
414.01	Coronary atherosclerosis of native coronary
414.02	Coronary atherosclerosis of autologous vein bypass graft
414.03	Coronary atherosclerosis of nonautologous biological bypass graft
414.1	Aneurysm of heart (wall)
414.11	Aneurysm of coronary vessels

414.19	Other aneurysm of heart
414.8	Other specified forms of chronic ischemic heart disease
414.9	Chronic ischemic heart disease, unspecified
423.1	Adhesive pericarditis
423.2	Constrictive pericarditis
424	Mitral valve disorders
425.0-425.9	Cardiomyopathy
426	Artrioventricular block, complete
426.12	Mobitz (type) II atriioventricular block
426.13	Other second degree atrioventricular block
426.2	Left bundle branch hemiblock
426.4	Right bundle branch block
426.53	Other bilateral bundle branch block
426.7	Anomalous atrioventricular excitation
426.9	Conduction disorder, unspecified
427	Paroxysmal supraventricular tachycardia
427.1	Paroxysmol ventricular tachycardia
427.31	Atrial fibrillation
427.32	Atrial flutter
427.41	Ventricular fibrillation
427.42	Ventricular flutter
427.5	Cardiac arrest
427.61	Supraventricular premature beats
427.69	Other premature beats
427.81	Sinoatrial node dysfunction
427.89	Other specified cardiac dysrhythmias
427.9	Cardiac dysrhythmia, unspecified
429.3	Cardiomegaly
429.4	Functional disturbances following cardiac surgery
429.9	Heart disease, unspecified
441.2	Thoracic anurism without mention of rupture
446	Poliarteritis nodosa
780.2	Syncope and collapse
785.1	Palpitations
959.1	Other and unspecified injury to trunk (chest wall)
E942.0	Cardiac rhythm regulators
E942.1	Cardiotonic glycosides and drugs of similar action
V45.00	Unspecified cardiac device
V45.01	Cardiac pacemaker
V45.02	Automatic implantable cardiac defibrillator
V45.09	Other specified cardiac device
V67.51	Followup examination following treatment with high-risk medication, not elsewhere classified

Diagnoses that Support Medical Necessity
Same as above.

ICD-9 Codes that DO NOT Support Medical Necessity
Any ICD-9 codes not listed as payable in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Diagnoses that DO NOT Support Medical Necessity
Any diagnosis not listed as payable in the "Diagnosis that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Reasons for Denial
When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9 codes
Any ICD-9 CM not included in this policy.

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding Guidelines
N/A

Documentation Requirements
Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of Holter monitor studies covered by the Medicare program. Also, the results of Holter studies covered by the Medicare program must be included in the patient's medical record.

If the provider of Holter studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation along with copies of the ordering/referring physician's order for the study. When ordering Holter studies from an independent physiological lab or other provider, the ordering/referring physician must state the reason for the Holter study in his order for the test.

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information and Basis for Decision
N/A

Advisory Committee Notes
This policy does not represent the sole opinion of the Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from cardiology consultants.

Start Date of Comment Period
March 25, 2002

End Date of Comment Period
May 10, 2002

Start Date of Notice Period
May 15, 2002

Revision History
Original policy – October 21, 1994
First revision – R1
New diagnoses were added to the original policy in order to support medical necessity.

Gloria M. Lebrón, Esq.
Vice President
Triple-S, Inc./Medicare Division

Gonzalo González-Liboy, MD, FACP
Medical Director
Triple-S, Inc./Medicare Division

GGL-1702

Contractor's Policy Number
VI/PR-02-026

Contractor Name
Triple-S, Inc.

Contractor Number
00973

Contractor Type
Carrier

LMRP Title
Implantable Dual Chamber Cardioverter-Defibrillator (ICD) for Ventricular Arrhythmias and Atrial Fibrillation

AMA CPT Copyright Statement

CMS National Coverage Policy
Title XVIII of the Social Security Act, Section 1862 (a)(7). This section excludes routine physical examinations.
Title XVIII of the Social Security Act, Section 1862 (a)(1)(A). This section allows coverage and payment for only those services considered medically reasonable and necessary.
Title XVIII of the Social Security Act, Section 1833 (e). This section prohibits Medicare payment for any claim that lacks the necessary information to process the claim.
Coverage Issues Manual, section 35-85. This section defines coverage for implantation of automatic defibrillators.
Coverage Issues Manual, section 35-87. This section defines coverage for implantation of automatic defibrillators.

Primary Geographic Jurisdiction
Puerto Rico and U.S. Virgin Islands.

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
July 1, 2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description
Traditional implantable cardioverter defibrillators (ICDs) have used in the management of vertricular arrhythmias, specifically vectricular tachycardia (VT) and ventricular fibrillations (VF). Recent technology has led to the development of dual chamber ICDs that utilize a sophisticated algorithm to detect and treat episodes of a VT, VF as well as atrial fibrillation (AF). The prevention and treatment of atrial fibrillation (AF) focuses first on maintaining or restoring sinus rhythm (SR) and then on controlling rate and preventing thromboembolic events. The use of an implantable cardioverter-defibrillator in atrial fibrillation is based on the clinical adage that "atrial fibrillation begets atrial fibrillation". Therefore prompt restoration of SR would decrease the persistence of AF and the secondary undesirable remodeling changes.

Indications and Limitations of Coverage and/or Medical Necessity
Indications
The dual chamber implantable cardioveter-defibrallator is covered for the treatment of patients with symptomatic drug refraction atria fibrillation and life threatening ventricular tachyarrhyhmias device which detects and treats episodes of Atrial Fibrillation (AF), Ventricular Tachycardia (VT) and Ventricular Fibrillation (VF). This policy reiterates the coverage indications of an ICD for ventricular arrhythmias and addresses the AF indication.

Limitations

Coverage benefits for the dual chamber ICD are limited to patients who are afflicted with both atrial fibrillations and one of the listed ventricular arrhythmias. The patient, must have one of the arrhyhmias outlines in A and atrial fibrillation described in B.

A. Ventricular arrhytmias

The implantation of an ICD is a covered service for patients who have had

(1) a documented episode of life-threatening ventricular tachyarrhythmia or cardiac arrest not associated with myocardial infarction, or

(2) a documented episode of cardiac arrest due to ventricular fibrillation not due to a transient or reversible cause, or

(3) ventricular tachyarrhythmia, either spontaneous or induced, not due to a transient or reversible cause, or

(4) familial or inherited conditions with a high risk or life-threatening ventricular tachyarrhythmias such as long QT syndrome or hyperthophic cardiomyopathy.

B. Atrial fibrillation

The patient must have recurrent symptomatic episodes of AF for which antiarrhythmic therapy is ineffective or not tolerated. Patients must have had at least two electrical cardioversions in the preceding 12 months.

CPT/HCPCS Section & Benefit Category
Surgery/Cardiology

CPT/HCPCS codes

33217 Insertion or repositioning of a transvenous electrode (15 days or more after the initial insertion); dual chamber (two electrodes) permanent pacemaker or dual chamber pacing cardioverter-fibrillation

33240 Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator

33249 Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator

93640 Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;

93641 with testing of single or dual chamber pacing cardioverter-defribillator pulse generator

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity
Truncated diagnosis codes are not acceptable. ICD-9 CM code listings may cover a range and include truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9 CM book appropriate to the year in which the claim is submitted.

It is not enough to link the procedure code to a correct, payable ICD-9 CM code. The diagnosis or clinical suspicion must be present for the procedure to be paid.

The primary codes must be accompanied by the secondary code.

Primary codes

425.1	hypertrophic obstructive cardiomyopathy
427.41	ventricular fibrillation
427.42	ventricular flutter
427.5	cardiac arrest
V12.50	unspecified circulatory disease (use only for personal history of prolonged QT syndrome)

Secondary code
427.31 atrial fibrillation

Diagnosis that Support Medical Necessity
Codes that support medical necessity as in ICD-9 codes above.

ICD-9 Codes that do not Support Medical Necessity
Any ICD-9 codes not listed as payable in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Diagnosis that do not Support Medical Necessity
Any diagnosis not listed as payable in the "Diagnosis that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Reasons for denial
- A claim submitted without a valid ICD-9 CM code will be returned as an incomplete claim under 1833(e).
- A claim submitted without one of the ICD-9 CM codes listed in the "ICD-9-CM Codes that Support Medical Necessity" section of this policy will be denied under 1862(a)(1)(A).
- A claim for services rendered in any place of service other than those indicated as payable in the "Coding Guidelines" section of this policy will be denied.

Noncovered ICD-9 codes
Any diagnosis not included in this policy.

Coding guidelines
1. Initial claims should be submitted with documentation of operative report and pre-op results of all tests including EPS studies.
2. This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with the Indications and Limitations within this policy.
3. Use code 33249 if services are performed by a single physician.
4. Use code 33240 (defibrillator pulse generator) and 33217 (electrodes) if these separate services are performed by different physicians.
5. Procedures codes 33217, 33240 and 33249 can only be billed in inpatient hospital (21).
6. The name and UPIN of the treating/ordering physician or qualified non-physician practitioner for procedure codes 93640 and 93641 must be on the claim in boxes 17 and 17a, respectively. If submitting electronically, this information must be in the EAO record, fields 22.0 and 20.0. Without this information, claims will be returned as unprocessable.

Documentation requirements
- Documentation supporting the medical necessity, such as ICD-9-CM codes must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.
- The standard procedure/operative report with a clinical indications must be available upon request. Additionally documentation of the history and management of both atrial and ventricular arrhythmias should be available for review.

Utilization guidelines
N/A

Other comments
For services that exceed the accepted standard of medical practice and may be deemed not medically necessary, the provider/supplier must provide the patient with an acceptable advance notice of Medicare's possible denial of payment. An advance beneficiary notice (ABN) should be signed when a provider/supplier does not want to accept financial responsibility for the service.

Sources of information and basis for decision

1. Arnsdorf, Morton, MD, MACC, "Nonpharmacologic strategies to prevent recurrent atrial fibrillation", Up To Date, Vol. 9, No. 3.
2. Levy, Samuel, MD, et al, "Implantable devices for the treatment of atrial fibrillation", Up To Date, Vol. 9, No. 3.
3. Maurits, C.E.F., et al, "The Natural History of Atrial Fibrillation", Journal of Cardiovascular Electrophysiology, Vol. 10, No. 9, September 1999
4. Tse, Hung-Fat, M.B.B.S., et al "Effect of the Implantable Atrial Defribillator on the Natural History of Atrial Fibrillation", Journal of Cardiovascular Electrophysiology, Vol. 10, No. 9, September 1999
5. Schoels, Wolfgang, MD, "Worldwide Clinical Experience with a New Dual-Chamber Implantable Cardioverter-Defibrillator System", Journal of Cardiovascular Electrophysiology, Ms. #00498.
6. Wellens, Hein, MD, et al, "Atrioverter: An Implantable Device for the Treatment of Atrial Fibrillation".
7. Fuster, Valentin, MD, PhD, FACC, et al, "ACC/AHA/ESC Guidelines for the Management of Patients with Atrial Fibrillation: Executive Summary", Journal of the American College of Cardiology, Vol. 38, No. 4, 2001.
8. Daoud, Emile, MD, et al, "Initial Clinical Experience with Ambulatory Use of an Implantable Atrial Defibrillator for Conversion of Atrial Fibrillation", Circulation, September 19, 2000.

Advisory Committee Notes

This policy does not represent the sole opinion of the Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from cardiovascular surgery/cardiology specialists.

Start date of comment period

March 25, 2002

Ending date of comment period

May 10, 2002

Start date of notice period

May 15, 2002

Revision history

N/A

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GGL-1703

Contractor's Policy Number
VI/PR-02-027

Contractor Name
Triple-S, Inc.

Contractor Number
00973

Contractor Type
Carrier

LMRP Title
Wireless Capsule Endoscopy

AMA CPT Copyright Statement

CMS National Coverage Policy
- Title XVIII of the Social Security Act, Section 1862 (a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1862 (a)(1)(A). This section allows coverage and payment for only those services considered medically reasonable and necessary.
- Title XVIII of the Social Security Act, Section 1833 (e). This section prohibits Medicare payment for any claim that lacks the necessary information to process the claim.

Primary Geographic Jurisdiction
Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
July 1, 2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Wireless capsule endoscopy is a noninvasive diagnostic imaging device for use in viewing the gastrointestinal tract, especially the small bowel, which is not accessible to standard upper endoscopy and colonoscopy. A small capsule (approximately 11 x 30 mm) is swallowed and moves through the GI tract propelled by peristalsis, transmitting video pictures. The video images are transmitted to sensors taped to the body and stored on a portable recorder. The strength of the signal is used to calculate the position of the capsule as it passes through the GI tract. Video images are stored on a portable recorder and later downloaded to computer, from which they may be viewed in real time. The capsule passes naturally from the body with the stool, and since it is disposable, is not recovered.

Indications and Limitations of Coverage and/or Medical Necessity

Indications
This test is indicated for the diagnosis of occult gastrointestinal bleeding, the site of which has not previously been identified by upper gastrointestinal endoscopy, colonoscopy, push enteroscopy or radiologic procedure. It may be especially helpful in the diagnosis of angiodysplasias of the GI tract.

Limitations
- Wireless capsule endoscopy is not payable in patients who have not undergone upper GI endoscopy and colonoscopy within the same spell of illness, which have failed to reveal a source of bleeding.
- This test is payable only for those beneficiaries with documented continuing GI blood loss and anemia secondary to bleeding.
- This test is not reimbursable for colorectal cancer screening.
- The test is payable only for services using FDA approved devices.
- This test is not reimbursable for the confirmation of lesions or pathology normally within the reach of upper or lower endoscopes (lesions proximal to the ligament of Treitz or distal to the ileum).
- This test is not payable for patients with hematemesis.
- This test is covered when performed by gastroenterologists, or independent diagnostic testing facilities under general supervision of a gastroenterologist.

CPT/HCPCS Section & Benefit Category
Medical Diagnostic Tests/Gastroenterology

CPT/HCPCS Codes
91299 Unlisted diagnostic gastroenterology procedure

Not Otherwise Classified (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
TRUNCATED DIAGNOSIS CODES ARE NOT ACCEPTABLE.

ICD-9-CM code listings may cover a range and include truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9-CM book appropriate to the year in which the claim is submitted.

It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical suspicion must be present for the procedure to be paid.

555.0	Ileitis; Regional enteritis or Crohn's disease of the ileum or jejunum
555.2	Regional enteritis of the small intestine with large intestine
557.0	Acute vascular insufficiency of the intestine
557.1	Chronic vascular insufficiency of the intestine
557.9	Unspecified vascular insufficiency of the intestine
558.1	Other noninfectious gastroenteritis and colitis: gastroenteritis and colitis due to radiation
558.2	Other noninfectious gastroenteritis and colitis: toxic gastroenteritis and colitis
558.9	Other noninfectious gastroenteritis and colitis: other and unspecified
562.02	Diverticulosis of the small intestine with hemorrhage
562.03	Diverticulitis of the small intestine with hemorrhage
569.85	Angiodysplasia of intestine with hemorrhage
578 .1	Blood in stool, melena
578.9	Hemorrhage of gastrointestinal tract, unspecified.
792.1	Nonspecific abnormal findings in other body substances; stool contents (occult stool)

Diagnoses that Support Medical Necessity
Same as above.

ICD-9-CM Codes that DO NOT Support Medical Necessity
Any ICD-9-CM codes not listed as payable in the "ICD-9-CM Codes that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Reasons for Denial
- A claim submitted without a valid ICD-9-CM code will be returned as an incomplete claim under 1833(e).
- A claim submitted without one of the ICD-9-CM codes listed in the "ICD-9-CM Codes that Support Medical Necessity" section of this policy will be denied under 1862 (a)(1)(A).
- A claim for services rendered in any place of service other than those indicated as payable in the "Coding Guidelines" section of this policy will be denied.
- Section 1862 (a)(7) of the Social Security Act does not extend Medicare coverage for screening procedures.
- A claim for wireless capsule endoscopy, submitted without the UPIN number of the referring/ ordering physician or qualified non-physician practitioner, will be returned as an incomplete claim under 1833 (e).
- A claim for wireless capsule endoscopy that does not indicate previous endoscopic exams (upper GI and colonoscopy) within the same spell of illness will be denied as not medically necessary.
- Claims submitted for more than one service per spell of illness will be denied as not medically necessary.

Noncovered ICD-9-CM Codes

V10.00	Personal history of malignant neoplasm; gastrointestinal tract; unspecified
V70.0	Routine general medical examination at a health facility.
V7 1.1	Observation for suspected malignant neoplasm.

Coding Guidelines

1 . This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with the Indications and Limitations within this policy.
2. The wireless capsule endoscopy should be coded with the range code, 91299, with the narrative entered in box 19 of the HCFA 1500 or electronic equivalent. This service consists of a technical portion of the service (provision of the capsule, hookup of the recording equipment, and downloading of the digital data to the computer with processing and creation of video images) and a professional component (review of the images and interpretation with report).
3. The professional component (modifier 26) may be billed in places of service I I (office), 12 (home), 21 (inpatient hospital, 22 (outpatient hospital), 23 (emer-geney-Feem)-, 31 (skilled nursing facility), 32 (nursing facility), 33 (custodial care facility), 47 local health clinic).
4. The global service or technical component (modifier TC) may be billed in places of service 11 (office), 12 (home), 32 (nursing facility), 33 (custodial care facility) and 47 (IDTF, under general supervision of a gastroenterologist).
5. The date of service should be entered as the date hook-up is performed, with an NOS of one (1), regardless of the number of days the recorder is wom.
6. The UPIN of the physician or qualified non-physician provider ordering the test must be included on the claim.

Documentation Requirements

- Documentation supporting the medical necessity, such as ICD-9-CM codes, must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.
- Photographic copies of the video images, with the beneficiary's name and the date of service included in the picture, must be available for review.
- The medical record must document the need for this test, and contain reports of previous negative upper and lower endoscopies performed prior to this wireless capsule endoscopy, but during the current spell of illness.
- The medical record must document the presence of gastrointestinal bleeding and anemia secondary to blood loss.
- Documentation must be available to Medicare upon request.

Utilization Guidelines

- It is expected that this test will be performed only once during any spell of illness.
- Claims for additional tests will be denied as not medically necessary in the absence of supportive documentation.

Other Comments

- For services that exceed the accepted standard of medical practice and may be deemed not medically necessary, the provider/supplier must provide the patient with an acceptable advance notice of Medicare's possible denial of payment. An advance beneficiary notice (ABN) should be signed when a provider/supplier does not want to accept financial responsibility for the service.
- This policy was developed to allow patient access and provide billing instructions for this new technology.

Sources of Information and Basis for Decision

Appleyard, Glukhovsky and Swain, The New England Journal of Medicine 344:232-233 (Jan 18, 2001)

Appleyard, et al, Gastroenterology 1 1 9:1431-1438 (2000)
National Digestive Diseases Information Clearinghouse, NIH publication No.01-4552 at http://www.niddk.nih.gov/health/digest/ddnews/winOl/5.htm

Policy from Empire, Medicare Services NY 2002

Advisory Committee Notes
This policy does not represent the sole opinion of the Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from policy from Empire and gastroenterology consultants in VI/PR.

Start Date of Comment Period
March 25, 2002

End Date of Comment Period
May 10, 2002

Start Date of Notice Period
May 15, 2002

Revision History
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GGL-1705

Contractor's Policy Number
VI/PR-02-029

Contractor's name
Triple-S, Inc.

Contractor's Number
00973

Contractor's type
Carrier

LMRP Title
Electrocardiogram (EKG, ECG)

AMA's CPT Copyright Statement

CMS National Coverage Policy

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section allows coverage and payment for only those services that are reasonable and necessary.

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section prohibits Medicare payment for routine or screening services.

- Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Primary Geographic Jurisdiction
Puerto Rico and US Virgin Islands

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
December 30, 1995

Original Policy Ending Date
June 30, 2002

Revision Effective Date
July 1, 2002

Revision Ending Date
N/A

LMRP description
The electrocardiogram, EKG or ECG, is a graphic representation of the electrical activity of the heart. The source of this electrical activity resides in the cardiac muscle syncitium as well as in cells with inherent automatic depolarization and conduction properties. A universally available standard machine obtains the recording by multiple partially oriented surface electrodes to trace the resultant electrical deflections.

These deflections may be influenced by intrinsic heart disease or by extracardiac causes that have secondary effects on the depolarization of both myocardial and conduction cells. Hence the EKG/ECG may have significant diagnostic implications for both heart conditions and seemingly non-cardiac clinical conditions.

Indications and Limitations of Coverage and/or Medical Necessity
The purpose of an EKG is to help identify primary conduction abnormalities, cardiac arrhythmias, cardiac hypertrophy, pericarditis, electrolyte imbalance, myocardial ischemia and the site and extent of a Myocardial Infarction (MI). Also:

- to monitor recovery from MI
- to evaluate the effectiveness of cardiac medication
- to observe pacemaker performance
- to evaluate persons with medical conditions or over 50 years old who will be submitted
- to surgical procedures
- to evaluate persons to be submitted to emergency surgeries

CPT/HCPCS Section and Benefit Category
Medicine / Cardiology / Electrocardiography

CPT/HCPCS codes
93000 Electrocardiogram, with interpretation and report; routine ECG with at least 12 leads
93005 Electrocardiogram, tracing only, without interpretation and report
93010 Electrocardiogram, interpretation and report only
93040 Rhythm ECG, one to three leads; with interpretation and report
93041 Rhythm ECG, one to three leads; tracing only without interpretation and report
93042 Rhythm ECG, one to three leads; interpretation and report only

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity
002.0-002.9 Typhoid and paratyphoid fevers

005.1-005.3	Food poisoning due to Clostridium
017.9	Tuberculosis of specified organs (endocardium-any valve-myocardium,pericardium)
018.0-018.9	Miliary tuberculosis
020.2	Septicemic plague
022.3	Anthrax septicemia
032.82	Diptheritic myocarditis
036.2	Meningococcal septicemia
036.40-036.43	Meningococcal carditis
038.0-038.9	Septicemia
040.0	Gas gangrene
042	Human immunodeficiency virus (HIV) disease
054.5	Herpetic septicemia
074.1	Epidemic pleurodynia
074.20-074.23	Coxsackie carditis
086.0	Chagas' disease with heart involvement
093.0-093.9	Cardiovascular syphilis
098.83-098.85	Gonococcal heart disease
112.5	Disseminated candidiasis (systemic candidiasis)
112.81	Candidal endocarditis
115.03	Histoplasma capsulatum pericarditis
115.04	Histoplasma capsulatum endocarditis
115.13	Histoplasma duboisii pericarditis
115.14	Histoplasma duboisii endocarditis
115.93	Histoplasmosis pericarditis
115.94	Histoplasmosis endocarditis
124	Trichinosis
130.3	Myocarditis due to toxoplasmosis
130.8	Multisystemic disseminated toxoplasmosis
135	Sarcoidosis
163.0-163.9	Malignant neoplasm of pleura
164.0-164.9	Malignant neoplasm of thymus, heart, and mediastinum
165.0-165.9	Malignant neoplasm of other and ill-defined sites within the respiratory system and intrathoracic organs
212.4	Benign neoplasm of pleura
212.5	Benign neoplasm of mediastinum
212.6	Benign neoplasm of thymus
212.7	Benign neoplasm of heart
242.00-242.91	Thyrotoxicosis with or without goiter
243	Congenital hypothyroidism
244.0-244.9	Acquired hypothyroidism
252.0-252.9	Disorders of parathyroid gland
255.0-255.9	Disorders of adrenal glands
265.0-265.2	Thiamin and niacin deficiency states
272.0-272.9	Disorders of lipid metabolism
274.82	Gouty tophi of heart
275.2	Disorders of magnesium metabolism
275.3	Disorders of phosphorus metabolism

275.40-275.49	Disorders of calcium metabolism
276.0-276.9	Disorders of fluid, electrolyte, and acid-base balance
277.3	Amyloidosis
282.60-282.69	Sickle-cell anemia
304.2	Cocaine dependence
304.4	Amphetamine and other psychostimulant dependence
304.6	Other specified drug dependence
305.50-305.53	Opioid abuse
305.60-305.63	Cocaine abuse
305.70-305.73	Amphetamine or related sympathomimetic abuse
306.2	Physiological malfunction arising from mental factors; cardiovascular
337.0	Idiopathic peripheral autonomic neuropathy
357.6	Polyneuropathy due to drugs
362.30-362.37	Retinal vascular occlusion
390	Rheumatic fever without mention of heart involvement
391.0-391.9	Rheumatic fever with heart involvement
392.0-392.9	Rheumatic chorea
393 Chronic	Rheumatic pericarditis
394.0-394.9	Diseases of mitral valve
395.0-395.9	Diseases of aortic valve
396.0-396.9	Diseases of mitral and aortic valves
397.0-397.9	Diseases of other endocardial structures
398.0-398.99	Other rheumatic heart disease
401.0-401.9	Essential hypertension
402.00-402.91	Hypertensive heart disease
403.00-403.91	Hypertensive renal disease
404.00-404.93	Hypertensive heart and renal disease
405.01-405.99	Secondary hypertension
410.00-410.92	Acute myocardial infarction
411.0-411.89	Other acute and subacute forms of ischemic heart disease
412 Old	Myocardial infarction
413.0-413.9	Angina pectoris
414.00-414.9	Other forms of chronic ischemic heart disease
414.1-414.19	Aneurysms of heart and vessels
414.8-414.9	Other specified forms of chronic ischemic heart disease
415.0-415.19	Acute pulmonary heart disease
416.0-416.9	Chronic pulmonary heart disease
417.0-417.9	Other diseases of pulmonary circulation
420.0-420.99	Acute pericarditis
421.0-421.9	Acute and subacute endocarditis
422.0-422.99	Acute myocarditis
423.0-423.9	Other diseases of pericardium
424.0-424.99	Other disease of endocardium
425.0-425.9	Cardiomyopathy
426.0-426.9	Conduction disorders
427.0-427.9	Cardiac dysrhythmia
428.0-428.9	Heart failure
429.0-429.9	Ill-defined descriptions and complications of heart disease

434.10-434.11	Occlusion of cerebral arteries; cerebral embolism
434.90-434.91	Occlusion of cerebral arteries; cerebral artery occlusion, unspecified
435.9	Unspecified transient cerebral ischemias
436	Acute, but ill-defined cerebrovascular disease
437.9	Unspecified, cerebrovascular disease or lesion
440.9	Generalized and unspecified atherosclerosis
441.00-441.9	Aortic aneurysm
442.89	Other aneurysm (mediastinal artery)
443.0-443.9	Other peripheral vascular disease
444.0-444.9	Arterial embolism
446.0	Polyarteritis nodosa
446.20	Hypersensitivity angiitis
446.7	Takayasu's disease
458.0-458.9	Hypotension
459.2	Compression of vein (vena cava syndrome [inferior][superior])
492.0-492.8	Emphysema
493.00-493.91	Asthma
506.1	Acute pulmonary edema due to fumes and vapors
511.0-511.9	Pleurisy
518.2	Compensatory emphysema
518.4	Acute edema of lung, unspecified
518.5	Pulmonary insufficiency following trauma and surgery
518.81	Respiratory failure
518.82	Other pulmonary insufficiency, not elsewhere classified
519.3	Other diseases of mediastinum, not elsewhere classified
530.0-530.5	Diseases of esophagus
530.81	Esophageal reflux
552.3	Diaphragmatic hernia with obstruction
575.0	Acute cholecystitis
575.10-575.12	Other cholecystitis
584.5 - 584.9	Acute renal failure
585	Chronic renal failure
611.71	Mastodynia
634.5	Abortion; complicated by shock
634.6	Abortion; complicated by embolism
635.5	Legally induced abortion; complicated by shock
635.6	Legally induced abortion; complicated by embolism
636.5	Illegally induced abortion; complicated by shock
636.6	Illegally induced abortion; complicated by embolism
637.5	Unspecified abortion; complicated by shock
637.6	Unspecified abortion; complicated by embolism
638.5	Failed attempted abortion; complicated by shock
638.6	Failed attempted abortion; complicated by embolism
639.5	Complications following abortion and ectopic and molar pregnancies; shock
639.6	Complications following abortion and ectopic and molar pregnancies; embolism
639.8	Other specified complications following abortion or ectopic or molar pregnancy (0cardiac arrest or failure)

642.00-642.94	Hypertension complicating pregnancy, childbirth, and the puerperium
648.50-648.54	Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium; congenital cardiovascular disorders
648.60-648.64	Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium; other cardiovascular diseases
659.0 - 659.9	Other indication for care on intervention related to labor and delivery not elsewhere classified
666.0 - 666.3	Post-partum hemorrhage
668.10-668.14	Complications of administration of anesthetic or other sedation in labor and delivery; cardiac complications
669.10-669.14	Other complications of labor and delivery, not elsewhere classified; shock following labor and delivery
669.20-669.24	Other complications of labor and delivery, not elsewhere classified; maternal hypotension syndrome
669.40-669.44	Other complications of labor and delivery, not elsewhere classified (cardiac arrest, failure)
673.00-673.84	Obstetrical pulmonary embolism
710.0	Systemic lupus erythematosus
714.2	Other rheumatoid arthritis with visceral or systemic involvement (rheumatoid carditis)
714.81	Rheumatoid lung
724.1	Pain in thoracic spine
729.5	Pain in limb
729.81-729.89	Other musculoskeletal symptoms referable to limbs
733.6	Tietze's disease (costochondral junction syndrome)
738.3	Acquired deformity of chest and rib
745.0-745.9	Bulbus cordia anomalies and anomalies of cardiac septal closure
746.00-746.9	Other congenital anomalies of heart
747.0-747.49	Other congenital anomalies of circulatory system
754.81	Other specified nonteratogenic anomalies; pectus excavatum
754.82	Other specified nonteratogenic anomalies; pectus carinatum
780.01-780.09	Alteration of consciousness
780.2	Syncope and collapse
780.4	Dizziness and giddiness
780.50-780.59	Sleep disturbances
780.7	Malaise and fatigue
782.3	Edema
782.5	Cyanosis
782.61-782.62	Pallor and flushing
784.1	Throat pain
785.0	Symptoms involving cardiovascular system; tachycardia, unspecified
785.1	Symptoms involving cardiovascular system; palpitations
785.2	Undiagnosed cardiac murmurs
785.50-785.59	Symptoms involving cardiovascular system; shock without mention f trauma
786.00-786.09	Dyspnea and respiratory abnormalities
786.50-786.59	Chest pain

787.1	Heartburn
789.00-789.09	Abdominal pain
790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase (LDH)
796.3	Nonspecific low blood pressure reading
799.0	Asphyxia
799.1	Respiratory arrest
807.00-807.09	Fracture of rib(s) and sternum
807.10-807.19	Fracture of rib(s) and sternum
807.2-807.4	Fracture of rib(s) and sternum
860.0-860.5	Traumatic pneumothorax and hemothorax
861.00-861.32	Injury to heart and lung
862.8	Injury to multiple and unspecified intrathoracic organs, without mention of open wound into cavity
862.9	Injury to multiple and unspecified intrathoracic organs, with open wound into cavity
875.0-875.1	Open wound of chest (wall)
901.0-901.89	Injury to blood vessels of thorax
922.1	Contusion of chest wall
926.8	Crushing injury of multiple sites of trunk
942.2 - 942.3	Second and third degree burns of trunk
946.2 - 946.3	Second and third degree burn of multiple specified sites
947.0 - 947.9	Burns of internal organs
948.1 - 948.9	Burns according to extent of body surface involved
951.8	Injury to other specified cranial nerves; vagus nerve
958.0 - 958.8	Certain early complication of trauma
959.1	Injury, other and unspecified; trunk (chest wall, interscapular region)
961.4	Antimalarial drugs poisoning
963.1	Poisoning by antineoplastic and immunosuppressive drugs
972.0-972.9	Poisoning by agents primarily affecting the cardiovascular system
977.0 - 977.9	Poisoning by other and unspecified drugs and medicine substances
986	Toxic effect of carbon monoxide
989.0 - 989.9	Toxic effect of other substances, chiefly nonmedicinal as to source
991.6	Hypothermia
992.0	Heat stroke and sunstroke
992.1	Heat syncope
992.3	Heat exhaustion, anhydrotic
993.2	Other and unspecified effects of high altitude
993.3	Caisson disease
993.4	Effects of air pressure caused by explosion
994.0	Effects of lightning
994.1	Drowning and nonfatal submersion
994.5	Exhaustion due to excessive exertion
994.7	Asphyxiation and strangulation
994.8	Electrocution and fatal effects of electrical current
995.0	Other anaphylactic shock
995.4	Shock due to anesthesia
995.60-995.69	Anaphylactic shock due to adverse food reaction

995.86	Malignant hypertermia
995.89	Other specified adverse effects, not elsewhere classified (malignant hyperpyrexia or hypothermia due to anesthesia)
996.00-996.09	Mechanical complication of cardiac device, implant, and graft
996.1	Mechanical complication of other vascular device, implant and graft
996.61	Infection and inflammatory reaction due to cardiac device, implant, and graft
996.71	Other complications of internal (biological)(synthetic) prosthetic device, implant, and graft; due to heart valve prosthesis
996.72	Other complications of internal (biological)(synthetic) prosthetic device, implant, and graft; due to Cardiac device, implant, and graft
996.80 - 996.89	Complication of transplanted organ
997.1	Cardiac complications during or resulting from a procedure
997.2	Peripheral vascular complications
997.3	Respiratory complications
998.0	Postoperative shock
999.1	Complications of medical care, not elsewhere classified; air embolism
999.4	Complications of medical care, not elsewhere classified; anaphylactic shock due to serum
999.5	Complications of medical care, not elsewhere classified; other serum reaction
999.9	Other and unspecified complications of medical care; not elsewhere classified; electroshock, inhalation, ultrasound, ventilation therapy
V15.1	Personal history of surgery to heart and great vessels
V42.1	Organ or tissue replaced by transplant; heart
V42.2	Organ or tissue replaced by transplant; heart valve
V43.2	Organ or tissue replaced by other means; heart
V43.3	Organ or tissue replaced by other means; heart valve
V45.00-V45.09	Cardiac device in situ
V45.81	Other postsurgical status; aortocoronary bypass status
V45.82	Other postsurgical status; percutaneous transluminal angioplasty status
V47.2	Other cardiorespiratory problems; cardiovascular exercise intolerance with pain (with); at rest, less than ordinary activity, ordinary activity
V53.3	Fitting or adjustment of cardiac device (reprogramming)
V53.31	Fitting or adjustment of cardiac pacemaker
V53.32	Fitting or adjustment of automatic implantable cardiac defibrillator
V53.39	Fitting or adjustment of other cardiac device
V71.7	Observation for suspected cardiovascular disease
V72.81-72.85	Preoperative evaluations; cardiovascular, respiratory, other, specified and unspecified

Diagnosis that Support Medical Necessity
See above.

ICD-9 Codes that do not Support Medical Necessity
Any ICD-9 codes not listed as payable in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Diagnosis that do not Support Medical Necessity
Any diagnosis not listed as payable in the "Diagnosis that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Reasons for denial
- Claims submitted with ICD-9 codes other than those listed above as covered.
- Documentation not supporting medical necessity
- Please, be aware it is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid but in addition, the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the beneficiary's medical record must support the medical necessity for the procedure. (Refer also to Reasons for Denial, Coding Guidelines, and the Documentation Requirements section of this policy). Electrocardiograms will also not be covered when they are not medically indicated or ordered on a screening (routine) basis.
- Inadequate medical record documentation
- Failure to submit the requested medical evidence
- Claims submitted with a ICD-9 code(s) other than those listed above

Noncovered ICD-9 codes
Any ICD-9 CM not included in this policy.

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding guidelines
- Use the appropriate revenue codes, HCPC, ICD-9 and units
- All ICD-9 diagnosis codes must be coded to the highest possible level of specificity

Documentation requirements
Documentation supporting the medical necessity of this diagnostic service must be kept on the provider's record and available to be furnished upon request. Failure to do so may result in rejection or denial of claim(s). This document should include but is not limited to: history and physical examination, notes documenting evaluation and management with relevant clinical signs, symptoms or abnormal laboratory test results. The patient's clinical record should further indicate changes/alterations and response or non-response in medications prescribed for the treatment of the patient's condition.

It is understood that any diagnosis information submitted must have (in the patient record) medical justification for components of said service. Subsequent determination that the medical record is lacking such justification will result in a retroactive denial under 1862(a)(1)(A).

Utilization guidelines
N/A

Other comments
N/A

Sources of Information and basis for decision

- Harrison's Principles of Internal Medicine, 1998.
- ICD-9-CM, 1999 and CPT-2000
- Braunwald E, Wilson JD, Martin JB, Fauci AS, Kasper DL) McGraw-Hill, New York (1994)
- Dorland's Illustrated Medical Dictionary, 28th ed. (Ed. WB Saunders Dictionary Staff) W. B. Saunders Co., Philadelphia (1994)
- Heart Disease A Textbook of Cardiovascular Medicine, 4th ed. (Ed. Braunwald E) W.B. Saunders Co., Philadelphia (1992)
- Medical policies from other Contractors; Empire & Noridian

Advisory Committee Notes

This policy does not represent the sole opinion of the Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from cardiology consultants.

Start date of comment period

March 25, 2002

Ending date of comment period

May 10, 2002

Start date of notice period

May 15, 2002

Revision history

Original policy – December 30, 1995
First Revision – R1
New diagnoses were added to the original policy in order to support medical necessity.

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GGL-1723

Contractor's policy number
VI/PR-02-030

Contractor name
Triple-S, Inc.

Contractor number
00973

Contractor type
Carrier

LMRP title
Lymphocyte Transformation

AMA CPT copyright statement

CMS National Coverage Policy
N/A

Primary Geographic Jurisdiction
Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
July 1, 2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description
Lymphocyte transformation tests evaluate lymphocyte competence using in vitro tests to assess the ability of the lymphocytes to proliferate and to recognize and respond to antigens. Two types of lymphocyte transformation tests, mitogen assay and antigen assay are discussed in this policy.

The mitogen assay, performed using nonspecific plant lectins, evaluates the mitoric response of T and B lymphocytes to a foreign antigen. In the mitogen assay, a purified culture of lymphocytes from the patient's blood is incubated with a nonspecific mitogen for 72 hours. The culture is then pulse-labeled with tritiated thymidine can be measured by a liquid scintillation spectrophotometer in counts per minute, which parallels the rate of mitosis. Lymphocyte responsiveness or the extent of mitosis, is then reported as a stimulation index, determined by dividing the counts per minute of the stimulated culture by the counts per minute of a control culture.

The antigen uses specific antigens, such as purified protein derivative (PPD), Candida, mumps, tetanus toxoid and streptokinase, to stimulate lymphocyte transformation. After incubation of 4 ½ to 7 days, transformation is measured by the same method used in the mitogen assay.
In the mitogen and antigen assays, a low stimulation index or unresponsiveness indicates a suppressed or defective immune system.

Indications and Limitations of Coverage and/or Medical Necessity
Medicare will consider a lymphocyte transformation test medically reasonable and necessary when performed for the following indications:

- To assess and monitor genetic and acquired immunodeficiency states (e.g., caused by marrow failure, certain drugs, etc.); and
- To monitor immunosuppressive or immunoenhancing therapy.

Note: This test is only covered when the patient has a suspected or known genetic or acquired immunologic disorder as demonstrated by the patient's history and physical. It is not covered as a screening test. In addition, it is expected that the results of this test will be used in the management of the patient.

CPT/HCPCS Section & Benefit Category
Immunology/Pathology and Laboratory

CPT/HCPCS codes
86353 Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity

042	Human immunodeficiency virus (HIV) disease
279.00-279.9	Disorders involving the immune mechanism
E933.1	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antineoplastic and immunosuppressive drugs

Diagnosis that Support Medical Necessity
Same as above.

ICD-9 Codes that do not Support Medical Necessity
Any ICD-9 codes not listed as payable in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Diagnosis that do not support medical necessity
Any diagnosis not listed as payable in the "Diagnosis that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Reasons for denial
When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9 codes
Any ICD-9 CM not included in this policy.

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding guidelines
Lymphocyte transformation is to be billed and reimbursed under 86353 code.

Documentation requirements
Medical record documentation maintained by the performing provider must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or laboratory results.

Documentation should support the criteria for coverage as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Utilization guidelines
The number of services billed to Medicare must strictly adhere to the medical necessity. Usually one service is acceptable per request.

Other comments
N/A

Sources of information and basis for decision
Illustrated Guide to Diagnostic Tests (2nd ed.) (1998). Springhouse Corporation.

Jacobs, D.S., DeMott, W.R., Grady, H.J., Horvat, R.T., Huestis, D.W., & Kasten B.L. (1996). Laboratory Test Handbook (4th ed.). Hudson: Lexi-Comp, Inc.

Advisory Committee Notes
This policy does not represent the sole opinion of the Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from laboratory services/CMD Florida.

Start date of comment period
March 25, 2002

Ending date of comment period
May 10, 2002

Start date of notice period
May 15, 2002

Revision history
N/A

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GGL-1731

Medical Review

MEDICAL REVIEW PROCESS

We would like to share with our provider community general information regarding the Medical Review process. It is important to keep our provider community informed about these issues.

Overview

All Medicare contractors are required to ensure that reimbursement is made only for those services that are reasonable and necessary. Additionally, for medically necessary services, the contractor is responsible for ensuring that they are rendered in the most cost-effective manner (e.g., consideration is given to the location of the service and the complexity and level of the care provided).

In order for Medicare to ensure that payment is made only for reasonable and necessary services, each Medicare contractor is required to perform extensive analysis of data on the frequency with which a service is allowed. The focus is on how physicians and services are trended and what Medicare does through the medical review process when coverage and utilization problems are identified, resulting in various plan of action to correct the problem.

Mission and Objectives of the Medical Review Process

The mission of the medical review process is to reduce the claim payment error rate. The data analysis involved in this process helps to identify potential billing problems. Once potential billing problems are identified, the contractor will validate them. When the causes of the validated problems have been determined, corrective actions are taken to correct any billing problems that cannot be justified.

The educational processes provided by Medicare ensure that a provider knows what to expect when a claim is submitted to the program.

The specific objectives of the medical review process include:

- Identification and prevention of inappropriate Medicare payments
- Utilization of national and local data to assure only those areas that present the most risk to the program are subjected to medical review
- Decline in denial rates (due to focused education)
- Increase in the effectiveness of newly developed Local Medical Review Policies (LMRPs)
- Education of providers on appropriate billing practices
- Ensuring the appropriate reimbursement of Medicare-covered services

Benefits to Medicare Providers

Medical review initiatives are designed to apply national payment criteria to define Medicare coverage of medical care through the development of medical policy, and to ensure that LMRPs and review guidelines are consistent with the accepted standards of medical practice. The medical review process provides the following benefits:

- ***Decreases denials***. Knowledge of appropriate claims guidelines can result in a reduction in filing errors and an increase in more timely payments.
- ***Improvement in the way Medicare reviews cases***. Development of LMRPs provide guidelines for the decision making process.
- ***Reduced claim reviews***. Because providers have a better understanding of when and what Medicare needs to support a service as it relates to claim documentation, the claim filing process is smoother and faster.
- ***Predictability in claim decisions***. Because local contractor policies are made available to all eligible providers through contractor publications and Web sites, there is less "guess work" on the behalf of the provider when furnishing information to support medical necessity.
- ***Emphasis on education***. Medicare offers educational opportunities through comprehensive articles and contractor-sponsored educational training events.

EVRE-5.06/Resident and New Physician Training/ CMS 03-02

PROGRESSIVE CORRECTIVE ACTION (PCA)

In order to keep our provider community informed about the Progressive Corrective Action (PCA), we would like to share more detailed information that will help you understand the whole PCA process.

What is it?

Medical Review PCA is a concept designed by the Centers for Medicare & Medicaid Services (CMS) for Medicare contractors to use when deploying resources and tools to conduct medical reviews. PCA ensures that medical review activities are targeted at identified problem areas and that corrective actions imposed are appropriate for the severity of the infraction of Medicare rules and regulations. There are four types of corrective actions that can result from medical review evaluations: education, policy development, prepayment review, and postpayment review.

How does it Works?

The decision to conduct medical review is driven by data analysis. Data analysis is the starting point in PCA to determine unusual or unexpected billing patterns that might suggest improper billing or payment. The data analysis may be general surveillance, or may be specific in response to complaints or reports from various agencies.

Validating the hypothesis of the data analysis is the next step. Before assigning significant resources to examine claims identified as potential problems, probe reviews are conducted. A probe review generally does not exceed 20-40 claims per provider for provider-specific problems, and does not exceed 100 claims distributed among the identified provider community

for general, widespread problems. All providers subject to a probe review are notified in writing that a probe review is being conducted, and are also notified in writing of the results of the review. Providers or facilities are asked to provide any and all medical documentation applicable to the claims in question.

What it Accomplishes?

Classification of the problem, if applicable, is the result of the probe review. The three classification levels are minor, moderate, or major. Provider-specific % error rate (number of claims paid in error), dollar amounts improperly paid are examples of items used to determine classification level.

If a minor problem is detected, the Medicare contractor will educate the provider on appropriate billing procedures, will collect the money on claims paid in error, and will conduct further analysis at a later date to ensure the problem was corrected.

If a moderate problem is detected, the contractor will educate the provider on appropriate billing procedures, will collect the money on the claims paid in error, and will initiate some level of prepayment medical review until the provider has demonstrated correction of his or her billing procedures.

If a major problem is detected, the contractor will educate the provider on appropriate billing procedures, will collect the money on the claims paid in error, will initiate a high level of prepayment medical view and/or a statistically valid random sample, payment suspension, and/or referral to the contractor's Benefit Integrity department (if and when appropriate).

It is important to mention that the Contractor will be evaluating the effectiveness of their corrective actions on targeted problem areas at least every 6 months until there is evidence that the problem is corrected.

Provider Education and Feedback

Along with the planned medical review activities, provider feedback and education around the review findings is an essential part of the medical review PCA process. When individual reviews are conducted, focused provider education is carried out. This means direct contact between the Medicare contractor and the provider through telephone contact, letter and/or face-to-face meeting. The overall goal of providing feedback and education is to ensure proper billing practices so that claims will be submitted and paid correctly.

EVRE-5.07/Resident and New Physician Training/CMS 03-02

ADMINISTRATIVE POLICIES RELATED TO PROCESSING CLAIMS FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES

Background

Section 4554(b)(1) of the Balanced Budget Act (BBA), Public Law 105-33 mandated the use of a negotiated rulemaking committee to develop national coverage and administrative policies for clinical diagnostic laboratory services payable under Part B of Medicare. BBA required that these national policies be designed to promote program integrity and national uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory services payable under Part B.

Policy

The administrative policies discussed herein apply to every diagnostic clinical laboratory service that is payable under Medicare Part B. Neither the place where the service was performed, nor the type of contractor that will process the request for payment has any effect on the applicability of these policies. A service done in a hospital laboratory, independent laboratory, physician/practitioner office laboratory or other type of CLIA approved laboratory service is subject to these administrative policies.

The treating physician must be the physician who orders any clinical diagnostic laboratory service.

Implementation

A. Limitation on Number of Diagnosis Codes

- Until implementation of the Health Insurance Portability and Accountability Act (HIPAA) requirement to accept eight or more diagnosis codes, some Medicare contractors may not have the capability to accept eight or more diagnosis codes in the diagnosis section of the claim. Claims containing any diagnosis code in excess of four (4) may be coded in the narrative field (Record HA0 from position 40).

B. Diagnosis and Procedure Codes Matching

- For claims submitted to carriers, the best way for laboratories to indicate that a service is non covered is to use the GY modifier to indicate a service is statutorily excluded or the GZ modifier to indicate a service is expected to be denied as not reasonable and necessary. A less preferable method is for a laboratory to submit a separate claim for the procedure that is not covered by Medicare, e.g. where the diagnosis code and procedure code do not correspond as required by the National Coverage Decision (NCD).

C. Ordering Practitioner

- Any of the administrative policies that relate to the individual who orders the service applies to a physician or a non-physician practitioner qualified under 42CFR410.32(a)(3) to order diagnostic services.
- Ordering practitioners include non-physician practitioners such as clinical nurse specialists, clinical psychologists, clinical social workers, nurse midwives, nurse practitioners, and physician assistants who furnish services that would be physician services if furnished by a physician and who work within the scope of their authority under State law and within the scope of the Medicare statutory benefit.*

*According to local regulations, non-physician practitioners are not allowed to order diagnostic services in Puerto Rico

D. Multiple Services

There are two CPT modifiers that identify multiple services for the same beneficiary on the same day. These modifiers are not interchangeable. The more frequently used modifier should be the '91'. Each has a specific use as described below.

- Modifier '59' indicates distinct procedural services.

  The modifier '59' is appropriate to report multiple service submissions by a clinical laboratory for the same beneficiary on the same day. These situations usually involve microbiology where samples or cultures are taken from a patient from different anatomical sites or different wounds, use the same CPT code, and then are tested the same day.

- Modifier '91' indicates repeat clinical diagnostic laboratory services.

  If an ordering physician requests a laboratory test that requires that several of the same services (CPT code) be performed for the same beneficiary on the same day, the laboratory should use modifier "91" to indicate that multiple clinical diagnostic laboratory tests were done on the same day.

Example: An arterial blood sample is drawn from a patient at three different intervals on the same day, and the blood testing is performed three times that same day, the CPT code 82803 – Gas, blood, any combination of pH, PCO2, PO2, CO2, HCO3 (including calculated 01 saturation). The laboratory should report the CPT code on the line item and code the modifier '91' after the CPT code. The information would appear as "82803 91" on the line item. Using either modifier does not relieve the laboratory of the responsibility to supply medical necessity documentation if requested by Medicare.

E. Narrative Diagnosis

- When required by local medical review policy (LMRP) or NCD, a laboratory that submits electronic claims must use ICD-9-CM codes rather than narrative descriptions. A laboratory that submits paper claims may use narrative descriptions.
- If a laboratory receives a requisition with a narrative description rather than an ICD-9-CM as the diagnosis, the laboratory may translate that narrative to the appropriate ICD-9-CM diagnosis code. The narrative does not have to exactly match the description of the submitted ICD-9-CM. The laboratory must maintain the requisition with the translated narrative description and submit it upon request.
- If the ordering physician submits an ICD-9-CM code on the requisition, the laboratory must use that code unless there is a reason to question the ordering physician to change the code. The laboratory must receive and maintain the documentation to alter the claim. The documentation may be written information from the ordering physician or a written note documenting the telephone call with the ordering physician. A faxed copy of the documentation is acceptable. The laboratory must maintain the documentation and submit it upon request.

F. Documentation Requirements

- The ordering physician must maintain documentation of medical necessity in the beneficiary's medical record.

- The laboratory must maintain the documentation that it receives from the ordering physician and must ensure that the information listed on the claim accurately reflects the documentation it received from the ordering physician.
- The laboratory may request additional diagnostic and other medical information from the physician to document that the services it bills are reasonable and necessary. If the laboratory requests additional documentation, it must request material relevant to the medical necessity of the specific service(s), taking into consideration current rules and regulations on patient confidentiality.

H. Signature on Requisition Form

Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record.

PM AB-02-030/CR1998/3-5-02/LV

Revisión Médica

EVALUACIÓN POSTPAGO A LOS CÓDIGOS DE CONSULTAS EN HOSPITAL

Debido al alto volumen de facturación de los códigos de consulta en hospital (99262-99263) en comparación con lo facturado en la nación durante el año 2001 decidimos realizar evaluaciones post pago de dichas reclamaciones. Esto como parte de las iniciativas del *Progressive Corrective Action.*

Para realizar este esfuerzo solicitamos expedientes a un grupo de proveedores de servicios médicos. Dichos expedientes fueron evaluados por nuestros Especialistas en Revisión. Los criterios de evaluación fueron validar el pago correcto de los servicios y que la documentación incluida en el expediente justificara el nivel de consulta facturado.

Deseamos compartir algunos de los hallazgos con respecto a la facturación del código 99263 (consulta en hospital):

1. El proveedor facturó una consulta en hospital y del expediente se desprende que realizó una visita subsiguiente a un paciente hospitalizado.
2. Se facturó el código de consulta inicial, cuando la documentación en el expediente sustenta que el paciente fue dado de alta.
3. Servicios facturados por un proveedor que no fue el que prestó el servicio.
4. Expedientes que documentan la decisión de admitir al paciente durante la consulta y para los cuales el proveedor factura la admisión al día siguiente de la consulta.

Deseamos informarles que los códigos de cuidado inicial o admisión en hospital (99221-99223) se utilizan para facturar el primer encuentro del médico de admisión con el paciente. Si el paciente es admitido al hospital en el curso de un encuentro, ya sea como resultado de una consulta en sala de emergencia, oficina o institución de enfermería especializada, todos los servicios de evaluación y manejo

Medical Review

POST-PAYMENT REVIEW OF HOSPITAL CONSULTATION CODES

Due to the high volume of claims billed with codes 99262 and 99263 (follow up – inpatient consultation) during year 2001 when compared to the nation we decided to execute a post payment review of these claims. This as part of the Progressive Corrective Action Initiative.

For this effort we requested medical records from a group of providers. Our Review Specialist evaluated these medical records with the purpose of validating the proper use of codes and that the documents included in the record justified the complexity level billed.

We would like to share some of the findings with respect to the use of code 99263:

1. *The provider billed for a consultation and documents in the medical record sustain that a subsequent hospital visit was carried out to an inpatient*
2. *The consultation code is billed when the documens in the medical record show a discharge summary for that date of service.*
3. *The provider that billed the service did not perform the same.*
4. *The medical records indicate that the decision taken during the consultation was to hospitalize the patient and we receive a claim for admission the day following the consultation.*

We would like to inform you that codes 99221-99223 are used to report the initial inpatient care provided the patient. When the provider decides to hospitalize the patient during the course of emergency room, office or skilled nursing home consultation all the services provided by the consulting physician are considered initial hospital visit . It is incorrect to bill for the consultation and the next day bill the initial hospital visit. Proper billing is to submit an initial claim for the

provistos por el médico consultor se consideran visita inicial o admisión al hospital cuando se realizan el mismo día. No es correcto facturar la consulta y al día siguiente facturar la admisión. La forma correcta de facturar ese primer encuentro es utilizar el nivel de consulta o admisión correspondiente y al día siguiente, los códigos de evaluación y manejo que representen la naturaleza o nivel de servicio prestado a paciente hospitalizado.

Para aquellos proveedores que prestan servicios en hospital, les sugerimos que verifiquen su facturación de manera que se aseguren que no están incurriendo en este tipo de práctica.

consultation or initial hospital visit and bill the following services as subsequent hospital services according to the level of service provided.

We suggest that if you provide inpatient services you review your billing patterns above mentioned and avoid those.

PCA 2002/DN/May 2002

INFORMACIÓN SOBRE FACTURACIÓN CONSOLIDADA PARA FACILIDADES DE ENFERMERÍA ESPECIALIZADA EN LA PAGINA DE INTERNET DE CMS

Desde el 1 de enero de 2002, bajo el tema "Consolidated Billing for Skilled Nursing Facility Residents Claims Billed to Medicare Carriers or DMERCs by Physicians, Non-Physician Practitioners, and Suppliers" los Centros para Servicios de Medicare y Medicaid (CMS) tiene disponible información sobre codificación de servicios correspondientes a facturación consolidada para facilidades de enfermería especializada. De acuerdo con el código de procedimiento, usted podrá determinar si los servicios que brinde a beneficiarios en una facilidad de enfermería especializada con estadía cubierta o no cubierta por la Parte A (beneficios de la Parte A agotados) están incluidos o excluidos de la facturación consolidada. La dirección electrónica de CMS para obtener la información es: www.hcfa.gov/medlearn/refsnf.htm

SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB) CODING INFORMATION ON CMS WEB SITE

As of January 1, 2002, coding information for Skilled Nursing Facilities Consolidated Billing may be found on the CMS Web site at www.hcfa.gov/medlearn/refsnf.htm under the topic "Consolidated Billing for Skilled Nursing Facility Residents Claims Billed to Medicare Carriers or DMERCs by Physicians, Non-Physician Practitioners, and Suppliers." You may use this information to determine by procedure code whether services rendered to beneficiaries in Part A covered SNF stays or non-Part A covered SNF stays, (Part A benefits exhausted), are included or excluded from CB.

Trans. B-02-002/CR1997/01-11-02/DG

Reembolso

POLÍTICA DE PAGO PARA EL TRANSPORTE EN AMBULANCIA AÉREA DE UN BENEFICIARIO FALLECIDO

Trasfondo

La reglamentación de Tarifas Fijas para Ambulancias prevee el pago parcial por el servicio de ambulancia aérea en los casos cuando ésta despegue para ir a recoger un beneficiario, pero el mismo ha sido declarado muerto antes de que la ambulancia aérea lo haya recogido.

Medicare tiene una política la cual autoriza el pago parcial por el servicio de ambulancia cuando esta inicia el viaje para recoger a un beneficiario, pero antes de que la ambulancia lo recoja, el beneficiario ha sido declarado muerto. Esta política no establece explícitamente que el servicio de ambulancia aérea esté incluido en la misma. La implantación de un sistema de tarifas fijas para ambulancias requiere una aclaración respecto a cómo esta política será implantada bajo el nuevo sistema de tarifas fijas.

Política

Medicare autoriza el pago por el servicio de ambulancia aérea cuando ésta despega para ir a recoger un beneficiario de Medicare, sí se certifica la muerte del beneficiario antes de que haya sido puesto en la ambulancia para ser trasladado (sea antes o después de que la ambulancia haya arribado a la escena). Esto es así siempre que el servicio de ambulancia aérea sea médicamente necesario. En tal situación, se aprobará la tarifa base que aplique, es decir, ambulancia aérea de ala fija o ala rotativa. Sin embargo, no se permitirá el pago por millaje ni por ajuste de área rural. Estos pagos sí procederán cuando el beneficiario esté vivo o no ha sido declarado muerto antes de ser trasladado.

Reimbursement

PAYMENT POLICY FOR AIR AMBULANCE TRANSPORTATION OF DECEASED BENEFICIARY

Background

The final regulation to establish an ambulance fee schedule contains a provision authorizing partial payment for an air ambulance service when an air ambulance takes off to pick up a beneficiary, but the beneficiary is pronounced dead before the pickup can be made.

Medicare has a longstanding policy to allow partial payment for an ambulance service where the ambulance begins its trip to pick up the beneficiary, but the beneficiary is pronounced dead before the pickup can be made. This policy does not explicitly include air ambulance service. The implementation of an ambulance fee schedule requires clarification regarding how this policy will be implemented under the fee schedule.

Policy

Medicare allows payment for an air ambulance service when the air ambulance takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is providing the air ambulance service would otherwise have been medically necessary. In such a circumstance, the allowed amount is the appropriate air base rate, i.e., fixed wing or rotary wing. However, no amount shall be allowed for mileage or for a rural adjustment that would have been allowed had the transport of a living beneficiary or of a beneficiary not yet pronounced dead been completed.

Reembolso

Para efectos de esta política, la declaración de muerte tendrá efectividad sólo cuando se haga por una persona autorizada por ley para realizar este tipo de declaración.

Esta política establece que no se pagarán aquellos casos en los cuales el "dispatcher" recibió la noticia de defunción con tiempo razonable para informar al piloto que no procediera con el vuelo. Tampoco se pagarán aquellos casos cuando la aeronave se desplace sobre la pista y no haya despegado.

Requisitos para Pago

Los suplidores deben usar el modificador QL (Paciente declarado muerto después de haberse llamado a la ambulancia) para indicar la circunstancia en que una ambulancia aérea despega para ir a recoger a un beneficiario, sí el beneficiario ha sido declarado muerto antes de que la ambulancia aérea lo haya recogido.

CR1961/PMAB-02-031/03-07-02/LV

Reimbursement

For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements.

This policy also states no amount shall be allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. Further, no amount shall be allowed if the aircraft has merely taxied but not taken off or, at a controlled airport, has been cleared to take off but not actually taken off.

Payment Requirements

Suppliers must use the modifier QL (Patient pronounced dead after ambulance called) to indicate the circumstance when an air ambulance takes off to pick up a beneficiary but the beneficiary is pronounced dead before the pickup can be made.

TARIFAS FIJAS DE CODIGOS DMEPOS SUJETOS A JURISDICCION LOCAL

A continuación indicamos la tarifa del código DMEPOS con jurisdicción local. Esta tarifa entró en vigor el 1 de enero del 2002:

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 fee became effective January 1, 2002.

Código HCPCS *HCPCS code*	Categoría *Category*	Tarifa fija PR *PR Fee Schedule*	Tarifa fija VI *VI Fee Schedule*
E0781RR	Capped Rental	$309.09	$263.56

IC/Transmittal AB-02-069/CR2161/May 9, 2002

Reembolso

TORADOL (CODIGO J1885) ACTUALIZACION TARIFA

La siguiente tabla incluye el nuevo precio para el medicamento Toradol. La tarifa tendrá vigencia 30 días después de la fecha de emisión de este boletín.

- Queremos recordarle que la política de pago para la facturación de las dosificaciones o concentraciones de este medicamento es como sigue:
- Se deberá usar la concentración aadecuada según la dosificación que se administre. Por ejemplo, si se administran 60mg., se deberá facturar la concentración de 60mg/2ml por la cantidad de $6.58. No se permitirá facturar 15 mg/ml cuatro veces.
- Las dosificaciones que pasen de los 60mg deberán facturarse combinando aquellas tarifas que sumen el total más bajo posible. Por ejemplo, la administración de 75mg deberá facturarse usando 60mg/ 2ml ($6.58 en la linea de la factura y 15mg/ml ($5.88) en la próxima linea de la factura. En ambas lineas deberá identificarse el código J1885.
- Se deberá mantener documentación en el récord del paciente indicando la concentración y la dosificación administrada.

Reimbursement

TORADOL (CODE J1885) PRICING UPDATE

The following table include the new price for the drug Toradol. These new fees will become effective 30 days after the emission date of this bulletin.

- *We would like to remind you that the payment policy for billing the concentration or dosage of this drug are the following:*
- *The appropriate concentration must be selected in accordance with the dosage administered. For example, if 60mg are administered, the 60mg/2ml concentration with an allowed amount of $6.58 should be billed. Four services of 15 mg/ml will not be allowed.*
- *Dosages over 60mg must be billed ensuring the lowest fee combination possible and should be broken down in the claim i.e. 75mg administered should be billed as 60mg/2ml ($6.58) on one line of the claim and 15mg/ml ($5.88) on the next line. Both lines should contain code J1885.*
- *Documentation to sustain concentration and dosage administered should be readily available in the medical record.*

DOSIFICACIONES ***DOSAGES***	**TARIFA** ***FEE***
15 mg/ml	$5.88
30 mg/ml	$6.10
60 mg/2ml	$6.58

Red Book 2002
EC/ProfDocs C1178/10-22-93

Reembolso

FACTURACIÓN CONSOLIDADA DE SERVICIOS DE SALUD EN EL HOGAR

La Facturación Consolidada de Servicios de Salud en el Hogar es un requisito del "Balanced Budget Amendment Act" de 1997. Ésta concierne a muchos grupos de proveedores.

Se llevarán a cabo denegaciones en la línea de la reclamación cuando un proveedor facture por servicios específicos prestados a un beneficiario durante un período cuando la agencia primaria de servicios de salud en el hogar facturó un episodio de cuidado para dicho beneficiario.

La agencia primaria de servicios de salud en el hogar no será responsable de reembolsar a los proveedores por servicios denegados ya que son parte de la facturación consolidada de servicios de salud en el hogar a menos que;

- el proveedor dé un servicio requerido en el plan de cuidado en el hogar y,
- el proveedor tenga un subcontrato con la agencia de servicios de salud en el hogar

Reimbursement

HOME HEALTH CONSOLIDATED BILLING

Home Health Consolidated Billing was required by the Balanced Budget Amendment Act of 1997. It affects many provider groups.

Line-item denials of claims occur for these providers if specific services are billed in a period of time when a primary Home Health Agency has billed a home health episode for a specific beneficiary.

The primary Home Health Agencies are not liable for reimbursement to providers for services denied because of Home Health Consolidated Billing unless:

- *the provider gives a service called for on the home health plan of care, and*
- *the provider has a subcontracting agreement with the home health agency*

AB-02-041/CR2080/03-29-02/IC

CODIGO DE MEDICAMENTOS NO CLASIFICADO J3490

Los siguientes medicamentos inyectables no tienen un código est ablecido por CMS, pero pueden facturarse al Programa Medicare utilizando el J3490 (Unclassified Drugs).

Para facturar estos medicamentos es necesario que se indique en la reclamación (Forma HCFA1500) la siguiente información en el encasillado 19 o en su equivalente en el formato NSF de facturación electrónica:

Medicamento / Drug	Dósis / Dosage	Tarifa / Fee
Cimetidine(Tagamet)	300mg/ml	$ 5.89
Famotidine (Pepcid)	10mg/ml	$ 1.95
Verapamil HCL (Isoptin)	5mg/2ml	$ 3.99
Nitroglycerin (Tridil)	5mg/ml	$ 1.59
Aranesp	25mcg	$ 118.46
Aranesp	40mcg	$ 189.53
Aranesp	60mcg	$ 284.29
Aranesp	100mcg	$ 473.81
Aranesp	200mcg	$ 947.63

a. Nombre del Medicamento

b. Concentración y dosis administrada

UNCLASSIFIED DRUGS CODE J3490

The following injectable medication do not have a permanent billing codes established by CMS, but can be billed to the Medicare Program using code J3490 (Unclassified Drugs).

When you submit a claim for any of these drugs, it is necessary for you to specify on the claim (HCFA1500) the following information on Block 19 or the equivalent in the NSF format for electronic claims:

a. Name of the drugs

b. Concentration and administered dosage

Rev. 09/1998-05/13/2002/ic

Reembolso

ACTUALIZACION TRIMESTRAL PRECIOS DE MEDICAMENTOS

A continuación le detallamos el procedimiento utilizado para la actualización trimestral de los precios de medicamentos. Además, le incluimos una lista de códigos actualizados para este trimestre. Estas tarifas serán vigentes para facturas recibidas 30 días después de la fecha de emisión.

Instrucciones para el Cómputo de Precios

Los medicamentos y productos biológicos se pagan a base del cargo más bajo entre lo facturado o el 95% del "Average Wholesale Price" (AWP) según requerido por el Código de Regulaciones Federales (42 CFR 405.517) y enmendado en el Federal Register (63 FR 58849). Las tarifas para los medicamentos y productos biológicos se desarrollan como sigue:

- Para medicamentos o productos biológicos de una sola fuente, el AWP será igual al AWP del único producto existente.
- Para medicamentos o productos biológicos de distintas fuentes, el AWP será igual a lo menor de lo siguiente:
  - La mediana del AWP de todas las formas genéricas del medicamento o producto biológico
  - El menor AWP de los productos de marca
- Después de determinar el AWP, se multiplicará por el 0.95 y éste será el nuevo límite de pago permitido para el medicamento o producto biológico.

Reimbursement

QUARTERLY PRICING UPDATE FOR DRUGS

The following are the normal drugs pricing and update procedures. In addition, we are including a list of codes updated for this quarter. These new fees will become effective for claims received 30 days after the emission date.

Methodology Used to Determined the Fees

Drugs and biological are paid based on the lower of the billed charge or 95% of the average wholesale price (AWP), as required in the Code of Federal Regulations, 42 CFR 405.517 and amended in Federal Register (63 FR 58849). Fees for drugs and biological are calculated as follows:

- *For a single-source drug or biological, the AWP equals the AWP of the single product.*
- *For a multiple-source drug or biological, the AWP is equal to the lesser of the following:*
  - *Median AWP of all of the generic forms of the drugs or biological.*
  - *The lowest brand name product AWP.*
- *After determining the AWP, it is multiplied by 0.95. The result is the new drug payment allowance limit.*

CR745/Transmittal AB-00-110/November 14,2000/IC
Data Source: Red Book CD ROM/April 2002

Códigos ***Codes***	**Medicamento** ***Dosis***	**Tarifa Part** ***Part Fee***	**Tarifa Non-Part** ***Non-Part Fee***
*J2780	Zantac/Ranitidine Hydrochloride, 25 mg	$ 1.89	$ 1.80
*J9293	Novatrone/Mitoxantrone Hydrochloride 5mg	$ 266.19	$ 252.88
*A9500	Technetium TC 99M Sestamibi,per dose	$ 121.69	$ 115.61
*A9502	Technetium TC 99M Tetrofosmin,per dose	$ 119.70	$ 113.71
J9217	Lupron Depot 7.5mg (1 month)	$ 592.60	$ 562.97
J9217	Lupron Depot 22.5mg (3 months)	$ 1,834.69	$ 1,742.95
J9217	Lupron Depot 30mg (4 months)	$ 2,446.25	$ 2,323.94

*****Estas tarifas serán efectivas inmediatamente.

Nota: Para calcular la tarifa de los medicamentos y productos biológicos, también se pueden utilizar otras concentraciones que no sean las descritas en los códigos de procedimientos HCPCS (ejemplo: dosis que se administren más frecuentemente).

*****_These fees are effective inmediately._

Note: Concentrations other than described by the procedure code may be used to calculate fees for drugs and biologicals (e.g., the most frequently administered dose).

Reembolso

NUEVAS PRUEBAS AL CERTIFICADO DE DISPENSA

Las siguientes pruebas han sido aprobadas por la Administración 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 que estos puedan ser reconocidos como pruebas de dispensa.

Reimbursement

NEW TESTS TO THE WAIVED CERTIFICATE

The following are the latest test 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*	FABRICANTE *MANUFACTURER*	CÓDIGO(S) CPT *CPT CODE(S)*
Forefront Diagnostics Drugfree@HOME THC/COC Test kit	Forefront Diagnostics Inc.	80101QW
GDS Technology STAT-Site Mhgb Test System	GDS Technology	85018QW

AB-02-070/CR2163/05-10-02/IC

TARIFAS "*GAP-FILLED*" PARA LABORATORIOS CLÍNICOS

En la página 3 de nuestra Carta Circular #M-01-11-002 (con fecha del 23 de noviembre de 2001 y dirigida a todos los Laboratorios Clínicos) publicamos los siguientes códigos CPT bajo el sub-tema "Códigos *Gap-Filled*" e indicamos que estas tarifas serían publicadas posteriormente. La siguiente tabla indica las tarifas para estos códigos, las cuales están vigentes desde el 1 de enero de 2002.

CR1887/11-05-01/EC

CLINICAL LABORATORY GAP FILLED FEES

On page 3 of our Circular Letter # M-01-11-002 (dated November 23, 2001 and addressed to All Clinical Laboratories) we published the following CPT codes under the sub-title "Gap-Filled Codes" and advises that these fees would be notified later on. The following table discloses the fees for these codes, which are effective as of January 1, 2002.

CODIGO *CODE*	TARIFA/*FEE*	
	PUERTO RICO	US VI
82274	$4.49	$8.98
82274QW	$4.49	$8.98
86336	$170.00	$21.53

Reembolso

CORRECCIÓN AL ARTÍCULO DE LA PRIMERA ACTUALIZACIÓN DE LAS TARIFAS FIJAS PARA MÉDICOS DE 2002

La siguiente tabla sustituye la que publicamos en el volumen 69 página 46 de nuestro boletín de enero, febrero, marzo 2002 . La información actualizada aparece en negrilla.

Reimbursement

CORRECTIONS TO THE ARTICLE OF THE FIRST UPDATE TO THE 2002 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

The following table substitutes the one published in volume 69 page 46 of our Jan, Feb, March 2002 bulletin. The updated information appears in bold.

CODIGO *CODE*	LUGAR DE SERVICIO *SETTING*	TARIFA PR *PR FEE*	TARIFA VI *VI FEE*
36533	Non-facility	$ 569.91	$ 771.68
	Facility	$ 264.75	$ 333.22
92136	Non-facility	$ 68.18	$ 93.61
	Facility	$ 68.18	$ 93.61
92136-TC	Non-facility	$ 44.16	$ 64.76
	Facility	$ 44.16	$ 64.76
92136-26	Non-facility	$ 24.02	$ 28.85
	Facility	$ 24.02	$ 28.85
93025	Non-facility	$ 192.80	$ 271.27
	Facility	$ 192.80	$ 271.27
93025-TC	Non-facility	$ 160.44	$ 232.49
	Facility	$ 160.44	$ 232.49
93025-26	Non-facility	$ 32.37	$ 38.77
	Facility	$ 32.37	$ 38.77
93784	**Non-facility**	**$ 31.39**	**$ 43.70**
	Facility	**$ 31.39**	**$ 43.70**
93786	Non-facility	$ 24.07	$ 34.80
	Facility	$ 24.07	$ 34.80
93790	Non-facility	$ 7.33	$ 8.89
	Facility	$ 7.33	$ 8.89
95250	Non-facility	$ 77.94	$ 112.20
	Facility	$ 77.94	$ 112.20
95903	**Non-facility**	**$ 40.41**	**$ 52.41**
	Facility	**$ 40.41**	**$ 52.41**
95903-TC	Non-facility	$ 14.12	$ 20.72
	Facility	$ 14.12	$ 20.72
95903-26	Non-facility	$ 26.29	$ 31.68
	Facility	$ 26.29	$ 31.68
97601	Non-facility	$ 32.07	$ 41.51
	Facility	$ 32.07	$ 41.51

Reembolso

SEGUNDA ACTUALIZACION A LA BASE DE DATOS DE LAS TARIFAS FIJAS PARA MEDICOS 2002

Los Centros para Servicios de Medicare y Medicaid notificó la segunda actualización trimestral a la base de datos de las Tarifas Fijas para Médicos del 2002.

Conforme a la Parte 3, 15902 del Manual de Medicare los cambios de esta actualización serán implementados al 1 de julio de 2002. Los cambios serán efectivos para reclamaciones con fecha de servicios de 1 de enero de 2002 en adelante.

Los cambios que se incluyen en esta primera actualización a la Base de Datos de las Tarifas Fijas para Médicos 2002 son las siguientes:

Reimbursement

SECOND UPDATE TO THE 2002 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

The Centers for Medicare and Medicaid Services notified the first Medicare Physician Fee Schedule Database (MPFSDB) quarterly update for 2002.

In accordance with the Medicare Carriers Manual Part 3, 15902, the changes in this update will be implemented on July 1, 2002. The changes will be effective for claims with dates of service January 1, 2002 or after.

Changes included in this second update to the 2002 Medicare Physician Fee Schedule Database are as follows:

CODIGO *CODE*	LUGAR DE SERVICIO *SETTING*	TARIFA PR *PR FEE*	TARIFA VI *VI FEE*
G0245	Non-facility	$ 48.41	$ 61.07
	Facility	$ 37.07	$ 44.77
G0246	Non-facility	$ 28.21	$ 36.07
	Facility	$ 18.93	$ 22.74
G0247	Non-facility	$ 30.62	$ 39.65
	Facility	$ 22.11	$ 27.43
G0248	Non-facility	$ 72.52	$ 104.42
	Facility	$ 72.52	$ 104.42
G0249	Non-facility	$ 51.39	$ 74.06
	Facility	$ 51.39	$ 74.06
G0250	Non-facility	$ 7.90	$ 9.61
	Facility	$ 7.90	$ 9.61

CPT Code:	G0245
Short Desc:	Initial foot exam ptlops
Proc Stat:	R
RVU Work:	0.88
Non-Fac PE RVU:	0.77
Fac PE RVU:	0.33
Malpractice RVU:	0.05
PC/TC:	0
SOS:	1
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	0
Bilt Surg:	0
Asst Surg:	0
Co Surg:	0
Team Surg:	0
Diag Supv:	09
TOS	1

NOTE: Effective for services performed on or after July 1, 2002.

CPT Code:	G0246
Short Desc:	Followup eval of foot pt lop
Proc Stat:	R
RVU Work:	0.45
Non-Fac PE RVU:	0.53
Fac PE RVU:	0.17
Malpractice RVU:	0.02
PC/TC:	0
SOS:	1
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	0
Bilt Surg:	0
Asst Surg:	0
Co Surg:	0
Team Surg:	0
Diag Supv:	09
TOS:	1

NOTE: Effective for services performed on or after July 1, 2002.

CPT Code:	G0247
Short Desc:	Routine footcare pt w lops
Proc Stat:	R
RVU Work:	0.50
Non-Fac PE RVU:	0.55
Fac PE RVU:	0.22
Malpractice RVU:	0.05
PC/TC:	0
SOS:	1
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	0
Bilt Surg:	0
Asst Surg:	0
Co Surg:	0
Team Surg:	0
Diag Supv:	09
TOS:	1

NOTE: Effective for services performed on or after July 1, 2002

CPT Code:	G0248
Short Desc:	Demostrate use home INR mon
Proc Stat:	R
RVU Work:	0.00
Non-Fac PE RVU:	2.81
Fac PE RVU:	2.81
Malpractice RVU:	0.01
PC/TC:	3
SOS:	1
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	0
Bilt Surg:	0
Asst Surg:	0
Co Surg:	0
Team Surg:	0
Diag Supv:	09
TOS Indicator:	1

NOTE: Effective for services performed on or after July 1, 2002

CPT Code:	G0249
Short Desc:	Provide test material,equipm
Proc Stat:	R
RVU Work:	0.00
Non-Fac PE RVU:	1.99
Fac PE RVU:	1.99
Malpractice RVU:	0.01
PC/TC:	3
SOS:	1
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	0
Bilt Surg:	0
Asst Surg:	0
Co Surg:	0
Team Surg:	0
Diag Supv:	09
TOS Indicator:	S

NOTE: Effective for services performed on or after July 1, 2002

CPT Code:	G0250
Short Desc:	MD review interpret of test
Proc Stat:	R
RVU Work:	0.18
Non-Fac PE RVU:	0.08
Fac PE RVU:	0.08
Malpractice RVU:	0.01
PC/TC:	2
SOS:	1
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	0
Bilt Surg:	0
Asst Surg:	0
Co Surg:	0
Team Surg:	0
Diag Supv:	09
TOS Indicator:	1

NOTE: Effective for services performed on or after July 1, 2002

CPT Code:	**G0251**
Long Desc:	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment
Short Desc:	Stereotactic radiosurgery
Proc Stat:	I
RVU Work:	0.00
Non-Fac PE RVU:	0.00
Fac PE RVU:	0.00
Malpractice RVU:	0.00
PC/TC:	0
SOS:	1
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	0
Bilt Surg:	0
Asst Surg:	0
Co Surg:	0
Team Surg:	0
Diag Supv:	09
TOS Indicator:	6

NOTE: Effective for services performed on or after April 1, 2002

CPT Code:	**Q3019**
Short Desc:	ALS emer trans no ALS servic
Proc Stat:	X
RVU Work:	0.00
Non-Fac PE RVU:	0.00
Fac PE RVU:	0.00
Malpractice RVU:	0.00
PC/TC:	9
SOS:	9
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	9
Bilt Surg:	9
Asst Surg:	9
Co Surg:	9
Team Surg:	9
Diag Supv:	09

NOTE: Effective for services performed on or after April 1, 2002

CPT Code:	**Q3020**
Short Desc:	ALS nonemer trans no ALS ser
Proc Stat:	X
RVU Work:	0.00
Non-Fac PE RVU:	0.00
Fac PE RVU:	0.00
Malpractice RVU:	0.00
PC/TC:	9
SOS:	9
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	9
Bilt Surg:	9
Asst Surg:	9
Co Surg:	9
Team Surg:	9
Diag Supv:	09

NOTE: Effective for services performed on or after April 1, 2002

CPT Code	Revision
19000	Bilateral Procedure Indicator = 0
19001	Bilateral Procedure Indicator = 0
19120	Bilateral Procedure Indicator = 0
19125	Bilateral Procedure Indicator = 0
19290	Bilateral Procedure Indicator = 0
37609	Bilateral Procedure Indicator = 1
50320	Multiple Procedure Indicator = 0
63030	Bilateral Procedure Indicator = 1
76085	CPT code 76085, computer aided detection, screening, is identified as an add-on service that can only be used in conjunction with CPT code 76092, screening mammogram. CPT code 76092 is not subject to the Part B deductible, so CPT code 76085 is also not subject to the Part B deductible.
90887	Procedure Status = B

CPT Code:	95824	95824	95824
Short Desc:	Electroencephalography		
Mod:		26	TC
ProcStat:	A	A	A
RVU Work:	0.74	0.74	0.00
Fac PE RVU:	0.80	0.38	0.42
Non-Fac PE RVU:	0.80	0.38	0.42
MP RVU:	0.05	0.03	0.02
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	9	9	9
No Rel Code:	0	0	0

IC/CR2161/5/1/2002

USING X12N 837 (VERSION 4010) WHEN SUBMITTING MEDICARE SECONDARY PAYER (MSP) CLAIMS

Effective October 16, 2002, Part B physicians and suppliers must submit all electronic MSP claims data to Medicare using the ANSI X12N 837 (version 4010), unless physician and suppliers request a one year extension to comply with HIPAA version 4010 under the provisions of the Administrative Simplification Compliance Act. Currently, there are fields to identify the other payer's allowed and paid amount on the 837, however, there is no field on the 837 to specifically identify the OTAF (Obligated to Accept as Payment in Full) amount. The OTAF amount is a payment (which is less than your charges) that you are required to accept or agree to accept as payment in full satisfaction of the patient's payment obligation. On most claims, the OTAF amount is greater than the amount the primary payer actually paid on the claim. The Medicare program uses the OTAF amount(s) when calculating its secondary liability on such claims when services are paid on other than a reasonable charge basis.

When you migrate to the X12N 4010 837, you must use the line level contract information (CN1) segment to report the OTAF. Report the OTAF in CN102 (Contract Amount) with a qualifier of "09" (Other) in CN101. If MSP data is received at the claim level, report the OTAF in 2300 CN102. If MSP data is received at the line level, report the OTAF in 2400 CN102. The X12N 4010 837 Professional Implementation Guide allows for claim level OTAF reporting using the CN1 segment as described above, as well as line level reporting using the line level CN1 segment. Furnish line level primary payer data, including the OTAF amount, when available.

The chart below identifies the segments and data elements that you must use to report: (1) the submitted charges, (2) the primary payer paid amount, (3) the primary payer allowed amount, and (4) the OTAF amount at the claim and the service line levels.

	837/3051	NSF	837 v 4010	Comments
Claim Total Submitted Charge	2-130-CLM02	XA0-12	2300 CLM02	Must be equal to the sum of the lines. If the lines are not equal, return the claim to the physician or supplier.
Claim Primary Payer Paid Amount	2-300-AMT02 AMT01 = D	DA1-14	2320 AMT02 AMT01 = D	Must be equal to the sum of the lines if the lines are available. If the lines are not equal, return the claim to the physician or supplier.
Claim Primary Payer Allowed Amount	2-300-AMT02 AMT01= B6	DA1-11	2320 AMT02 AMT01 = B6	Must be equal to the sum of the lines if the lines are available. If the lines are not equal, return the claim to the physician or supplier.
Claim OTAF Amount			2300 CN102 CN101=09, if 2400 CN101=09 is not available	Must be equal to the sum of the lines. If the lines are not equal, return the claim to the physician or supplier. The claim level CN1 should be used only when the service line CN1 is not available.
Line Submitted Charge	2-370-SV102	FA0-13	2400 SV102	None
Line Primary Payer Paid Amount	2-475-AMT AMT01 = D	FA0-35	2430 SVD02	None
Line Primary Payer Allowed Amount	2-475-AMT02 AMT01= B6	FB0-06	2400 AMT02 AMT01 = AAE	If there is no value in the Allowed Amount field, use the value in the Approved Amount field.
Line OTAF	2-475-AMT02 AMT01=CT	FA0-48	2400 CN102 CN101 = 09	None

B-02-025/CR2007
4-16-02/FA

Reclamaciones

FACTURAS CON FECHA DE SERVICIO POSTERIOR A LA FECHA DE DEFUNCIÓN

De acuerdo con las directrices de CMS con respecto al pago de reclamaciones por servicios a beneficiarios fallecidos, auditaremos a nivel postpago toda reclamación con fecha posterior a la fecha de defunción del beneficiario.

Nuestro Departamento de Reclamaciones enviará carta de sobrepago a todo proveedor que facturó por servicios brindados a beneficiarios con fecha posterior a la fecha de defunción del mismo.

Claims

BILLED DATE OF SERVICE AFTER A BENEFICIARY'S DATE OF DEATH

In response to CMS's guidelines regarding payment of claims of deceased beneficiaries, we will be conducting a post-payment review of all claims identified as billed after the beneficiary's death.

This article alerts providers that if they have billed for services rendered a beneficiary after the beneficiary's date of death they will be receiving an overpayment letter from our Claim's Department.

CR 2065/Transmittal AB-02-046/May 22,2002 els

CLAIMS IMPROPERLY REJECTED BY COMMON WORKING FILE DUPLICATE CROSSOVER EDIT

In our Jan. Feb. March bulletin (volume 69, pages 64 to 75) we published instructions on Consolidate Billing for Skilled Nursing Facility Residents. Shortly after this publication, during the April 2002 Release an edit for duplicate crossover on Skilled Nursing Facility claims was installed. This edit caused improperly rejected claims during April 1 to 15 2002. If you received a rejection with **Action Code CG (This is a duplicate of a charge already submitted)** during this period, which you understand is incorrect please resubmit the your claim for proper processing.

JSM-1586/May14, 2002/ic

Contrato

LA INICIATIVA DE "DO NOT FORWARD"

Los Centros para los servicios de Medicare y Medicaid (CMS por sus siglas en inglés) requieren que los "carriers" y los contratistas regionales de equipo médico duradero (DMERCs, por sus siglas en inglés) utilicen sobres con la nota impresa "Return Service Requested" para todos los cheques y remesas de pago que envían a los proveedores y suplidores. Esta iniciativa aplica sólo a las direcciones a las que se envían los pagos (Pay To address) y la correspondencia (Mailing address). La dirección física no se consideró en esta iniciativa.

Cuando un cheque es devuelto por el servicio postal el mismo será cancelado por personal de finanzas del contratista o DMERC y se añadirá un indicador a este proveedor/suplidor como "Do not Forward". Las reclamaciones sometidas posterior a este indicador serán procesadas y adjudicadas pero el pago se retendrá hasta que el proveedor/suplidor nos autorice un cambio en su dirección y el indicador sea removido.

Proceso de cambiar la dirección para contratistas y DMERCs

Si a usted le están reteniendo los pagos debido a problemas con su dirección y necesita cambiar la misma, deberá solicitar el cambio a través del formulario CMS 855I/B. El formulario debe estar firmado en original por el proveedor o por una persona debidamente autorizada. No se aceptarán facsímiles, copias ni sellos. Lo importante de este proceso es actualizar la dirección a la que se envían los pagos (Pay To) y la correspondencia (Mailing Address). Luego que el contratista verifica la información en el formulario CMS 855I/B, actualiza la dirección y se remueve el indicador de "Do not Forward" es entonces que se liberan todos los pagos retenidos por este proceso y se envían a los proveedores/suplidores.

Contract

THE "DO NOT FORWARD" (DNF) INITIATIVE

The Centers for Medicare and Medicaid Services (CMS) require carriers and DMERCs to use "Return Service Requested" envelopes for all checks and remittance advice, they mail to providers and suppliers. This initiative applies only to the "Pay To" address and "Mailing address". Physical addresses are not taken into consideration in this initiative.

When the check is returned by the postal service the carrier or DMERCs financial staff must cancel the returned check and notify the enrollment staff that the provider must be flagged "Do not Forward". Subsequent claims submitted by a flagged provider or supplier must be process to completion but checks are not generated until an authorized address correction is received and the flag removed.

Change of Address Process for Local Carriers and DMERCs

If due to problems with your address your payments have been withheld, and you need a change of address, you must complete a Form CMS 855I/B. The form must bear an original signature from the provider or an authorized representative of the entity that completed the original registration form. No copies, faxes, or stamps are acceptable. For purposes of this process, the most important address is the "Pay To" and "Mailing address". If the provider or supplier do not furnish the "Pay To" and "Mailing address" on Form CMS 855I/B, it will be returned to the provider or supplier. Enrollment staff will verify the address, they will update the address for the provider or supplier and remove the "Do Not Forward" flag. Once this process is complete withheld payments will be released and sent to the provider/supplier.

Contrato

Usted puede obtener el formulario 855I/B en nuestra página de internet: www.triples-med.org o comunicarse con uno de nuestros representantes de servicio al 1-877-715-1921.

Las instrucciones para la utilización de la nota impresa "Return Service Requested" en los sobres que contengan cheques están vigentes desde el 1 de octubre de 2000. Las instrucciones para la utilización de sobres impresos con dicha nota para las remesas de pago estarán en vigor el 1 de octubre 2002.

Sugerimos que aquellos proveedores que han confrontado problemas con su correspondencia se suscriban a pago directo (EFT por sus siglas en inglés). Los proveedores suscritos a este método de pago han notado mejoras en el proceso administrativo de sus oficinas. EFT es un método seguro para recibir sus pago, además simplifica la reconciliación de los reembolsos realizados por Medicare.

A través de EFT, Medicare transfiere sus pagos directamente a su cuenta de cheque o ahorros de su banco preferido. Los depósitos que Medicare efectúe a cuenta serán debidamente informados en el estado de cuenta que mensualmente le envía su banco.

Sí desea suscribirse a EFT, favor de completar el formulario adjunto y someta el mismo con un cheque CANCELADO.

Contract

You can obtain form 855 I/B at our web page www.triples-med.org or you may contact one of our Customer Service Representatives at 1-877-715-1921.

The instructions to use "Return Service Requested" envelopes for all checks became effective on October 1, 2000. Instructions to use "Return Service Requested" envelopes for remittance advice will become effective on October 1, 2002.

We suggest that those providers that have experienced problems with their mail consider the use of Electronic Funds Transfer (EFT). According to those providers that have subscribed to EFT, this payment method has improved their administrative process. EFT has provided these providers with a safer means of receiving Medicare reimbursements. It also represents a financial advantage since it makes payment reconciliation simpler.

Through EFT, Medicare deposits your payments directly to your checking or savings account of the bank of your preference. These deposits will be duly reported on your bank's monthly account statement.

If you are interested in subscribing to EFT complete the enclosed form submit the same to our office with a VOID check.

B-02-023/CR 681/CR2038/ 04-12-02/ IC

Contrato | Contract

U.S. Department of Health and Human Services
Health Care Financing Administration

FORM APPROVED
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFERS

Provider/Physician Name	Provider/Physician ID Number

I hereby authorize _____, hereinafter called COMPANY, to initiate credit entries and if necessary, adjustments for any credit entries in error to my ☐ Checking ☐ Savings account (*select one*) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit the same to such account.

Depository Name	Branch	
City	State	Zip Code
Transit Number	Account Number	

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Name (Please Print)	Title (Please Print)
Signature	Date

HCFA-588 (12-92)

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp., Vol. 1, Page 419 and Page 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

Furnishing information is voluntary, but without it we will not be able to process your electronic funds transfer.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0626. The time required to complete this information collection is estimated to average 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information and Regulatory Affairs, Office of management and Budget, Washington, D.C. 20503.

☆U.S. GOVERNMENT PRINTING OFFICE: 1998 -452-485/85023

Contrato

FORMULARIOS PARA LA INSCRIPCIÓN DE PROVEEDORES/ SUPLIDORES EN FORMATO ELECTRÓNICO

Los Centros para Servicios de Medicare y Medicaid (CMS, antes HCFA) tiene disponible cinco formularios de Medicare para la inscripción de proveedores/suplidores en formato electrónico. Puede acceder a través de la siguiente página de CMS en Internet: http://www.hcfa.gov/medicare/enrollment/forms/.

Estos formularios incluyen el CMS 855A, CMS 855B, CMS 855I, CMS 855R y CMS 855S. Se ofrece, además, una extensa guía con instrucciones detalladas de cómo obtener estos formularios. Los proveedores/ suplidores pueden completar el formulario en su computadora, grabar éste como un archivo e imprimirlo para la firma y enviarlo al contratista o intermediario. En este momento, los proveedores/suplidores no pueden enviar estos formularios electrónicamente.

Contract

ELECTRONIC MEDICARE PROVIDER/SUPPLIER ENROLLMENT FORMS

The Center for Medicare and Medicaid Services has five electronic Medicare Provider/Supplier Enrollment forms that can be accessed at http://www.hcfa.gov/medicare/enrollment/forms/ on the CMS web site.

These forms include the CMS 855A, CMS 855B, CMS 855I, CMS 855R and CMS 855S. A comprehensive user guide, providing detailed instructions on how to download these applications, is also available on the web site. Providers/suppliers can complete a form on their computer, save it as a file, and print the completed form for signature and submission. Providers/suppliers cannot submit these forms electronically at this time.

B-02-012/CR2045/ 02-28-02/ IC

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 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 la lista de los proveedores reintegrados al Programa Medicare y en la siguiente página la lista de los proveedores que han sido excluídos 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 Medicare providers, we have included the list of the reinstated providers to the Medicare Program and on the next page the list of excluded providers to the Medicare Program:

Proveedores Reinstalados en el programa Medicare
Providers Reinstated in the Medicare Program

NOMBRE/ *NAME*	DIRECCION/ *ADDRESS*	FECHA EFECTIVIDAD / *EFFECTIVE DATE*
Capó Fernández, Yolanda	Plaza Vega Baja Pearl Vission Express Vega Baja, PR 00693	January 15, 2002

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*
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
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 / Urb. Santa Rosa Bayamón, PR 00960	Indefinite	September 20, 2001
Jimenez Casso, José	Urb. Santa Rosa / 51-37 Ave. Main Bayamón, PR 00959	Indefinite	January 20, 2002
López Morales, Angel	Ave. A Buenas Bloque 20 #31 Urb. Santa Rosa Bayamón, PR 00959	Indefinite	January 20, 2002
Ramos, Mélendez, Marcos U.	P.O. Box 999 Rio Grande, PR 00745	Indefinite	April 20, 2000
Caro Acevedo, Eduardo	Santa Rosa Mall / Suite 201 Segundo Nivel Bayamon, PR 00959	Indefinite	March 20, 2002
Montañez López, Carlos W.	Optica Marbella / Carr. 107 Km 1 Aguadilla, PR 00603	Indefinite	March 20, 2002
Olivari milan, Jose A.	Bo. Miradero / Carr. 102 Km 19 HM 2 Cabo Rojo, PR 00623	Indefinite	April 18, 2002
Vigo Sierra, Myrna L.	Bo. Miradero / Carr. 102 Km 19 HM 2 Cabo Rojo, PR 00623	Indefinite	April 18, 2002
Santini Olivieri, Francisco A.	4 Calle Hostos Juana Diaz, PR 00795	Indefinite	April 18, 2002

Integridad del Programa

¡ESTÉ ALERTA!

La División de Medicare recibió un Alerta Nacional de Fraude con relación al asunto publicado en el volumen 64 de nuestro Boletín Medicare Informa. Es por ello que publicamos nuevamente el artículo.

AVISO IMPORTANTE A LOS PROVEEDORES DE MEDICARE

Recientemente recibimos información de que personas están visitando a los proveedores con el propósito de "instalarles" en su computadora personal un programa de facturación electrónica. Estas personas alegan representar a CMS o Medicare pero no utilizan una identificación oficial. Las personas le indican al proveedor que el programa cumple con los cambios de la reglamentación HIPAA y a través de un disco compacto acceden a la computadora personal del proveedor.

Deseamos informarles a todos nuestros proveedores que en este momento ni CMS ni este Carrier están enviando personas para instalar programas de facturación relacionado con los cambios que requiere HIPAA. Si en un futuro este Carrier toma esta iniciativa, la misma será notificada por los medios oficiales de comunicación que tiene Medicare. Además, nuestro personal estará debidamente identificado de manera tal que usted pueda validar que en efecto es un representante del Carrier.

Esté alerta, verifique la identidad de cualquier persona que le haga este tipo de acercamiento o le ofrezca servicios. Recuerde que a través de la computadora se puede acceder información privada de los beneficiarios y del proveedor, que luego puede ser utilizada para estafar al Programa Medicare.

Re: NMFA 2001-07/LC/4-2002

Program Integrity

BE AWARE!

The Medicare Division received a National Medicare Fraud Alert regarding the subject of an article published in Volume 64 of our Medicare Bulletin. This a reprint of that article.

IMPORTANT NOTICE TO ALL MEDICARE PROVIDERS

Recently we have received information that individuals are visiting providers offering to install in their personal computers software for electronic Medicare billing. These persons identify themselves as CMS or Medicare representatives, but they are not showing an official identification. They inform the provider that the software is in compliance with the new HIPAA regulation and through a compact disk they access the provider's personal computer.

We wish to notify all providers that at this moment neither CMS nor this Carrier is sending personnel to "install" electronic billing software related with the changes in the HIPAA regulation. If in the future, this Carrier takes this initiative, we will notify you through Medicare's official communications. Furthermore, our representatives will identify themselves in a way that you can validate that he or she is a representative of our Carrier.

Be alert, verify the identity of any person that makes such an approach or that offers these services. Remember that through your personal computer valuable information of your beneficiaries or your personal information could be accessed and this information can be used to defraud the Medicare Program.

Relaciones con la Comunidad

NUEVO MODIFICADOR PERMANENTE PARA CUANDO SE REQUIERE CONSERVAR DOCUMENTACIÓN EN EXPEDIENTE

Se implantó un nuevo modificador nacional para ser utilizado por proveedores y suplidores en aquellos casos en que la política de un contratista de Medicare requiera que se conserve en el expediente documentación específica en relación con la reclamación enviada.

En toda factura por servicios brindados desde el 1 de julio de 2002, los cuales afecte esta directriz, se debe utilizar el modificador:

> **KX**: "Documentación específica requerida en expediente"

Este modificador es necesario sólo en facturas en las que la política nacional o local específicamente requiere su uso para un equipo médico o servicio en particular. La Parte B de Medicare puede requerir expedientes médicos, órdenes médicas, equipo médico o cualquier servicio por el cual paga. Sin embargo, los suplidores y proveedores no necesitan utilizar el nuevo modificador con todo código HCPCS o línea de servicio en cada factura. El nuevo modificador se utilizará solo cuando la factura corresponda a equipo médico o servicios para los cuales una política local o nacional requiera su uso.

Tr.B-02-003/CR1948/01-22-02/LV
Tr.B-02-026/CR2155/04-25-02

Community Relations

NEW PERMANENT MODIFIER FOR "SPECIFIC REQUIRED DOCUMENTATION ON FILE"

A new national modifier has been established to be used by providers or suppliers when a contractor's policy specifically requires the use of a modifier for "specific required documentation on file."

Any claim for services performed on and after July 1, 2002, for which this instruction applies, must be submitted using modifier:

> ***KX**: "Specific Required Documentation on File"*

This modifier is required only on claims where national policy or LMRPs specifically require its use for a particular item or service. Medicare Part B requires "documentation" (e.g., medical records, a prescription) for any item or service for which it pays. However, suppliers and providers need not use the new modifier on every Healthcare Common Procedure Coding System (HCPCS) code or line item on every claim. Providers and suppliers need to use the modifier only when the claim is for items or services for which LMRP or national policy requires its use.

Relaciones con la Comunidad

NUEVA FUENTE DE INFORMACIÓN AL PROVEEDOR DISPONIBLE EN LA PÁGINA ELECTRÓNICA DE CMS

El 22 de abril de 2002, Los Centros para Servicios de Medicare y Medicaid (CMS) publicaron el primer ejemplar de *The CMS Quarterly Provider Update.* Los futuros ejemplares se publicarán el primer día laborable de cada trimestre subsiguiente. Estas actualizaciones trimestrales incluirán todos los cambios a las instrucciones de Medicare que afectarán a los proveedores o que puedan ser de interés para ellos. Éstas proveerán un recurso único para información nacional de Medicare a los proveedores y les dará un alcance de las próximas instrucciones y reglamentaciones.

La primera publicación es un documento creado para Internet que se encuentra disponible en: http://www.cms.hhs.gov/providerupdate. Para facilitar el uso de este documento a los proveedores individuales, las reglamentaciones e instrucciones se organizarán de acuerdo con los intereses del usuario.

Cada actualización incluirá el texto completo de instrucciones a implantarse en 90 días o más, después de su publicación. Por ejemplo, las instrucciones incluidas en la actualización de abril tendrán fecha de implantación del 1 de julio de 2002 o más tarde. Las listas de reglamentaciones serán presentadas en dos partes. Una parte contendrá todas las reglamentaciones que CMS planifica publicar dentro de los próximos 90 días. La segunda parte incluirá enlaces al texto de todas las reglamentaciones publicadas en el trimestre anterior.

La meta de CMS facilitarle a los proveedores el entender y cumplir con las reglamentaciones e instrucciones de Medicare y brindarles tiempo para revisar y reaccionar a próximos cambios en el programa. Para mejorar futuros ejemplares del *The CMS Quarterly Provider Update* y asegurar que éstos respondan a las necesidades de los proveedores, se incluirá un formulario para comentarios en cada ejemplar. CMS exhorta a aquellos que acceden la publicación a utilizar dicho formulario para que envíen comentarios sobre su utilidad, organización y formato.

Community Relations

NEW SOURCE OF PROVIDER INFORMATION AVAILABLE ON CMS WEB SITE

The Centers for Medicare and Medicaid Services (CMS) released the first issue of The CMS Quarterly Provider Update *on April 22, 2002. Future issues will be released the first work day of each subsequent calendar quarter. These quarterly Updates will include all changes to Medicare instructions that affect providers, or may be of interest to them. They will provide a single source for national Medicare provider information and give providers advance notice on upcoming instructions and regulations.*

The first release is a Web-based document and is available at http://www.cms.hhs.gov/providerupdate. For ease of use by individual providers, regulations and instructions are collated and sorted based on the interests of the user.

Each Update will include the full text of instructions to be implemented 90 or more days after its release. For example, instructions included in the April Update will have an implementation date of July 1, 2002 or later. The listings of regulations will be presented in two parts. One part will list all regulations CMS plans to publish within the next 90 days. The second part will include hyperlinks to the text of all regulations published in the previous quarter.

CMS' goal is to make it easier for providers to understand and comply with Medicare regulations and instructions and to give them time to review and react to upcoming program changes. To improve future issues of the Update and ensure they are responsive to provider needs, a feedback form will be included with each issue. CMS encourages anyone accessing the Update to use the feedback form to forward comments on its utility, organization and format.

AB-02-049/CR1868/4-24-02/LV

Relaciones con la Comunidad

PAGOS POR SERVICIOS DE TERAPIA DENEGADOS INDEBIDAMENTE

En abril de 2001 HCFA (ahora CMS) publicó una lista actualizada de códigos HCPCS correspondientes a servicios sujetos a facturación consolidada de servicios de salud en el hogar. Estos servicios serán denegados si son facturados a cualquier intermediario o *carrier* de Medicare durante un episodio de salud en el hogar. Esto es debido a que el pago se le provee a la agencia de salud en el hogar que atiende el episodio. (Referirse al volumen 66, página 62 de nuestro boletín de abril, mayo, junio 2001).

CMS instaló éditos en el sistema para procesar facturas por servicios y suministros correspondientes a los códigos en la mencionada lista, con fechas de servicio que coincidan con un episodio abierto de cuidado de salud en el hogar bajo el sistema de pago prospectivo.

Debido a los éditos que fueron instalados en octubre de 2000 a septiembre 2001, algunas reclamaciones por servicios de terapia que debían ser pagadas, fueron incorrectamente denegadas. Estas denegaciones ocurrieron en aquellos casos en que el beneficiario recibió servicios de terapia antes de que finalizara el periodo establecido de 60 días basado en el sistema de solicitud de pago adelantado (RAP, por sus siglas en inglés), pero antes de que la agencia de salud en el hogar enviara la reclamación para finalizar dicho episodio.

Los terapeutas que enviaron las reclamaciones recibieron denegaciones con la siguiente nota:

> **B15**: "Reclamación denegada/reducida porque este procedimiento/servicio no se paga separadamente"

En octubre de 2001 CMS revisó los éditos para corregir este problema. Por lo tanto, las reclamaciones por servicios de terapia y suministros que se envíen bajo estas circunstancias no serán rechazadas como incluidas en el episodio de cuidado de salud en el hogar bajo el sistema de pago prospectivo, si fueron procesada desde el 1 de octubre de 2001.

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PAYMENT FOR THERAPY SERVICES WRONGFULLY DENIED

An updated list of Healthcare Common Procedure Coding System (HCPCS) codes corresponding to services that were subject to home health consolidated billing was released by HCFA (Now CMS) on April 2001. These services are subject to denial when billed to either Medicare intermediaries or carriers at the same time as a home health episode because payment is provided to the home health agency creating the episode. (See Volume 66, page 62 of our April, May and June 2001 bulletin).

CMS installed edits in the system to process claims for services and supplies with dates of service falling within an open home health Prospective Payment System (HH PPS) episode of care corresponding to the codes on the list.

Due to the edits that were in place October 2000 through September 2001, some claims for therapy services that should have been paid were improperly denied. These improper denials occurred when the beneficiary received therapy services prior to the end of the 60-day period that was established based on the request for advanced payment (RAP) but before the home health agency filed the claim to end the episode.

The therapists got this denial with remittance advice notice:

> ***B15**: "Claim denied/reduced because this procedure/service is not paid separately."*

CMS revised the edits to correct this problem in October 2001. Therefore, claims that are submitted for therapy services and supplies under these conditions are not being rejected as bundled into HH PPS episode if processed on or after October 1, 2001.

Relaciones con la Comunidad

Los terapeutas que pueden volver a enviar las reclamaciones denegadas siempre que cumplan con los siguientes criterios:

- Las reclamaciones denegadas fueron sometidas desde el 1 de octubre de 2000, pero antes del 1 de octubre de 2001
- Las reclamaciones correspondían a servicios de terapia incluidos en la facturación consolidada de servicios de salud en el hogar

Las facturas se pagarán si no confligen con el periodo entre la primera y la última fecha de servicio de un episodio de servicios de salud en el hogar. De confligir, serán nuevamente denegadas debido a que el sistema ha sido correctamente editado para que funcione de acuerdo con el sistema de facturación consolidada de servicios de salud en el hogar.

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Therapists may resubmit the denied claims where each of the following criteria are met:

- *Claims were submitted on or after October 1, 2000 but before October 1, 2001.*
- *Claims were for therapy services bundled into home health consolidated billing.*

These resubmitted claims will be paid if they do not overlap with the period between the first and last service date in a home health episode, but if they do overlap with such periods, they will again be denied because they are correctly being edited for home health consolidated billing.

B-02-009/CR1991/2-08-02/LV

IMPORTANT DRUG WARNING

COUNTERFEITING OF EPOGEN®

May 24, 2002 ADDITIONAL COUNTERFEIT LOTS

Amgen Inc. is updating its information to patients, physicians, pharmacies, and wholesalers to report additional counterfeit EPOGEN® (Epoetin alfa). In addition to lot number P002970, discussed in the notice below dated May 8, 2002, the following lot numbers contain counterfeit drug product.

EPOGEN® 40,000 U/ml
Lot Number: P001091 Expiration: 09/02
Lot Number: P001486 Expiration: 12/02

Please carefully review the information below in examining EPOGEN® before use.

May 8, 2002

Dear Health Care Professional:

Amgen Inc. recently became aware of the existence in the U.S. of a counterfeit drug product labeled as EPOGEN® (Epoetin alfa) 40,000 U/ml vials in ten-pack boxes, lot number P002970 and expiration 7/03. In cooperation with the U.S. Food and Drug Administration (FDA), Amgen is informing patients, physicians, pharmacies, and wholesalers about this potentially serious health risk. EPOGEN® is primarily used for the treatment of anemia associated with chronic renal failure for patients on dialysis.

The counterfeit vials examined by Amgen to date contain a clear liquid that contains active ingredient. However, the concentration of active ingredient is approximately 20 times lower than expected for EPOGEN® 40,000 U/ml vials.

Pharmacists and all other health care professionals should carefully examine EPOGEN® before use. The following information may help in determining if the product you have is counterfeit. In order to view pictures illustrating these differences, please log onto Amgen's web site at www.amgen.com/corporate/AmgenNews.html.

Features of authentic EPOGEN®	Features of counterfeit product
Amgen logo on carton closure label on exterior of box will shift colors from blue to purple when viewed at different heights.	Amgen logo on carton closure label on exterior of the box lacks color shifting properties (remains blue when viewed at different heights).
Degree sign present for storage temperature on vial label. "Store at 2° to 8° C"	Degree sign missing from storage temperature on vial label. "Store at 2 to 8 C"

If you receive any product that you suspect is counterfeit, quarantine it and store it under labeled conditions. Please promptly contact FDA for further instructions at 1-800-835-4709. If you have questions about EPOGEN®, please contact Amgen Medical Information at **1-800-772-6436**. Please convey this information to your staff and any others who administer EPOGEN®. You should instruct them on what to look for and what to do in the event they find a suspect counterfeit vial.

Amgen does not recommend the purchase of Amgen products from wholesalers that do not currently purchase EPOGEN® directly from Amgen. A list of wholesalers that currently purchase EPOGEN® directly from Amgen can be found on its website at www.amgen.com/product/productCenter.html. The parties on this list are the only wholesalers whom Amgen currently sells to for distribution of its products. If you have purchased Amgen product from another source, you should verify the origin of that product by contacting the distributor.

Amgen is cooperating fully with the FDA to investigate this matter and prevent the further distribution of counterfeit product. To Amgen's knowledge, the counterfeit product has only been found in distribution in the U.S.

Full product information and any updates on this situation are available on the web at www.amgen.com.

William Sheridan, MB, BS, FRACP
Vice President, Medical Affairs
Amgen Inc.
Other Contact Information:
U.S. Food and Drug Administration (for press inquiries): (301) 827-6242

SULZER INTER-OP ACETABULAR SHELL RECALL SETTLEMENT WITH CMS

The Centers for Medicare and Medicaid Services (CMS) and Sulzer Orthopedics have resolved a dispute concerning the application of the Medicare Secondary Payer (MSP) laws to a Sulzer recall of certain Inter-Op acetabular shells for hip implants. This article summarizes the dispute and its resolution and provides guidance to physicians and other suppliers on the actions the physicians and other suppliers need to take as a result.

In December 2000, Sulzer Orthopedics recalled approximately 17,500 Inter-Op acetabular shells used in connection with hip implant procedures. Sulzer advised providers, physicians and recipients that it would cover the cost of "unreimbursed medical expenses" related to the monitoring and possible replacement of the hip implants and related services. The MSP laws preclude Medicare payment for services when payment has been made, or can reasonably be expected to be made, under a liability insurance policy or plan (including a plan of self-insurance). The CMS considered Sulzer's initial assurance of payment for "unreimbursed medical expenses" to constitute a "reasonable expectation of payment under a liability insurance policy or plan" and held that Sulzer (and its insurers) were the primary payers for these services. Sulzer disagreed and takes the position that it is not subject to recovery under the MSP provisions.

The CMS and Sulzer agreed to try to resolve the dispute through negotiation. The CMS asked its Medicare contractors to advise providers and suppliers to hold claims while it determined whether the claims should be sent to Sulzer or the appropriate Medicare contractor for processing. If a physician or other supplier did not wish to await such guidance from CMS, it could submit a paper claim with the annotation that the claim was related to the Sulzer recall. Such claims were to be held by the Medicare contractors until CMS determined whether Medicare should process the claims.

The CMS and Sulzer have reached a final settlement regarding the processing of claims related to medical services provided to Medicare beneficiaries in conjunction with a revision of a recalled Inter-Op acetabular shell. Under the settlement, Medicare will process any claims for such services and should not look to Sulzer, its liability insurance plans, the Sulzer Class Action Settlement, or the Medicare beneficiaries for repayment of any claims in connection with the hip implant devices. Other Medicare payment and coverage rules for these services will be applied. The CMS has further agreed that Medicare will consider there to exist "good cause" for failure to submit an assigned physician or other supplier claim within 1 year of the date of service but filed before November 30, 2002, if the supplier submits a hard copy claim and includes with the claim a signed statement that the services delineated on the claim were related to a revision of a Sulzer Inter-Op acetabular shell that was recalled in December 2000; and the delay in submitting the claim was attributable to CMS's advice to hold claims. Physicians and other suppliers are encouraged to submit claims related to the Sulzer recall as soon as possible.

If a physician or other supplier submits an initial claim to Medicare for primary payment and receives such primary payment, under the terms of the settlement, physicians or other suppliers may bill Sulzer for Medicare deductibles, Medicare coinsurance and services not covered by Medicare under applicable Medicare coverage guidelines. If a physician or other supplier receives a payment from Sulzer, its liability insurance plans or the Sulzer Class Action Settlement, it may not bill Medicare on a secondary payer basis.

JSM 1592/May 20, 2002/dmg

A TODOS LOS PROFESIONALES DE LA SALUD

Le notificamos que el boletín **Medicare Informa** correspondiente al trimestre de julio a septiembre de 2002, no se publicará en papel.

Por lo tanto, no recibirán el boletín. Podrán acceder el mismo en nuestra página de Internet a la siguiente dirección: www.triples-med.org a partir de la primera semana de septiembre de 2002.

TO ALL HEALTH CARE PRACTITIONERS

*The **Medicare Informa** bulletin corresponding to the July-September 2002 quarter will not be printed and mailed.*

This bulletin will be posted at our website: www.triples-med.org, it should be available for your viewing the first week of September 2002.

JSM/petbulletin/May 22,2002/els

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