Medicare Informa
División Medicare / Parte B

¡Qué Bueno Que Preguntó!

TRANSACCIÓN 270/271 – PETICIÓN Y RESPUESTA DE INFORMACIÓN DE ELEGIBILIDAD

A diferencia de otras transacciones electrónicas implantadas por Medicare, las peticiones de información de elegibilidad no serán procesadas por el contratista de Medicare. Estas transacciones serán dirigidas al archivo común (CWF) a través de la Red de Centros de Cómputos de Medicare (MDCN).

La petición y respuesta de información de elegibilidad será una transacción en tiempo real. Medicare no aceptará transacciones de elegibilidad en grupo o "batch". Las transacciones de elegibilidad en tiempo real deben componerse de un segmento ISA, GS, ST, SE, GE y IEA. La versión requerida para la transacción 270/271 es 4010A1.

Cont. en la página 4

We Are Glad You Asked!

270/271 – ELIGIBILITY INQUIRY / RESPONSE IMPLEMENTATION

Unlike other Electronic Data Interchange (EDI) transactions implemented by Medicare, electronic eligibility queries will by-pass the Medicare contractors and will be routed to the Common Working File (CWF) region via a connection to the Medicare Data Center Network (MDCN) through the appropriate data center.

Eligibility inquiry and response transactions will be real-time. Medicare will not support batch eligibility transactions. Real-time 270s are to be submitted as one ISA- one GS- one ST- one SE- one GE- one IEA. Usage of the 4010A1 version of the 270/271 transaction is required.

Cont. on page 4

Emission Date: September 19, 2003

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

Volume 75 / July, Aug., and Sept.,2003

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 libre de cargo en nuestra página de internet en 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

AMA DISCLAIMER OF WARRANTIES AND LIABILITIES

CPT is provided "as is" without warranty of any kind, either expressed or implied, including but not limited to, the implied warranties of merchantability and fitness for a particular purpose. AMA warrants that due to the nature of CPT, it does not manipulate or process dates, therefore there is no Year 2000 issue with CPT. AMA disclaims responsibility for any errors in CPT that may arise as a result of CPT being used in conjunction with any software and/or hardware system that is not Year 2000 compliant. No fee schedules, basic unit, relative values or related listings are included in CPT. The AMA does not directly or indirectly practice medicine or dispense medical services. The responsibility for the content of this file/product is with Triple-S, Inc. and CMS and no endorsement by the AMA is intended or implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, non-use, or interpretation of information contained or not contained in this file/product. This Agreement will terminate upon notice if you violate its terms. The AMA is a third party beneficiary to this Agreement.

Colaboradores en esta Edición:

Reembolso/Contrato/Sistemas

Marilyn Miranda/Everlitz Rosado/Ida Casablanca

Evaluación

Dra. Linda Casado / Rosa González

Reclamaciones

Iván Véliz Santana / Meyra Rivera

Relaciones con la Comunidad

Félix M. Rosario / Eneida Mora

Comunicaciones/Edición/Montaje

Damaris Gill / Eva Lisa Santiago
Nancy Lausell Sáenz / María E. Ortiz

MOA2003

TABLA DE CONTENIDO

AMA DISCLAIMER OF WARRANTIES AND LIABILITIES

CPT is provided "as is" without warranty of any kind, either expressed or implied, including but not limited to, the implied warranties of merchantability and fitness for a particular purpose. AMA warrants that due to the nature of CPT, it does not manipulate or process dates, therefore there is no Year 2000 issue with CPT. AMA disclaims responsibility for any errors in CPT that may arise as a result of CPT being used in conjunction with any software and/or hardware system that is not Year 2000 compliant. No fee schedules, basic unit, relative values or related listings are included in CPT. The AMA does not directly or indirectly practice medicine or dispense medical services. The responsibility for the content of this file/product is with Triple-S, Inc. and CMS and no endorsement by the AMA is intended or implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, non-use, or interpretation of information contained or not contained in this file/product. This Agreement will terminate upon notice if you violate its terms. The AMA is a third party beneficiary to this Agreement.

Contributors to this Edition:

Reimbursement/Contract/Systems

Marilyn Miranda/Everlitz Rosado/Ida Casablanca

Evaluation

Dra. Linda Casado / Rosa González

Claims

Iván Véliz Santana / Meyra Rivera

Community Relations

Félix M. Rosario / Eneida Mora

Communications/Editing/Layout

Damaris Gill / Eva Lisa Santiago

Nancy Lausell Sáenz / María E. Ortiz

MOA2003

TABLE OF CONTENTS

¡Qué Bueno Que Preguntó!

Viene de la Portada...

Los proveedores interesados en utilizar esta transacción deben:

- Establecer una conexión directa con el centro de datos a través de los servicios de IVANS

  o

- Establecer un contrato con un proveedor de servicios que tenga la capacidad de canalizar la transacción de elegibilidad en nombre del proveedor.

¿Quién es IVANS?

IVANS es una entidad que sirve como medio para establecer conexiones a través de la red privada de AT&T. IVANS provee conexión directa para acceder información de elegibilidad para aquellos proveedores autorizados a obtener la misma electrónicamente. Todo contratista de Medicare debe ofrecerle a sus proveedores la opción de conexión a IVANS para obtener información de elegibilidad.

Los proveedores de servicios de salud o suplidores de servicios de información interesados en establecer una conexión con IVANS deben:

1. Solicitar los servicios a través del contratista de Medicare.
2. Someter un contrato de EDI, si no lo han sometido anteriormente.
3. El contratista de Medicare notificará a IVANS y proveerá la información de contacto del proveedor autorizado a obtener información de elegibilidad de Medicare electrónicamente.

Los proveedores que decidan establecer un contrato con otro suplidor de servicios de información deben:

- Firmar un contrato con el suplidor de servicios de información. Este contrato debe incluir especificaciones de seguridad y privacidad, obtener número de identificación y contraseña para acceder la información, instalar cualquier programa requerido por el suplidor y pagar los costos asociados a los servicios.

We Are Glad You Asked!

From the Cover Page...

Providers must decide whether they will:

- *Establish a direct connection with the data center via IVANS*

  or

- *Contract with a network service vendor that will channel eligibility data requests to and from the data center on behalf of the provider.*

Who is IVANS?

IVANS is an agent for establishment of AT&T private network connections. IVANS can supply direct connections for eligibility data retrieval to those providers and network service vendors that have been authorized to access this data electronically. Each Medicare contractor must offer providers and network service vendors the option to connect via IVANS.

Providers or network service vendors interested in establishing an IVANS connection for eligibility data should:

1. *Contact the Medicare contractor to request the services.*
2. *Submit an EDI agreement, if not already in file.*
3. *The Medicare contractor will notify IVANS and supply them with the name and contact information for the provider or network service vendor approved to receive eligibility data from Medicare electronically.*

Providers who decide to contract with another network service vendor must:

- *Sign an agreement with the network service vendor, that includes security and privacy specifications for the data, obtain passwords and ID numbers from that vendor for provider staff authorized to obtain the information, pay costs as assessed by the vendor, and load software from the vendor to establish that connection;*

¡Qué Bueno Que Preguntó!

Viene de la Portada...

- Someter al contratista de Medicare copia del contrato firmado con el suplidor de servicios de información, firmar un contrato de EDI con el contratista de Medicare si no lo ha hecho anteriormente, comprometerse a notificar al contratista de Medicare sobre cualquier cambio en el acuerdo establecido con el suplidor de servicios de información o si cancelan el contrato con dicho vendedor. Si el proveedor no va a realizar otras transacciones electrónicas además a obtener información de elegibilidad, debe modificarse el contrato de EDI para no incluir la información específica a otras transacciones.

Para propósitos de la transacción de elegibilidad, los "clearinghouses" son considerados como suplidores de servicios de información ("network service vendors"). Los "clearinghouses" deben firmar un contrato con el proveedor. Los facturadores que no proveen servicios de traslación se consideran subcontratistas del proveedor. A pesar de que los facturadores están requeridos a firmar un acuerdo de privacidad, no es necesario que firmen un contrato de suplidor de servicios de información.

We Are Glad You Asked!

From the Cover Page...

- *Furnish the Medicare contractor with a signed statement from their authorized network service vendor. Sign a Medicare Electronic Data Interchange (EDI) agreement with the contractor if not previously done, and agree to notify the contractor of any change in vendor or if they cease to use a vendor to obtain eligibility data. In the event the provider will not submit claims electronically, the EDI agreement must be modified to exclude language specific to claims or to transactions other than eligibility queries.*

For eligibility data purposes, clearinghouses authorized to collect eligibility data on behalf of providers are also considered network service vendors and must sign a network service vendor agreement. Billing agents that do not provide translation services are considered provider subcontractors. Although billing agents must sign an agreement with the providers to safeguard beneficiary specific data that may be accessed, a billing agent is not considered a network service vendor for eligibility access purposes and is not required to sign a network service agreement.

CR#2576/AB-03-036/April 15, 2003/js

Health Insurance Portability and Accountability Act (HIPAA)

CÓDIGOS DE TAXONOMÍA PARA LOS PROVEEDORES DE SERVICIOS DE CUIDADO DE LA SALUD

La ley HIPAA establece la utilización de ciertos estándares en las transacciones electrónicas relacionadas a servicios de salud. Algunos de estos estándares son los códigos de taxonomía para los proveedores de servicios de salud (HPTC, por sus siglas en inglés). El código de taxonomía identifica la especialidad del proveedor que ofrece servicios a los beneficiarios.

El "National Uniform Claim Commitee" es la entidad responsable de mantener los códigos de taxonomía. "The Washington Publishing Company" publica las actualizaciones a los códigos de taxonomía a través de su sitio de Internet www.wpc-edi.com. La última actualización a los códigos es la versión 3.0.1 del 1 de abril de 2003. CMS provee una referencia a los códigos de taxonomía en la sección de contratación en su sitio de Internet. El enlace para acceder la referencia que provee CMS es http://cms.hhs.gov/providers/enrollment/taxonomy.pdf.

Nota: Para acceder este documento necesita tener instalado en su computadora el programa Acrobat Reader.

HEALTHCARE PROVIDER TAXONOMY CODES (HPTC) CROSSWALK

The Health Insurance Portability and Accountability Act (HIPAA) mandated the adoption of standards for conducting certain electronic data interchange health transactions. One of these standards is the HPTCs. This is the code that identifies the type of health care provider involved in furnishing services to beneficiaries.

The National Uniform Claim Committee maintains the HPTC set. The Washington Publishing Company (WPC) publishes the code set on its web site www.wpc-edi.com. The latest update is dated April 1, 2003 and the new version is 3.0.1. CMS provides a taxonomy codes crosswalk on the provider enrollment section of their web site. The web link for the crosswalk is http://cms.hhs.gov/providers/enrollment/taxonomy.pdf.

Note: You will need to have Acrobat Reader installed on your computer to access the crosswalk document.

CR2766/PM AB-03-063/August 15, 2003/JS

REMITTANCE ADVICE REMARK AND REASON CODE UPDATE

CMS is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers, including Medicare, have to use reason and remark codes approved by X12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment.

The list of remark codes is available at: http://www.cms.hhs.gov/providers/edi/hipaadoc.asp or at: http://www.wpc-edi.com/hipaa/ and it is updated three times a year.

The Health Care Code Maintenance Committee is responsible for the health care claim adjustment reason codes. The committee did not approve any reason code change in February 2003.

CR2788/PM AB-03-095/July 3, 2003/ICR/els

Health Insurance Portability and Accountability Act (HIPAA)

MÚLTIPLES PAGADORES PRIMARIOS EN RECLAMACIONES MEDICARE PARTE B

A continuación información sobre la facturación de Coordinación de Beneficios a través de la transacción 837:

1. Cuando Medicare es Pagador Secundario después de un Pagador Primario

   La Sección 1.4.2, "Coordinación de Beneficios" de la versión **837 Profesional, Guía de Implementación 4010** (IG, por sus siglas en inglés) ofrece el modelo a seguir al someter reclamaciones de Medicare Pagador Secundario (MSP, por sus siglas en inglés). Puede acceder el IG en: http://hipaa.wpc-edi.com/HIPAA_40.asp. El ejemplo 1 en la Sección 1.4.2.1 discute la metodología de como someter reclamaciones electrónicas proveedor-a pagador-a proveedor. Se debe utilizar la sección y segmento adecuado en la 837 para identificar la cantidad pagada por el otro pagador, la cantidad permitida y la cantidad obligada a aceptar como pago total.

CANTIDAD PAGADA PAGADOR PRIMARIO:

Para la línea de servicio, proveedores y suplidores deben indicar la cantidad pagada por el Pagador Primario por el servicio en la sección ID 2430 SVD02 de la 837.

Para el nivel de información de la reclamación, proveedores y suplidores deben indicar la cantidad pagada por el otro pagador por esa reclamación en la sección ID 2320 AMT02 AMT01=D de la 837.

CANTIDAD PERMITIDA POR EL PAGADOR PRIMARIO:

Para la línea de servicio, proveedores y suplidores indicarán la cantidad permitida de esa línea de servicio por el Pagador Primario en el campo de Cantidad Aprobada, sección ID 2400 AMT02 segmento con el AAE como calificador en el 2400 AMT01 de la 837.

MULTIPLE PRIMARY PAYERS ON MEDICARE PART B CLAIMS

The following information provides assistance on billing Coordination of Benefits through transaction 837:

1. *When Medicare is Secondary Payer Following One Primary Payer*

   *Section 1.4.2, titled "Coordination of Benefits," found in the **837 Professional, version 4010 Implementation Guide (IG)** provides the models to follow for the submission of Medicare Secondary Payer (MSP) claims (you can access the IG at http://hipaa.wpc-edi.com/HIPAA_40.asp). Providers must follow model 1 in section 1.4.2.1 that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. The appropriate loops and segments to identify the other payer paid amount, allowed amount, and the obligated to accept payment in full amount on the 837 must be used.*

PRIMARY PAYER PAID AMOUNT:

For line level services, physicians and suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

For claim level information, physicians and suppliers must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

PRIMARY PAYER ALLOWED AMOUNT:

For line level services, physicians and suppliers must indicate the primary payer allowed amount for that service line in the Approved Amount field, loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837.

Cont. on next page

Para el nivel de información de la reclamación, proveedores y suplidores indicarán la cantidad permitida para el Pagador Primario en el campo de Cantidad Permitida, sección ID 2320 AMT02 AMT01=B6.

CANTIDAD OBLIGADA A ACEPTAR COMO PAGO TOTAL (OTAF, POR SUS SIGLAS EN INGLÉS):

Para la línea de servicio, proveedores y suplidores deben indicar la cantidad OTAF para esa línea de servicio en la sección 2400 CN102 CN101=09. La cantidad OTAF será mayor que cero.

Para el nivel de información de la reclamación, proveedores y suplidores deben indicar la cantidad OTAF en la sección 2300 CN102 CN101=09. La cantidad OTAF será mayor que cero.

2. Cuando Medicare es Pagador Secundario después de dos Pagadores Primarios

Someter Reclamaciones MSP en Papel con Múltiples Pagadores Primarios

Puede haber situaciones cuando más de un Pagador Primario a Medicare paga una reclamación; por ejemplo, un plan de salud grupal del patrono hace un pago primario por un servicio y posteriormente otro plan de salud grupal también hace un pago primario por el mismo servicio. Reclamaciones con múltiples Pagadores Primarios no podrán enviarse electrónicamente a Medicare. Tendrá que someterse la reclamación en el formulario CMS-1500.

Proveedores y suplidores tendrán que enviar a Medicare, junto a la reclamación que se procesará, la Explicación de Beneficios (EOB, por sus siglas en inglés) o la Remesa del otro pagador.

For claim level information, physicians and suppliers must indicate the primary payer allowed amount in the Allowed Amount field, Loop ID 2320 AMT02 AMT01 = B6.

OBLIGATED TO ACCEPT AS PAYMENT IN FULL AMOUNT (OTAF):

For line level services, physicians and suppliers must indicate the OTAF amount for that service line in loop 2400 CN102 CN 101 = 09. The OTAF amount must be greater than zero.

For claim level information, physicians and suppliers must indicate the OTAF amount in loop 2300 CN102 CN101 = 09. The OTAF amount must be greater than zero.

2. *When Medicare is the Secondary Payer Following Two Primary Payers*

Submission of Hardcopy MSP Claims With Multiple Primary Payers

There may be situations where more than one primary insurer to Medicare makes payment on a claim; for example, an employer group health plan makes a primary payment for a service and, subsequently, another group health plan also makes a primary payment for the same service. Claims with multiple primary payers cannot be sent electronically to Medicare. A hardcopy claim must be submitted on Form CMS-1500.

Physicians and suppliers must attach the other payers' Explanation of Benefits (EOB), or remittance advice, to the claim when sending it to Medicare for processing.

CR2758/PM B-03-050/07-03-03/els

45 Days Final Policies...

VI/PR-03-001- Transurethral Radiofrequency Destruction of the Prostate (TUNA)

Contractors Policy Number

VI/PR-03-001

Contractor Name

Triple-S, Inc.

Contractor Number

00973

Contractor type

Carrier

LMRP title

Transurethral Radiofrequency Destruction of the Prostate (TUNA)

AMA's CPT copyright statement

"CPT codes, descriptions and other data only are copyright 2001American Medical Association. All rights reserved. Applicable FARS/DFARS Clauses Apply".

CMS National Coverage Policy

Title XVIII of the Social Security Act, Section 1862 (a)(7). This section excludes routine physical examinations.

Primary Geographic Jurisdiction

Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction

N/A

CMS Region

New York, Region II

CMS Consortium

Northeastern

Original Policy Effective Date

July 15, 2003

Original Policy Ending Date

N/A

Revision Effective Date

N/A

Revision Ending Date

N/A

LMRP description

Transurethral radiofrequency thermotherapy of the prostate is a method of treating benign prostatic hypertrophy (BPH). This procedure delivers selective thermal energy to the prostate while preserving the urethra and adjacent structures.

This procedure is also known as transurethral needle ablation of the prostate (TUNA). This procedure uses the TUNA System Catheter that was approved by FDA on October 8, 1996.

TUNA is ordinarily done in an outpatient setting, including the office, and is appropriate when the indications listed below are met.

Indications and limitations of coverage and/or medical necessity

Effective for services provided, transurethral destruction of prostate tissue, by radiofrequency thermotherapy, will be reimbursable for the treatment of hyperplasia of the prostate and the following indications and limitations of coverage are met.

1. Appropriate indications for the use of TUNA are:
    - BPH of significant degree
    - Co-factors, such as cardiac disease, pulmonary conditions or other situations such as electrolyte problems or significant bleeding (as is possible with transurethral prostatectomy) that would pose a significant risk to the patient.
2. Limitations (contraindications) for the use of TUNA are:
    - Prostate or bladder cancer;
    - Prostate gland with an obstructive median lobe;
    - Neurogenic bladder;
    - Active cystolithiasis, gross hematuria, urethral stricture, bladder, neck contracture, acute prostatitis or diabetes mellitus affecting bladder function; or,
    - Active urinary tract infection
3. Use of TUNA is allowed only in the following places of service: (11) office, (21) inpatient hospital, and (22) outpatient hospital.

CPT/HCPCS Section and benefit category

Male genital – Surgery / Physicians' services

CPT/HCPCS codes

53852 Transurethral destruction of prostate tissue; by radiofrequency thermotherapy

Not Otherwise Classified (NOC)

N/A

ICD-9 codes that Support Medical Necessity

600.0 Hypertrophy (benign) of prostate

600.2 Benign localized hyperplasia of prostate

Diagnosis that Support Medical Necessity

Same as above.

ICD-9 codes that do not Support Medical Necessity

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

Diagnosis that not Support Medical Necessity

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

Reasons for denial

- The presence of any or the previously delineated contraindications.
- The safety and efficacy of TUNA for other prostatic conditions has not been established at this time, and are, therefore, not covered by Medicare.
- A claim submitted without one of the ICD-9 CM diagnosis codes listed in the "Covered ICD.9 CM Codes" section of this policy will be denied under 1862(a)(1)(A).
- A claim for services rendered in any place of service other than those indicated as payable in the "Limitations and Indications of Coverage" section of this policy will be denied.
- Documentation (if requested) that does not indicate the required indications.

Non-covered ICD-9 codes

Any ICD-9 CM not included in this policy.

Non-covered diagnosis

Any diagnosis not included in this policy.

Coding guidelines

Procedure code 53852 should be used to report transurethral radiofrequency thermotherapy of the prostate.

If procedure is not performed for the eligible condition and is not reported with the appropriate ICD-9 CM code that represents this condition, the service will be denied. Use of TUNA is only allowed in places of service office (11), inpatient hospital (21), and outpatient hospital (22).

Documentation requirements

The clinical record must document all the required indications and the absence of the limitations (contraindications).

Documentation must be available to Medicare upon request.

Appropriate ICD-9 CM diagnosis code(s) must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.

Utilization guidelines

N/A

Other comments

This Carrier can allow payment only for CPT code 53852. It cannot allow payment for the TUNA catheter, other equipment, supplies, room charge, or facility fee.

For services that exceed the accepted standard of medical practice and may be deemed not medically necessary, the provider must provide the patient with an acceptable advance notice or Medicare's possible denial of payment and a waiver of liability should thus be signed when a provider does not want to accept the financial responsibility of the service.

Sources of Information and basis for decision

TUNA Procedure Manual, VidaMed

Other Carrier policies and Empire Medicare Services (NY)

Local Urology Consultants

Advisory Committee Notes

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

Start date of comment period

March 17, 2003

Ending date of comment period

May 1, 2003

Start date of notice period

June 9, 2003

Revision history

N/A

GGL-1957

45 Days Final Policies...

VI/PR-03-002- Arthrocentesis, Aspiration and/or Injection of Joints, Bursa or Ganglion Cyst

Contractors Policy Number

VI/PR-03-002

Contractor Name

Triple-S, Inc.

Contractor Number

00973

Contractor type

Carrier

LMRP title

Arthrocentesis, Aspiration and/or Injection of Joints, Bursa or Ganglion Cyst

AMA's CPT copyright statement

"CPT codes, descriptions and other data only are copyright 2001American Medical Association. All rights reserved. Applicable FARS/DFARS Clauses Apply".

CMS National Coverage Policy

Title XVIII of the Social Security Act, Section 1862 (a)(7). This section excludes routine physical checkups.

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

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

Primary Geographic Jurisdiction

Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction

N/A

CMS Region

New York, Region II

CMS Consortium

Northeastern

Original Policy Effective Date

June 11, 2001

Original Policy Ending Date

July 24, 2003

Revision Effective Date

July 25, 2003

Revision Ending Date

N/A

LMRP description

Arthrocentesis and aspiration of joints is the removal of joint fluid for diagnostic analysis and/or to relieve pain and swelling in the joint. Joint injection is the therapeutic introduction or instillation of medication into the joint space for relief of pain or treatment of inflammation or infection. These procedures are performed under aseptic conditions using needle and syringe. Joint fluid is most commonly analyzed for blood cells, crystals, protein, glucose and bacteria, as well as cultured for other infectious agents. The most common medications injected into joints are anesthetic agents and corticosteroids.

Bursae are fluid-filled sacs that lie between muscles, tendons, ligaments and bones. They are also found subcutaneously over bony prominences near joints. Bursae serve to reduce friction or pressure to the tendons and soft tissue structures during motion. Bursitis (inflammation of the bursa) can be treated with therapeutic removal of fluid or injection of anesthetic and/or corticosteroid medications. This is performed under aseptic conditions using needle and syringe.

Ganglion cysts are relatively common lesions resulting from mucoid, cystic degeneration of soft tissues adjacent to a joint space or tendon sheath. They are generally found on or about the wrist, the dorsum of the hand or the joints of the fingers. They may also be found on the dorsum of the feet, ankles or the joints of the toes. Often, ganglion cysts are asymptomatic and do not require treatment. When treatment is indicated, therapeutic modalities include needle aspiration, followed by instillation of corticosteroids and/or anesthetic. This is performed under aseptic conditions using needle and syringe. Surgical excision may be indicated if the ganglion cyst recurs or conservative measures repeatedly fail to relieve symptoms.

Indications and limitations of coverage and/or medical necessity

Procedures described by CPT codes 20600-20612 may be diagnostic services, therapeutic services, or both.

Indications:

Arthrocentesis, aspiration or injection of a joint, bursa or ganglion cyst is considered medically necessary in the following circumstances:

1. There is localized pain, swelling, warmth, redness or loss of function
   - at a joint, attributable to an inflammatory or infectious intra-articular process,
   - at the site of a bursa attributable to inflammation of the bursa,
   - or at a ganglion cyst, attributable to inflammation of the cyst, or impingement of the cyst on adjacent structures.
   - and when the inflammation is not responsive to oral analgesic/anti-inflammatory medication or other conservative measures of treatment.
2. There is an accumulation of fluid in the joint or bursa and removal is indicated for diagnostic analysis, culture and/or to relieve pressure/pain.
3. Pyarthrosis (joint infection) is present and aspiration/injection is necessary for draining/analyzing infected fluid, decompressing the joint, or instilling medication.

4. A symptomatic ganglion significantly limits the patient's activity or the cyst recurs despite repeated non-surgical treatments/modalities.

Limitations:

1. Injection or aspiration of soft tissue structures other than true joints, bursae or ganglion cysts are not payable under CPT codes 20600-20612 and should not be billed using these codes.
2. Injection/aspiration of a joint, bursa or cyst during any patient encounter is limited to one service per joint, bursa or cyst. For example, if a joint is aspirated and injected during the same encounter, only one procedure should be billed and it is coded as one (1) unit, regardless of the number of medications given, or the number of times the joint space is entered. The anatomic ICD-9 CM code should match the size of the joint injected.
3. Since there are no true bursae in the lesser toes and it is virtually impossible to inject intra-articularly into the distal interphalangeal joints of the lesser toes, CPT 20600 is not reimbursable for these services. Medical records must document the exact toe, joint or bursa injected in all cases.
4. The term "adventitious bursa" refers to the local development of inflammatory tissue in response to chronic pressure or irritation. This part of the natural process of corn and callus formation. Medicare statutorily excludes the direct treatment of corns and calluses. Since adventitious bursae of the toes are directly related to corn formation, and since anesthetic/corticosteroid injection of these structures provides only temporary and limited relief from inflammatory pain, coverage is limited and repeat frequent injections are not considered reasonable and necessary except as described below. Definitive treatment of chronic pain due to corns and calluses requires removal of the inciting pressure/irritation, such as by shoe modification and/or surgical intervention.

   Exception: For the uncommon situation where inflamed soft tissue (adventitious bursae) under or around digital corns, particularly interdigital corns, becomes so painful as to require immediate intervention by local anesthetic/corticosteroid injection, payment may be made up to two such injections per patient per year. These injections should be coded using CPT 20600 and ICD-9 CM 726.79 – toe bursitis, which is reserved for this circumstance, and appropriate toe modifiers and medication codes (J codes).
5. Physical therapy treatment/modalities performed in conjunction with arthrocentesis/injection, at the same patient encounter, and for the same pathophysiological condition are not considered reasonable and necessary and will not be reimbursed.
6. Repeated intra-articular injections of corticosteroids have been shown to cause joint destruction and when given in juxtaposition to tendons, to cause tendon rupture. With the exception of joint viscosupplementation with hyaluronase polymers such as Synvisc (which may initially require 3 weekly injections), or Hyalgan (which may initially require up to 5 weekly injections), more than two therapeutic injections of the same medication to a joint, bursa or ganglion cyst is indicated only if there has been a significant documented clinical response to prior similar injections. Claims for multiple therapeutic injections of the same medication into a joint, bursa or ganglion cyst will be denied as not reasonable and necessary if the medical record fails to indicate that there has been a significant initial or ongoing clinical response. For guidelines concerning joint viscosupplementation with hyaluronase polymers such as Synvisc or Hyalgan, please see Triple-S Medicare policy, Medicare Informa, Vol. 52 (January-February-March 1999, p. 18), "Hyaluronase Polymers".

CPT/HCPCS codes

20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (Eg, fingers, toes)

20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (Eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (Eg, shoulder, hip, knee joint, subacromial bursa)
20612	Arthrocentesis, aspiration and/or injection of ganglion cyst(s); any location

Not Otherwise Classified (NOC)

N/A

ICD-9 codes that Support Medical Necessity

Truncated diagnosis codes are not acceptable.

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

It is enough to link the procedure code to a correct, payable ICD-9 CM diagnosis code. The diagnosis or clinical suspicion must be present for the procedure to be paid.

For CPT 20600:

274.0	gouty arthropathy
696.0	psoriatic arthropathy
711.04	pyogenic arthritis involving hand
711.07	pyogenic arthritis involving ankle and foot
712.84	other specified crystal arthropathies involving hand
712.87	other specified crystal arthropathies involving ankle and foot
714.0	rheumatoid arthritis
715.04	osteoarthrosis of hand, generalized
715.17	osteoarthrosis of foot, localized, primary
715.24	osteoarthrosis localized secondary involving hand
715.27	osteoarthrosis localized secondary involving ankle and foot
715.34	osteoarthrosis localized not specified whether primary or secondary involving hand
715.37	osteoarthrosis of foot, localized, not specified whether primary or secondary
715.89	osteoarthrosis involving, or with mention of more than one site, but not specified as generalized
715.94	osteoarthrosis unspecified whether generalized or localized involving hand
715.97	osteoarthrosis unspecified whether generalized or localized involving ankle and foot
716.14	traumatic arthropathy involving hand
716.17	traumatic arthropathy involving ankle and foot
716.19	traumatic arthropathy of multiple sites

716.54	unspecified polyarthropathy or polyarthritis involving hand
716.57	unspecified polyarthropathy or polyarthritis involving ankle and foot
716.59	unspecified polyarthropathy or polyarthritis involving multiple sites
716.84	other specified arthropathy involving hand
716.87	other specified arthropathy involving ankle and foot
716.89	other specified arthropathy involving multiple sites
716.94	unspecified arthropathy involving hand
716.97	unspecified arthropathy involving ankle and foot
716.99	unspecified arthropathy involving multiple sites
719.04	effusion of hand joint
719.07	effusion of ankle and foot joint
719.09	effusion of joint of multiple sites
719.14	hemarthrosis involving hand
719.17	hemarthrosis involving ankle and foot
719.19	hemarthrosis involving multiple sites
719.24	villonodular synovitis involving hand
719.27	villonodular synovitis involving ankle and foot
719.44	pain in joint involving hand
719.47	pain in joint involving ankle and foot
719.49	pain in joint, multiple sites
726.4	enthesopathy of carpus
726.70	enthesopathy of ankle and tarsus unspecified
726.73	calcaneal spur
726.79	other enthesopathy of ankle and tarsus
726.8	other peripheral enthesopathies
727.03	trigger finger (acquired)
727.41	ganglion cyst of joint
727.42	ganglion of tendon sheath
727.43	ganglion unspecified
727.49	other ganglion and cyst of synovium tendon and bursa
728.71	plantar fascial fibromatosis
735.2	hallux rigidus

For CPT code 20605:

274.0	gouty arthropathy
696.0	psoriatic arthropathy
711.03	pyogenic arthritis involving forearm
711.07	pyogenic arthritis involving ankle and foot
712.83	other specified crystal arthropathies involving forearm
712.87	other specified crystal arthropathies involving ankle and foot
714.0	rheumatoid arthritis
715.09	osteoarthrosis generalized involving multiple sites
715.13	osteoarthrosis localized primary involving forearm
715.17	osteoarthrosis localized primary involving ankle and foot
715.23	osteoarthrosis localized secondary involving forearm
715.27	osteoarthrosis localized secondary involving ankle and foot
715.33	osteoarthrosis of foream, localized, not specified whether primary or secondary
715.37	osteoarthrosis of ankle, localized, not specified whether primary or secondary
715.89	osteoarthrosis involving or with mention of more than one site, but not specified as generalized
715.93	osteoarthrosis of foream, unspecified whether generalized or localized
715.97	osteoarthrosis unspecified involving ankle and foot
716.13	traumatic arthropathy involving forearm
716.17	traumatic arthropathy involving ankle an forearm
716.57	unspecified polyarthropathy or polyarthritis involving ankle and foot
716.87	other specified arthropathy involving ankle and foot
716.93	unspecified arthropathy involving forearm
716.97	unspecified arthropathy involving ankle and foot
716.99	unspecified arthropathy involving multiple sites
719.03	effusion of forearm joint
719.06	effusion of joint of the ankle
719.07	effusion of ankle and foot joint
719.09	effusion of joint of multiple sites
719.23	villonodular synovitis involving forearm
719.27	villonodular synovitis involving ankle and foot
719.29	villonodular synovitis involving multiple sites

719.43	pain in joint involving forearm
719.47	pain in joint involving ankle and foot
719.49	pain in joint involving multiple sites
726.33	olecranon bursitis
726.70	enthesopathy of ankle and tarsus unspecified
727.06	tenosynovitis of foot and ankle
727.41	ganglion of joint
727.49	other ganglion and cyst of synovium tendon and bursa

For CPT code 20610:

274.0	gouty arthropathy
696.0	psoriatic arthropathy
711.01	pyogenic arthritis involving shoulder region
711.05	pyogenic arthritis involving pelvic region and thigh
711.06	pyogenic arthritis involving lower leg
712.81	other specified crystal arthropathies involving shoulder region
712.85	other specified crystal arthropathies involving pelvic region and thigh
712.86	other specified crystal arthropathies involving lower leg
714.0	rheumatoid arthritis
715.09	osteoarthrosis generalized involving multiple sites
715.11	osteoarthrosis localized primary involving shoulder region
715.12	osteoarthrosis localized primary involving upper arm
715.15	osteoarthrosis localized primary involving pelvic region and thigh
715.16	osteoarthrosis localized primary involving lower leg
715.21	osteoarthrosis localized secondary involving shoulder region
715.22	osteoarthrosis localized secondary involving upper arm
715.25	osteoarthrosis localized secondary involving pelvic region and thigh
715.26	osteoarthrosis localized secondary involving lower leg
715.31	osteoarthrosis of shoulder region, localized, not specified whether primary or secondary
715.32	osteoarthrosis of upper arm, localized, not specified whether primary or secondary
715.35	osteoarthrosis not specified whether primary or secondary involving pelvic region and thigh
715.89	osteoarthrosis involving or with mention of more than one site, but not specified as generalized
715.91	osteoarthrosis unspecified whether generalized or localized involving shoulder region

715.92	osteoarthrosis unspecified whether generalized or localized involving upper arm
715.95	osteoarthrosis unspecified whether generalized or localized involving pelvic region and thigh
716.11	traumatic arthropathy involving shoulder region
716.12	traumatic arthropathy involving upper arm
716.15	traumatic arthropathy involving pelvic region and thigh
716.19	traumatic arthropathy involving multiple sites
716.59	unspecified polyarthropathy or polyarthritis involving multiple sites
716.91	unspecified arthropathy involving shoulder region
716.92	unspecified arthropathy involving upper arm
716.95	unspecified arthropathy involving pelvic region and thigh
716.96	unspecified arthropathy involving lower leg
716.99	unspecified arthropathy involving multiple sites
717.0	old bucket handle tear of medial meniscus
717.1	derangement of anterior horn of medial meniscus
717.2	derangement of posterior horn of medial meniscus
717.40	derangement of lateral meniscus unspecified
717.41	bucket handle tear of lateral meniscus
717.42	derangement of anterior horn of lateral meniscus
717.43	derangement of posterior horn of lateral meniscus
717.5	derangement of meniscus not elsewhere classified
719.01	effusion of joint of shoulder region
719.02	effusion of upper arm joint
719.05	effusion of joint of pelvic region and thigh
719.06	effusion of lower leg joint
719.09	effusion of joint of multiple sites
719.21	villonodular synovitis involving shoulder region
719.22	villonodular synovitis involving upper arm
719.25	villonodular synovitis involving pelvic region and thigh
719.26	villonodular synovitis involving lower leg
719.29	villonodular synovitis involving multiple sites
719.41	pain in joint involving shoulder region
719.42	pain in joint involving upper arm

719.45 pain in joint involving pelvic region and thigh

719.46 pain in joint involving lower leg

719.49 pain in joint involving multiple sites

720.2 sacroiliitis not elsewhere classified

726.0 adhesive capsulitis of shoulder

726.10 disorders of bursae and tendons in shoulder region unspecified

726.11 calcifying tendinitis of shoulder

726.5 enthesopathy of hip region

726.60 enthesopathy of knee unspecified

726.61 pes anserinus tendinitis or bursitis

727.41 ganglion of joint

727.49 other ganglion and cyst of synovium tendon and bursa

727.61 complete rupture of rotator cuff

848.41 sternoclavicular (joint) (ligament) sprain

848.42 chondrosternal (joint) sprain

For CPT code 20612

715.00-716.03 osteoarthrosis

Diagnosis that Support Medical Necessity

Same as above.

ICD-9 codes that do not Support Medical Necessity

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

Diagnosis that not Support Medical Necessity

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

Reasons for denial

Claims lacking adequate documentation in the medical record as required in the "Documentation Requirements" section of this policy will be denied as not reasonable and necessary. Documentation should include all of the following: patient complaint, medical history, objective physical findings, specific anatomic site of the procedure, working or actual diagnosis, the drug(s) and the amount(s) injected, the quantity and quality of material drained, expected outcomes, and response to joint injections/ aspirations noted on follow-up visits. Documentation must be present in the medical records and available to Medicare upon request.

When the documentation does not meet the criteria for the service(s) rendered or it does not establish the medical necessity for the service(s), such service(s) will be denied as not reasonable and necessary under Section 1862(a)(1) of the law.

Claims for injection or aspiration of soft tissue structures other than true joints, bursae or ganglion cysts will be denied as not reasonable and necessary.

Claims for injection into the DIP joints or bursae of the toes will be denied for lack of medical necessity.

A claim submitted without a valid ICD-9 CM diagnosis code will be returned as an incomplete claim under 1833(e).

Claims for a multiple therapeutic injections of the same medication into a joint, bursa or ganglion cyst will be denied as not reasonable and necessary if the medical record fails to indicate that there has been a significant clinical response.

A claim submitted without one of the ICD-9 CM diagnosis codes listed in the "ICD-9 CM Diagnosis Codes that Support Medical Necessity" section of this policy will be denied under 1862(a)(1)(A).

Use of a "covered" ICD-9 CM code does not guarantee reimbursement. Claims will be denied if the record does not document that medical necessity criteria were met.

Services performed for diagnoses not listed as reimbursable in this policy or for excessive frequency will be denied as not medically necessary. Frequency is considered excessive when services are performed more frequently than stated in the Utilization Guidelines section of this policy, and the reason for additional services is not justified by documentation.

Injections of anatomic structures that do not match the anatomic ICD-9 CM code will be denied as not medically necessary.

Injection/aspiration of a joint, bursa or cyst during any patient encounter is limited to one service per joint, bursa or cyst. For example, if a joint is aspirated and injected during the same encounter, only one procedure should be billed and it is coded as one (1) unit, regardless of the number of medications given, or the number of times the joint space is entered. The anatomic ICD-9 CM code should match the size of the joint injected.

Non-specific diagnoses such as back pain, lumbago or sciatica are not valid for joint and bursa injections/ aspirations.

A claim for services rendered in any place of service other than those indicated as payable in the "Coding Guidelines" section of this policy will be denied.

Non-covered ICD-9 codes

Any ICD-9 CM not included in this policy.

Non-covered diagnosis

Any diagnosis not included in this policy.

Coding guidelines

1. ICD-9 CM codes must be used to the highest level of specificity.
2. Reimbursement for the cost of the drug or biological used in an arthrocentesis/joint injection is allowed in addition to the procedure. Use the appropriate "J" code for the drug used. The arthrocentesis/joint injection code and the "J" code must both be billed on the same claim for services in any non-facility setting.
3. Injection/aspiration of a joint during any patient encounter is limited to one service per joint. That is, if a joint is aspirated and injected during the same encounter, only one procedure should be billed and it is coded as one (1) unit, regardless of the number of medications given, or the

number of times the joint space is entered. The anatomic ICD-9 CM code should match the size of the joint injected.

4. Payment for multiple injections may be allowed to the same provider on the same day if performed on different anatomical sites using different syringes. These must be billed with the 59 modifier, unless the procedure is performed bilaterally, in which case the 50 modifier may be used instead. Standard payment adjustment rules for multiple surgical procedures apply.

5. An evaluation and management (E & M) service may be billed on the same day as the procedure is the E & M service represents a significant separately identifiable service. Modifier 25 must be appended to the E & M visit. Evaluation of the effect of a prior injection is not considered a "separately identifiable service".

6. Codes 10160 and 64450 are bundled into codes 20600-20610 when billed on the same day by the same provider, for the same anatomic site or structure.

7. Services performed on the foot or hand must be submitted with the appropriate foot/toe or hand/finger location modifiers. Failure to submit the appropriate modifiers will result in unnecessary delay in payment of claims.

   TA left foot, great toe

   T1 left foot, second digit

   T2 left foot, third digit

   T3 left foot, fourth digit

   T4 left foot, fifth digit

   T5 right foot, great toe

   T6 right foot, second digit

   T7 right foot, third digit

   T8 right foot, fourth digit

8. For the uncommon situation where inflamed soft tissue (adventitious bursae) under or around digital corns, particularly interdigital corns, becomes so painful as to require immediate intervention by local anesthetic/corticosteroid injection, payment may be made up to two such injections per patient per year. These injections should be coded using CPT 20600 and ICD-9 CM 726.79 – toe bursitis, which is reserved for this circumstance, and appropriate toe modifiers and medication codes (J codes).

9. Payable places of service: office (11); home (12); inpatient hospital (21); outpatient hospital (22); emergency room (23); ambulatory surgical center (24); skilled nursing facility (31); nursing facility (32); custodial care facility (33); comprehensive inpatient rehabilitation facility (61); comprehensive outpatient rehabilitation facility (62).

Documentation requirements

Documentation supporting the medical necessity, such as ICD-9 CM diagnosis codes, must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.

The medical record must contain a formal report of the results of joint fluid analysis for any joint aspiration performed for possible infection, crystal arthropathy, or other conditions requiring joint fluid analysis for evaluation.

The medical record must indicate that for repeat therapeutic injection of the same medication into a joint, bursa or ganglion cyst that the patient has had significant documented clinical response to prior similar injections.

The medical record must clearly document the medical necessity of services performed at more frequent intervals, in greater numbers per patient, or in greater numbers per visit, than stated in the Utilization Guidelines section of this policy.

Documentation must be available to Medicare upon request.

Utilization guidelines

As stated before, repeated intraarticular injections of corticosteroids have been shown to cause joint destruction and when given in juxtaposition to tendons, to cause tendon rupture.

Other comments

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

This policy supersedes Policy VI/PR 03-002. Analysis of data indicated that these services are being billed at an excessive rate per patient on the same date of service, are being repeated at unusually frequent intervals, and are being administered for an unusually prolonged period of time. In addition, these services are being billed with inappropriate diagnosis for the CPT description of the code (i.e., a diagnosis involving a small joint with a CPT code for a large joint) or with a diagnosis that does not substantiate medical necessity.

Sources of Information and basis for decision

1. Other carriers policy:
   - Group Health, Inc. (NY) Part B, policy effective 10/01/01
   - Florida Medicare Part B, policy effective 9/15/96
   - North Carolina, Medicare Part B, policy effective 3/15/99
   - Ohio/West Virginia, Medicare Part B, policy effective 7/01/96
2. Dodd LG, Layfield LJ. Fine needle aspiration cytology of ganglion cysts. Diagn Cytopathol 1996 Dec; 15(5): 377-81.
3. Harrison's Principles of Internal Medicine.
4. Robert's W. Knee aspiration and injection. The Physician and Sportsmedicine, Vol. 26 No 1, January 1998.
5. Sea Shore Plastic and Hand Surgery Center: Microsurgery Ganglion Cysts, 1998.
6. University of Iowa Family Practice Handbook, 3rd Edition, Chapter 6. Orthopedics: Shoulder Pain.
7. Local Rheumatology Medicare Consultants

Advisory Committee Notes

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

Start date of comment period

March 17, 2003

Ending date of comment period

May 1, 2003

Start date of notice period

June 9, 2003

Revision history

REVISION NUMBER	EFFECTIVE DATE OF THE REVISION	CHANGES
VI/PR-03-01		1. Additional new CPT code (20612). 2. Revision of ICD-9 codes with addition of diagnostic codes. 3. Revision of indications and limitations.

GGL-1958

Contractors Policy Number

VI/PR-03-003

Contractor Name

Triple-S, Inc.

Contractor Number

00973

Contractor type

Carrier

LMRP title

Panretinal Photocoagulation

AMA's CPT copyright statement

CMS National Coverage Policy

Social Security Act, Section 1862 (a)(1) prohibits Medicare payment for services which are not reasonable and necessary for the diagnosis or treatment of illness or injury. Medicare has historically interpreted the statutory terms "reasonable and necessary" to mean that a service must be safe and effective, and not experimental.

Social Security Act, Section 1862(a)(7) prohibits Medicare payment for routine or screening services.

Primary Geographic Jurisdiction

Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction

N/A

CMS Region

New York, Region II

CMS Consortium

Northeastern

Original Policy Effective Date

July 15, 2003

Original Policy Ending Date

N/A

Revision Effective Date

N/A

Revision Ending Date

N/A

LMRP description

Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions; photocoagulation (laser or xenon arc).

Indications and limitations of coverage and/or medical necessity

Photocoagulation using a laser or xenon arc is a covered service when it is used for the treatment of extensive or progressive retinopathy.

Medicare allowance includes reimbursement for the same or related procedures performed in the same eye during the global surgery period of the first procedure. Therefore, it would not be appropriate to bill 67227 during the global surgery period of 67228 in the same eye.

Although Medicare only makes one payment for 67228, the reimbursement methodology for this code has taken into account the need for more than one session to treat the patient successfully.

Medically necessary services that are clearly distinct unrelated procedures and are not reoperations or treatment for complications may be paid separately. Such services performed within the post-operative period of another surgery should be billed with Modifier 79.

CPT/HCPCS Section and benefit category

Surgery: Eye and Ocular Adnexa / Physician's services

CPT/HCPCS codes

67228 Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; photocoagulation (laser or xenon arc).

Not Otherwise Classified (NOC)

N/A

ICD-9 codes that Support Medical Necessity

361.00

361.05

361.10

361.12

362.02

362.12

362.18

362.21

362.29

362.35

362.36

362.84

364.42

365.63

Diagnosis that Support Medical Necessity

Same as above.

ICD-9 codes that do not Support Medical Necessity

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

Diagnosis that not Support Medical Necessity

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

Reasons for denial

In the absence of the above conditions, the procedure will be considered to be not medically necessary and will be denied.

Non-covered ICD-9 codes

Any ICD-9 CM not included in this policy.

Non-covered diagnosis

Any diagnosis not included in this policy.

Coding guidelines

Panretinal photocoagulation will not be covered for diagnoses not listed. Documentation supporting the medical necessity for the procedure, such as ICD-9 codes, must be submitted with each claim. Use RT and LT modifiers to define the operative site.

Documentation requirements

Documentation in the medical records must reflect medical necessity for the procedure. All procedures require clear operative notes which document the indications and details of the procedure.

Utilization guidelines

N/A

Other comments

N/A

Sources of Information and basis for decision

Ophthalmology consultants

Other carriers' policies; CAHABA Government Benefit Administration

Advisory Committee Notes

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

45 Days Final Policies...

VI/PR-03-003 - Panretinal Photocoagulation

Start date of comment period

March 17, 2003

Ending date of comment period

May 1, 2003

Start date of notice period

June 9, 2003

Revision history

N/A

GGL-1959

Contractor policy number

VI/PR-03-004

Contractor Name

Triple-S, Inc.

Contractor number

00973

Contractor type

Carrier

LMRP title

Ophthalmoscopy Extended

AMA CPT copyright statement

CMS National Coverage Policy

- Title XVIII of the Social Security Act, Section 1862 (a)(7). This section excludes routine physical examination.
- Title XVIII of the Social Security Act, Section 1862 (a)(1)(A). This section allows coverage and payment for only those services considered medically reasonable and necessary.
- Title XVIII of the Social Security Act, Section 1833 (e). This section prohibits Medicare Payment for any claim which lacks the necessary information to process the claim.
- Medicare Carriers Manual 2320

Primary Geographic Jurisdiction

Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction

N/A

CMS Region

New York, Region II

CMS Consortium

Northeastern

Original Policy Effective Date

June 11, 2001

Original Policy Ending Date

July 24, 2003

Revision Effective Date

July 25, 2003

Revision Ending Date

N/A

LMRP description

Extended ophthalmoscopy is the inspection of the interior of the eye and is a more extensive examination than a routine ophthalmoscopy. This inspection permits visualization of the optic disk, arteries, veins, retina, choroid, and media and is directed toward the condition of the vessels, the color of the tissue and the character of the optic nerve. The methods of viewing the ocular fundus include indirect ophthalmoscopy, by which a larger field is obtained, but with magnification of two to three X; and biomicroscopy combined with a lens to neutralize corneal refracting power.

Indications and limitations of coverage and/or medical necessity

An extended ophthalmoscopy will be considered medically reasonable and necessary when any one of the following circumstances is present.

- The patient has a malignant neoplasm of the retina or choroid. This may appear as a single, round or oval, slightly elevated, gray or nonpigmented lesion.
- The patient has a retained (old) intraocular foreign body, either magnetic or nonmagnetic. Signs and symptoms may include a statement by the patient that something has hit his/her eye (foreign body sensation), normal or blurred vision, pain or no discomfort, and tearing.
- The patient has retinal hemorrhage, edema, ischemia, exudates and deposits, hereditary retinal dystrophies or peripheral retinal degeneration.
- The patient has retinal detachment with or without retinal defect. The patient may complain of light flashes, dark floating specks, and blurred vision that becomes progressively worse. The patient may describe this as “a curtain came down over my eyes.”
- The patient has symptoms suggestive of retinal defect (ex: flashes and/or floaters).
- The patient has retinal defects without retinal detachment.
- The patient has diabetic retinopathy (i.e., background retinopathy or proliferative retinopathy), retinal vascular occlusion, or separation of the retinal layers. This may be evidenced by microaneurysms, cotton wool spots, exudates, hemorrhages, or fibrous proliferation.
- The patient has experienced sudden visual loss or transient visual loss. This may be described as “trouble seeing or vision going in and out.”
- The patient has chorioretinitis, chorioretinal scars or choroidal degeneration, dystrophies, hemorrhage and rupture, or detachment.
- The patient has Vogt-Koyanagi syndrome. This disease is characterized by bilateral uveitis, dysacousia, meningeal irritation, whitening of patches of hair (poliosis), vitiligo, and retinal detachment. The disease can be initiated by a severe headache, deep orbital pain, vertigo, and nausea.

- The patient has sustained a penetrating wound to the orbit resulting in the retention of a foreign body in the eye.
- The patient has sustained a blunt injury to the eye or pariorbita.
- The patient has disorders of the vitreous body (i.e., vitreous hemorrhage or posterior vitreous detachment). Spots before the eyes (floaters) and flashing lights (photopsia) can be signs/symptoms of these disorders.
- The patient has posterior scleritis. Signs and symptoms may include severe pain and inflammation, proptosis, limited ocular movements, and a loss of a portion of the visual field.
- The patient has degenerative disorders of the globe.
- The patient has retinoschisis and retinal cysts. Patients may complain of light flashes and floaters.
- The patient has signs and symptoms of endophthalmitis, which may include severe pain, redness, photophobia, and profound loss of vision.
- The patient has glaucoma or is a glaucoma suspect. This may be evidenced by increased intraocular pressure or progressive cupping of the optic nerve.
- Systemic disorders which may be associated with retinal pathology.
- High axial length myopia
- Retinal edema
- Metamorphopsia
- High-risk medication for retinopathy or optic neuropathy.
- Choroidal nevus being evaluated for malignant transformation

The patient's medical record must meet the documentation requirements set forth in this policy.

Limitations:

1. Routine ophthalmoscopy and biomicroscopy are part of an ophthalmologic examination and are not separately payable.
2. If indirect ophthalmoscopy is done without a drawing, the service is not separately payable and is part of a general ophthalmologic exam (92002-92014).
3. Extended ophthalmoscopy (codes 92225, 92226) performed during the global surgery period of an ophthalmologic surgery procedure by the same provider doing the surgery will not be separately payable unless unrelated to the condition for which the surgery was performed.

Payable places of service include office (11), inpatient hospital (21), outpatient hospital (22), emergency room hospital (23), ambulatory surgical center (24) and skilled nursing facility (31).

CPT/HCPCS Section & Benefit Category

Medicine/opthalmology

CPT/HCPCS codes

92225 Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; initial

92226 Subsequent

Not Otherwise Classified (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

Truncated diagnosis codes are not acceptable.

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

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

115.92	Ocular histoplasmosis
130.2	Chorioretinitis due to toxoplasmosis
190.0	Malignant meoplasm of eyeball, except conjunctiva, cornea, retina, and choroids
190.5	Malignant neoplasm of retina
190.6	Malignant neoplasm of choroids
224.5	Benign neoplasm, retina
224.6	Benign neoplasm of choroids
225.1	Benign neoplasm of cranial nerves
237.70-237.72	Neurofibromatosis
250.00-250.53	Diabetes with ophthalmic manifestations
360.00-360.04	Purulent endophthalmitis
360.11	Sympathetic uveitis
360.12	Panuveitis
360.13	Parasitic endophthalmitis NOS
360.19	Phacoanaphylactic endophthalmitis
360.21	Progressive high (degenerative) myopia
360.23	Siderosis
360.24	Chalcosis
360.50	Foreign body, magnetic, intraocular, unspecified
360.52	Foreign body, magnetic, in iris or ciliary body

360.53	Foreign body, magnetic, in lens
360.54	Foreign body, magnetic, in vitreous
360.55	Foreign body, magnetic, in posterior wall
360.59	Foreign body, magnetic, in other or multiple sites
360.60	Foreign body, intraocular, unspecified
360.61	Foreign body, intraocular, in anterior chamber
360.62	Foreign body, intraocular, in iris or ciliary body
360.63	Foreign body, intraocular, in lens
360.64	Foreign body, intraocular, in vitreous
360.65	Foreign body, intraocular, in posterior wall
360.69	Foreign body, intraocular, in other or multiple sites
360.81-360.89	Other disorders of globe
360.9	Unspecified disorder of globe
361.00-361.07	Retinal detachment with retinal defect
361.10-361.19	Retinoschisis and retinal cysts
361.2	Serous retinal detachment
361.30-361.33	Retinal defects without detachment
361.81	Traction detachment of retina
361.89	Other forms of retinal detachment
361.9	Unspecified retinal detachment
362.01-362.02	Diabetic retinopathy
362.10-362.18	Other background retinopathy and retinal changes
362.21-362.29	Other proliferative retinopathy
362.30-362.37	Retinal vascular occlusion
362.40-362.43	Separation of retinal layers
362.50-362.57	Degeneration of macula and posterior pole
362.60-362.66	Peripheral retinal degenerations
362.70-362.77	Hereditary retinal dystrophies
362.81	Retinal hemorrhage
362.82	Retinal exudates and deposits
362.83	Retinal edema

362.84 Retinal ischemia

362.89 Other retinal disorders

363.00-363.08 Focal chorioretinitis and focal retinochoroiditis

363.10-363.15 Disseminated chorioretinitis and disseminated

363.20 Chorioretinitis, unspecified

363.21 Pars planitis

363.22 Harada's disease

363.30-363.35 Chorioretinal scars

363.40-363.43 Choriordal degenerations

363.50-363.57 Hereditary choroidal dystrophies

363.61-363.63 Choroidal hemorrhage and rupture

363.70-363.72 Choroidal detachment

363.8 Other disorders of choroids

363.9 Unspecified disorder of choriod

364.00-364.04 Acute and subacute iridocyclitis

364.10-364.11 Chronic iridocyclitis

364.21 Fuchs' heterochromic cyclitits

364.22 Glaucomatocyclitic crises

364.23 Lens-induced iridocyclitis

364.24 Vogt-Koyanagi syndrome

364.3 Unspecified iridocyclitis

364.41-364.42 Vascular disorders of iris and ciliary body

364.51-364.59 Degenerations of iris and ciliary body

364.60-364.64 Cysts of iris, ciliary body, and anterior chamber

364.70-364.77 Adhesions and disruptions of iris and ciliary body

364.8 Other disorders of iris and ciliary body

364.9 Unspecified disorder of iris and ciliary body

365.00-365.04 Borderline glaucoma

365.10-365.15 Open-angle glaucoma

365.20-365.24 Primary angle-closing glaucoma

365.31-365.32	Corticosteroid-induced glaucoma
365.41-365.44	Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes
365.51-365.59	Glaucoma associated with disorders of the lens
365.60-365.65	Glaucoma associated with other ocular disorders
365.81-365.89	Other specified forms of glaucoma
365.9	Unspecified glaucoma
368.10	Subjective visual disturbance, Unspecified
368.11	Sudden visual loss
368.12	Transient visual loss
368.13	Subjective visual disturbance, Visual discomfort
368.14	Subjective visual disturbance, Visual distortions of shape and size
368.15	Other visual distortions and entoptic phenomena
368.16	Subjective visual disturbance, Psychophysical visual disturbances
368.40-368.47	Visual field defects
368.60-368.69	Night blindness
368.8	Other specified visual disturbances
368.9	Blindness and low vision
376.40-376.47	Deformity of orbit
376.50-376.52	Enophthalmos
376.6	Retained (old) foreign body following penetrating wound of orbit
377.00	Papilledema, unspecified
377.01-377.04	Papilledema
377.10-377.16	Optic atrophy
377.21-377.24	Other disorders of the optic disc
377.30	Optic neuritis, unspecified
377.31	Optic neuritis, optic papillitis
377.32	Optic neuritis, Retrobulbar neuritis (acute)
377.33	Nutritional optic atrophy
377.34	Toxic optic neuropathy
377.39	Optic neuritis, Other
377.41	Ischemic optic neuropathy

377.42	Hemorrhage in optic nerve sheaths
377.49	Other (compression of the optic nerve)
377.51-377.54	Disorder of optic chiasm
379.07	Posterior scleritis
379.21-379.29	Disorders of vitreous body
379.32	Subluxation of lens
379.34	Posterior dislocation of lens
714.0	Rheumatoid arthritis
714.30-714.33	Juvenile chronic polyarthritis
743.51-743.59	Congenital anomalies of posterior segment
759.5	Tuberous sclerosis
759.6	Other hamartoses, not elsewhere classified
759.82	Marfan syndrome
871.5-871.9	Penetration of eyeball with foreign body (magnetic, nonmagnetic)
921.3	Contusion of eyeball
958.1	Fat embolism as an early complication of trauma
995.50-995.59	Child maltreatment syndrome
V58.69	Long Term (Current) Use Of Other Medications, High Risk Medications
V67.51	Follow-up examination; completed treatment with high-risk medication, not elsewhere classified

Diagnosis that Support Medical Necessity

Same as above

ICD-9 codes that do not Support Medical Necessity

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

Diagnosis that do not Support Medical Necessity

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

Reasons for denial

- Any ICD-9-CM code which indicates the service to be routine in nature.
- A claim for services rendered in any place of service other than those indicated as payable in the "Indication and Limitation of Coverage and/or Medical Necessity" section of this policy will be denied.

- A claim submitted without a valid ICD-9 CM diagnosis code will be returned as an incomplete claim under 1833(e).
- A claim submitted without one of the ICD-9 CM diagnosis codes listed in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy will be denied under 1862(a)(1)(A).
- A claim for extended ophthalmoscopy rendered in any place of service other than those indicated as payable in the "Coding Guidelines" section of this policy will be denied.
- A claim without the appropriate modifier (RT, LT or 50) will be denied for missing information.
- Section 1862(a)(7) of the Social Security Act does not extend Medicare coverage for screening procedures.
- A claim for extended ophthalmoscopy will be denied if the medical record does not document that the pupil was dilated.
- Claims for extended ophthalmoscopy performed with a frequency greater than that which is medically necessary for the diagnosis or treatment of ophthalmologic conditions may be denied.
- Claims for extended ophthalmoscopy performed during the global surgery period of an ophthalmologic surgery procedure will be denied unless the ophthalmoscopy is done for a condition unrelated to that for which the surgery was performed.
- Claims for extended ophthalmoscopy for which the service did not include a qualified retinal drawing (Please see Appendix A) will be denied and the service will be considered to be part of an intermediate or complex ophthalmologic examination (CPT codes 92002-92014).
- Subsequent extended ophthalmoscopy (code 92226) will be denied if billed with codes 92002 or 92004 (ophthalmological services, new patient).
- If fundus photography and extended ophthalmoscopy are performed on the same day (same eye), the extended ophthalmoscopy may be denied as not medically necessary if it is anticipated that no new additional information, above that available from the photography, will be obtained.
- Only ophthalmologists and optometrists will be reimbursed for extended ophthalmoscopy.

Noncovered ICD-9 codes

V72.0

V80.0

V80.2

V82.9

Noncovered diagnosis

Any diagnosis not included in this policy.

Coding guidelines

Reimbursement for an ophthalmoscopy; initial (CPT code 92225) and an ophthalmoscopy; subsequent (CPT code 92226) will not be made on the same day for the same eye by the same provider. If an initial

ophthalmoscopy (CPT code 92225) and a subsequent ophthalmoscopy (CPT code 92226) are performed on different eyes modifier RT and LT should be reported to indicate that the services were performed on different eyes.

Routine ophthalmoscopy is part of an ophthalmologic service and is not reported separately.

Payable places of service include office (11), inpatient hospital (21), outpatient hospital (22), emergency room hospital (23), ambulatory surgical center (24) and skilled nursing facility (31).

- Codes 92225 and 92226 are unilateral codes and must be submitted with a site modifier (LT, RT or 50). Only one of these modifiers may be billed on a claim line. Bilateral services must be billed with a 50 modifier, rather than RT and LT on the same line.
- Ophthalmoscopy is classified as a professional service. Therefore, the use of modifiers for professional or technical components (26, TC) is not appropriate for these codes.
- Code 92225 is payable with 92002, 92004, 92012 and 92014. Code 92226 is payable with 92012 and 92014.
- Extended ophthalmoscopy (codes 92225, 92226) during the global surgery period, by the same provider who performed ophthalmologic surgery, should be coded with a 79 modifier (in addition to the site modifiers), if it is unrelated to the condition for which the surgery was performed.
- The initial code (92225) may be used more than once if the patient has not been evaluated by that physician or group of physicians within the last 3 years.

Documentation requirements

Documentation supporting the medical necessity, including retinal drawings, should be legible, maintained in the patient's medical record, and must be available to the carrier upon request. A drawing must accurately represent normal, abnormal and common findings such as; lattice degeneration, hypertensive vascular changes, proliferative diabetic retinopathy, as well as retinal detachments, holes, tears or tumors.

Documentation specific to the method of examination (e.g., lens, instrument used) should be maintained in the medical record.

Additionally, the following documentation criteria must be maintained in the patients' medical record and available to the carrier upon request.

1. There must be a separate detailed sketch. Minimal size 3-4 inches available upon request.
2. All items noted must be identified and labeled.
3. It is highly recommended that all drawings should be in standard colors.
4. All findings and a plan of action should be documented in notes.
5. Documentation supporting the medical necessity of this item, such as ICD-9-CM diagnosis codes, must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary

Documentation in the patient's medical record for a diagnosis of glaucoma (ICD-9-CM codes 365.00-365.9) must include all of the following:

1. A detailed drawing of the optic nerve,
2. Documentation of cupping, disc rim
3. Documentation of any surrounding pathology around the optic nerve.

Utilization guidelines

It is customary that conditions coded with ICD-9 CM codes 360.0-365.9 may require up to five (5) or six (6) examinations per eye, per year.

For ICD-9 CM codes 190.0, 190.5, 190.6, 224.5 and 224.6, up to four (4) examinations may be required per eye, per year.

Other conditions usually require no more than one (1) or two (2) examinations per eye, per year.

Other comments

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

This policy supersedes Triple-S Medicare Division's Ophthalmoscopy policy, PR/VI 01-13, which will be end dated effective June 10, 2001.

Sources of information and basis for decision

Consultants in Ophthalmology

Consultants in Optometry

Other Carrier Policies

Empire Medicare Services NJ Medical Director

Newell, F. (1992). Ophthalmology-Principles and Concepts. St. Louis: Mosby.

McPhee, S., Papadakis, M., and Tierney, L., (1996). Current Medical Diagnosis and Treatment. Stanford: Appleton and Lange.

Advisory Committee Notes

This policy does not reflect the sole opinion of the Carrier Medical Director. This policy was developed in consultation with the medical community via the Carrier Advisory Committee, which includes representatives from all related specialties.

Start date of comment period

March 17, 2003

Ending date of comment period

May 1, 2003

Start date of notice period

June 9, 2003

Revision history

REVISION NUMBER	EFFECTIVE DATE OF THE REVISION	CHANGES
PR R 02-03		This represents a revision for policy of Ophthalmoscopy Extended published in the bulletin Medicare Informa (June 2001), Volume 65, effective date of services, June 11, 2001. New diagnoses were added, from the original, in order to support the medical necessity. The reviewed policy is more specific for indications and limitations of coverage, reasons for denials, coding and utilization guidelines and documentation requirements.

GGL-1462

Contractors Policy Number

VI/PR-03-005

Contractor Name

Triple-S, Inc.

Contractor Number

00973

Contractor type

Carrier

LMRP title

Injection, tendon sheath, ligament, trigger points or ganglion cyst

AMA's CPT copyright statement

CMS National Coverage Policy

N/A

Primary Geographic Jurisdiction

Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction

N/A

CMS Region

New York, Region II

CMS Consortium

Northeastern

Original Policy Effective Date

July 22, 1996

Original Policy Ending Date

July 24, 2003

Revision Effective Date

July 25, 2003

Revision Ending Date

N/A

LMRP description

Injection of local anesthetic frequently combined with a water soluble steroid into a tendon sheath, ligament, trigger point or ganglion cyst for relief of pain.

Indications and limitations of coverage and/or medical necessity

Medicare will provide coverage for tendon sheath, ligament or trigger point injections which are medically necessary based on specific symptoms, illness or injuries. The ICD-9 code must correlate with the need for the injection.

CPT/HCPCS Section and benefit category

Surgery/Physician's services

CPT/HCPCS codes

20550 Injection(s); tendon sheath, ligament

20551 Injection(s); tendon origin/insertion

20552 Injection(s); single or multiple trigger point(s), one or two muscle(s)

20553 Injection(s); single or multiple trigger point(s), three or more muscle(s)

Not Otherwise Classified (NOC)

N/A

ICD-9 codes that Support Medical Necessity

726.0
726.10
726.19
726.2
726.30
726.39
726.4
726.5
726.60
726.69
726.70
726.79
727.00
727.01
727.03
727.06
727.1
727.3
727.41
727.49
727.81

727.82
728.10
728.19
728.6
728.71
728.79
728.81
728.82
729.0
729.2

Diagnosis that Support Medical Necessity

Same as above.

ICD-9 codes that do not Support Medical Necessity

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

Diagnosis that not Support Medical Necessity

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

Reasons for denial

Medicare will not provide coverage for injections without appropriate medical necessity.

Non-covered ICD-9 codes

Any ICD-9 CM not included in this policy.

Non-covered diagnosis

Any diagnosis not included in this policy.

Coding guidelines

For aspiration and/or injection of ganglion cyst, use codes 20600, 20605, 20610 or 20612. Please note that codes 20550, 20551, 20552 and 20553 are components of 20600, 20605, 20610 and 20612 per the Correct Coding Initiative (CCI) and separate coverage is not allowed.

Codes 20552-20553 are reported one time per session, regardless of the number of injections or muscles injected.

Codes 20550 and 20551 should be reported one time for multiple or single injections to a tendon sheath, ligament, tendon origin or tendon insertion performed. Thus, multiple injections to the same tendon sheaths, tendon origins, tendon insertion, or ligaments would be reported one time only, while injections to multiple tendon sheaths, tendon origins, tendon insertion, or ligaments are reported one time for each injection.

Documentation requirements

Medical documentation for all tendon sheath, ligament or trigger point injections which are covered by Medicare is expected to indicate the clear and concise medical necessity within the patient's medical record, should review become necessary.

Utilization guidelines

N/A

Other comments

Please note the CPT codes in this policy are affected by multiple CCI edits.

Sources of Information and basis for decision

- AMA CPT Changes 2003
- Other Carrier policies: Cigna Medicare
- Local Rheumatology/Physical Therapy consultants
- Scientific American Medicine

Advisory Committee Notes

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

Start date of comment period

March 17, 2003

Ending date of comment period

May 1, 2003

Start date of notice period

June 9, 2003

Revision history

REVISION NUMBER	EFFECTIVE DATE OF THE REVISION	CHANGES
PR R 03-01		Review of policy published on Medicare Informa, Medical Policies III, Volume 38, page 33, with addition of ICD-9 codes.

GGL-1962

CHANGES TO THE LABORATORY NATIONAL COVERAGE DETERMINATION (NCD) EDIT SOFTWARE FOR OCTOBER 1, 2003

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Nationally uniform software has been developed by Computer Sciences Corporation and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003. The laboratory edit module for the NCDs will be updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCD.

The following changes are made to the edit module effective for services furnished on or after October 1, 2003.

1. In accordance with the decision memorandum published on the coverage Internet site on July 17, 2003, (see http://cms.hhs.gov/ncdr/memo.asp?id=94), we are adding diagnosis code 401.1, benign essential hypertension, to the list of ICD-9-CM codes covered by Medicare for lipid testing. Hypertension may be viewed as a cause of atherosclerosis that requires tighter management when accompanied by dyslipidemia.

2. ICD-9-CM codes are updated annually. New ICD-9-CM codes can render some of the presently covered codes inappropriate. Most commonly, codes are expanded so that additional digits are necessary. For example, a code that presently is displayed as 4 digits may be expanded to require 5 digits. The coding changes below are considered ministerial in that we are merely replacing existing codes within the NCD with the more current code structure or adding new codes that are within an existing covered range. We are making the following specific changes to the NCDs and edit module. However, because we provide a 90-day grace period for new ICD-9-CM codes, we will not actually be removing the codes from the edit module until the January 2004 release.

   - In the serum iron studies NCD list of covered diagnoses, we are removing code 282.4 and replacing it with 282.41, 282.42, and 282.49. We are removing code V43.2 and replacing it with V43.21 and V43.22. We are also adding new ICD-9-CM diagnosis codes 282.64, 282.68, and 289.52.

   - In the urine culture bacterial NCD list of covered diagnoses, we are removing code 600.0 and replacing it with 600.00 and 600.01; removing code 600.1 and replacing it with 600.10 and 600.11; removing 600.2 and replacing it with 600.20 and 600.21; and removing 600.9 and replacing it with 600.90 and 600.91. We are also adding the following new codes: 780.93, 780.94, 785.52, and 788.63.

   - In the human immunodeficiency virus testing (diagnosis) NCD list of covered diagnoses, we are removing ICD-9-CM diagnosis code 348.3 and replacing it with 348.30 and 348.39; and removing code 530.2 and replacing it with 530.20, 530.21, and 530.85. We are also adding new code 331.19.

- In the blood counts NCD list of ICD-9-CM codes that do not support medical necessity, we are removing code 600.0 and replacing it with 600.00 and 600.01; removing code 600.1 and replacing it with 600.10 and 600.11; removing 600.2 and replacing it with 600.20 and 600.21; and removing 600.9 and replacing it with 600.90 and 600.91. We are also removing code V04.8 and replacing it with V04.81, V04.82, and V04.89; removing V53.9 and replacing it with V53.90, V53.91 and V53.99; removing V54.0 and replacing it with V54.01, V54.02, and V54.09. In addition, we are adding the following new codes: 799.81, V25.03, V45.85, and V65.46.
- In the partial thromboplastin time NCD list of covered diagnoses, we are removing code 767.1 and replacing it with 767.11.
- In the prothrombin time NCD list of covered diagnoses, we are removing code 767.1 and replacing it with 767.11. We are also removing code V43.2 and replacing it with V43.21 and V43.22. In addition, we are adding new code 414.07.
- In the collagen cross-links NCD list of covered diagnoses, we are adding new code V58.65.
- In the blood glucose NCD list of covered diagnoses, we are removing code 790.2 and replacing it with 790.21, 790.22, and 790.29; and removing 348.3 and replacing it with 348.31.We are also adding new codes 414.07, V58.63, V58.64, and V58.65.
- In the glycated hemoglobin NCD list of covered diagnoses, we are removing code 790.2 and replacing it with 790.21, 790.22, and 790.29.
- In the thyroid testing NCD list of covered diagnoses, we are removing code 331.1 and replacing it with 331.11 and 331.19. We are also adding new codes 728.87, 780.93 and 780.94.
- In the lipid testing NCD list of covered diagnoses, we are adding codes 414.07, V58.63, and V58.64.
- In the prostate specific antigen NCD list of covered procedures, we are adding new code 788.63.
- In the gamma glutamyl transferase NCD list of covered diagnoses, we are adding new codes 282.64, 282.68, 289.52, V58.63, and V58.64.
- In the fecal occult blood NCD list of covered diagnoses, we are removing code 530.2 and replacing it with new codes 530.20, 530.21, and 530.85. We are also adding new codes V58.63, V58.64, and V58.65.
- In the list of ICD-9-CM codes denied that are applicable to all 23 NCDs, we are removing code V65.1 and replacing it with V65.11 and V65.19.

CR 2814/PM AB-03-104/07-25-03/RGM-2023

Políticas de Pago

SERVICIOS DE DIÁLISIS PARA PACIENTES HOSPITALIZADOS Y AMBULATORIOS REALIZADOS EL MISMO DÍA DEL SERVICIO DE EVALUACIÓN Y MANEJO

A partir del 1 de octubre de 2003, los códigos 90935 y 90937 se utilizarán para reclamaciones de servicios ambulatorios de hemodiálisis aguda (para pacientes que se espera recuperen sus funciones renales). Anteriormente, estos códigos fueron utilizados para servicios de diálisis aguda sólo para pacientes hospitalizados.

Los códigos CPT 90935 y 90937 se utilizan para informar "ESRD" hemodiálisis en pacientes hospitalizados y "non-ESRD" hemodiálisis en pacientes ambulatorios (Ej. Pacientes con insuficiencia renal aguda que requieran un breve período de diálisis antes de la recuperación).

Los códigos CPT 90945 y 90947 se utilizan para informar todos los procedimientos de no hemodiálisis.

Los servicios de evaluación y manejo realizados el mismo día que el servicio de diálisis relacionado a los pacientes con enfermedades renales están incluidos en el pago de estos cuatro códigos (90935, 90937, 90945 y 90947), excepto los siguientes:

Los códigos de evaluación y manejo pueden ser facturados el mismo día que los servicios de diálisis cuando se utiliza el modificador 25: servicio de evaluación y manejo significante y separadamente identificable por el mismo médico el mismo día.

Si el criterio indicado anteriormente no se cumple, el servicio de diálisis se cubrirá, pero el código de evaluación y manejo se denegará. Además, no estará permitido el pago de más de un servicio de diálisis por día.

99201-99205	Office or Other Outpatient Visit for an Established Patient
99211-99215	Office or Other Outpatient Visit for an Established Patient
99221-99233	Initial Hospital Care for a New or Established Patient
99238-99239	Hospital Discharge Day Management Services
99241-99245	Office or Other Outpatient Consultations, New or Established Patient
99251-99255	Initial Inpatient Consultations, New or Established Patient
99291-99292	Critical Care Services

Billing Policies

INPATIENT AND OUTPATIENT DIALYSIS SERVICES ON SAME DATE AS AN EVALUATION AND MANAGEMENT (E&M) SERVICE

Effective for dates of service October 1, 2003, CPT codes 90935 and 90937 should be used on claims for physicians' services for outpatient acute hemodialysis services (patients who are expected to regain their renal functions). Prior to this date, these codes were used for acute dialysis services only when they were furnished on an inpatient basis.

CPT codes 90935 and 90937 are used to report inpatient end stage renal disease (ESRD) hemodialysis and outpatient hemodialysis performed on non-ESRD patients (e.g., patients in acute renal failure requiring a brief period of dialysis prior to recovery).

CPT codes 90945 and 90947 are used to report all non-hemodialysis procedures.

All four of these codes include payment for any E&M services related to the patient's renal disease that are provided on the same date as the dialysis service. Therefore, payment for all E&M services are bundled into the payment for 90935, 90937, 90945, and 90947 with the following exception:

E&M services may be reported on the same date as a dialysis service with the use of modifier 25 (significant, separately identifiable evaluation and management service by same physician on same day).

If the above criteria are not met, the dialysis service will be covered and the E&M service will be denied. Furthermore, payment for more than one dialysis service per day is not allowed.

CR2622/Trans 1810/07-25-03/ICR

Políticas de Pago

ACTUALIZACIÓN DE LOS CÓDIGOS HCPCS PARA LA FACTURACIÓN CONSOLIDADA EN EL CUIDADO EN EL HOGAR

CMS emitió la tercera actualización trimestral para la facturación consolidada de Salud en el Hogar para el año natural 2003.

Esta actualización añade tres códigos de materiales de no-rutinarios a la lista de códigos sujetos a la facturación consolidada. Las reclamaciones sometidas con algún código en esta lista no se pagarán en las fechas en donde el beneficiario, para el cual el servicio es facturado, esté en un episodio de cuidado en el hogar. Medicare sólo reembolsará a la agencia primaria que haya iniciado los episodios de cuidado en el hogar. Terapias realizadas por médicos, suministros incidentales a servicios médicos y suministros utilizados en instituciones no están sujetos a la facturación consolidada de HH.

La próxima actualización a la lista de códigos sujetos a la facturación consolidada se llevará a cabo para el año natural 2004.

Códigos añadidos:

K0614= chem./antiseptic solution, 8oz.

K0620 = tubular elastic dressing

K0621= gauze, non-impreg pack strip

El código 97014 - "Electric stimulation therapy" se eliminó.

Los nuevos códigos identificados en cada actualización describen los mismos servicios que fueron usados para determinar la tarifa de pago aplicable al Sistema de Pago Prospectivo de Cuidado de Salud en el Hogar.

La lista actualizada de los códigos sujetos a la Facturación Consolidada de Servicios de Salud en el Hogar, está disponible en www.cms.hhs.gov/medlearn/refhha.asp.

Billing Policies

UPDATE OF HEALTHCARE HCPCS CODES USED FOR HOME HEALTH (HH) CONSOLIDATED BILLING ENFORCEMENT

CMS issued the third quarterly HH consolidated billing update for calendar year 2003.

This update adds three non-routine supply codes to the list of codes subject to consolidated billing. Claims submitted with services appearing on this list will not be paid on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The next update to the list of codes subject to consolidated billing will be the calendar year 2004 annual update.

Added:

K0614 = chem./antiseptic solution, 8 oz.

K0620 = tubular elastic dressing

K0621 = gauze, non-impreg pack strip

Code 97014 - Electric stimulation therapy was deleted.

The new coding identified in each update describes the same services that were used to determine the applicable HH Prospective Payment System (PPS) payment rates.

For an updated list of codes subject to HH consolidated billing, please see the HH consolidated billing master code list available at: www.cms.hhs.gov/medlearn/refhha.asp.

CR2776/Transmittal AB-03-096/July 3, 2003/ERO/els CR2892/ PM-AB-03-136/August 29, 2003

Políticas de Pago

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 CMS 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.

Billing Policies

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 CMS 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.

LISTA ACTUALIZADA (HPSA) *UPDATED HPSA LIST*	
PUERTO RICO	**US VIRGIN ISLANDS**
Aguas Buenas	Fredericksted South West, St. Croix
Caguas	
Cidra	Fredericksted North West, St. Croix
Gurabo	
Juncos	

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

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:August 13, 2003/MOA

Políticas de Pago

ÚLTIMA ACTUALIZACIÓN A LA BASE DE DATOS DE LAS TARIFAS FIJAS DEL 2003 PARA MÉDICOS

A continuación la última actualización a la Base de Datos de las Tarifas Fijas del 2003 para Médicos (MPFSDB, por sus siglas en inglés).

Los cambios de esta actualización se implementarán el 1 de octubre de 2003. Estos serán vigentes para reclamaciones con fechas de servicio del 1 de marzo de 2003 en adelante, excepto aquellos que indiquen otra fecha de en este artículo.

Los cambios incluidos en esta actualización son los siguientes:

Cambio de Estatus en Código de Procedimiento

El código de procedimiento G0027 involuntariamente fue eliminado del MPFSDB, el mismo se restableció. Este cambio será vigente al 1 de enero de 2003.

Cambio en los Indicadores de Procedimientos

El indicador de Supervisión Diagnóstica cambió de 09 a 01 para los siguientes códigos:

G0248

G0249

El indicador de Procedimiento Múltiple cambió de 2 a 0 para los siguientes códigos:

78306

78306-26

78306-TC

78320

78320-26

78320-TC

El indicador de Procedimiento Bilateral cambió a 2 para los códigos:

0025T

92136-26

Billing Policies

FINAL UPDATE TO THE 2003 MEDICARE PHYSICIANS FEE SCHEDULE DATABASE

The following is the final update to the 2003 Medicare Physicians Fee Schedule Database (MPFSDB).

The changes in this update will be implemented on October 1, 2003. The changes will be effective for claims with dates of services of March 1, 2003 and thereafter (except for those which have a different date as indicated in this article).

Changes included in this final update are as follows:

Procedure Code Status Changes

Procedure code G0027 was inadvertently deleted from the MPFSDB and is now being reinstated. This change is effective January 1, 2003.

Processing Indicator Changes

The Diagnostic Supervision indicator for the following codes is changing from 09 to 01:

G0248

G0249

For the following codes the Multiple Procedure indicator is changing from 2 to 0:

78306

78306-26

78306-TC

78320

78320-26

78320-TC

The Bilateral Indicator for the following codes changed to 2:

0025T

92136-26

Políticas de Pago

Definición de los indicadores de Procedimiento

Indicador de Supervisión Diagnóstica = 01

- Procedimiento debe realizarse bajo la supervisión general de un médico.
- Indicador de Procedimiento Múltiple =0
- No aplica regla de ajuste de pagos para procedimientos múltiples.

Indicador de Procedimiento Bilateral = 2

- 150 por ciento de ajuste de pago para procedimiento bilateral no aplica.

Nuevos Códigos

Los siguientes códigos se añadieron al MPFSDB, éstos serán vigentes para fechas de servicio del 1 de octubre de 2003 en adelante.

G0296 = "PET image restaging thyroid cancer"

G0296-26 = "Professional Component"

G0296-TC = "Technical Component"

Q4076 = "Dopamine hcl 40 mg"

Q4077 = "Treprostinil, 1 mg"

Q4078 = "Ammonia N-13, per dose"

Cambio de código base de Endoscopia

El código base cambió de 52347 a 52010

Cambios en las Unidades de Valor Relativo (RVU)

A continuación los códigos de servicio con sus respectivos cambios en las Unidades de Valor Relativo:

Billing Policies

Processing Indicator Definitions

Diagnostic supervision indicator = 01

- *Procedure must be performed under the general supervision of a physician.*
- *Multiple procedure indicator =0*
- *No payment adjustment rules apply.*

Bilateral indicator = 2

- *150% payment adjustment for bilateral procedures does not apply.*

New Codes

The following codes are being added to the MPFSDB, effective for services starting on October 1, 2003 and thereafter.

G0296=PET image restaging thyroid cancer

G0296-26 = professional component

G0296-TC = technical component

Q4076 = Dopamine hcl 40 mg

Q4077 = Treprostinil, 1 mg

Q4078 = Ammonia N-13, per dose

Endoscopic Base Code

The endoscopic base code is changing from code 52347 to 52010

Relative Value Units (RVU) Changes

The following are the codes of service with changes in the Relative Value Units:

RVU TYPES TIPOS DE RVU'S	CODES CÓDIGOS	
	G0296-26	93012
Work RVU RVU de trabajo	1.87	n/a
Facility Practice Expense RVU RVU Gastos de Práctica en Instalación Hospitalaria	0.73	5.99
Non-Facility Practice Expense RVU RVU Gastos de Práctica en Instalación No-Hospitalaria	0.73	n/a
Malpractice RVU RVU de Impericia Médica	0.07	n/a

Políticas de Pago

La siguiente tabla indica las nuevas tarifas de los códigos donde los por cientos de las Unidades de Valor Relativo cambiaron.

Billing Policies

The following table indicates the new charges that apply to the codes where the RVU changes:

Códigos *Codes*	Lugar *Setting*	Puerto Rico *Fees*	US Virgin Islands *Fees*
G0296-26	Non-Facility	$80.43	$96.43
	Facility	$80.43	$96.43
93012	Non-Facility	$158.40	$230.94
	Facility	$158.40	$230.94

CR2853/PM AB-03-119/8-8-03/ERO/els

ACTUALIZACIÓN TRIMESTRAL A LA FACTURACIÓN CONSOLIDADA DE ENFERMERÍA ESPECIALIZADA

Bajo los requisitos de la facturación consolidada, Los Centros de Enfermería Especializada (SNF, por sus siglas en inglés) deben someter sus reclamaciones al Intermediario Fiscal para todos los servicios de la Parte A y Parte B de Medicare que sus residentes reciben durante el período de cubierta de la estadía Parte A excepto por algunos servicios excluidos. Para beneficiarios en una estadía Parte B, sólo los servicios de terapia física, ocupacional y del habla deben ser consolidados.

Por ende, para reclamaciones con fecha de servicio de 1 de octubre de 2003 en adelante, el código de procedimiento 92597 se considerará parte de los servicios de terapia y no puede se pagará separadamente por el contratista de la Parte B. El pago de este servicio está incluido en el pago hecho al SNF.

Si desea obtener información adicional, puede acceder la página electrónica de CMS en: www.cms.hhs.gov/medlearn/snfcode.asp.

QUARTERLY UPDATE FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING

Under the consolidated billing requirements, the SNF must submit Medicare claims to the fiscal intermediary (FI) for all Part A and Part B services that its residents receive during the course of a covered Part A stay except for a small number of excluded services. For beneficiaries in a Part B stay, only physical, occupational and speech therapy services must be consolidated.

For claims with dates of service October 1, 2003 and thereafter, CPT code 92597 will be considered part of the therapy services that cannot be paid separately by the carrier. Payment for this service is included in the payment made to the SNF.

For further information see The Centers for Medicare and Medicaid Services (CMS) Web site at: www.cms.hhs.gov/medlearn/snfcode.asp.

CR2781/Transmittal AB-034-094/July 3, 2003/ICR-els

Políticas de Pago

DEMORA A LA IMPLANTACIÓN DE LA LIMITACIÓN MONETARIA POR SERVICIOS DE REHABILITACIÓN A PACIENTES NO HOSPITALIZADOS

Debido a argumentos en litigio presentados en el Tribunal Federal, los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) determinaron posponer la implementación de la limitación monetaria por servicios de rehabilitación a pacientes no hospitalizados. La fecha de implementación cambia del 1 de julio de 2003 al 1 de septiembre de 2003.

La limitación monetaria no afectará los servicios de rehabilitación ofrecidos del 1 de enero de 2003 al 31 de agosto de 2003 a pacientes no hospitalizados. Comenzando el 1 de septiembre de 2003 en adelante los servicios prestados estarán sujetos a la limitación. El artículo "Limitación Monetaria de Reclamaciones por Servicios de Rehabilitación a Pacientes No Hospitalizados" publicado en el Boletín **Medicare Informa** edición de abril, mayo, junio de 2003, páginas 86 a la 93, detalla esta política de pago. Notarán que solamente cambia la fecha de implementación.

La totalidad de los $1,590 por cada limitación aplicará a los servicios de rehabilitación a pacientes no hospitalizados ofrecidos del 1 de septiembre de 2003 al 31 de diciembre de 2003.

Reclamaciones Denegadas

Se actualizó la fecha de implementación para que las reclamaciones con fechas de servicio del 1 de julio al 31 de agosto de 2003 no estén sujetas a la limitación monetaria. Aunque poco probable, si se denegó alguna reclamación con estas fechas de servicio por exceder la limitación monetaria, el contratista ajustará la misma y pagará la cantidad correcta.

Billing Policies

DELAY IN IMPLEMENTATION OF OUTPATIENT THERAPY CAPS

To address issues arising in Federal Court litigation, the Centers for Medicare and Medicaid Services (CMS) has elected to delay implementation date of the outpatient therapy limitations from July 1, 2003, to September 1, 2003.

Therapy caps will not affect outpatient therapy services provided from January 1, 2003 through August 31, 2003. Services rendered September 1, 2003 and thereafter will be subject to outpatient therapy caps. An article on this subject was included in pages 86 to 93 of our April, May & June 2003 ***Medicare Informa****. You will note that only the implementation date has changed.*

The full amount of $1,590 for each cap will apply to therapy services rendered between September 1, 2003, and December 31, 2003.

Denied Claims

The implementation date was adjusted so that claims with dates of service July 1 through August 31, 2003, are not subject to financial limitations. Although unlikely, if a claim with these dates of service is denied due to amounts exceeding the therapy limitations the carrier will adjust the claim to pay the appropriate amount.

PM AB-03-097, CR2837/ July 17, 2003 /dmg/els

Políticas de Pago

PAGOS DENEGADOS POR SERVICIOS OFRECIDOS A BENEFICIARIOS EXTRANJEROS QUE NO VIVEN LEGALMENTE EN ESTADOS UNIDOS

Los Centros para Servicios de Medicare y Medicaid (CMS, pos sus siglas en inglés) proporcionaron los siguientes procedimientos para el proceso de reclamaciones para todos los contratistas de Medicare que procesan reclamaciones de servicios ofrecidos a beneficiaros extranjeros.

La Sección 401 del "Personal Responsibility and Work Opportunity Reconciliation Act" de 1996 (PRWORA, por sus siglas en inglés) prohíbe a los extranjeros no cualificados recibir beneficios públicos federales, incluyendo Medicare. El término "extranjero cualificado" incluye los siguientes seis grupos de extranjeros.

1. Extranjeros admitidos legalmente para obtener permanencia bajo el Acta de Inmigración y Nacionalidad.
2. Extranjeros a quienes le han otorgado asilo bajo la Sección 208 del Acta.
3. Refugiados admitidos en Estados Unidos bajo la Sección 207 del Acta.
4. Extranjeros bajo libertad condicional en Estados Unidos por al menos un año bajo la Sección 212(d)(5) del Acta.
5. Extranjeros cuya deportación haya sido aplazada bajo la Sección 243(h) del Acta.
6. Extranjeros a quienes le han otorgado entrada condicional de acuerdo a la Sección 203(a)(7) del Acta vigente antes del 1 de abril de 1980.

Se añadieron dos grupos de extranjeros cualificados a este estatuto.

Estos grupos son los siguientes:

1. Algunos cubanos y haitianos recién llegados a Estados Unidos

Billing Policies

PAYMENT DENIAL FOR MEDICARE SERVICES FURNISHED TO ALIEN BENEFICIARIES WHO ARE NOT LAWFULLY PRESENT IN THE UNITED STATES

The Centers for Medicare & Medicaid Services (CMS) has provided the following claims processing procedures for all Medicare contractors that process claims containing Medicare services submitted for alien beneficiaries.

Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) prohibited aliens who are not "qualified aliens" from receiving federal public benefits including Medicare. The term "qualified alien" is defined to include six groups of aliens as follows:

1. *Aliens who are lawfully admitted for permanent residence under the Immigration and Nationality Act (Act);*
2. *Aliens who are granted asylum under section 208 of the Act;*
3. *Refugees admitted into the United States under section 207 of the Act;*
4. *Aliens who are paroled into the United States under section 212(d)(5) of the Act for a period of at least 1 year;*
5. *Aliens whose deportation is being withheld under section 243(h) of the Act; or*
6. *Aliens who are granted conditional entry pursuant to section 203(a)(7) of the Act as in effect prior to April 1, 1980.*

Two groups of qualified aliens were added to the statute after the original enactment of the restriction in the 1996 Welfare Reform statute. These groups are:

1. *Certain Cuban and Haitian entrants to the United States; and*

Políticas de Pago

2. Algunos extranjeros maltratados

Bajo los términos del "Personal Responsibility and Work Opportunity Reconciliation Act", los extranjeros no cualificados no pueden recibir beneficios de Medicare.

La Sección 5561 del Balanced Budget Act de 1997 (BBA, por sus siglas en inglés) corrigió la Sección 401 del PRWORA para crear una exención de Medicare para prohibir la elegibilidad a beneficiarios extranjeros no cualificados que viven legalmente en Estados Unidos y reúnen otras condiciones.

Bajo las disposiciones de la ley, debe pagarse por servicios ofrecidos a un extranjero que vive legalmente en Estados Unidos, quien está autorizado a recibir un salario tributable para propósitos de elegibilidad de beneficios de Medicare. La definición para "viviendo legalmente en Estados Unidos" la puede encontrar en la Sección 8CFR 103.12.

Pago por Beneficios de Medicare

No se pagará por ningún servicio médico ofrecido a beneficiarios extranjeros que no vivan legalmente en Estados Unidos.

CR2825/PM-AB-03-115/August 1, 2003/dmg

Billing Policies

2. Certain "battered aliens."

Under the terms of the PRWORA, non-qualified aliens could not receive Medicare benefits.

Section 5561 of the Balanced Budget Act of 1997 (BBA) amended section 401 of the PRWORA to create a Medicare exemption to the prohibition on eligibility for non-qualified alien beneficiaries, who are lawfully present in the United States and who meet certain other conditions.

Under the provisions of the final rule, payment may be made for services furnished to an alien who is lawfully present in the United States (and, provided that with respect to benefits payable under Part A of Title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for Medicare benefits). The definition for "lawfully present in the United States" is found at 8 CFR 103.12.

Payment for Medicare Benefits

No payments will be made for Medicare services furnished to an alien beneficiary who is not lawfully present in the United States.

Ambulancia

TERCERA ACLARACIÓN A LA POLÍTICA DE MEDICARE RELACIONADA A LA IMPLANTACIÓN DE LAS TARIFAS DE AMBULANCIA

Las siguientes aclaraciones, organizadas por categoría, reflejan la política de Medicare con relación a la implementación de las Tarifas Fijas de Ambulancia y complementan las instrucciones previamente impartidas.

a. Apelaciones a las Tarifas Fijas de Ambulancia

La reglamentación final de Ambulancia publicada el 27 de febrero de 2002, estableció una tarifa fija para el pago de los servicios de ambulancia bajo el Programa Medicare por medio de la Sección 1834(1) del Acta de Seguro Social. Las Tarifas Fijas de Ambulancia están vigentes para las reclamaciones con fechas de servicio del 1 de abril de 2002 en adelante. La reglamentación final**,** establece un período de transición de cinco años mediante el cuál el pago estará basado en una tarifa combinada (un por ciento de la tarifa fija de ambulancia sumada a un por ciento del cargo razonable). La Sección 1834 (1)(5) del Acta de Seguro Social y 42CFR§414.625, dispone que los proveedores de transportación en ambulancia no podrán apelar las cantidades establecidas como Tarifa Fija.

b. Ajustes al Cargo Razonable

La reglamentación final **del 13 de diciembre de 2002 establece el procedimiento que los contratistas seguirán** si se determina que el cargo a aprobarse es insuficiente o excesivo. Este procedimiento decreta, que si el margen para las situaciones antes expuesta está dentro de un margen de un 15 por ciento, no se realizará ajustes a la porción del cargo razonable. Esta regla no aplica al sistema de los Pagos

Ambulance

THIRD CLARIFICATION OF MEDICARE POLICY REGARDING THE IMPLEMENTATION OF AMBULANCE FEE SCHEDULE

The following clarifications, organized by category, reflect Medicare's policy regarding the implementation of the Ambulance Fee Schedule and supplement previously issued instructions.

a. Ambulance Fee Schedule Appeals

The ambulance final rule published on February 27, 2002, established a fee schedule for the payment of ambulance services under the Medicare program, thereby implementing §1834(1) of the Social Security Act. The Ambulance Fee Schedule is effective for claims with dates of service on or after April 1, 2002. The final rule established a five-year transition period, during which time payment will be based on a blended amount, based in part on the Ambulance Fee Schedule and in part on reasonable charge. In accordance with §1834(1)(5) of the Social Security Act and 42 CFR §414.625, ambulance providers may not appeal the fee schedule amounts.

b. Inherent Reasonable (IR) Adjustments

*The final rule implementing inherent reasonable (IR) adjustments to Medicare payment allowances was published in the **Federal Register on December 13, 2002.** The criteria for applying IR, specified in the final rule, includes a threshold of 15 percent that must be met before IR adjustments may be made. That is, if a payment allowance is determined to be either deficient or excessive by an amount that is less than*

Cont. on next page

Prospectivos. Este ajuste aplicará solamente a la porción de Cargo Razonable del pago combinado para los servicios de ambulancia durante el período de transición.

Tan pronto CMS emita las instrucciones finales a este particular, le ofreceremos más información.

c. Proveedores que Solicitan Cambio al Método de Facturación Durante el Período de Transición

Para el 31 de marzo de 2002, a los proveedores de servicios de transportación en ambulancia se les requirió que escogieran un método de facturación. Ante la ausencia de cualquier elección, los contratistas le asignaron el Método 2 de facturación al proveedor que utilizaba múltiples métodos de facturación. Durante el período de transición (período que comprende del 1 de abril de 2002 hasta el 31 de diciembre de 2005) el proveedor no podrá cambiar el método de facturación.

A partir del 1 de enero de 2006 que es cuando comienza la implementación total de las Tarifas Fijas de Ambulancia, el Método de Facturación para todos los proveedores de ambulancia será el Método 2.

d. Requisitos Para La Nota Por Adelantado Del Beneficiario (ABN, por sus siglas en inglés)

i. Requisitos del ABN para Transportes de No-Emergencia

EL ABN (Forma CMS-R-131) es una notificación por escrito que el médico o proveedor le entrega al beneficiario de Medicare antes de ofrecerle el servicio o resultados cuando éste entiende que Medicare no pagará por alguno o todos los servicios o resultados basados en ciertas exclusiones estatutarias de Medicare.

Un ABN se utiliza en raras ocasiones para servicios de ambulancia y puede utilizarse solamente para *transportes* de no-emergencia. Un ABN no se puede utilizar cuando un beneficiario está bajo

15 percent, then no IR adjustment may be made. Prospective payment systems, including the Ambulance Fee Schedule, are exempt from IR. Therefore, IR applies only to the reasonable charge portion of the blended payment for ambulance services during the transition period.

As soon as CMS releases the final instructions regarding this matter we will provide you more information.

c. Providers Requests to Change Billing Methods During the Transition Period

Ambulance providers were required to elect a single billing method by March 31, 2002. In the absence of any election, carriers were required to convert providers using multiple billing methods to billing Method 2. During the transition period, April 1, 2002 through December 31, 2005, a provider may not change its billing method. Effective with the full implementation of the Ambulance Fee Schedule beginning January 1, 2006, all ambulance providers will be converted to billing Method 2.

d. Advance Beneficiary Notice (ABN) Requirements

i. ABN Requirements for Non-Emergency Transports

The ABN (form CMS-R-131) is a written notice a physician or provider gives to a Medicare beneficiary before items or services are furnished when the physician or provider believes that Medicare will not pay for some or all of the items or services on the basis of certain Medicare statutory exclusions.

An ABN is rarely used for ambulance services, and may only be issued for non-emergency transports. An ABN may not be used when a beneficiary is

Cont. on next page

Ambulancia

una gran presión. Se considera que un beneficiario está bajo una gran presión cuando su condición médica requiere cuidado de emergencia.

Un ABN puede ser necesario y podría utilizarse para la transportación de no-emergencia en las siguientes situaciones:

a. Una transportación por ambulancia aérea cuando la entidad que transporta al paciente tiene una base razonable para creer que el transporte puede hacerse seguro y eficientemente a través de una ambulancia terrestre.

b. El nivel de cuidado baja de categoría. Un ejemplo de esto es cuando un servicio ALS- 2 baja a un ALS-1 o de un ALS baje a un BLS o cuando el transporte de un nivel más bajo está cubierto.

Un ABN no se necesita y no debe utilizarse en las siguientes situaciones:

a. Donde el paciente pueda ser transportado de una manera segura por otros medios de transportación (estas son denegaciones bajo la Sección 1861(s)(7) del Acta del Seguro Social).

b. Cuando no se cumpla con el requisito del origen o destino requerido (estas denegaciones están basadas en la Reglamentación 42 CFR 410.40 y bajo la Sección 1861(s)(7) denegatorias) del Acta del Seguro Social.

c. Por millaje que sea más allá de la institución apropiada más cercana (por la misma razón mencionada anteriormente en la situación “b”).

d. Donde el “PCS” o la alternativa aceptada (Ej. carta certificada) no se obtiene.

e. Paciente que se da de alta a su conveniencia (ejemplo: un paciente hospitalizado en una institución que puede atender sus necesidades, pero quiere ser trasladado a un segundo hospital para estar más cerca de un familiar)

Ambulance

under great duress. A beneficiary is considered to be under great duress when his or her medical condition requires emergency care.

An ABN may be needed and may be used for non-emergency *transports in the following situations:*

a. A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.

b. A level of care downgrade, e.g., from ALS-2 to ALS-1, or from ALS to Basic Life Support (BLS), when the transport at the lower level of care is a covered transport.

An ABN is not needed, and should not be used, in the following situations:

a. Where the patient could be transported safely by other means (these are denials under §1861(s)(7) of the Social Security Act (the Act)).

b. When not meeting with the origin or destination requirement (these denials are based on 42 CFR 410.40 and generally also constitute §1861(s)(7) denials).

c. For mileage that is beyond the nearest appropriate facility (for the same reason as “b” above).

d. Where the PCS or accepted alternative (e.g., certified mail) is not obtained (for the same reason as “b” above).

e. A convenience discharge, e.g., where the patient is an inpatient at one hospital that can care for their needs, but wants to be transferred to a second hospital to be closer to family (for the same reason as “b” above).

Cont. on next page

Ambulancia

El Aviso de Exclusión de los Beneficios de Medicare (NEMB, por sus siglas en inglés, Forma CMS 20007) es un formulario opcional que CMS desarrolló para asistir a los proveedores y donde éstos pueden notificarle a los beneficiarios que los servicios que están recibiendo, están excluidos de los beneficios de Medicare. Cuando el uso de un ABN no es apropiado porque la necesidad médica no es la base para la denegación esperada, se puede utilizar un NEMB. En los casos en que el ABN no es apropiado, los proveedores de ambulancia pueden desarrollar su propio procedimiento para comunicarle a los beneficiarios que a ellos se le facturará por los servicios excluidos.

El formulario CMS-20007 NEMB está disponible en español e inglés ''online''. Puede obtener más información bajo el tema ''CMS Beneficiary Notices Initiative'' a través de la página electrónica de CMS en http://www.cms.hhs.gov/medicare/bni/.

En las situaciones antes expuestas donde no es apropiado un ABN, marque el encasillado #1 del NEMB y escriba la razón relevante en el espacio superior del encasillado, arriba de donde dice ''Medicare no pagará por'', por ejemplo:

- "Transporte de ambulancia que no cumple con el requisito de origen o destino''
- "Transporte de ambulancia donde el paciente puede ser *transportado* de una manera segura a través de otros medios de transportación"
- "Transporte por conveniencia personal''

La siguiente tabla resume las situaciones donde se puede utilizar un ABN con relación a los servicios de ambulancia.

Ambulance

The Notice of Exclusions from Medicare Benefits (NEMB, form CMS-20007) is an optional form that CMS developed to assist providers in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. When an ABN is not appropriate to use because medical necessity is not the basis for the expected denial, an NEMB may be used. Ambulance providers may develop their own process to communicate to beneficiaries that they will be billed for excluded services, for which the ABN is not appropriate.

The NEMB form CMS-20007 is available in English and Spanish online and can be accessed at the CMS Beneficiary Notices Initiative Web page at http://www.cms.hhs.gov/medicare/bni/.

In the case of the situations listed above for which an ABN is not appropriate, on the NEMB, check Box #1 and write the relevant reason in the "Medicare will not pay for" space (above check Box #1), for example:

- *"Ambulance transports that do not meet an origin or destination requirement"*
- *"Ambulance transports where the patient could be transported safely by other means"*
- *"Personal convenience transports."*

The following table summarizes situations when an ABN is applicable regarding ambulance services:

Cont. on next page

Ambulancia

Ambulance

Situation	Statutory Provision	ABN Applicable	Limitation On Liability Applicable	Responsible for Payment
Other means of transportation not contraindicated	1861(s)(7) - Benefit Category	NO. An NEMB may be used.	NO	BENEFICIARY
Air to Ground Downcoding	1862(a)(1)(A) Reasonable & Necessary	YES **	YES	SUPPLIER/ PROVIDER or BENEFICIARY if ABN is signed
ALS to BLS Downcoding	1862(a)(1)(A) Reasonable & Necessary	YES**	YES	SUPPLIER/ PROVIDER or BENEFICIARY if ABN is signed
Mileage Partial Denial	1861(s)(7) - Benefit Category	NO. An NEMB may be used.	NO	BENEFICIARY

**Indica que se utiliza un ABN. No obstante, si es un transporte de emergencia, los ABN no deben utilizarse, ya que se considera que los beneficiarios están bajo gran presión'.

ii Requisitos del ABN para Vuelos Internacionales

Los servicios prestados fuera de los Estados Unidos a beneficiarios de Medicare están excluidos de la cubierta de Medicare bajo la Sección §1862(a)(4) del Acta. Por lo tanto, cuando el punto de recogida es fuera de los EE.UU. incluyendo el punto de recogida fuera de los territorios de EE.UU., entonces el transporte desde el punto de recogida hasta el lugar de entrada más cercano a los EE.UU. está excluido. En estos casos, el uso del ABN no es indicado, pero el beneficiario debe ser informado de que Medicare no pagará por la porción internacional del vuelo. En tal caso, un NEMB podría utilizarse marcando en el encasillado #2 y encasillado seis (6) de la columna izquierda (atención médica recibida fuera de los EE.UU.) y escribiendo la razón relevante al lado de "Medicare no pagará por" (espacio superior del encasillado #1), por ejemplo:

- "Transporte de Ambulancia Fuera de los EE.UU."

***Indicates that an ABN is applicable. However, if it is an emergency transport, ABNs cannot be used, since beneficiaries are considered under great duress in such situations.*

ii. ABN Requirements for International Flights

Absent the rare circumstance of coverage of an ambulance service under §1814(f) of the Act, services outside the United States furnished to a Medicare beneficiary are statutorily excluded from Medicare coverage under §1862(a)(4) of the Act. Thus, when the point of pickup is outside the United States, including a point of pickup outside of the U.S. territories, then the transport from the point of pickup to the nearest U.S. point of entry is statutorily excluded. The use of an ABN is not indicated but the beneficiary should be informed that Medicare would not pay for the international portion of the flight. An NEMB may be used, in which case, on the NEMB, check Box #2 and the sixth box in the left column ("Health care received outside of the USA") and write the relevant reason in the "Medicare will not pay for" space (above check Box #1), for example:

- *"Ambulance transports outside of the USA."*

Cont. on next page

Ambulancia

Si el beneficiario (o su representante) desea una determinación formal de Medicare de una reclamación por un transporte con origen fuera de EE.UU., la entidad que ofreció el transporte tendrá que llenar y enviar una reclamación a Medicare.

Siguiendo la porción internacional del vuelo, si el beneficiario es transportado por la ambulancia desde el punto de entrada más cercano (incluyendo el mismo avión utilizado para transportar al beneficiario en el vuelo internacional), entonces las reglas de Medicare aplican. Si el beneficiario es transportado desde el punto de entrada más cercano a la institución apropiada más cercana, y si se cumple con los requisitos de Medicare, el *transporte* estará cubierto y se pagará. Si la entidad de transporte tiene una base razonable para creer que la porción doméstica del vuelo de no-emergencia no estará cubierta porque no es razonable y necesario bajo la reglamentación de Medicare, entonces el uso de ABN es adecuado para el transporte de los servicios de no-emergencia.

e. Requisitos para Certificados de Necesidad Médica (PCS, por sus siglas en inglés)

i. Requisitos para Transportación por Servicios de Emergencia-PCS

Los requisitos de PCS están especificados en la reglamentación 42 CFR §410.40 (d). El PCS no es requisito si la transportación es una de emergencia. La respuesta a una emergencia se define como el nivel de servicio BLS o ALS1 prestado ante una contestación inmediata de una llamada 911 ó su equivalente. No es relevante para esta determinación el diagnóstico del paciente o si el transporte es documentado como "emergencia" dado a la condición del paciente. (Ver inciso h más adelante para más información con relación a la definición emergencia).

Ambulance

If the beneficiary (or his/her representative) desires a formal Medicare determination on a claim for a transport originating outside the U.S., then the transporting entity must file a claim to Medicare.

Following the international portion of a flight, if the beneficiary is then transported from the nearest point of entry by ambulance, including the same aircraft used to transport the beneficiary on the international flight, then standard Medicare rules apply. If the beneficiary is transported from the nearest point of entry to the nearest appropriate facility, then, if all other Medicare rules are met, the transport would be covered and payable. If the transporting entity has a reasonable basis to believe that the domestic portion of a non-emergency flight would not be covered because it is not reasonable and necessary under Medicare rules, then use of an ABN is indicated for non-emergency ambulance transports.

e. PCS Requirements

i. PCS Requirements for Emergency Transports

The regulations governing PCS requirements are specified at 42 CFR §410.40(d). A PCS is not required if the transport is an emergency transport. An emergency response is defined as a BLS or ALS-1 level of service provided in immediate response to a 911 call or the equivalent. The patient's diagnosis, and whether the transport is documented as an "emergency" due to the patient's condition, is not relevant to this determination. See item h. for more information concerning the Medicare definition of "emergency."

Cont. on next page

Ambulancia

ii Requisitos de PCS por Servicios de Ambulancia Repetitivos

Los requisitos PCS para servicios de ambulancia de no-emergencia planificados y repetitivos se encuentran en la reglamentación 42 CFR §410.40 (d)(2). Un servicio de ambulancia repetitivo es definido como una transportación de ambulancia médicamente necesaria y que es prestada tres veces por lo menos en tres semanas. La terapia respiratoria y el diálisis son tipos de tratamientos por los cuales los servicios de ambulancia repetitivos son frecuentemente necesarios. No obstante, el requisito de someter el formulario PCS para los servicios de ambulancia de no-emergencia están basados en un estándar cuantitativo (tres veces o más durante un período de 10 días o por lo menos una vez en la semana por lo menos en tres semanas). De igual forma, un itinerario regular por servicios de ambulancia para visitas de seguimiento, ya sean de rutina o inesperadas**,** no son repetitivos para propósitos de este requisito a menos que se cumpla con uno de los estándares.

iii. Formularios PCS Generados por Computadora y Firmas Electrónicas

Los proveedores pueden utilizar formularios PCS y firmas electrónicas que cumplan los requisitos de PCS de la Reglamentación 42 CFR §410.40 (d).

iv. Evidencia de Envío Cuando no se Puede Obtener un PCS

Cuando no se puede obtener el PCS de acuerdo con la Reglamentación §410.40 (d)(3)(iv), el proveedor de servicios de ambulancia puede enviar una carta a través de Correo Certificado del Servicio Postal de los EE.UU. (USPS, por sus siglas en inglés) con acuse de recibo del envío u otro servicio comercial similar demostrando el envío de la carta como evidencia de que intentó obtener el PCS.

Ambulance

ii. PCS Requirements for Repetitive Ambulance Services

The regulations governing PCS requirements for repetitive, scheduled, non-emergency ambulance services are specified at 42 CFR §410.40(d)(2). A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least three weeks. Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary. However, the requirement for submitting the PCS form for repetitive, scheduled, non-emergency ambulance services is based on the quantitative standard (three or more times during a ten-day period or at least once per week for at least three weeks). Similarly, regularly scheduled ambulance services for follow-up visits, whether routine or unexpected, are not "repetitive" for purposes of this requirement unless one of the quantitative standards is met.

iii. Computer Generated PCS Forms and Electronic Signatures

Providers may use computer-generated PCS forms and computerized physician signatures to meet the PCS requirements of 42 CFR §410.40(d)

iv. Proof of Mailing When a PCS Cannot Be Obtained

When a PCS cannot be obtained in accordance with §410.40(d)(3)(iv), a provider may send a letter via U.S. Postal Service (USPS) Certified Mail with a return receipt proof of mailing or other similar commercial service demonstrating delivery of the letter as evidence of the attempt to obtain the

Cont. on next page

Ambulancia

Los proveedores pueden utilizar el formulario 3817 de Correo Certificado del Servicio Postal como una alternativa para certificar el envío.

f. Facturación por el Millaje Aéreo

En las reclamaciones por transportaciones aéreas se puede reclamar por todo el millaje que comienza calculándose desde el punto de recogida e incluye lo que aplica a: *"ramp to taxiway, taxiway to runway, takeoff run, air miles roll out upon landing, and taxiing after landing."*

g. Intervenciones ALS No Exitosas

Una intervención ALS es un procedimiento que de acuerdo con el estado y las leyes locales van más allá del alcance de la práctica de un técnico-básico de emergencias médicas (EMT-Basic, por sus siglas en inglés). Un intento sin éxito para realizar una intervención ALS (ejemplo: una intubación ''endotracheal'' que se intentó, pero sin éxito) puede cualificar el transporte para facturar el nivel ALS apropiado; siempre y cuando la intervención fuera médicamente necesaria si se hubiera logrado.

h. Estableciendo un Transporte ALS Basado en una Evaluación ALS

Cuando se despacha una ambulancia BLS y se realiza una evaluación ALS, el traslado puede facturarse como ALS solamente para las situaciones de emergencia. Medicare paga la tarifa de nivel BLS para la transportación de no-emergencia a pesar de que se preste un servicio ALS. Para propósitos de Medicare, los servicios de ambulancia de emergencia dependen de cómo salió la ambulancia y como respondió. Un estatus de emergencia no depende de asistencia prestada después que la ambulancia llegue. Una "respuesta a una emergencia" se define como un servicio BLS o ALS-1 que fue prestado como una respuesta inmediata a una llamada 911 ó su equivalente. Una "respuesta

Ambulance

PCS. Providers may also use the U.S. Postal Service Certificate of Mailing, Form 3817 as an acceptable alternative to certified mail.

f. Billing for Air Mileage

Claims for air transports may account for all mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing, and taxiing after landing.

g. Unsuccessful ALS Interventions

An ALS intervention is a procedure that is, in accordance with state and local laws, beyond the scope of practice of an emergency medical technician-basic (EMT-Basic). An unsuccessful attempt to perform an ALS intervention (e.g., endotracheal intubations was attempted, but was unsuccessful) may qualify the transport for billing at the appropriate ALS level provided that the intervention would have been reasonable and necessary had it been successful.

h. Establishing an ALS Transport Based on an ALS Assessment

When a BLS ambulance is dispatched and an ALS assessment is performed, the transport may be billed as ALS only for emergency transports. Medicare pays the BLS-level rate for non-emergency transports regardless of whether an ALS assessment is performed. For Medicare program purposes, an emergency level of ambulance services depends upon how the ambulance was dispatched and how it responded. Emergency status does not depend upon whether an assessment was furnished after the ambulance arrived. An "emergency response" is defined as a BLS or ALS-1 level of service that has been provided in immediate response to a 911 call or the equivalent". An immediate response is one in which the ambulance

Cont. on next page

inmediata" es una en la cual el proveedor de ambulancia comienza lo antes posible a tomar los pasos necesarios para responder a la llamada. Una emergencia se determina a base de la información disponible al despachador al momento de la llamada, basándose en el protocolo de salida. La asistencia ALS sólo es pertinente respecto al pago por un transporte ALS de emergencia. Esto significa, que la asistencia ALS puede ser pertinente para determinar si un transporte de emergencia se paga al nivel BLS o ALS. No obstante, la asistencia ALS no se relaciona con que el transporte cualifique para el pago de un nivel de emergencia. Además, el identificar un servicio como una respuesta de emergencia no tiene que ver con el estatus bajo la reglamentación SSA 1861(s)(7), aunque la transportación por otros medios sea viable.

i. Respuesta ALS Obligatoria

Durante el período de transición, Medicare aprueba el nivel de pago ALS para el transporte de emergencia y no-emergencia cuando el vehículo ALS es el que se utiliza, pero no se presta un servicio ALS en áreas donde una respuesta ALS es obligatoria. Según establecido en instrucciones previas, existen dos códigos HCPCS temporeros para la facturación de estos servicios. El código HCPCS Q3019 aplica cuando un vehículo ALS es utilizado para una **transportación de emergencia**, pero no se ha prestado un servicio de nivel ALS. El código HCPCS Q3020 aplica cuando un vehículo ALS se utiliza para una **transportación de no-emergencia,** pero no se ha prestado un servicio de nivel ALS. La porción del pago combinado que corresponde a la tarifa fija está basada en el nivel BLS de emergencia o no-emergencia según aplique y la porción del pago combinado que corresponde al cargo razonable es la tarifa del nivel ALS emergencia/no-emergencia.

provider begins as quickly as possible to take the steps necessary to respond to the call. An emergency is determined based on the information available to the dispatcher at the time of the call, based on standard dispatch protocols. An ALS assessment is relevant only with respect to payment for an ALS emergency transport. That is, the ALS assessment may be relevant to determine whether an emergency transport is payable at the BLS or ALS level. However, an ALS assessment has no bearing on whether the transport qualifies for emergency-level payment. Furthermore, identifying a service as an emergency response has no bearing on its status under SSA 1861(s)(7), i.e., whether transportation by other means is feasible.

i. Mandated ALS Response

During the transition period, Medicare allows the ALS-level payment for emergency and non-emergency transports when an ALS vehicle is used but no ALS service is furnished in areas where an ALS-only response is mandated. As stated in previously issued instructions, two temporary HCPCS codes have been established to allow billing for these services during the transition period. HCPCS code Q3019 applies when an ALS vehicle is used ***for an emergency transport****, but no ALS-level service is furnished. HCPCS code Q3020 applies when an ALS vehicle is used* ***for a non-emergency transport****, but no ALS level service is furnished. The fee schedule portion of the blended payment is based on the emergency or non-emergency BLS level, as applicable, and the reasonable charge portion of the blended payment is the ALS emergency/ non-emergency rate.*

Cont. on next page

Ambulancia

El uso de vehículos ALS para prestar servicios de nivel BLS ocurre frecuentemente en jurisdicciones locales donde es requisito que todas las ambulancias sean ALS. No obstante, una agencia de gobierno que preste servicios de ambulancia en una o más jurisdicciones políticas puede cualificar como "respuesta ALS obligatoria" si los términos del contrato requieren que sean ALS solamente los que atiendan todos los servicios. Un ejemplo de esto es: una localidad donde no hay una ordenanza que requiera "ALS solamente" para responder a un EMS; pero que existe un contrato con un proveedor para los servicios 911 que requiere una respuesta de un ALS para los servicios solicitados, por lo que el requisito contractual para ofrecer esos servicios puede cualificar como "respuesta ALS obligatoria". El contratista determinará si en la totalidad de las circunstancias cualquier requisito contractual es equivalente a una "respuesta ALS obligatoria''. Nótese que el vehículo ALS debe cumplir los requisitos de la tripulación especificados en la reglamentación 42 CFR § 410.41.

La política de pagar de acuerdo a los servicios médicamente necesarios continúa bajo las Tarifas Fijas de Ambulancia. Esto significa que el pago está basado en el nivel de servicio prestado, no en el vehículo utilizado. Aunque el gobierno local requiera respuestas de ALS para todas sus llamadas, Medicare paga solamente por el nivel de servicio prestado, y solamente cuando el servicio es médicamente necesario. El uso de los códigos Q3019 y Q3020 es válido solamente durante el período de transición.

j. Transportación Dentro de una misma Institución

Un transporte dentro de la misma institución(un traslado dentro de un área, terreno o campus de una facilidad) no está dentro del alcance de los beneficios de

Ambulance

The use of an ALS vehicle to furnish only BLS-level services would most often occur in local jurisdictions that mandate all ambulances to be ALS. However, a contract with a government agency to furnish general ambulance services in one or more specific political jurisdictions may also qualify as a "mandated ALS response" if the terms of the contract require an ALS-only response for all requests for service. For example, in a locality where there is no ordinance requiring an "ALS only" EMS response, but there is a contract with a supplier for 911 services that requires an ALS response to all requests for services, the contractual requirement to provide such services may qualify as a "mandated ALS response". The carrier must determine whether, in the totality of the circumstances, any particular contractual requirement is tantamount to a "mandated ALS response". Note that the ALS vehicle must meet the crew requirements specified in 42 CFR §410.41.

The policy of paying according to the medically necessary services actually furnished continues under the Ambulance Fee Schedule. That is, payment is based on the level of service provided, not on the vehicle used. Even if a local government requires an ALS response for all calls, Medicare pays only for the level of service provided, and then only when the service is medically necessary. The use of Q3019 and Q3020 is effective only during the transition period.

j. *Intra-facility Transports*

An intra-facility transport, i.e., a transport within the certified campus of a facility, is not within the scope of the Medicare ambulance benefit because it fails to meet Medicare origin and destination requirements. (See CFR §413.65(a)(2) for a definition of "certified campus.") Medicare payment to a facility for the cost of facility-based treatment includes an allowance for intra-facility movement of the beneficiary. No separate Medicare

Medicare para ambulancia porque no cumple con los requisitos de origen y destino de Medicare (Ver CFR § 413.65 (a)(2) para la definición de "terreno/campus"). El reembolso de Medicare por transportación a una institución es un pago completo que incluye todo lo médicamente necesario, servicios que estén cubiertos por Medicare y prestados a un beneficiario mientras está en tratamiento en la institución.

k. Servicios Médicos Prestados Durante el Transporte en Ambulancia

Bajo las tarifas fijas de ambulancia, el pago por todos los servicios relacionados a dicha transportación (incluyendo servicios de ambulancia que debían ser realizados por un médico) está incluido en la tarifa base de transportación en ambulancia. Por lo tanto, bajo las tarifas fijas de ambulancia no se realiza un pago por separado por tal servicio. No obstante, si durante el transporte en ambulancia un médico presta servicios que están cubiertos como servicios médicos y no-cubiertos bajo los beneficios de ambulancia, entonces el médico podrá facturar y recibir un pago por separado por dichos servicios.

l. Facturar al Beneficiario por Servicios no Cubiertos

Cuando un proveedor de ambulancia utiliza un ABN porque el servicio no es razonable y necesario, podrá cobrar solamente la cantidad del coaseguro y el deducible. Si un transporte está claramente excluido por otra razón (Ej. Transporte se origina fuera de Estados Unidos), o si no hay una categoría de beneficio para el servicio, el proveedor podrá facturar su cargo privado y cobrar el mismo al momento de la selección del servicio. En esta situación, el proveedor podrá notificar al beneficiario antes de prestar el servicio que tal transportación no estará cubierta por Medicare (Bajo esta situación, un NEMB es el que tendrá que utilizarse, ya que el uso de un ABN no será el más apropiado en estos casos).

payment may be made for such a transport. Moreover, it is improper for a provider to bill Medicare for an intra-facility transport to receive a Medicare denial since the Medicare facility payment constitutes payment in full for all medically necessary, Medicare-covered services furnished to the beneficiary while undergoing treatment at the facility. As such, billing the beneficiary or another insurer for such included services would be similarly improper.

k. Physician Services Provided During an Ambulance Transport

Under the Ambulance Fee Schedule, payment for all ambulance-related items and services (including ambulance services that happen to be furnished by a physician) is included in the base payment for the ambulance transport. Therefore, under the Ambulance Fee Schedule, there is no separate payment for these services. However, if, during an ambulance transport, a physician furnishes a service(s) that is covered as a physician's service, and not covered under the Medicare ambulance benefit, then the physician may bill and be paid separately from the Ambulance Fee Schedule payment for such a service.

l. Billing the Beneficiary for Noncovered Services

When a provider issues an ABN because the service is not reasonable and necessary, it may only collect up front the coinsurance amount and deductible from the beneficiary. If a transport is clearly statutorily excluded for another reason (e.g., it originates outside the United States), or if there is no benefit category for the service, the provider may charge the individual its full fee and collect the fee at a time of its choosing. In this situation, the provider may wish to advise the beneficiary, in advance of furnishing the service, that such transportation is not covered under Medicare. (An NEMB may be used, since an ABN is not appropriate.)

Transmittal AB-03-106/CR2770/July 25, 2003

ESTABLISHING NEW REQUIREMENTS FOR ICD-9-CM CODING ON CLAIMS SUBMITTED TO MEDICARE CARRIERS - INCREASED ROLE FOR PHYSICIANS/PRACTITIONERS

Effective for dates of service on or after October 1, 2003, ICD-9-CM diagnosis codes must be included on all Medicare electronic and paper claims billed to Part B carriers, with the exception of ambulance claims. Providers and suppliers rely on physicians to provide a diagnosis code or narrative diagnostic statement on orders/referrals. This guidance serves as a reminder that physicians/practitioners must provide a diagnosis on all orders and referrals.

Background

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), a final rule published in the **Federal Register** on August 17, 2000, established new standards, requirements, and implementation specifications for health plans, health care clearing houses, and health care providers who transmit any health information in an electronic form. The applicable electronic format for transmitting Medicare claims information is the ASC X12N 837. The implementation specifications define the new requirements for these formats. The ASC X12N 837 Professional Implementation Guide (version 4010A.1) requires a diagnosis on "all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims)."

PM B-03-045 (CR2725) clarified that based upon the implementation specifications for HIPAA, an ICD-9-CM code is not required for all ambulance supplier claims but is required for all other professional claims, e.g., Physicians, Non-Physician Practitioners, Independent Clinical Diagnostic Laboratories, Occupational and Physical Therapists, Independent Diagnostic Testing Facilities, Audiologists, and Ambulatory Surgery Centers. Although the HIPAA requirements apply only to electronic claims, in order to maintain consistency in claims processing, CMS has mandated that these ICD-9-CM requirements will be applied to paper claims as well as electronic claims.

New Policy

Effective for dates of service on or after October 1, 2003, all paper and electronic claims submitted to carriers must contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers (specialty type 59). Carriers will return as unprocessable paper and electronic claims that do not contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers (specialty type 59).

Carriers will no longer place invalid or valid diagnosis codes on any claim prior to sending the claim to the Common Working File and their coordination-of-benefits trading partners. Therefore, the diagnosis code must be entered on the claim by the submitter.

Immunization Claims

For claims submitted by mass immunizers and any other entities billing for flu and pneumonia vaccinations, Medicare carriers will no longer be able to enter missing diagnosis codes on claims. The diagnosis code must be entered on the claim by the submitter.

Mammography Screening Claims

For claims submitted for screening mammography services, Medicare carriers will no longer be able to enter missing diagnosis codes on claims. The diagnosis code must be entered on the claim by the submitter. Claims for mammography services with no ICD-9-CM code will be returned as unprocessable by carriers.

HIPAA Requirements Affect Physicians/Practitioners When a Diagnostic Test is Ordered

Section 4317 of the Balanced Budget Act of 1997 provides, with respect to diagnostic laboratory and certain other services, that "if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the services to provide diagnostic or other medical information to the entity, the physician or practitioner ordering the service shall provide that information to the entity at the time the service is ordered by the physician or practitioner." A laboratory or other provider must report on a claim for Medicare payment the diagnostic code(s) furnished by the ordering/ referring physician/ practitioner. In the absence of such coding information, the laboratory or other provider may determine the appropriate diagnostic code based on the ordering/referring physician/practitioner's narrative diagnostic statement or seek diagnostic information from the ordering/referring physician/ practitioner. However, a laboratory or other provider may not report on a claim for Medicare payment a diagnosis code in the absence of physician/practitioner-supplied diagnostic information supporting such code.

When providers/suppliers (except ambulance suppliers) submit a claim to a Medicare Part B carrier, they must assign an ICD-9-CM code to the service as follows:

(1) Coding When Diagnosis is Known

Assign an ICD-9-CM code that provides the highest degree of accuracy and completeness. In the past, there has been some confusion about the meaning of "highest degree of specificity" and in "reporting the correct number of digits." In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning level of specificity, ICD-9-CM codes contain either 3, 4, or 5 digits. If a 3-digit code has a 4-digit code that further describes it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has a 5-digit code that further describes it, then the 4-digit code is not acceptable for claim submission.

(2) Coding When Diagnosis is Unknown

Diagnoses documented as "probable," "suspected," "questionable," "rule-out," or "working diagnosis" should not be coded as though they exist. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit such as signs, symptoms, abnormal test results, exposure to communicable disease, or other reason for the visit. (See *ICD-9-CM Official Guidelines for Coding and Reporting*, page 49, available at http://www.cdc.gov/nchs/data/icd9/icdguide.pdf.)

Information for Laboratories

- Include the ICD-9-CM diagnosis code, as furnished by the physician/practitioner.

- If a diagnosis or narrative diagnosis is not submitted by the physician/practitioner, laboratories must request this information from the physician/practitioner who ordered the service.

Information for Ambulance Suppliers

- Since emergency medical technicians and paramedics do not have the necessary training to make a diagnosis, diagnosis is not available at the time of transport. It is the condition of the patient at the time of transport, rather than the patient's diagnosis, that determines whether transport and services are payable under the Medicare ambulance benefit.

- Carriers may request the trip sheet that documents the condition of the patient, including patient's chief complaints, at the time patient was loaded onto the ambulance in order to determine whether ambulance transport and services were medically necessary.

Timely and Accurate Claims Processing

With the exception of ambulance suppliers, physicians/practitioners submitting claims to Medicare Part B carriers must include a valid ICD-9-CM code in order to have their claims processed and paid as quickly as possible. Therefore, physicians/practitioners must ensure that all necessary information is included on orders/referrals. Failure to do so will result in processing delays and nonpayment of covered services.

CR2784-06/11/03-DG

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:

Enrollment

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 del programa Medicare
Providers Reinstated from the Medicare Program

NOMBRE *NAME*	DIRECCION *ADDRESS*	FECHA EFECTIVIDAD EFFECTIVE DATE
Capó Fernández, Yolanda	Plaza Vega Baja Pearl Vission Express Vega Baja, PR 00693	January 15, 2002
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***	**DIRECCION** ***ADDRESS***	**FECHA 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 Bayamon, 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
Mercado Franci, José A.	Villa Clarita 2 6 St. # 46 Fajardo, PR 00738	August 20, 2000

Proveedores Excluídos del programa Medicare *Providers Excluded from the Medicare Program*		
NOMBRE ***NAME***	**DIRECCION** ***ADDRESS***	**FECHA EFECTIVIDAD** **EFFECTIVE DATE**
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 German, PR 00683	February 20, 2003
Pillot Costas, Juan R.	41 Calle Concordia Ponce, PR 00731	April 20, 2003
Pintado García, Isidoro	55 calle Comercio Suite 3 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

Contrato

PROCESO DE CONTRATACIÓN PARA PROVEEDORES QUE SOMETAN RECLAMACIONES A MEDICARE PARA RETIRADOS FERROVIARIOS

A partir del 6 de octubre de 2003, no será necesario someter una solicitud de Contratista Ferroviario de Medicare (RMC, por sus siglas en inglés) para la contratación o cambios a su número de proveedor. Toda la información será recogida a través del proceso de contratación del Programa Medicare Parte B. Deberá continuar sometiendo las reclamaciones al RMC y asegurarse antes de someterlas que la información del proveedor/suplidor sea la misma que la utilizada para someter reclamaciones a su Contratista de Medicare Parte B. Los nuevos proveedores/suplidores deberán obtener un número de proveedor a través del contratista de Medicare Parte B. (Esto nos asegurará de que usted ha sido contratado por la Parte B de Medicare).

Para nuevos proveedores/suplidores de RMC, una vez haya sometido su reclamación a RMC, se le asignará un RMC PIN (Provider Identification Number). Su archivo de proveedor se buscará en PECOS. Si la información no está en PECOS, usted tiene que someter una forma CMS 855 a su contratista de Medicare Parte B. Una vez el contratista de Medicare Parte B haya asignado el número de proveedor, esta información se actualizará en el archivo maestro PECOS y el RMC recogerá la información de PECOS.

Si usted es un proveedor de RMC, deberá utilizar su número de proveedor para someter las reclamaciones al RMC. Cualquier cambio de información debe realizarse a través del contratista de Medicare Parte B. Éste se encargará de actualizar la información en el archivo maestro PECOS.

Enrollment

ENROLLMENT PROCESS FOR PROVIDERS THAT SUBMIT CLAIMS TO THE RAILROAD MEDICARE CARRIER

Beginning October 6, 2003, you will no longer be required to submit an RMC (Railroad Retirement Carrier) application for enrollment/changes. All enrollment information will be captured through your Medicare Part B enrollment process. You will still be required to submit your claims to the RMC. Make sure that prior to submitting your claims, the provider/supplier information is the same as that used to submit claims to your Medicare Part B Carrier. New providers/suppliers should obtain a Medicare Part B Provider Identification Number (PIN) first. (This will give an assurance that you are enrolled at the Part B Carrier).

For new RMC provider/suppliers you will be issued an RMC PIN once your claim has been submitted. Your provider record will be obtained through PECOS. If your information is not on PECOS, then a CMS 855 application needs to be submitted to your Medicare Part B carrier. Once your Medicare Part B Carrier assigns you a PIN number, you will be obtained a RMC PIN and your claim will be processed.

If you are a RMC provider, you should use your RMC PIN to submit your claims. Any changes to your provider information should be done through your Medicare Part B carrier. Your Medicare Part B carrier will be responsible for updating your record on the master file in PECOS.

CR2777/Transmittal B-03-054/July 25, 2003/SS/ICR

NOTES

ACTUALIZACIÓN TRIMESTRAL DE PRECIOS MEDICAMENTOS

(MÉTODO SIMPLE DE PRECIOS-SDP)

La actualización trimestral de precios en los medicamentos está publicada en nuestra página de Internet; www.triples-med.org en la sección Tarifas Fijas de 2003 bajo Estandarización de Precios para Medicamentos Cubiertos por Medicare.

Estas tarifas serán vigentes al 1 de octubre de 2003.

QUARTERLY PRICING UPDATE FOR DRUGS

(SINGLE DRUG PRICER-SDP)

The quarterly pricing update for drugs is published in our Internet page www.triples-med.org in section 2003 Fee Schedules under Standardizing for Medicare Covered Drugs.

These fees will be effective on October 1, 2003.

CR2381/AB-02-174/12-03-2002/SDP/OCTOBER 2003/mm

MEDICARE INFORMA
B0X 71391
SAN JUAN, PR 00936

RETURN POSTAGE REQUESTED

PRSRT STD
U.S. POSTAGE PAID
SAN JUAN, P.R.
PERMIT NO. 2563