Medicare Informa

División Medicare / Parte B

¡Qué Bueno Que Preguntó!

ALERTA HIPAA

Recuerde que a partir de 16 de octubre de 2003, es obligatorio para los proveedores de Medicare facturar electrónicamente y en el formato ANSI X12 en cumplimiento con la ley HIPAA[1]. Le exhortamos a que haga la transición lo antes posible para evitar dilaciones en el pago de sus reclamaciones. Para más información, favor de referirse al **Medicare Informa**, Vol. 74 o visite nuestra página en Internet www.triples-med.org.

[1] Una de las excepciones mayores a la regla de facturación electrónica obligatoria es para reclamaciones sometidas por "proveedor de servicios o suplidor pequeño" se define como: un proveedor de servicio con menos de 25 empleados; o un médico, proveedor, facilidad o suplidor con menos de 10 empleados. Además, habrá otras excepciones las cuales puede conseguir en www.cms.hhs.gov/hipaa/hipaa2.

We Are Glad You Asked!

HIPAA AWARENESS

Remember that effective October 16, 2003 it will be mandatory for providers to bill electronically using the ANSI X12 format as required by HIPAA[1]. We encourage you to complete the transition early in order to avoid delays in payment of your claims. For more information on this subject you may refer to Vol. 74 of the ***Medicare Informa*** *or visit our Internet page at www.triples-med.org.*

[1]One of the major exceptions is for claims submitted by "a small provider of services or supplier". The term "small provider of services or supplier" is defined to mean: a provider of services with fewer than 25 full-time equivalent employees; or a physician, practitioner, facility or supplier (other than provider of services) with fewer than 10 full-time equivalent employees. There will be other limited exceptions that you could find at www.cms.hhs.gov/hipaa/hipaa2.

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

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

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

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¡Qué Bueno Que Preguntó!

CANCELACIÓN AUTOMÁTICA DE AJUSTES MASIVOS PARA JULIO 2003

Durante los pasados meses CMS ha estado instruyendo a la comunidad médica sobre los ajustes masivos automáticos que comenzarán en julio de 2003. El Manual de Tarifas Fijas para Médicos no fue efectivo hasta el 1 de marzo de 2003 (demora desde el 1 de enero de 2003). Estos ajustes serán necesarios como resultado de una limitación en el sistema de pago de Medicare, el cual retrasó la implantación del Manual de Tarifas Fijas para Médicos, lo que resultó en el pago incorrecto de un gran número de reclamaciones.

Esta noticia se anunció en varios foros de "Physician Open Door" y a través de la página electrónica y boletines de los contratistas. Debido a que los servicios médicos de enero y febrero 2003 sometidos entre el 1 de marzo y el 30 de junio de 2003 pudieron haber resultado en un pago incorrecto, CMS instruyó a los contratistas de Medicare a ajustar estas reclamaciones automáticamente comenzando en julio de 2003 para recobrar cualquier sobrepago.

BUENAS NOTICIAS...

Queremos notificarle que CMS ha determinado que **NO** le pedirá a los contratistas de Medicare que procedan con el ajuste automático de julio y los recobros de los pagos indebidos. Si hay un pago incorrecto, usted no recibirá ninguna carta relacionada al pago incorrecto basado en la demora del Manual de Tarifas Fijas para Médicos de 2003. Esto, además, significa que los beneficiarios de Medicare no recibirán copias de las cartas de cobro que podrían causarles confusión. Sin embargo, usted debe conocer que si le informa a Medicare sobre un pago incorrecto recibido para los servicios de enero o febrero de 2003, el contratista lo procesará como un ajuste.

JSM 2012/June 26, 2003

We Are Glad You Asked!

CANCELLATION OF THE AUTOMATIC JULY 2003 MASS ADJUSTMENTS

Over the past several months, the Centers for Medicare & Medicaid Services (CMS) had been educating the physician community about the automatic mass adjustments that were going to occur beginning in July, 2003. The Medicare Physician Fee Schedule (MPFS) did not become effective until March 1, 2003 (delayed from January 1, 2003). These adjustments were going to be necessary as a result of a limitation in the Medicare payment system, which delayed the implementation of the MPFS, and which resulted in the incorrect payment of a substantial number of claims.

This news had been announced at several of the Physician Open Door Forums, and via carriers' web sites, and bulletins. Because January 2003 and February 2003 physician services submitted between March 1 and June 30, 2003 may have resulted in an incorrect payment, CMS had previously directed Medicare carriers to automatically adjust these claims, beginning in July 2003, and to recover any applicable overpayments.

THE GOOD NEWS ....

*We now want to inform you that CMS has determined that it will **NOT** require Medicare carriers to go forward with the automatic July mass adjustments and resulting collection of overpayments. If an overpayment exists, you will not be receiving any "Demand" letters related to an incorrect payment based on the delay of the 2003 MPFS. This also means that Medicare beneficiaries will not be receiving copies of those "Demand" letters that would have potentially caused unnecessary confusion to them. You should be aware, however, that if you bring to the attention of the Medicare carrier that an incorrect payment for January or February 2003 was received, the carrier will still process such an adjustment.*

¡Qué Bueno Que Preguntó!

PREGUNTAS MAS FRECUENTES SOBRE EL FORMATO X12

1. **¿Por qué se elimina el programa de Medifast?**

   Porque el programa de Medifast no cumple con el nuevo formato en programación X12 designado por el congreso en la ley HIPAA para envío de facturas. Este entra en vigor el 16 de octubre de 2003. (Si desea más detalles puede acceder nuestra página electrónica en: www.triples-med.org.)

2. **¿Por qué se establece un formato en programación diferente?**

   El Congreso aprobó la ley HIPAA que obliga a todo plan médico y proveedor de salud a cambiar a un formato de facturación uniforme a partir del 16 de octubre de 2003.

3. **¿Por qué el área de Sistemas Medicare no crea un programa para la facturación en X12?**

   Al uniformizar o estandarizar los formatos para la facturación en un futuro cercano Medicare no proveerá un programa gratuito de facturación electrónica. Dada esta realidad y la complejidad de la programación X12 la parte privada de Triple-S y la División Medicare se unieron para desarrollar un solo producto que llene las necesidades de ambas entidades.

4. **Si SES PROFESIONAL es un programa para Medicare, ¿por qué debo llamar a SES "Help Desk" para problemas técnicos?**

   SES PROFESIONAL es un programa creado por el equipo de sistemas de Triple-S, Inc. para facturar servicios de salud a Triple-S y Medicare. SES "Help Desk" es el grupo de personas llamadas a responder su pregunta técnica. Puede comunicarse con ellos al 787-793-5223.

We Are Glad You Asked!

MOST FREQUENT QUESTIONS ABOUT THE X12 FORMAT

1. ***Why eliminate the Medifast program?***

   Because the Medifast program does not comply with the new programming Format X12 designated by Congress in the HIPAA claims submission. The X12 format will be in effect on October 16, 2003. (For more details you may access our Internet page at: www.triples-med.org.)

2. ***Why is a different programming format established?***

   Congress approved HIPAA, which compels every health plan and health provider to change to a uniform billing format beginning October 16, 2003.

3. ***Why does the Systems section of Medicare not make a program for claims submission in X12?***

   When the billing formats unify or standardize in the near future, Medicare will not provide a free program for electronic billing. Given this reality and the programming complexity of the X12, Triple–S private side and the Medicare Division joined forces to create a product that fits the needs of both entities.

4. ***If SES PROFESSIONAL is a Medicare Program, why should I call SES Help Desk for technical problems?***

   SES PROFESSIONAL is a program created by the Triple-S Inc. Systems team to invoice Triple-S and Medicare for health services. SES Help Desk is the group of persons who can answer your technical questions. You may contact them at 787-793-5223.

Cont. on next page

¡Qué Bueno Que Preguntó!

5. **¿Cuál es la diferencia entre el apoyo que me ofrece la sección de EMC versus SES "Help Desk"?**

   El área de EMC resolverá toda aquella situación correspondiente a facturación electrónica Medicare, mientras el SES "Help Desk" resolverá toda aquella situación de índole técnica del programa SES PROFESIONAL.

6. **¿Es obligatorio que los usuarios de Medifast adquieran el programa SES PROFESIONAL?**

   No, SES PROFESIONAL es una alternativa libre de costo para aquellos proveedores que facturan a Medicare que así lo soliciten.

7. **¿Dónde puedo obtener la lista de "VENDORS"?**

   Puede acceder la lista más reciente de "VENDORS" a través de nuestra página electrónica en: www.triples-med.org. Además, puede encontrarla en la última edición del boletín trimestral **Medicare Informa**.

8. **¿Que debo hacer luego de recibir el programa de SES PROFESIONAL por correo?**

   Siga los siguientes pasos:

   - Lea las instrucciones de instalación que se acompaña con el programa
   - Instale el programa tal y como lo explica las instrucciones
   - Inscríbase para recibir el adiestramiento del programa SES PROFESIONAL que la División Medicare de Triple-S, Inc. ofrece gratuitamente
   - Complete el formulario, Hoja de Control EMC, y radique la misma en la División Medicare de Triple-S, Inc.
   - Espere contestación escrita de Medicare confirmando el cambio al formato X12
   - En caso de tener pregunta o duda acerca de la instalación o el funcionamiento de SES PROFESIONAL favor de comunicarse con el "Help Desk" de Triple-S al 787-793-5223.

We Are Glad You Asked!

5. ***What is the difference between the backing of the EMC section and SES Help Desk?***

   The EMC area will solve any situation corresponding to Medicare electronic billing while SES Help Desk will solve any technical situation of the program.

6. ***Is it compulsory that the Medifast users obtain the SES PROFESSIONAL Program?***

   No, SES PROFESSIONAL is a free option for providers who bill Medicare and request it.

7. ***Where can I obtain the list of Vendors?***

   The most recent Vendors list may be accessed at our Internet page at: www.triples-med.org. In addition, you may find the list in our latest edition of the quarterly bulletin ***Medicare Informa****.*

8. ***What should I do after I receive the SES PROFESSIONAL program by mail?***

   Follow these steps:

   - *Read the installation instructions which are enclosed with the program*
   - *Install the program as per the instructions*
   - *Register for the free SES PROFESSIONAL programming training sessions offered by Triple-S, Inc. Medicare Division*
   - *Complete the EMC Control Sheet and bring it to Medicare Division of Triple-S, Inc.*
   - *Wait for Medicare's written confirmation of the change to X12*
   - *If you have any questions or doubts about the installation or operation of SES PROFESSIONAL, please contact the Triple-S Help Desk at 787-793-5223.*

Cont. on next page

¡Qué Bueno Que Preguntó!

9. ¿Cómo se maneja el programa?

Como parte del programa SES PROFESIONAL puede acceder una opción que se encuentra en el manual del usuario junto a las guías de facturación de Medicare. (Actualmente sólo en la versión de Isla Vírgenes. Próximamente estará disponible la versión traducida al español.)

10. Si tengo algún problema o situación mientras manejo el programa, ¿a qué número de teléfono debo comunicarme para ayuda?

Si la situación presentada es de manejo de la entrada de datos para cómo crear la factura de Medicare, deberá comunicarse a la 787-749-4949 extensión 2381.

Si la situación presentada es técnica o sobre el funcionamiento del programa deberá comunicarse al SES "Help Desk" al 787-793-5223.

11. Cómo proveedor activo en la facturación electrónica, ¿tengo que solicitar un nuevo número de remitente para la transición al nuevo formato X12?

No, una vez Medicare reciba la Hoja de Control de EMC actualizará su número de remitente.

12. ¿Por qué tengo que completar la Hoja de Control de EMC?

La Hoja de Control de EMC se utiliza para informar a Medicare que usted está listo para facturar en el nuevo formato X12. Al recibir el formulario, Medicare actualizará su número de remitente para reconocer el nuevo formato. Además, se utiliza para pedir acceso al medio de comunicación BBS; esto de no tener sistema de comunicación. Podrá encontrar una Hoja de Control EMC en nuestra última edición del boletín trimestral **Medicare Informa** o en nuestra página electrónica en: www.triples-med.org.

We Are Glad You Asked!

9. How does the program operate?

You may access an option that, as part of the SES PROFESSIONAL program, contains the User's Manual together with Medicare billing guides. At the moment, only in the Virgin Islands version. It will soon be available in the Spanish version.

10. If I have a problem or situation while using the program, what telephone number must I contact for help?

If the situation deals with data entry to create a Medicare claim, you should contact 787-749-4949 extension 2381. If the situation is technical or about the operation of the program, you should contact the SES Help Desk at 787-793-5223.

11. As an active provider with electronic claims, do I have to request a new remittance number to transition to the new X12 format?

No, once Medicare receives the EMC Control Sheet the sender number will be updated.

12. Why do I have to complete the EMC Control Sheet?

The EMC Control Sheet is used to notify Medicare that you are ready to bill in the new X12 format. Upon receipt of the form, Medicare will update your sender number to recognize the new format. In addition, it is used to request access to the BBS Communication System; if you do not have a communication system. You may find a EMC Control Sheet in our latest edition of the quarterly bulletin ***Medicare Informa*** *or at our Internet page at: www.triples-med.org.*

¡Qué Bueno Que Preguntó!

13.¿Tengo alguna otra alternativa que no sea SES como sistema de comunicación?

Sí, puede solicitar acceso al sistema de comunicación BBS de Medicare al completar la Hoja de Control de EMC.

14.¿Puedo seguir utilizando BBS aunque utilice el programa de facturación SES PROFESIONAL?

Medicare recomienda a aquellos usuarios de SES PROFESIONAL que sometan sus reclamaciones a través del medio de comunicación de SES. Los que opten por utilizar BBS tendrán la responsabilidad de manualmente distribuir en los directorios correspondientes los archivos de Errores y Explicaciones de Pago. Además, recomendamos fuertemente que una vez seleccione un medio de comunicación utilice el mismo constantemente. De esta manera se facilitará su proceso de reconciliación de facturas.

15.Si utilizo un programa privado distinto a SES PROFESIONAL para facturar a Medicare; ¿qué medio de comunicación debo utilizar?

Usted puede utilizar cualquiera de los dos medios de comunicación; SES o BBS. Refiérase a su "VENDOR" para establecer el medio de comunicación más adecuado para envió y reconciliación de facturas. Medicare recomienda fuertemente que una vez seleccione un medio de comunicación utilice el mismo constantemente. De esta manera se facilitará su proceso de reconciliación de facturas.

16.¿Cómo puedo extraer los informes de Medicare?

El programa de SES PROFESIONAL extrae automáticamente los archivos de informes; éstos pueden accederse seleccionando la pestaña ("Tab") de comunicación en la barra de herramientas ("Toolbar") a la izquierda de la pantalla. Luego, en el Menú superior seleccionará "Informes/Cartas" y en la opción de Resumen, podrá ver los archivos

We Are Glad You Asked!

13.Do I have any alternative other than SES as a communication system?

Yes, you may request access to Medicare's BBS Communication System completing the EMC Control Sheet.

14.May I continue using BBS although I use the SES PROFESSIONAL billing program?

It is Medicare's recommendation to those SES PROFESSIONAL users, to submit their claims through the SES Communication's System. Those who opt to use BBS will have the responsibility of manually distributing in the corresponding directories the files for Errors and Payment Explanations. Besides, we strongly recommend that once you choose a means of communication to constantly use the same means of communication. This will facilitate the claims reconciliation process.

15.If I use a private program other than SES PROFESSIONAL to bill Medicare, what means of communication should I use?

You may use any of the two means of communication: SES or BBS. Refer to your vendor to establish the means of communication most suitable for claims submission and reconciliation. Medicare strongly recommends that once you select a communication system to constantly use the same one. This will facilitate the claims reconciliation process.

16.How can I download the Medicare reports?

The SES PROFESSIONAL program automatically downloads the report files; this can be accessed by selecting the communication Tab, in the toolbar at the left of the screen. Then in the upper menu, your will select "Reports/Letters", and in the option of Summary, you can

¡Qué Bueno Que Preguntó!

que le han llegado, entre estos, Informes de Error, Remesas de Pago, 997's, etc. Si desea ver alguno de estos archivos, seleccione la opción de "Ver Informes", podrá seleccionar "Tipo de Informe". Luego en la sección "Nombre de Archivo" aparecerá una lista con los archivos disponibles. **Es muy importante no cancelar el proceso de envío de informes**. El cancelarlo tiene como consecuencia el que no se actualicen los datos en SES PROFESIONAL, conllevando el que usted no pueda accederlos posteriormente. Los tipos de informes que pueden acceder son: Informes de Error y Remesas de Pago.

17. ¿Cómo puedo saber el resultado del archivo enviado luego de obtener mi confirmación de envío a través del medio de comunicación? (o sea ¿mis facturas pasaron bien?)

Debe verificar el Informe de Error de sus reclamaciones el próximo día laborable luego de efectuada su transmisión. De no aparecer este, favor de verificar el archivo 997 el cual se genera cuando existen errores de sintaxis. Si necesita ayuda para interpretar el informe, favor de comunicarse con el "VENDOR" de su sistema de facturación. Si su programa es SES PROFESIONAL favor de llamar a la sección de EMC al teléfono 787-749-4949 extensión 2381.

18. ¿Qué referencia puedo utilizar para interpretar el Informe 997?

Si utiliza un programa de facturación diferente a SES PROFESIONAL, favor de comunicarse con su "VENDOR" para la interpretación del Informe 997. Si utiliza el programa SES PROFESIONAL favor de llamar al SES "Help Desk" al 787-793-5223

19. ¿Por cuánto tiempo se mantiene la cuenta de BBS activa si no la utilizo?

La cuenta de BBS se mantiene activa por seis meses. Si pasa este tiempo y desea reactivarla debe completar la Hoja de Control de EMC nuevamente y radicarla en la División Medicare de Triple-S, Inc.

We Are Glad You Asked!

see the files which you have received, among these, Error Letters, Payment Remittance, 997's, etc. If you wish to see any of these files select the option of "See Reports", where you will choose "Type of Report". Then in the section "File Name" a list of the available files will show up. It is very important not to cancel the files transfer process. To cancel the process, implies that the data in the SES PROFESSIONAL will not be updated, and you will not be able to access it in the future. The types of reports that you may access are: Error Reports and Payment Remittance.

17. How will I know the outcome of the file transferred after getting the transfer confirmation through the communication system? (In other words, did my claims transfer correctly?)

You must verify the Error Report of your claims the following working day after your transmission. If it does not turn up, please check the 997 File that is generated when system errors exist. If you need help understanding the report, please contact your billing system's vendor. If your program is SES PROFESSIONAL, please call the EMC section at 787-749-4949 extension 2381.

18. What reference can I use to interpret the 997 Report?

If you use a billing program other than SES PROFESSIONAL, please contact your vendor for the interpretation of the 997 File. If you use SES PROFESSIONAL, please call the SES Help Desk at 787-793-5223.

19. For how long is the BBS account active if I do not use it?

The BBS account will be active for six months. If you wish to reactivate the account after the six months, you must again complete the EMC Control Sheet and bring it to the Medicare Division of Triple-S, Inc.

¡Qué Bueno Que Preguntó!

20. Una vez complete la transición al formato X12, ¿puedo utilizar el método de "diskette" para envío de reclamaciones electrónicas de Medicare?

No, ya que la ley HIPAA no considera los "diskettes" como medio de facturación electrónica.

21. Si en el proceso de comunicación por SES me aparece el mensaje de 'Time Out', ¿qué debo hacer?

Debe comunicarse con el SES "Help Desk" para que ellos le ayuden con el proceso de transmisión.

22. Si en el programa de facturación de SES PROFESIONAL aparece un mensaje de error, ¿qué debo hacer?

Debe comunicarse con el SES "Help Desk" al 787-793-5223.

23. Mis facturas pasaron sin error en el Informe de Errores, pero el pago llega en cero.

Debe comunicarse con nuestro Centro de Llamadas de Medicare al 1-877-715-1921 para que ellos identifiquen la razón de no pago. Si es una situación que debe ser resuelta por la sección de EMC el representante de servicio tomará nota sobre su inquietud. La sección de EMC le llamará no mas tarde de dos días laborables y responderá a su duda .

24. Si tengo un programa privado y hago el envío por el medio de comunicación de SES; ¿tengo que tomar el adiestramiento que ofrece Medicare?

No, solo se ofrece el adiestramiento a proveedores que han adquirido el programa de facturación SES PROFESIONAL. Si se presentase alguna duda de cómo manejar el medio de comunicación de SES debe solicitar ayuda a través del SES "Help Desk" o comunicarse con su "VENDOR" del programa para recibir instrucciones de envío o manejo.

We Are Glad You Asked!

20. Once the transition to X12 is complete, may I continue to use diskettes for electronic claims submission to Medicare?

No, since HIPAA does consider diskettes as a means of electronic claims submission.

21. If during the communication process with SES I receive the message "Time Out", what should I do?

You should contact the SES Help Desk for them to assist you with the transmission process.

22. If an Error message appears in the billing program of SES PROFESSIONAL, what should I do?

Contact the SES Help Desk at 787-793-5223.

23. My claims transferred without Error, but the payment came in zero?

You should contact our Medicare Call Center at 1-877-715-1921 for them to identify the reason for no payment. If it is a situation that must be solved by the EMC section the Service Representative will take note of your concern. Our EMC section will call no later than two working days and answer your doubts.

24. If I have a private program and I send my file through SES, do I have to take the training offered by Medicare?

No, the training offered by Medicare is only for providers who have the SES PROFESSIONAL program. If you have doubts on how to use SES, ask for assistance through the SES Help Desk or contact your vendor to receive instructions on transmission or operation of the program.

Medicare Division/July 24, 2003/els

EMC CONTROL SHEET

❑Add New Provider to BBS
❑Update Provider Data

Provider ID: 00_____

Biller ID: ___00000_____

Provider Name: _____

Provider Phone: _____

Billing Software Name and Version: _____

Type of service requested:

❑ Send Medicare claims files
❑ Receive Remittance files

Submit Claims in Format	Receive Remittance in Format
❑ 837 X12N	❑ 835 X12
❑ NSF	❑ NSF

I certify that I am/will be submitting claims in the format indicated above.

_____ _____
Date Signature

For System Area internal use only:

Assigned User ID:_____

Activation Date:_____

Activated by:_____

Testing and Other Help Available Before the October 16, 2003 Compliance Date for Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Standards

Dear Medicare Provider,

Will you be ready to bill Medicare effective October 16?

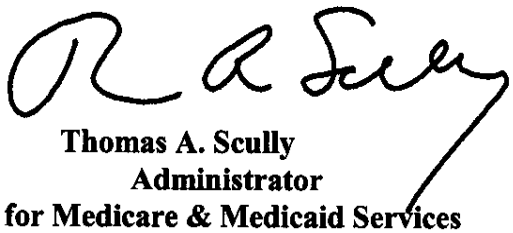
Should you be concerned about getting your Medicare claims paid starting October 16? If you are not ready to use the HIPAA standard transaction and code sets by October 16, you may not get paid!

HIPAA is more than a privacy law; it touches many aspects of health care, including the bills you submit to all health insurers, not just Medicare. Effective October 16, 2003, all electronic transactions covered by HIPAA must comply with these standards for format and content. For example, the electronic claim that a physician or hospital sends to a health plan must be compliant and health plans are only allowed to process compliant transactions. Any non-compliant claims submitted after the October deadline will be returned to you, unpaid.

You may have thought that you can still submit paper bills to Medicare, but in many cases, this is not true. The Administrative Simplification Compliance Act (ASCA) includes a provision that requires electronic submissions to Medicare effective October 16, 2003, with a few exceptions[1].

CMS and its contractors are eager to help you through this transition. Testing with your carrier or fiscal intermediary is required to assure that you and your business partners can send and receive HIPAA compliant transactions. Medicare contractors are ready to test with you now! To schedule testing, contact your Medicare carrier or fiscal intermediary. For more information, please review the helpful HIPAA resources, shown below.

Although we have all been working hard to achieve HIPAA compliance and the benefits it will bring, there is still much to be done. Time is growing short; please be sure to test and start sending and receiving HIPAA compliant transactions as early as possible to avoid any last-minute problems.



Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

[1] One of the major exceptions is for claims submitted by "a small provider of services or supplier." The term "small provider of services or supplier" is defined to mean: a provider of services with fewer than 25 full-time equivalent employees; or a physician, practitioner, facility or supplier (other than provider of services) with fewer than 10 full-time equivalent employees. There will be other limited exceptions.

HELPFUL HIPAA RESOURCES

Upcoming Satellite Broadcasts
HIPAA 101 – The Basics of Administrative Simplification

July 16, 2003
2:00 – 3:00 p.m. ET

July 30, 2003
2:00 – 3:00 p.m. ET

www.cms.hhs.gov/medlearn
Register to be a Host Site for Satellite Broadcasts

www.cms.hhs.gov/hipaa/hipaa2
General HIPAA Information
Educational Materials
Frequently Asked Questions
HIPAA Administrative Simplification Information Series for Providers
Links to Additional HIPAA Web Pages

www.eventstreams.com/cms/tm_001
View HIPAA Educational Webcast
Topics:
HIPAA Basics
Provider Steps for Getting Paid Under HIPAA

askHIPAA@cms.hhs.gov
Request Answers to Your HIPAA Administrative Simplification Questions

1-866-282-0659
HIPAA Hotline Staff Will Answer Your HIPAA Administrative Simplification Questions or Direct You to the Appropriate Resources

Local Carriers and Fiscal Intermediaries
HIPAA Scheduling and Testing

Health Insurance Portability and Accountability Act (HIPAA)

TRANSICIÓN A HIPAA

Según lo establece la Ley HIPAA, a partir del 16 de octubre de 2003 toda reclamación electrónica sometida a Medicare deberá ser en el formato ANSI X12 837 versión 4010A1. Los proveedores que facturan por medios electrónicos deberán actualizar los sistemas de facturación para que generen las reclamaciones en el formato requerido por HIPAA. En nuestra página de Internet en www.triples-med.org hemos publicado una lista de los suplidores de programas de facturación que han completado el proceso de pruebas con Medicare para la transacción 837. Los proveedores que actualmente someten reclamaciones por medios electrónicos y utilizan un programa de facturación aprobado por Medicare no se les requiere someter pruebas para la transacción 837. El requisito de someter pruebas aplica a todo aquel proveedor que por primera vez vaya a someter reclamaciones por medios electrónicos, indistintamente del programa de facturación que utilice.

Si usted es usuario del programa "Medifast" y opta por la transición al programa SES Profesional, v.4.0, usted deberá seguir los siguientes pasos en su transición:

1. Tomé el adiestramiento para el uso de SES Profesional v.4.0 si no lo ha tomado anteriormente.
   (Para registrarse puede llamar al teléfono 787-749-4949 extensión 4408).
2. Transfiera la base de datos del programa "Medifast" al programa SES Profesional v.4.0.
3. Someta a Medicare el formulario "EMC Control Sheet" cuando éste listo para facturar en el nuevo formato ANSI X12.

Los requisitos mínimos que debe tener su computadora personal para utilizar el programa SES Profesional v.4.0:

- Windows® 95, 98, ME o XP
- Procesador Pentium® II o superior
- 1 GB espacio en disco disponible
- 128 MB RAM
- Adaptador de video de 800x600
- CD-ROM Drive

HIPAA TRANSITION

The HIPAA Law requires the ANSI X12 837 version 4010A1 for all electronic claims submitted after October 16, 2003. Medicare providers must update their billing systems in accordance with the transactions and code sets required by HIPAA. Our website at: www.triples-med.org provides a list of electronic billing software suppliers who successfully completed the testing process with Medicare for the ANSI X12 837 transaction. Providers using Medicare approved electronic billing software are not required to submit test files for the 837 transactions. The testing requirement applies to those providers submitting electronically for the first time, regardless of the billing software used.

Providers currently using Medifast who choose to use SES Professional v. 4.0 should complete the following steps prior to transitioning to the new software:

1. *Train to use the SES Professional v.4.0 if you have not done so previously (To register for the training please call 787-749-4949 extension 4408)*
2. *Import the Medifast database to SES Professional v. 4.0*
3. *Submit the EMC Control Sheet once you are ready to submit claims in the ANSI X12 format.*

SES Professional v.4.0 minimum requirements:

- *Windows® 95, 98, ME o XP*
- *Pentium® II or a better CPU*
- *1 GB free hard disk space*
- *128 MB RAM*
- *Video Adapter capable of 800x600 resolution*
- *CD-ROM drive*

Health Insurance Portability and Accountability Act (HIPAA)

Puede utilizar el "EMC Control Sheet" para solicitar facturar reclamaciones electrónicamente usando el formato X12 establecido por HIPAA. El proveedor o su representante autorizado, en el caso de un grupo en práctica independiente, debe firmar el documento. No se procesará documento alguno que no esté firmado por el proveedor o su representante autorizado. Si usted es usuario de otro programa de facturación que haya completado pruebas debidamente con Medicare para el formato X12 usted deberá someter el formulario "EMC Control Sheet" sólo cuando esté listo para comenzar a facturar bajo dicho nuevo programa.

Una vez complete el formulario "EMC Control Sheet" debe enviarlo en original por correo a la siguiente dirección:

The EMC Control Sheet serves as a request to submit electronic claims using the X12 format established by HIPAA. The provider, or authorized representative in the case of a physician group, must sign the document. Documents signed by other than the provider or authorized representative will not be processed. Providers who intend to use other Medicare approved billing software should submit the EMC Control Sheet once the provider is ready to start using the new software.

Once the form is complete it should be mailed to the following address:

Triple-S, Inc./Medicare Division
Provider Enrollment
P.O. Box 71391
San Juan, Puerto Rico 00936-1391

Si lo prefiere, el formulario puede ser entregado personalmente en la Sala de Información de Medicare localizada en el primer piso de nuestro edificio principal. Tan pronto se procese el formulario, le notificaremos por escrito la fecha de vigencia de su cambio. El proveedor podrá facturar utilizando el nuevo programa a partir de la fecha indicada en nuestra carta de confirmación. Una vez actualizado nuestro sistema, éste sólo aceptará reclamaciones electrónicas 837 X12 y producirá la remesa electrónicamente en el formato 835 X12.

Las reclamaciones en el formato ANSI X12 pasarán por varios niveles de validación antes de entrar al proceso de adjudicación. Como parte del proceso de validación se producirá una transacción o informe de error notificando cualquier problema que se haya identificado en las reclamaciones sometidas. En los casos que se identifiquen problemas de integridad en la transacción o en la información incluida en la misma, se producirá la transacción 997. Esta transacción sirve como confirmación de recibo de la transacción o archivo sometido además de proveer detalles sobre los errores identificados en el mismo. Para obtener más información sobre la transacción 997 puede referirse a la guía de implementación de la transacción ANSI X12 837 disponible en el sitio de Internet del Washington Publishing Company en: www.wpc-edi.com.

Or, if you prefer, you can hand it over to one of our Service Representative's at our Medicare Information Office located in the first floor of our main building. As soon as our office processes the form, we will send a letter confirming that the request has been completed. Our confirmation letter will inform you when you can start using the SES Professional v.4.0 software. Please note that once we process the form our system will be updated to only accept electronic claims in the 837 X12 format and electronic remittance advices will be produced in the 835 X12 format.

Claims in the ANSI X12 format will go through various validation levels before entering the adjudication process. As part of the validation process a transaction or error report will be produced which identifies problems in the submitted claims. In those cases where integrity errors are identified in the transaction or the information included in the transaction, Transaction 997 will be produced. The same serves as a confirmation of receipt of the submitted file in addition of providing details of the errors. To obtain more information regarding Transaction 997 please see the Implementation Guide of Transaction ANSI X12 837 available at the Washington Publishing Company internet page: www.wpc-edi.com.

RESUMEN DEL PROCESO DE VALIDACIÓN PARA LAS RECLAMACIONES SOMETIDAS EN EL FORMATO ANSI X12 837

Reclamaciones sometidas a través del sistema de SES	Reclamaciones sometidas a través del Medicare Bulletin Board System (BBS)
• El sistema de SES proveerá un informe de confirmación de recibo el cual incluye un resumen de las reclamaciones sometidas. • En caso de que se identifiquen problemas de integridad en la transacción (primer nivel de validación), el sistema de SES proveerá la transacción 997. • Luego de pasar por el primer nivel de validación las reclamaciones son enviadas a Medicare para proceso. • Medicare ejecuta el segundo nivel de validación y produce la transacción 997 para aquellos casos en que se identifican problemas de integridad de la información en la transacción sometida. Esta transacción 997 estará disponible para el proveedor el próximo día laborable. • Las reclamaciones que no presentaron errores en los primeros dos niveles de validación son sometidas al sistema de Medicare para un tercer nivel de validación y posteriormente al proceso de adjudicación en los casos que aplique. • Como parte del tercer nivel de validación se produce el informe de errores de Medicare. Este es el último nivel de validación donde se identifican las reclamaciones aceptadas que pasarán al proceso de adjudicación. Este informe de errores estará disponible el próximo día laborable luego de haber sometido el archivo.	• **Medicare ejecuta el primer y segundo nivel de validación y produce la transacción 997 para aquellos casos en que se identifican problemas de integridad de la información en la transacción sometida. Esta transacción 997 va a estar disponible al proveedor el próximo día laborable.** • **Las reclamaciones que no presentaron errores en los primeros dos niveles de validación son sometidas al sistema de Medicare para un tercer nivel de validación y posteriormente al proceso de adjudicación en los casos que aplique.** • **Como parte del tercer nivel de validación se produce el informe de errores de Medicare. Este es el último nivel de validación donde se identifican las reclamaciones aceptadas que pasarán al proceso de adjudicación. Este informe de errores estará disponible el próximo día laborable luego de haber sometido el archivo.**
Interpretación de la transacción 997 **Los usuarios de SES Profesional versión 4.0 que reciban alguna transacción 997 deberán llamar al "Help Desk" de SES al 787-793-5223 en caso de necesitar ayuda con la interpretación o explicación de la misma. Los proveedores que utilicen otro programa de facturación deberán comunicarse con su suplidor para recibir ayuda en la interpretación de la transacción 997.**	

Health Insurance Portability and Accountability Act (HIPAA)

ANSI X12 837 CLAIMS VALIDATION PROCESS SUMMARY

Claims submitted through the SES system	Claims submitted through the Medicare Bulletin Board System (BBS)
• The SES system will provide an acknowledgement report that will show a summary or total amount of the claims included in the file. This report serves as a confirmation that the file was received. • If transaction integrity errors are found, the SES system will provide the ANSI X12 997 (Functional Acknowledgment) transaction. This transaction will include details on what errors were identified at the transaction level. This step is what is known as level one editing. • Claims with no level one error are transferred to Medicare for further processing. • Medicare executes the level two editing and creates the ANSI X12 997 if data integrity errors are found. This transaction will be electronically sent to the submitter. • Claims with no level one or level two errors are submitted to the last portion of the validation process at the Medicare Shared System level. At this step the Medicare system will create an error report identifying accepted and rejected claims. This error report will be available for the submitter's review the next working day. Accepted claims will go through the regular adjudication process.	• **Medicare executes level one and level two editing and creates the ANSI X12 997 if data integrity errors are found. This transaction will be electronically sent to the submitter.** • **In the event that a 997 transaction is produced, it will be available for the submitter the next working day.** • **Claims with no level one or level two errors are submitted to the last portion of the validation process at the Medicare Shared System level. At this step the Medicare system will create an error report identifying accepted and rejected claims. This error report will be available for the submitter's review the next working day. Accepted claims will go through the regular adjudication process.**
997 Transaction Interpretation **SES Professional v. 4.0 users who receive a 997 transaction should contact the Medicare EMC Section at 787-749-4949 extension 4470, for assistance with this transaction. Providers using other billing software should contact the billing software supplier or maintainer for assistance with the 997 transactions.**	

Todos los procesos de validación se completarán en el periodo de un día laborable y no afectarán el tiempo de adjudicación y pago para las reclamaciones aceptadas.

Aunque Medicare está autorizado a recibir reclamaciones en el formato NSF hasta el 15 de octubre de 2003, recomendamos fuertemente que usted haga todos los arreglos para la transición al nuevo formato ANSI X12 con anticipación razonable para que evite demoras innecesarias en su proceso de facturación y cobro de reclamaciones.

The validation process described above will be completed in a working day time period. The validation process will not affect the claims processing and payment timeliness.

Although Medicare will accept National Standard Format (NSF) claims until October 15, 2003, we encourage providers to transition to the HIPAA formats as soon as possible. An early transition will avoid delays in the claims processing and payment period.

Systems/July 18, 2003/JS/els

UPDATES TO THE HEALTH CARE PROVIDER TAXONOMY CODE (HPTC)

The Provider Taxonomy code set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute (ANSI) Accredited Standards Committee Insurance Subcommittee health care transactions. The ANSI X12 837 transaction uses the Provider Taxonomy Code (HPTC) to indicate the provider type or specialty. The HPTC's are scheduled for update twice per year (tentatively April and October). The HPTC code list is available from the Washington Publishing Company at **http://www.wpc-edi.com/codes/** .

ANSI X12 claims submitters should update their billing software to use the updated codes no later than 60 days after the official update release. The latest Taxonomy Code update was released on April 4, 2003. As of June 16, 2003 ANSI X12 837 claims will be subject to validation on the Taxonomy Code values. Electronic claims submitters and electronic billing software vendors should ensure that their systems are updated with the latest Taxonomy Codes. Failing to update the Taxonomy Code values used for electronic billing may result in claims being rejected. Refer to the Washington Publishing Company website to obtain the updated Taxonomy Code list.

CR2698/B-03-042/5-23-03/JS/els

PROVEEDORES/VENDORSQUE PASARON PRUEBAS HIPAA FORMATO X12N (TRANSACCIÓN 837)

La siguiente tabla identifica 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.

HIPAA TESTING FOR PROVIDERS/ VENDORS (837 TRANSACTION)

The following table 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.

Vendor's Name Program Name	Type of Claims Tested	Address / Phone Numbers	837 Production Version	HIPAA Testing Completion Date
MASS: Medical Accounting Systems Software VisualMass 7.0	-Visit/Consultation -Laboratory Procedure -Surgery Procedure	PO Box 397 Manatí, PR 00674 787-854-8638 787-884-7214	004010X098	September 12, 2002
Medical Computer System Medical Biller V7	- UPIN - Visit/Consultation - Diagnostic Tests - Laboratory Procedure	4 Calle Barcelona URB Torrimar Guaynabo PR 00966 medbiller@coqui.net (787) (787) 793-8299 Fax	004010X098	October 25, 2002
Structured Systems Corp Medical Practice 6.2	-Visit/Consultation -Diagnostic Tests -Referring Provider/UPIN - Surgery Procedure	PO Box 50335 Levittown, PR 00950 787-795-5072	004010X098	September 20, 2002
TurboMed, Inc. TurboMed ver. 1.01	-Visit/Consultation -Diagnostic Tests -Referring Provider/UPIN	Box 1811 Arecibo, PR 00613 787-898-1437	004010X098	September 25, 2002
CompuSoft de Puerto Rico LabSoft Ver. 2H15	- Laboratory Services	Urb Borinquen Calle 4H 18-C Cabo Rojo, PR 00623 787-851-2867 787-851-6320	004010X098	October 9, 2002
Advance Data Support MedOne Ver. 2.0	- Visit/Consultation	PO Box 8512 Bayamón, PR 00960 787-269-3830 787-269-5620 787-841-0396	004010X098	October 11, 2002
Blás Menendez y Assoc. MedicMax v2.11.20	-Surgery -Visit/Consultation -Purchase -Service	PO Box 3226 Guaynabo PR 00970 787-783-6102	004010X098	November 6, 2002

cont. on next page

Health Insurance Portability and Accountability Act (HIPAA)

Vendor's Name Program Name	Type of Claims Tested	Address / Phone Numbers	837 Production Version	HIPAA Testing Completion Date
Air Information Systems Medi+2000	-Visit/Consultation -Diagnostic Tests -UPIN	PO Box 270152 San Juan, PR 00927 787-294-1161 787-793-0046 Fax: 787-775-4123	004010X098	April 24, 2003
The Right Answer TRA Medical Billing System ver. 5.0	- Visit/Consultation - UPIN Data - Ambulatory Surgery - Emergency procedures - Radiology Services - Mammography Procedures - Anesthesia Procedures - Laboratory Services	PMB 396 405 Ave. Esmeralda Suite #2 Guaynabo, PR 00969 Tel. 787-272-8787 787-643-3738 FAX: 787-272-6106	004010X098	April 15, 2003
Lab Warehouse, Inc. Best 2000 Ver. 20030520	- Laboratory Procedures	13 Calle 65 de Infantería Esq. Calle Concordia Lajas, PR 00667 Tel. 787-899-2900	004010X098	April 16, 2003
WebMD	- Radiology Services - UPIN	26 Century Boulevard Nashville TN 37214	004010X098	June 30, 2003
TekPro, Inc. Pro-LAB	- UPIN - Visit/Consultation	Edif. Darlington Suite 1203 Ave. Muñoz Rivera Río Piedras, PR 00925 787-753-1136	004010X098	June 27, 2003
Lamars Computerized Services Control Total, Versión HIPAA	- Laboratory Procedure	Urb La Cumbre 9 Kennedy St Río Piedras, PR 00926 Tels: 787-720-9697 Fax: 787-272-5824 lamars@centennialpr.net	004010X098	June 11, 2003
Softech Winmds Versión: 3.0	- Visit/Consultation - UPIN	POBox 190408 San Juan, PR 00919 787-720-7547 787-420-0859 www.winmbs.com softek@prtc.net	004010X098	June 27, 2003
JCL Systems, Inc. Med Center	- Visit/Consultation - Laboratory Procedure - Surgery Procedure	Box 144 53 Ave. Esmeralda Guaynabo PR 00969 787-630-7881	004010X098	February 24, 2003

Actualizado/Updated: July 14, 2003

ACLARACIÓN SOBRE LA REGLA DE PRIVACIDAD DE HIPAA Y SOCIOS DE NEGOCIOS

La Regla de Privacidad de HIPAA define socio de negocio como una persona o entidad que participa en el uso o divulgación de información individual de salud en nombre de una entidad cubierta.

De acuerdo a esta definición, los contratistas de Medicare que realizan actividades relacionadas al cuidado de la salud incluyendo el uso de información protegida de salud en nombre del programa de Medicare **no** son considerados socios de negocio de los proveedores, suplidores o planes de salud. Asimismo, los proveedores, suplidores y planes de salud **no** son considerados socios de negocio de los contratistas de Medicare a menos que el proveedor, suplidor o plan de salud haga alguna gestión en nombre del contratista de Medicare. Por esta razón los contratistas de Medicare no firmarán acuerdos de socios de negocio con ningún proveedor, suplidor o plan de salud con la excepción de que las entidades antes mencionadas realicen funciones en nombre del contratista de Medicare.

Ha surgido la duda con relación a si son socios de negocio de los contratistas de Medicare los socios de intercambio de datos ("trading partners") que reciben e intercambian datos de reclamaciones. Actualmente, este contratista de Medicare realiza acuerdos de intercambio de datos con un sinnúmero de pagadores, incluyendo aseguradores Medigap, planes de salud suplementarios a Medicare para empleados retirados, así como la agencia estatal que maneja los fondos de Medicaid con el propósito de adjudicar reclamaciones de responsabilidad secundaria. Este intercambio de datos de reclamaciones se conoce como "intercambio de información de reclamaciones".

Para propósitos de Coordinación de Beneficios, contratistas de Medicare y sus socios de intercambio de datos no son socios de negocio, ya que ninguno hace el trabajo en nombre del otro; por lo tanto, los contratistas de Medicare no firmarán acuerdos de socios de negocio con aseguradores suplementarios (socios de intercambio de datos).

GUIDANCE ON THE HIPAA PRIVACY RULE BUSINESS ASSOCIATE PROVISIONS

The HIPAA Privacy Rule defines business associate as a person or entity that performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information on behalf of a covered entity.

*Based on this definition, Medicare contractors that perform health care activities involving the use of protected health information on behalf of the Medicare Fee For Service health plan are **not** business associates of providers, physicians, suppliers or other health plans. Likewise, providers, physicians, suppliers, or other health plans are **not** business associates of the Medicare contractor, unless the provider, physician, supplier or other health plan is doing work on behalf of the Medicare contractor. For these reasons, Medicare Fee For Service contractors will not sign business associate agreements with any provider, physician, supplier, or other plan unless the provider, physician, supplier, or other health plan is doing work on their behalf.*

Questions have been raised about whether there is a business associate relationship between Medicare contractors and the trading partners that receive crossover claims data from them. Currently, this Medicare Contractor executes trading partner agreements (TPAs) with a host of payers, including Medigap insurers, Medicare supplemental/employee retiree health plans as well as the state Medicaid Agency for the purpose of exchanging adjudicated Medicare claims for secondary liability determination by those partners. This exchange of data is commonly referred to as the "claims crossover process".

For coordination of benefits (COB) purposes, Medicare contractors and trading partners are not business associates since neither entity is doing work on the other's behalf; therefore, the Medicare Fee For Service contractors will not sign business associate agreements with supplemental insurers (trading partners).

CR2712/AB-03-078/05-23-03/JS/ELS

HIPAA OUTREACH

The April 14, 2003 HIPAA privacy deadline and the April 16, 2003 testing deadline, have passed, and the October 16, 2003 deadline for compliance with the HIPAA electronic transactions and code set standards is approaching quickly. Many providers are only now starting to think about what they need to do to become HIPAA compliant. To avoid being a HIPAA covered entity, some consultants are suggesting that providers consider switching from electronic transmission to paper claims. Their advice is extremely shortsighted and certainly not a panacea, especially for Medicare providers. Consider the following:

Requirement to go to electronic claims

Medicare will not accept paper claims, effective October 16, 2003. There will be exceptions for small providers and under other limited situations. Regulations are expected soon.

Negative fiscal impact of paper claims

Processing paper claims takes longer than electronic claims and has an increased rate of error. Faster payment can be made for electronic claims submitted to Medicare. Electronic Medicare claims can be paid 14 days after they are received while paper claims cannot be paid before 28 days after receipt. In addition, processing paper claims has increased administrative, postage and handling costs.

Changes to business processes

Switching from electronic transmission to paper claims would have numerous repercussions on the business processes of your office. Remember that HIPAA transactions include more than just claims submission. Providers often conduct eligibility queries, claim status queries, and referral transmission electronically. All of these would have to be done on paper to avoid being a HIPAA covered entity, ultimately leaving less time for patient care and more time devoted to administration. However, you could decide to do some paper transactions and some electronic transactions, but remember that the electronic transactions must be HIPAA compliant.

General HIPAA Information

What is HIPAA?

Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996. There are four main areas that comprise administrative simplification:

1. Electronic Transactions and code sets
2. Unique Identifiers
3. Privacy
4. Security

What are the HIPAA transactions?

Electronic Transaction Standards have been developed for the following exchanges of information that providers conduct:

1. Health care claims or equivalent encounter information;

2. Health care payment and remittance advice;
3. Health care claims status
4. Eligibility inquiry
5. Referral certification and authorization
6. Claims attachment (standards forthcoming)
7. First report of injury (standards forthcoming)

What is a HIPAA covered entity?

Under HIPAA, all health care clearinghouses, all health plans, and those health care providers that conduct certain transactions in electronic form or who use a billing service to conduct transactions on their behalf are considered covered entities.

What is "electronic"?

The term "electronic" is used to describe moving health care data via the Internet, an extranet, leased lines, dial-up lines such as for "direct data entry", or DDE, private networks, point of service, and health data that is physically moved from one location to another using magnetic tape, disk or CD media. For example, if a provider transmits information electronically by transmitting claims, conducting eligibility queries, conducting claim status queries or referrals, they would be considered a covered entity under HIPAA.

A benefit to consider

HIPAA efficiencies include using the same format for all payers rather than separate formats for each payer, as is often done today.

HIPAA Deadlines:

April 14, 2003	Privacy - all covered entities except small health plans.
April 16, 2003	Electronic Health Care Transactions and Code Sets - all covered entities must have started internal software and systems testing.
October 16, 2003	Electronic Health Care Transactions and Code Sets - all covered entities that filed for an extension and small health plans.
April 14, 2004	Privacy - small health plans.
April 21, 2005	Security - all covered entities except small health plans.
April 21, 2006	Security - small health plans.

Where to go for help:

CMS website: http://www.cms.hhs.gov/hipaa/hipaa2

HIPAA hotline: 1-866-282-0659 AskHIPAA mailbox,

Send an email to askhipaa@cms.hhs.gov

For more information on privacy, visit http://www.hhs.gov/ocr/hipaa. For privacy questions, call 1-866-627-7748.

POSITRON EMISSION TOMOGRAPHY (PET) SCANS

The following is a revision and an addendum to the previous article on the subject:

Positron Emission Tomography (PET) Scans, is revised to specify that we have expanded coverage for: Noninvasive imaging of the perfusion of the heart using FDA-approved Ammonia N-13 tracer; and for: Restaging of recurrent or residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan.

Also for: Soft Tissue Sarcoma, and for: Dementia and Neurogenerative Diseases, Medicare maintains its national noncoverage determinations for all uses of FDG-PET.

This revision to the Coverage Issues Manual is a national coverage determination (NCD). NCDs are binding on all Medicare carriers, intermediaries, peer review organizations, health maintenance organizations, competitive medical plans, and health prepayment plans. Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on a Medicare+Choice Organization. In addition, an administrative law judge may not review an NCD.

The following are the HCPS codes to bill Medicare for these procedures and materials:

- For Perfusion of the Heart HCPCS codes series G0030-G0047.
- For thyroid Cancer Management, a new code (G0296) shall be assigned.

  Long Description: PET imaging, full and partial ring PET scanner only, for restaging of previously treating Thyroid cancer of follicular origin following negative I-131 whole body scan.

  Short Description: PET imge Restag Thyroid cancer.
- A new code HCPCS code, Q4078, shall be assigned to the Ammonia N-13 tracer.

  Long Description: Supply of radiopharmaceutical diagnostic imaging agent, Ammonia N-13, per dose.

  Short Description: Ammonia N-13, per dose.
- Claims for PET scan services shall be billed on Form CMS-1500, or the electronic equivalent with the appropriate HCPCS and diagnosis codes. Expanded coverage is effective for claims with dates of service on or after October 1, 2003.

POSITRON EMISSION TOMOGRAPHY (PET) SCANS

I. General Description

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the [human] body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceuticals) such as 2 [F 18] Fluoro-D-Glucose (FDG), that are administered intravenously to the patient.

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The following indications may be covered for PET under certain circumstances. Details of Medicare PET coverage are discussed later in this section. Unless otherwise indicated, the clinical conditions below are covered when PET utilizes FDG as a tracer.

NOTE: This section lists all Medicare-covered uses of PET scans. A particular use of PET scans is not covered unless this section specifically provides that such use is covered. Although this section lists some non-covered uses of PET scans, it does not constitute an exhaustive list of all non-covered uses.

Clinical Condition	Effective Date	Coverage
Solitary Pulmonary Nodules (SPNs)	January 1, 1998	Characterization
Lung Cancer (Non Small Cell)	January 1, 1998	Initial staging
Lung Cancer (Non Small Cell)	July 1, 2001	Diagnosis, staging and restaging
Esophageal Cancer	July 1, 2001	Diagnosis, staging and restaging
Colorectal Cancer	July 1, 1999	Determining location of tumors if rising CEA level suggests recurrence
Colorectal Cancer	July 1, 2001	Diagnosis, staging and restaging
Lymphoma	July 1, 1999	Staging and restaging only when used as an alternative to Gallium scan
Lymphoma	July 1, 2001	Diagnosis, staging and restaging
Melanoma	July 1, 1999	Evaluating recurrence prior to surgery as an alternative to a Gallium scan
Melanoma	July 1, 2001	Diagnosis, staging and restaging; Non-covered for evaluating regional nodes
Breast Cancer	October 1, 2002	As an adjunct to standard imaging modalities for staging patients with distant metastasis or restaging patients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated
Head and Neck Cancers (excluding CNS and thyroid	July 1, 2001	Diagnosis, staging and restaging
Thyroid Cancer	October 1, 2003	Restaging of recurrent or residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan performed
Myocardial Viability	July 1, 2001 to September 30, 2002	Covered only following inconclusive SPECT
Myocardial Viability	October 1, 2002	Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan
Refractory Seizures	July 1, 2001	Covered for pre-surgical evaluation only
Perfusion of the heart using Rubidium 82* tracer	March 14, 1995	Covered for noninvasive imaging of the perfusion of the heart
Perfusion of the heart using ammonia N-13* tracer	October 1, 2003	Covered for noninvasive imaging of the perfusion of the heart

***Not FDG-PET**

II. General Conditions of Coverage for FDG PET

A. Allowable FDG PET Systems

1. Definitions: For purposes of this section:

a. "Any FDA approved" means all systems approved or cleared for marketing by the FDA to image radionuclides in the body.

b. "FDA approved" means that the system indicated has been approved or cleared for marketing by the FDA to image radionuclides in the body.

c. "Certain coincidence systems" refers to the systems that have all the following features:

- Crystal at least 5/8-inch thick;
- Techniques to minimize or correct for scatter and/or randoms; and
- Digital detectors and iterative reconstruction.

Scans performed with gamma camera PET systems with crystals thinner than 5/8-inch will not be covered by Medicare. In addition, scans performed with systems with crystals greater than or equal to 5/8-inch in thickness, but that do not meet the other listed design characteristics are not covered by Medicare.

2. Allowable PET systems by covered clinical indication:

	Allowable Type of FDG PET System		
Covered Clinical Condition	**Prior to July 1, 2001**	**July 1, 2001 through December 31, 2001**	**On or after January 1, 2002**
Characterization of single pulmonary nodules	Effective 1/1/1998, any FDA approved	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Initial staging of lung cancer (non small cell)	Effective 1/1/1998, any FDA approved	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Determining location of colorectal tumors if rising CEA level suggests recurrence	Effective 7/1/1999, any FDA approved	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Staging or restaging of lymphoma only when used as an alternative to a gallium scan	Effective 7/1/1999, any FDA approved	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems

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	Allowable Type of FDG PET System		
Covered Clinical Condition	**Prior to July 1, 2001**	**July 1, 2001 through December 31, 2001**	**On or after January 1, 2002**
Evaluating recurrence of melanoma prior to surgery as an alternative to a gallium scan	Effective 7/1/1999, any FDA approved.	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Diagnosis, staging, and restaging of colorectal cancer	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of esophageal cancer	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of head and neck cancers (excluding CNS and	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of lung cancer (non small cell)	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of lymphoma	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of melanoma (noncovered for evaluating regional nodes)	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Determination of myocardial viability only following an inconclusive SPECT	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Presurgical evaluation of refractory seizures	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Breast Cancer	Not covered	Not covered	Effective October 1, 2002, full and partial ring
Thyroid Cancer	Not covered	Not covered	Effective October 1, 2003, full and partial ring
Myocardial Viability Primary or initial diagnosis prior to revascularization	Not covered	Not covered	Effective October 1, 2002, full and partial ring

B. Regardless of any other terms or conditions, all uses of FDG PET scans, in order to be covered by the Medicare program, must meet the following general conditions prior to June 30, 2001:

1. Submission of claims for payment must include any information Medicare requires to assure that the PET scans performed were: (a) medically necessary, (b) did not unnecessarily duplicate other covered diagnostic tests, and (c) did not involve investigational drugs or procedures using investigational drugs, as determined by the Food and Drug Administration (FDA).

2. The PET scan entity submitting claims for payment must keep such patient records as Medicare requires on file for each patient for whom a PET scan claim is made.

C. Regardless of any other terms or conditions, all uses of FDG PET scans, in order to be covered by the Medicare program, must meet the following general conditions as of July 1,2001:

1. The provider of the PET scan should maintain on file the doctor's referral and documentation that the procedure involved only FDA approved drugs and devices, as is normal business practice.

2. The ordering physician is responsible for documenting the medical necessity of the study and that it meets the conditions specified in the instructions. The physician should have documentation in the beneficiary's medical record to support the referral to the PET scan provider.

III. Covered Indications for PET Scans and Limitations/Requirements for Usage

For all uses of PET relating to malignancies the following **conditions** apply:

1. Diagnosis: PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.

PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific signs and symptoms of disease).

2. Staging and or Restaging: PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

3. Monitoring: Use of PET to monitor tumor response during the planned course of therapy (i.e., when no change in therapy is being contemplated) is not covered except for breast cancer. Restaging only occurs after a course of treatment is completed, and this is covered, subject to the conditions above.

IV. Coverage of PET for Perfusion of the Heart

A. Rubidium 82

Effective for services performed on or after March 14, 1995, PET scans performed at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical Rubidium 82 (Rb 82) are covered, provided the requirements below are met.

Requirements:

- The PET scan, whether at rest alone, or rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT); or

- The PET scan, whether at rest alone or rest with stress, is used following a SPECT that was found to be inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test(s) whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.)

- For any PET scan for which Medicare payment is claimed for dates of services prior to July 1, 2001, the claimant must submit additional specified information on the claim form (including proper codes and/or modifiers), to indicate the results of the PET scan. The claimant must also include information on whether the PET scan was done after an inconclusive noninvasive cardiac test. The information submitted with respect to the previous noninvasive cardiac test must specify the type of test done prior to the PET scan and whether it was inconclusive or unsatisfactory. These explanations are in the form of special G codes used for billing PET scans using Rb 82. Beginning July 1, 2001, claims should be submitted with the appropriate codes.

B. Ammonia N-13

Effective for services performed on or after October 1, 2003, PET scans performed at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical ammonia N-13 are covered, provided the requirements below are met.

Requirements:

- The PET scan, whether at rest alone, or rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT); or

- The PET scan, whether at rest alone or rest with stress, is used following a SPECT that was found to be inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.)

V. Coverage of FDG PET for Lung Cancer

The coverage for FDG PET for lung cancer, effective January 1, 1998, has been expanded. Beginning July 1, 2001, usage of FDG PET for lung cancer has been expanded to include diagnosis, staging, and restaging (see section III) of the disease.

A. Effective for services performed on or after January 1, 1998, Medicare covers regional FDG PET chest scans, on any FDA approved scanner, for the characterization of single pulmonary nodules (SPNs). The primary purpose of such characterization should be to determine the likelihood of malignancy in order to plan future management and treatment for the patient. Beginning July 1, 2001, documentation should be maintained in the beneficiary's medical file at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

Requirements:

- There must be evidence of primary tumor. Claims for regional PET chest scans for characterizing SPNs should include evidence of the initial detection of a primary lung tumor, usually by computed tomography (CT). This should include, but is not restricted to, a report on the results of such CT or other detection method, indicating an indeterminate or possibly malignant lesion, not exceeding four centimeters (cm) in diameter.

- PET scan claims must include the results of concurrent thoracic CT (as noted above), which is necessary for anatomic information, in order to ensure that the PET scan is properly coordinated with other diagnostic modalities.

- In cases of serial evaluation of SPNs using both CT and regional PET chest scanning, such PET scans will not be covered if repeated within **90** days following a negative PET scan.

NOTE: A tissue sampling procedure (TSP) is <u>not routinely covered</u> in the case of a negative PET scan for characterization of SPNs, since the patient is presumed not to have a malignant lesion, based upon the PET scan results. When there has been a negative PET, the provider must submit additional information with the claim to support the necessity of a TSP, for review by the Medicare contractor.

B. Effective for services performed from January 1, 1998 through June 30, 2001, Medicare approved coverage of FDG PET for initial staging of non-small-cell lung carcinoma (NSCLC).

Limitations: This service is covered only when the primary cancerous lung tumor has been pathologically confirmed; claims for PET must include a statement or other evidence of the detection of such primary lung tumor. The evidence should include, but is not restricted to, a surgical pathology report, which documents the presence of an NSCLC. Whole body PET scan results and results of concurrent computed tomography (CT) and follow-up lymph node biopsy must be properly coordinated with other diagnostic modalities. Claims must include both:

- The results of concurrent thoracic CT, necessary for anatomic information, and

- The results of any lymph node biopsy performed to finalize whether the patient will be a surgical candidate. The ordering physician is responsible for providing this biopsy result to the PET facility.

NOTE: Where the patient is considered a surgical candidate, (given the presumed absence of metastatic NSCLC unless medical review supports a determination of medical necessity of a biopsy) a lymph node biopsy will not be covered in the case of a negative CT and negative PET. A lymph node biopsy will be covered in all other cases, i.e., positive CT + positive PET; negative CT + positive PET; positive CT + negative PET.

C. Beginning July 1, 2001, Medicare covers FDG PET for diagnosis, staging, and restaging of NSCLC. Documentation should be maintained in the beneficiary's medical file to support the medical necessity of the procedure, as is normal business practice.

Requirements: PET is covered in either/or both of the following circumstances:

- Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.
- Staging and/or Restaging - PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Documentation should be maintained in the beneficiary's medical record at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

VI. Coverage of FDG PET for Esophageal Cancer

A. Beginning July 1, 2001, Medicare covers FDG PET for the diagnosis, staging, and restaging of esophageal cancer. Medical evidence is present to support the use of FDG PET in pre surgical staging of esophageal cancer.

Requirements: PET is covered in either/or both of the following circumstances:

- Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers as well as in melanoma should be rare.

- Staging and/or Restaging - PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient, and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Documentation should be maintained in the beneficiary's medical record at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

VII. Coverage of FDG PET for Colorectal Cancer

Medicare coverage of FDG PET for colorectal cancer where there is a rising level of carcinoembryonic antigen (CEA) was effective July 1, 1999 through June 30, 2001. Beginning July 1, 2001, usage of FDG PET for colorectal cancer has been expanded to include diagnosis, staging, and restaging of the disease (see part III).

A. Effective July 1, 1999, Medicare covers FDG PET for patients with recurrent colorectal carcinomas, which are suggested by rising levels of the biochemical tumor marker CEA.

1. Frequency Limitations: Whole body PET scans for assessment of recurrence of colorectal cancer cannot be ordered more frequently than once every 12 months unless medical necessity documentation supports a separate re-elevation of CEA within this period.

2. Limitations: Because this service is covered only in those cases in which there has been a recurrence of colorectal tumor, claims for PET should include a statement or other evidence of previous colorectal tumor, through June 30, 2001.

B. Beginning July 1, 2001, Medicare coverage has been expanded for colorectal carcinomas for diagnosis, staging and re-staging. New medical evidence supports the use of FDG PET as a useful tool in determining the presence of hepatic/extrahepatic metastases in the primary staging of colorectal carcinoma, prior to selecting a treatment regimen. Use of FDG PET is also supported in evaluating recurrent colorectal cancer beyond the limited presentation of a rising CEA level where the patient presents clinical signs or symptoms of recurrence.

Requirements: PET is covered in either/both of the following circumstances:

Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.

- Staging and/or Restaging - PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

VIII. Coverage of FDG PET for Lymphoma

Medicare coverage of FDG PET to stage and re-stage lymphoma as alternative to a Gallium scan, was effective July 1, 1999. Beginning July 1, 2001, usage of FDG PET for lymphoma has been expanded to include diagnosis, staging and restaging (see section III) of the disease.

A. Effective July 1, 1999, FDG PET is covered for the staging and restaging of lymphoma.

Requirements:

- FDG PET is covered only for staging or follow-up restaging of lymphoma. Claims must include a statement or other evidence of previous diagnosis of lymphoma when used as an alternative to a Gallium scan

- To ensure that the PET scan is properly coordinated with other diagnostic modalities, claims must include the results of concurrent computed tomography (CT) and/or other diagnostic modalities when they are necessary for additional anatomic information.

- In order to ensure that the PET scan is covered only as an alternative to a Gallium scan, no PET scan may be covered in cases where it is done within 50 days of a Gallium scan done by the same facility where the patient has remained during the 50-day period. Gallium scans done by another facility less than 50 days prior to the PET scan will not be counted against this screen. The purpose of this screen is to assure that PET scans are covered only when done as an alternative

to a Gallium scan within the same facility. We are aware that, in order to assure proper patient care, the treating physician may conclude that previously performed Gallium scans are either inconclusive or not sufficiently reliable.

Frequency Limitation for Restaging: PET scans will be allowed for restaging no sooner than 50 days following the last staging PET scan or Gallium scan, unless sufficient evidence is presented to convince the Medicare contractor that the restaging at an earlier date is medically necessary. Since PET scans for restaging are generally done following cycles of chemotherapy, and since such cycles usually take at least 8 weeks, we believe this screen will adequately prevent medically unnecessary scans while allowing some adjustments for unusual cases. In all cases, the determination of the medical necessity for a PET scan for re-staging lymphoma is the responsibility of the local Medicare contractor.

Beginning July 1, 2001, documentation should be maintained in the beneficiary's medical record at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

B. Effective for services performed on or after July 1, 2001, the Medicare program has broadened coverage of FDG PET for the diagnosis, staging and restaging of lymphoma.

Requirements: PET is covered in either/both of the following circumstances:

- Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.

- Staging and/or Restaging - PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient, and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

IX. Coverage of FDG PET for Melanoma

Medicare covered the evaluation of recurrent melanoma prior to surgery when used as an alternative

to a Gallium scan, effective July 1, 1999. For services furnished on or after July 1, 2001 FDG PET is covered for the diagnosis, staging, and restaging of malignant melanoma (see part III). FDG PET is not covered for the use of evaluating regional nodes in melanoma patients.

A. Effective for services furnished July 1, 1999 through June 30, 2001, in the case of patients with recurrent melanoma prior to surgery, FDG PET (when used as an alternative to a Gallium scan) is covered for tumor evaluation.

Frequency Limitations: Whole body PET scans cannot be ordered more frequently than once every 12 months, unless medical necessity documentation, maintained in the beneficiaries medical record, supports the specific need for anatomic localization of possible recurrent tumor within this period.

Limitations: The FDG PET scan is covered only as an alternative to a Gallium scan. PET scans can not be covered in cases where it is done within 50 days of a Gallium scan done by the same PET facility where the patient has remained under the care of the same facility during the 50-day period. Gallium scans done by another facility less than 50 days prior to the PET scan will not be counted against this screen. The purpose of this screen is to assure that PET scans are covered only when done as an alternative to a Gallium scan within the same facility. We are aware that, in order to assure proper patient care, the treating physician may conclude that previously performed Gallium scans are either inconclusive or not sufficiently reliable to make the determination covered by this provision. Therefore, we will apply this 50-day rule only to PET scans done by the same facility that performed the Gallium scan.

Beginning July 1, 2001, documentation should be maintained in the beneficiary's medical file at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

B. Effective for services performed on or after July 1, 2001 FDG PET scan coverage for the diagnosis, staging and restaging of melanoma (not the evaluation regional nodes) has been broadened.

Limitations: **PET scans are not covered for the evaluation of regional nodes**.

Requirements: PET is covered in either/both of the following circumstances:

Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.

- Staging and/or Restaging - PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient, and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to

determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical file, as is normal business practice.

X. Coverage of FDG PET for Head and Neck Cancers

Effective for services performed on or after July 1, 2001, Medicare will provide coverage for cancer of the head and neck, excluding the central nervous system (CNS) and thyroid. The head and neck cancers encompass a diverse set of malignancies of which the majority is squamous cell carcinomas. Patients may present with metastases to cervical lymph nodes but conventional forms of diagnostic imaging fail to identify the primary tumor. Patients that present with cancer of the head and neck are left with two options either to have a neck dissection or to have radiation of both sides of the neck with random biopsies. PET scanning attempts to reveal the site of primary tumor to prevent the adverse effects of random biopsies or unneeded radiation.

Requirements: PET is covered in either/or both of the following circumstances:

- Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.

- Staging and/or Restaging – PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient, and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

XI. Coverage of FDG PET for Myocardial Viability

The identification of patients with partial loss of heart muscle movement or hibernating myocardium is important in selecting candidates with compromised ventricular function to determine

appropriateness for revascularization. Diagnostic tests such as FDG PET distinguish between dysfunctional but viable myocardial tissue and scar tissue in order to affect management decisions in patients with ischemic cardiomyopathy and left ventricular dysfunction.

FDG PET is covered for the determination of myocardial viability following an inconclusive SPECT from July 1, 2001 through September 30, 2002. Only full ring PET scanners are covered from July 1, 2001 through December 31, 2001. However, as of January 1, 2002, full and partial ring scanners are covered.

Beginning October 1, 2002, Medicare covers FDG PET for the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization, or following an inconclusive SPECT. Studies performed by full and partial ring scanners are covered.

Limitations: In the event that a patient has received a single photon computed tomography test (SPECT) with inconclusive results, a PET scan may be covered. However, if a patient received a FDG PET study with inconclusive results, a follow up SPECT is not covered.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

XII. Coverage of FDG PET for Refractory Seizures

Beginning July 1, 2001, Medicare will cover FDG-PET for pre-surgical evaluation for the purpose of localization of a focus of refractory seizure activity.

Limitations: Covered only for pre-surgical evaluation.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

Breast Cancer

Beginning October 1, 2002, Medicare covers FDG PET as an adjunct to other imaging modalities for staging patients with distant metastasis, or restaging patients with locoregional recurrence or metastasis. Monitoring treatment of a breast cancer tumor when a change in therapy is contemplated is also covered as an adjunct to other imaging modalities.

Limitations: Effective October 1, 2002, Medicare continues to have a national non-coverage determination for initial diagnosis of breast cancer and staging of axillary lymph nodes. Medicare coverage for staging patients with distant metastasis or restaging patients with locoregional recurrence or metastasis; and for monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated, is only covered as an adjunct to other imaging modalities.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

Thyroid Cancer

1. Effective for services furnished on or after October 1, 2003, Medicare covers the use of FDG PET for thyroid cancer only for restaging of recurrent or residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan performed.

2. All other uses of FDG PET in the diagnosis and treatment of thyroid cancer remain noncovered.

Soft Tissue Sarcoma – NOT COVERED

Following a thorough review of the scientific literature, including a technology assessment on the topic, Medicare maintains its national noncoverage determination for all uses of FDG PET for soft tissue sarcoma.

XVI. Dementia and Neurogenerative Diseases – NOT COVERED

Following a thorough review of the scientific literature, including a technology assessment on the topic and consideration by the Medicare Coverage Advisory Committee, Medicare maintains its national noncoverage determination for all uses of FDG-PET for the diagnosis and management of dementia or other neurogenerative diseases.

CR 2687/CIM 171/PM AB-03-092/6-20-03/GGL-2013

STEM CELL TRANSPLANTATION

Coverage Issues Manual Section 35-30 was revised. For clarity, we are publishing this section in its totality.

Stem Cell Transplantation

Stem Cell Transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (HDCT) and/or radiotherapy used to treat various malignancies. Allogeneic stem cell transplant may also be used to restore function in recipients having an inherited or acquired deficiency or defect.

A. Allogeneic Stem Cell Transplantation – allogeneic stem cell transplantation (ICD-9-CM) procedure codes 41.02, 41.03, 41.05 and 41.08) is a procedure in which a portion of a healthy donor's stem cell or bone marrow is obtained and prepared for intravenous infusion.

1) **Covered Conditions** – the following uses of allogeneic bone marrow transplantation are covered under Medicare:

- Effective for services performed on or after August 1, 1978, for the treatment of leukemia, leukemia in remission (ICD-9-CM codes 204.00 through 208.091), or aplastic anemia (ICD-9-CM codes 284.0 through 284.9) when it is reasonable and necessary; and

2) **Non-covered conditions** – Effective May 24, 1996, allogeneic stem cell transplantation is not covered as treatment for multiple myeloma (ICD-9-CM codes 203.0 and 238.6).

B. Autologous Stem Cell Transplantation (Effective for Services Performed on or after 04/28/89). Autologous stem cell transplantation (ICD-CM procedure codes 41.01, 41.04, 41.07 and 41.09) is a technique for restoring stem cells using the patient's own previously stored cells.

1) **Covered Conditions** – Autologous stem cell transplantation (ICD-9-CM codes 41.01, 41.04, 41.07, 41.09, CPT-4 code 38241) is considered reasonable and necessary under S1862(a)(1)(A) of the Act for the following conditions and is covered under Medicare for patients with:

√ Acute leukemia in remission (ICD-9-CM codes 204.01, lymphoid; 205.01, myeloid; 206.01, monocytic; 207.01, acute erythremia and erythroleukemia; and 208.01, unspecified cell type) who have a high probability of relapse and who have no human leucocyte antigens (HLA)-matched;

√ Resistance non-Hodgkin's lymphomas (ICD-9-CM codes 200.00-200.08, 200.10-200.18, 200.20-200.28, 200.80-200.88, 202.00-202.08, 202.80-202.88, and 202.90-202.98) or those presenting with poor prognostic features following an initial response;

- √ Recurrent of refractory neuroblastoma (see ICD-9-CM Neoplasm by site, malignant); or
- √ Advanced Hodgkin's disease (ICD-9-CM codes 201.00-201.98) who have failed conventional therapy and have no HLA-matched donor;
- √ Effective October 1, 2000, single AuSCT is only covered for Durie-Salmon Stage II or III patients that fit the following requirements:

  a. Newly diagnosed or responsive multiple myeloma. This includes those patients with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50 percent decrease either in measurable paraprotein [serum and/or urine] or in bone marrow infiltration, sustained for at least 1 month), and those in responsive relapse; and

  b. Adequate cardiac renal, pulmonary, and hepatic function

NOTE: Tandem transplantation for multiple myeloma remains non-covered.

2) **Non covered Conditions** – Insufficient data exists to established definite conclusions regarding the efficacy of autologous stem cell transplantation for the following conditions:

- √ Acute leukemia not in remission (ICD-9-CM codes 204.00, 205.00, 206.00, 207.00, and 208.00);
- √ Chronic granulocytic leukemia (ICD-9-CM codes 205.10 and 205.11);
- √ Solids tumors (other than neuroblastoma) (ICD-9-CM codes 140.0-199.1);
- √ Up to October 1, 2000, multiple myeloma;
- √ Tandem transplantation (multiple rounds of autologous stem cell transplantation) for patients with multiple myeloma;
- √ Effective October 1, 2000, non-primary (AL) amyloidosis (ICD-9-CM 277.23);
- √ Effective October 1, 2000, primary (AL) amyloidosis (ICD-9-CM 27723) for Medicare beneficiaries age 64 or older.

In these cases, autologous stem cell transplantation is not considered reasonable and necessary within the meaning of S1862(a)(1)(A) of the Act and is not covered under Medicare.

CR 2604-CIM #169-04/25/03-GGL-1998

MAGNETIC RESONANCE ANGIOGRAPHY (MRA)

Coverage is provided for billing and payment for MRA. Previously, Medicare provided limited coverage for MRA of the abdomen and chest. For claims with dates of service on or after July 1,2003, Medicare coverage has been expanded for use of MRA for diagnosing pathology in the renal or aorticoiliac arteries.

For the purpose of clarity and more complete information we are publishing section 50-14 for the Medicare cover issue manual (MCIM) in "TOTO".

Magnetic Resonance Angiography

Magnetic Resonance Angiography (MRA) is a non-invasive diagnostic test that is an application of magnetic resonance imaging (MRI). By analyzing the amount of energy released from tissues exposed to a strong magnetic field, MRA provides images of normal and diseased blood vessels as well as visualization and quantification of blood flow through these vessels.

Phase contrast (PC) and time-of-flight (TOF) are the available MRA techniques at the time these instructions are being issued. PC measures the difference between the phases of proton spins in tissue and blood and measures both the venous and arterial blood flow at any point in the cardiac cycle. TOF measures the difference between the amount of magnetization of tissue and blood and provides information on the structure of blood vessels, thus indirectly indicating blood flow. Two-dimensional (2D) and three-dimensional (3D) images can be obtained using each method.

Contrast-enhanced MRA (CE-MRA) involves blood flow imaging after the patient receives an intravenous injection of a contrast agent. Gadolinium, a non-ionic element, is the foundation of all contrast agents currently in use. Gadolinium affects the way in which tissue respond to magnetization, resulting in better visualization of structures when compared to un-enhanced studies. Unlike ionic (i.e. iodine-based) contrast agents used in conventional contrast angiography (CA), allergic reactions to gadolinium are extremely rare. Additionally, gadolinium does not cause the kidney failure occasionally seen with ionic contrast agents. Digital subtraction angiography (DSA) is a computer-augmented form of CA that obtains digital blood flow images as contrast agent courses through a blood vessel. The computer "substracts" bone and other tissue from the image, thereby improving visualization of blood vessels. Physicians elect to use a specific MRA or CA technique based upon clinical information from each patient.

In a National Coverage Analysis decision memorandum, issued on April 15, 2003, CMS reviewed scientific and clinical literature on MRA, and set forth its basis for the following coverage policy. Below are the only indications for which Medicare coverage is allowed for MRA. All other uses of MRA not listed in this manual are not covered.

A. **Head and Neck** – Studies have proven that MRA is effective for evaluating flow in internal carotid vessels of the head and neck. However, not all potential applications of MRA have been shown to be reasonable and necessary. All of the following criteria must apply in order for Medicare to provide coverage for MRA of the head and neck:

   1. MRA is used to evaluate the carotid arteries, the circle of Willis, the anterior, middle or posterior cerebral arteries, the vertebral or basilar arteries of the venous sinuses.

   2. MRA is used to verify the need for anticipated surgery for conditions that include, but are not limited to, tumor, aneurysms, vascular malformations, vascular occlusion, or thrombosis.

Within this broad category of disorders, medical necessity is the underlying determinant of the need for an MRA. Because MRA and CA perform the same diagnostic function, the medical records should clearly justify and demonstrate the existence of medical necessity.

3. MRA and contrast angiography (CA) are not expected to be performed on the same patient for diagnostic purposes prior to the application of anticipated therapy. Only one of these tests will be covered routinely unless the physician can demonstrate the medical need to perform both test.

B. Peripheral Arteries of Lower Extremities – Studies have proven that MRA of peripheral arteries is useful in determining the presence and extent of peripheral vascular disease in lower extremities. This procedure is non-invasive and has been shown to find occult vessels in some patients for which those vessels were not apparent when CA was performed. Medicare will cover either MRA or CA to evaluate peripheral arteries of the lower extremities. However, both MRA and CA may be useful is some cases, such as:

1. A patient has had CA and this test was unable to identify a viable run-off vessel for bypass. When exploratory surgery is not believed to be a reasonable medical course of action for this patient MRA may be performed to identify the viable runoff vessel.

2. A patient has had MRA, but the results are inconclusive.

C. Abdomen and Pelvis – Effective for dates of service on or after July 1, 1999, MRA is covered for pre-operative evaluation of patients undergoing elective abdominal aortic aneurysm (AAA) repair. Scientific evidence reveals MRA is considered comparable to CA in determinating the extent of AAA, as well as evaluating aortoiliac occlusion disease and renal artery pathology that may be necessary in the surgical planning of AAA repair. These studies also reveal that MRA could provide a net benefit to the patient. If preoperative CA is avoided, then patients are not exposed to the risks associated with invasive procedures, contrast media, end-organ damage, or arterial injury.

Effective for dates of service on or after July 1, 2003 MRA coverage has been expanded to include imaging the renal arteries and the aortoiliac arteries in the absence of AAA or aortic dissection. MRA should be obtained in those circumstances in which using MRA is expected to obtaining CA, when physician history, physical examination, and standard assessment tools provide insufficient information for patient management, and obtaining an MRA has a high probability of positively affecting patient management. However, CA may be ordered after obtaining the results of an MRA in those rare instances where medical necessity is demonstrated.

D. Chest

1. **Diagnosis of Pulmonary Embolism** – current scientific data has shown that diagnostic pulmonary MRAs are improving due to recent developments such as faster imaging capabilities and gadolinium-enhancement. However, these advances in MRA are not significant enough to warrant replacement of pulmonary angiography in the diagnosis of pulmonary embolism for patients who have no contraindication to receiving intravenous iodinated contrast material. Patients who are allergic to iodinated contrast material face high risk of developing complications if they undergo pulmonary angiography or computed tomography angiography. Therefore, Medicare will cover MRA of the chest for diagnosing a suspected pulmonary embolism only when it is contraindicated for the patient to receive intravascular iodinated contrast material.

2. **Evaluation of Thoracic Aortic Dissection and Aneurysm** – studies have shown that MRA of the chest has a high level of diagnostic accuracy for pre-operative and post-operative evaluation of aortic dissection of aneurysm. Depending on the clinical presentation, MRA is used as an alternative to other non-invasive imaging technologies, such as Transesophageal echocardiography and CT. Generally, Medicare will provide coverage only for MRA or for CA when used as a diagnostic test. However, if both MRA and CA of the chest are used, the physician must demonstrate the medical need for performing these tests.

While the intent of this policy is to provide reimbursement for either MRA or CA, CMS is also allowing flexibility for physicians to amke appropriate deecisions concerning the use of these tests based on the needs of individual patients.

CR2673/CIM#170-/05/09/2003-GGL-1997

AMBULATORY BLOOD PRESSURE

Effective July 1, 2003, the Centers for Medicaid and Medicare Services has revised section **50-42 of the Coverage Issues Manual. This section was revised to specify that a physician must interpret the data obtained through ambulatory blood pressure monitoring**. However, the requirement previously stating that the interpretation must be done in the physician's office was removed from this section.

Following is revised section 50-42 of the Coverage Issues Manual:

Ambulatory blood pressure monitoring (ABPM) involves the use of a noninvasive device, which is used to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and are later interpreted by the physician. ABPM must be performed for at least 24 hours to meet coverage criteria.

ABPM is only covered for those patients with suspected white coat hypertension. Suspected white coat hypertension is defined as

1. Office blood pressure >140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit;
2. At least two documented blood pressure measurements taken outside the office which are <140/90 mm Hg; and
3. No evidence of end-organ damage.

The information obtained by ABPM is necessary in order to determine the appropriate management of the patient. ABPM is not covered for any other uses. In the rare circumstance that ABPM needs to be performed more than once in a patient, the qualifying criteria described above must be met for each subsequent ABPM test.

For those patients that undergo ABPM and have an ambulatory blood pressure of <135/85 with no evidence of end-organ damage, it is likely that their cardiovascular risk is similar to that of normotensives. They should be followed over time. Patients for which ABPM demonstrates a blood pressure of >135/85 may be at increased cardiovascular risk, and a physician may wish to consider antihypertensive therapy.

NOTE: ABPM for patients with suspected "white coat hypertension" as defined in section 50-42 above is represented by ICD-9-CM code 796.2. Any other diagnosis reported will be denied as noncovered.

CR 2625, Trans. 168/LC/03-28-03

MEDICARE PAYMENTS FOR PART B MENTAL HEALTH SERVICES

The Office of Inspector General (OIG) recently studied the appropriateness of Medicare Part B payments for mental health services and recommended that we promote provider awareness of the requirements for payment of these services. OIG reports can be accessed at http://www.oig.hhs.gov/oei/oeisearch.html. This article explains Medicare's guidelines for payment of Part B mental health services including qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for evaluation and management (E/M) services involving a general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment.

Qualification Requirements for Mental Health Providers

Providers of mental health services must be qualified to perform the specific mental health services that are billed to Medicare. In order for services to be covered, mental health professionals must be working within their State Scope of Practice Act and licensed or certified to perform mental health services by the State in which the services are performed. Qualification requirements for mental health professionals are listed below.

* **A qualified physician must:**

1. Be legally authorized to practice by the State in which he/she performs the functions or actions, and
2. Be acting within the scope of his/her license.

* **A clinical psychologist must**:

1. Hold a doctoral degree in psychology; and
2. Be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he/she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Refer to regulations found at 42 CFR §410.71 and the Medicare Carriers Manual Part 3, Chapter II, §2150 for the covered services of a clinical psychologist.

* **A clinical social worker must**:

1. Possess a master's or doctor's degree in social work;
2. After obtaining the degree, have performed at least two years of supervised clinical social work; and
3. Be licensed or certified as a clinical social worker by the State in which the services are performed.

In States that do not provide for licensure or certification as a clinical social worker, the individual must:

1. Be licensed or certified at the highest level of practice provided by the laws of the State in which the services are performed; and

2. Have completed at least two years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, skilled nursing facility, or clinic.

Refer to regulations found at 42 CFR §410.73 and the Medicare Carriers Manual Part 3, Chapter II, §2152 for the covered services of a clinical social worker.

* **A nurse practitioner must:**

1. Be a registered professional nurse who is authorized to practice as a nurse practitioner delivering mental health services by the laws of the State in which services are furnished; and

2. Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners, or be:

   - A registered professional nurse who is authorized to practice as a nurse practitioner by the laws of the State in which the services are furnished, and has been granted a Medicare billing number as a nurse practitioner by December 31, 2000;

   - A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2001; or

   - A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2003, and possesses a master's degree in nursing.

Refer to regulations found at 42 CFR §410.75 and the Medicare Carriers Manual Part 3, Chapter II, §2158 for the covered services of a nurse practitioner.

* **A clinical nurse specialist must**:

1. Be a registered nurse who is currently licensed to practice in the State where he/she practices and authorized to perform the services of a clinical nurse specialist in accordance with State law;

2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and

3. Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

Refer to regulations found at 42 CFR §410.76 and the Medicare Carriers Manual Part 3, Chapter II, §2160 for the covered services of a certified nurse specialist.

* **A physician assistant must:**

1. Be a physician assistant who is licensed to practice as a physician assistant by the laws of the State in which services are furnished; and

2. Have graduated from a physician assistant educational program accredited by the Commission on Accreditation of Allied Health Education Programs, or passed the national certification examination administered by the National Commission on Certification of Physician Assistants.

Refer to regulations found at 42 CFR §410.74 and the Medicare Carriers Manual Part 3, Chapter II, §2156 for the covered services of a physician assistant.

Incident to Services

Certain nonphysician practitioners such as clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants may have services furnished incident to their professional services. To the extent that they are licensed or authorized by the State to furnish mental health services, these practitioners could have others provide some services as an incident to overall mental health services. There is no national policy that specifies the qualifications for individuals who may furnish these incidental services. In the absence of national policy, contractors can implement local medical review policies that determine who can furnish mental health services incident to the professional services of these specific nonphysician practitioners.

Therefore, inconsistencies may be found in policy in terms of billing and payment to nonphysician practitioners for incident to mental health services. The requirements found in the Medicare Carriers Manual Part 3, Chapter II, §2050.1 are also applicable to services furnished incident to the professional services of certain nonphysician practitioners.

Refer to the following requirements found on the American Psychological Association's (APA) Web site at http://www.apa.org/practice/medincident.html:

* Qualifications of Ancillary Personnel

*Graduate Medical Education (GME). (Current psychiatric residency programs require the teaching physician to be present during the "key portion" of any service in which a resident is involved. This would require either direct observation of the service, or use of a one-way mirror or video equipment (emphasis added). Thus, if psychiatry interns provide services, they must be observed.)

Reasonable and Necessary Services

Section 1862(a)(1)(A) of the Social Security Act states that all Medicare Part B services, including mental health services, must be "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service.

Partial hospitalization programs are structured to provide intensive psychiatric care through active treatment for patients who would otherwise require inpatient psychiatric care. These programs are used to prevent psychiatric hospitalization or shorten an inpatient stay and transition the patient to a less intensive level of care.

Reasonable Expectation of Improvement

Services must be for the purpose of diagnostic study or be reasonably expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning. The goal of a course of therapy is not necessarily restoration of the patient to the level of functioning exhibited prior to the onset of illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with longterm, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration

or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that a patient's condition would deteriorate, relapse further, or require hospitalization if treatment services are withdrawn, this criterion would be met.

General Principles of Medical Record Documentation

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

* The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time;

* Communication and continuity of care among providers involved in the patient's care;

* Accurate and timely claims review and payment;

* Appropriate utilization review and quality of care evaluations; and

* Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of medical and surgical services for Medicare payments include the following, if applicable to the specific setting/encounter:

* Medical records should be complete and legible;

* Documentation of each patient encounter should include:

    - Reason for encounter and relevant history;

    - Physical examination findings and prior diagnostic test results;

    - Assessment, clinical impression, and diagnosis;

    - Plan for care; and

    - Date and legible identity of observer;

* If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;

* Past and present diagnoses should be accessible for treating and/or consulting physician;

* Appropriate health risk factors should be identified;

* Patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and

* CPT and ICD-9-CM codes reported on health insurance claim form should be supported by documentation in the medical record.

Documentation Guidelines for E/M Services Involving a General Psychiatric Examination or the Single System Psychiatric Examination

* Providers should thoroughly familiarize themselves with documentation guidelines for E/M services. These guidelines are available on the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/medlearn/emdoc.asp.

* The Medicare Resident & New Physician Training manual, Chapter 6, (March 2002 edition) also contains the latest revisions to documentation guidelines for E/M services. Publication is available at http://www.cms.hhs.gov/medlearn or upon request from the Medicare Learning Network at medlearn@cms.hhs.gov.

Documentation Guidelines for Psychiatric Diagnostic or Evaluative Interview Procedures, Psychiatric Therapeutic Procedures, Central Nervous System Assessment, and Health and Behavior Assessment

* Providers should follow the documentation guidance for psychiatric diagnostic or evaluative interview procedures and psychiatric therapeutic procedures (CPT codes 90801 - 90802, 90804 - 90899 under the Psychiatry Section), overview and definitions for central nervous system assessment (CPT codes 96100 - 96117), and health and behavior assessment (CPT codes 96150 - 96155) as described in the Physicians' Current Procedural Terminology, which is an annual publication developed by the American Medical Association (AMA). Available from the AMA at http://www.ama-assn.org/ama/pub/category/3113.html.

* Refer to Program Memorandum A-02-129 dated January 3, 2003 for the 2003 update of the Hospital Outpatient Prospective Payment System (OPPS), which provides current revenue and HCPCS codes for the Partial Hospitalization Program.

* Providers should confer with the local carrier to determine if a local medical review policy has been written regarding documentation requirements.

PM AB-03-037/CR 2520/March 28, 2003/GGL-1985

MAMMOGRAPHY COMPUTER AIDED DETECTION (CAD) EQUIPMENT

This article is to clarify that mammography-related (CAD) equipment does not require Food and Drug Administration (FDA) certification. Certification from FDA is needed only for screening and diagnostic mammograms (film and digital). The CAD add-on codes involved in this process are 76085 and G0236.

The CAD process can provide either digitalization of film radiographic images with computer analysis or computer analysis of direct digital mammography.

This note is specially directed to affected providers community.

CR2743CIM#AB-03-072-05/16/03-GGL1999

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HOSPICE CARE ENHANCES DIGNITY AND PEACE AS LIFE NEARS ITS END

Much of the pain and sense of hopelessness that may accompany terminal illness can be eased by services specifically designed to address these needs. Hospice care, a fully reimbursable Medicare Part A benefits option for beneficiaries and providers since 1983, offers the services designed to address the physical and emotional pain through effective palliative treatment when cure is not possible. In the event that a beneficiary has been advised by his/her physician, that a cure for his/her illness is no longer possible, Medicare beneficiaries may discuss hospice care as an option. Physicians and other health care practitioners can be encouraged that the Medicare program includes a hospice benefit that provides coverage for a variety of services and products designed for those with terminal diagnoses. When properly certified and appropriately managed, hospice care is a supportive and valuable covered treatment option.

Physicians and health care providers in the community, skilled nursing facilities, and hospitals are urged to raise awareness among their patients about the hospice benefit and its availability. Further, a beneficiary may independently elect hospice care. The beneficiary may discuss this option in the event that he or she has a terminal diagnosis; however, in all such cases, a physician must certify that the beneficiary has a terminal diagnosis with a six-month prognosis, if the illness runs its usual course.

Hospice care that is covered by Medicare is chosen for specified amounts of time known as "election periods." Essentially, a physician may certify a patient for hospice care coverage for two initial 90-day election periods, followed by an unlimited number of 60-day election periods. Each election period requires that the physician certify a terminal illness. Payment is made for each day of the election period based on one of four per diem rates set by Medicare, commensurate with the level of care.

Generally speaking, the hospice benefit is intended primarily for use by patients whose prognosis is terminal, with six months or less of life expectancy. The Medicare program recognizes that terminal illnesses do not have entirely predictable courses; therefore, the benefit is available for extended periods of time beyond six months provided that proper certification is made at the start of each coverage period.

Recognizing that prognoses can be uncertain and may change, Medicare's benefit is not limited in terms of time. Hospice care is available as long as the patient's prognosis meets the law's six-month test.

This test is a general one. As the governing statute says: "The certification of terminal illness of an individual who elects hospice shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."

CMS recognizes that making medical prognostication of life expectancy is not always an exact science. Thus, physicians need not be concerned. There is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill.

Many physicians appreciate the fact that hospice care enables family and loved ones to participate in the experience and to get help from the hospice in managing their own feelings and reactions to the illness. The value of hospice care is recognized and advanced by many physicians and other health professionals. One professional organization, the American Academy of Hospice and Palliative Medicine (formerly the Academy of Hospice Physicians) focuses its efforts on the "prevention and relief of suffering among patients and families" through palliative therapy, education and counseling. Among the Academy's objectives are to "bring the hospice approach into mainstream medicine and eliminate the dichotomy whereby patients receive either curative or palliative care."

This distinction is important because despite a growing appreciation for hospice care both as a philosophy and as a fully covered Medicare benefit, there appears to be two perceived barriers to its broader acceptance.

First is an understandable reticence to contemplate the end of life. A 1999 survey conducted by the National Hospice and Palliative Care Organization (NHPCO) found that Americans generally are reticent to discuss hospice care with their elderly parents. According to the survey, less than one in four of us have put into writing how we wish to be cared for at life's end. About one in five have not contemplated the subject at all, and a slightly smaller number told the surveyors they have thought about it but have not shared their thoughts with others.

The second perceived barrier is a lack of knowledge on the part of both patients and practitioners that the covered hospice benefits are both broad and readily available virtually everywhere in the country. As with other covered services, payments for hospice care generally are made to providers based on prospectively-set rates that are updated every year for inflation. Hospice care is primarily a specialized type of home health care, and as is the case with the home health care benefit, hospices are served by regional intermediaries for Medicare billings, payments, cost reports and audits.

Medicaid in many states also covers hospice care. Medicare covers a number of specific services as defined in regulation and in the Medicare Hospice Program Manual. Most of these services are familiar to health care professionals and other practitioners who have worked with skilled nursing facilities (SNFs) and home health services. Covered services include:

- Medical and nursing care
- Medical equipment (such as wheelchairs or walkers)
- Pharmaceutical therapy for pain relief and symptom control
- Home health aide and homemaker services
- Social work services
- Physical and occupational therapy
- Speech therapy
- Diet counseling
- Bereavement and other counseling services
- Case management

In 1999, 474,270 individuals received hospice care at 2,281 certified hospice programs in the United States. In 2000 there were 2,266 certified hospices. In 2001, approximately 580,000 individuals received hospice care at 2, 277 (as of August 2001) certified hospice programs. The hospice setting also is appropriate for patients who suffer from terminal illnesses such as lung disease or end-stage heart ailments, cancer, Alzheimer's disease, and terminally ill AIDS patients. Hospice is not about death, but rather about the quality of life as it nears its end, for all concerned – the patient, family and friends, and the health professional community.

For more information: go online to check the Medicare Learning Network at www.cms.gov/medlearn/; or see a related informational brochure on hospice care at: www.medicare.gov/Publications/home.asp.

CR#2570/PM-AB-03-040/ March 28, 2003/dg

LOCAL MEDICAL REVIEW POLICY (LMRP) RECONSIDERATION PROCESS

The LMRP Reconsideration Process is a mechanism by which interested parties can request a revision to an LMRP. The LMRP Reconsideration Process is available only for final LMRPs. The whole LMRP or any part of the LMRP may be reconsidered, i.e., Benefit Category Provisions, Utilization Guidelines, Covered ICD-9 codes, etc. Contractors must respond timely to requests for LMRP reconsideration. In addition, contractors may revise or retire their LMRPs at any time on their own initiatives.

When a contractor receives a request for policy review in accordance with regulations he may choose to initiate an LMRP reconsideration following the specific process.

Requests for LMRP reconsideration:

- Requests for reconsideration must be submitted in writing and must identify the language that the requestor wants added to or deleted from an LMRP. The request must include a justification supported by new evidence, which may materially affect the LMRP's content or basis. Copies of published evidence must be included.
- The level of evidence required for LMRP reconsideration is the same as that is required for new/revised LMRP development.
- Any LMRP reconsideration that, in the judgment of the contractor, does not meet these criteria is invalid.
- Contractors may consolidate valid requests if similar requests are received.

Reconsideration requests will be accepted only for LMRP's published in final form. Requests will not be accepted for other documents including:

- National Coverage Decisions (NCD);
- Coverage provisions in interpretive manuals;
- Draft LMRPs;
- Template LMRPs, unless or until they are adopted by the contractor;
- Retired LMRPs;
- Individual claim determinations;
- Bulletins, articles, training materials; and
- Any instance, in which no LMRP exists, i.e., requests for development of an LMRP.

If modification of the LMRP would conflict with an NCD, the request would not be valid. The contractor should refer the requestor to the NCD reconsideration process (www.cms.hhs.gov/coverage/Bal.htm).

VALID LMRP RECONSIDERATION REQUEST REQUIREMENTS

This contractor will consider LMRP's reconsideration request from:

- Beneficiaries residing or receiving care in a contractor's jurisdiction; and
- Providers doing business in a contractor's jurisdiction.
- Contractor may consider LMRP's reconsideration requests from any interested party doing business in a contractor's jurisdiction.

Process

1. The requestor should submit a valid LMRP reconsideration request to the appropriate contractor, following instructions on the contractor's web site.
2. Within 30 days of the day the request is received, the contractor must determine whether the request is valid or invalid. If the request is invalid, the contractor must respond, in writing, to the requester explaining why the request was invalid. If the request is valid, the contractor should follow the requirements below.
3. Within 90 days of the day the request was received, the contractor must make a final LMRP reconsideration decision on the valid request and notify the requestor of the decision with its rationale. Decision options include retiring the policy, no revision, revision to a more restrictive policy, or revision to a less restrictive policy.
4. If the decision is either to retire the LMRP or to make no revision to the LMRP, then within 90 days of the day the request was received, the contractor must inform the requestor of that decision with its rationale.
5. If the decision is to revise the LMRP, follow the normal process for LMRP development.
6. Contractors must keep an internal list of the LMRP Reconsideration Requests received and the relevant dates, subject and disposition of each one.

CR 2196/PIM Transmittal 28/July 10, 2002/GGL-1844

CHANGES TO THE LABORATORY NATIONAL COVERAGE DETERMINATION (NCD) FOR JULY 1, 2003

The following changes to the Laboratory National Coverage Determination will be effective for services furnished July 1, 2003 and thereafter:

1. In accordance with the decision memorandum published on the coverage Internet site on March 21, 2003, (see http://cms.hhs.gov/ncdr/memo.asp?id=88) CMS adding the following Current Procedure Terminology (CPT) code to the blood counts NCD:

   a. 85004, Blood count automated differential white blood cell (WBC) count;

   b. 85032, Manual cell count (erythrocyte, leukocyte, or platelet) each; and 85049, Platelet, automated.

These codes were added to the January 2003 CPT book. Upon review of these codes, CMS determined that they are essentially the same as codes that were originally included in the blood count NCD as negotiated by the rulemaking committee.

2. Complying with the decision memorandum published on the coverage Internet site on May 16, 2003 (see http://cms.hhs.gov/ncdr/memo.asp?id=91) CMS is deleting the range 730.07-730.27 from the list of covered procedures for blood glucose testing. This range was erroneously described as osteomyelitis of the tarsal bones. CMS is substituting the following ICD-9-CM codes in the list of covered diagnoses for blood glucose testing which more accurately reflect the intent of the committee to cover osteomyelitis of the ankle and foot: 730.07, Acute osteomyelitis of ankle and foot; 730.17, Chronic osteomyelitis of ankle and foot; and 730.27, Unspecified osteomyelitis of ankle and foot.

3. Moreover, the NCD coding manual released for the January and April updates inadvertently repeated the ICD-9-CM code number 136.2 with two different definitions (first as "Specific infections by free living amebae" and later as "pneumocystosis") in the list of covered diagnoses for HIV testing (diagnosis). . Thus, CMS is changing the NCD coding manual only to show the correct ICD-9-CM code for pneumocystosis is 136.3.

Updates to National Coverage Determination are posted quarterly by CMS at http://cms.hhs.gov/ncd/labindexlist.asp. If you provide clinical laboratory services it is very important that you visit this section of the site to keep informed of any change in the diagnosis code accepted for the tests covered by this rule.

Ref: CR # 2737/ PM-AB-03-084/ June 6, 2003/dmg

EXPANDED COVERAGE FOR PET SCANS

On April 16, 2003, The Centers for Medicare & Medicaid Services (CMS) announced its intent to expand coverage of positron emission tomography (PET) for Medicare beneficiaries with thyroid cancer and heart disease. This expanded coverage enhances physicians' current evaluative options, and are examples of CMS' commitment to making new medical technologies available to its beneficiaries when evidence is adequate to conclude that the technology is reasonable and necessary for diagnosis or treatment of an illness.

Thyroid Cancer:

Thyroid cancer constitutes less than one percent (1%) of all human malignant tumors. In a small number of these patients, the usually accurate Iodine-131 whole body scan is not helpful in identifying recurrent disease following initial treatment. In these patients, CMS determined that the evidence is adequate to conclude that PET is reasonable and necessary, with certain limitations, for management of patients with recurrent thyroid cancer.

Cardiac Diseases:

Cardiovascular disease is a broad term encompassing conditions such as hypertension, coronary artery disease, and congestive heart failure. These conditions cause significant morbidity and mortality in the Medicare population. CMS determined that the evidence is adequate to conclude that cardiac imaging with PET, using the radiopharmacological ammonia N-13, is reasonable and necessary, with certain limitations, for the diagnosis and management of patients with known or suspected coronary artery disease.

PET Coverage Not Expanded

Alzheimer's Disease:

Alzheimer's disease (AD) is an age-related and irreversible brain disorder that occurs gradually and results in memory loss, behavior and personality changes, and a decline in thinking abilities. AD is the most common cause of dementia representing approximately two-thirds of cases.

PET has been **proposed** as a diagnostic tool in the management of patients with AD. CMS's review of the evidence concluded that PET did not improve patient outcomes in this group of beneficiaries and, therefore, CMS will continue its present noncoverage policy. The clinical benefit of using PET for patients with AD has not been demonstrated.

To provide the best of emerging medical technology for Medicare beneficiaries, CMS will design a demonstration to evaluate the appropriate role of PET for patients with suspected dementia. CMS will work with Health and Human Services' National Institutes of Health to convene a multi-disciplinary expert meeting with geriatricians, neurologists, radiologists, PET experts, and patient advocates to fully explore the value of PET for AD.

Soft Tissue Sarcoma:

CMS has decided against expanding coverage of PET for soft tissue sarcoma, a rare type of cancer for which current imaging techniques have good diagnostic capabilities. CMS determined that the evidence was not adequate to conclude that PET for soft tissue sarcoma was reasonable and necessary and, therefore, CMS will continue its present noncoverage policy.

Other Coverage:

Medicare covers PET, with certain limitations, for the diagnosis, staging and restaging of various cancers, including lung, esophageal, colorectal, lymphoma, head and neck, and breast along with myocardial viability and pre-surgery evaluation of refractory seizures.

JointsigMemoPETSCANS#4.doc/ June 16, 2003/dmg

Gonzalo V. González-Liboy, MD FACP

COVERAGE OF THE COMPRESSION GARMENTS IN THE TREATMENT OF VENOUS STASIS ULCERS

This article provides instructions regarding the coverage of compression garments when treating venous stasis ulcers.

Background

The accepted standard of care for the treatment of venous stasis ulcers includes the use of sustained limb compression. In the past, gradient compression stockings have not been covered for this purpose. Effective for items furnished on or after October 1, 2003, gradient compression stockings that serve a therapeutic or protective function and that are needed to secure a primary dressing may be covered as surgical dressings when the requirements PM have been met.

Implementation

Effective for items furnished on or after October 1, 2003, gradient compression stockings falling under the following codes may be covered when the beneficiary has an open venous stasis ulcer that has been treated by a physician or other healthcare professional requiring medically necessary debridement, and when the gradient stocking can be proven to deliver compression greater than 30 mm Hg. And less than 50 mm Hg.

Applicable Healthcare Common Procedure Coding System (HCPCS) Codes:

L8110 – GRADIENT COMPRESSION STOCKING, BELOW KNEE, 30-40 MMHG, EACH

L8120 – GRADIENT COMPRESSION STOCKING, BELOW KNEE, 40-50 MMHG, EACH

Applicable Common Procedure Coding System (HCPCS) Modifier:

AW – ITEM FURNISHED IN CONJUNCTION WITH A SURGICAL DRESSING should follow each of the above codes.

Codes L8110, L8120, with modifier AW should be used for gradient compression stockings only when all of the requirements specified in this article have been met.

Payments for these services will be in accordance to instructions published in Medicare Informa, Volume 73 (Jan-Feb-March 2003) page 103. HCPCS code ranges for L800 to L8490 will be reimbursed by DME Regional Center.

GGL-2002/PM-AB-03-090/CR 2739/ June 20, 2003

Gonzalo V. González-Liboy, MD FACP

DOCUMENTATION OF PSYCHOTHERAPY TECHNIQUES

Recent post-payment medical record reviews indicate that providers of psychiatry & psychology services are not adequately documenting therapeutic techniques used in psychotherapy sessions. An assessment of the patient's mental status or writing the diagnosis is not enough evidence to support psychotherapy services. The CPT Code Book defines the psychotherapy codes specifically, including insight oriented, behavior modifying, and/or supportive techniques. Therapy notes should include at least one of these techniques and how they were used to help a patient's particular problem. Notes that do not include the specific psychotherapy techniques applied will be denied as not meeting the Carrier's policy guidelines.

Especially problematic are providers who bill individual psychotherapy with medical evaluation and management services. In many instances, the documentation includes an assessment of the patient's mental status and medications prescribed, but do not include the psychotherapy portion of the service. Upon review, these services have been reduced to medication management services only or denied, determination based on each individual case.

Each psychotherapy note should include the psychotherapy techniques used and how they benefited the patient in reaching his/her goals. Psychotherapy notes do not have to include intimate details of the patient's problems, but do have to meet medical necessity guidelines. Examples of documentation of psychotherapy techniques used may include, but are not limited, to the following:

1. "Supportive psychotherapy was utilized to help alleviate the patient's depression."
2. "Behavior modifying techniques were used to change the patient's maladaptive behavior. Positive reinforcement was used when the patient did not exhibit violent outbursts."
3. "Insight oriented psychotherapy was utilized to help the patient identify what negative thought are contributing to her depressed feelings."

In addition, each patient's record must include a plan of care. This plan of care should include visit frequency, expected duration of therapy services, and measurable and realistic goals. The plan of care may be documented in the actual visit note or may be documented separately and kept in the patient record.

This Carrier requests all providers to appropriately document the rendered services. Should you have any doubts, do not hesitate to contact us at (787) 749-4144.

Courtesy of Dr. Pubillones/COSVI

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MEDICARE BENEFICIARIES IN STATE OR LOCAL CUSTODY UNDER A PENAL AUTHORITY

Under **Sections 1862(a)(2) and (3) of the Social Security Act**, the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if these are paid for directly or indirectly by a government entity. These provisions are implemented by regulations at **42 CFR §411.4(a)** and **411.4(b)** which state: "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

A recent audit of Medicare disbursements identified payments for beneficiaries who, on the date of service on the claim, were in State or local custody under the authority of a penal statute. The Centers for Medicare and Medicaid (CMS) are establishing claim level editing using data received from the Social Security Administration (SSA). The data will contain the names of the Medicare beneficiaries and time periods where the beneficiary is in State or local custody. This data will be compared to the data on the incoming claims. Claims where the dates from the SSA file and the dates of service on the claim overlap will be rejected and will contain a trailer to the Medicare contractor indicating the date span covered.

Policy

CMS presumes that a State or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, effective April 1, 2003 Medicare will deny payment for items and services furnished to beneficiaries in State or local government custody unless, it is determined that the State or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way, and with the same vigor, as it pursues other debts.

However, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of **42 CFR 411.4(b)** should indicate this fact on the claim. Providers should use the "63" condition code. They should also use the QJ modifier which reads: "Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements of 42 CFR 411.4(b)".

Appeals

If a claim is denied in whole or in part under this policy, the provider may appeal the initial determination on the basis that, on the date of service, (1) the conditions of § 411.4(b) were met, or (2) the beneficiary was not, in fact, in the custody of a state or local government under authority of a penal statute.

CR2022/Transmittal AB-02-164/mm/els

Evaluación

"COMPREHENSIVE ERROR RATE TESTING PROGRAM"

El rápido crecimiento en los costos de salud y la preocupación existente sobre las vulnerabilidades del programa Medicare, motivó al Congreso a autorizar a Los Centros para Servicios de Medicare y Medicaid (CMS, por sus siglas en inglés) para iniciar contrataciones con entidades que ayuden a proteger la integridad del programa. Estas entidades son conocidas como "*Program Safeguard Contractors"* (PSC, por sus siglas en inglés). La función principal de estos contratistas es identificar áreas de potencial vulnerabilidad o problemas del programa Medicare que conlleven el pago incorrecto de reclamaciones. Con este propósito, CMS desarrolló el programa del "*Comprehensive Error Rate Testing"* (CERT, por sus siglas en inglés) y seleccionó a la compañía AdvanceMed, anteriormente conocida como Dyncorp, para dirigir este programa.

El propósito principal del programa de CERT es tener revisiones médicas independientes a las realizadas por sus contratistas. AdvanceMed selecciona periódicamente para revisión una muestra aleatoria de las reclamaciones que recibe cada contratista. Dicha muestra incluye reclamaciones pagadas o denegadas con el único propósito de asegurarse que la acción tomada por el Contratista fue correcta.

El personal de CERT a cargo de llevar a cabo la revisión médica de los casos está compuesto por enfermeras, médicos consultores, un director médico y otros profesionales de la salud.

La función principal del Programa CERT es la identificación del pago correcto de las reclamaciones en cuatro categorías. Estas categorías son:

- A nivel nacional
- A nivel del contratista
- Por proveedor
- Por beneficios

Evaluation

COMPREHENSIVE ERROR RATE TESTING PROGRAM

Considering the rapid increase in health cost and the growing concern over the vulnerability of the Medicare program, The Centers for Medicare and Medicaid Services (CMS) were authorized by Congress to contract other entities to protect the integrity of the Medicare program. These entities are known as Program Safeguard Contractors (PSC). The primary function of the PSC is to identify potential program vulnerabilities and problems resulting in inappropriate Medicare payments. Therefore, CMS developed the Comprehensive Error Rate Testing (CERT) Program and selected AdvanceMed (previously known as DynCorp) to direct it.

The purpose of the CERT Program is to have independent medical reviewers periodically evaluate random samples of Medicare claims as soon as they are submitted to the Medicare Contractor. The selection for review covers paid and denied claims with the sole purpose to ensure that the decision made was appropriate.

The CERT medical review staff includes nurses, a medical director, physician consultants and other qualified healthcare practitioners.

The main goal of the CERT Program is to identify the correctness of the claim payment in four major categories. These categories are:

- *National*
- *Contractor*
- *Provider type*
- *Benefits*

cont. on next page

Evaluación

AdvanceMed seleccionó un total de 1,172 reclamaciones para Puerto Rico y 1,098 para las Islas Vírgenes Americanas para el período del 1 de enero de 2001 al 31 de agosto de 2001. Una vez las reclamaciones fueron identificadas, se registraron en un sistema de base de datos. Además, se enviaron cartas a cada uno de los proveedores de las reclamaciones seleccionadas para revisión, solicitándole a éstos que sometieran el expediente médico relacionado a los servicios facturados. Aquellos expedientes que se recibieron fueron evaluados por el personal de AdvanceMed. Aquellos casos en que el proveedor de servicio no sometió la documentación solicitada fueron considerados como reclamaciones pagadas en error.

El término utilizado para identificar la corrección del pago de reclamaciones es "E*rror Rate*". El "E*rror Rate*" de reclamaciones pagadas se puede resumir en cinco categorías de pago indebido. Estas categorías son:

1. Documentación insuficiente – incluye aquellos casos para los cuales el proveedor sometió documentación. Sin embargo, dichos documentos no fueron suficiente para sustentar el servicio prestado.
2. Falta de documentación – incluye aquellos casos donde el proveedor no sometió ningún tipo de documentación a pesar de los múltiples intentos realizados por AdvanceMed.
3. Falta de necesidad médica - incluye aquellos casos en que luego de revisar toda la documentación en el expediente, los especialistas de revisión determinaron que el servicio no era médicamente necesario.
4. Codificación incorrecta – incluye aquellos casos en los cuales la documentación en el expediente médico no justificaba el nivel de complejidad o el servicio facturado.
5. Servicios no cubiertos – incluye aquellos casos donde el proveedor facturó a Medicare por un servicio cubierto. Sin embargo al evaluarse el expediente médico, los especialistas de revisión de AdvanceMed determinaron que el servicio prestado es un servicio no cubierto por Medicare.

Evaluation

AdvanceMed selected for review a total of 1,172 claims for Puerto Rico and 1,098 claims for the US Virgin Islands covering the period of January 1, 2001 through August 31, 2001. Once the claims were chosen, the claim data was entered into a tracking and reporting database and letters were sent to the physicians of the sampled claims asking them to submit the corresponding medical records. The information received was reviewed, and those claims for which physicians did not submit the medical records, were identified as paid in error.

The term for identifying the correctness of the claim payment is Error Rate. The paid claim Error Rate can be broken down into five categories, which are:

1. *Insufficient documents – includes situations where the provider submitted some documents for the sampled beneficiary, but such documentation was determined to be inconclusive to support the rendered service.*
2. *Lack of documents – includes those providers which did not submit documents after the full process of pursuing documentation had been exhausted.*
3. *Lack of medical necessity – includes circumstances when there was sufficient documents in the medical record to allow the medical review staff to make an informed decision that the service or item provided was not medically necessary.*
4. *Incorrect coding – included those services which were billed and paid but, according to the medical record, do not accurately reflect the service actually provided.*
5. *Non-covered services – included services, treatment, or equipment that were paid as covered services but general law prohibits Medicare coverage for those items.*

Evaluación

Uno de los hallazgos más significativos de la revisión realizada por AdvanceMed fue la falta de documentación de los servicios.

Deseamos enfatizar la importancia que tiene el que usted como proveedor envíe el expediente o documentación médica cuando AdvanceMed así lo solicite. De lo contrario, esta reclamación será considerada como pagada incorrectamente por lo que tendremos que recuperar el dinero pagado. Además, es de suma importancia que en el expediente médico estén debidamente documentados todos los servicios prestados. Igualmente, es importante que dicha documentación sustente los niveles de complejidad facturados. Estamos seguros que podemos contar con usted para ayudarnos a reducir nuestro "Error Rate".

Evaluation

As you can see, one of the major problems identified during the AdvanceMed review is the lack of documentation.

We emphasize the importance of responding when you receive a letter from AdvanceMed asking for medical records, otherwise, the claim will be classified as an error and we will have to recoup the payment. In addition, it is of utmost importance that documents for services rendered are in the medical record and that these support the level of service billed. We rely on your cooperation in order to reduce our Error Rate.

Medical Review/July 18, 2003/RG/els

Reembolso

NUEVA TARIFA ("GAP-FILLED") PARA LOS CÓDIGOS 82274 Y 82274QW

Según se informó en la Carta Circular número M-03-01-001 (del 15 de enero de 2003), las tarifas "gap-filled" para los códigos 82274 y 82274QW fueron revisadas. La siguiente tabla indica las tarifas para estos códigos, las cuales tienen vigencia desde el 1 de enero de 2003.

Este código de procedimiento se utiliza para detectar sangre oculta en las heces fecales y contempla la toma de una hasta tres muestras. Estas se pagarán con una sola tarifa que será la correspondiente al código de referencia.

Reimbursement

NEW FEE (GAP-FILLED) FOR CODES 82274 AND 82274QW

According to the Circular Letter Number M-03-01-001 (dated January 15, 2003), the gap-filled amount for codes 82274 and 82274QW has been revised. The following table discloses the fees for these codes, which are effective as of January 1, 2003.

These procedure codes are utilized to detect blood in the feces. The fee includes 1-3 simultaneous determinations, which will be paid in one fee.

CR 2420/TRANS. AB-02-163/11-8-2002/ERO/GGL1995/els

CODIGO	TARIFA / *FEE*	
CODE	Puerto Rico	VI
82274	$18.43	$19.37
82274QW	$18.43	$19.37

FECHA LIMITE PARA SOMETER RECLAMACIONES

La Sección 3004 del Manual del Carrier Medicare establece una fecha límite dentro de la cual una reclamación puede ser sometida a Medicare. Usted tiene un mínimo de 15 meses y hasta un máximo de 27 para someter sus reclamaciones. Por ejemplo:

CLAIMS FILLING LIMITATION

Section 3004 of the Medicare Carriers Manual establishes a time limit for submitting claims to Medicare. You have a minimum of 15 months and a maximum of 27 months to submit your claims. For example:

Para Servicios Prestados Entre las Fechas: *For Services Furnished Between:*	Fecha Límite *Time Limit*
10-01-02 to 9-30-03	12/31/04
10-01-03 to 9-30-04	12/31/05
10-01-04 to 9-30-05	12/31/06

No obstante, la Sección 3041 establece que al reembolso por servicios para los cuales se acepta la asignación y que son facturados después de un año de ofrecerse el servicio, se le aplica una reducción en tarifa de un diez por ciento.

Nonetheless, Section 3041 states that assigned services that are not filed within one year of the date of the service is reduced by ten percent.

DG-Ofic. Com. CMS/7-14-98

Reembolso

CÓDIGOS TEMPOREROS Q4052 Y Q4053

CMS ha establecido dos nuevos códigos Q para la facturación de Octreotide y Pegfilgrastim los cuales entran en vigor el 1 de julio de 2003.

Las tarifas y descripción de los códigos son las siguientes:

NOTA: El código HCPCS J2352 no debe utilizarse más para reportar el Octreotide (depot form).

Reimbursement

TEMPORARY CODES Q4052 AND Q4053

CMS has established two new "Q" codes for billing Octreotide and Pegfilgrastim. These new codes will become effective July 1, 2003.

The fees and the code descriptions are as follows:

***NOTE:** The HCPCS code J2352 may no longer be used to report the depot form of Octreotide.*

CÓDIGO *CODE*	DESCRIPCIÓN *DESCRIPTION*	TARIFA *FEE*
Q4052	Injection, Octreotide, Depot Form for Intramuscular Injection, 1 mg	$88.69
Q4053	Injection, Pegfilgrastim, 1 mg	$467.09

CR 2798/Transmittal B-03-048/June 20,2003/mm/July SDP file

ACTUALIZACIÓN DE LOS CÓDIGOS Y PAGOS PARA CENTROS DE CIRUGÍA AMBULATORIA

Los Centros de Servicios Medicare y Medicaid (CMS, por sus siglas en inglés) notificaron los nuevos códigos y los que serán eliminados de la Lista de Códigos de Procedimientos de los Centros de Cirugía Ambulatoria (ASC, por sus siglas en inglés).

CMS establece el pago a la instalación de salud cuando los procedimientos quirúrgicos son prestados en ASC's certificados por Medicare.

Para información adicional puede referirse a http://www.access.gpo.gov/su_docs/fedreg/a030328c.html, **Center for Medicare & Medicaid Services, Rules**," Medicare: Ambulatory Surgical Centers; rate setting methodology, payment rates and policies, and covered surgical procedures list, 15267-15312 [03-7236].

En la siguientes páginas encontraran los códigos nuevos y los códigos eliminados, los cuales tendrán fecha de efectividad para servicios prestados comenzando el 1 de julio de 2003.

CODE AND PAYMENT UPDATES FOR AMBULATORY SURGICAL CENTERS (ASC'S)

The Centers for Medicare & Medicaid (CMS) notified the deletions and additions to the Ambulatory Surgical Center (ASCs) Procedures Code List.

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

*For additional information refer to http://www.access.gpo.gov/su_docs/fedreg/a030328c.html, **Center for Medicare & Medicaid Services, Rules**, " Medicare: Ambulatory surgical centers; rate setting methodology, payment rates and policies, and covered surgical procedures list, 15267-15312 [03-7236]."*

On the next pages you will find the added and deleted codes, which will be effective for services performed starting July 1, 2003 and thereafter.

Transmittal AB-03-032/CR 2574/February 28, 2003/ERO/els

CODIGOS AÑADIDOS / *ADDED CODES*					
CODIGO *CODE*	**GRUPO** *GROUP*	**CODIGO** *CODE*	**GRUPO** *GROUP*	**CODIGO** *CODE*	**GRUPO** *GROUP*
10121	2	25830	5	31085	4
11010	2	26185	4	31087	4
11011	2	26546	4	31400	2
11012	2	26608	4	31420	2
15351	2	27067	5	31623	2
15401	2	27257	3	31624	2
15775	3	27329	4	31643	2
15776	3	27347	4	33222	2
15820	3	27357	5	33223	2
15821	3	27358	5	35188	4
15822	3	27496	5	35207	4
15823	5	27497	3	35875	9
15824	3	27498	3	35876	9
15825	3	27499	3	36260	3
15826	3	27594	3	36488	1
15828	3	27600	3	36490	1
15829	5	27601	3	36831	9
15831	3	27602	3	36870	9
15832	3	27647	3	37607	3
15833	3	27889	3	37650	2
15834	3	27892	3	37790	3
15835	3	27893	3	38570	9
15876	3	27894	3	38571	9
15877	3	28011	3	38572	9
15878	3	28022	2	40700	7
15879	3	28024	2	40701	7
19316	4	28052	2	40720	7
19324	4	28126	3	40761	3
19325	9	28153	3	42226	5
19355	4	28160	3	42415	7
20692	3	28234	2	42820	3
20693	3	28270	3	42825	4
21015	3	28289	3	42830	4
21029	2	28531	3	42835	4
21046	2	29800	3	42890	7
21047	2	29827	5	42892	7
21121	7	29848	9	42972	3
21122	7	29860	4	43201	1
21123	7	29861	4	43205	1
21127	9	29862	9	43231	2
21181	7	29863	4	43232	2
21295	1	29891	3	43236	2
21296	1	29892	3	43240	2
21336	4	29893	9	43242	2
21345	7	29899	3	43244	2
23031	3	30460	7	43256	3
24006	4	30462	9	43653	9
24305	4	30465	9	44370	9
24341	3	30545	5	44376	2

CODIGOS AÑADIDOS / *ADDED CODES*					
CODIGO ***CODE***	**GRUPO** ***GROUP***	**CODIGO** ***CODE***	**GRUPO** ***GROUP***	**CODIGO** ***CODE***	**GRUPO** ***GROUP***
24345	2	52510	3	58550	9
25337	5	52647	9	58560	3
44379	9	52648	9	58562	3
44383	9	30930	4	59160	3
45160	2	31081	4	59320	1
45190	9	53080	3	59812	5
45335	1	53270	2	44377	2
45340	1	53850	9	44378	2
45381	2	54000	2	59820	5
45386	2	54111	2	59821	5
46288	4	54112	2	59840	5
46615	2	54150	1	59841	5
46761	3	54160	2	59870	5
46762	7	54304	3	59871	5
46917	1	54308	3	61886	3
47511	9	54312	3	62287	9
47556	9	54316	3	62355	2
49422	1	54318	3	64553	1
49495	4	54322	3	64573	1
49496	4	54324	3	64577	1
49500	4	54326	3	64580	1
49501	9	54328	3	64585	1
49507	9	54340	3	64821	4
49521	9	54344	3	64885	2
49553	9	54348	3	64886	2
49557	9	54352	3	65772	4
49561	9	54380	3	65775	4
49566	9	54385	3	66825	4
49568	7	54400	3	67027	4
49572	9	54401	3	67334	4
49580	4	54405	3	67335	4
49582	9	54406	3	67900	4
49587	9	54408	3	68115	2
49600	4	54410	3	68770	4
50947	9	54415	3	69300	3
50948	9	54416	3	69714	9
51050	4	54522	3	69715	9
51065	4	54690	9	69717	9
51080	1	55250	2	69718	9
51520	4	55550	9	G0260	1
51715	3	55725	2		
52282	9	55859	9		
52327	2	57023	1		
52341	3	57289	5		
52342	3	57291	5		
52343	3	57415	2		
52344	3	57556	5		
52345	3	58350	3		
52346	3	58545	9		
52355	4	58546	9		

CODIGOS ELIMINADOS / *DELETED CODES*					
CODIGO **CODE**	**GRUPO** ***GROUP***	**CODIGO** ***CODE***	**GRUPO** ***GROUP***	**CODIGO** ***CODE***	**GRUPO** ***GROUP***
15756	*3*	24151	*4*	44345	*4*
15757	*3*	24152	*3*	44346	*4*
15758	*3*	24153	*4*	49000	*4*
15842	*4*	25065	*1*	49400	*1*
16030	*1*	25170	*3*	49425	*2*
16035	*2*	26035	*4*	50020	*2*
19260	*5*	26037	*4*	50040	*3*
19364	*5*	26551	*4*	50520	*1*
20660	*2*	26553	*2*	50570	*1*
20661	*3*	26554	*2*	50572	*1*
20662	*3*	26992	*2*	50574	*1*
20663	*3*	27030	*3*	50576	*1*
20665	*1*	27303	*2*	50578	*1*
20955	*4*	27440	*5*	50580	*1*
20962	*4*	27507	*4*	50684	*1*
20969	*4*	27511	*4*	50690	*1*
20970	*4*	27513	*5*	51005	*1*
20972	*4*	27524	*3*	51600	*1*
20973	*4*	27535	*3*	51605	*1*
21041	*2*	27613	*1*	51610	*1*
21343	*5*	27715	*4*	51725	*1*
21360	*4*	30124	*1*	51865	*4*
21365	*5*	31584	*4*	51900	*4*
21385	*5*	31600	*2*	51920	*3*
21386	*5*	31710	*1*	54125	*2*
21387	*5*	31715	*1*	55600	*1*
21390	*7*	31785	*4*	55605	*1*
21395	*7*	31800	*2*	55650	*1*
21406	*4*	32002	*2*	56405	*2*
21407	*5*	32005	*2*	56605	*1*
21422	*5*	32020	*2*	57310	*3*
21470	*5*	34101	*3*	57311	*4*
21495	*4*	38700	*2*	57320	*3*
21510	*3*	38790	*1*	57800	*1*
21550	*1*	40805	*2*	58551	*5*
21620	*2*	40806	*1*	60220	*2*
21810	*2*	40820	*1*	60225	*3*
21920	*1*	41000	*1*	62256	*2*
22100	*3*	41105	*2*	62351	*2*
22101	*3*	41110	*1*	62367	*2*
22102	*3*	41115	*1*	62368	*2*
22103	*3*	41805	*1*	69424	*1*
22325	*3*	41806	*1*	69710	*3*
22326	*3*	42104	*2*		
22327	*3*	42106	*2*		
22328	*3*	42160	*1*		
23065	*1*	42225	*5*		
24065	*1*	42281	*3*		
24150	*3*	42335	*3*		

Reembolso

REQUISITOS PARA INFORME DE CARGOS RAZONABLES DE SERVICIOS DE AMBULANCIA PARA CUIDADO DIRIGIDO

El 1 de abril de 2002 CMS implementó el nuevo método de pago por tarifa fija para todos los servicios de ambulancia. Este método de pago aplica a reclamaciones con fechas de servicios desde el 1 de abril de 2002. Bajo las tarifas fijas, los servicios de ambulancia cubiertos por Medicare se pagan basado en la cantidad menor entre la cantidad facturada o la cantidad de la tarifa fija de ambulancia.

Comenzando en el año calendario 2003 y continuando hasta el 2005, los contratistas prepararán un informe anual de cuidado dirigido. En el mismo se indicará el índice de cargo prevaleciente (IIC) de las cantidades del cargo razonable para los códigos HCPCS de ambulancia por localidad.

Durante la transición a las tarifas fijas para ambulancia (2003-2005), las operaciones de cuidado dirigido contratadas por CMS estarán disponibles para accesar el informe de precios de cargos razonables en la página de servicios de ambulancia de CMS localizada en el Internet a través de http://www.cms.hhs.gov/suppliers/ambulance/.

Las operaciones de cuidado dirigido podrán solicitar información adicional con relación a los cargos razonables (e.j. cantidades específicas de los cargos razonables acostumbrados de un suplidor) al contratista por cada localidad donde el cuidado de manejo dirigido preste servicios de ambulancia.

Reimbursement

MANAGED CARE REASONABLE CHARGE DATA DISCLOSURE REQUIREMENTS FOR AMBULANCE SERVICES

On April 1, 2002, CMS implemented a new fee schedule that applies to all ambulance services. The ambulance fee schedule is effective for claims with dates of service starting April 1, 2002. Under the fee schedule, ambulance services covered under Medicare are paid based on the lower of the actualbilled amount or the ambulance fee schedule amount.

Beginning in CY 2003, and continuing through CY 2005, carriers will prepare an annual managed care disclosure file in text file format (e.g., ASCII) containing the prevailing inflation index charge (IIC) reasonable charge amounts for each ambulance HCPCS code by locality.

During the transition to the ambulance fee schedule (CY 2003 through 2005), CMS-contracted managed care operations will be able to access reasonable charge pricing data on the CMS ambulance services Web site located at http://www.cms.hhs.gov/suppliers/ambulance/.

Managed care operations may request additional reasonable charge data (e.g., supplier-specific customary reasonable charge amounts) from their carrier for each locality in which the managed care operation provides ambulance services.

CR2561/Transmittal B-03-029/April 25, 2003/ ICR

Reembolso

PERMITIDO EL PAGO POR SEPARADO DE MEDICAMENTOS A LA FACTURACIÓN CONSOLIDADA DE INSTALACIONES DE SALUD DE ENFERMERÍA ESPECIALIZADA

A partir del 1 de abril de 2002 se implementaron éditos para identificar los códigos HCPCS para servicios de ambulancia que fueron excluidos del "Skilled Nursing Facilities Consolidated Billing" (SNF CB por sus siglas en inglés). Estos cambios en codificación añadieron éditos para denegar el pago por separado de servicios de ambulancia a beneficiarios en una estadía SNF cubierta bajo la Parte A. Luego de la implantación de estos códigos HCPCS para servicios de ambulancia y servicios auxiliares, se identificaron códigos de medicamentos que pueden ser facturados separadamente cuando son provistos como parte del transporte de ambulancia.

Cuando se facture por transportes de ambulancia, los suplidores de ambulancia deben indicar si el transporte era parte de la estadía de SNF cubierta por la Parte A, usando el modificador de origen/destino apropiado (Por ejemplo, "NH" para servicios de SNF a hospital). Para los suplidores que utilizan el modificador "NN" para identificar los servicios con origen/destino de SNF a SNF, estos no pueden ser pagados separadamente cuando el beneficiario está en una estadía de SNF cubierta por la Parte A; o sea, resultará en una denegación. Algunos códigos de medicamentos tales como: J7030, J7040, J7042, J7050, J7051 y J7130 pueden ser facturados separadamente cuando son provistos durante el transporte desde o hasta un SNF cuando un beneficiario está en una estadía Parte A. **Medicamentos o suplidos pueden ser pagados por separado únicamente para contratistas que así lo permitan.** Estos medicamentos no se pagan por separado cuando son provistos durante una transportación inter-SNF.

Reimbursement

SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB) BYPASS TO ALLOW SEPARATE PAYMENT FOR DRUGS

Effective April 1, 2002, edits were implemented to identify HCPCS codes for ambulance services that are either subject to or excluded from SNF consolidated billing (CB). This coding change added edits to deny payment of some separately billed ambulance services for beneficiaries in a SNF Part A covered stay. After the implementation additional HCPCS codes for ambulance and ancillary services were identified and added to the SNF CB edit in August 2002. Since these updates, CMS has identified additional HCPCS codes for drugs that may be separately billable when provided as part of an ambulance transport.

When billing for ambulance transports, suppliers indicate whether the transport was part of a SNF Part A covered stay, using the appropriate origin/destination modifier (e.g., "NH" for a transport from a SNF to a hospital). Suppliers bill with an "NN" origin/destination modifier when a SNF to SNF transport occurs. A transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a claim for such a transport. Certain drugs, including HCPCS codes J7030, J7040, J7042, J7050, J7051, and J7130 may be billed separately when provided during an ambulance transport to or from a SNF when a beneficiary is in a Part A stay. ***These items are only separately billable for those suppliers in carrier jurisdictions that paid separately for drugs prior to the implementation of the fee schedule on April 1, 2002.*** *These items are not separately billable when provided during an inter-SNF transport.*

CR2707/Transmittal B-03-039/May 9, 2003/ICR/els

Reembolso

CÓDIGOS DE DIAGNÓSTICO PARA SERVICIOS DE PRUEBAS DE CERNIMIENTO Y EXAMEN PÉLVICO

Los Centros para Servicios de Medicare y Medicaid han añadido dos nuevos códigos de diagnóstico para pruebas de cernimiento y examen pélvico para pacientes de bajo riesgo. Estos son V76.47 y V76.49 que han sido añadidos a proveedores para el uso en mujeres sin cuello de útero.

La siguiente lista muestra los códigos de diagnóstico a utilizar en pacientes de bajo riesgo para pruebas de cernimiento y examen pélvico, los cuales estarán en vigencia el 1 de octubre de 2003:

Reimbursement

DIAGNOSIS CODES FOR SCREENING PAP SMEAR AND PELVIC EXAMINATION SERVICES

The Centers for Medicare and Medicaid Services (CMS) have added two new diagnosis codes for low risk patients for Pap smear and Pelvic examinations. These are V76.47 and V76.49 that has been added for providers to use for women without a cervix.

The following chart lists the diagnosis codes for low risk or high-risk patients for pap smear and pelvic examinations which will become effective October 1, 2003:

Códigos de Diagnóstico de Bajo Riesgo ***Low Risk Diagnosis Codes***	**Definiciones** ***Definitions***
V76.2	Cervix (routine cervical papanicolaou smear)
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites
Códigos de Diagnóstico de Alto Riesgo ***High Risk Diagnosis Code***	**Definiciones** ***Definitions***
V15.89	Other

No hubo cambios a los códigos HCPCS para facturar pruebas de cernimiento.

There are no changes to the HCPCS codes used to bill screening Pap smears.

CR 2637/Transmittal AB-03-054/ May 2, 2003/ ICR/els

ACLARACIÓN PARA EL CÓDIGO J7342

CMS notificó que la tarifa de **$15.40** para el código **J7342** tiene fecha de efectividad por servicios prestados desde el 1 de enero de 2003.

CLARIFICATION FOR CODE J7342

*CMS has notified that the fee of **$15.40** for code **J7342** is effective for services rendered on January 1, 2003 and thereafter.*

CR 2772/AB-03-080/May 30, 2003/ERO/els

Reembolso

SEGUNDA ACTUALIZACIÓN A LA BASE DE DATOS DE LAS TARIFAS FIJAS PARA MÉDICOS

Los Centros de Servicios para Medicare y Medicaid (CMS, por sus siglas en inglés) notificaron la segunda actualización a la Base de Datos de las Tarifas Fijas para Médicos para el 2003.

De acuerdo con la Parte 3, Sección 15902 del **Manual de Medicare,** los cambios de esta actualización se implantarán el 1 de julio de 2003. Estos serán vigentes para reclamaciones con fechas de servicio del 1 de marzo de 2003 en adelante.

Los cambios incluidos en esta actualización a la Base de Datos de las Tarifas Fijas para Médicos del 2003 están disponibles en nuestra página de Internet www.triples-med.org desde el 29 de mayo de 2003 y son los siguientes:

Reimbursement

SECOND UPDATE TO THE 2003 MEDICARE PHYSICIANS FEE SCHEDULE DATABASE

The Centers for Medicare & Medicaid Services (CMS) notified the second Medicare Physicians Fee Schedule Database (MPFSDB) update for 2003.

*In accordance with the **Medicare Carriers Manual** Part 3, section 15902, the changes in this update will be implemented on July 1, 2003. The changes will be effective for claims with dates of service on March 1, 2003 and thereafter (except for those that have a different effective date indicated in this article).*

Changes included in this second update to the 2003 Medicare Physician Fee Schedule Database have been accessible at our Web **page** *www.triples-med.org since May 29, 2003. The changes are as follows:*

CPT Code	**Revision**
G0124	Facility PE RVU = 0.19 Non Facility PE RVU = 0.19
G0141	Facility PE RVU = 0.19 Non Facility PE RVU = 0.19

CPT Code	**Revision**
G0219	Work RVU = 0.00 Facility PE RVU = 0.00 Non-Facility PE RVU = 0.00 Malpractice RVU = 0.00
G0219 – 26	Work RVU = 0.00 Facility PE RVU = 0.00 Non-Facility PE RVU = 0.00 Malpractice RVU = 0.00
G0247	Long Description: Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (lops) to include if present, at least the following: (1) local care of superficial (i.e. wounds superficial to fascia and muscle) wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

G0255 Work RVU = 0.00
Facility PE RVU = 0.00
Non-Facility PE RVU = 0.00
Malpractice RVU = 0.00

G0255 – 26 Work RVU = 0.00
Facility PE RVU = 0.00
Non-Facility PE RVU = 0.00
Malpractice RVU = 0.00

G0272 Multiple Procedure Indicator = 0

**** Effective for services performed on or after January 1, 2003**

Effective for services performed on or after January 1, 2003

G0289 EndoBase Code = Remove 29870

Effective for services performed on or after January 1, 2003

J3370 Description: Vancomycin hcl injection
Proc Stat = E
PC/TC = 9
SOS = 9
Mult Surg = 9
Bilt Surg = 9
Asst Surg = 9
Co Surg = 9
Team Surg = 9

J7308 Procedure Status = D

Effective for services performed on or after January 1, 2003

P3001 Facility PE RVU = 0.19
Non Facility PE RVU = 0.19

V5274 Procedure Status = N

Effective for services performed on or after January 1, 2003

17004 Multiple Procedure Indicator = 0

17304 Multiple Procedure Indicator = 0

36470 Bilateral Indicator = 1

36471 Bilateral Indicator = 1

51798 Facility PE RVU = 0.58
Non-Facility PE RVU = 0.58

53853	Facility PE RVU = 3.67 Non-Facility PE RVU = 38.96
55870	Descriptor: Electroejaculation
65220	Non-Facility PE RVU = 3.50
66821	Facility PE RVU = 3.39 Non-Facility PE RVU = 3.83
66984	Facility PE RVU = 7.65 Non-Facility PE RVU = 7.65
67820	Non-Facility PE RVU = 1.14
67825	Non-Facility PE RVU = 1.62

CPT Code(s):	72198	72198 – 26	72198 - TC
Description:	Mr angio pelvis w/o&w/dye		
Proc Stat:	A	A	A
Work RVU:	1.80	1.80	0.00
Non Facility PE RVU:	11.86	0.70	11.16
Facility PE RVU:	11.86	0.70	11.16
Malpractice RVU:	0.57	0.08	0.49
PC/TC:	1	1	1
SOS:	1	1	1
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0

CPT Code	**Revision**
76519	Facility PE RVU = 1.93 Non-Facility PE RVU = 1.93
76519 - TC	Facility PE RVU = 1.68 Non-Facility PE RVU = 1.68
87271	Short Descriptor: Cytomegalovirus

CPT Code(s):	90871
Description:	Electroconvulsive therapy
Proc Stat:	N
RVU Work:	0.00
Non-Fac PE RVU:	0.00
Fac PE RVU:	0.00
Malpractice RVU:	0.00
PC/TC:	9
SOS:	9
Mult Surg:	9
Bilt Surg:	9
Asst Surg:	9
Co Surg:	9
Team Surg:	9

****Effective for services performed on or after April 1, 2003**

CPT Code	Revision
92014	Non-Facility PE RVU = 1.37
92081	Facility PE RVU = 0.89 Non-Facility PE RVU = 0.89
92081 – TC	Facility PE RVU = 0.73 Non-Facility PE RVU = 0.73
92083	Facility PE RVU = 1.37 Non-Facility PE RVU = 1.37
92083 – TC	Facility PE RVU = 1.14 Non-Facility PE RVU = 1.14
92135	Facility PE RVU = 1.32 Non-Facility PE RVU = 1.32
92135 – TC	Facility PE RVU = 1.16 Non-Facility PE RVU = 1.16
92235	Facility PE RVU = 2.69 Non-Facility PE RVU = 2.69
92235 – TC	Facility PE RVU = 2.31 Non-Facility PE RVU = 2.31
92250	Facility PE RVU = 1.55 Non-Facility PE RVU = 1.55
92250 – TC	Facility PE RVU = 1.35 Non-Facility PE RVU = 1.35
92601 – 92604	Diagnostic Supervision Indicator = 05
94014	Facility PE RVU = 0.98 Non-Facility PE RVU = 0.98
94015	Facility PE RVU = 0.81 Non-Facility PE RVU = 0.81

CPT Code: 90801
Description: Psychiatric diagnostic interview examination

The psychiatric diagnostic interview examination as identified by CPT code 90801 was added to the list of Medicare telehealth services through the Physician Fee Schedule for Calendar Year 2003 final rule. The final rule is effective for services furnished on or after March 1, 2003. Therefore, the effective date for payment of the psychiatric diagnostic interview examination as a telehealth service, e.g., 90801 modifier GT, is March 1, 2003.

Transmittal AB-02-160, Change Request 2403, dated November 8, 2002 previously indicated that the addition of the psychiatric diagnostic interview examination to the list of Medicare telehealth services was effective January 1, 2003.

In situations where a critical access hospital (CAH) has elected payment method II for CAH patients, intermediaries should make payment for telehealth services provided by the physician or practitioner according to § 415.22 of the Medicare Hospital Manual. In all other cases, telehealth services provided by the physician or practitioner at the distant site are billed to the carrier.

La siguiente tabla indica las nuevas tarifas de los códigos donde los porcientos de las unidades de valor relativo cambiaron.

The following are the new fees that apply to the CPT codes where the relative value units change.

Codes	Setting	Puerto Rico Fees	Virgin Islands Fees	Codes	Setting	Puerto Rico Fees	Virgin Islands Fees
G0124	Non-Facility	$18.69	$22.43	76519-TC	Non-Facility	$44.61	$65.43
	Facility	$18.69	$22.43		Facility	$44.61	$65.43
G0141	Non-Facility	$18.69	$22.43	92014	Non-Facility	$71.73	$91.34
	Facility	$18.69	$22.43		Facility	$48.42	$57.85
P3001	Non-Facility	$18.69	$22.43	92081	Non-Facility	$35.18	$47.01
	Facility	$18.69	$22.43		Facility	$35.18	$47.01
51798	Non-Facility	$15.90	$24.41	92081-TC	Non-Facility	$19.22	$27.84
	Facility	$15.90	$24.41		Facility	$19.22	$27.84
53853	Non-Facility	$1,192.96	$1,662.09	92083	Non-Facility	$52.29	$70.04
	Facility	$268.67	$334.07		Facility	$52.29	$70.04
65220	Non-Facility	$115.19	$158.76	92083-TC	Non-Facility	$29.96	$43.27
	Facility	$28.23	$33.82		Facility	$29.96	$43.27
66821	Non-Facility	$177.48	$231.24	92135	Non-Facility	$46.12	$62.84
	Facility	$165.96	$214.68		Facility	$46.12	$62.84
66984	Non-Facility	$536.05	$666.14	92135-TC	Non-Facility	$30.48	$44.02
	Facility	$536.05	$666.14		Facility	$30.48	$44.02
67820	Non-Facility	$59.11	$75.97	92235	Non-Facility	$97.41	$132.56
	Facility	$39.20	$47.37		Facility	$97.41	$132.56
67825	Non-Facility	$87.76	$112.16	92235-TC	Non-Facility	$61.01	$88.77
	Facility	$72.31	$89.96		Facility	$61.01	$88.77
72198	Non-Facility	$374.73	$531.22	92250	Non-Facility	$55.06	$74.69
	Facility	$374.73	$531.22		Facility	$55.06	$74.69
72198-26	Non-Facility	$77.48	$93.19	92250-TC	Non-Facility	$35.46	$51.17
	Facility	$77.48	$93.19		Facility	$35.46	$51.17
72198-TC	Non-Facility	$297.25	$438.03	94014	Non-Facility	$42.82	$56.44
	Facility	$297.25	$438.03		Facility	$42.82	$56.44
76519	Non-Facility	$68.76	$94.38	94015	Non-Facility	$21.32	$30.85
	Facility	$68.76	$94.38		Facility	$21.32	$30.85

CR2734/Trans.AB-03-070/May 9, 2003/ERO/els

Reembolso

NOTA ACLARATORIA

En el artículo de la Segunda Actualización a la Base de Datos de las Tarifas para Médicos se informa que los códigos 72198, 72198-26, 72198-TC tendrán estatus A para fecha de servicios del 1 de enero de 2003 en adelante. Aclaramos que estos cambios tendrán vigencia para reclamaciones con fecha de servicio del 1 de julio de 2003 en adelante. Por lo tanto, se estarán denegando como no cubiertas las reclamaciones recibidas con fecha de servicio de 1 de marzo de 2003 al 30 de junio de 2003.

Reimbursement

CLARIFICATION NOTE

As part of a Second Update to the 2003 Medicare Physician Fee Schedule Database codes 72198, 72198-26, 72198-TC will have status code equal A effective for date of services January 1, 2003. There is a clarification to this instructions; these changes will be effective for claims with date of services July 1, 2003 or later. Therefore, the claims received with dates of service of March 1, 2003 at June 30, 2003 will be denied as not covered services.

JSM CI-1996/June 16,2003/ERO

NUEVAS PRUEBAS AL CERTIFICADO DE DISPENSA

A continuación 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.

NEW TESTS TO THE WAIVED CERTIFICATE

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The Current Procedural Terminology (CPT) codes for these new tests must have modifier QW to be recognized as a waived test.

CÓDIGO CPT *CPT CODE*	**DESCRIPCIÓN** *DESCRIPTION*	**FECHA DE EFECTIVIDAD** *EFFECTIVE DATE*
81003 QW	Hypoguard Diascreen® Urine Chemistry Analyzer	December 6, 2002
83036QW	Bio-Rad Micromat II Hemglobin A1c Prescription Home Use Test	December 17, 2002
82273QW	Aerscher Hemaprompt FG	February 11, 2003
87880QW	Immunostics Immuno/Strep A Detector	February 13, 2002
87880QW	Stanbio QuStick Strep A	March 5, 2003
86701QW	OraSure Technologies OraQuick Rapid HIV-1 Antibody Test	January 31, 2003

Existe una Determinación de Cubierta Nacional (NCD por sus siglas en inglés) para los inmunoensayos y la hemoglobina glicosilada utilizados en múltiples métodos de VIH-1. Estos NCDs aplicarán a reclamaciones con los códigos 83036QW y 86701QW.

There is a National Coverage Determination (NCD) for glycated hemoglobin and for immunoassays performed by multiple step methods for HIV-1. These NCDs will be applied to claims for CPT code 83036QW and 86701QW.

CR2685/Transmittal AB-03-056/ May 2, 2003/mm

Reembolso

MÉTODO SIMPLE DE PRECIOS

La presencia o ausencia de un medicamento en la lista de Métodos Simple de Precios (SDP por sus siglas en inglés) no representa una determinación de cubierta o no-cubierta del medicamento por Medicare. Además, la tarifa que aparece en dicha lista corresponde al pago máximo permitido por medicamento sí el contratista determina que el mismo cumple con los requisitos de cubierta. Igualmente, la ausencia de un medicamento de la lista significa que si el contratista determina cubrir dicho medicamento tendrá que establecer la tarifa a reembolsar conforme a la política de estandarización de precios para medicamentos. Los contratistas determinan si cierto medicamento cumple con los requisitos de cubierta y si ese es el caso, determina si el reembolso por el medicamento se podrá realizar para la condición para la cual fue administrada. Los ejemplos de estas determinaciones incluyen, pero no están limitadas a aquellas que establecen que un medicamento o ruta de administración es razonable y necesario para el tratamiento de la condición del beneficiario, si el medicamento podrá ser excluido por ser auto-administrable y si existe una alternativa menos costosa del medicamento.

La lista de los medicamentos está publicada en nuestra página de Internet; http://www.triples-med.org en la sección Tarifas Fijas de 2003 bajo Estandarización de Precios para Medicamentos cubiertos por Medicare.

Reimbursement

SINGLE DRUG PRICER (SDP)

The presence or absence of a particular drug on the SDP file does not represent a determination that the Medicare program either covers or does not cover that drug. The amounts shown on the SDP file indicate the maximum Medicare payment allowance, if the Medicare contractor determines that the drug meets the program's requirements for coverage. Similarly, the absence of a particular drug from the SDP file means that if the Medicare contractor determines that the drug is covered by Medicare, the local contractor must then determine the program's payment allowance by applying the program's standard drug payment policy rules. Medicare contractors separately determine whether a particular drug meets the program's general requirements for coverage and, if so, whether payment may be made for the drug in the particular circumstance under which it was furnished. Examples of this latter determination include but are not limited to determinations as to whether a particular drug and route of administration are reasonable and necessary to treat the beneficiary's condition, whether a drug may be excluded from payment because it is usually self-administered, and whether a least costly alternative to the drug exists.

The list of the drugs is published in our Internet page http://www.triples-med.org in section 2003 Fee Schedules under Standardizing for Medicare Covered Drugs.

CR2381/AB-02-174/12-03-2002/SDP JULIO 2003/mm
CR2544/AB-03-14/02-07-03/DG

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.

DMO:COPB:TMC:MAY 06, 2003/MOA

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	

Contrato

PROVEEDORES SANCIONADOS

Proveedores sancionados son aquellos que han violado las obligaciones de su contrato con Medicare o Medicaid. A estos proveedores no se les permite facturar al Programa Medicare. Los 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. La sección 4304 del "Balanced Budget Act" (BBA, por sus siglas en inglés) modificó la sección 1128A(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 excluido, 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 excluido 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, en esta página encontrará la lista de los proveedores reinstalados y en las siguientes páginas encontrará la lista de los proveedores actualmente excluidos 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. 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 pages the list of excluded providers to the Medicare Program:

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

Nombre / *Name*	**Dirección / *Address***	**Fecha de Efectividad** ***Effective Date***
Capó Fernández, Yolanda	Plaza Vega Baja / Pearl Vission Express Vega Baja, PR 00693	January 15, 2002
Pérez Cuevas, Reynaldo	Centro Visual de Florida Florida, PR 00650	March 6, 2003
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*	**Dirección / *Address***	**Fecha de Efectividad** ***Effective Date***
Alvarado Sánchez, Mayda C.	56 Georgetti St. Comerío, PR 00782	September 3, 1997
Alvarez Valentin, Mario	Urb. Valencia 1 52 Calle Pedro Cruz-Marg Juncos, PR 00777	July 18, 2002
Arce Forestier, Nestor	3 Muñoz Rivera St. Camuy, PR 00627	August 20, 1998
Arrillaga, Abenamar	Ext. Hermanas Davila / 23 - J St. Bayamón, PR 00959	May 18, 2000
Atocha Sánchez, José M.	720 Ponce De León Ave. San Juan, PR 00918	April 29, 1996
Baco Cuebas, German A.	Urb. Ponce De Leon 11 Calla Granada Mayaguez, PR 00680	January 20, 2003
Baez López, Roberto	Calle Victor Salaberry #32 Guanica, PR 00653	February 20, 2003
Bailey, Colin D H	227 Golden Rock Dev Est Christiansted St. croix, VI 008204	April 1, 1992
Canabal Enriquez, Jose M	170 Calle Luna San German, PR 00683	April 20, 2003
Caro Acevedo, Eduardo	Santa Rosa Mall Suite 201 - Segundo Nivel Bayamón, PR 00959	March 20, 2002
Cruz Baez, Edgar A	Hospital Dr. Pila / Ave. Las Americas Ponce, PR 00731	February 20, 2003
Davila Aponte, Wanda E	63 Calle Nogal / Monte Casino Toa Alta, PR 00953	May 20, 2002
Escalante Santos, Gilberto	Urb. Summit Hills / 596 Torrecillas St. Rio Piedras, PR 00920	June 10, 1994
Francis Ambulance	99 Manolo Flores St. Fajardo, PR 00738	August 20, 2000
Garcia Medina, Benjamin A	Calle Aibonito 1468 Santurce, PR 00907	April 20, 2003
Grana Díaz, Roberto	Urb Sagrado Corazón 1616 Calle Sta Eduviges San Juan, PR 00926	May 20, 2001
Jimenez Casso, José	Urb. Santa Rosa / 51-37 Ave. Main Bayamón, PR 00959	January 20, 2002
Kutcher Olivo, Roberto	Calle Betances 80 Canóvanas, PR 00629	March 20, 2001
López Morales, Angel	Ave. A Buenas Bloque 20 #31 Urb. Santa Rosa Bayamón, PR 00959	January 20, 2002
Maisonet Correa, Carlos	61 Marginal / Urb. Santa Rosa Bayamón, PR 00960	September 20, 2001

Proveedores Excluídos del Programa Medicare *Providers Excluded from the Medicare Program*		
Nombre / *Name*	**Dirección / *Address***	**Fecha de Efectividad** ***Effective Date***
Mercado Franci, José A.	Villa Clarita 2 / 6 St. # 46 Fajardo, PR 00738	August 20, 2000
Montañez López, Carlos W.	Optica Marbella / Carr. 107 Km 1 Aguadilla, PR 00603	March 20, 2002
Moreno Torres, Edwin	134 Calle José I. Quinton Coamo, PR 00769	December 20, 1998
Olivari Milán, Jose A.	Bo. Miradero / Carr. 102 Km 19 HM 2 Cabo Rojo, PR 00623	April 18, 2002
Ortega Ortíz, Orlando	Bo. Cuevas / Carretera 132 Peñuelas, PR 00624	February 20, 2003
Ortíz Ramos, Jorge L.	17St. - 3D1 / Covadonga Toa Baja, PR 00949	December 20, 1999
Ortíz Vargas, Daniel	Hospital Area de Yauco / Clinicas CASPRI Yauco, PR 00698	February 20, 2003
Perea Vicente, Miguel A.	Ctro. Salud San German / Calle St. Javilla San Germán, PR 00683	February 20, 2003
Pillot Costas, Juan R.	41 Calle Concordia Ponce, PR 00731	April 20, 2003
Pintado García, Isidoro	55 calle Comercio Yauco, PR 00698	June 19, 2003
Quiñones Acevedo, Pablo	Irurregui Plaza 201 Rio Piedra, PR 00925	February 20, 2003
Ramos, Mélendez, Marcos U.	P.O. Box 999 Rio Grande, PR 00745	April 20, 2000
Rivera Cruz, Carlos	205 Lauro Piñero Ave. Ceiba, PR 00735	December 20, 1999
Rivera López, Aixa	Pearl Vision / 52-E José De Diego St. Cayey, PR 00736	September 20, 2000
Rutkowski Whitehead, Morris E.	371 San Jorge St. Santurce, PR 00912	July 14, 1993
Santini Olivieri, Francisco A.	4 Calle Hostos Juana Diaz, PR 00795	April 18, 2002
Soto Santiago, Reynaldo	Res. Levisticos del Oeste / J104 Cabo Rojo, PR 00623	February 20, 2003
Soto Vázquez, Julio M.	Villa Rosa III / B27 - 1St. Guayama, PR 00784	May 17, 1991
Stella, Edgar	513 Street / Tintillo Hills Bayamón, PR 00966	January 29, 1986
Texidor Sánchez, Carmen I.	25 St. - Z-19 / Rio Verde Caguas, PR 00725	August 20, 2000
Vega Delgado, Marisol	Portal De Los Pinos / B19 Calle 2 San Juan, PR 00936	January 20, 2003
Vigo Sierra, Myrna L.	Bo. Miradero / Carr. 102 Km 19 HM 2 Cabo Rojo, PR 00623	April 18, 2002
Yemat Perez, Alex A.	Barrio Obrero / 2041 Calle Borinquen Santurce, PR 00907	May 20, 2002

Relaciones con la Comunidad

MANEJO DEL VOLUMEN DE APELACIONES EN MEDICARE

En un esfuerzo para manejar las apelaciones que llegan durante el año fiscal 2003 con los recursos concedidos, los Centros para Servicios de Medicare y Medicaid (CMS) han provisto guías relativas al proceso de apelaciones.

Las solicitudes de apelación sometidas **sin** la documentación de apoyo necesaria recibirán una prioridad secundaria a las solicitudes de apelación que lleguen **con** la documentación adecuada. Consecuentemente, las determinaciones o decisiones, las solicitudes de apelación (reconsideraciones, revisiones, audiencias con el oficial de audiencias, audiencias ante un juez de Ley Administrativo (ALJ) y referidos de agencias que se someten sin la documentación adecuada para apoyar la contención de que la determinación inicial fue incorrecta posiblemente se retiren.

La siguiente información le ayudará con el proceso de apelación (apelativo) y más específicamente provee una aclaración en cuanto a la información adecuada para someter solicitudes de apelación.

No todas las solicitudes de apelación requerirán que usted someta documentación como expedientes de hospital, informes de procedimiento, resultados de laboratorios, etc. Una gran mayoría de apelaciones resulta de información omitida en la reclamación cuando se sometió para proceso originalmente. Algunos ejemplos incluyen, pero no están limitados a los siguientes:

- Someter un código ICD-9CM de diagnóstico incorrecto
- Omitir los modificadores

Hay casos que requerirán que su oficina someta documentación de apoyo (adicional) al momento de iniciar su solicitud apelativa. Sólo usted puede decidir qué documentación apoya mejor su reclamación. Por favor, provea toda información y documentación relevante al momento que solicita su apelación inicial.

Community Relations

MANAGING MEDICARE APPEAL WORKLOADS

In an effort to manage incoming appeals during fiscal year (FY) 2003 with the given resources, the Centers for Medicare & Medicaid Services (CMS) have provided guidance relative to processing appeals.

*Incoming appeal requests submitted **without** necessary supporting documentation will be given secondary priority to appeal requests submitted **with** appropriate documentation. Consequently, determinations or decisions on appeal requests (reconsiderations, reviews, Hearing Officer hearings, Administrative Law Judge (ALJ) hearings, and agency referrals) that are submitted without appropriate documentation to support the contention that the initial determination was incorrect could possibly be delayed.*

The following information will assist you with the appeals process, and more specifically, provide clarification regarding the appropriate information to submit with appeal requests.

Not all review appeal requests will require you to submit documentation such as hospital records, procedure reports, lab results, etc. A large majority of appeals result from information that was omitted from the claim when it was originally submitted for processing. Examples include, but are not limited to the following:

- *Submission of an incorrect ICD-9-CM diagnosis code*
- *Omission of modifiers*

There are instances that will require your office to submit supporting documentation at the time of your initial appeal request. Only you can decide which documentation best supports your claim. Please provide all relevant information and documentation at the time the initial appeal is requested.

CR2330/AB-03-052/05-02-03/FMR/els/em

Relaciones con la Comunidad

"QUARTERLY PROVIDER UPDATE"

El "Quarterly Provider Update" es un recurso comprensivo publicado por los Centros para Servicios de Medicare y Medicaid (CMS) el primer día laboral de cada trimestre. Detalla todos los cambios no reguladores a Medicare incluyendo memorandos del Programa, cambios a los manuales, y de cualquier otra instrucción que podría afectar al proveedor. Las regulaciones y las instrucciones publicadas en el trimestre anterior también se incluyen en la actualización. El propósito del "Quarterly Provider Update" es:

- Informar sobre nuevos desarrollos en el Programa;
- Ayudar a entender los programas de CMS y a cumplir con las regulaciones e instrucciones de Medicare;
- Asegurar tiempo para reaccionar y para prepararse para los nuevos requisitos;
- Anunciar lo nuevo y los cambios en un itinerario predecible;
- Comunicar los días específicos en que los asuntos de CMS serán publicados en el "Federal Register".

Para recibir notificación cuando las regulaciones e instrucciones del programa se actualizan durante el trimestre, suscríbase al envío electrónico del "Quarterly Provider Update" a través de la siguiente dirección: http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1

El "Quarterly Provider Update" se puede acceder en http://www.cms.gov/providerupdate/main.asp.

Le sugerimos conserve esta dirección electrónica entre sus favoritas y que la visite a menudo para obtener información valiosa.

Community Relations

QUARTERLY PROVIDER UPDATE

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, Manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- *Inform providers about new developments in the Medicare program;*
- *Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;*
- *Ensure that providers have time to react and prepare for new requirements;*
- *Announce new or changing Medicare requirements on a predictable schedule; and*
- *Communicate the specific days that CMS business will be published in the Federal Register.*

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list) at http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1

The Quarterly Provider Update can be accessed at http://www.cms.gov/providerupdate/main.asp .

We encourage you to bookmark this Web site and visit it often for this valuable information.

CR2686/PM-AB-03-075/5-23-03/dmg

SERVICIOS DE ADIESTRAMIENTO PARA EL AUTO-MANEJO DE LA DIABETES

El servicio de Adiestramiento para el Auto Manejo de la Diabetes (DSMT, por sus siglas en inglés) es un programa que educa y motiva a los beneficiarios para lograr un exitoso auto manejo de la diabetes. El programa incluye: educación relacionada con auto monitorizar el azúcar en sangre, dietas y ejercicios y un plan de tratamiento diseñado específicamente para pacientes quienes son insulina dependiente.

Los servicios de DSMT se pagarán sólo si el médico o el profesional de la salud cualificado, que administra la condición de diabetes del beneficiario, certifica que dichos servicios son necesarios y refiere al paciente al programa. El referido debe incluir un plan de cuidado médico completo relacionado a la condición diabética del beneficiario.

Un médico, individuo o entidad puede ofrecer los servicios de DSMT siempre y cuando cumpla con lo siguiente:

- Provea otros servicios para los cuales Medicare puede pagar;
- Pueda recibir pagos de Medicare según **42 Code for Federal Register (CFR) 424.73 o 424.80**, la cual expone las prohibiciones bajo la asignación de beneficios y re-asignación de reclamaciones;
- Someta documentación necesaria a, y es acreditado por, una organización acreditativa aprobada por los Centros de Servicios para Medicare y Medicaid (CMS, según sus siglas en inglés) conforme a **42 CFR 410.142** para cumplir con el conjunto de estándares de calidad descritos en **42 CFR 410.144** y;
- Suministra a CMS documentación, según solicitada, incluyendo los resultados medidos de la diabetes desarrollados en **42 CFR 410.146**.

DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES

A Diabetes Outpatient Self-Management and Training (DSMT) service is a program that educates beneficiaries in the successful self-management of diabetes. This program provides education on self-monitoring of blood glucose, diet and exercise. It includes an insulin treatment plan, developed specifically for the patient who is insulin-dependent and motivates patients to use the skills for self-management.

DSMT services are covered only if the physician or qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed and refers the patient to the DSMT program. The referral must be done under a comprehensive plan of care related to the beneficiary's diabetic condition.

A physician, individual or entity that meet the following conditions may provide DSMT services if:

- *Furnishes other services for which direct Medicare payment may be made;*
- *May properly receive Medicare payment under **42 Code for Federal Register (CFR) 424.73 or 424.80** which sets forth prohibitions on assignment and reassignment of claims;*
- *Submits necessary documentation to, and is accredited by, an accreditation organization approved by The Centers for Medicare and Medicaid Services (CMS) under **42 CFR 410.142** to meet one of the sets of quality standards described at **42 CFR 410.144** and;*
- *Provides CMS with documentation, as requested, including diabetes outcome measurements set forth at **42 CFR 410.146**.*

Cont. on next page

Relaciones con la Comunidad

Cualquier proveedor o suplidor que ofrezca otros servicios o suplidos individuales de acuerdo con Medicare y cumpla con los estándares de calidad al igual que las estipulaciones aprobadas por CMS conforme a **42 CFR 410.145,** podrá recibir reembolso por el adiestramiento para el auto-manejo de la diabetes. La *norma "incidental" de supervisión y otros requisitos "incidental"* de la §1861 (s)(2)(A) de la ley de Seguro Social *no aplican a los servicios de DSMT*. Es más probable que las entidades y no los individuos facturen por los servicios de DSMT. Estos proveedores certificados tienen que recibir pagos actualmente por otros servicios de Medicare.

Community Relations

*Any certified provider or supplier that furnishes other individual items or services under Medicare that meet CMS' quality standards and meet the conditions for CMS approval pursuant to **42 CFR 410.145**, may receive reimbursement for diabetes training. The "incident to" supervision rules and other "incident to" requirements of §1861 (s)(2)(A) of the Social Security Act do not apply to DSMT services. Entities are more likely than individuals to bill for DSMT services. These certified providers must be currently receiving payment for other Medicare services.*

CR2157/B-03-043/5-23-03/els

DIRECTORIO NACIONAL DE MÉDICOS PARTICIPANTES

El Directorio Nacional de Médicos Participantes contiene información importante sobre los médicos participantes de Medicare para el uso de beneficiarios, sus familiares y sus cuidadores.

Con el propósito de asegurarnos que el Directorio incluya la información más reciente, los médicos participantes podrán verificar la exactitud de sus listas y usar la página electrónica de Medicare para notificar a CMS sobre alguna información incorrecta, algún cambio o para dejar saber que sus nombres no se encuentran en el Directorio.

INFORMACIÓN INCLUIDA EN EL DIRECTORIO

- √ Nombre y dirección
- √ Especialidad médica
- √ Número teléfono oficina
- √ Universidad y año de graduación
- √ Certificación de especialidad médica
- √ Género
- √ Privilegios de hospital

NATIONAL PARTICIPATING PHYSICIAN DIRECTORY

The National Participating Physician Directory contains valuable information about Medicare participating physicians for the use of beneficiaries, their families, and their caregivers.

In order to ensure that the Directory includes the most up-to-date information, practicing physicians should check the accuracy of their listings and use the feedback tool on our web site to notify CMS about any information that is incorrect, has changed, or to advise us if you are not listed in the Directory.

INFORMATION INCLUDED IN THE DIRECTORY

- √ *Name and address (including a mapping feature)*
- √ *Medical specialty*
- √ *Business telephone number*
- √ *Medical school and year of graduation*
- √ *Board certification in a medical specialty*
- √ *Gender*
- √ *Hospital affiliation*

Relaciones con la Comunidad

- √ Conoce otros idiomas
- √ Programa de residencia o internado (pronto)
- √ Sanciones contra médicos (pronto)
- √ Si aceptan pacientes nuevos de Medicare (pronto)

Cómo Verificar la Exactitud de Su Información

La exactitud de esta lista puede verificarse oprimiendo "Directorio de Médicos Participantes" en la página electrónica de Medicare (www.Medicare.gov). Esta página tiene disponible el mecanismo para corregir cualquier información incorrecta y realizar algún cambio o para dejar saber que su nombre no se encuentra en el Directorio. El Directorio se actualizará mensualmente. Para información adicional sobre el Directorio, oprima en "Physician Note" que se encuentra al final de la página. También puede acceder al Directorio desde la página electrónica de CMS (www.cms.hhs.gov/physicians) bajo "Participation".

NOTA: Solamente médicos participantes que aceptaron la asignación en todas las reclamaciones de Medicare y servicios cubiertos están incluidos en el Directorio.

Community Relations

- √ *Foreign language*
- √ *Residency and internship program (coming soon)*
- √ *Sanctions against individual physicians (coming soon)*
- √ *Whether accepting new Medicare patients (coming soon)*

How to Check Accuracy of Your Information

The accuracy of your listing can be checked by clicking on the "Participating Physician Directory "from the home page of Medicare (www.Medicare.gov). Our feedback tool is available to correct any information that is incorrect, has changed, or to advise us if you are not listed in the Directory. The Directory will be updated on a monthly basis. For additional information about the Directory, click on "Physician Note" at the bottom of the page. You may also link to the Directory from the CMS web site at www.cms.hhs.gov/physicians under "Participation".

***NOTE**: Only participating physicians who have agreed to accept assignment on all Medicare claims and covered services are included in the Directory.*

JSM 1987/06/0903/nls/dmg

Relaciones con la Comunidad

TRANSFERENCIA ELECTRÓNICA DE FONDOS

El método de pago directo a través de transferencia electrónica (EFT por sus siglas en inglés) permite que Medicare le deposite sus pagos a su cuenta bancaria. Dicha transferencia puede realizarse a su cuenta de cheques o ahorros del banco de su preferencia.

Los depósitos que Medicare efectúe a su cuenta bancaria serán debidamente informados en los estados de cuenta que mensualmente le envía su banco.

Le incluimos el formulario CMS 588 que debe completar para acogerse a este método de depósito. Debe incluir cheque cancelado si es una cuenta de cheque y copia del estado de cuenta si es de una de ahorros. Debe eliminar toda información personal, excepto el nombre y el número de cuenta.

Para mayor información, favor de llamarnos al 1-877-715-1921.

Community Relations

ELECTRONIC FUNDS TRANSFER

The Electronic Funds Transfer (EFT) payment method allows Medicare to deposit payments directly to your bank account. You can receive your payments deposited to the checking or savings account of the bank of your choice.

The amount Medicare deposits into your account will be duly reported on your bank's monthly account statement.

We include CMS Form 588 which should be completed to enroll in this process. You must inclose a cancelled check, if it's a cheking account or copy of the bank statement, if it's a savings account. Remove all personal information except your name and account number

If you have any doubts, call us at 1-877-715-1921.

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

FORM APPROVED
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFERS

Provider/Physician Name	Provider/Physician ID Number

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

Depository Name	Branch	
City	State	Zip Code
Transit Number	Account Number	

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

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

HCFA-588 (12-92)

Relaciones con la Comunidad

LIMITACIÓN MONETARIA DE RECLAMACIONES POR SERVICIOS DE REHABILITACIÓN A PACIENTES NO HOSPITALIZADOS

Este artículo explica la aplicación de limitación monetaria de los Centros de Servicios de Medicare y Medicaid (CMS, por sus siglas en inglés) para los servicios de rehabilitación a pacientes no hospitalizados. Estos servicios incluyen Terapia Física (PT, por sus siglas en inglés), Patología del Habla y Lenguaje (SLP) y Terapia Ocupacional (OT) para reclamaciones sometidas con fecha de servicio del 1 de julio de 2003 en adelante.

Trasfondo

La limitación monetaria para los servicios de terapia física en práctica independiente a pacientes no hospitalizados comenzó en el 1972; la de terapia ocupacional en 1987. El "Balanced Budget Act" del 1997 aumentó los límites presupuestarios para incluir todos los servicios de PT, SLP y OT en toda práctica independiente, excepto servicios ambulatorios de hospital. Estos límites entraban en vigor en 1999, pero no se implementaron debido a los asuntos del año 2000. El "Balanced Budget Refinement Act" de 1999 y el "Benefits Improvement and Protection Act" del 2000 suspendieron las limitaciones para los años 2000, 2001 y 2002. La moratoria expiró el 31 de diciembre de 2002.

Descripción

Los límites aplican a los servicios de terapia de rehabilitación (PT, SLP y OT) provistos por cualquier proveedor/suplidor excepto servicios de terapia a pacientes no hospitalizados en: 1) un hospital a un paciente no internado o a un paciente internado que haya agotado los beneficios de la Parte A y 2) otra entidad bajo arreglo con un hospital para proveer estos mismos servicios.

NOTA: Únicamente los servicios facturados por el hospital como facturas tipo 12x ó 13x están exentos de las limitaciones en los servicios de terapia.

Community Relations

FINANCIAL LIMITATION OF CLAIMS FOR OUTPATIENT REHABILITATION SERVICES

This article explains the Centers for Medicare & Medicaid Services' (CMS) implementation of the financial limitation for outpatient rehabilitation services including physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) claims submitted with dates of service on and after July 1, 2003.

Background

Financial limits on outpatient PT services provided in private practice settings began in 1972, and included OT services provided in private practice settings in 1987. The Balanced Budget Act of 1997 expanded the caps to include all PT, SLP, and OT services in every outpatient setting except outpatient hospital. These caps were effective in 1999, but were not fully implemented due to Y2K issues. The Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 suspended the caps for the years 2000, 2001, and 2002. The moratorium expired on December 31, 2002.

Description

The caps apply to outpatient rehabilitation (PT, SLP, and OT) services provided by any provider/supplier except outpatient therapy services provided by: 1) a hospital to an outpatient or to an inpatient who has exhausted Part A benefits and 2) another entity under an arrangement with a hospital to provide the same services to the same beneficiaries.

***NOTE:** Only services billed by the hospital as bill type 12x or 13x are exempt from limitations on therapy services.*

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Relaciones con la Comunidad

Para instituciones de Enfermería Especializada (SNF, por sus siglas en inglés) esta limitación aplica a los servicios de rehabilitación provistos a aquellos residentes de la institución SNF en estadías no cubiertas (tipo 22x) que están en una sección de la institución certificada por Medicare – ejemplo: una que está certificada sólo por Medicare o que está igualmente certificada por Medicare como SNF y por Medicaid como una institución de Asistencia de Enfermería (NF, por sus siglas en inglés).

Para los residentes de las instituciones SNF, la facturación consolidada requiere que todos los servicios de rehabilitación a pacientes no hospitalizados sean facturados a la Parte B por la institución.

Si un residente ha alcanzado la limitación monetaria y permanece en la sección de la institución SNF certificada por Medicare, no se hará ningún otro pago a la SNF ni a ninguna otra entidad. Por lo tanto, los residentes de una SNF que están sujetos a la facturación consolidada no podrán obtener servicios de un hospital como paciente no internado luego de haber excedido las limitaciones.

Una vez alcanzada la limitación monetaria, los residentes del SNF que están en una sección no certificada por Medicare – ejemplo: una certificada solamente por Medicare como NF o no certificada por algún programa – se utiliza el tipo de factura 23x. Para residentes del SNF en secciones no certificadas por Medicare y no residente de la SNF que asisten a la SNF para tratamiento externo (factura tipo 23x) el tratamiento de terapia, considerado médicamente necesario, podrá ser cubierto en el departamento de servicios ambulatorios de un hospital luego de haber sobrepasado la limitación monetaria.

Las limitaciones no aplican a residentes de SNF en una estadía cubierta bajo la Parte A, incluyendo “swing beds”. Los servicios de rehabilitación están incluidos en el pago por día que la SNF recibe bajo el Sistema de Pagos Prospectivos (PPS, por sus siglas en inglés) para la estadía cubierta. Igualmente,

Community Relations

For skilled nursing facilities (SNF), this limitation does apply to rehabilitation services furnished to those SNF residents in non-covered stays (bill type 22x) who are in a Medicare-certified section of the facility - i.e., one that is either certified by Medicare alone or is dually certified (by Medicare as a SNF and by Medicaid as a nursing facility (NF)).

For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF.

If a resident has reached the financial limitation and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, SNF residents who are in a non-Medicare certified section of the facility - i.e., one that is certified only by Medicaid as a NF or that is not certified at all by either program - use bill type 23x . For SNF residents in non-Medicare certified portions of the facility and SNF non-residents who go to the SNF for outpatient treatment (bill type 23x) medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded.

Limitations do not apply to SNF residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the PPS for the covered stay. Similarly, limitations do not apply to any therapy services billed under PPS Home Health or inpatient hospitals, including critical access hospitals.

Cont. on next page

Relaciones con la Comunidad

las limitaciones no aplican a los servicios de terapia facturados bajo el PPS de Salud en el Hogar o pacientes internados en un hospital, incluyendo hospitales de acceso crítico.

Los límites aplican a servicios de terapia de rehabilitación a pacientes no hospitalizados provistos por:

- Médicos
- Enfermeros Practicantes (esta especialidad está cubierta en Islas Vírgenes de E.U., pero no en Puerto Rico)
- Enfermeros Clínicos (especialistas)
- Médicos Asistentes (esta especialidad está cubierta en Islas Vírgenes de E.U., pero no en Puerto Rico)
- Terapista Físico
- Terapista Ocupacional
- Patólogos del Habla y Lenguaje

Los arreglos afectados por los límites presupuestarios consisten de todos los arreglos pagados usando las tarifas de pago para médicos de Medicare (excepto el arreglo de servicios ambulatorios de hospital) incluyendo:

- Centros de Servicios de Rehabilitación Inclusiva a pacientes no hospitalizados;
- Proveedores de terapia física a pacientes no hospitalizados, ejemplo: centros/ agencias de servicios ambulatorios de rehabilitación;
- Servicios de la Parte B en instituciones SNF (ver detalles para arreglos con SNF's mencionados arriba);
- Agencias de cuidado en el hogar que proveen terapias a pacientes no confinados al hogar:
- Oficinas de médicos;
- Oficinas de practicantes no médicos y
- Oficinas independientes de Terapista Físico y Ocupacional.

Los límites anuales por beneficiario para el 2003 son:

- $1,590 para PT y SLP combinados
- $1,590 para OT

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The limits apply to outpatient rehabilitation therapy services provided by:

- *Physicians;*
- *Nurse practitioners (This specialty is covered in the U.S. Virgin Islands but not in Puerto Rico);*
- *Clinical nurse specialists;*
- *Physician's assistants (This specialty is covered in the U.S. Virgin Islands but not in Puerto Rico);*
- *Physical therapists;*
- *Occupational therapists; and*
- *Speech-language pathologists.*

Settings affected by the caps consist of all settings paid using the Medicare Physician Fee Schedule except the outpatient hospital setting including:

- *Comprehensive outpatient rehabilitation facilities;*
- *Outpatient physical therapy providers, e.g., outpatient rehabilitation facilities/rehabilitation agencies;*
- *Part B services in skilled nursing facilities (see above details for SNF settings);*
- *Home health agencies providing therapies to patients who are not homebound;*
- *Physician offices;*
- *Non-physician practitioner offices; and*
- *Physical and occupational therapist private practices.*

The 2003 limits per beneficiary per year are:

- *$1,590 for PT and SLP combined; and*
- *$1,590 for OT*

Cont. on next page

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En el 2003 los límites presupuestarios se implementarán a las reclamaciones sometidas a partir del 1 de julio de 2003. Debido a restricciones del sistema, los límites no pudieron implementarse desde el 1 de enero al 30 de junio de 2003. El límite total de $1,590 está disponible para el uso del beneficiario entre el 1 de julio de 2003 al 31 de diciembre de 2003. En el 2004 y años subsiguientes, los límites aplicarán para todo el año.

Instrucciones de Facturación

El servicio de terapia, no importa quien lo realice, debe cumplir con las normas y condiciones que aplican a los servicios de terapia. Por ejemplo: debe haber un plan de cuidado apropiado y documentación que apoye la necesidad médica cada vez que se facturan servicios de terapia a Medicare.

Deducibles y coaseguros se sustraen de la cantidad aprobada. Por ejemplo, si el deducible anual ha sido cubierto y se reciben servicios que suman $1,590 (el límite de la cantidad aprobada), Medicare paga 80% de la cantidad aprobada ($1,272) y el beneficiario paga $318 de coaseguro.

Proveedores/Suplidores deben añadir los modificadores GP, GN, GO a las reclamaciones. Estos identifican el tipo de servicio de terapia (PT, SLP, OT) indicado en el plan de cuidado. Es necesario un plan de cuidado para los servicios de terapia cada vez que éstos, descritos más adelante por los modificadores de servicios de terapia, son facturados a Medicare. Servicios de terapia facturados sin modificadores pertinentes al "Healthcare Common Procedure Coding System" (HCPCS, por sus siglas en inglés) o "revenue codes" serán devueltos.

A partir del 1 de enero de 2003, las definiciones de los modificadores de servicios de terapia cambiaron como sigue:

- GN servicios prestados bajo un plan de cuidado de SLP para paciente no hospitalizado
- GO servicios prestados bajo un plan de cuidado OT para paciente no hospitalizado
- GP servicios prestados bajo un plan de cuidado PT para paciente no hospitalizado

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In 2003, the caps will be implemented beginning with claims submitted for dates of service on and after July 1, 2003. Due to systems limitations, the caps could not be implemented between January 1, 2003 and June 30, 2003. The full $1590 limit is available for beneficiary use between July 1, 2003 and December 31, 2003. In 2004 and subsequent years, the caps will apply to the entire year.

Billing Instructions

Therapy services, no matter who performs them, must meet the standards and conditions that apply to therapy services. For example, there must be an appropriate plan of care and documentation that supports medical necessity whenever therapy services are billed to Medicare.

Deductibles and co-insurance are subtracted from the allowed amount. For example, if the deductible for the year has been met and services are received that total $1,590 (the limit of the allowed amount), Medicare pays 80 percent of the allowed amount ($1,272) and the beneficiary pays $318 in co-insurance.

Providers/suppliers must continue to add a modifier (GP, GN, GO) to claims, which identify the type of service (PT, SLP, OT) that represents the therapy plan of care. A therapy plan of care is required whenever therapy services, represented by therapy codes noted below, are billed to Medicare. Therapy service claims without modifiers on applicable HCPCS or revenue codes will be returned.

Effective January 1, 2003 the definitions of the therapy modifiers have been changed as follows:

- *GN Services delivered under an outpatient speech-language pathology plan of care*
- *GO Services delivered under an outpatient occupational therapy plan of care*
- *GP Services delivered under an outpatient physical therapy plan of care*

Cont. on next page

Relaciones con la Comunidad

Estos modificadores no permiten que un proveedor rinda servicios para los cuales no está reconocido por Medicare para prestar.

Solamente los servicios de PT, SLP y OT están incluidos en las limitaciones. Otros servicios tales como terapia respiratoria o nutricional no deben usar los modificadores GN, GO, GP. Por ejemplo, si un audiólogo (especialidad "64'') realiza un procedimiento audiológico (HCPCS), los modificadores mencionados no deben utilizarse, ya que estos procedimientos no están sujetos a la limitación monetaria.

NOTA: Por primera vez se seguirán de cerca estos límites para todos los proveedores/suplidores, incluyendo reclamaciones de médicos y practicantes no médicos (NPP, por sus siglas en inglés). El pago de la reclamación depende del uso del modificador. Por consiguiente, todos, incluyendo médicos y NPPS que proveen estos servicios, deben asegurarse de que el modificador adecuado (GN, GO o GP) es incluido en cada código por servicios de terapia. Los modificadores deben reflejar el plan de cuidado bajo el cual el servicio se prestó antes que la especialidad de la persona que provee el servicio. Algunos códigos HCPCS pueden utilizarse bajo más de un tipo de plan de cuidado (PT,OT,SLP), en cuyo caso el médico o NPP debe escoger el modificador adecuado a su plan. El no incluir uno de los modificadores para estos servicios resultará en la devolución de la reclamación sin procesar.

Códigos HCPCS Aplicables a los Servicios de Rehabilitación a Pacientes No Hospitalizados

Los siguientes códigos aplican a cada limitación monetaria, excepto según indicado más adelante. (**NOTA:** La lista de los códigos no implica que los servicios estén cubiertos.)

Community Relations

These modifiers do not allow a provider to deliver services that they are not recognized by Medicare to perform.

Only physical therapy, occupational therapy and speech-language pathology services are included in the limitations. Other services such as respiratory therapy, or nutrition therapy should not use the GN, GO and GP modifiers. For example, if an audiologist (specialty code "64") performs an audiology procedure (HCPCS), the above modifiers should not be reported, as these procedures are not subject to the financial limitation.

***NOTE:** For the first time, these limits will be tracked for all provider/supplier types, including physicians' and non-physician practitioners' (NPP) claims. Claim payment depends on the use of the modifier. Therefore everyone, including physicians and NPPs who provide these services, should make certain that the appropriate modifier (GN, GO or GP) is included on each code for therapy services. Modifiers should reflect the plan of care under which the service is provided, rather than the specialty of the person who provides the service. Certain HCPCS codes may be used under more than one type of plan of care (PT, OT, SLP), in which case the physician or NPP should chose the appropriate modifier for their plan. Failure to include one of these code modifiers for these services will result in the claim/service being returned as unprocessable.*

Applicable Outpatient Rehabilitation HCPCS Codes

*The following codes apply to each financial limitation except as noted below. (**NOTE:** Listing of the following codes does not imply that services are covered.)*

Cont. on next page

Códigos HCPCS Aplicables para los Servicios de Rehabilitación a Pacientes Externos
Applicable Outpatient Rehabilitation HCPCS Codes

29065+	29075+	29085+	29086+	29105+	29125+	29126+	29130+	29131+	29200
29220	29240	29260	29280	29345+	29355+	29365+	29405+	29425+	29445+
29505+	29515+	29520	29530	29540	29550	29580+	29590	64550	90901
90911	92506	92507	92508	92526	92597	92601++	92602++	92603++	92604++
92607	92608	92609	92610	92611	92612	92614	92616	95831	95832
95833	95834	95851	95852	96000	96001	96002	96003	96105	96110*
96111	96115	97001	97002	97003	97004	97012	97016	97018	97020
97022	97024	97026	97028	97032	97033	97034	97035	97036	97039
97110	97112	97113	97116	97124	97139	97140	97150	97504**	97520
97530	97532	97533	97535	97537	97542	97601+	97703	97750	97799*
V5362*	V5364*	V5363*	G0279***	G0280***	G0281	G0283	0020T***	0029T***	

*****El resumen del archivo de las tarifas de pagos a médicos no indica un precio para los códigos 96110, 97799, V5362, V5363 y V5364 ya que el contratista establece los precios. Por lo tanto, debe contactar al contratista para obtener la tarifa correcta de estos códigos.

******El código 97504 no debe informarse con el código 97116. No obstante, sí el código 97504 se realizó en una extremidad superior y el código 97116 (adiestramiento para caminar) también se realizó, ambos códigos pueden facturarse con el modificador 59 para señalar una región anatómica distinta.

*******El resumen del archivo de tarifas no indica un precio para los códigos G0279, G0280, 0020T, 0029T ya que el contratista fija el precio. Por lo tanto, debe contactar al contratista para obtener la cantidad correcta.

+Estos códigos para yesos y entablillados no aplicarán a las limitaciones monetarias cuando los facturan médicos y NPPS. Cuando estos códigos son facturados por otros proveedores/ suplidores (facturas tipo 22x,23x,34x,74x, y 75x) o por terapista físico u ocupacional en práctica independiente, especialidades “65” y “67”, estos deben facturar con el modificador GO o GP. Las especialidades “73” y “74” no se incluyen porque ya no aplican.

++Si un procedimiento de audiología (HCPCS) es realizado por un audiólogo, los modificadores anteriores no deben utilizarse ya que estos procedimientos no están sujetos a la limitación monetaria.

*******The physician fee schedule abstract file described below does not contain a price for codes 96110, 97799, V5362, V5363, and V5364 since they are priced by the carrier. Therefore, contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.*

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

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

+*These codes for casts and splints will not apply to the financial limitations when billed by physicians and NPPs, as appropriate. When these codes are billed by other providers/suppliers (bill types 22X, 23X, 34X, 74X, and 75X) or physical therapists or occupational therapists in private practice, specialty codes “65” and “67,” they must be billed with a GO or GP modifier. Specialty codes 73 and 74 were not included because they are no longer applicable.*

++*If an audiology procedure (HCPCS) code is performed by an audiologist, the above modifiers should not be reported, as these procedures are not subject to the financial limitation. When these HCPCS codes are billed under a speech language pathology plan of care, they should be accompanied with a GN modifier and applied to the financial limitation.*

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Relaciones con la Comunidad

Notificación al Beneficiario

A los proveedores/suplidores se les denegará el pago de los servicios que excedan las limitaciones. Por lo tanto, es recomendado que hagan todo esfuerzo en investigar si un paciente ha recibido terapias previas antes de aceptarlo para tratamiento. Como CMS sólo puede informar sobre reclamaciones sometidas, los proveedores/ suplidores deben llevar la cuenta de los gastos en su propia localidad u oficina e informar al beneficiario cuando es responsable del pago por los servicios. Los proveedores y suplidores deben comunicarle a los beneficiarios que ellos serán responsables del 100 por ciento de los costos de la terapia una vez se alcanza el límite a menos que los servicios adicionales se presten directamente o bajo arreglos con un hospital. Se recomienda que los proveedores/suplidores notifiquen a los beneficiarios sobre esta responsabilidad al primer encuentro para la terapia, de esa manera permiten que los beneficiarios tomen decisiones informadas relacionadas con su cuidado continuo y su responsabilidad monetaria.

CMS desarrolló el Aviso de Exclusión de Beneficios de Medicare (NEMB, por sus siglas en inglés)(Formulario número CMS 20007) para informar a los beneficiarios que los servicios que actualmente reciben están excluidos de los beneficios de Medicare. El uso del NEMB es opcional. Los proveedores/suplidores pueden desarrollar su propio proceso para comunicarle a los beneficiarios que serán facturados por los servicios sobre los límites establecidos. (No utilice el formulario de Aviso Adelantado al Beneficiario).

El Formulario NEMB puede obtenerse en: http://www.cms.hhs.gov/medlearn/refabn.asp. (Baje la página para seleccionar la versión en inglés o español).

En el NEMB marque el encasillado número uno y escriba una razón para las limitaciones como sigue: “”Medicare no pagará por terapia física y patología del habla y lenguaje sobre $ 1,590". Sustituya servicios de terapia ocupacional en lugar de PT y SLP para pacientes bajo un plan de cuidado de OT.

A partir del 1 de julio de 2003, CMS incluirá un mensaje genérico en cada aviso de Resumen

Community Relations

Beneficiary Notification

Providers/suppliers will be denied payment for services that exceed the limitations. Therefore, it is recommended that they make every effort to learn if prior therapy was performed before a patient is accepted for treatment. Since CMS can only report claims that have been submitted, providers/suppliers should track expenditures in their own facility or office and inform beneficiaries when they may become liable for payment. Providers and suppliers are encouraged to inform beneficiaries that they will be responsible for 100 percent of therapy costs after the limit has been met unless additional services are furnished directly or under arrangement by a hospital. It is recommended that they notify beneficiaries about this responsibility at the first therapy encounter, thereby allowing beneficiaries to make informed decisions regarding their continued care and financial responsibility.

CMS developed the Notice of Exclusion from Medicare Benefits (NEMB) (Form No. CMS-20007) to assist in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. Use of the NEMB form is optional. Providers/suppliers may develop their own process to communicate to beneficiaries that they will be billed for services over the cap. (Do not use the Advance Beneficiary Notice form.)

The NEMB form can be found at: http://www.cms.hhs.gov/medlearn/refabn.asp. (Page down twice for both English and Spanish versions.)

On the NEMB, check Box #1 and write a reason for the limitations as follows: “Medicare will not pay for physical therapy and speech-language pathology over $1,590. Substitute “occupational therapy services” in place of PT and SLP for patients under an OT plan of care.

Beginning on July 1, 2003, CMS will include a generic message on each Medicare

Cont. on next page

de Medicare (MSN, por sus siglas en inglés) que incluya servicios de terapia. En éste, explicará que Medicare provee hasta un máximo de $1,590 para servicios de terapia física y patología del habla y lenguaje combinados y hasta $1,590 para terapia ocupacional y que servicios adicionales, médicamente necesarios, sobre estos límites son cubiertos solamente en el Departamento de Servicios Ambulatorios de un hospital. CMS seguirá de cerca el total de los costos aprobados para los servicios de terapia sometidos para pago. Los beneficiarios recibirán un mensaje en el MSN cuando el límite presupuestario ha sido excedido y el pago es denegado. Comenzando el 1 de octubre de 2003, CMS incluirá un mensaje en el MSN que informará al beneficiario la cantidad acumulada del límite presupuestario para los costos aprobados para este año calendario. Proveedores con acceso a HIQA pueden obtener las cantidades acumuladas por beneficiario de esta base de datos. Cuando HIPAA entre en vigor (planificado para octubre de 2003) las cantidades acumuladas para terapia estarán disponibles en las pantallas ELGA y ELGB. Los beneficiarios y proveedores que no pueden acceder esta información pueden contactar al Centro de Llamadas de su intermediario o contratista para obtener estas cantidades.

Apelaciones

Beneficiarios pueden apelar las reclamaciones denegadas por haber excedido el límite presupuestario para terapias. Se debe asesorar al beneficiario sobre sus derechos apelativos establecidos en el **Código 42 del Registro Federal (CFR) Parte 405, Sub-parte G**. Médicos, terapista y otros proveedores que acepten la asignación de beneficio también pueden apelar las denegaciones. Aquellos que no acepten la asignación de beneficios y proveedores institucionales no tienen derecho apelativo.

Para información adicional sobre la limitación monetaria para servicios de rehabilitación a pacientes no hospitalizados, refiérase a la presentación en Power Point que CMS desarrolló para ayudar a los proveedores a entender estos límites monetarios, en: http:/www.cms.hhs.gov/medlearn/therapy.

Summary Notice (MSN) containing therapy services which states that Medicare provides up to $1,590 a year for PT and SLP services combined and up to $1,590 for OT services and that additional medically necessary services over these limits are covered only in a hospital outpatient department. CMS will track the total dollar amount of allowed costs for therapy services reported for payment. Beneficiaries will receive a message on the MSN indicating when the caps have been exceeded and payment is denied. Beginning October 1, 2003, CMS plans to include an MSN message that informs beneficiaries of the amount of allowed cost that has accrued during this calendar year toward the cap. Providers (facilities) with access to HIQA may obtain the accrued amounts for beneficiaries from this database. When HIPAA goes into effect, (planned for October 2003) the accrued therapy amounts will be available on the ELGA and ELGB screens. Beneficiaries and providers without access to this information may contact the call center at their intermediary or carrier to obtain these amounts.

Appeals

*Beneficiaries may appeal claims denied due to exceeding therapy caps. The beneficiary is to be advised of his or her appeal rights set forth in **42 Code for Federal Register (CFR) Part 405, subpart G**. Physicians, therapists, and other suppliers who accept assignment may also appeal denials. Physicians, therapists and other suppliers who do not accept assignment, and institutional providers do not have the right to appeal.*

For additional information about the financial limitation for outpatient rehabilitation services, refer to a PowerPoint presentation that CMS developed to assist providers in understanding these financial limits at http://www.cms.hhs.gov/medlearn/therapy.

CR2306/AB-03-073/5-23-03/els

Reclamaciones

COBRO DE TARIFAS POR SERVICIOS PAGOS HECHOS DURANTE PERÍODOS DE INSCRIPCIÓN DE CUIDADO DIRIGIDO

Este artículo provee guías a los médicos, proveedores y suplidores con relación a las actividades de cobro por pagos en exceso que el Centro para Servicios de Medicare & Medicaid (CMS, por sus siglas en inglés) asociará las aprobaciones erróneas en el pago de tarifas por servicios (FFS) en las reclamaciones durante los períodos de cuidado dirigido.

El BBRA (Budget of Reconciliation Act) de 1999 requiere "inscripción del mes en curso," lo que significa que la fecha de efectividad de la inscripción está basada en la fecha en que el beneficiario firma una solicitud de matrícula en una organización de Medicare Plus Choice. La fecha de efectividad de la inscripción, así como la fecha de M+CO es responsable en proveer los servicios de Medicare al beneficiario, es el primer día del mes siguiente luego que el beneficiario completó y firmó la solicitud para la inscripción del M+CO.

Los sistemas de información electrónica de CMS pueden experimentar retrasos durante el tiempo en que servicios de Medicare y artículos se pagan doble: a través de la tarifa por servicios (FFS) el contratista de Medicare y el sistema de pago del Cuidado Dirigido en una tasa per capita mensual para el beneficiario. Cuando el sistema de información reconoce que el beneficiario está inscrito en un M+CO, el M+CO recibe los pagos por capita por el beneficiario, retroactivo a la fecha de efectividad de la inscripción. Durante el período de tiempo entre la fecha de efectividad de la inscripción y cuando los sistemas de información se actualizan, médicos, proveedores y suplidores no podían estar informados de la inscripción del beneficiario en el M+CO y facturar por el sistema de tarifa por Servicios y artículos prestados al beneficiario.

Claims

COLLECTION OF FEE-FOR-SERVICE PAYMENTS MADE DURING PERIODS OF MANAGED CARE ENROLLMENT

This article provides guidance for physicians, providers, and suppliers regarding overpayment recovery activities that the Centers for Medicare & Medicaid Services (CMS) will undertake connected to erroneous approvals for payment of fee-for-service (FFS) claims during periods of Managed Care enrollment.

The 1999 Balanced Budget Reconciliation Act (BBRA) requires "current month enrollment," which means that the effective date of enrollment is based upon the date a beneficiary signs an application for enrollment in a Medicare + Choice Organization (M+CO). The effective date of enrollment, as well as the date the M+CO is responsible for providing Medicare services to the beneficiary, is the first day of the month following receipt of the beneficiary's completed, signed application for enrollment in the M+CO.

The CMS electronic data systems may experience time lags, during which time Medicare services and items are paid twice: through the FFS Medicare contractor and the Managed Care Payment systems in the monthly capitation rate for the beneficiary. When the electronic data systems recognize that a beneficiary has enrolled in a M+CO, the M+CO receives capitation payments for the beneficiary, retroactive to the effective date of enrollment. During the period of time between the effective date of enrollment and when the CMS electronic data system updates, physicians, providers, and suppliers may not be aware of the beneficiary's enrollment in the M+CO and bill the Medicare FFS system for services and items provided to that beneficiary.

Reclamaciones

Efectivo al 1 de octubre de 2003 el contratista de CMS iniciará los procedimientos de cobro por pagos en exceso para retirar los pagos originales de la Parte A y B y generar ajustes para actualizar o cancelar reclamaciones asociadas a aprobaciones incorrectas de pagos por la Tarifa por Servicios (FFS) durante los períodos de inscripción de cuidado dirigido.

Si tiene preguntas relacionadas con este artículo, favor de comunicarse con uno de nuestros representantes de servicio de Relaciones con la Comunidad al 1-877-715-1921, quien gustosamente le atenderá.

Claims

Effective October 1, 2003, CMS contractors will initiative overpayment recovery procedures to retract original Part A and Part B payments and generate adjustments to update or cancel claims connected to erroneous approvals for payment of FFS claims during periods of Managed Care enrollment.

If you have questions regarding this article, please contact our Community Relations Customer Representatives at 1-877-715-1921, who will gladly assist you.

ICD-9-CM DIAGNOSTIC CODES UPDATE

In accordance with instructions issued by the Centers for Medicare & Medicaid Services (CMS) physicians may begin using the updated ICD-9-CM codes for claims submitted on October 1, 2003 and thereafter. The new, revised and deleted ICD-9-CM codes have been posted at the Centers for Medicare and Medicaid Services (CMS) Website at the following address: http://www.cms.hhs.gov/medlearn/icd9code.asp.

The update of the ICD-9-CM codes may be obtained at:

American Medical Association
P.O. Box 7046Dover, DE 19903
1-800-621-8335

The old or new ICD-9-CM codes will be accepted from October 1, 2003 through December 31, 2003. Starting January 1, 2004, the updated codes must be used. It is important that you use the most recent version of the ICD-9-CM coding book and code the highest level of specificity.

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