Medicare Informa
División Medicare / Parte B

¡Qué Bueno Que Preguntó!

INSTRUCCIONES PROVISIONALES PARA LA ACTUALIZACIÓN ANUAL DE TARIFAS FIJAS DE MÉDICOS

Los Centros para Servicios de Medicare y Medicaid (CMS) anualmente revisan las tarifas fijas de médicos siguiendo las instrucciones publicadas en la reglamentación final (Final Rule) sobre este tema. En vista de la demora en la emisión de esta reglamentación, los planes para implantar las tarifas fijas del 2003 tienen que ser modificados. Por esta razón, CMS ha emitido las siguientes instrucciones provisionales, que estarán vigentes hasta que la reglamentación final esté disponible:

Cont. en pág. 4

We Are Glad You Asked!

INTERIM INSTRUCTIONS FOR CALENDAR YEAR 2003 PHYSICIAN FEE SCHEDULE SERVICES

CMS updates the Medicare Physician Fee Schedule (MPFS) annually following the instructions set-forth in the MPFS final regulation. In view of the delay in emission of this regulation, implementation plans for calendar year (CY) 2003 MPFS update must be modified. Therefore, CMS has issued the following interim instructions, which will be in effect until the final regulation is available:

Cont. 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

Volume 72 / Oct., Nov., and Dec., 2002

Emission Date: 12/23/02

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

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¡Qué Bueno Que Preguntó!

1) Las reclamaciones por servicios sujetos a las tarifas fijas de médicos (incluyendo servicios de anestesia) realizados en el 2003 serán reembolsadas conforme a las tarifas del 2002.

2) Los servicios no sujetos a tarifas fijas de médicos se pagarán acorde a las tarifas del 2003.

3) Toda reclamación que contenga códigos de procedimientos HCPCS cuya vigencia comience al año 2003 se suspenderá hasta que se asignen las tarifas para los mismos.

4) El estatus de participación del proveedor se mantendrá igual que durante el año 2002.

La reglamentación final incluirá información sobre la fecha de vigor de las nuevas tarifas. En ese momento, CMS emitirá instrucciones sobre como implantar los cambios en tarifas fijas. Sí usted tiene duda acerca de la reglamentación provisional, favor de comunicarse con nosotros al 1-877-715-1921.

We Are Glad You Asked!

1) Claims for MPFS services (including anesthesia) performed in CY 2003 will be paid at the CY 2002 payment rate.

2) Services not paid under the physician fee schedule will be processed with the 2003 payment rates.

3) Contractors will suspend claims that include new 2003 MPFS HCPCS procedure codes until the CY 2003 fee schedule is assigned.

4) Providers will retain their 2002 participation status.

When the final rule is published, it will include an effective date for the new rates. At that time CMS will issue further instructions. Should you in the meantime have any questions, please contact us at 1-877-715-1921.

JSM/CI-1813, 12-10-02/ dmg

Health Insurance Portability and Accountability Act (HIPAA)

IMPLEMENTATION OF HIPAA HEALTH CARE ELIGIBILITY BENEFIT INQUIRY/RESPONSE TRANSACTION (270/271) STANDARD

In order to implement the HIPAA administrative simplification provisions, the 270/271 has been named under 45 CFR 162 as the electronic data interchange (EDI) standard for Health Care Eligibility Benefit Inquiry/Response. Following is important information on how Medicare will implement the 270/271 transactions:

- The 270/271 will be supported in real-time by Medicare and not in batch;
- The 270/271 implementation guide adopted for national use under HIPAA can be obtained at www.wpc-edi.com/HIPAA;
- A provider that prefers to obtain eligibility data in an EDI format but that does not want to use the 270/271 version 4010 may contract with a clearinghouse to translate the information on its behalf; however, that provider would be liable for those clearinghouse costs;
- Provider, clearinghouse, and vendor testing is not required prior to production use, but will be conducted if requested, and there will not be a charge for such testing;
- The following information will be returned in the 271 eligibility data response as applicable:

— — — — —

Carrier number
Provider number
Requester ID
Date & time stamp
Surname
First initial
HICN
Zip code
Date of birth
Date of death
Sex code
Applicable date
Current Part B entitlement date
Current Part B termination date
HMO ID code
HMO option code
HMO entitlement date
HMO termination date
Other program entitlement
  Workers compensation
  Black lung
MSP Data (can occur up to 5 times):
  MSP code
  MSP effective date
  MSP termination date
  MSP insurers name
  MSP insurers address
  MSP insurers city, state/zip
  Lifetime reserve days
Part A Spell Data:
  Hospital days remaining
  Co-insurance hospital days remaining
  SNF days remaining
  Co-insurance days remaining
  Inpatient deductible remaining
  Date of earliest billing action
  Date of latest billing action
Part B Spell Data:
  Most recent Part B year
  Part B cash deductible remaining
  Part B physical/speech therapy limit remaining
Part B occupational therapy limit remaining
  Hospice period number
  Hospice start date
  Hospice termination date
  Pap risk indicator
  Pap date
Mammography risk indicator:
  Mammography date
  Screening risk indicator
  Tech or prof
  Recent dates
Glaucoma risk indicator:
  Tech or prof
  Recent dates
Colorectal risk indicator
  Tech or prof
  Recent dates

— — — — —

Prostate risk indicator:
Tech or prof
Recent dates
Pelvic risk indicator:
Tech or prof
Recent dates
ESRD first code
ESRD effective date
Transplant indicator
Transplant discharge date
HHEH data (current two episodes):
HHEH start date
HHEH end date
HHEH date of earliest billing action
HHEH date of latest billing action
HHEB Data (current two episodes):
HHBP start date

Further information regarding the 270/271 implementation and testing will be available in future publications.

CR 2223/ PM B-02-051/js

PROVEEDORES/VENDORS QUE PASARON PRUEBAS HIPAA FORMATO X12N (TRANSACCIÓN 837)

Las tablas en las páginas 7 y 8 identifican a aquellos Proveedores y vendedores de programas de facturación electrónica que han completado exitosamente las pruebas "HIPAA X12N 837 Professional" realizadas por Triple-S, Inc. / División de Medicare. Sus programas pueden ser utilizados por los proveedores de Medicare para el envío de reclamaciones en formato X12N.

Cont. en pág. 7

HIPAA TESTING FOR PROVIDERS/ VENDORS THAT HAVE COMPLETED X12N FORMAT (837 TRANSACTION)

The tables on pages 7 and 8 identifies those providers and billing software vendors that have successfully completed "HIPAA X12N 837 Professional" testing with Triple-S, Inc. / Medicare Division. Their programs may be used by Medicare providers to submit X12N electronic claims.

Cont. on page 7

Health Insurance Portability and Accountability Act (HIPAA)

NOMBRE DEL "VENDOR" Y NOMBRE DE PROGRAMA	TIPOS DE PRUEBAS	FECHA DE CERTIFICACIÓN EN PRUEBAS HIPAA
MASS: Medical Accounting Systems Software VisualMass 7.0	-Visitas/Consultas -Procedimientos de Laboratorios Clínicos -Procedimientos Quirúrgicos	12 de septiembre de 2002
Medical Computer System	-Visitas/Consultas -Procedimientos de Laboratorios Clínicos	25 de octubre de 2002
Structured Systems Corp Medical Practice 6.2	-Visitas/Consultas -Pruebas Diagnósticas -Referidos Médicos - Procedimientos Quirúrgicos	20 de septiembre de 2002
TurboMed, Inc. TurboMed ver. 1.01	-Visitas/Consultas - Pruebas Diagnósticas -Referring Provider/UPIN	25 de septiembre de 2002
CompuSoft de Puerto Rico LabSoft Ver. 2H15	- Pruebas de Laboratorios Clínicos	9 de octubre de 2002
Advance Data Support MedOne Ver. 2.0	-Visitas/Consultas	11 de octubre de 2002
Blás Menendez y Assoc. MedicMax v2.11.20	-Visitas/ Consultas -Procedimientos -Quirúrgicos -Pruebas -Compradas -Referidos Médicos	6 de noviembre de 2002

Health Insurance Portability and Accountability Act (HIPAA)

VENDOR'S NAME PROGRAM NAME	CLAIM TYPES TESTED	HIPAA TESTING COMPLETION DATE
MASS: Medical Accounting Systems Software VisualMass 7.0	-Visit/Consultation -Laboratory Procedure -Surgery Procedure	September 12, 2002
Medical Computer System	-Visit/Consultation - Laboratory Procedure	October 25, 2002
Structured Systems Corp Medical Practice 6.2	-Visit/Consultation -Diagnostic Tests -Referring Provider/UPIN - Surgery Procedure	September 20, 2002
TurboMed, Inc. TurboMed ver. 1.01	-Visit/Consultation -Diagnostic Tests -Referring Provider/UPIN	Septiembre 25, 2002
CompuSoft de Puerto Rico LabSoft Ver. 2H15	- Laboratory Services	October 9, 2002
Advance Data Support MedOne Ver. 2.0	-Visit/Consultation	October 11, 2002
Blás Menendez y Assoc. MedicMax v2.11.20	- Visit / Consultation - Surgery - Purchase Service - Referring Provider	November 6, 2002

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

PERCUTANEOUS IMAGE-GUIDED BREAST BIOPSY

Percutaneous image-guided breast biopsy is a method of obtaining a breast biopsy through a percutaneous incision by employing image guidance systems. Image guidance systems may be either ultrasound or stereotactic.

The Breast Imaging Reporting and Data System (or BIRADS system) employed by the American College of Radiology provides a standardized lexicon with which radiologists may report their interpretation of a mammogram. The BIRADS grading of mammograms is as follows: Grade I-Negative, Grade II-Benign finding, Grade III-Probably benign, Grade IV-Suspicious abnormality, and Grade V-Highly suggestive of malignant neoplasm.

A. Nonpalpable Breast Lesions

Effective January 1, 2003, Medicare covers percutaneous image-guided breast biopsy using stereotactic or ultrasound imaging for a radiographic abnormality that is nonpalpable and is graded as a BIRADS III, IV, or V.

B. Palpable Breast Lesions

Effective January 1, 2003, Medicare covers percutaneous image guided breast biopsy using stereotactic or ultrasound imaging for palpable lesions that are difficult to biopsy using palpation alone.

PM AB-02-128/CR 2232/07-27-02/GGL-1908

REQUISITO DE NOTIFICACIÓN RELACIONADA A POLÍTICAS MÉDICAS LOCALES

Comenzando el 1 de enero de 2003 los Centros para Servicios de Medicare y Medicaid requerirán a sus contratistas informar a los beneficiarios si la denegación parcial o total de una reclamación se fundamenta en la aplicación de una nueva política médica local (LMRP por sus siglas en inglés). El propósito de esta instrucción es que los beneficiarios conozcan por qué las reclamaciones han sido denegadas, de manera que puedan decidir si apelan dichas denegaciones. Para lograrlo, se les incluirá un nuevo mensaje en el Resumen de Medicare que se utilizará en unión a otros mensajes ya existentes. Conforme a las instrucciones emitidas por CMS, a continuación el enlace a la página electrónica que contiene el texto de: ***Notice of Proposed Settlement and Fairness Hearing in Erringer v. Thompson Litigation;*** http://cms.hhs.gov/erringersettlement.asp.

NOTICE REQUIREMENT RELATED TO LOCAL MEDICAL REVIEW POLICIES (LMRP)

Beginning January 1, 2003, the Centers for Medicare and Medicaid Services will require contractors to give notice to Medicare beneficiaries when claims are denied in part or in whole based on application of a Local Medical Review Policy (LMRP). The purpose of this directive is to make beneficiaries aware of the reason for the claim denial, so they may decide whether to appeal those claims. A new Medicare Summary Notice message will be used in conjunction with other existing messages to accomplish this. Complying with CMS instructions we are providing you the link to the ***Notice of Proposed Settlement and Fairness Hearing in Erringer v. Thompson Litigation;*** *http://cms.hhs.gov/erringersettlement.asp.*

CR2081/Trans.AB-02-155/11-01-02/LV/CR2472
Trans.AB-02-169/11-22-02/LV

GUIDANCE FOR APPLYING THE MEDICARE SELF-ADMINISTERED DRUGS (SAD) EXCLUSION

The following are considered SAD and are not subject to reimbursement:

HCPCS	DESCRIPTOR
J3030	Imitrex (Sumatriptan-succinate) (6 mg)
J1820	Insulin, up to 100 units humalog, regular, NPH (lent or ultralent)
J9218	Lupron (Leuprolide acetate) per 1 mg.
J0630	Injection calcitonin salmon (up to 400 units) Miacalcin
J0275	Alprostadil (suppository) (Muse)
J2940	Somatrem, injection 1mg (Protopin)
J2941	Somatropin, 1 mg Humatrope
J3030	Imitrex (Sumatriptan-succinate) (6 mg)
J1820	Insulin, up to 100 units humalog, regular, NPH (lent or ultralent)
J9218	Lupron (Leuprolide acetate) per 1 mg.
J0630	Injection calcitonin salmon (up to 400 units) Miacalcin
J0275	Alprostadil (suppository) (Muse)
J2940	Somatrem, injection 1mg (Protopin)
J2941	Somatropin, 1 mg Humatrope

The criterion for the selection of self-administered drugs (SAD) follows Program Memorandum AB-02-072, Change Request 2200, implemented August 1, 2002. Modeled along CMS guidelines, the exclusion of these drugs was deemed necessary even though they may have been previously covered under “Incident to” provisions.

For the purpose of applying this exclusion the term “usually self-administered” means self-administered more than 50 percent of the time for all Medicare beneficiaries who use the drug, and are not in the hospital. If the drug is self administered by the patient more than 50 percent of the time the drug is excluded for coverage. The determination of exclusion or coverage is based on a drug-by-drug basis and not on a bene-by-bene basis.

Upon review of each drug, its indication and administration route, this carrier arrived at a single policy determination for both Puerto Rico and the US Virgin Islands.

This list will be granted a 45-day notice period. In the interim, this Carrier will maintain current medical review payment procedures. After the 45-day period, payment for claims with dates of service of July 24, 2002 and thereafter will be denied as “non-covered” drugs. This list will be regularly reviewed and updated.

Evaluation

PROGRESSIVE CORRECTIVE ACTION YEAR 2003

This article is being published as a reminder of the Progressive Corrective Action initiative and its objective and in order to present some charts that were omitted in our previous publication.

As you know Medicare Part-B Fiscal Intermediaries have the responsibility of selecting a list of procedure codes identified as aberrant to perform different analysis concerning the utilization of these services. This action is based on Medicare Program Integrity Manual.

The procedure codes are selected following the criterions stipulated by Centers for Medicare & Medicaid Services (CMS) for each particular year. Among the criterions involved there are:

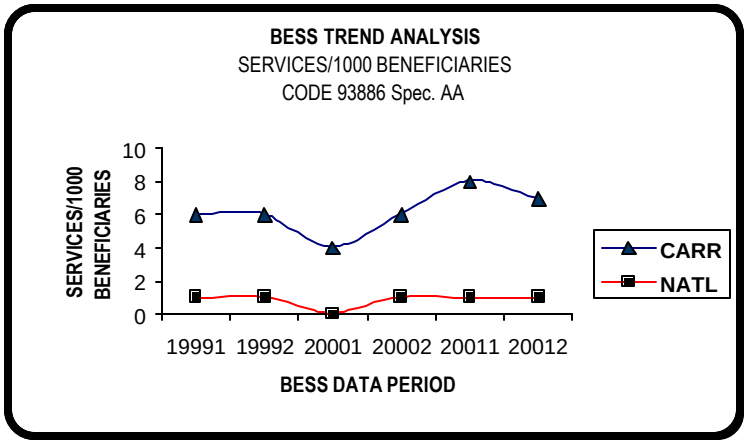
- Total volume of services rendered
- Total amounts paid for services rendered
- Allowed services/allowed charges per each 1,000 beneficiaries
- Carriers national ranking in terms of allowed services/allowed charges
- Significant changes from one period to another
- Adverse impact on beneficiaries

The data related with these procedures, identified as aberrant, is obtained from CMS' on line BESS system (Medicare - Part B Extract Summary System) which can be accessed by all carriers in the nation. The BESS system compiles information from all Medicare Part-B claims processed nationally. The reports produced by this system are provided to each carrier every six (6) months for their individual analysis.

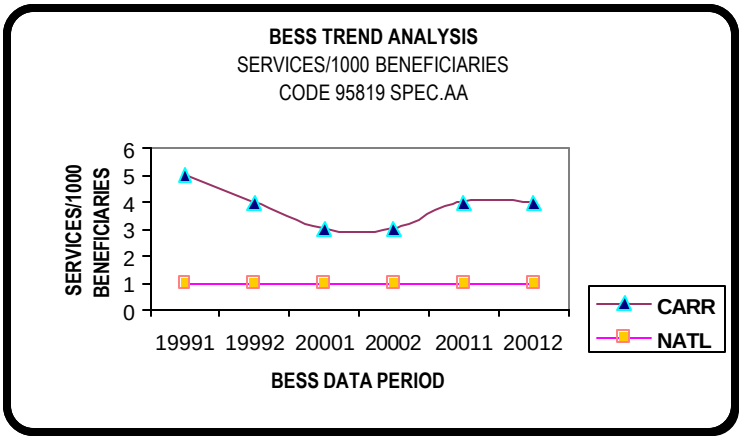
For fiscal year 2003, this carrier selected a total of ten (10) procedure codes to be analyzed under the Progressive Corrective Action concept.

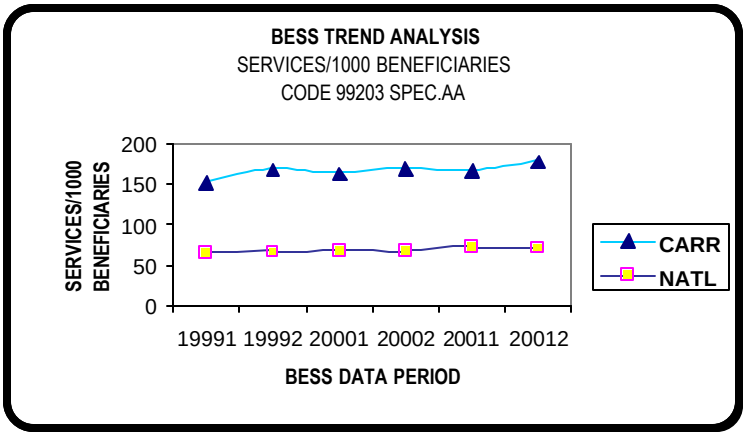
RG/October 2002

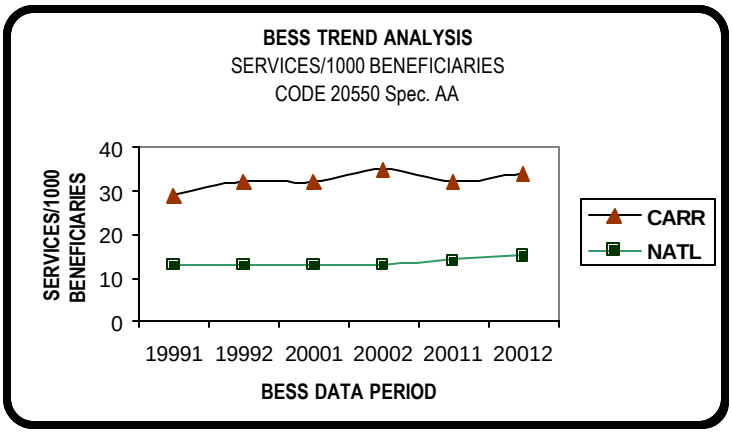
BESS TREND ANALYSIS

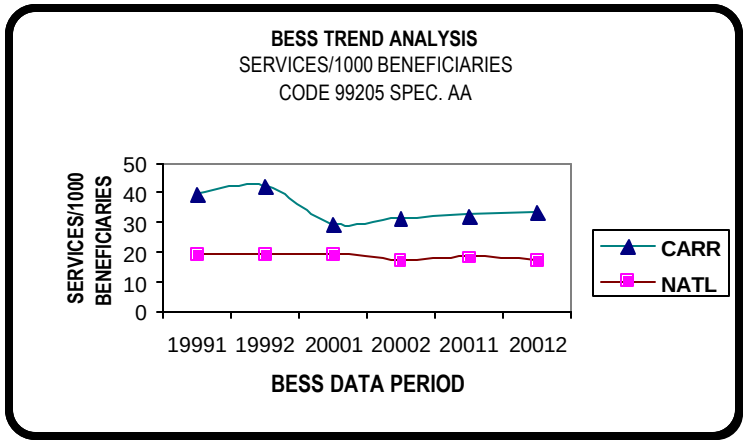


BESS TREND ANALYSIS









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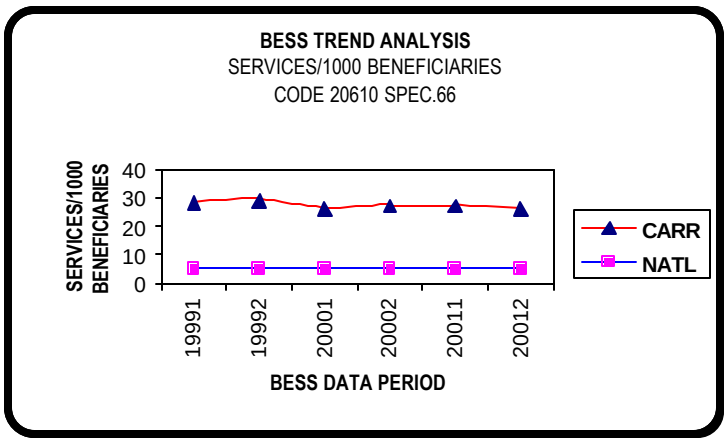

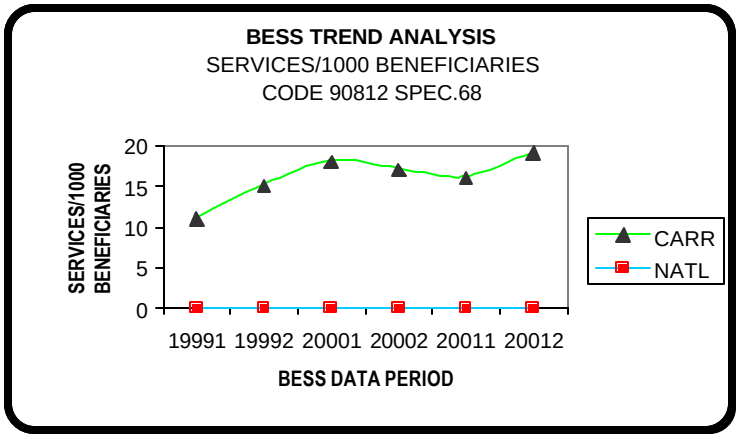

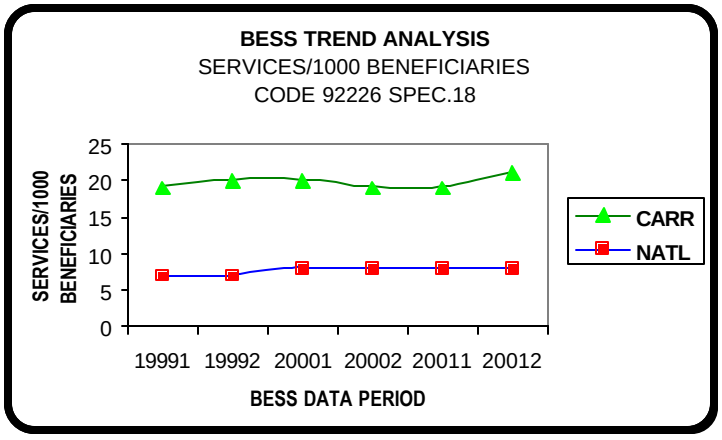

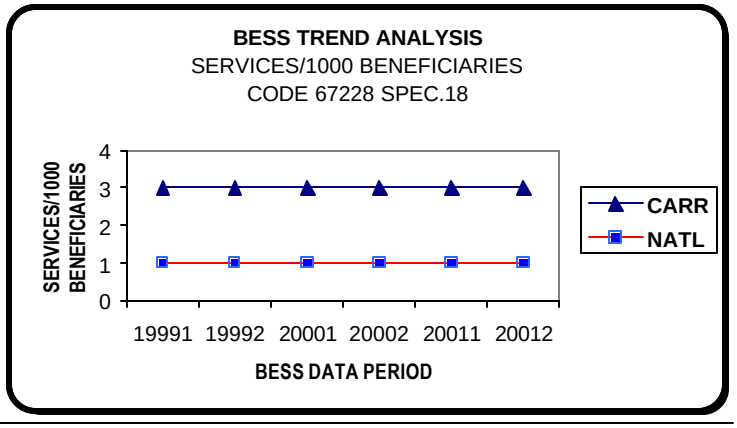

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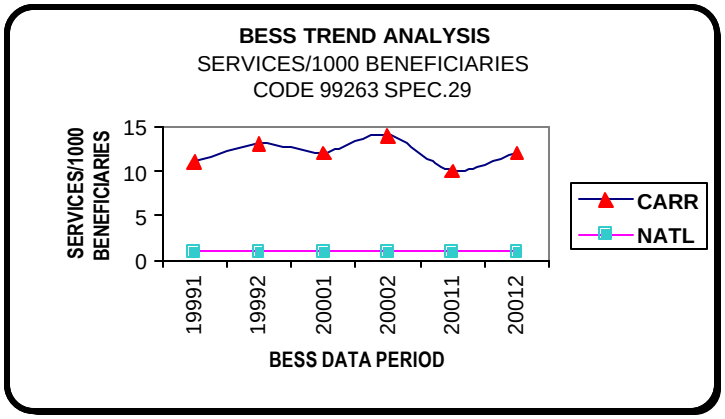

OPORTUNIDAD DE EXTENSIÓN PARA CUMPLIR CON LAS DETERMINACIONES DE CUBIERTAS NACIONALES

La sección 4554(b)(1) del "Balanced Budget Act (BBA) Public Law 105-33" hizo obligatorio el uso de un comité negociador (Negotiated Rulemaking Committee) para elaborar cubiertas nacionales y políticas administrativas para el pago de servicios de laboratorio clínico bajo la Parte B de Medicare. El BBA requiere que estas políticas nacionales se diseñen para fomentar la integridad del programa, la uniformidad nacional en las determinaciones de cubiertas y para simplificar los requisitos administrativos con respecto a los servicios de laboratorio clínico que se pagan bajo la Parte B.

Estos cambios aplican a todo servicio de laboratorio cubierto por la parte B de Medicare. Ni el lugar donde se prestan los servicios, ni el contratista que procesa las reclamaciones afectan la aplicabilidad de estas políticas. Un servicio de laboratorio clínico realizado en el laboratorio de un hospital, laboratorio independiente, laboratorio en oficina médica u otro tipo de servicio de laboratorio aprobado por CLIA está sujeto a estas políticas administrativas. Las políticas administrativas del comité negociador están publicadas en el " Federal Register" del 23 de noviembre de 2001, 66 FR 58788. Estas disposiciones serán efectivas el 25 de noviembre de 2002.

EXTENSION OPPORTUNITY TO COMPLY WITH NATIONAL COVERAGE DETERMINATIONS

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. The BBA required that these national policies be designed to promote program integrity, national uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory services payable under Part B.

These changes 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 clinical laboratory 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 administrative policies for the Negotiated Rulemaking for Clinical Diagnostic Laboratory Services were published in the final regulation of the Federal Register dated November 23, 2001, 66 FR 58788. The effective date for these provisions is November 25, 2002.

Evaluation

Conforme a esas políticas administrativas, los Centros para Servicios de Medicare y Medicaid (CMS por sus siglas en inglés) han emitido cubiertas nacionales (*National Coverage Determinations)* para los siguientes códigos de laboratorio: 87086-87088, 87184-87186, 87536, 87539, 85007-85008, 85013-85014, 85018, 85021-85025, 85027, 85031, 85048, 85590, 85595, 85730, 85610, 82278, 83540, 83550, 84466, 82523, 82962, 82985, 83036, 84436, 84439, 84443, 84479, 80162, 82105, 82378, 84702, 86304, 86300-86301, 84153, 82977, 87340, 86803, 86705, 82270. Deseamos hacer énfasis en la importancia de acceder la información sobre los códigos de diagnóstico relacionados y aceptados para estas pruebas en la siguiente dirección: www.cms.hhs.gov/manuals/pm_trans/AB02110.pdf.

CMS concederá un periodo de gracia de hasta 12 meses a partir del 25 de noviembre de 2002 en aquellas reclamaciones con fecha de servicio del 25 de noviembre de 2002 en adelante. Aquel proveedor de servicios que requiera realizar cambios en su sistema de facturación electrónica, para cumplir con los requisitos de las cubiertas nacionales, y estime que no pueda completar los mismos en la fecha establecida, podrá acogerse al periodo de gracia.

Las entidades que deseen solicitar el periodo de gracia para implantar los cambios en sistema deben notificarnos por escrito no más tarde del **15 de diciembre de 2002**. Una vez usted reciba de este contratista la aprobación a su solicitud de extensión podrá proceder a enviar las reclamaciones por servicios brindados del 25 de noviembre de 2002 en adelante. La siguiente información detalla el proceso para solicitar dicha extensión y lo que ésta debe incluir:

1. Una descripción de los cambios en sistema que no podrán implantarse a tiempo,
2. Una descripción de las acciones tomadas por la entidad para implantar estos cambios a tiempo,

The Centers for Medicare and Medicaid Services have issued National Coverage Determinations (NDC) for the following clinical laboratory codes: 87086-87088, 87184-87186, 87536, 87539, 85007-85008, 85013-85014, 85018, 85021-85025, 85027, 85031, 85048, 85590, 85595, 85730, 85610, 82278, 83540, 83550, 84466, 82523, 82962, 82985, 83036, 84436, 84439, 84443, 84479, 80162, 82105, 82378, 84702, 86304, 86300-86301, 84153, 82977, 87340, 86803, 86705, 82270. These National Coverage Determinations will be effective November 25, 2002. We emphasize the importance of accessing the information on the diagnostic codes related and accepted for these laboratory tests through CMS' webpage at: www.cms.hhs.gov/manuals/pm_trans/AB02110.pdf.

CMS will grant a grace period of up to 12 months from November 25, 2002 for claims with dates of service of November 25, 2002 and thereafter, to accommodate any provider system changes required by the policy changes or clarifications resulting from the provisions of this rule. Providers that must perform changes to their electronic billing system to comply with NDC requirements and judge that these changes will not be completed by the given date can request the grace period.

Entities that want to request a grace period to allow for additional time to implement computerized system changes must contact us in writing no later than ***December 15, 2002****. Once Medicare approves your extension request you can proceed to submit claims for services rendered on November 25, 2002 and thereafter. The following information outlines the process for requesting a grace period and what it must include:*

1. *A description of the nature of the system changes not able to be implemented timely,*
2. *A description of the actions the entity has taken to implement timely,*

Evaluation

3. Un plan de trabajo detallando el tiempo y una descripción de las tareas que la entidad tomará hasta completar la implantación,
4. Las fechas cuando las tareas serán realizadas,
5. La fecha en que la entidad estará en cumplimiento total.

La solicitud de extensión debe enviarse en papel a la atención de:

Srta. Rosa González, Gerente

Departamento de Revisión Médica

PO Box 71391

San Juan, PR 00936-1391

o en forma electrónica a www.triples-med.org sección de "Determinación de Cubierta Nacional".

Si para la fecha de implantación la solicitud no cumple con los requisitos aquí señalados, las reclamaciones se rechazarán.

De tener alguna duda pueden llamar al 1-877-715-1921.

CR2169/PM-AB-02-129/9-25-02/DMG/CR2130/PM-AB-02-110/7-31-02/DMG

3. A work plan with a timeline providing a detailed description of the tasks which the entity shall undertake to accomplish full implementation, and
4. The dates when tasks shall be performed,
5. The date that the entity will be able to implement fully.

The application for the extension should be sent attention to:

Ms. Rosa González

Medical Review Manager

PO Box 71391

San Juan, PR 00936-1391

or e-mailed the National Coverage Determinations link of our webpage, the address is www.triples-med.org.

If the request does not meet the requirements of these instructions by the revised implementation date, claims will be returned as unprocessable.

Should you have any questions, please call 1-877-715-1921.

CLARIFICATION REGARDING IMPLEMENTATION OF THE AMBULANCE FEE SCHEDULE

Medicare reimbursement for ambulance services is limited to those covered services determined to be medically reasonable and necessary in the diagnosis or treatment of an injury or illness. Medical necessity is confirmed when the patient's clinical condition is such that the use of any other method of transportation such as taxi, private car or other type of vehicle would endanger the patient's medical state. "In any case, in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service" (Medicare Carrier's Manual, 2120.A) The patient's condition at the time of the transport is the determining factor in whether a trip will be covered.

During the implementation of the ambulance fee schedule, issues concerning the interpretation of Medicare policy have arisen which require clarification. The following information provides additional guidance on these issues and supplements previously issued instructions regarding the implementation of the ambulance fee schedule:

Ambulance Fee Schedule

The ambulance final rule published on February 27, 2002, in the Federal Register (67FR), pages 9100 through 9135 sets up a fee schedule for the payment of ambulance services under the Medicare program. Implementation of this final rule was effective for dates of service beginning April 1, 2002. It established a five-year transition period, during which time payment will be based on a blended amount, a mix of the ambulance fee schedule and reasonable charge, as applicable.

The percentages for the blended rate during the transition period are as follows:

Transition Year	Reasonable Charge Cost Percent	Fee Schedule Percent
Year One – 4/01/02-12/31/02	80	20
Year Two – CY 2003	60	40
Year Three – CY 2004	40	60
Year Four – CY 2005	20	80
Year Five - CY 2006	0	100

The fee schedule's effective date is based on the date of service for the claim, and not the date of processing. Claims with a date of service prior to April 1, 2002 may not be resubmitted for processing under the new ambulance fee schedule guidelines. These claims are processed using the reasonable charge methodology, as applicable, which was in place prior to the fee schedule.

Sources of Additional Information

The ambulance fee schedule final rule also provides the formula for calculating the ambulance fee schedule amount and examples of payment rate calculations. The zip code public use file posted on the CMS web site (under Ambulance Fee Schedule, Zip Code File for Ambulance Services) can be used to determine the locality that applies for a particular geographic area. Likewise, the ambulance fee schedule public use file is posted on the CMS web site located at www.cms.hhs.gov/medlearn.

No Transport

The Medicare ambulance benefit is a transportation benefit. If no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. This policy applies to situations, in which the beneficiary refuses to be transported, even if medical services are provided prior to loading the

beneficiary onto the ambulance (e.g., BLS or ALS assessment). However, the entity that provides a non-covered service to a Medicare beneficiary may bill the beneficiary for the service.

Zip Codes

- Area without a Zip Code:

  In areas without an apparent zip code, it is the provider's/supplier's responsibility to confirm that the point-of-pickup does not have a zip code that has been assigned by the U.S. Postal Service (USPS). If the provider/supplier has made a good faith effort to confirm that no zip code for the point-of-pickup exists, it may use the zip code nearest to the point-of-pickup.

  Providers and suppliers should document their confirmation with the USPS, or other authoritative source, that the point-of-pickup does not have an assigned zip code and annotate the claim to indicate a surrogate zip code has been used (e.g., "Surrogate zip code; POP in No-zip"). Providers and suppliers should maintain this documentation and provide it to their carrier upon request.

- New Zip Codes:

  New zip codes are considered urban until CMS determines that the zip code is located in a rural area. Thus, until a zip code is added to the Medicare zip code file with a rural designation, it will be considered an urban zip code. However, despite the default designation of new zip codes as "urban", carriers have discretion to determine that a new zip code is rural until designated otherwise. If the contractor designates a new zip code as rural, and CMS later changes the designation to urban, then the contractor, as well as any provider or supplier paid for mileage or for air services with a rural adjustment, will be held harmless for this adjustment.

  Providers and suppliers should annotate claims using a new zip code with a remark to that effect. Providers and suppliers should maintain documentation of the new zip code and provide it to their carrier upon request.

  If the provider or supplier believes that a new zip code that the contractor has designated as urban should be designated as rural (under the standard established by the Medicare fee schedule regulation), it may appeal the determination with the carrier, as applicable, in accordance with standard procedures.

- Reporting Inaccurate Zip Code Information

  The provider or supplier that knowingly and willfully reports a surrogate zip code because he/she does not know the proper zip code may be engaging in abusive and potentially fraudulent billing. Furthermore, a provider or supplier that specifies a surrogate rural zip code on a claim when not appropriate to do so, for the purpose of receiving a higher payment than would have been paid otherwise, may be committing abuse and potential fraud.

BLS/ALS Joint Responses

In situations where a BLS (Basic Life Support) entity provides the transport of the beneficiary and an ALS (Advanced Life Support) entity provides a service that meets the fee schedule definition or an ALS intervention (e.g., ALS assessment, Paramedic Intercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exist. Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their carrier upon request.

While there must be a written agreement in place between the BLS supplier that furnishes the transport and the ALS entity that furnishes the ALS service, Medicare does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment may be made. In this situation, the ALS entity's services are not covered and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

Ground to Air Ambulance Transports

When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance may bill Medicare for the level of service provided and mileage from the point-of-pickup to the point-of-transfer to the air ambulance.

Mileage

- Local Billing Practices for Carrier-Based Mileage Calculations

  Payment is allowed for all medically necessary mileage. That is, Medicare allows payment for mileage incurred transporting the beneficiary to the nearest appropriate facility (or transfer point in the case of an air to ground or ground to air transfer).

- Rural Adjustment Versus Lower of Submitted Charge or Fee Schedule Amount

  Although a transport with a point-of-pickup located in a rural area is subject to a rural adjustment for mileage, Medicare still pays the lesser of the billed charge or the applicable fee schedule amount for mileage. Thus, when rural mileage is involved, Medicare will compare the fee schedule rural mileage payment rate blended with the reasonable charge mileage amount to the provider's/ supplier's actual charge for mileage, and pay the lesser amount.

- Billing Rural Mileage

  Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item on the CMS-1500 or equivalent electronic claim form.

- Calculating the Rural Adjustment

  If the point-of-pickup is a rural zip code, the following calculations determine the rural adjustment portion of the payment allowance. The rural adjustment for ground mileage is 1.5 times the urban mileage allowance for the first 17 loaded miles, and 1.25 times the urban mileage allowance for any loaded miles between 18 and 50, inclusive. The rural adjustment for air ambulance services (fixed wing or rotary wing) is 1.5 times both the applicable air service rate and the total mileage amount.

- Additional Air Mileage

  Additional air mileage may be allowed in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include, but are not limited to, the following:

  - Military base and other restricted zones, air-defense zones and similar FAA restrictions and prohibitions.
  - Hazardous weather.
  - Variances in departure patterns and clearance routes required by an air traffic controller.

If the air transport meets the criteria for medical necessity, Medicare pays the actual miles flown for legitimate reasons as determined by the Medicare contractor, once the Medicare beneficiary is loaded onto the air ambulance.

The following definitions apply to both land and water (hereafter collectively referred to as "ground") ambulance services unless otherwise specified as applying to air ambulance services:

Adjusted Base Rate

Adjusted Base Rate is the payment made to a provider/supplier for ambulance services exclusive of mileage.

Application: With respect to ground service levels, the **adjusted base rate** is the payment amount that results from multiplying the **conversion factor** (CF) by the applicable relative value unit (RVU) and applying the **geographic adjustment factor** (GAF). With respect to fixed wing and rotary wing services, the **adjusted base rate** is equal to the national base rate (which, in the case of air ambulance services, is announced as part of the fee schedule (FS) and is not calculated by means of a CF and RVU adjusted by the provider's/supplier's GAF.

Advanced Life Support Assessment

Advanced Life Support (ALS) Assessment is an assessment performed by an ALS crew as part of an **emergency response** that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

Application: The determination to respond emergently with an ALS ambulance must be in accord with 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of 911 or equivalent service. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advanced Life Support Intervention

Advanced Life Support (ALS) Intervention is a procedure that is, in accordance with local law, beyond the scope of practice of an Emergency Medical Technician-Basic (EMT-Basic).

Application: An ALS Intervention must be medically necessary to qualify as an intervention for payment of an ALS level of service. An ALS Intervention applies only to ground transports.

Advanced Life Support, Level 1

Advanced Life Support, Level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an **ALS Assessment** or at least one **ALS Intervention.**

Advanced Life Support, Level 2

Advanced Life Support, Level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport and the provision of at least one of the ALS2 procedures listed below.

Application: Crystalloid fluids include fluids such as 5 percent Dextrose in water, Saline and Lactated Ringer's. Medications that are administered by other means, for example: intramuscularly/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment. In other words, the administration of 1/3rd of a qualifying dose three times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given three times might = X (where X is a standard/ protocol drug amount), but the same sequence does not equal three times X. Thus, if three administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol. An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of Intravenous (IV) Epinephrine in the treatment of pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25mg, 0.25mg and 0.50mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association (AHA), Advanced Cardiac Life Support (ACLS) protocol, calls for Epinephrine to be administered in 1mg increments every three to five minutes. Therefore, in order to receive payment for an ALS2 level of service, three separate administrations of Epinephrine in 1mg increments must be administered for the treatment of pulseless VF/VT. A second example that would not qualify for the ALS2 payment level is the use of Adenosine in increments of 2mg, 2mg and 2mg for a total of 6mg in the treatment of an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). According to ACLS guidelines, 6mg of Adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12mg of Adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12mg dose of Adenosine can be administered for a total of 30mg of Adenosine. Three separate administrations of the drug Adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

For purposes of this definition, the ALS2 procedures are:

1) Manual defibrillation/cardio version
2) Endotracheal intubation
3) Central venous line
4) Cardiac pacing
5) Chest decompression
6) Surgical airway
7) Intraosseous line

Endotracheal intubation is one of the services that qualify for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport also qualifies as an ALS2 procedure.

Advanced Life Support (ALS) Personnel

ALS personnel are individuals trained to the level of the Emergency Medical Technician-Intermediate (**EMT-Intermediate**) or Paramedic.

Basic Life Support

Basic Life Support (BLS) is transportation by ground ambulance vehicle that provides transportation plus the equipment and staff needed for such basic services as control of bleeding, splinting fractures, treatment for shock and cardio-pulmonary resuscitation (CPR). The vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and in non-emergency situations is capable of transporting beneficiaries with acute medical conditions. At minimum, the ambulance must contain a stretcher, clean linens, emergency medical supplies, oxygen equipment and other lifesaving emergency medical equipment and be equipped with emergency warning lights, sirens and telecommunications equipment as required by local law. The ambulance crew must consist of at least two members; one of them must be certified as an Emergency Medical Technician (EMT) by the local authority and be legally authorized to operate all lifesaving and life sustaining equipment on board the vehicle. The ambulance crew must also have completed both the standard and advanced first aid courses or have had equivalent training in the application of first aid.

Conversion Factor (CF)

CF is the nationally uniform dollar value that, when multiplied by **relative value units** for a service, results in the **unadjusted base rate** amount for that service.

Application: The CF is, in effect, equal to the unadjusted national ground base rate for a BLS transport. The CF is updated annually for inflation by a factor specified in the statute. The inflated CF is applied to the RVUs of the different levels of ground ambulance service resulting in payment amounts under the ambulance fee schedule.

Emergency Response

Emergency Response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or equivalent. An immediate response is one in which the ambulance provider/ supplier begins as quickly as possible to take the steps necessary to respond to the call.

Application: The phrase “911 call or equivalent” is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor. Regardless of the medium by which the call is made (e.g., a radio call could be appropriate) the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. An emergency call need not come through 911. However, the determination to respond emergently must be in accord with 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider’s/supplier’s dispatch protocol and the dispatcher’s actions must meet, at a minimum, the standards of the dispatch protocol of 911 or equivalent service. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary’s condition (for example, symptoms) at the scene determines the appropriate level of payment.

Fixed Wing (FW) Air Ambulance

FW Air Ambulance is the transportation by a fixed wing aircraft that is certified by the Federal Aviation Administration (FAA) as a **fixed wing air ambulance** and the provision of medically necessary services and supplies.

Geographic Adjustment Factor

Geographic Adjustment Factor (GAF) is a value that is applied to a portion of the **unadjusted base rate** amount in order to reflect the relative costs of furnishing ambulance services from one area of the island to another. The GAF is equal to the practice expense (PE) portion of the geographic practice cost index (GPCI) from the physician fee schedule.

Application: For ground ambulance services, the PE portion of the GPCI is applied to 70 percent of the **unadjusted base rate.** For air ambulance services, the PE portion of the GPCI is applied to 50 percent of the **unadjusted base rate.**

Goldsmith Modification

Goldsmith Modification is the methodology for the identification of rural census tracts that are located within large metropolitan counties of at least 1,225 square miles, but are so isolated from the metropolitan core of that county by distance or physical features as to be more rural than urban in character.

Loaded Mileage

Loaded Mileage is the number of miles for which the Medicare beneficiary is transported in the ambulance vehicle.

Application: Payment is made for each loaded mile. Air mileage is based on loaded miles flown, as expressed in statute miles. There are three mileage payment rates: 1) for ground and water; 2) for FW; and 3) rotary wing RW. For air ambulance, the point of origin includes the beneficiary's loading point and runway taxiing until the beneficiary is offloaded from the air ambulance.

Point of Pick-Up

Point of Pick-Up is the location of the beneficiary at the time he or she is placed on board the ambulance.

Application: The zip code of the **point of pick-up** must be reported on each claim for ambulance services, so that the correct GAF and **Rural Adjustment Factor** (RAF) may be applied, as appropriate.

Relative Value Units

Relative Value Units (RVUs) measure the value of ambulance services relative to the value of a base level ambulance service.

Application: The RVUs for the ambulance fee schedule are as follows:

Service Level	RVUs
BLS	1.00
BLS – Emergency	1.60
ALS1	1.20
ALS1-Emergency	1.90
ALS2	2.75
PI	1.75

RVUs are not applicable to FW and RW services.

Rotary Wing (RW) Air Ambulance

RW Air Ambulance is the transportation by a helicopter that is certified by the FAA as a rotary wing ambulance, including the provision of medically necessary supplies and services.

Rural Adjustment Factor (RAF)

RAF is an adjustment applied to the payment amount for ambulance services when the **point of pick-up** is in a rural area.

Application: For ground ambulance services, a 50 percent increase is applied to the ambulance fee schedule mileage rate for each of the first 17 miles; a 25 percent increase is applied to the ambulance fee schedule mileage rate for mileage between 18 and 50 miles; and the urban ambulance fee schedule mileage rate applies to every mile over 50 miles. For air ambulance services, a 50 percent increase is applied to the total air ambulance fee schedule amount for air services; that is, the adjustment applies to the sum of the **adjusted base rate** and ambulance fee schedule rate for all of the loaded air mileage.

Services in a Rural Area

Services in a Rural Area are services that are furnished (1) in an area outside a Metropolitan Statistical Area (MSA); or (2) an area identified as rural using the **Goldsmith modification** even though the area is within an MSA.

Unadjusted Base Rate

Unadjusted Base Rate is the national general payment amount for ambulance services exclusive of mileage without application of the GAF. These are general national numbers that do not relate to an individual provider/supplier until the GAF is applied to them.

Application: The **unadjusted base rate** is the payment amount that results from multiplying the CF by the RVU without applying the GAF.

Remittance Advice Message for Ambulance Services

The following Remittance Advice Code and Message, for claims with a date of service starting on the implementation date for the ambulance fee schedule of April 1, 2002, explains the reimbursement for ambulance services:

- N114 – During the transition to the ambulance fee schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amount, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.

This information/clarifications of Medicare policy regarding the implementation of the Ambulance Fee Schedule are not intended to replace previously issued instructions and does not encompass all issues that have been addressed to date. Additional issues will be addressed in the future.

CR#2295 & 2297/AB-02-130 & AB-02-131/ Sept. 27,2002/els/CR#2262/AB-02-148/October 25, 2002/els

REMITTANCE ADVICE CODING UPDATE

CMS is the national maintainer of remittance advice remark codes used by both Medicare and non-Medicare entities. Under the Health Insurance Portability and Accountability Act (HIPAA), all payers have to use reason and remark codes approved by X-12 recognized maintainers of those code sets instead of proprietary codes to explain any adjustment in the payment. As a result, a significant number of remark code changes in the future will be requested by non-Medicare entities, and may not impact Medicare.

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year after each X12 trimester meeting at http://www.wpc-edi.com/hipaa/.

The list of remark codes is available at http://www.cms.hhs.gov/medicare/edi/hipaadoc.asp and http://www.wpc-edi.com/hipaa/, and the list is updated each March, July, and November.

The following list summarizes changes made through June 30, 2002:

New Remark Codes

Code	Current Narrative
N113	You or someone in your group practice has already submitted a claim for an initial visit for this beneficiary. Medicare pays only once per beneficiary per physician, group practice, or provider for an initial visit.
N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
N115	This decision is based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is reasonable and necessary. A copy of this policy is available at www.LMRP.net
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

Modified Remark Codes

M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we

would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim either within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier, or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

- If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or
- If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days. Your request for review should include any additional information necessary to support your position.

If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. However, a review request that is received more than 30 days after the date of this notice does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(l) of the Social Security Act and 42 CFR 411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Please contact this office if you have any questions about this notice.

M27 The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later (or, for a medical insurance review, within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later). You may make the request through any Social Security office or through this office.

MA01 (Initial Part B determination, Medicare carrier or intermediary)—If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later, unless you have a good reason for being late.

(NOTE: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA or hospice may appeal only if the claim involves a medical necessity denial, a SNF decertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

(**NOTE**: Carriers who issue telephone review decisions should add: If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.)

MA02 (Initial Medicare Part A determination)—If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. Decisions made by a QIO must be appealed to that QIO within 60 days. (An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF non-certified bed denial, or a home health denial

because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

N103 Social Security records indicate that this beneficiary was a prisoner when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in State or local custody under a penal authority, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

The following codes were modified before February 28, 2002:

Code	Current Narrative
MA49	Missing/Incomplete/invalid six-digit provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50	Missing/Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51	Missing/Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA82	Did not complete or enter the correct physician/physician assistant/nurse practitioner/ clinical nurse specialist/supplier's billing number/NPI and/or billing name, address, city, state, zip code, and phone number.
MA112	Our records indicate that the performing physician/physician assistant/clinical nurse specialist/certified registered nurse anesthetist/anesthesia assistant/supplier/nurse practitioner is a member of a group practice; however, you did not complete or enter accurately the group's name, address, zip code and their carrier assigned individual and group PINs. (Substitute "NPI" for "PIN" when effective.)

The committee approved the following reason code changes in June 2002:

New Reason Codes

Code	Current Narrative
145	Premium payment withholding
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provide contracted/negotiated rate expired or not in file
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.

Modified Reason Codes

Code	Current Narrative
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure/revenue code is inconsistent with the provider type/specialty (taxonomy).
108	Payment adjusted because rent/purchase guidelines were not met.

CR2395/Transmittal AB-02-142/10/18/2002/ ICR

PAYMENT POLICY FOR AMBULANCE TRANSPORT OF MULTIPLE PATIENTS

The following states the payment policy and claims processing instructions for ambulance services when multiple patients are transported simultaneously in the same ambulance. The Centers for Medicare & Medicaid Services (CMS) expects that the vast majority of instances when multi-patient transport occurs will be during emergency situations, i.e. car accidents, plane crashes, terrorist attacks, among others. Ambulance transport for ESRD patients, who meet the medical necessity requirements, should not be shared in non-emergency situations.

POLICY (APRIL 1, 2002)

If two patients are transported simultaneously to the same destination, Medicare will allow 75 percent of the payment allowance for the base rate applicable to the level of care furnished to each Medicare beneficiary, plus 50 percent of the total mileage payment allowance for the entire trip.

If three or more patients are transported to the same destination simultaneously, then the payment allowance for the Medicare beneficiary (or each of them) is equal to 60 percent of the base rate applicable to the level of care furnished the beneficiary. However, the number of patients onboard will prorate a single payment allowance for mileage.

The applicable percentage is based on the total number of patients transported,

including Medicare beneficiaries and non-Medicare patients.

If a multi-patient transport includes multiple destinations, then the Medicare allowed amount for mileage depends upon whether it is for an emergency or non-emergency ground transport:

a) For an emergency ground transport, which includes BLS-E, ALS1-E, ALS2, and SCT, the mileage payment will be based on the number of miles to the nearest appropriate facility for each patient, divided by the number of patients on board when the vehicle arrives at the facility. This formula applies cumulatively for beneficiaries who are the second and third patient to be delivered.

b) For a non-emergency ground transport, which includes BLS and ALS1, the mileage payment will be based on the number of miles from the point of pick-up to the nearest appropriate facility for each beneficiary, divided by the number of beneficiaries on board when the vehicle arrives at the facility. This formula applies cumulatively for beneficiaries for multiple points of pick-up. Mileage other than the mileage that would be incurred by transporting the beneficiary directly from the point of pick-up to the nearest appropriate facility is not covered. Thus, for non-emergency transports, the extra mileage that may be incurred by having multi-destinations will not be taken into account.

This policy applies to both ground and air transports.

IMPLEMENTATION (BILLING INSTRUCTIONS)

1. For each Medicare beneficiary use modifier "GM" with the ambulance service code and the mileage code to report multiple patients transport.
2. The following documentation is require to specify the particulars of a multiple transport in item 19 of the CMS-1500 or electronic fields ANSI ASC X12N version 4010 (837 transaction) or NSF for those who filed the HIPAA extension:
   - Total number of patients transported simultaneously in the same ambulance.
   - The health insurance claim number for each Medicare beneficiary.
3. Submit the charge applicable to the appropriate service rendered to each beneficiary and the total mileage for the trip.
4. Submit all associated Medicare claims for that multiple transport within a reasonable number of days of submitting the first claim.

TRANSMITTAL B-02-060/CR 1945/9-27-2002/mm/els//SL/NYRO/10-29-2002

PSYCHOTROPIC DRUG USE IN SKILLED NURSING FACILITIES (SNF)

In response to concerns expressed by the Senate Special Committee on Aging, the Office of Inspector General (OIG) studied the extent to which psychotropic drugs are being used in nursing homes as inappropriate chemical restraints. The OIG found that, in general, these drugs are being used appropriately. Where there are problems, they are related to inappropriate dosage, chronic use, and lack of documented benefit to the resident, and unnecessary duplicate drug therapy. This article explains Medicare's guidelines for psychotropic drug use in SNFs including the definition of an unnecessary drug, justification for drug use outside guidelines, and antipsychotic drugs.

Definition of an Unnecessary Drug

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- In excessive dose (including duplicate drug therapy);
- For excessive duration;

- Without adequate monitoring;
- Without adequate indications[1] for its use;
- In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the above reasons.

  NOTE: When a resident receives duplicate drug therapy, an evaluation should be completed for accumulation of the adverse effects.

- Resident assessment;
- Plan of care;
- Reports of significant change;
- Progress notes;
- Laboratory reports;
- Professional consults;
- Drug orders; or
- Observation and interview of the resident.

Justification for Drug Use Outside Guidelines

A drug used outside these guidelines must be based on sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug. Some examples of evidence that would support a justification as to why a drug is being used outside these guidelines, but in the best interest of the resident, may include:

- A physician's note indicating that the dosage, duration, indication, and monitoring are clinically appropriate and the reasons as to why they are clinically appropriate. The note should demonstrate that the physician has carefully considered the risk/benefit to the resident in using a drug outside the guidelines.
- A medical or psychiatric consultation or evaluation (e.g., Geriatric Depression Scale) confirming the physician's judgment that use of a drug outside the guidelines is in the best interest of the resident.
- Documentation of a physician, nursing, or other health professional indicating that the resident is being monitored for adverse consequences or complications of the drug therapy;

— — — —

[1] Adequate indications for use means that there is a valid clinical reason for the resident to receive the drug based on some, but not necessarily all, of the following

- Documentation confirming that previous attempts at dosage reduction have been unsuccessful;
- Documentation (including MDS documentation) showing the resident's subjective or objective improvement or maintenance of function while taking the medication;
- Documentation showing that the resident's decline or deterioration has been evaluated by the interdisciplinary team to determine whether a particular drug, a particular dose, or duration of therapy may be the cause; and
- Documentation showing why the resident's age, weight, or other factors would require a unique drug dose or drug duration, indication, or monitoring.

Guidelines for Use of Antipsychotic Drugs

SNFs must ensure, based on a comprehensive assessment of the resident, that:

I. When an antipsychotic drug has not been used in the past, it is not given unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following specific conditions:

- Schizophrenia;
- Schizo-affective disorder;
- Delusional disorder;
- Psychotic mood disorders (including mania and depression with psychotic features);
- Acute psychotic episodes;
- Brief reactive psychosis;
- Schizophreniform disorder;
- Atypical psychosis;
- Tourette's disorder;
- Huntington's disease;
- Organic mental syndromes (now called delirium, dementia, and amnesic and other cognitive disorders by DSM-IV) with associated psychotic and/or agitated behaviors which:

A. Have been quantitatively and objectively documented. This documentation is necessary to assist in:

- Assessing whether the resident's behavioral symptom is in need of some form of intervention.
- Determining whether the behavioral symptom is transitory or permanent.
- Relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine).

- Ruling out environmental causes (e.g., excessive heat, noise, overcrowding).
- Ruling out medical causes (e.g., pain, constipation, fever, infection).

B. *Are persistent;*

C. Are not caused by preventable reasons; and

D. C*ause the resident to:*

- Present a danger to himself/herself or to others;
- Continuously scream, yell, or pace and results in an impairment of functional capacity; or
- Experience psychotic symptoms (e.g., hallucinations, paranoia, delusions) that are not exhibited as dangerous behaviors or as screaming, yelling, or pacing but result in distress or impairment of functional capacity.

· Short-term (7 day) symptomatic treatment of hiccups, nausea, vomiting, or pruritus. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can be treated for longer periods of time.

Antipsychotics should not be used if the only indication is one or more of the following:

· Wandering;

· Poor self care;

· Restlessness;

· Impaired memory;

· Anxiety;

· Depression (without psychotic features);

· Insomnia;

· Unsociability;

· Indifference to surroundings;

· Fidgeting;

· Nervousness;

· Uncooperativeness; or

· Agitated behaviors that do not represent danger to the resident or others.

II. U*nless clinically contraindicated, gradual dose reductions of the antipsychotic drug and* behavioral interventions are considered in an effort to discontinue the drug. Close supervision should be provided when gradual dose reductions are carried out. If the gradual dose reduction causes an adverse effect on the resident and is discontinued, documentation of this decision and the reasons for it should be included in the clinical record. Gradual dose reductions consist of tapering the daily dose to determine whether symptoms can be controlled by a lower dose or the drug can be altogether eliminated.

NOTE: A Behavior intervention is a modification of the resident's behavior or environment, including staff approaches to care, to the largest degree possible to accommodate the behavioral symptoms.

NOTE: Clinically contraindicated means that gradual dose reductions or behavioral interventions need not be undertaken if:

- The resident has a history of recurrence of psychotic symptoms (e.g., delusions, hallucinations) that have been stabilized with a maintenance dose of a antipsychotic drug without incurring significant side effects and has one of the following specific conditions:
  - Schizophrenia;
  - Schizo-affective disorder;
  - D*elusional disorder;*
  - Psychotic mood disorders (including mania and depression with psychotic features);
  - Acute psychotic episodes;
  - Brief reactive psychosis;
  - Schizophreniform disorder;
  - Atypical psychosis;
  - Tourette's disorder; or
  - Huntington's disease
- The resident has organic mental syndrome, and gradual dose reductions have been attempted twice in one year that resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction or a return to previous dose reduction was necessary; or
- The resident's physician provides a justification as to why the continued use of the drug and the dose of the drug are clinically appropriate. This justification should include:
  - A diagnosis that includes a description of the symptoms (not simply a diagnostic label or code);
  - A discussion of the differential psychiatric and medical diagnosis (e.g., why the resident's behavioral symptom is thought to be the result of a dementia with associated psychosis and/or agitated behaviors and not the result of an unrecognized painful medical condition or a psychosocial or environmental stressor);
  - A description of the justification for the choice of a particular treatment or treatments; and
  - A discussion of why the present dose is necessary to manage the resident's symptoms.

CR2318/PMAB-02-143/10-25-02

Reembolso

A TODOS LOS CENTROS DE CIRUGÍA AMBULATORIA

ACTUALIZACIÓN DE TARIFAS

Conforme con la Sección 1833 (1)(2)(C) del Acta del Seguro Social, el Centro de Servicios Medicare & Medicaid (CMS) autorizó la actualización de tarifas de pago a los Centros de Cirugía Ambulatoria. Estas nuevas tarifas son efectivas para los servicios prestados a partir del 1 de octubre de 2002. El índice de los valores utilizado en áreas urbanas y rurales es parte de la actualización para el año fiscal 2003 del Sistema de Pagos Prospectivos de Hospitales (Hospital Prospective Payment System).

La primera tabla identificada como **TARIFAS DE PAGO ASC 2002-2003** contiene las nuevas tarifas por grupo (categoría) y área geográfica. Este año, CMS incluyó el Grupo 9 como nivel de pago. En el año fiscal 2003, CMS añadirá varios procedimientos a la lista de ASC que utilizarán el Grupo 9 como nivel de pago. Los números romanos presentados en la tabla de tarifas indican las áreas y los cargos que aplicarán a cada una de éstas. Dichas áreas se incluyen en la segunda tabla identificada como **Áreas Urbanas**.

Reimbursement

TO ALL AMBULATORY SURGICAL CENTERS

PAYMENT RATE UPDATES

In accordance with Section 1833 (1)(2)(C) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) authorized an update of the payment rates to the Ambulatory Surgical Centers. These new fees are effective for services rendered October 1, 2002 and thereafter. The wage index values used for urban and rural areas are part of the fiscal year 2003 update of the hospital inpatient prospective payment system (PPS).

*The first table identified as **ASC PAYMENT RATES 2002-2003** contains the new payment rates arranged by group (category) and geographic area. This year, CMS included Group 9 as a payment level. In fiscal year 2003, CMS plans to add several procedures to the ASC list that will utilize this payment level. The roman numerals presented in the payment rate table indicate the areas and the charge that will apply to each one of them. These areas are detailed in the second table identified as **Urban Areas**.*

GROUP/	FEE	I 0.4587	II 0.4356	III 0.4408	IV 0.4914	V 0.5169	VI 0.4741	VII 0.4356
1	333.00	$ 270.90	$ 268.25	$ 268.85	$ 274.65	$ 277.58	$ 272.67	$ 268.25
2	446.00	$ 362.83	$ 359.28	$ 360.08	$ 367.86	$ 371.77	$ 365.20	$ 359.28
3	510.00	$ 414.90	$ 410.84	$ 411.75	$ 420.64	$ 425.12	$ 417.60	$ 410.84
4	630.00	$ 512.52	$ 507.51	$ 508.63	$ 519.62	$ 525.15	$ 515.86	$ 507.51
5	717.00	$ 583.30	$ 577.59	$ 578.87	$ 591.37	$ 597.67	$ 587.10	$ 577.59
*6	826.00	$ 699.94	$ 694.56	$ 695.77	$ 707.56	$ 713.49	$ 703.53	$ 694.56
7	995.00	$ 809.45	$ 801.54	$ 803.32	$ 820.66	$ 829.40	$ 814.73	$ 801.54
*8	973.00	$ 819.53	$ 812.98	$ 814.45	$ 828.80	$ 836.03	$ 823.89	$ 812.98
9	1,339.00	$ 1,089.31	$ 1,078.65	$ 1,081.05	$ 1,104.39	$ 1,116.15	$ 1,096.41	$ 1,078.65

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

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

Trans.AB-02-124/ CR 2316/August 28, 2002/mm

ACTUALIZACIÓN ANUAL DE LOS CÓDIGOS PARA LA FACTURACIÓN CONSOLIDADA DE SERVICIOS EN ENTIDADES DE ENFERMERÍA ESPECIALIZADA

Durante la primera semana de diciembre de 2002, CMS añadirá nuevos códigos HCPCS (Healthcare Common Procedure Coding System) a su lista de éditos. Estos éditos permitirán a los contratistas efectuar los pagos apropiadamente y conforme a la política de facturación consolidada para servicios en entidades de enfermería especializada. (Véase el artículo publicado en la página 69 del volumen 64 de nuestro boletín)

Los archivos que contienen los nuevos códigos serán publicados en la página de Internet de CMS: www.cms.hhs.gov/medlearn/snfcode.asp

ANNUAL UPDATE FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING

By the first week of December 2002, newly established Healthcare Common Procedure Coding System codes will be added to the list of CMS' edits. These edits will allow carriers to make appropriate payments in accordance with policy for SNF consolidated billing. (See article published in volume 69, page 64 of our bulletin).

New codes files will be posted to the CMS Web site at www.cms.hhs.gov/medlearn/snfcode.asp

CR2446/TransB-02-076/11-01-02/ICR

Reembolso

ESTANDARIZACIÓN DE PRECIOS PARA MEDICAMENTOS CUBIERTOS POR MEDICARE

Los Centros para Servicios de Medicare y Medicaid (CMS, por sus siglas en inglés) implantarán a partir del 1 de enero de 2003 un "Single Drug Pricer*" (SDP)* (Método Simple de Precios) para medicamentos y biológicos (de aquí en adelante, medicamentos). Este SDP aplicará a la cubierta de medicamentos bajo la Parte B de Medicare y para los cuales los Contratistas locales fijan los precios.

CMS ha recibido muchas críticas con respecto a gastos excesivos relacionados a las tarifas de pago de aproximadamente 400 medicamentos que se pagan actualmente a base del Precio de Venta Promedio (AWP por sus siglas en inglés*);* por ejemplo en oficinas de médicos, centros de servicios ambulatorios en hospitales, centros de diálisis, entre otros. Actualmente, esta tarifa de pago se establece a base del 95% del AWP del medicamento. No obstante, en ocasiones estos pagos varían. Por consiguiente, CMS establecerá el SDP para identificar correctamente las diferencias entre los Contratistas y así fijar tarifas de pago uniformes para Medicare según contemplado por la Reglamentación 42 C.F.R.405.517. Los precios de los medicamentos se controlarán y fijarán centralmente, lo que significa que los médicos y otros participantes recibirán el mismo pago por el mismo medicamento independientemente donde se someta la reclamación.

CMS continuará, según es costumbre, de fijar la tarifa por cada medicamento basado en el 95% del AWP*,* al igual que dependerá de las publicaciones (*ej. RedBook y First Data Bank*) para identificar el precio de venta promedio*(*AWP*).* CMS le facilitará a los Contratistas, con la excepción de DMERCs y los Intermediarios Fiscales, los archivos con los precios de los medicamentos. Los Contratistas adjudicarán las reclamaciones a base de las descripciones y precios provisto en estos archivo.

CMS espera que esta iniciativa refleje un paso innovador para resolver algunos de los problemas relacionados con el precio de los medicamentos cubiertos por Medicare.

Reimbursement

STANDARDIZING PRICES FOR MEDICARE COVERED DRUGS

On January 1, 2003, the Centers for Medicare & Medicaid Services (CMS) will be implementing a Single Drug Pricer (SDP) for drugs and biologicals (hereinafter "drugs") with respect to drugs covered under Medicare Part B and priced by local carriers.

CMS has received much criticism concerning excessive expenditures related to the payment rates for the approximately 400 drugs that are currently paid based on 95 percent Average Wholesale Price (AWP); i.e., physicians' offices, outpatient hospitals, dialysis centers, etc. Currently, this payment rate is set at 95 percent of the drug's AWP; however, these payments have sometimes varied. Accordingly, CMS is establishing the SDP to correct identified differences amongst its local carriers and is developing a uniform Medicare payment allowance as contemplated by Regulation 42 C.F.R. 405.517. Drug prices will be created centrally, thus being more closely monitored. As a result, physicians and other practitioners will receive the same payment for the same drug regardless of where their claim for the drug is submitted.

CMS will continue, in accordance with its longstanding practice, to set a price for each drug based on 95 percent of AWP, and will continue to rely on published compilations (e.g., Redbook *and* First Data Bank*) to identify wholesale drug prices. Carriers, with the exception of DMERCs, and Fiscal Intermediaries will be provided with drug pricing files from CMS and will adjudicate claims on the basis of the descriptions and prices shown on these files.*

CMS believes that this initiative reflects an innovative approach to resolving some of the problems relating to the pricing of Medicare-covered drugs.

CR2381/Transmittal AB-02-174/December 3,2002/mm/els

Reembolso

TARIFAS FIJAS DE CÓDIGOS DMEPOS SUJETOS A JURISDICCIÓN LOCAL PARA EL AÑO 2003

A continuación indicamos las tarifas de los códigos para equipo médico duradero y suministros ortóticos y protésicos (DMEPOS por sus siglas en inglés) con jurisdicción local. El factor de actualización para DMEPOS en el 2003 es de 1.1 por ciento. Estas tarifas serán efectivas al 1 de enero de 2003.

Reimbursement

2003 FEE SCHEDULE FOR DMEPOS CODES SUBJECT TO LOCAL CARRIER JURISDICTION

The following are the fees for DMEPOS codes subject to local carrier jurisdiction. The 2003 DMEPOS update factor is 1.1 percent for all items except oxygen and oxygen equipment. The fees will become effective on January 1, 2003.

CR 2378/ab-02-152/October 25, 2002/mm

CÓDIGO HCPCS *HCPCS CODE*	CATEGORÍA *CATEGORY*	TARIFAS FIJAS PR *PR FEE SCHEDULE*	TARIFAS FIJAS VI *VI FEE SCHEDULE*
E0749RR	Capped Rental	$ 458.34	$ 238.29
E0616	Inexpensive or Routinely Purchased DME	$ 2,327.25	$ 2,746.16
E0782NU	Inexpensive or Routinely Purchased DME	$ 3,996.06	$ 4,110.93
E0782UE	Inexpensive or Routinely Purchased DME	$ 2,997.03	$ 3,083.20
E0782RR	Inexpensive or Routinely Purchased DME	$ 399.62	$ 411.11
E0783NU	Inexpensive or Routinely Purchased DME	$ 7,127.77	$ 7,761.34
E0783RR	Inexpensive or Routinely Purchased DME	$ 712.78	$ 776.15
E0785	Inexpensive or Routinely Purchased DME	$ 404.11	$ 404.11
E0786	Inexpensive or Routinely Purchased DME	$ 6,599.46	$ 6,594.15
L8600	Prosthetic / Orthotic	$ 261.44	$ 445.81
L8603	Prosthetic / Orthotic	$ 364.66	$ 362.92
L8610	Prosthetic / Orthotic	$ 533.55	$ 482.34
L8612	Prosthetic / Orthotic	$ 533.55	$ 466.08
L8613	Prosthetic / Orthotic	$ 277.43	$ 218.87
L8614	Prosthetic / Orthotic	$ 16,642.34	$ 13,219.82
L8619	Prosthetic / Orthotic	$ 7,144.46	$ 5,247.46
L8630	Prosthetic / Orthotic	$ 234.77	$ 221.97
L8641	Prosthetic / Orthotic	$ 224.10	$ 229.56
L8642	Prosthetic / Orthotic	$ 224.10	$ 211.63
L8658	Prosthetic / Orthotic	$ 133.38	$ 205.40
L8670	Prosthetic / Orthotic	$ 320.12	$ 249.16

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

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

Reembolso

CAMBIO DE JURISDICCIÓN PARA LA CÁMARA HIPERBÁRICA PARA USO TÓPICO

Las cámaras hiperbáricas para uso tópico son suministros desechables para ser utilizados por el paciente en el hogar. Conforme al *Coverage Issues Manual*, sección 35-10 (D), las reclamaciones por este tipo de artículo serán denegadas por considerarse el servicio médicamente innecesario.

Efectivo el 1 de enero de 2003, la jurisdicción para el proceso de las reclamaciones por este artículo cambiará del contratista local de la Parte B al contratista regional de equipo médico (DMERC por sus siglas en inglés).

El código HCPCS para este artículo es **A4575 – *Topical Hyperbaric Oxygen Chamber, disposable***.

CÓDIGO CORRECTO PARA LA VACUNA DE INFLUENZA

Los Centros de Servicio para Medicare y Medicaid (CMS por sus siglas en inglés) notificaron que la vacuna de influenza, "Whole Virus Vaccine" (código 90659) no fue producida para la temporada del 2002.

La vacuna de influenza debe facturarse con el código 90658 para la temporada del 2002.

> **90658**: Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet infection use

Reimbursement

CHANGE IN JURISDICTION FOR TOPICAL HYPERBARIC OXYGEN CHAMBER

Topical hyperbaric oxygen chambers are disposable items that are used in the home. In accordance with the Coverage Issues Manual, §35-10 (D), claims for topical hyperbaric oxygen must be denied as not medically necessary.

Effective for dates of service January 1, 2003 and thereafter, jurisdiction for processing claims for this item will change from local carrier to the Durable Medical Equipment Regional Carriers (DMERCs).

*The HCPCS code for this item is **A4575 - Topical hyperbaric oxygen chamber, disposable.***

CR2177/PMB-02-044/07/24/02/ICR

CORRECT CODING FOR INFLUENZA VACCINE

The Centers for Medicare & Medicaid Services notified that the Whole Virus Vaccine (code 90659) was not produced for the 2002 flu season.

The influenza vaccine for the 2002 flu season should be billed using code 90658.

> ***90658**: Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet infection use*

CMS-Joint Signature Letter/October 25,2002/mm

Reembolso

FACTOR DE INFLACIÓN DE AMBULANCIA PARA EL 2003

Trasfondo

La sección 1834(l)(3)(A) del Acta del Seguro Social establece la base para la actualización del límite de pago para los servicios de ambulancia. Específicamente, esta sección provee para una actualización en los pagos del 2003 igual al porciento de aumento en el índice de precios del consumidor para todos los **consumidores urbanos** durante el periodo de doce meses que termina en junio del año anterior. El resultado de este por ciento se conoce como Factor de Inflación de Ambulancia (AIF por sus siglas en inglés).

Durante el periodo de transición, el *AIF* se aplicará a la porción de la tarifa fija y a la porción del cargo razonable que componen la tarifa combinada de cada suplidor de ambulancia. Estas dos cantidades se suman para así determinar la cantidad del pago total de cada suplidor.

Política

El Factor de Inflación de Ambulancia para el año calendario 2003 es **1.1 por ciento**. Los por cientos utilizados para combinar los dos componentes de las cantidades de pago para servicios de ambulancia en el 2003 son **60 por ciento** para el cargo razonable y **40 por ciento** de la tarifa fija.

El requisito del deducible y coaseguro de la Parte B aplica.

Implantación

El factor de inflación de 1.1 por ciento del 2003 será aplicado a los límites de pago que estuvieron vigentes durante el año calendario 2002. Esta aplicación es con el propósito de determinar los límites de pago que aplicarán al periodo del 1 de enero de 2003 hasta el 31 de diciembre de 2003.

Reimbursement

AMBULANCE INFLATION FACTOR FOR 2003 (AIF)

Background

*Section 1834(l)(3)(A) of the Social Security Act (the Act) provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2003 that is equal to the percentage increase in the consumer price index for all **urban consumers** (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the AIF.*

During the transition period, the AIF is applied to both the fee schedule portion and to the reasonable charge portion of the blended payment amount separately for each ambulance supplier. Then, these two amounts are added together to determine the total payment amount for each supplier.

Policy

*The AIF for calendar year (CY) 2003 is **1.1 percent**. The blending percentages used to combine the two components of the payment amounts for ambulance services for CY 2003 are **60 percent** of the reasonable charge and **40 percent** of the ambulance fee schedule. Part B coinsurance and deductible requirements apply.*

Implementation

The 2003 AIF of 1.1 percent will be apply to the payment limits that were in effect during calendar year 2002 in order to determine the payment limits applicable for the period January 1, 2003 through December 31, 2003.

CR 2489/AB-02-173/November 29,2002/mm

Reembolso

PROCESAMIENTO DE CÓDIGO ICD-9 USANDO FECHA DE SERVICIO Y NO DE RECIBO

La ley HIPAA dispone que los grupos de códigos nacionales deben ser aceptados por fecha de servicio y no de recibo. El sistema se modificará de manera que las reclamaciones recibidas a partir del 1 de enero de 2003 se procesen con los ICD-9 por fecha de servicio y no de recibo. El sistema validará el código de diagnóstico según la fecha de servicio y a su vez que el código de servicio haga correlación con el código de diagnóstico. Por lo tanto, los proveedores, así como su personal de facturación, deben conocer los códigos de diagnóstico que están en vigor al momento de prestar el servicio.

El periodo de gracia de 90 días continuará vigente cada año. Durante el periodo que comprende del 1 de octubre al 31 de diciembre de cada año se aceptarán tanto los códigos nuevos y viejos de ICD-9.

CR2209/PM B-02-064/11/11/2002/ICR/els

Reimbursement

PROCESS ICD-9-CM CODES USING DATE OF SERVICE AND NOT DATE OF RECEIPT

According to the Health Insurance Portability and Accountability Act (HIPAA), national code sets must be date of service compliant. Therefore, ICD-9-CM codes must be processed based on date of service instead of date of receipt. Starting January 1, 2003 the system will process all claims received with ICD-9-CM diagnosis codes by date of service and not date of receipt. The system will be able to edit for the validity of diagnosis codes based on the date of service of the procedure code to which the diagnosis code is correlated. Providers and their billing staff must have knowledge of which diagnosis code is in effect at the time the service is rendered.

The 90-day grace period will still apply. From October 1 through December 31 of each year both old and new codes for dates of service will be allowed.

RECLAMACIONES POR SERVICIOS DE TERAPIA SUJETAS A LA FACTURACIÓN CONSOLIDADA DEL CUIDADO EN EL HOGAR

Puede que existan situaciones bajo el Plan de Cuidado en el Hogar para los cuales los Centros para Servicios de Medicare y Medicaid (CMS por sus siglas en inglés) no tienen el expediente del episodio de cuidado en el hogar o una solicitud de pago anticipado (RAP por sus siglas en inglés). El siguiente código de comentario aparecerá en la remesa de pago por servicios de terapia posiblemente sujetos a facturación consolidada del Cuidado en el Hogar:

CLAIMS FOR THERAPY SERVICES SUBJECT TO HOME HEALTH CONSOLIDATED BILLING

There may be situations in which a beneficiary is under a home health plan of care, but CMS does not yet have a record of either a request for anticipated payment (RAP) or a home health claim for the episode of care. The following remark code will appear on the remittance advice for therapy services that may be subject to consolidated billing:

Cont. on next page

CÓDIGO DE COMENTARIO		
Número	**Mensaje**	**Condiciones**
N116	Este pago se hace condicionalmente porque el servicio fue provisto en la casa y es posible que el paciente este bajo un episodio de cuidado de salud en el hogar. Cuando un paciente es atendido bajo un episodio de cuidado de salud en el hogar, la facturación consolidada requiere que ciertos servicios de terapia y suplidos, como estos, sean incluidos en el pago a la Agencia de Cuidado en el Hogar (HHAs por sus siglas en inglés). Si se establece que el paciente está bajo un episodio de cuidado de salud en el hogar, este pago se recuperará.	Este mensaje aparecerá en las explicaciones de pago cuando CMS indique que el servicio es pagable y se cumple con estas tres condiciones: 1. El lugar de servicio es "12 casa." 2. El código de HCPCS es un código de terapia sujeto a la facturación consolidada para el cuidado de la salud en el hogar (refiérase al más reciente artículo donde se indican los códigos y servicios que se afectan; volumen 71 del **Medicare Informa** Pág. 94). 3. CMS no ha devuelto un mensaje donde indica la presencia de un RAP.
Remark Code		
Number	***Message***	***Conditions***
N116	*This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.*	*This message will appear on the remittance advice when CMS indicates that the service is payable, and all three of the following conditions are true:* *1. The place of service is "12 home."* *3. The HCPCS code is a therapy code subject to home health consolidated billing (refer to the most recent PM announcing affected services and codes; **"Medicare Informa"** Volume 71, pag. 94).* *4. CMS has not returned a message indicating the presence of a RAP.*

Reembolso

NUEVAS PRUEBAS AL CERTIFICADO DE DISPENSA

En la lista a continuación se mencionan las pruebas que recientemente la Administración Federal de Drogas y Alimentos aprobó como pruebas de dispensa bajo el *Clinical Laboratory Improvement Amendments* (CLIA por sus siglas en inglés) A los códigos de procedimiento *(Current Procedural Terminology)* correspondientes a estas nuevas pruebas, se les debe añadir el modificador QW para que sean reconocidas como pruebas de dispensa.

Reimbursement

NEW TESTS TO THE WAIVED CERTIFICATE

Listed below are the latest tests approved by the Food and Drug Administration as a 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.

CR2413/TransAB-02-154/11/1/02/ICR

NOMBRE DE LA PRUEBA *TEST NAME*	**FABRICANTE** *MANUFACTURER*	**CODIGO(S) CPT** *CPT CODE(S)*
Roche Diagnostics Coaguchek PST	Roche Diagnostics	85610QW
Quidel QuickVue Advance pH and Amines Test	Quidel Corporation	82120QW 83986QW
Cholestech GDX A1C Test	Cholestech Corporation	83036QW
Quidel QuickVue In-Line Strep A	Quidel Corporation	87880QW
HemoCue Glucose 201 Microcuvettes and Glucose 201 Analyzer	HemoCue, Inc.	82947QW, 82950QW 82951QW, 82952QW
Genzyme OSOM Strep A Ultra Test -25 Test Kit Size	Genzyme Corporation	87880QW
O2 Unlimited Donna Ovulation Tester	O2 Unlimited Corp.	87210QW
Stesans Maybe? Mom Mini Ovulation Microscope	LEC Associates	87210QW
Diagnostic Chemicals ImmunoDip Urinary Albumin Test	Diagnostic Chemicals Limited	83518QW

Reembolso

ACTUALIZACIÓN A LOS CARGOS RAZONABLES PARA EL 2003 PARA ENTABLILLADOS, YESOS Y CIERTOS CÓDIGOS DE LENTE INTRAOCULAR

El pago para los códigos de entablillados, yesos y lentes intraoculares continúan basados en cargos razonables. El pago por implante de lentes intraoculares está basado en cargo razonable solamente para el implante en la oficina de un médico.

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

Entablillados y Enyesados

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

Los códigos para entablillados y yesos deben ser utilizados solo para facturar servicios para reducir una fractura o dislocación.

Implante de lentes intraoculares en la oficina de un médico

V2630 V2631 V2632

Los siguientes códigos fueron aumentados de acuerdo a la sección 5025 del Manual de Medicare. El aumento de inflación para el 2003 es de 1.1 por ciento.

Reimbursement

2003 REASONABLE CHARGE UPDATE FOR SPLINTS, CASTS AND CERTAIN INTRAOCULAR LENSES

Payment for splints, casts, and intraocular lenses continues to be made on a reasonable charge basis. Payment for intraocular lenses is made on a reasonable charge basis only for lenses implanted in a physician's office.

The following codes are subject to the reasonable charge update:

Splints and Casts Used to Reduce a Fracture or Dislocation

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

The codes for splints and casts are to be used only for splints and casts used to reduce a fracture or dislocation.

Intraocular Lenses Implanted in a Physician's Office

V2630 V2631 V2632

The following fees have been increased in accordance with section 5025 of the Medicare Carriers Manual. The inflation increase for 2003 is 1.1 percent.

Cont. on next page

PAGOS PARA ENTABLILLADOS Y YESOS PARA EL 2003
2003 PAYMENT AMOUNT FOR SPLINTS AND CASTS

CODIGO *CODE*	TARIFA *FEE*	CODIGO *CODE*	TARIFA *FEE*
A4565	$6.37	Q4025	$28.02
Q4001	$36.28	Q4026	$87.48
Q4002	$137.14	Q4027	$14.01
Q4003	$26.06	Q4028	$43.75
Q4004	$90.23	Q4029	$21.42
Q4005	$9.60	Q4030	$56.39
Q4006	$21.66	Q4031	$10.72
Q4007	$4.81	Q4032	$28.20
Q4008	$10.83	Q4033	$19.98
Q4009	$6.41	Q4034	$49.71
Q4010	$14.44	Q4035	$10.00
Q4011	$3.20	Q4036	$24.86
Q4012	$7.22	Q4037	$12.19
Q4013	$11.67	Q4038	$30.54
Q4014	$19.69	Q4039	$6.11
Q4015	$5.83	Q4040	$15.28
Q4016	$9.85	Q4041	$14.82
Q4017	$6.75	Q4042	$25.31
Q4018	$10.77	Q4043	$7.41
Q4019	$3.38	Q4044	$12.66
Q4020	$5.39	Q4045	$8.60
Q4021	$4.99	Q4046	$13.84
Q4022	$9.02	Q4047	$4.30
Q4023	$2.51	Q4048	$6.93
Q4024	$4.51	Q4049	$1.57

TARIFAS PARA IMPLANTE DE LENTES INTRAOCULARES EN EL 2003
2003 INTRAOCULAR LENSES IMPLANTED FEES

CODIGO *CODE*	TARIFA *FEE*
V2630	$763.73
V2631	$393.73
V2632	$480.48

CR 2371/AB-02-136/OCTOBER 11, 2002/MM

Reembolso

PAGO A DIETISTAS POR SERVICIOS DE ADIESTRAMIENTO PARA EL AUTO MANEJO DE LA DIABETES (DSMT POR SUS SIGLAS EN INGLÉS)

La sección 4105 del "Balanced Budget Act" de 1997 permite la cubierta de los servicios de Adiestramiento para el Auto-Manejo de la Diabetes cuando este es administrado por un proveedor certificado que cumple con ciertos criterios de calidad. El programa DSMT educa a los beneficiarios en como lograr un exitoso auto manejo de la diabetes. El programa incluye: educación relacionada al auto monitoreo del azúcar en sangre, dietas y ejercicios y un plan de tratamiento diseñado específicamente para pacientes quienes son insulino dependiente. Además, el programa motiva a los beneficiarios al auto manejo de su diabetes.

Los suplidores y proveedores que facturan servicios o suministros a Medicare, y estén acreditados para representar el programa DSMT, pueden facturar y recibir pagos por todo el programa DSMT. A partir del 1 de enero de 2002 los Dietistas que tienen número con Medicare pueden recibir pago por el programa completo de DSMT. Sin embargo, un Dietista no puede ser el único proveedor de servicio del DSMT; éste deberá formar parte de un grupo multidisciplinario del programa de DSMT.

Si usted ha cumplido con la política antes descrita y sus reclamaciones se han denegado, puede comunicarse al 1-800-715-1921 y nosotros le adjudicaremos las reclamaciones a través del proceso de revisión.

Nota : Para solicitar su número de identificación debe completar un formulario CMS 855I y 855R. Estos formularios pueden obtenerse en nuestra oficina o a través de la siguiente dirección electrónica: http://www.cms.hhs.gov/medicare/enrollment/forms.

CR2386/PM B-02-062/10/04/2002/ICR/els

Reimbursement

PAYMENT TO REGISTERED DIETITIANS FOR DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING (DSMT) SERVICES

Section 4105 of the Balanced Billing Act of 1997 allows Medicare coverage of DSMT when a certified provider, who meets certain quality standards, furnishes the services. The DSMT program educates beneficiaries in the successful self-management of diabetes. The program includes: education regarding self-monitoring of blood glucose, diet and exercise, and insulin treatment plan developed specifically for the patient who is insulin-dependent. The program also motivates patients towards self-management of their diabetes.

Suppliers and providers who bill for Medicare services or items, and who represent a DSMT program that is accredited, can bill and receive payment for the entire DSMT program. As of January 1, 2002, Registered Dietitians that have Medicare provider numbers can bill for the entire DSMT program. Nonetheless, a Registered Dietitian may not be the sole provider of the DSMT service; he or she should be part of a multi-disciplinary team in the DSMT program.

If you have complied with the above-mentioned policy and your claims have been denied, contact us at 1-800-715-1921 and we will adjudicate the claims through the appeal process.

***Note**: To request the provider identification number, CMS 855I and 855R forms should be completed. These forms may be obtained at our offices or at the following web address: http://www.cms.hhs.gov/medicare/enrollment/forms.*

Reembolso

LISTA REVISADA DE ÁREAS HPSA

La reglamentación de Medicare establece que el Contratista de la Parte B realice revisiones trimestrales a los pagos efectuados como incentivo a los profesionales de la salud que prestan servicios en áreas de escasez (HPSA, por sus siglas en inglés).

La designación y clasificación de las áreas de escasez de profesionales de la salud son hechas por los Servicios de Salud Pública – Oficina para la Designación de Áreas de Escasez (Public Health Service – Office Shortage Designation). Para reclamar el incentivo, los servicios deben prestarse en un lugar clasificado como de escasez de profesionales de la salud. Además, se deberá utilizar en el encasillado 24d del formulario HCFA 1500 el modificador que aplique de estos dos:

QB: Para los servicios rendidos en áreas rurales de escasez.

QU: Para los servicios rendidos en áreas urbanas de escasez.

A continuación la lista actualizada de los pueblos clasificados como Áreas de Escasez de Profesionales de la Salud.

Si tiene alguna pregunta relacionada con esta información o cualquier otra información publicada en esta comunicación, puede llamarnos al 1-877-715-1921.

Reimbursement

UPDATED HPSA LIST

Medicare regulations require Part B Carriers to conduct quarterly reviews of the incentive payments for services rendered in any rural or urban Health Professional Shortage Area (HPSA).

The Federal Public Health Service Office of Shortage Designation makes the designation and classification of these areas. To qualify for the incentive payment, the services must be rendered in a HPSA and it is necessary to use the following modifiers in block 24d (procedure code) of the HCFA 1500 form:

***QB**: For services rendered in rural HPSAs.*

***QU**: For services rendered in urban HPSAs.*

The following is an updated list of Health Professional Shortage Areas.

If you have any questions concerning this or any other information published in this communication, please call us at 1-877-715-1921.

LISTA ACTUALIZADA (HPSA) *UPDATED HPSA LISTA*	
PUERTO RICO	**ISLAS VIRGENES**
Aguas Buenas	Fredericksted South West, St. Croix
Caguas	
Cidra	Fredericksted North West, St. Croix
Gurabo	
Juncos	

FMR/DBHPP:BSPB:TMC/11/4/2002

Reembolso

ACTUALIZACIÓN DE LOS CÓDIGOS QUE IDENTIFICAN EL LUGAR DE SERVICIO

Los códigos que identifican los distintos lugares de servicio aceptados por los Centros para Servicios de Medicare y Medicaid (CMS) fueron actualizados. Los nuevos códigos serán vigentes el 1 de enero de 2003.

Este contratista actualizó el sistema de acuerdo con las tarifas de instalaciones hospitalarias y las no hospitalarias.

- Transacciones estándar HIPAA
- Reclamaciones en papel
- Formato Nacional Estándar (National Standard Format) y cualquier otra transacción electrónica estándar no HIPAA

¿Cómo se procesarán las reclamaciones utilizando estos nuevos lugares de servicio?

Los códigos de lugar de servicio detallados a continuación son válidos bajo HIPAA. Se aplicarán las políticas de pago y de cubierta apropiadas a los nuevos códigos en todas las reclamaciones electrónicas y en papel, correlacionando estos códigos con los códigos existentes. Las reclamaciones se procesarán según los requisitos indicados en los códigos de lugar de servicio existentes.

Uso del código (15) para Identificar Unidad Móvil

Cuando los servicios se proveen en una unidad móvil, a menudo estos se brindan para una entidad la cual tiene un código de lugar de servicio. Por ejemplo, cuando una unidad móvil es enviada a una oficina médica o a una instalación de enfermería especializada. Si una unidad móvil está sirviendo a una entidad para la cual existe otro código de lugar de servicio, el proveedor debe utilizar el código de lugar de servicio que corresponde a dicha entidad. Pero si la unidad móvil no está sirviendo a una entidad que pueda ser descrita por un código existente, entonces puede utilizar el código de lugar de servicio 15.

Reimbursement

UPDATES TO THE PLACE OF SERVICE (POS) CODE SET

The Centers for Medicare and Medicaid Services (CMS) has updated the Place of Service (POS) Code Set. New codes will become effective January 1, 2003.

This Carrier has updated the system in order to be consistent with the facility and non-facility rate designations as listed:

- *For HIPAA Standard Transactions*
- *For Paper Claims*
- *For National Standard Format and other Non-HIPAA-Standard-Electronic Transactions*

How Claims will be Processed Using the New POS Codes

All of the POS codes listed in the code set are valid under HIPAA. For electronic and paper claims, the appropriate payment and coverage policy will be applied to the new codes by cross walking them to the existing codes noted in the attached table. Claims will be processed according to the requirements of the indicated existing POS code.

How to Use the Mobile Unit Code (15)

When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician's office or a skilled nursing facility. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity that could be described by an existing POS code, the providers are to use the Mobile Unit POS code 15.

POS Code/Name Description (*=New code)	Payment Rate Facility = F Nonfacility=NF	Crosswalk to
01-02 /Unassigned		N/A
03* /School A facility whose primary purpose is education.	NF	11/Office
04* /Homeless Shelter A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).	NF	11/Office
09-10 /Unassigned		--
11 /Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	NF	--
12 /Home Location, other than a hospital or other facility, where the patient receives care in a private residence.	NF	--
13-14 /Unassigned		--
15* /Mobile Unit A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.	NF	11/Office
16-19 /Unassigned	--	--
20* /Urgent Care Facility Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	NF	11/Office
21 /Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	F	--

POS Code/Name Description (*=New code)	Payment Rate Facility = F Nonfacility=NF	Crosswalk to
22 /Outpatient Hospital A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	F	--
23 /Emergency Room – Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	F	--
24 /Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.	F Note: pay at the nonfacility rate for payable procedures not on the ASC list	--
25 /Birthing Center A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.	NF	--
26 /Military Treatment Facility A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).	F	--
27-30/ Unassigned		--

POS Code/Name Description (*=New code)	Payment Rate Facility = F Nonfacility =NF	Crosswalk to
32 /Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	NF	--
33 /Custodial Care Facility A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.	NF	--
34 /Hospice A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	F	--
35-40 Unassigned		--
41 /Ambulance--Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F	--
42 /Ambulance -- Air or Water An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F	--
43-49 /Unassigned		--
50 /Federally Qualified Health Center A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.	NF	--
51 /Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	F	--

POS Code/Name Description (*=New code)	Payment Rate Facility = F Nonfacility =NF	Crosswalk to
52 /Psychiatric Facility-Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	F	--
53 /Community Mental Health Center A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.	F	--
54 /Intermediate Care Facility/Mentally Retarded A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.	NF	--
55 /Residential Substance Abuse Treatment Facility A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	NF	--

POS Code/Name Description (*=New code)	Payment Rate Facility = F Nonfacility =NF	Crosswalk to
56 /Psychiatric Residential Treatment Center A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	F	--
57-59 /Unassigned		--
60 /Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	NF	--
61 /Comprehensive Inpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	F	--
62 /Comprehensive Outpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	NF	--
63-64 /Unassigned		--

POS Code/Name Description (*=New code)	Payment Rate Facility = F Nonfacility=NF	Crosswalk to
65 /End-Stage Renal Disease Treatment Facility A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	N	--
66-70 /Unassigned		--
71 /State or Local Public Health Clinic A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician. **72 /Rural Health Clinic** A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	NF NF	-- --
73-80 /Unassigned		
81 /Independent Laboratory A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	NF	--
82-98 /Unassigned		--
99 /Other Place of Service Other place of service not identified above.		--

CR2259/PM B-02-055/08/07/2002/ICR

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 mesualmente. Los contratistas reciben mensualmente una lista de CMS, que incluye las exclusiones y reintegraciones efectuadas por la Oficina del Inspector General (OIG). Las exclusiones tienen vigencia a los 20 días de la fecha de notificación al proveedor. Estas exclusiones y reintegraciones serán vigentes en 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 del "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. Estas penalidades se aplicarán en los casos en los cuales una persona contrata un proveedor excluído, con el propósito de ofrecer 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" como "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 la lista de los proveedores reintegrados al Programa Medicare en esta página y en la página 57 la lista de los proveedores excluídos del 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 in the "Medicare Carrier Manual" 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 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 on this page 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 Vision Express Vega Baja, PR 00693	January 15, 2002
Rosado Montalvo, Héctor	Ponce Plaza Alfonso XII - Int. Isabel St. Ponce, PR 00731	August 23, 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
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
Davila Aponte, Wanda E	63 Calle Nogal Monte Casino Toa Alta, PR 00953	Indefinite	May 20, 2002
Yemat Perez, Alex A.	Barrio Obrero 2041 Calle Borinquen Santurce, PR 00907	Indefinite	May 20, 2002
Alvarez Valentin, Mario	Urb. Valencia 1 52 Calle Pedro Cruz-Marg Juncos, PR 00777	Indefinite	July 18, 2002

RECLAMACIONES

ERRORES SIMPLES DE FACTURACIÓN

Este Contratista devuelve aproximadamente 17,000 reclamaciones al mes, debido a falta de información indispensable para su procesamiento. La acción de devolver una reclamación afecta las operaciones del contratista, pero más a las del proveedor, ya que, no recibirá con prontitud el reembolso por el servicio brindado.

La mayoría de las reclamaciones devueltas carecen de la siguiente información:

CLAIMS

SIMPLE CLAIM SUBMISSION ERRORS

This Contractor returns approximately 17,000 claims a month, due to lack of information essential for their processing. Returned claims affect this Carrier's operations, but much more that of providers since you will not receive prompt reimbursement for the services rendered.

Most of the returned claims fail to include the following information:

Descripción del error	Encasillado CMS - 1500	Código		Que acción debe tomar el proveedor
		Rechazo	Nota	
Tipo de seguro incompleto o inválido	1	CO-16	MA86	Revisar la factura sometida, corregir la información radicada y someter una nueva reclamción. Estas devoluciones no tienen el derecho apelativo.
Número de beneficiario incorrecto	1A	CO-16	MA61	
Nombre del beneficiario incorrecto	2	CO-16	MA36	
Información MSP incorrecta	10B y 11	CO-16	MA83	
Total de cargos incorrectos	28	CO-16	MA85	
Omisión de firma del proveedor	31	CO-16	MA81	
Diágnostico o código incorrecto o inválido	21 y 24E	CO-16	M76	Revisar la factura devuelta, corregir la información de código ICD-9 y someter una nueva reclamación.
Nombre del médico que refirió u ordenó el servicio.	17	CO-16	MA102	Completar los encasillados 17 y 17A y radicar una nueva reclamación.
Identificación incorrecta del número del proveedor que participa en el grupo de práctica	24K	CO-16	MA112	Completar y radicar una nueva reclamación con el número correspondiente al médico del grupo de práctica.
Modificador que no corresponde al procedimiento HCPCS realizado.	24D	CO-16	M76	Completar y radicar una nueva reclamación con el modificador correcto
Omisión de dirección del proveedor	33	CO-16	MA82	Completar y radicar una nueva reclamación que incluya la dirección fisica de proveedor de los servicios.

RECLAMACIONES

CLAIMS

Error Description	CMS - 1500 Item	Code		Action to be taken
		Remark	Note	
Health Insurance Plan not identified.	1	CO-16	MA86	Verify the information submitted,correct the pertinent information and submit a new corrected claim.
Incomplete or incorrect beneficiary identification number	1A	CO-16	MA61	
Incorrect beneficiary name	2	CO-16	MA36	
Incorrect MSP information	10B y 11	CO-16	MA83	
Total charge in error	28	CO-16	MA85	
Missing provider's signature	31	CO-16	MA81	
Incorrect or invalid diagnosis code	21 y 24E	CO-16	M76	Complete and submit a new claim. Include the most comprehensive ICD-9 code.
Missing information on ordering or referring physician	17	CO-16	MA102	Complete and submit a new claim. Ensure items 17 & 17A are filled.
Missing or incorrect information regarding the rendering physician within the group practice	24K	CO-16	MA112	Complete and submit a new claim which includes the number and suffix of the performing provider.
Modifier does not correlate to the procedure performed	24D	CO-16	M76	Complete and submit a new claim. Reassure that the modifier correlates to the service performed.
Missing physician's address	33	CO-16	MA82	Complete and submit a new claim. Make certain that the provider's address is included.

No se concede el derecho apelativo (solicitud de revisión) a reclamaciones devueltas con los códigos de acción CO-16 y los códigos de comentario M76, MA112, M61,MA102 y M78. En estos casos, el proveedor debe someter una nueva reclamación completa en todas sus partes.

Nota: Una gran cantidad de reclamaciones en papel, CMS-1500, no se controlan ni procesan ya que en el encasillado número uno, no se indica el plan médico al cual se desea facturar.

Si la reclamación es por un servicio prestado a un beneficiario para el cual el Programa Medicare es asegurador primario, se deberá indicar "MEDICARE" en el encasillado.

En los próximos boletines les ofreceremos más información sobre errores simples. Esto evitará que sus reclamaciones sean devueltas por falta de información necesaria para el procesamiento de las mismas.

Claims returned with action code CO-16 and remark codes M76, MA112, M61, MA102 and M78 have no appeal rights. The provider should submit a new claim correcting the claim submission error.

***Note:** A vast number of paper claims, CMS-1500, cannot be controlled and processed due to item number one of the claim form not indicating the health insurance plan that should be billed for the service.*

If the claim is for services rendered to a beneficiary where Medicare is the primary insurer, the "MEDICARE" block should be marked.

In our next issues we will provide more information on simple claim submission errors to avoid so that claims are not returned.

Relaciones con la Comunidad

BENEFICIARIOS DE MEDICARE DEPORTADOS

Los Centros para Servicios de Medicare y Medicaid (CMS, por sus siglas en inglés) no pagarán por servicios prestados a beneficiarios deportados. A partir del 1 de abril de 2003, CMS denegará reclamaciones por servicios y suministros en las cuales las fechas de servicios se sobreponen a la fecha de deportación.

El siguiente mensaje a proveedores y suplidores aparecerá en las reclamaciones denegadas: "Los expedientes del Seguro Social indican que este individuo fue deportado. El pagador no cubre suministros ni servicios provistos a individuos que han sido deportados."

El mensaje en la Remesa de Pago del beneficiario deportado dirá: **"La reclamación fue denegada porque información de la Administración del Seguro Social indica que usted fue deportado(a)."**

Las reclamaciones denegadas disponen del derecho apelativo.

Community Relations

DEPORTED MEDICARE BENEFICIARIES

The Centers for Medicare and Medicaid Services (CMS) will not make payments for services provided a beneficiary who has been deported. Effective April 1, 2003, CMS will deny claims for items and services where the dates of service overlap the date of deportation.

The Reason Message that follows will appear in supplier's and provider's claims which are denied: "Social Security Records indicate that this individual has been deported. The payer does not cover items and services furnished to individuals who have been deported."

Beneficiaries will receive the following message in their Medicare Summary Notice: ***"Claim denied because information received from the Social Security Administration indicates that you have been deported."***

Denied claims will be provided appeal rights.

CR2377/AB-02-162/11-8-02/LV/els

USO CORRECTO DEL "*UNIQUE PHYSICIAN IDENTIFICATION NUMBER"* (UPIN) SUSTITUTO

El UPIN sustituto se utiliza cuando no se ha asignado un UPIN oficial. El médico debe utilizar un UPIN sustituto mientras el Contratista procesa la designación de UPIN. Tan pronto el Contratista asigna un número de UPIN, se debe descontinuar el uso del UPIN sustituto.

Uno de los siguientes UPIN sustitutos se utilizará mientras se espera por el UPIN asignado:

Residentes —UPIN sustituto *RES000* se utiliza para médico interno, residente o "fellow". No obstante, si el médico residente ya tiene su UPIN, lo utilizará en lugar del sustituto. Si

CORRECT USE OF SURROGATE UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN)

The surrogate UPIN is used when an official UPIN has not yet been assigned. The physician must use a surrogate UPIN while the Contractor is processing the assignment of his/her UPIN. As soon as a UPIN has been assigned, the surrogate UPIN must not be used.

Until a UPIN is assigned, you can use one of the following surrogate UPINs:

Residents— *Surrogate UPIN* RES000 is *for a physician meeting the description of "intern, resident", or "fellow". However, if a resident already obtained a UPIN, that number is to be used instead of the resident surrogate. If a*

el médico abandona el hospital para establecer su práctica privada y no obtuvo su UPIN, éste podrá usar el sustituto utilizado en el hospital hasta tanto se le asigne su UPIN.

Médicos activos en el Servicio Militar, Departamento de Veteranos y Servicios de Salud Pública — Médicos o proveedores de cuidado de la salud activos en el servicio militar, Departamento de Veteranos o Servicio de Salud Publica no están exentos del requisito de obtener un UPIN, especialmente si ellos van a brindar servicios a los beneficiarios de Medicare o referir beneficiarios a otros servicios. Podrán utilizar uno de los siguientes UPIN sustitutos hasta que se le asigne su UPIN:

- *VAD000* – Médicos activos en el servicio militar de los Estados Unidos y aquellos empleados del Departamento de Veteranos.
- *PHS000* – Médicos sirviendo en el Servicio de Salud Pública incluyendo el "Indian Health Service".

Médicos Retirados -- A los médicos retirados no se les asigna UPIN y deben utilizar el sustituto RET000. Si tuvieron un UPIN durante su práctica privada deben utilizarlo y no utilizar el UPIN sustituto.

UPIN para "Usos Especiales" — Para aquellas situaciones en las cuales no aplica ninguna de las categorías arriba descritas, existe un UPIN sustituto adicional, *OTH000*. Se debe utilizar *OTH000* cuando el tipo de servicio requiere un UPIN pero al médico o al médico que refiere no se le ha asignado un UPIN y no califica para algún UPIN sustituto.

Este Contratista auditará el uso del UPIN sustituto. A los proveedores que sobreutilizen los UPINs sustitutos se les notificará y solicitará una acción correctiva.

Para obtener el UPIN del médico que le ha ordenado o referido servicios puede acceder la siguiente página electrónica : http://upin.ecare.com//.

physician leaves the hospital for private practice and did not receive a UPIN, the physician may continue to use the surrogate used in the hospital until a UPIN is assigned.

Physician with Military, Department of Veterans Affairs and Public Health Service *—Physician/health care practitioners serving in the military or with the Department of Veterans Affairs or the Public Health Service are not exempt from the requirement of obtaining a UPIN, particularly if they plan to provide services to Medicare beneficiaries or refer beneficiaries for other services. Until a UPIN is assigned, you are to use one of the following surrogate UPINs:*

- VAD000- *Physicians serving on active duty in the military of the United States and those employed by the Department of Veterans Affairs.*
- PHS000- *Physicians serving in the Public Health Service, including the Indian Health Service.*

Retired Physicians — *Retired physicians are not issued UPINs and are to use the surrogate* RET000*. Retired physicians who were assigned a UPIN before leaving their medical practice must use that number.*

"Special Use" UPIN*—Situations may evolve that do not fall within the above categories. Therefore, one additional surrogate UPIN,* OTH000 *is provided. Use OTH000 when the type of service requires a UPIN but the ordering/referring physician has not been assigned one and does not qualify for one of the other surrogates.*

This Contractor will be auditing the use of surrogate UPINs. Providers overutilizing these numbers will be notified and corrective actions will be requested.

You can access and obtain the UPIN of the physician who ordered or referred the service at the following web address: http://upin.ecare.com//

CR2286/Transmittal 27/10/25/2002/ICR/els

Relaciones con la Comunidad

ACTUALIZACIÓN ANUAL DE CÓDIGOS HCPCS DE SERVICIOS DE SALUD EN EL HOGAR UTILIZADOS EN FACTURACIÓN CONSOLIDADA

En abril de 2001, los Centros para Servicios de Medicare y Medicaid establecieron el proceso de actualización periódica de las listas de códigos pertenecientes al *Healthcare Common Procedure Coding System (HCPCS)* sujetos a la disposición de facturación consolidada del Sistema de Pago Prospectivo de Servicios de Salud en el Hogar (HH PPS por sus siglas en inglés). Las reclamaciones que contengan servicios que figuren en esta lista, que sean sometidas al Intermediario Fiscal o a los Contratistas de la Parte B, incluyendo a los Contratistas Regionales de Equipo Médico Duradero (DMERCs), no serán pagadas cuando los servicios facturados hayan sido prestados en las fechas en que un beneficiario se encuentre en un episodio de servicios de salud en el hogar. Medicare solamente reembolsará a las agencias primarias de servicios de salud en el hogar que hayan iniciado servicios durante este periodo. Nótese que suministros incidentales a los servicios médicos, así como suministros utilizados en un marco institucional, no están sujetos a facturación consolidada de servicios de salud en el hogar.

En julio de 2002 CMS estableció que las actualizaciones a la lista de códigos sujetos a la disposición de facturación consolidada de Servicios de Salud en el Hogar podrían ocurrir trimestralmente para reflejar la creación temporera de códigos HCPCS. Estos códigos temporeros pueden describir servicios sujetos a facturación consolidada además de la lista permanente de códigos HCPCS que se actualiza anualmente.

Esta publicación provee la primera actualización trimestral de dichos códigos para el año calendario 2003. La misma incorpora nuevos códigos temporeros, así como la actualización de todos los códigos HCPCS y códigos CPT que están sujetos a facturación consolidada. Antes de la próxima actualización anual, podrían ocurrir otras actualizaciones durante los restantes trimestres

Community Relations

ANNUAL UPDATE OF HCPCS CODES USED FOR HOME HEALTH CONSOLIDATED BILLING ENFORCEMENT

In April 2001, CMS established the process of periodically updating the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). Services appearing on this list of submitted claims, to Medicare Fiscal Intermediaries and Carriers including Durable Medical Equipment Regional Carriers (DMERCs), will not be paid on dates when a beneficiary for whom such a service is being billed is in a home health episode. Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode period. Note that items incidental to physician services, as well as supplies used in institutional settings are not subject to HH consolidated billing.

On July 2002, CMS established that updates of the HH consolidated billing code list would occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes. These temporary codes may describe services subject to consolidated billing in addition to the permanent list of HCPCS codes that is updated annually.

This publication provides the first quarterly HH consolidated billing update for calendar year 2003. It incorporates new temporary codes, as well as the annual update of all HCPCS codes and CPT codes that are subject to consolidated billing. Therefore, this PM is referred to as an annual update. Other updates for the remaining quarters of the calendar year will occur as needed due to the creation of new temporary codes representing services subject to HH consolidated billing prior to the next annual update.

Relaciones con la Comunidad

del año, según fuere necesario, debido a la creación de nuevos códigos temporeros que representen servicios sujetos a facturación consolidada de servicios de salud en el hogar.

La nueva codificación identificada en cada actualización describe los mismos servicios que fueron utilizados para determinar las tarifas de pago aplicables a HH PPS. Estas actualizaciones no añadirán servicios adicionales; esto es, las nuevas actualizaciones son requeridas debido a cambios en el sistema de codificación, no porque los servicios sujetos a facturación consolidada de servicios de salud en el hogar sean redefinidos.

Community Relations

The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

CR2402/Trans AB-02-137/10-11-02/LV

Crosswalk of Changes to Home Health Consolidated Billing Coding
January 2003 Update

Note new codes replace deleted codes when both appear on the same line.

Therapy Changes

New Code	New Code Description	Deleted Code	Deleted Code Description
G0279	Excorp shock tx, elbow epi		
G0280	Excorp shock tx other than		
G0281	Elec stim unattend for press		
G0282	Elect stim wound care not pd		
G0283	Elec stim other than wound		
92601	Cochlear implt f/up exam < 7		
92602	Reprogram cochlear implt < 7		
92603	Cochlear implt f/up exam 7 >		
92604	Reprogram cochlear implt 7 >		
92605	Eval for nonspeech device rx	92597	Oral speech therapy eval
92606	Non-speech device service	92597	Oral speech therapy eval
92607	Ex for speech device rx, 1hr	92597	Oral speech therapy eval
92608	Ex for speech device rx addl		
92609	Use of speech device service		
92610	Evaluate swallowing function	92525	Oral function evaluation
92611	Motion fluoroscopy/swallow	92525	Oral function evaluation
92612	Endoscopy swallow tst (fees)		
92614	Laryngoscopic sensory test		
92616	Fees w/laryngeal sense test		
96000	Motion analysis, video/3d		
96001	Motion test w/ft press meas		
96002	Dynamic surface emg		
96003	Dynamic fine wire emg		
		92598	Mod voice prosthetic
0019T	Extracorp shock wave tx, ms		
0020T	Extracorp shock wave tx, ft		

Crosswalk of Changes to Home Health Consolidated Billing Coding
January 2003 Update

Supply Changes

New Code	New Code Description	Deleted Code	Deleted Code Description
A4405	Nonpectin based ostomy paste	K0561	Nonpectin based ostomy paste
A4406	Pectin based ostomy paste	K0562	Pectin based ostomy paste
A4407	Ext wear ost skn barr <=4sq"	K0563	Ext wear ost skn barr <=4sq"
A4408	Ext wear ost skn barr >4sq"	K0564	Ext wear ost skn barr >4sq"
A4409	Ost skn barr w flng <=4 sq"	K0565	Ost skn barr w flng <=4sq"
A4410	Ost skn barr w flng >4sq"	K0566	Ost skn barr w flng >4sq"
A5061	Pouch drainable w barrier at	K0567	1 pc drainable ost pouch
A5061	Pouch drainable w barrier at	K0568	1 pc cnvx drainable ost pouch
A4413	2 pc drainable ost pouch	K0569	2 pc drainable ost pouch
A4414	Ostomy sknbarr w flng <=4sq"	K0570	Ostomy skn barr w flng<=4sq"
A4415	Ostomy skn barr w flng >4sq"	K0571	Ostomy skn barr w flng >4sq"
A4368	Ostomy filter	K0574	Ostomy pouch filter
		K0575	Ost pouch rustle free material
		K0576	Ostomy pouch comfort panel
		K0577	Ostomy pouch odor barrier
		K0578	Urinary pouch faucet/drain
A4422	Ost pouch absorbent material	K0579	Ost pouch absorbent material
		K0580	Ost pouch locking flange
A4458	Reusable enema bag		
A4656	Needle, any size, each		
A4657	Syringe, with or without needle, each		
A4712	Sterile water inj per 10 ml		
A4930	Sterile, gloves per pair		
A6011	Collagen gel/paste wound fil		
A6410	Sterile eye pad		
A7043	Vacuum drainage bottle/tubing		
K0581	Ost pch clsd w barrier/filtr		
K0582	Ost pch w bar/bltinconv/fltr		
K0583	Ost pch clsd w/o bar w filtr		
K0584	Ost pch for bar w flange/flt		
K0585	Ost pch clsd for bar w lk fl		
K0586	Ost pch for bar w lk fl/fltr		
K0587	Ost pch drain w bar & filter		
K0588	Ost pch drain for barrier fl		
K0589	Ost pch drain 2 piece system		
K0590	Ost pch drain/barr lk flng/f		
K0591	Urine ost pouch w faucet/tap		
K0592	Urine ost pouch w bltinconv		
K0593	Ost urine pch w b/bltin conv		
K0594	Ost pch urine w barrier/tapv		
K0595	Os pch urine w bar/fange/tap		
K0596	Urine ost pch bar w lock fln		
K0597	Ost pch urine w lock flng/ft		

LISTA COMPLETA DE CÓDIGOS HCPCS SUJETOS A FACTURACIÓN CONSOLIDADA DE SERVICIOS DE SALUD EN EL HOGAR

COMPREHENSIVE LIST OF HCPCS CODES SUBJECT TO HOME HEALTH CONSOLIDATED BILLING

JANUARY 2003 UPDATE

Therapy Codes

G0193	Endoscopic study swallow functn
G0194	Sensory testing endoscopic study
G0195	Clinical eval swallowing funct
G0196	Eval of swallowing with radioopa
G0197	Eval of pt for prescip speech devi
G0198	Patient adapation & train for spe
G0199	Reevaluation of patient use spec
G0200	Eval of patient prescip of voice p
G0201	Modi for training in use voice pro
G0279	Excorp shock tx, elbow epi
G0280	Excorp shock tx other than
G0281	Elec stim unattend for press
G0282	Elect stim wound care not pd
G0283	Elec stim other than wound
0019T	Extracorp shock wave tx, ms
0020T	Extracorp shock wave tx, ft
64550	Apply neurostimulator
90901	Biofeedback train, any meth
90911	Biofeedback peri/uro/rectal
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92510	Rehab for ear implant
92526	Oral function therapy
92601	Cochlear implt f/up exam < 7
92602	Reprogram cochlear implt < 7
92603	Cochlear implt f/up exam 7 >
92604	Reprogram cochlear implt 7 >
92605	Eval for nonspeech device rx
92606	Non-speech device service
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
96000	Motion analysis, video/3d

Therapy Codes

96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97012	Mechanical traction therapy
97014	Electric stimulation therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97020	Microwave therapy
97022	Whirlpool therapy
97024	Diathermy treatment
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97504	Orthotic training
97520	Prosthetic training
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97601	Wound care selective
97602	Wound care non-selective
97703	Prosthetic checkout
97750	Physical performance test
97799	Physical medicine procedure

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Supply Codes

A4212	Non coring needle or stylet
A4310	Insert tray w/o bag/cath
A4311	Catheter w/o bag 2-way latex
A4312	Cath w/o bag 2-way silicone
A4313	Catheter w/bag 3-way
A4314	Cath w/drainage 2-way latex
A4315	Cath w/drainage 2-way silcne
A4316	Cath w/drainage 3-way
A4319	Sterile H2O irrigation solut
A4320	Irrigation tray
A4321	Cath therapeutic irrig agent
A4322	Irrigation syringe
A4323	Saline irrigation solution
A4324	Male ext cath w/adh coating
A4325	Male ext cath w/adh strip
A4326	Male external catheter
A4327	Fem urinary collect dev cup
A4328	Fem urinary collect pouch
A4330	Stool collection pouch
A4331	Extension drainage tubing
A4332	Lubricant for cath insertion
A4333	Urinary cath anchor device
A4334	Urinary cath leg strap
A4335	Incontinence supply
A4338	Indwelling catheter latex
A4340	Indwelling catheter special
A4344	Cath indw foley 2 way silicn
A4346	Cath indw foley 3 way
A4347	Male external catheter
A4348	Male ext cath extended wear
A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter
A4353	Intermittent urinary cath
A4354	Cath insertion tray w/bag
A4355	Bladder irrigation tubing
A4356	Ext ureth clmp or compr dvc
A4357	Bedside drainage bag
A4358	Urinary leg bag
A4359	Urinary suspensory w/o leg b
A4361	Ostomy face plate
A4362	Solid skin barrier
A4364	Liq adhes for facial prosth
A4365	Adhesive remover wipes
A4367	Ostomy belt
A4368	Ostomy filter
A4368	Ostomy pouch filter

Supply Codes

A4369	Skin barrier liquid per oz
A4371	Skin barrier powder per oz
A4372	Skin barrier solid 4x4 equiv
A4373	Skin barrier with flange
A4375	Drainable plastic pch w fcpl
A4376	Drainable rubber pch w fcplt
A4377	Drainable plstic pch w/o fp
A4378	Drainable rubber pch w/o fp
A4379	Urinary plastic pouch w fcpl
A4380	Urinary rubber pouch w fcplt
A4381	Urinary plastic pouch w/o fp
A4382	Urinary hvy plstc pch w/o fp
A4383	Urinary rubber pouch w/o fp
A4384	Ostomy faceplt/silicone ring
A4385	Ost skn barrier sld ext wear
A4387	Ost clsd pouch w att st barr
A4388	Drainable pch w ex wear barr
A4389	Drainable pch w st wear barr
A4390	Drainable pch ex wear convex
A4391	Urinary pouch w ex wear barr
A4392	Urinary pouch w st wear barr
A4393	Urine pch w ex wear bar conv
A4394	Ostomy pouch liq deodorant
A4395	Ostomy pouch solid deodorant
A4396	Peristomal hernia supprt blt
A4397	Irrigation supply sleeve
A4398	Ostomy irrigation bag
A4399	Ostomy irrig cone/cath w brs
A4400	Ostomy irrigation set
A4402	Lubricant per ounce
A4404	Ostomy ring each
A4405	Nonpectin based ostomy paste
A4406	Pectin based ostomy paste
A4407	Ext wear ost skn barr <=4sq”
A4408	Ext wear ost skn barr >4sq”
A4409	Ost skn barr w flng <=4 sq”
A4410	Ost skn barr w flng >4sq”
A4413	2 pc drainable ost pouch w/ filter
A4414	Ostomy skn barr w/ flng < 4sq"
A4415	Ostomy skn barr w/ flng > 4sq"
A4421	Ostomy supply misc
A4422	Ost pouch absorbent material
A4455	Adhesive remover per ounce
A4458	Reusable enema bag
A4460	Elastic compression bandage
A4462	Abdmnl drssng holder/binder

Comprehensive List of HCPCS Codes Subject to Home Health Consolidated Billing
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Supply Codes	
A4481	Tracheostoma filter
A4622	Tracheostomy or larngectomy
A4623	Tracheostomy inner cannula
A4625	Trach care kit for new trach
A4626	Tracheostomy cleaning brush
A4649	Surgical supplies
A4656	Needle, any size, each
A4657	Syringe, with or without needle, each
A4712	Sterile water inj per 10 ml
A4930	Sterile, gloves per pair
A5051	Pouch clsd w barr attached
A5052	Clsd ostomy pouch w/o barr
A5053	Clsd ostomy pouch faceplate
A5054	Clsd ostomy pouch w/flange
A5055	Stoma cap
A5061	Pouch drainable w barrier at
A5062	Drnble ostomy pouch w/o barr
A5063	Drain ostomy pouch w/flange
A5071	Urinary pouch w/barrier
A5072	Urinary pouch w/o barrier
A5073	Urinary pouch on barr w/flng
A5081	Continent stoma plug
A5082	Continent stoma catheter
A5093	Ostomy accessory convex inse
A5102	Bedside drain btl w/wo tube
A5105	Urinary suspensory
A5112	Urinary leg bag
A5113	Latex leg strap
A5114	Foam/fabric leg strap
A5119	Skin barrier wipes box pr 50
A5121	Solid skin barrier 6x6
A5122	Solid skin barrier 8x8
A5126	Disk/foam pad +or- adhesive
A5131	Appliance cleaner
A6010	Collagen based wound filler, dry foam
A6011	Collagen gel/paste wound fil
A6020	Collage wound dressing
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6154	Wound pouch each
A6196	Alginate dressing <=16 sq in
A6197	Alginate drsg >16 <=48 sq in
A6198	alginate dressing > 48 sq in
A6199	Alginate drsg wound filler

Supply Codes	
A6200	Compos drsg <=16 no border
A6201	Compos drsg >16<=48 no bdr
A6202	Compos drsg >48 no border
A6203	Composite drsg <= 16 sq in
A6204	Composite drsg >16<=48 sq in
A6205	Composite drsg > 48 sq in
A6206	Contact layer <= 16 sq in
A6207	Contact layer >16<= 48 sq in
A6208	Contact layer > 48 sq in
A6209	Foam drsg <=16 sq in w/o bdr
A6210	Foam drg >16<=48 sq in w/o b
A6211	Foam drg > 48 sq in w/o brdr
A6212	Foam drg <=16 sq in w/border
A6213	Foam drg >16<=48 sq in w/bdr
A6214	Foam drg > 48 sq in w/border
A6215	Foam dressing wound filler
A6219	Gauze <= 16 sq in w/border
A6220	Gauze >16 <=48 sq in w/bordr
A6221	Gauze > 48 sq in w/border
A6222	Gauze <=16 in no w/sal w/o b
A6223	Gauze >16<=48 no w/sal w/o b
A6224	Gauze > 48 in no w/sal w/o b
A6228	Gauze <= 16 sq in water/sal
A6229	Gauze >16<=48 sq in watr/sal
A6230	Gauze > 48 sq in water/salne
A6231	Hydrogel dsg<=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
A6234	Hydrocolld drg <=16 w/o bdr
A6235	Hydrocolld drg >16<=48 w/o b
A6236	Hydrocolld drg > 48 in w/o b
A6237	Hydrocolld drg <=16 in w/bdr
A6238	Hydrocolld drg >16<=48 w/bdr
A6239	Hydrocolld drg > 48 in w/bdr
A6240	Hydrocolld drg filler paste
A6241	Hydrocolloid drg filler dry
A6242	Hydrogel drg <=16 in w/o bdr
A6243	Hydrogel drg >16<=48 w/o bdr
A6244	Hydrogel drg >48 in w/o bdr
A6245	Hydrogel drg <= 16 in w/bdr
A6246	Hydrogel drg >16<=48 in w/b
A6247	Hydrogel drg > 48 sq in w/b
A6248	Hydrogel drsg gel filler
A6251	Absorpt drg <=16 sq in w/o b
A6252	Absorpt drg >16 <=48 w/o bdr
A6253	Absorpt drg > 48 sq in w/o b

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Supply Codes

A6254	Absorpt drg <=16 sq in w/bdr
A6255	Absorpt drg >16<=48 in w/bdr
A6256	Absorpt drg > 48 sq in w/bdr
A6257	Transparent film <= 16 sq in
A6258	Transparent film >16<=48 in
A6259	Transparent film > 48 sq in
A6261	Wound filler gel/paste /oz
A6262	Wound filler dry form / gram
A6266	Impreg gauze no h20/sal/yard
A6402	Sterile gauze <= 16 sq in
A6403	Sterile gauze>16 <= 48 sq in
A6404	Sterile gauze > 48 sq in
A6405	Sterile elastic gauze /yd
A6406	Sterile non-elastic gauze/yd
A6410	Sterile eye pad
A7043	Vacuum drainage bottle & tubing
A7501	Tracheostoma valve w diaphra
A7502	Replacement diaphragm/fplate
A7503	HMES filter holder or cap
A7504	Tracheostoma HMES filter
A7505	HMES or trach valve housing
A7506	HMES/trachvalve adhesivedisk
A7507	Integrated filter & holder
A7508	Housing & Integrated Adhesiv
A7509	Heat & moisture exchange sys
K0581	Ost pch clsd w barrier/filtr
K0582	Ost pch w bar/bltinconv/fltr
K0583	Ost pch clsd w/o bar w filtr
K0584	Ost pch for bar w flange/flt
K0585	Ost pch clsd for bar w lk fl
K0586	Ost pch for bar w lk fl/fltr
K0587	Ost pch drain w bar & filter
K0588	Ost pch drain for barrier fl
K0589	Ost pch drain 2 piece system
K0590	Ost pch drain/barr lk flng/f
K0591	Urine ost pouch w faucet/tap
K0592	Urine ost pouch w bltinconv
K0593	Ost urine pch w b/bltin conv
K0594	Ost pch urine w barrier/tapv
K0595	Os pch urine w bar/fange/tap
K0596	Urine ost pch bar w lock fln
K0597	Ost pch urine w lock flng/ft

NOTA AL BENEFICIARIO

PRIMAS, DEDUCIBLES Y COASEGUROS DE MEDICARE PARA EL AÑO 2003

SEGURO DE HOSPITAL (PARTE A)

Deducible - $840.00 (Por período de beneficio)

Coaseguro - $210.00 (diarios desde el día 61 al 90 de cada período de beneficios).

- $420.00 (diarios desde el día 91 al 150 por los restantes 60 días de reserva de por vida).

FACILIDAD DE ENFERMERÍA ESPECIALIZADA (SKILLED NURSING FACILITY)

- Hasta $105.00 diarios desde el día 21 al 100 de cada período de beneficio.

SEGURO MÉDICO (PARTE B)

Deducible - $100.00 Anuales

Coaseguros - Después de cubrir $100.00 de deducible, usted sólo pagará un 20% por los servicios cubiertos por Medicare.

PRIMA MENSUAL DE LA PARTE B:

- $58.70

MESSAGE TO THE BENEFICIARY

PREMIUMS, DEDUCTIBLES, AND COINSURANCES OF MEDICARE FOR 2003

HOSPITAL INSURANCE (PART A)

Deductible -$840.00 (Per Benefit Period)

Co-Insurance -$210.00 (a day for the 61st–90th day each benefit period)

-$420.00 a day for the 91st– 150th day for each lifetime reserve day (total of lifetime reserve days-non-renewable).

SKILLED NURSING FACILITY

- Up to $105.00 a day for the 21st–100th day each benefit period.

MEDICAL INSURANCE (PART B)

Deducible - -$100.00 per year

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

PART B PREMIUM:

-$58.70 per month

http://www.medicare.gov/

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