Medicare Informa

División Medicare / Parte B

¡Qué Bueno Que Preguntó!

REMESA ELECTRÓNICA QUE CUMPLE CON LAS ESPECIFICACIONES DE HIPAA

La transacción X12N ANSI–835 provee la versión de la Remesa de Pago Electrónica que cumple con las especificaciones de HIPAA.

Los proveedores que elijan recibir la remesa electrónicamente deberán aceptar la versión 4010 A1 de la transacción 835 y tener una aplicación que traduzca estos datos a un informe legible. SES Pro V4.0 traduce la información de este archivo a través de la opción de "Informes".

Aquel proveedor, agente de facturación, socio de negocio, vendedor de programa o "clearinghouse" que elija contratar el servicio de traducción deberá asumir los costos del mismo.

El programa "PC-Print" no saldrá al mercado para la versión 835 versión 4010.

We Are Glad You Asked!

HIPAA COMPLAINT ELECTRONIC REMITTANCE NOTICE

Transaction X12N ANSI-835 provides the HIPAA compliant version of the Electronic Remittance Advice.

Providers that elect to receive an electronic remittance advice (ERA) must accept version 4010A1 of transaction 835 and have an application that translates that data into a comprehensible report. SES Pro V 4.0 translates this file information through the "Report" menu option of the software.

Any provider, provider-billing service, trading partner, vendor or clearinghouse that elects to use a clearinghouse for translation services are liable for those costs.

The PC-Print software will not be issued for use with 835 version 4010.

Emission Date: December 11, 2003

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

Volume 76 / Oct., Nov., and Dec.,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

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¡Qué Bueno Que Preguntó!

CÓMO USAR LA OPCIÓN DE INFORMES DE SES PRO V4.0

El programa de SES Pro V4.0 extrae automáticamente los archivos de informes; éstos pueden accederse seleccionando la pestaña ("Tab") de comunicación en la barra de herramientas ("Toolbar") a la izquierda de la pantalla. Luego, en el Menú superior, seleccionará "Informes/Cartas", aquí encontrará la opción de "Ver Informes". A su vez la opción "Ver Informes" le permite acceder la opción "Tipos de Informes" donde aparecen los archivos que usted ha recibido, entre estos: Informes de Error, Remesas de Pago – X12 ANSI 835, Informe de error en sintaxis - 997.

Una vez seleccione un informe, el programa SES Pro V4.0 comenzará el proceso de bajar el mismo, es muy importante no cancelar el proceso de envío de informes. Cancelarlo tiene como consecuencia el que no se actualicen los datos en SES Pro V4.0, conllevando el que usted no pueda accederlos posteriormente.

We Are Glad You Asked!

USING THE REPORT OPTION OF SES PRO V 4.0

The SES Pro V 4.0 program automatically downloads the report files; these can be accessed by selecting the communication Tab of the toolbar, which appears at the left of the screen. Then, at the upper menu, you may choose "Reports/Letters", here you will find the "View Report" option. The "View Report option allows you to opt for "Report Type", where the files you have received are displayed, among these: Error Letters, Payment Remittance X-12 ANSI 835, and Syntax Error Report 997.

Once you select a report, SES Pro V4.0 will start the downloading process. It is very important not to cancel the file transfer process. Canceling the process implies that the data in SES Profesional will not be updated, and you will be unable to access it in the future.

Oct. 2003/vv/dmg

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 which includes the changes made from March 1, 2003 to June 30, 2003 is available at: http://www.cms.hhs.gov/providers/edi/hipaadoc.asp or at: http://www.wpc-edi.com/codes/Codes.asp

By January 1, 2004, we must have completed entry of all applicable code text changes, new codes and deactivations into production. The remittance advice notices we issue thereafter will include these updates. It is advisable you keep abreast of these change so you can have a clear understanding of the adjudication of your claims.

Ref. CR# 2975/ Trans. 32/ Nov. 21, 2003/ dmg/vv

¡Qué Bueno Que Preguntó!

ERRORES MÁS COMUNES AL COMPLETAR EL FORMULARIO CMS 855

1) ¿Cuáles son las secciones del Formulario CMS 855 que siempre se deben completar?

   Las secciones 1, 2 y 15 siempre deben completarse. Esto también aplica cuando el Oficial de Contratos le solicita completar alguna sección que fue omitida o completada incorrectamente.

2) Cuándo hay cambio de dirección, ¿Qué secciones se deben completar?

   Cuando hay cambio de *dirección postal,* se debe completar la sección 2B del Formulario CMS 855I y la sección 2C del Formulario CMS 855B. Además, se debe indicar si los cheques van a ser enviados a esta misma dirección en la sección 2C del formulario CMS 855I y 4F del formulario CMS 855B.

   Si el cambio es de *dirección física,* se debe completar la sección 4B del Formulario CMS 855I y la sección 4A en el Formulario CMS 855B. Asimismo, se debe informar la dirección dónde estará el historial médico de los beneficiarios completando la sección 4D del Formulario CMS 855I y la sección 4G del formulario CMS 855B.

3) ¿Es importante indicar la fecha de vigencia en todas las secciones que así lo solicitan?

   Sí, en todas las secciones que soliciten fecha. De no indicarse esta información, la solicitud puede ser devuelta.

4) ¿Es importante indicar la fecha en que se comenzó en una localidad?

   Sí, en todas las secciones que le soliciten una fecha debe indicarla. De no indicarse esta información, la solicitud puede ser devuelta.

5) ¿Las secciones 8 y 9 de los Formularios CMS 855I y 855B piden la misma información?

We Are Glad You Asked!

COMMON ERRORS WHEN COMPLETING FORM CMS 855

1) Which sections of Form CMS 855 should always be completed?

Sections 1, 2 and 15 of Form CMS 855 must always be completed. This also applies when the Provider Enrollment Officer requests that you complete any section, which was omitted or incorrect.

2) For a change of address, which sections should be completed?

If you want to change your mailing address, you must complete sections 2B of the Form CMS 855I and 2C of the Form CMS 855B. In addition, you must indicate in section 2C of the Form CMS 855I and 4F of the Form CMS 855B if payments are going to be sent to the mailing address.

If you want to change your private practice physical address, you must complete section 4B of the Form CMS 855I and section 4A of the Form CMS 855B. You must also indicate where the beneficiary's medical records will be located completing section 4D of the Form CMS 855I and 4G of the Form CMS 855B.

3) Is the effective date a requirement in sections that request it?

Yes, you must indicate the effective date in all sections that request it. If you do not indicate it, Form CMS 855 will be returned to you as incomplete.

4) Is the date a private practice started operations in a specific location important?

Yes, you must indicate the effective date in all sections that request it. If you do not, we will return Form CMS 855 to you as incomplete.

5) Do sections 8 and 9 of Forms CMS 855I and CMS 855B request the same information?

¡Qué Bueno Que Preguntó!

No, la sección 8 de ambos formularios se utiliza para indicar la compañía que estará llevando a cabo la facturación. Por otro lado, la sección 9 de ambos formularios se utiliza para indicar el "clearinghouse" que llevará a cabo la facturación.

6) Algunas secciones no me aplican, ¿Debo indicarlo o puedo dejarla en blanco?

Las secciones que no le aplican debe indicarlas marcando la letra 'A' en la sección correspondiente.

7) ¿Tengo que completar una nueva página si me equivoco en alguna información?

Sí, los Formularios CMS 855 deben ser completados en forma legible y no deben tener tachaduras ni corrector líquido.

8) ¿Qué secciones debe completar una compañía de ambulancia cuando actualiza documentos en su expediente?

La compañía de ambulancia debe completar las secciones 1, 2, 15 y el anejo 1 del Formulario CMS 855B cada vez que actualice los documentos en su expediente.

9) ¿Qué información puedo incluir en el campo de comentarios?

El campo de comentarios ayuda al Oficial de Contratos a agilizar la evaluación. Este campo puede utilizarse para informar algún otro número de teléfono en el cual se le pueda contactar, horario de su oficina para saber a qué hora podemos comunicarnos con usted, extensiones telefónicas de su oficina y cualquier circunstancia especial que debemos considerar durante el proceso de contratación.

10) ¿Qué persona está autorizada a dar información de la solicitud?

El Oficial de Contratos sólo puede verificar la información del Formulario CMS 855 con el Proveedor, Persona Contacto, Representante Autorizado u Oficial delegado.

We Are Glad You Asked!

No, section 8 of both forms is used to indicate the billing company and section 9 of both forms is used to indicate the clearinghouse company that will do the billing.

6) If a section does not apply, do I have to indicate that it does not apply or can it be left in blank?

If a section does not apply, check letter A of the corresponding section.

7) If I make a mistake completing the Form CMS 855, must I fill out a new form?

Yes, Form CMS 855 must be completely clear and cannot have any erasures or liquid paper marks.

8) Which sections must be completed to update an ambulance company's file?

All ambulance companies must complete sections 1, 2, 15 and attachment 1 of the Form CMS 855B to update their files.

9) What information should be included in the Comment Field?

The Comment Field helps the Provider Enrollment Officer expedite the enrollment process. You can include in this field any other phone number where you can be reached, your office hours so that we can contact you during this time, your office extension numbers and any special circumstance that we should take into consideration during the enrollment process.

10) Who is authorized to answer questions related to Form CMS 855?

The Provider Enrollment Officer can only verify information of the Form CMS 855 with the Provider, Contact Person, Authorized Representative or delegated Official.

¡Qué Bueno Que Preguntó!

11)¿Qué debo recordar cuando completo el Formulario CMS 855R para reasignar beneficios?

Al completar el formulario CMS 855R, no debe omitir las siguientes secciones:

- Sección 3 - "Income Reporting field", número de proveedor y número de UPIN
- Sección 6 - nombre del grupo y firma del proveedor que reasigna beneficios
- Las fechas a través de todo el formulario
- Sección 7 - firma del Representante Autorizado u Oficial delegado

12)¿Qué documentos debo incluir con el Formulario CMS 855?

La siguiente documentación debe ser sometida con el Formulario CMS 855 para solicitar número de proveedor:

MÉDICOS:

- Copia del Diploma
- Copia de la Certificación de Educación Continua de la Junta Examinadora de Médicos
- "Good Standing" de la Junta Examinadora de Médicos en original y con fecha de no más de 30 días de expedido
- Copia de la Licencia de Medicina
- Copia del Certificado de Especialidad (si aplica)
- Copia de la Certificación Negativa de Antecedentes Penales
- Copia del Certificado de Sustancias Controladas
- Si va a reactivar su número de proveedor, debe completar el Formulario CMS 1500

Nota: Si su práctica independiente es en un hospital, debe incluir copia del contrato con el hospital.

We Are Glad You Asked!

11)For reassignment of benefits, which sections must be completed?

You must not omit the following sections on Form CMS 855R:

- *Section 3 – 'Income Reporting field', provider number and UPIN.*
- *Section 6 – Group name and the provider who reassigns benefits signature*
- *All dates throughout the form*
- *Section 7 – Authorized Representative or delegated Official's signature*

12)Which documents must be submitted with the Form CMS 855?

To request a provider number the following documents must be included with Form CMS 855:

PHYSICIANS:

- *Copy of Diploma*
- *Copy of Certificate of Registry and Medical Education from the Board of Medical Examiners*
- *Certificate of Good Standing from the Board of Medical Examiners in original, no more than 30 days after issued*
- *Copy of Physician License*
- *Copy of Specialty Certificate (if applicable)*
- *Copy of Negative Certificate of Prior Penal Record*
- *Copy of Controlled Substance Certificate*
- *For the provider number reactivation, you must complete Form CMS1500*

***Note**: If the practice is in a Hospital, you must include a copy of the contract with the hospital.*

¡Qué Bueno Que Preguntó!

PROFESIONALES DE LA SALUD:

- Copia del Diploma
- "Good Standing", de la Junta que le aplique, en original y con fecha de no más de 30 días de expedido
- Copia de la Licencia Profesional
- Copia de la Certificación de CMS (si aplica)
- Copia de la Certificación Negativa de Antecedentes Penales

Sicólogos Clínicos:

- Copia del grado de Doctorado

Trabajador Social Clínico:

- Copia del grado de Maestría o Doctorado en trabajo social
- Certificación de por lo menos 2 años de práctica supervisada

Dietistas y Nutricionistas:

Bajo la cubierta de Medicare Parte B para Terapia Médica de Nutrición (MNT, por sus siglas en inglés) sólo los Dietistas Registrados o Profesionales de la Nutrición pueden proveer estos servicios. Un Dietista Registrado o un Profesional de la Nutrición se refiere a Dietistas o Nutricionistas con licencia o certificado estatal al 21 de diciembre de 2002 o un individuo que al 22 de diciembre de 2000:

- Poseía un Bachillerato o un grado mayor de un colegio o universidad acreditada regionalmente o una universidad en los Estados Unidos con los requisitos académicos completados en el programa de nutrición o dietética acreditada por una organización nacional reconocida para este propósito;
- Completó por lo menos 900 horas de práctica supervisada de dietética bajo la supervisión de un Dietista Registrado o un Profesional de la Nutrición; y

We Are Glad You Asked!

NON - PHYSICIANS:

- *Copy of Diploma*
- *Certificate of Good Standing (from the applicable Board) in original and no more than 30 days after issued*
- *Copy of Professional License*
- *Copy of CMS Certification (if applicable)*
- *Copy of Negative Certificate of Prior Penal Record*

For Clinical Psychologists

- *Copy of Doctor's Degree*

For Clinical Social Workers:

- *Copy of Master or Doctor's degree in social work*
- *Certificate of at least 2 years of supervised clinical social work.*

For Dietitians and Nutritionists:

For coverage of Medicare Part B Medical Nutrition Therapy (MNT), only a registered dietitian or nutrition professional may provide these services. "Registered dietitian or nutrition professional" means a dietitian or nutritionist licensed or certified in a State as of December 21,2002; or an individual whom, as of December 22, 2000 had:

- *a Bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose;*
- *completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and*

¡Qué Bueno Que Preguntó!

- Tenga licencia o certificado de Dietista o Profesional de la Nutrición emitido por el Estado donde se proveen los servicios. En un Estado que no provea una certificación o licenciatura, el individuo se considerará como que cumplió con estos requisitos si ella o él está reconocido como un Dietista Registrado por la Comisión de Registros de la Dietética o la organización sucesora, o cumple con las primeras dos condiciones de esta sección.

Nota: Terapistas Físicos y Ocupacionales pueden contratarse como grupo en sus propias especialidades. Audiólogos y Sicólogos no pueden contratarse como grupo.

SERVICIOS DE AMBULANCIA

- Copia de la Resolución y Orden de la Comisión de Servicio Público
- Copia de la Licencia y autorización de la Comisión de Servicio Público para cada vehículo
- Copia del Certificado de Inspección del Departamento de Salud para cada vehículo
- Copia de la Licencia del Comité Examinador de Emergencias Médicas para cada Técnico de Emergencias Médicas (EMT, por sus siglas en inglés), no menos de 6 EMT
- Verificación de licencia con fecha de no más de 30 días de expedida
- Evidencia del Número Social Patronal
- Formulario CMS 855 B - Anejo 1

SERVICIOS DE AMBULANCIA AÈREA

- Copia de la Licencia y autorización de la Comisión de Servicio Público para cada vehículo
- Evidencia del Seguro Social Patronal
- Copia del Certificado de la FAA Parte 135

We Are Glad You Asked!

- *is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a Registered Dietitian by the Commission on Dietetic Registration or its successor organization, or meets the requirements of the first two bullets of this section.*

***Note**: Physical Therapists and Occupational Therapists may enroll as a group with their own specialties. Audiologists and Psychologists cannot enroll as a group.*

AMBULANCE SERVICE:

- *Copy of Order and Resolution from the Public Service Commission (PSC)*
- *Copy of License and authorization for each vehicle from the PSC*
- *Copy of Certificate of Inspection from the Department of Health for each vehicle*
- *Copy of License for each Emergency Medical Technician (EMT) from the Medical Emergencies Examiners Committee (minimum of 6 EMT's)*
- *License verification no more than 30 days after issued.*
- *Evidence of Employer Identification Number*
- *Form CMS 855B - Attachment 1*

AIR AMBULANCE SERVICE:

- *Copy of License and authorization for each vehicle from the PSC*
- *Evidence of Employer Identification Number*
- *Copy of FAA Part 135 Certificate*

¡Qué Bueno Que Preguntó!

LABORATORIO CLÍNICO

- Evidencia del Seguro Social Patronal
- Copia del Certificado de CLIA
- Copia del Certificado de Necesidad
- Copia de la Licencia del Laboratorio
- Copia del Contrato de Compraventa (si el dueño anterior tenía número de proveedor con Medicare)

CENTROS DE CIRUGÍA AMBULATORIA

- Evidencia del Seguro Social Patronal
- Copia del Certificado de CMS

INSTALACIONES INDEPENDIENTES PARA PRUEBAS DIAGNÓSTICAS

- Evidencia del Seguro Social Patronal
- Formulario CMS 855 Anejo 2
- Nombre y número de Medicare de todos los médicos

Nota: Todos los médicos deben estar registrados como proveedores de Medicare

- Copia de la licencia de los técnicos que realizan las pruebas
- El médico que supervisa debe indicar el tipo de supervisión que provee:

Supervisión Directa / Personal

El médico debe estar registrado en el Programa de Medicare con el contratista de Medicare para el cual el formulario es sometido.

Supervisión General

Debe estar licenciado en todos los estados donde ella o él realiza la supervisión directa. Si el médico que supervisa no está registrado con el contratista de Medicare para el cual somete la solicitud, ella o él debe someter copia de la licencia del Estado para el cual somete la solicitud.

GRUPOS (ESPECIALIDAD MÚLTIPLE O UNA SOLA ESPECIALIDAD)

- Evidencia de Seguro Social Patronal

We Are Glad You Asked!

CLINICAL LABS

- *Evidence of Employer Identification Number*
- *Copy of CLIA Certificate*
- *Copy of Certificate of Necessity*
- *Copy of the Laboratory License*
- *Copy of the Purchase Contract (if the previous owner was enrolled in the Medicare Program)*

AMBULATORY SURGICAL CENTERS

- *Evidence of Employer Identification Number*
- *Copy of CMS Certificate*

INDEPENDENT DIAGNOSTIC TESTING FACILITIES:

- *Evidence of Employer Identification Number*
- *Form CMS 855 Attachment 2*
- *Name and Medicare Provider Number of all the Physicians*

***Note**: All of the physicians must be enrolled in the Medicare Program.*

- *Copy of Professional License of the Non-Physician Personnel (Technicians) who perform tests*
- *Supervising Physician must indicate the type of supervision she/he provides:*

Personal /Direct Supervision:

The physician must be currently enrolled in the Medicare Program with the Medicare carrier in which this application is being submitted.

General Supervision

Must be licensed in all States where she/he will be performing the General Supervision. If the Supervising Physician is not enrolled with the Medicare carrier to which this application is being submitted, she/he must submit a copy of her/his current State license in which his application is being submitted.

GROUPS (SINGLE OR MULTIPLE SPECIALTY):

- *Evidence of Employer Identification Number*

¡Qué Bueno Que Preguntó!

- Formulario CMS 855R por cada proveedor que compone el grupo

Nota: Cada componente del grupo debe adquirir un número de proveedor individual con el Programa Medicare antes de registrarse como parte del grupo. No someta el Formulario 855R hasta que usted no adquiera un número de proveedor.

We Are Glad You Asked!

- *Form CMS 855R for each group member*

***Note**: Each group member must be individually enrolled in the Medicare Program before enrolling in a group. Do not submit Form 855R until the individual provider number is assigned.*

Enrollment/August, 2003

¿QUÉ ES EL "PROVIDER COMMUNICATIONS (PCOM) ADVISORY GROUP"?

¡Aproveche la oportunidad de formar parte de este importante grupo!

El "PCOM Group" (según se conoce por sus siglas en inglés) provee sugerencias relacionadas con adiestramientos, el desarrollo de materiales educativos dirigidos a proveedores y fechas y lugares adecuados para actividades educativas. Este grupo identifica asuntos que puedan afectar a los proveedores y recomienda vías de comunicación eficaces para diseminar la información. El grupo sólo sirve como un ente consultor en aspectos educativos a la comunidad médica y no cuenta con autoridad para sancionar.

En el "PCOM" se incluyen representantes de varias especialidades médicas, así como de asociaciones médicas y profesionales. También se incluyen en el grupo representantes de organizaciones de facturación y administración de oficinas médicas. Nuestra meta para el año fiscal 2004 es aumentar la participación de médicos que residen fuera del área metropolitana.

El grupo se reúne trimestralmente por un espacio aproximado de dos horas y las reuniones se llevan a cabo usualmente en el anfiteatro de Triple-S. No obstante, para facilitar la participación de aquel proveedor que vive fuera del área metropolitana, planificamos realizar las reuniones simultáneamente a través de conferencias telefónicas.

THE PROVIDER COMMUNICATIONS (PCOM) ADVISORY GROUP

Become part of the PCOM Group Today!

The PCOM Advisory Group provides input and feedback on: training topics, provider education materials, dates and locations for provider educational workshops and events. The group also identifies salient issues, and recommends effective means of disseminating information. The PCOM Advisory Group serves as a consultant resource, and not an approval or sanctioning authority.

The PCOM Advisory Group includes representatives of various providers' specialties including Medical professional associations as well as billing organizations representatives. Our goal for FY 2004 is to recruit more physicians from remote locations of the island.

The PCOM Advisory Group meets on a quarterly basis for approximately two hours. These meetings are usually held at the Triple-S, Inc amphitheater. However, to accommodate participation from providers outside the metro area, we plan to hold conference calls simultaneous to the meeting.

Cont. on next page

¡Qué Bueno Que Preguntó!

Le exhortamos a que se una a este distinguido grupo. Tendrá la oportunidad de aportar ideas y sugerencias que nos ayuden a mantener medios de comunicación eficientes con los proveedores de la Parte B de Medicare.

Si interesa formar parte de este grupo, puede comunicarse con la Sra. Julie Rivera, Coordinadora Educativa de Medicare al (787) 749-4949 ext. 4455 o con el Sr. Félix M. Rosario, Gerente de Relaciones con la Comunidad al (787) 749-4088 ó a: frosario@triples-med.org.

fmr/els/November, 2003

We Are Glad You Asked!

We encourage you to become part of this distinguished group. As a member you will have the opportunity to contribute with ideas that can help us maintain efficient communication channels with Medicare Part B providers.

If you are interested in becoming a member of the PCOM Advisory Group, please contact Ms. Julie Rivera, our Outreach Coordinator, at (787) 749-4949 ext. 4455 or Mr. Felix M. Rosario, Community Relations Manager at (787) 749-4088 or at: frosario@triples-med.org.

MANEJO DEL FORMULARIO CMS 855

El 3 de noviembre de 2003 comenzamos a usar un nuevo sistema para procesar, actualizar y asignar número de proveedor. Actualmente, estamos transfiriendo nuestra información de proveedores a este nuevo sistema. Solicitamos su indulgencia durante este período de transición; aseguramos procesar su petición en sesenta días o menos.

En nuestro próximo boletín ofreceremos más información sobre este sistema de manejo del formulario CMS 855.

HANDLING FORM CMS 855

On November 3, 2003 we started using a new system to process, update and assign provider numbers. We are presently transferring all our provider data to this new system. We request your indulgence during this period; we assure you that your petition will be handled within sixty days or less.

In our next bulletin we will provide more information on this system developed to handle the CMS 855 form.

November 2003/ICR

¡Qué Bueno Que Preguntó!

EL NUEVO MANUAL DE CMS

El 1 de octubre de 2003 los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) comenzaron la transición del sistema del manual actual en papel a un manual electrónico. El proceso incluye la modernización, actualización y consolidación de las instrucciones de varios programas de CMS en un manual electrónico para todos los usuarios. El nuevo manual se conoce como el Manual Electrónico de CMS y se encuentra en: http://www.cms.hhs.gov/manuals.

Este nuevo manual está organizado por área funcional (Ej. Información de elegibilidad, procesamiento de reclamaciones, política de beneficios, integridad del programa). La orientación funcional del nuevo manual elimina significativamente la redundancia entre los diferentes manuales al mismo tiempo que moderniza el proceso de actualizar el manual. Así, las instrucciones de CMS al programa de Medicare estarán disponibles en una manera conveniente y accesible.

Específicamente, el Manual Electrónico de CMS incluye los siguientes campos funcionales:

We Are Glad You Asked!

THE NEW CMS MANUAL SYSTEM

Beginning October 1, 2003, The Centers for Medicare and Medicaid Services (CMS) will transition from a paper-based manual system to a Web-based system. The process includes the streamlining, updating, and consolidating of CMS' various program instructions into an electronic Web-based manual system for all users. The new system is called the online CMS Manual System and is located at: http://www.cms.hhs.gov/manuals.

The new online CMS Manual System will be organized by functional area, (e.g., eligibility, entitlement, claims processing, benefit policy, program integrity). The functional orientation of the new manual will eliminate significant redundancy within the manuals and will streamline the updating process, thus making CMS program instructions available in a more timely and accessible fashion.

Specifically, the CMS Manual System will include the following functional areas:

Pub. 100-01—Medicare General Information, Eligibility, and Entitlement
Pub. 100-02—Medicare Benefit Policy
Pub. 100-03—Medicare National Coverage Determinations
Pub. 100-04—Medicare Claims Processing
Pub. 100-05—Medicare Secondary Payer
Pub. 100-06—Medicare Financial Management
Pub. 100-07—Medicare State Operations
Pub. 100-08—Medicare Program Integrity
Pub. 100-09—Medicare Contractor Beneficiary and Provider Communications
Pub. 100-10—Medicare Quality Improvement Organization
Pub. 100-11—Reserved
Pub. 100-12—State Medicaid
Pub. 100-13—Medicaid State Children's Health Insurance Program
Pub. 100-14—Medicare End Stage Renal Disease Network Organization
Pub. 100-15—Medicare State Buy-In
Pub. 100-16—Medicare Managed Care
Pub. 100-17—Medicare Business Partners Systems Security
Pub. 100-18—Medicare Business Partners Security Oversight
Pub. 100-19—Demonstrations
Pub. 100-20—One-Time Notification

¡Qué Bueno Que Preguntó!

La siguiente tabla identifica los manuales que se utilizaron para crear la versión electrónica, la misma es sólo un breve resumen. Se está desarrollando una referencia que guiará al usuario de una sección específica del viejo manual al lugar donde aparece la información en el nuevo manual. Además, el manual electrónico tendrá una referencia que indicará como se obtuvo la información en cada sección.

We Are Glad You Asked!

The table below identifies what current paper-based manuals were used to construct the new Internet-only manuals. It is just a cursory overview. A detailed crosswalk is being developed to guide you from a specific section of the old manual to where the information now appears in the new manuals. In addition, the Internet-only manual will have a crosswalk to show how the information in each section was derived.

Manual en Papel / *Paper-Based Manuals*	**Manual Electrónico / *Internet Only Manuals***
Pub. 06--Medicare Coverage Issues Pub. 09--Medicare Outpatient Physical Therapy Pub. 10--Medicare Hospital Pub. 11--Medicare Home Health Agency Pub. 12--Medicare Skilled Nursing Facility Pub. 13--Medicare Intermediary Manual, Parts 1, 2, 3, and 4 Pub. 14--Medicare Carriers Manual, Parts 1, 2, 3, and 4 Pub. 21--Medicare Hospice Pub. 27--Medicare Rural Health Clinic and Federally Qualified Health Center Pub. 29--Medicare Renal Dialysis Facility **Program Memoranda** Pub. 60A--Intermediaries Pub. 60B--Carriers Pub. 60AB--Intermediaries/Carriers **NOTE:** Information derived from Pub. 06 to Pub. 60AB was used to develop Pub. 100-01 to Pub. 100-09 for the Internet-only manual.	Pub. 100-01--Medicare General Information, Eligibility, and Entitlement Pub. 100-02--Medicare Benefit Policy Pub. 100-03--Medicare National Coverage Determinations Pub. 100-04--Medicare Claims Processing Pub. 100-05--Medicare Secondary Payer Pub. 100-06--Medicare Financial Management Pub. 100-08--Medicare Program Integrity Pub. 100-09--Medicare Contractor Beneficiary and Provider Communications
Pub. 19--Medicare Peer Review Organization	Pub. 100-10--Medicare Quality Improvement Organization
Pub. 07--Medicare State Operations	Pub. 100-07--Medicare State Operations
Pub. 45--State Medicaid	Pub. 100-12--State Medicaid Pub. 100-13--Medicaid State Children's Health Insurance Program
Pub. 81--Medicare End Stage Renal Disease Network Organizations	Pub. 100-14--Medicare End Stage Renal Disease Network Organizations
Pub. 24--Medicare State Buy-In	Pub. 100-15--Medicare State Buy-In
Pub. 75--Health Maintenance Organization/ Competitive Medical Plan Pub. 76--Health Maintenance Organization/ Competitive Medical Plan (PM) Pub. 77--Manual for Federally Qualified Health Maintenance Organizations	Pub. 100-16--Medicare Managed Care
Pub. 13--Medicare Intermediaries Manual, Part 2 Pub. 14--Medicare Carriers Manual, Part 2	Pub. 100-17--Business Partners System Security
Pub. 13--Medicare Intermediaries Manual, Part 2 Pub. 14--Medicare Carriers Manual, Part 2	Pub. 100-18--Business Partners Security Oversight
Demonstrations (PMs)	Pub 100-19 -- Demonstrations
Instrucciones del programa que impactan varios manuales o no impactan ninguno. *Program instructions that impact multiple manuals or have no manual impact.*	Pub 100-20 --One-Time Notification

CR2886/Transmittal 2/September 12, 2003/els

Health Insurance Portability and Accountability Act (HIPAA)

ELEMENTOS INDISPENSABLES Y DECLARACIONES NECESARIAS PARA UNA AUTORIZACIÓN DE PRIVACIDAD VÁLIDA

La Regla de Privacidad ("Privacy Rule") de la Ley HIPAA establece las claúsulas que se requieren en la autorización del individuo para el uso o divulgación de información de salud protegida (PHI, por sus siglas en inglés). Además, incluye la lista de elementos indispensables y declaraciones necesarias para una autorización válida. Una autorización es un documento en el cual el individuo da su consentimiento a la entidad cubierta para que utilice o divulgue su PHI para todo aquel propósito que no tiene relación a tratamiento, pago o cuidado de la salud (Ej., propósitos de mercadeo o a un tercero definido por el individuo). Una entidad cubierta no tiene que obtener una autorización para utilizar o divulgar PHI para tratamiento, pago o cuidado de la salud.

Los elementos indispensables para una autorización válida son los siguientes:

1. Una descripción de la información que se utilizará o divulgará descrita en una manera específica y explicativa;
2. El nombre u otra identificación específica de la persona o categoría de las personas autorizadas a solicitar el uso o divulgación;
3. El nombre u otra identificación específica de la persona o categoría de personas a quienes la entidad cubierta puede solicitar el uso o divulgación;
4. Una descripción del propósito para el que se solicita el uso o divulgación. La declaración, "a petición del individuo", es suficiente descripción del propósito cuando el beneficiario inicia la autorización y no, o elige no, proveer una declaración del propósito;
5. Una fecha de expiración o expiración del suceso que se relacione al individuo o al propósito del uso o divulgación; y
6. La firma del individuo y fecha. Si el representante del individuo firma la autorización, debe proveer una descripción

CORE ELEMENTS AND REQUIRED STATEMENTS FOR A VALID PRIVACY AUTHORIZATION

The HIPAA Privacy Rule sets forth the provisions for when an individual's authorization is required for uses and disclosures of protected health information (PHI). It also lists the core elements and required statements necessary for a valid authorization. An authorization is a document where an individual gives a covered entity permission to use or disclose his or her PHI for a purpose not related to treatment, payment or health care operations (e.g., marketing or to a third party specified by the individual). A covered entity is not required to obtain an authorization for the use or disclosure of PHI for treatment, payment or health care operations.

The core elements of a valid authorization are the following:

1. *A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;*
2. *The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;*
3. *The name or other specific identification of the person(s) or class of persons, to whom the covered entity may make the requested use or disclosure;*
4. *A description of each purpose of the requested use or disclosure. The statement, "at the request of the individual" is a sufficient description of the purpose when the beneficiary initiates the authorization and does not, or elects not to, provide a statement of the purpose;*
5. *An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure; and*
6. *The signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such*

de la autoridad para actuar por el individuo. A pesar de que la Regla de Privacidad de la Ley HIPAA sólo requiere una descripción de la autoridad del representante para actuar por el individuo, los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) solicitan se adjunte a la autorización documentación que demuestre la autoridad del representante (Ej., Poder otorgado ante un abogado).

Además de los elementos indispensables, la autorización debe incluir declaraciones adecuadas que adviertan lo siguiente:

a) El derecho del individuo a revocar la autorización por escrito, cómo puede revocarla y las excepciones al derecho de revocar, como sigue:

"Reconozco mi derecho a revocar mi autorización en cualquier momento, por escrito, excepto al grado que Medicare ya actuó basado en mi autorización".

Para cancelar la autorización debe enviar la petición por escrito a: Medicare Triple-S, Inc., P.O. Box 71391, San Juan, PR 00936-1391, 1-800-981-7015;

b) La incapacidad de supeditar tratamiento, pago, inscripción, elegibilidad de beneficios por la autorización:

"Entiendo que mi rechazo a autorizar la divulgación de mi información médica no tendrá consecuencias en mi inscripción, elegibilidad de beneficios o la cantidad que Medicare paga por los servicios de salud que recibo".

c) La posibilidad de que información divulgada conforme a la autorización esté sujeta a ser divulgada nuevamente por el que la recibió y no esté protegida.

"La información personal médica que yo autoricé a Medicare a divulgar puede estar sujeta a ser divulgada nuevamente y sin protección de ley".

d) La autorización debe estar escrita en lenguaje sencillo.

e) Se le proveerá al individuo copia de la autorización firmada.

representative's authority to act for the individual must also be provided. Although the HIPAA Privacy Rule only requires a description of the representative's authority to act for the individual, the Centers for Medicare and Medicaid Services (CMS) are requiring that documentation showing their authority be attached to the authorization (e.g., Power of Attorney).

In addition to the core elements, the authorization must contain adequate statements that advises the following:

a) The individual's right to revoke the authorization in writing, how the individual may revoke the authorization, and the exceptions to the right to revoke as follows:

"I acknowledge I have the right to withdraw my authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission."

To cancel your authorization, send a written request to: Medicare Triple-S, Inc., P.O. Box 71391, San Juan, PR 00936-1391, 1-800-981-7015";

b) The inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization:

"I understand refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive";

c) The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer protected:

"The personal medical information that I authorized Medicare to disclose may be subject to re-disclosure and no longer protected by law";

d) The authorization must be written in plain language;

e) A signed copy of the authorization will be provided to the individual.

CR2816/Trans. AB-03-147/September 26, 2003/els

Health Insurance Portability and Accountability Act (HIPAA)

FORMULARIO DE AUTORIZACIÓN DE MEDICARE

Es obligación de Medicare proteger la información médica personal del beneficiario.

Medicare tiene el derecho de usar y divulgar la información médica personal de sus beneficiarios para pagar por el cuidado de la salud y para operar el Programa Medicare. Por ejemplo: Medicare puede usar su información médica personal para asegurarle a usted y a otros beneficiarios servicios de salud de calidad, para proveer servicios al cliente o para resolver cualquier problema que usted tenga. Además, Medicare puede usar o divulgar su información médica personal en circunstancias limitadas con propósitos jurídicos o para investigaciones que reúnan todos los requisitos legales. Para cualquier otro propósito, Medicare sólo puede divulgar su información médica personal con su autorización por escrito.

Usted puede autorizar a que Medicare divulgue su información médica personal a algún conocido suyo completando y firmando la siguiente información. Debe devolverla a:

Triple-S, Inc.
P.O. Box 71391
San Juan, PR 00936-1391
1-800-981-7015

_____ _____
Nombre beneficiario **Número Medicare**

Autorizo a Medicare a divulgar la siguiente información médica personal:

☐ Toda la información de Medicare o
Marque una o más de las siguientes:

☐ Un servicio solamente: Fecha de servicio:_____

Médico/suplidor: _____

☐ Todos los servicios del médico/suplidor
_____
(nombre del médico/suplidor)

☐ Información de Elegibilidad Medicare

☐ Información sobre otra cubierta de salud

☐ Información sobre deducible para el año _____

☐ Copia del Resumen de Medicare para:

Fecha de servicio	Médico/proveedor/hospital/instalación hospitalaria
_____	_____
_____	_____

Health Insurance Portability and Accountability Act (HIPAA)

☐ Otro (especifique):

_____

Favor de anotar el nombre, dirección y teléfono de la persona, agencia, compañía u organización que usted autoriza para que Medicare divulgue su información médica personal:

_____

_____

_____

Propósito de la divulgación – la razón por la cual usted quiere que Medicare libere información a la persona, agencia, compañía u organización indicada anteriormente (si usted no desea indicar el propósito, describa el uso como "según la solicitud del individuo").

_____

_____

_____

Plazo para la autorización (favor marcar uno):

☐ Período de tiempo específico desde: _____ hasta: _____

☐ Para un solo evento (debe estar relacionado con el individuo o con el propósito para el cual se solicita la autorización)

Autorizo el uso de la copia (incluso copia electrónica) de este formulario y la divulgación de mi información médica personal antes descrita. El negarme a autorizar la divulgación no tendrá efecto en mi condición de beneficiario de Medicare, en la elegibilidad de beneficios o la cantidad que Medicare paga por los servicios de salud que recibo.

_____ _____

Firma del beneficiario o representante autorizado* **Fecha**

*Si usted está firma como un representante autorizado, favor describir el fundamento de donde surge su autoridad para actuar por el beneficiario e incluya documentación adecuada (por ejemplo: poder otorgado ante un abogado o compromiso del representante).

ATENCIÓN:

La información médica personal que usted autoriza a Medicare divulgar podría re-divulgarse y no estar protegida por ley.

Usted tiene el derecho de revocar, por escrito, esta autorización en cualquier momento, excepto al grado que Medicare actuó basado en su permiso. Para revocar su autorización, puede enviar su solicitud por escrito a:

Triple-S, Inc.
P.O. Box 71391
San Juan, PR 00936-1391

Health Insurance Portability and Accountability Act (HIPAA)

MEDICARE AUTHORIZATION FORM

By law, Medicare is required to protect your personal medical information.

Medicare has the right to use and give out ("disclose") your personal medical information to pay for your health care and to operate the Medicare Program. For example, Medicare may use your personal medical information to make sure you and other Medicare beneficiaries get quality health care, customer services, or to resolve any complaints you may have. Medicare may also use or give out your personal medical information in other limited circumstances, such as for law enforcement purposes or for research studies that meet all privacy law requirements. For any other purpose, Medicare may only disclose your personal medical information with your written permission ("authorization").

You can authorize Medicare to disclose your personal medical information to someone you know by completing this form and signing below. Return to:

Triple-S, Inc.
P.O. Box 71391
San Juan, PR 00936-1391
1-800-981-7015

_____ _____
Name of Beneficiary **Medicare Number**

I authorize Medicare to disclose the following personal medical information:

❑ All Medicare Information ***or***

Check one or more of the following:

❑ One service only Date of service: _____
Doctor/supplier: _____

❑ All services from these doctor(s) or supplier(s):

_____
(Name of provider/supplier)

❑ Medicare eligibility information
❑ Information on other health coverage
❑ Deductible information for the year of: _____
❑ Copy of Medicare Summary Notice for:

Date of Service	Doctor / Supplier/Hospital / Facility
_____	_____
_____	_____

❑ Other (please specify)*:*

_____

Health Insurance Portability and Accountability Act (HIPAA)

Please write the name of the person, agency, company or organization, including address and telephone number, to whom you are authorizing Medicare to disclose your personal medical information:

_____

_____

_____

Purpose of the disclosure – the reason why you want Medicare to release information to the person, agency, company or organization listed above (if you do not want to provide a statement of the purpose, describe the use as "at the request of the individual"):

_____

_____

_____

The time period, subject to the applicable law (Please check one):

- ❑ One time release
- ❑ Specific time period for release from: _____ to _____

I authorize the use of a copy (including electronic copy) of this form and the disclosure of my personal medical information described above. I understand that refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

_____ _____

Signature of Beneficiary or Authorized Representative* **Date**

*If you are signing as an authorized representative, please describe the basis for your authority to act for the beneficiary and attach appropriate documentation (for example, Power of Attorney or Appointment of Representative)

PLEASE NOTE:
The personal medical information that you authorize Medicare to disclose may be subject to re-disclosure and no longer protected by law.

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, you must send the request in writing to:

Triple-S, Inc.
P. O. Box 71391
San Juan, PR 00936-1391

Health Insurance Portability and Accountability Act (HIPAA)

COMPANION DOCUMENT FOR THE ACCREDITED STANDARDS COMMITTEE (ASC) X12N 276/277 HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE

Triple-S will process your request for claim status information in batch, central processing unit to central processing unit (CPU to CPU).

Upon receipt of your 276, we will generate the following:

- 997 for syntax errors within one working day.

- 277 within one working day.

Triple-S will process your 276 as identified in the implementation guide and create a 277 as identified in the implementation guide. At least the minimum response data will be sent.

Triple-S keeps its online paid claims file for 18 months. After that time, paid claims are stored in an off-line paid claims history file. A 276 inquiry for a claim that has reached history, will result in a 277 response with a health care claim status code "35" (claim not found).

The 276 transaction must utilize delimiters as defined in the standard. The delimiters selected must not occur in the transmitted data elements. The delimiters used in a 277 response or in an acknowledgment may not necessarily be the same as the delimiters submitted in the original 276 request transaction.

All alphabetic characters in the 277 transaction will be upper case. If lower case characters are included in the 276 request, they will be converted to upper case for data storage and return processing purposes.

Multiple functional groups (GS to GE segments) can be sent in one interchange (ISA to IEA segments). Multiple 276s or 277s (ST through SE) can be included in a single functional group.

For Medicare the subscriber and patient are the same person. The Dependent Level hierarchical level is never used.

CR2742/Transmittal AB-03-141/September 26, 2003/JS

"VENDORS" QUE HAN REALIZADO PRUEBAS EN EL FORMATO X12N (TRANSACCIÓN 837)

Las tablas que aparecen en las páginas 20 y 21 identifican a aquellos Proveedores y vendedores de programas de facturación electrónica que han completado exitosamente las pruebas "HIPAA X12N 837 Professional" realizadas por Triple-S, Inc. / División de Medicare. Sus programas pueden ser utilizados por los proveedores de Medicare para el envío de reclamaciones en formato X12N.

VENDORS THAT HAS TESTED X12N FORMAT (837 TRANSACTION)

The tables on pages 20 and 21identifies those providers and billing software vendors that have successfully completed "HIPAA X12N 837 Professional" testing with Triple-S, Inc. / Medicare Division. Their programs may be used by Medicare providers to submit X12N electronic claims.

Cont. on next page

Health Insurance Portability and Accountability Act (HIPAA)

Vendor's Name Program Name	Type of Claims Tested	Address / Phone Numbers	837 Production Version	HIPAA Testing Completion Date
MASS: Medical Accounting Systems Software VisualMass 7.0	-Visit/Consultation -Laboratory Procedure -Surgery Procedure	PO Box 397 Manatí, PR 00674 787-854-8638 787-884-7214	004010X098	9/12/02
Medical Computer System Medical Biller V7	-UPIN -Visit/Consultation -Diagnostic Tests -Laboratory Procedure	4 Calle Barcelona URB Torrimar Guaynabo PR 00966 medbiller@coqui.net (787) 793-8833 Fax (787) 793-8299	004010X098	10/25/02
Structured Systems Corp Medical Practice 6.2	-Visit/Consultation -Diagnostic Tests -Referring Provider/UPIN -Surgery Procedure -Laboratory Procedures	PO Box 50335 Levittown, PR 00950 787-795-5072	004010X098 004010X098A1	9/20/02 9/15/03
TurboMed, Inc. TurboMed ver. 1.01	-Visit/Consultation -Diagnostic Tests -Referring Provider/UPIN	Box 1811 Arecibo, PR 00613 787-898-1437	004010X098 004010X098A1	9/25/02 9/23/03
CompuSoft de Puerto Rico LabSoft Ver. 2H15	-Laboratory Services	Urb Borinquen Calle 4H 18-C Cabo Rojo, PR 00623 787-851-2867 787-851-6320	004010X098	10/9/02
Advance Data Support MedOne Ver. 2.0	-Visit/Consultation	PO Box 8512 Bayamón, PR 00960 787-269-3830 787-269-5620 787-841-0396	004010X098	10/11/02
Blás Menendez y Assoc. MedicMax v2.11.20	-Surgery -Visit/Consultation -Purchase -Service -Referring Provider	PO Box 3226 Guaynabo PR 00970 787-783-6102	004010X098	11/6/02
Air Information Systems Medi+2000	-Visit/Consultation -Diagnostic Tests -UPIN - Ambulance	PO Box 270152 San Juan, PR 00927-0152 787-294-1161 787-793-0046 Fax: 787-775-4123	004010X098 004010X098A1	4/24/03 9/15/03
The Right Answer TRA Medical Billing System ver. 5.0	-Visit/Consultation -UPIN Data -Ambulatory Surgery -Emergency procedures -Radiology Services -Mammography Procedures -Anesthesia Procedures -Laboratory Services	PMB 396 405 Ave. Esmeralda Suite #2 Guaynabo, PR 00969-3738 787-272-8787 787-643-3738 Fax: 787-272-6106	004010X098	4/15/03
Lab Warehouse, Inc. Best 2000 Ver. 20030520	-Laboratory Procedures	13 Calle 65 de Infantería Esq. Calle Concordia Lajas, PR 00667 Tel. 787-899-2900	004010X098	4/16/03
WebMD	-Radiology Services -UPIN	26 Century Boulevard Nashville TN 37214	004010X098	6/30/03

Cont. on next page

Health Insurance Portability and Accountability Act (HIPAA)

Vendor's Name Program Name	Type of Claims Tested	Address / Phone Numbers	837 Production Version	HIPAA Testing Completion Date
TekPro, Inc. MedicPro 3.5	-Visit/Consultation -UPIN Data -Physical Therapy -Emergency procedures -Radiology Services -Mammography Procedures -Anesthesia Procedures -Laboratory Services	Isabel Andreu Aguilar #103 Edif. Insuramerica Ste. 301 Hato Rey, PR 00925 tekpro@prtc.net 787-753-1136 787-753-1189 Fax 787-763-1262	004010X098 004010X098A1	6/27/03 9/23/03
Lamars Computerized Services Control Total, Versión HIPAA	-Laboratory Procedure -UPIN	Urb La Cumbre 9 Kennedy St Río Piedras, PR 00926 Tels: 787-720-9697 Fax: 787-272-5824 lamars@centennialpr.net	004010X098 004010X098A1	6/11/03 9/15/03
Computer Softek Inc. WinMBS Versión: 3.0	-Visit/Consultation -UPIN	POBox 190408 San Juan, PR 00919-0408 787-720-7547 787-420-0859 www.winmbs.com softek@prtc.net	004010X098	6/27/03
JCL Systems, Inc. Med Center	-Visit/Consultation -Laboratory Procedure -Surgery Procedure	Box 144 53 Ave. Esmeralda Guaynabo PR 00969 787-630-7881	004010X098 004010X098A1	2/24/03 9/15/03
Simplesoft PR Inc. Medical Orders System Version 2.1	-Visit / Consultation -UPIN -MSP Claims	210 Sol San Juan PR 00901 787-696-4594	004010X098	7/28/03
Royal Computer Systems Inc. MEDITRACK 1.0	-Visit / Consultation -Surgery Procedure	Box 362863 San Juan, P.R. 787-764-8383 787-251-4429 emartinez@wns.net www.meditrak-pr.info	004010X098A1	10/6/03
Health Computer Systems SAIL v.5.03	-Visit / Consultation -Anestesia -UPIN	PO Box 270030 San Juan, PR 00927-0030 787-781-9868 hcspr@att.net http://www.hcspr.com	004010X098A1	10/15/03
OFFI-PLUS, INC OFFI-MED Version 7.02	-Visit / Consultation -Surgery	PO Box 1132 Trujillo Alto, PR 00977-1132 787-283-0804 PCS 787-642-9035 FAX: 787-292-0222 offiplus@prtc.net offiplus@libertypr.net	004010X098A1	10/15/03
Aranay Interactive Systems InstantMed Version 7.0	-Anesthesia Procedure -UPIN	609 Miramar Ave. Suite 101 San Juan PR 00907 787-225-4466 apinzon@aranay.com	004010X098A1	10/22/03
Multi Soft Developers, MSD WABS MEDICAL BILLING	-Radiology Services -UPIN	Ave. Americo Miranda #1110 San Juan, PR 00921 787 793-5725 787 783-3266 www.genius-msd.com	004010X098A1	10/22/03

Updated as of: October 27, 2003

Health Insurance Portability and Accountability Act (HIPAA)

CLAIM STATUS TRANSACTION - 276/277

Claim Status codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-2, STC10-2 and STC11-2 composite elements. They provide detail on general status communicated in the Claim Status Category Codes carried in STC01-1, STC10-1 and STC11-1. For users who are new to the Claim Status transaction, please review the **276/277 Implementation Guide** for utilizing claim status codes. Claim status codes communicate information about the status of a claim, i.e., whether it's been received, suspended, or paid. The Claim Status transaction is not used as a financial transaction.

The following list includes recently added codes:

490	Other Procedure Code for Service(s) Rendered *Note: New as of 2/03*
491	Entity not eligible for encounter submission *Note: New as of 2/03*
492	Other Procedure Date *Note: New as of 2/03*
493	Version/Release/Industry ID code not currently supported by information holder *Note: New as of 2/03*
494	Real-Time requests not supported by the information holder, resubmit as batch request *Note: New as of 2/03*

CONTINGENCY PLAN FOR HIPAA TRANSACTION AND CODE SETS

After a careful analysis of Medicare provider, submitter and other trading partner HIPAA readiness, Medicare will continue to accept and send standard and non-standard versions and/or formats for any electronic transaction for a limited time period beyond October 16, 2003.

This is a temporary measure to maintain provider cash flow and minimize operational disruption while trading partners who are not compliant on October 16, 2003, work with Medicare to achieve full compliance.

This contingency plan is only for a limited time. Providers, who must continue to bill and receive non-compliant formats, should test and move into production on the HIPAA required formats as soon as possible, or risk possible cash flow problems.

JSM CI-2117/September 23, 2003/els

Health Insurance Portability and Accountability Act (HIPAA)

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

Los códigos de taxonomía para los proveedores de salud (HPTC, por sus siglas en inglés) son códigos diseñados para clasificar a los proveedores de servicios de cuidado de la salud de acuerdo a la especialidad del proveedor, específicamente dentro de las transacciones relacionadas a servicios de salud de la "American Nacional Standards Institute Accredited Standards Committee Insurance Subcommitee". Estos códigos se publican dos veces al año (enero y julio) y son vigentes en abril y octubre.

El "Washington Publishing Company" publicó la versión 3.1 de la lista de los códigos de taxonomía para los proveedores de servicios de cuidado de la salud, vigente en octubre 2003. La misma está disponible a través de su sitio en Internet http://www.wpc-edi.com/codes/. Esta lista incluye los códigos que fueron aprobados en la versión 3.0 y códigos añadidos a la nueva versión 3.1. La lista está disponible de dos maneras; se puede obtener libre de costos del sistema o se puede adquirir mediante suscribción al "Washington Publishing Company". El formato electrónico le facilitará montar automáticamente estos códigos a su programa de facturación.

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

CR2901/Pub. 100-4 MCP/Trans. 4/October 3, 2003/JS

HEALTHCARE PROVIDER TAXONOMY CODES (HPTC)

The Provider Taxonomy Code set (HPTC) is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute Accredited Standards Committee Insurance Subcommittee health care transactions. The HPTC's are published twice a year (January and July) and are effective April and October.

The HPTC code list version 3.1, which is effective October 2003, is now available from the Washington Publishing Company http://www.wpc-edi.com/codes/. This listing includes active codes approved for use in the previous HPTC version 3.0 and codes that have been added to the new HPTC version 3.1. This code list is available in two forms. The first form is a free PDF download and the second form, which is an electronic representation of the list, may be purchased from WPC on a subscription basis. The electronic representation will facilitate the automatic loading of the code set.

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

Health Insurance Portability and Accountability Act (HIPAA)

PREGUNTAS MAS FRECUENTES SOBRE EL FORMATO X12

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

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

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

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

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

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

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

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

MOST FREQUENT QUESTIONS ABOUT THE X12 FORMAT

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

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

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

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

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

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

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

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

Cont. on next page

Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

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

   Puede acceder la lista más reciente de "VENDORS" a través de nuestra página electrónica en: www.triples-med.org.

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

   Siga los siguientes pasos:

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

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

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

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

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

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

   The most recent Vendors list may be accessed at our Internet page at: www.triples-med.org.

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

   Follow these steps:

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

Health Insurance Portability and Accountability Act (HIPAA)

9. ¿Cómo se maneja el programa?

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

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

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

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

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

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

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

La Hoja de Control de EMC se utiliza para informar a Medicare que usted está listo para facturar en el nuevo formato X12. Al recibir el formulario, Medicare actualizará su número de remitente para reconocer el nuevo formato. Podrá encontrar en la página 32 una Hoja de Control EMC o en nuestra página electrónica en: www.triples-med.org.

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

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

9. How does the program operate?

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

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

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

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

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

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

The EMC Control Sheet is used to notify Medicare that you are ready to bill in the new X12 format. Upon receipt of the form, Medicare will update your sender number to recognize the new format. On page 32 you may find an EMC Control Sheet or at our Internet page at: www.triples-med.org.

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

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

Cont. on next page

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

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

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

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

16.¿Cómo puedo extraer los informes de Medicare?

El programa de SES PROFESIONAL extrae automáticamente los archivos de informes; éstos pueden accederse seleccionando la pestaña ("Tab") de comunicación en la barra de herramientas ("Toolbar") a la izquierda de la pantalla. Luego, en el Menú superior seleccionará "Informes/Cartas" y en la opción de "Ver Informes", podrá ver los archivos que le han llegado, entre estos, Informes de Error, Remesas de Pago, 997's, etc.

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

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

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

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

16.How can I download the Medicare reports?

The SES PROFESSIONAL program automatically downloads the report files; this can be accessed by selecting the communication Tab, in the toolbar at the left of the screen. Then in the upper menu, your will select "Reports/Letters", thru the "View Report" option, you can see the files which you have received, among these, Error Letters, Payment Remittance, 997's, etc.

Cont. on next page

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Division/November, 2003/els

EMC CONTROL SHEET

Complete this form to transition your billing software to a HIPAA X12 format.

Provider ID: 00_____

Biller ID: _____00000_____

Provider Name:_____

Provider Phone:_____

Name of Billing Software:

❑ SESPRO	❑ Medical Computer System	❑ Structure Systems Corp.	❑ Turbo Med, Inc.	❑ Compusoft de PR-Lab soft
❑ Medi+2000	❑ TRA Medical Billing	❑ Best 2000	❑ MedicPro	❑ Control Total
❑ WinMBS	❑ Med Center	❑ Medical Orders System	❑ MEDITRACK	❑ SAIL
❑ Instant Med	❑ Offi-Med	❑ MASS	❑ Other _____	

I certify that I will be submitting claims in the software indicated above.

_____ _____

Date **Signature**

For System Area internal use only:

Assigned User ID:_____

Activation Date:_____

Activated by:_____

BBS ACTIVATION SHEET

_____

❑Add New Provider to BBS
❑Update Provider Data

Provider ID: 00_____

Biller ID: ___00000_____

Provider Name: _____

Provider Phone: _____

Billing Software Name and Version: _____

Type of service requested:

❑ Send Medicare claims files
❑ Receive Remittance files

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

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

_____ _____
Date Signature

For System Area internal use only:

Assigned User ID :_____

Activation Date :_____

Activated by :_____

TriCenturion, LLC

TRICENTURION, LLC

La Ley HIPAA de 1996 autoriza a los Centros de Servicios de Medicare y Medicaid (CMS, por sus siglas en inglés) a contratar organizaciones que lleven a cabo actividades de salvaguardia para el Programa Medicare. Estas actividades pueden incluir revisiones médicas, investigaciones de fraude, auditorías de informes de costo y análisis de información. La organización contratada por CMS para llevar a cabo estas actividades se le conoce como Programa de Contratistas de Salvaguardia (PSC, por sus siglas en inglés). En respuesta a ésto, CMS seleccionó a TriCenturion, compañía fundada en el 1998.

Desde el 1 de octubre de 2003, TriCenturion, LLC asumió las actividades para prevenir y disuadir el fraude y el abuso y para llevar a cabo otras funciones que anteriormente proporcionaba la Cooperativa de Seguros de Vida de Puerto Rico (Parte A) y Triple-S, Inc./ Medicare (Parte B). Los otros servicios de la Parte A y Parte B de Medicare se continuarán proporcionán a través de la Cooperativa de Seguros de Vida de Puerto Rico y Triple-S, Inc./Medicare respectivamente.

De necesitar información relacionada con los servicios que ofrece TriCenturion, puede comunicarse con su Director de Integridad al Programa cuya responsabilidad es desarrollar casos e investigaciones. Este puede ayudarle con necesidades específicas, desarrollo de casos e investigaciones. Por otro lado, el Especialista de la Educación del Fraude puede ayudarle con cualquier adiestramiento e información sobre Integridad al Programa. También, puede acceder a su dirección electrónica www.tricenturion.com para información sobre su programa de servicios.

Si usted tiene alguna pregunta sobre la transición de los trabajos de la Sección de Integridad al Programa de los contratistas de Medicare a TriCenturion, puede comunicarse al (904) 791-6105.

TRICENTURION, LLC

The Health Insurance Portability and Accountability Act of 1996 includes a provision that authorizes the Centers for Medicare & Medicaid Services (CMS) to enter into contracts with organizations other than traditional Medicare contractors to perform Medicare program safeguards activities. These activities may include medical reviews, fraud investigations, cost report audits, and data analysis. The organizations that enter into contracts with CMS to perform these activities are known as Program Safeguard Contractors (PSC). In response to this, CMS choose TriCenturion, LLC.

As of October 1, 2003, TriCenturion, LLC (TriCenturion) assumed the fraud and abuse detection, deterrence, and development activities that are currently being provided by Triple-S/Medicare and Cooperativa de Seguros de Vida de Puerto Rico (COSVI). All other Part A Intermediary services and Part B Carrier services will continue to be provided by COSVI and Triple-S, respectively.

If need information pertaining services provided by TriCenturion, you may contact the Utilization Management Benefit Integrity Director, who has overall responsibility for case development and investigations. Here you can obtain specific fraud investigation inquiries and needs. Furthermore, the Fraud Education Specialist can assist you with any Medicare Benefit Integrity training and information. You can find information regarding their services at their web site www.tricenturion.com.

If you have any questions regarding the transition of the Program Integrity work from the Medicare contractors to TriCenturion or any other questions, please contact (904) 791-6105.

Stephen Quindoza/Tricenturion/Sept. 10, 2003

HOME HEALTH CARE: The Medicare Benefits

Medicare will help cover home health care costs for beneficiaries who meet the following four (4) conditions:

- Your doctor must decide that you need medical care at home, and make a plan for your care at home;
- You must need at least one of the following: intermittent skilled nursing care, or physical therapy or speech-language therapy or continue to need occupational therapy;
- You must be homebound. This means that you are normally unable to leave home unassisted. Being homebound means that leaving home is a major effort. When you leave home, it must be to get medical care, or for short, infrequent non-medical reasons such as a trip to get a haircut, or to attend religious services or adult day care.
- The home health agency caring for you must be approved by the Medicare program.

If you meet all four (4) of the conditions above, Medicare will help cover:

- Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and correctly by a licensed nurse (either a registered nurse or licensed practical nurse)
- Home health aide services on a part time or intermittent basis. A home health aide does not have a nursing license. The aide provides services that give additional support to the nurse. These services include help with personal care such as bathing, using the toilet or dressing. These types of services do not need the skills of a licensed nurse. Medicare does not cover home health aide services unless you are also getting skilled care such as nursing care or other therapy. The home health aide services must be part of the home care for your injury or illness.
- Physical therapy, speech-language therapy and occupational therapy for as long as your doctor says you need it.
  - o Physical therapy, which includes exercise to regain movement and strength to a body area, and training on how to use special equipment or do daily activities, like how to get in and out of a wheelchair or bathtub
  - o Speech-language therapy (pathology services), which includes exercise to regain and strengthen speech skills
  - o Occupational therapy, which helps you to become able to do usual daily activities by yourself. You might learn new ways to eat, put on clothes, comb your hair, and new ways to do other usual daily activities. You may continue to receive occupational therapy even if you no longer need other skilled care.
- Medical social services to help you with social and emotional concerns related to your illness. This might include counseling or help in finding resources in your community.
- Certain medical supplies, like wound dressings, but not prescription drugs.
- Certain medical equipment, such as a wheelchair or walker. Medicare usually pays 80% of the approved amount for some medical equipment.

Medicare does not pay for:

- 24-hour a day care at home.
- Meals delivered to your home.
- Personal care given by home health aides, like bathing, using the toilet, or help in getting dressed when this is the only care you need.
- Prescription drugs (with a few exceptions –ask your doctor).
- Homemaker services like cleaning, laundry and shopping.

For more information about Medicare coverage of home health care call 1-800-MEDICARE, or visit www.medicare.gov and click on “Publications” to read *Medicare and Home Health Care*.

MEDICAL REVIEW

UPDATE TO COVERAGE AND BILLING POLICY FOR IMPLANTABLE AUTOMATIC DEFIBRILLATORS

The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating.

The National Coverage Determination (NCD) will be effective on October 1, 2003; to expand coverage of implantable automatic defibrillators for Medicare managed care and fee-for-service patients. Providers will be reimbursed for services to managed care patients under the expanded coverage indications effective October 1, 2003, according to the NCD on a fee-for-service basis until capitation rates are adjusted.

A. Effective July 1, 1991 the following services are covered:

1) Documented episode of cardiac arrest due to ventricular fibrillation (VF), not due to a transient or reversible cause;

2) Documented sustained ventricular tachyarrhythmia (VT), either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute myocardial infarction (MI) and not due to a transient or reversible cause;

3) Documented familial or inherited conditions with a high risk of life-threatening VT, such as long QT syndrome or hypertrophic cardiomyopathy.

As stated in the NCD, the following indications will be covered when rendered on October 1, 2003 and thereafter:

4) Coronary artery disease with a documented prior MI, a measured left ventricular ejection fraction d" 0.35, and inducible, sustained VT of VF at EP study. (The MI must have occurred more than 4 weeks prior to defibrillator insertion. The EP test must be performed more than 4 weeks after the qualifying MI.);

5) Documented prior MI and measured left ventricular ejection fraction d" 0.30 and a QRS duration of > 120 milliseconds. Patients must not have:

   a. New York Heart Association classification IV;

   b. Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;

   c. Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within past 3 months;

   d. Had an enzyme-positive MI within past month;

   e. Clinical symptoms or findings that would make them a candidate for coronary revascularization; or

   f. Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year.

B. All patients considered for implantation of a defibrillator must not have irreversible brain damage, disease of dysfunction that precludes the ability to give informed consent.

C. MIs must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Angiography, radionuclide scanning, or echocardiography must measure ejection fractions.

D. All other indications remain non-covered except in Category B IDE clinical trials (60 CFR 48417) or as a routine cost in clinical trials defined under CIM 30-1.

NOTE: Refer to Coverage Issues Manual, Section 35-85 (revisions effective October 1, 2003).

Billing Instructions For Providers Who Render Services To Fee-For-Service And Managed Care Patients

A. Providers who offer expanded implantable automatic defibrillators services to fee-for-service patients:

- Claims for these services cannot be billed using modifier KZ, condition code 78, or for services outside of this expanded coverage.

B. Providers who furnish expanded implantable automatic defibrillator services to managed care patients:

- Are encouraged not to submit claims for services performed on October 1, 2003 and thereafter, because Medicare will not be able to process the claims until January 5, 2004.
- Must use modifier KZ (new coverage not implemented by managed care) when billing for services rendered on October 1, 2003 and thereafter.
- Providers billing fiscal intermediaries on October 1, 2003 and thereafter must use condition code 78 (payment for coverage not implemented by HMO).
- Providers who are paid under the Outpatient Prospective Payment System (OPPS) must bill all services related to this expanded coverage on one claim and for the same date of service, using condition code 78.
- Providers billing carriers and providers who are paid under the OPPS must split the bills if they overlap September 2003 and October 2003.
- Patients who receive these services must pay any applicable coinsurance amounts.
- For services to manage care patients whose indications fall outside this expanded coverage, providers must not bill using condition code 78 or modifier KZ.

C. Procedure Codes

NOTE: The physician should bill for the appropriate service from the following range of CPT codes. These services should be billed to the proper Medicare carrier for payment.

- 33240 • 33241 • 33243 • 33244 • 33245 • 33246 • 33249

NOTE: The new G codes listed below are payable under OPPS effective October 1, 2003. These new G codes are **NOT** payable under the Medicare Physician Fee Schedule and, therefore, should not be billed to Medicare carriers.

- G0297 • G0298 • G0299 • G0300 • ICD-9-CM Procedure Code 37.94 (for 11X TOBs)

CR 2880/AB-03-134/August 22, 2003/FR/LC
CR 2880/CIM/Transmittal 173/August 22, 2003/FR/LC
CR 2922/OTN Pub.100-20/Transmittal 4/September 22, 2003/els

MEDICAL POLICY

EXPANDED COVERAGE FOR VENTRICULAR ASSIST DEVICES (VADS) AND BILLING INSTRUCTIONS FOR CLAIMS FOR BENEFICIARIES IN A MEDICARE + CHOICE (M+C) PLAN

For services performed October 1, 2003 and thereafter, Ventricular Assist Devices (VADs) are covered when used as destination therapy if they have received approval from the Food and Drug Administration (FDA) for that purpose, the VAD is used according to FDA-approved labeling instructions, the patient meets specified criteria, and the procedure is performed in specified facilities. All other indications for the use of VADs remain the same.

Destination therapy is for patients that require permanent mechanical cardiac support. VADs used for destination therapy are covered only if they have received approval from the FDA for that purpose, and the device is used according to the FDA-approved labeling instructions. VADs are covered for patients who have chronic end-stage heart failure (New York Heart Association Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of less than 2 years), are not candidates for heart transplantation, and meet all of the following conditions:

a. The patient's Class IV heart failure symptoms have failed to respond to optimal medical management, including dietary salt restriction, diuretics, digitalis, beta-blockers, and ACE inhibitors (if tolerated) for at least 60 of the last 90 days;

b. The patient has a left ventricular ejection fraction (LVEF) < 25%;

c. The patient has demonstrated functional limitation with a peak oxygen consumption of < 12 ml/kg/min; **or** the patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion; **and**,

d. The patient has the appropriate body size (³ 1.5 m^2) to support the VAD implantation.

In addition, the Centers for Medicare & Medicaid Services (CMS) has determined that VAD implantation as destination therapy is reasonable and necessary only when the procedure is performed in a Medicare-approved heart transplant facility that, between January 1, 2001, and September 30, 2003, implanted at least 15 VADs as a bridge-to-transplant or as destination therapy. These devices must have been approved by the FDA for destination therapy or as a bridge-to-transplant, or have been implanted as part of an FDA investigational device exemption (IDE) trial for one of these two indications. VADs implanted for other investigational indications or for support of blood circulation post-cardiotomy do not satisfy the volume requirement for this purpose. Since the relationship between volume and outcomes has not been well established for VAD use, facilities that have minimal deficiencies in meeting this standard may apply and include a request for an exception based upon additional factors. Some of the factors CMS will consider are geographic location of the center, number of destination procedures performed, and patient outcomes from VAD procedures completed.

Furthermore, this facility must be an active, continuous member of a national, audited registry that requires submission of health data on all VAD destination therapy patients from the date of implantation throughout the remainder of their lives. This registry must have the ability to accommodate data related to any device approved by the FDA for destination therapy regardless of manufacturer. The registry must also provide such routine reports as may be specified by CMS, and must have standards for data quality and timeliness of data submissions such that hospitals failing to meet them will be removed from membership. CMS believes that the registry sponsored by the International Society for Heart and Lung Transplantation is an example of a registry that meets these characteristics.

Hospitals also must have in place, staff and procedures that ensure that prospective VAD recipients receive all information necessary to assist them in giving appropriate informed consent for the procedure so that they and their families are fully aware of the aftercare requirements and potential limitations, as well as benefits, following VAD implantation.

CMS plans to develop accreditation standards for facilities that implant VADs and, when implemented, VAD implantation will be considered reasonable and necessary only at accredited facilities.

A list of facilities eligible for Medicare reimbursement for VADs as destination therapy will be maintained on our Web site and available at www.cms.hhs.gov/coverage/lvadfacility.asp. To be placed on this list, facilities must submit a letter to the Director, Coverage and Analysis Group, 7500 Security Blvd, Mailstop C1-09-06, Baltimore, MD 21244. This letter must be received by CMS within 90 days of the issue date on this transmittal. The letter must include the following information:

- Facility's name and complete address;
- Facility's Medicare provider number;
- List of all implantations between January 1, 2001, and September 30, 2003, with the following information:
  - Date of implantation,
  - Indication for implantation (only destination and bridge-to-transplant can be reported; post-cardiotomy VAD implants are not to be included),
  - Device name and manufacturer, and,
  - Date of device removal and reason (e.g., transplantation, recovery, device malfunction), or date and cause of patient's death;
- Point-of-contact for questions with telephone number;
- Registry to which patient information will be submitted**; and,**
- Signature of a senior facility administrative official.

Facilities not meeting the minimal standards and requesting exception should, in addition to supplying the information above, include the factors that they deem critical in requesting the exception to the standards.

CMS will review the information contained in the above letters. When the review is complete, all necessary information is received, and criteria are met, CMS will include the name of the newly Medicare-approved facility on the CMS Web site. No reimbursement for destination

therapy will be made for implantations performed before the date the facility is added to the CMS Web site. Each newly approved facility will also receive a formal letter from CMS stating the official approval date it was added to the list.

BILLING INSTRUCTIONS FOR CLAIMS FOR BENEFICIARIES IN A MEDICARE+CHOICE (M+C) PLAN:

Until Medicare capitation rates to M+C organizations are adjusted to account for this expanded VADs coverage, Medicare will pay providers on a fee-for-service basis for VADs that fall under the new indication for destination therapy.

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The fee-for-service claims processing system automatically excludes claims for services provided for risk M+C beneficiaries except in certain circumstances for which editing has been created.

Physicians and suppliers should use modifier **KZ** (new coverage not implemented by managed care) when billing for services for VADs for beneficiaries in an M+C plan when conditions fall under the new indications for destination therapy, which are effective October 1, 2003.

Until the new capitation rates to M+C organizations are in effect to include the cost of this expanded coverage, payment for VADs furnished to beneficiaries enrolled in risk M+C plans will be determined according to the applicable fee-for-service rules, except that beneficiaries are not responsible for the Part A and Part B deductibles. M+C enrollees are liable for the coinsurance amounts applicable to services paid under Medicare fee-for-service rules.

Claims for dates of service 10/01/2003 and thereafter will be held by carriers until January 5, 2004, when system changes will be implemented to allow the claims to process.

CR# 2958/Pub.100-4 Trans. #10/Pub.100-3 Trans#2/ dmg/lc

GUIDELINES FOR MEDICARE PART B LABORATORY TESTING

This article explains the Centers for Medicare & Medicaid Services' (CMS) coverage policies for diagnostic and screening prostate specific antigen (PSA) laboratory tests under Medicare Part B. It also explains the importance of including the date of service on orders for laboratory testing.

DIAGNOSTIC PSA LABORATORY TESTING

- Under §4554(b)(1) of the Balanced Budget Act (BBA), Public Law 105-33 mandated the use of negotiated rulemaking with interested parties in the laboratory community in order to promote uniformity, administrative simplicity, and program integrity regarding coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B. As a result of this negotiated rulemaking, a National Coverage Decision (NCD) was developed for the diagnostic PSA test, which is a tumor marker for adenocarcinoma of the prostate and may be useful in the differential diagnosis of men presenting with as yet undiagnosed disseminated metastatic disease. When used in conjunction with other prostate cancer tests, such as digital rectal examination, the PSA test may assist in the decision-making process for diagnosing prostate cancer. PSA also serves as a marker in following the progress of most prostate tumors once a diagnosis has been established, as an aid in the management of prostate cancer patients, and in detecting metastatic or persistent disease in patients following treatment. The test is of proven value in differentiating benign from malignant disease men with lower urinary tract signs and symptoms (i.e., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia, and incontinence) as well as patients with palpably abnormal prostate glands on physical exam, and in patients with other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder.
- The NCD for diagnostic PSA tests does not apply to screening PSA tests.
- Use CPT/HCPCS code 84153 for diagnostic PSA testing.

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MEDICAL POLICY

SCREENING PSA LABORATORY TESTING

- Screening PSA testing measures the level of prostate specific antigen in the patient's blood for the early detection of the marker for adenocarcinoma of the prostate subject to coverage, frequency, and payment limitations as follows:
  - Covered at a frequency of once every 12 months for men who have attained age 50 if at least 11 months have passed following the month in which the last Medicare-covered screening PSA test was performed; and
  - Must be ordered by the patient's physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is authorized under State law to perform the examination, fully knowledgeable about patient's medical condition, and who would be responsible for using the results of any examination (test) performed in the overall management of the patient's specific medical problem which includes explaining the results of the test to the patient.
- Use HCPCS code G0103 for the screening PSA test.

Reminder:

DATE OF SERVICE FOR LABORATORY TESTING

We published in our **Medicare Informa**, Volume 72, pages 14-16 this information related to the National Coverage Determination.

During the clinical diagnostic laboratory services negotiated rulemaking, CMS learned that there was considerable variability regarding the date of service on laboratory claims. In order to promote uniformity, the committee recommended a national policy related to the date of service on laboratory claims. CMS published a proposed rule for public comment on March 10, 2000 (65 FR 13082) and published the rule final on November 23, 2001 (66 FR 58788). The final rule states that:

- The date of service for laboratory tests that is reported on the claim is to be the date the tested specimen was collected; and
- The person obtaining the specimen must furnish the date of collection of the specimen to the entity billing Medicare.

Physicians or their staff who draw specimens for testing **must** report the date of collection of the specimen on orders for laboratory tests. Laboratories may refuse to perform tests on orders for laboratory tests that do not include the information they need in order to seek payment for services performed, i.e., the date of collection of the specimen.

CR2841/Transmittal AB-03-132/August 22,2003/ICR

MEDICAL POLICY

CPT CODE FOR LUNG VOLUME REDUCTION SURGERY AND INSTRUCTIONS FOR PROCESSING CLAIMS FOR BENEFICIARIES IN A RISK M+C PLAN

Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

A. *Covered Indications*

Medicare-covered LVRS approaches are limited to bilateral excision of a damaged lung with stapling performed via median sternotomy or video-assisted thoracoscopic surgery.

1. National Emphysema Treatment Trial (NETT) participants (effective for services performed on or after August 11, 1997):

   Medicare provides coverage to those beneficiaries who are participating in the NETT trial for all services integral to the study and for which the Medicare statute does not prohibit coverage.

2. Medicare will only consider LVRS reasonable and necessary when all of the following requirements are met (effective for services performed on or after January 1, 2004):

- The patient satisfies all the criteria outlined below:

ASSESSMENT	CRITERIA
History and physical examination	Consistent with emphysema
	BMI, $\leq$ 31.1 kg/m^2 (men) or $\leq$ 32.3 kg/m^2 (women)
	Stable with $\leq$ 20 mg prednisone (or equivalent) qd
Radiographic	High Resolution Computer Tomography (HRCT) scan evidence of bilateral emphysema
Pulmonary function (pre-rehabilitation)	Forced expiratory volume in one second (FEV_1) $\leq$ 45% predicted ($\geq$ 15% predicted if age $\geq$ 70 years)
	Total lung capacity (TLC) $\geq$ 100% predicted post-bronchodilator
	Residual volume (RV) $\geq$ 150% predicted post-bronchodilator
Arterial blood gas level (pre-rehabilitation)	PCO_2, $\leq$ 60 mm Hg (PCO_2, $\leq$ 55 mm Hg if 1-mile above sea level)
	PO_2, $\geq$ 45 mm Hg on room air (PO_2, $\geq$ 30 mm Hg if 1-mile above sea level)
Cardiac assessment	Approval for surgery by cardiologist if any of the following are present: Unstable angina; left-ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram; LVEF < 45%; dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction; arrhythmia (> 5 premature ventricular contractions per minute; cardiac rhythm other than sinus; premature ventricular contractions on EKG at rest)
Surgical assessment	Approval for surgery by pulmonary physician, thoracic surgeon, and anesthesiologist post-rehabilitation
Exercise	Post-rehabilitation 6-min walk of $\geq$140 m; able to complete 3 min. unloaded pedaling in exercise tolerance test (pre- and post-rehabilitation)
Consent	Signed consents for screening and rehabilitation
Smoking	Plasma cotinine level $\leq$ 13.7 ng/mL (or arterial carboxyhemoglobin $\leq$ 2.5% if using nicotine products)
	Nonsmoking for 4 months prior to initial interview and throughout evaluation for surgery
Preoperative diagnostic and therapeutic program adherence	Must complete assessment for and program of preoperative services in preparation for surgery

b. In addition, the patient must have:

- Severe upper lobe predominant emphysema (as defined by radiologist assessment of upper lobe predominance on CT scan), **or**
- Severe non-upper lobe emphysema with low exercise capacity.

  Patients with low exercise capacity are those whose maximal exercise capacity is at or below 25 watts for women and 40 watts (w) for men after completion of the preoperative therapeutic program in preparation for LVRS. Exercise capacity is measured by incremental, maximal, symptom-limited exercise with a cycle ergometer utilizing 5 or 10 watt/minute ramp on 30% oxygen after 3 minutes of unloaded pedaling.

c. The surgery must be performed at facilities that were identified by the National Heart, Lung, and Blood Institute to meet the thresholds for participation in the NETT, and at sites that have been approved by Medicare as lung transplant facilities. These facilities are listed on the Centers for Medicare & Medicaid Services (CMS) Web site at www.cms.hhs.gov/coverage/lvrsfacility.pdf. CMS is currently working to develop accreditation standards for facilities to perform LVRS and when implemented, will consider LVRS to be reasonable and necessary only at accredited facilities.

d. The surgery must be preceded and followed by a program of diagnostic and therapeutic services consistent with those provided in the NETT and designed to maximize the patient's potential to successfully undergo and recover from surgery. The program must include a 6- to 10-week series of at least 16, and no more than 20, preoperative sessions, each lasting a minimum of 2 hours. It must also include at least 6, and no more than 10, postoperative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks of the LVRS. This program must be consistent with the care plan developed by the treating physician following performance of a comprehensive evaluation of the patient's medical, psychosocial and nutritional needs, be consistent with the preoperative and postoperative services provided in the NETT, and arranged, monitored, and performed under the coordination of the facility where the surgery takes place.

Noncovered Indications:

1. LVRS is not covered in **any** of the following clinical circumstances:

   a. Patient characteristics carry a high risk for perioperative morbidity and/or mortality;

   b. The disease is unsuitable for LVRS;

   c. Medical conditions or other circumstances make it likely that the patient will be unable to complete the preoperative and postoperative pulmonary diagnostic and therapeutic program required for surgery;

   d. The patient presents with $FEV_1 \leq 20\%$ of predicted value, and either homogeneous distribution of emphysema on CT scan**, or** carbon monoxide diffusing capacity of $\leq$ 20% of predicted value (high-risk group identified October 2001 by the NETT); or

   e. The patient satisfies the criteria outlined above in section 2(a), and has severe, non-upper lobe emphysema with high exercise capacity. High exercise capacity is defined as a maximal workload at the completion of the preoperative diagnostic and therapeutic program that is above 25 w for women and 40 w for men (under the measurement conditions for cycle ergometry specified above).

2. All other indications for LVRS not otherwise specified remain noncovered.

Billing instructions for claims for beneficiaries in a Medicare+Choice (M+C) plan:

Until Medicare capitation rates to M+C organizations are adjusted to account for this LVRS coverage, Medicare will pay providers on a fee-for-service basis for LVRS **when all of the requirements are met (effective for services performed on or after January 1, 2004).**

To report this service, the following CPT code should be used:

32491- Excision plication of emphysematous lung(s) (bullous or non-bulluos) for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure.

The following ICD-9 CM Code should be reported with CPT code 32491

492.8-Other Emphysema

The fee-for-service claims processing system automatically excludes claims for services provided for risk M+C beneficiaries except in certain circumstances for which editing has been created.

Physicians and suppliers should use modifier **KZ** (new coverage not implemented by managed care) when billing for services for LVRS for beneficiaries in an M+C plan effective January 1, 2004.

Until the new capitation rates to M+C organizations are in effect to include the cost of this expanded coverage, payment for LVRS furnished to beneficiaries enrolled in risk M+C plans will be determined according to the applicable fee-for-service rules, except that beneficiaries are not responsible for the Part A and Part B deductibles. M+C enrollees are liable for the coinsurance amounts applicable to services paid under Medicare fee-for-service rules.

We will hold all claims for CPT code 32491 with modifier KZ from January 1, 2004, through March 31, 2004, until April 5, 2004, when system changes will be implemented to allow the claims to process, or until the systems changes are made.

CR# 2688 /Trans. 27 & 3/Oct. 4, 2003/lc

Políticas de Pago

MEDICAMENTO BORTEZOMIB (VELCADE) PARA EL TRATAMIENTO DE MIELOMA MÚLTIPLE

La Administración Federal de Drogas y Alimentos (FDA, por sus siglas en inglés) aprobó el medicamento Bortezomib (Velcade) inyectable. Este medicamento es para el tratamiento a pacientes con mieloma múltiple que previamente recibieron dos terapias donde se demostró que la enfermedad es resistente al tratamiento (continúa su progreso a pesar del tratamiento). La cubierta está vigente desde el 13 de mayo de 2003.

Las reclamaciones de Bortezomib deben someterse utilizando el código no clasificado **J9999 (*not otherwise classified, antineoplastic drug*)**. Se debe indicar el nombre del medicamento y la dosis administrada en el encasillado 19 del formulario CMS-1500 ó su equivalente en el formato de facturación electrónica. Se aprobará $1,039.68 por el vial de 3.5 mg.

La administración del medicamento es de forma intravenosa y debe reportarse con el código 90784. Si el proveedor ofrece otro servicio al paciente el mismo día que le administre el medicamento, el pago por la inyección será parte del pago de dicho servicio.

La indicación de mieloma múltiple aprobada por el FDA debe indicarse con el código de diagnóstico 203.00 (mieloma múltiple, sin mención de remisión).

FDA NDA 21-602/Redbook 05-21-2003/mm/els

Billing Policies

BORTEZOMIB (VELCADE) FOR THE TREATMENT OF MULTIPLE MYELOMA

The Food and Drug Administration (FDA) approved the bortezomib (Velcade) injection for the treatment of patients with multiple myeloma, who have received at least two previous therapies and have demonstrated disease progression in the last therapy. The effective date of this coverage is May 13, 2003.

*Claims for bortezomib should be submitted under HCPCS code **J9999 (not otherwise classified, antineoplastic drugs)**. The name of the drug and dosage administered should be listed in Item 19 of the CMS-1500 form or its equivalent in the electronic format. The amount to be approved for a 3.5 mg vial is $1,039.68.*

Administration of the drug is by intravenous injection (bolus) and should be reported with CPT code 90784. If other services are performed by the same provider on the day of the injection, the payment for the injection will be bundled into the payment for these services.

The FDA approved indication of multiple myeloma should be reported with ICD-9-CM code 203.00 (multiple myeloma, without mention of remission).

Políticas de Pago

INFORMACIÓN NUEVA SOBRE LA LIMITACIÓN FINANCIERA EN SERVICIOS DE TERAPIAS

La siguiente información actualiza la publicada en nuestro boletín Medicare Informa, volumen 74, páginas 86–93 "Limitación Monetaria de Reclamaciones por Servicios de Rehabilitación a Pacientes no Hospitalizados".

Los servicios ambulatorios de terapia física, patología del habla y terapia ocupacional ofrecidos del 1 de septiembre de 2003, en adelante están sujetos a limitación financiera. Durante el periodo del 1 de septiembre de 2003 hasta el 31 de diciembre de 2003, el límite combinado para las terapias físicas y del habla es de $1,590. Además, hay un límite separado de $1,590 para las terapias ocupacionales. La limitación financiera para los servicios provistos del 1 de enero de 2004 hasta el 31 de diciembre de 2004, será $1,640 para las terapias físicas y del habla. El límite de terapias ocupacionales también aumenta a $1,640. De estos limites, Medicare paga hasta el 80%. Estos limites no se aplican a la terapia que usted recibe en un hospital ambulatorio, a menos que usted resida en un hospital ambulatorio, a menos que usted resida en un centro de enfermería especializada y que ocupe una cama certificada por Medicare.

Recuerden que los códigos que están en la lista de "Códigos HCPCS aplicables a la rehabilitación ambulatoria" deben ser facturados con uno de los siguientes modificadores de terapia:

Modificadores de Terapia:

GN - servicios prestados bajo un plan de cuidado de SLP (Speech-language pathology) para paciente no hospitalizado

GO - servicios prestados bajo un plan de cuidado OT para paciente no hospitalizado

GP - servicios prestados bajo un plan de cuidado PT para paciente no hospitalizado

Billing Policies

FINANCIAL LIMITATION ON THERAPY SERVICES

The following updates the information published in our ***Medicare Informa*** *bulletin, volume 74, pages 86 through 93 on "Financial Limitation on Therapy Services".*

Outpatient physical therapy (PT), speech-language pathology (SLP) and occupational therapy (OT) services received on September 1, 2003 and thereafter are subject to a financial limitation. For the period September 1, 2003 through December 31, 2003, the combined limit for PT and SLP services is $1,590. A separate limit of $1,590 exists for OT services. The financial limitation for services January 1, 2004 through December 31, 2004, will be $1,640 for PT and SLP services. The OT financial limitation also increases to $1,640. Medicare covers up to 80 percent of these limits. These limits do not apply to therapy offered at hospital outpatient department, unless the beneficiary is a resident of and occupy a Medicare-certified bed in a skilled nursing facility

Remember that codes, which appear in the "Applicable Outpatient Rehabilitation HCPCS Codes List", should be billed with one of the following therapy modifiers:

Therapy Modifiers:

***GN** - Services delivered under an outpatient speech-language pathology plan of care.*

***GO** - Services delivered under an outpatient occupational therapy plan of care.*

***GP** - Services delivered under an outpatient physical therapy plan of care.*

Códigos HCPCS aplicables a la Rehabilitación Ambulatoria *Applicable Outpatient Rehabilitation HCPCS Codes List*							
29065+	29075+	29085+	29086+	29105+	29125+	29126+	29130+
29131+	29200+	29220+	29240+	29260+	29280+	29345+	29355+
29365+	29405+	29425+	29445+	29505+	29515+	29520+	29530+
29540+	29550+	29580+	29590+	64550+	90901+	90911+	92506
92507	92508	92526	92597	92607	92608	92609	92610+
92611+	92612+	92614+	92616+	95831+	95832+	95833+	95834+
95851+	95852+	96000+	96001+	96002+	96003+	96105+	96110+*
96111+	96115+	97001	97002	97003	97004	97010****	97012
97016	97018	97020	97022	97024	97026	97028	97032
97033	97034	97035	97036	97039	97110	97112	97113
97116	97124	97139	97140	97150	97504**	97520	97530
97532	97533	97535	97537	97542	97601+	97703	97750
97755	97799*	G0279+***	G0280+***	G0281	G0283	0020T+***	0029T+***

*Las tarifas fijas de médicos no indican una tarifa para los códigos 96110, 97799, V5362, V5363 y V5364, el contratista establecerá las tarifas. Por lo tanto, antes de facturar estos códigos debe contactarnos para obtener la tarifa correcta.

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

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

****El código 97010 está atado a otros códigos. Aunque se facture solo o con otro procedimiento no se paga.

+Estos códigos no están sujetos a las limitaciones financieras cuando no sean realizados bajo un plan de terapia y facturados por cualquier profesional de la salud que no sea terapista física u ocupacional. Esta limitación financiera tampoco aplica a los fisioterapeutas o terapistas ocupacionales en practica grupal. Los médicos y profesionales

**The physician fee schedule does not contain a fee for codes 96110, 97799, V5362, V5363, and V5364, they shall be carrier priced. Therefore, before billing for these codes you should contact this carrier to obtain the appropriate fee amount.*

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

****The physician fee schedule does not contain a fee for codes G0279, G0280, 0020T, 0029T; they will also be priced by the carrier. In addition, the carrier will determine coverage for these codes. Therefore, contact the carrier to obtain the appropriate fee and payment policy.*

*****Code 97010 should be bundled. Regardless of whether it is billed alone or in conjunction with another therapy code, never make payment separately for this code.*

+These codes will not apply to the financial limits when they are not performed under a therapy plan of care and they are billed by health care professionals other than PTs or OTs. Physiotherapy and Occupational Therapy groups are also excluded form the

Políticas de Pago

de la salud deben usar solamente los modificadores de terapia con los códigos mencionados anteriormente cuando los servicios son provistos bajo un plan de terapia.

++Si un procedimiento de audiología (HCPCS) es realizado por un audiólogo, los modificadores anteriores no deben utilizarse, ya que los servicios del audiólogo no están sujetos a la limitación monetaria. No obstante, si estos códigos HCPCS se facturan bajo un plan de cuidado de patología del habla, deben acompañarse con un modificador "GN" y aplicarse a la limitación monetaria.

El facturar un código HCPCS que no aparezca en la lista anterior con un modificador de terapia puede resultar en cargos incorrectos al límite financiero.

JSM 2100/Sept. 5, 2003/ CR 2821_PM-B03-065/Aug. 22, 2003
CR2973-Transmittal 30-Nov. 14, 2003/ICR

Billing Policies

financial limitation. Physicians and non-physician practitioners should only use therapy modifiers with the above codes when the services are provided under a therapy plan of care.

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

Billing a HCPCS code that is not listed above with a therapy modifier may result in charges incorrectly applied to the financial limitation.

AUMENTO EN LA TARIFA DE LA VACUNA DE NEUMOCOCCAL A PARTIR DEL 1 DE OCTUBRE DE 2003

A partir del 1 de octubre de 2003, la tarifa de la vacuna de Pneumococcal aumentará al cargo mínimo entre lo facturado o $18.62. El deducible anual y el co-aseguro no aplican. Todos los médicos, profesionales de la salud y suplidores que administren la vacuna de Pneumococcal deben aceptar la asignación en la reclamación de la vacuna.

Para información adicional acerca de inmunizaciones, puede referirse a la Guía Rápida de Inmunización en www.cms.hhs.gov/medlearn/refimmu.asp.

JSM-2076/August 20, 2003/ICR

PNEUMOCOCCAL VACCINE PAYMENT INCREASE EFFECTIVE OCTOBER 1, 2003

Effective October 1, 2003, the Medicare Part B payment for the Pneumococcal vaccine will be increased to the lower of the charge billed to Medicare or $18.62. Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the Pneumococcal vaccination must take assignment on the claim for the vaccine.

For additional information about immunizations, refer to the Immunizations Quick Reference Guide at www.cms.hhs.gov/medlearn/refimmu.asp.

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FACTURACIÓN PARA LOS NEUROESTIMULADORES

Los códigos de neuroestimuladores están clasificados por Medicare como equipos médicos duraderos y se cubren a través de la jurisdicción local. Al no tener una tarifa establecida para su reembolso, el mismo se determina conforme a la factura del manufacturero. Esto significa que las reclamaciones por estos equipos deberán someterse a nosotros e incluir copia de la factura del manufacturero. A continuación le indicamos los códigos de neuroestimuladores que se pagarán:

E0756 = implantable neurostimulator pulse generarator

E0754 = patient programmer (external) for use with implantable programmable neurostimulator pulse generator.

E0752 = implantable neurostimulator electrode, each

ACLARACIÓN:

El código E0753 se eliminó el 31 de marzo de 2002, el mismo se sustituyó por el código E0752. La diferencia entre ambos es que el E0753 incluía 4 electrodos mientras que el E0752 incluye sólo un electrodo. Por lo tanto, cuando facturen el código E0752, debe indicar en el encasillado 24G de la CMS 1500 o su equivalente en la reclamación electrónica el número de electrodos utilizados.

Por otro lado, los electrodos de la fase de prueba pueden utilizarse en la implantación del equipo. De ser necesario cambiar los electrodos; esto debe ser documentado para propósito de revisión médica.

Billing Policies

NEUROSTIMULATOR BILLING

Medicare classifies neurostimulator codes as Durable Medical Equipment with local jurisdiction coverage. These codes do not have an established fee; therefore their reimbursement is based on the manufacturer's invoice. For this reason, claims for neurostimulators should be submitted to us and should include copy of the manufacturer's invoice. The following are the codes covered for neurostimulators:

E0756 = implantable neurostimulator pulse generator

E0754 = patient programmer (external) for use with implantable programmable neurostimulator pulse generator.

E0752 = implantable neurostimulator electrode, each

CLARIFICATION:

Code E0753 was eliminated on March 31, 2002; it was replaced by code E0752. The difference between both codes is that E0753 included four electrodes and E0752 includes only one. Thus, when billing code E0752, you must indicate the number of electrodes used in field 24 G of the CMS 1500 form or the equivalent electronic claim field.

Moreover, electrodes used in the testing phase could be used in the implementation phase. If a change of electrodes is necessary, this event should be documented for medical review purposes.

Ref. September 26, 2003/er/dmg

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NUEVAS PRUEBAS AL CERTIFICADO DE DISPENSA

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

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NEW TEST TO THE WAIVED CERTIFICATE

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

CÓDIGO CPT *CPT CODE*	**DESCRIPCIÓN** *DESCRIPTION*	**FECHA DE EFECTIVIDAD** *EFFECTIVE DATE*
86308QW	Genzyme OSOM Mono Test	March 6, 2003
87077QW	GI Supply, Div. Chek-Med System HP One	March 24, 2003
80101QW	ADC CLIA Waived Marijuana (THC) Test	April 29, 2003
80101QW	ADC CLIA Waived Multiple Drug Test	April 29, 2003
80101QW	ADC CLIA Waived Marijuana (THC) and Cocaine Test	April 30, 2003
87804QW	Binax Now Flu A Test	May 8, 2003
87804QW	Binax Now Flu B Test	May 8, 2003
83518QW	Beckman Coulter ICON Microalb	May 13, 2003
85018QW	Hemocue Donor Hemoglobin Checker System	May 14, 2003
87880QW	Acon Strep A Twist Rapid Test	June 12, 2003
83001QW	Applied Biotech, Inc. RU25 Plus FSH Menopause Test	June 24, 2004
87880QW	Instant Technologies iStrep A	July 3, 2003
87880QW	Beckman Coulter Icon SC Strep A Test	August 6, 2003

CR 2791-CR 2935/Transm. 5 /October 1, 2003/ERO

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CÓDIGOS ICD-9-CM AÑADIDOS A LA ACTUALIZACIÓN DEL 1 DE OCTUBRE DE 2003

El Centro Nacional para Estadísticas de la Salud (NCHS, por sus siglas en inglés) publicó los siguientes códigos ICD-9-CM:

079.82	SARS-associated coronavirus
480.3	Pneumonia due to SARS-associated coronavirus
V01.82	Exposure to SARS-associated coronavirus

Estos nuevos códigos tienen vigencia desde el 1 de octubre de 2003. Puede acceder esta información en la dirección electrónica de CMS en: http://www.cms.hhs.gov/medlearn/icd9code.asp

Si desea un addendum de diagnósticos completo e índice, debe transferir estos datos de la dirección electrónica del NCHS en: www.cdc.gov/nchs/icd9.htm.

CR2842/Transmittal AB-03-129/08-22-03/mm/els

ACTUALIZACIÓN DE LOS ÉDITOS CCI (CORRECT CODING INITIATIVE), VERSIÓN 10.0

La Versión 10.0 de los códigos CCI está disponible en la página electrónica de CMS: http://cms.hhs.gov/physicians/cciedits/default.asp.

CR 2938/Pub. 100-08, MPI Transm. 55/Oct. 31, 2003/dge

Billing Policies

ADDITION OF ICD-9-CM CODES TO THE OCTOBER 1, 2003 UPDATE

The following new and revised ICD-9-CM codes were released by the National Center for Health Statistics (NCHS):

These new ICD-9-CM codes became effective October 1, 2003. This information can be found on the CMS Web site, http://www.cms.hhs.gov/medlearn/icd9code.asp.

If you wish to have an updated full diagnostic addendum and index, you must download it from the NCHS Web site at www.cdc.gov/nchs/icd9.htm.

QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI) EDITS, VERSION 10.0

Version 10.0 of the Correct Coding Initiative will be effective January 1, 2004. This version is available through the CMS website: http://cms.hhs.gov/physicians/cciedits/default.asp.

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ACTUALIZACIÓN DE TARIFAS PARA CÓDIGOS SUJETOS A CARGOS RAZONABLES

El pago para los códigos de entablillados, yesos, materiales y equipo de diálisis, zapatos terapeúticos y lentes intraoculares continúa basado en cargos razonables.

Los problemas relacionados a los cargos para yesos y entablillados no se han resueltos; por lo tanto, los pagos de yesos y entablillados realizados en el 2004 continuarán basándose en las cantidades "gap filled".

En 2004 estas cantidades para entablillados y yesos se basarán en el aumento del 2.1% del 2003.

Las tarifas para los siguientes códigos fueron aumentadas de acuerdo a la Sección 42 CFR 405.51:

Implante de Lentes Intraoculares en la Oficina de un Médico:

V2630	$779.77
V2631	$402.00
V2632	$490.57

Entablillados y Enyesados para Reducir Fracturas o Dislocaciones:

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FEES UPDATE FOR CODES SUBJECT TO REASONABLE CHARGE

Payment for splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes, and intraocular lenses continues to be made on a reasonable charge basis.

Since the problems associated with the charge data for splints and casts have not yet been resolved, payment for splints and casts furnished in 2004 will continue to be based on gap-filled amounts.

The 2004 gap-filled amounts for splints and casts will be based on the 2003 amounts increased by 2.1 percent.

The fees for the following codes have been increased in accordance with Section 42 CFR 405.501:

Intraocular Lenses Implanted in a Physician's Office:

V2630	*$779.77*
V2631	*$402.00*
V2632	*$490.57*

Splints and Casts Used to Reduce a Fracture or Dislocation:

Código *Code*	Tarifa *Fee*	Código *Code*	Tarifa *Fee*	Código *Code*	Tarifa *Fee*	Código *Code*	Tarifa *Fee*
A4565	$6.50	Q4013	$11.91	Q4026	$89.32	Q4039	$6.23
Q4001	$37.05	Q4014	$20.11	Q4027	$14.31	Q4040	$15.60
Q4002	$140.02	Q4015	$5.96	Q4028	$44.66	Q4041	$15.13
Q4003	$26.61	Q4016	$10.05	Q4029	$21.87	Q4042	$25.84
Q4004	$92.13	Q4017	$6.90	Q4030	$57.58	Q4043	$7.57
Q4005	$9.81	Q4018	$10.99	Q4031	$10.94	Q4044	$12.92
Q4006	$22.11	Q4019	$3.45	Q4032	$28.79	Q4045	$8.78
Q4007	$4.91	Q4020	$5.50	Q4033	$20.40	Q4046	$14.13
Q4008	$11.06	Q4021	$5.10	Q4034	$50.75	Q4047	$4.39
Q4009	$6.54	Q4022	$9.21	Q4035	$10.21	Q4048	$7.07
Q4010	$14.74	Q4023	$2.56	Q4036	$25.38	Q4049	$1.60
Q4011	$3.27	Q4024	$4.60	Q4037	$12.45		
Q4012	$7.37	Q4025	$28.61	Q4038	$31.18		

Pub. 100-4 MCP/Trans. 9/CR 2941/Oct. 17, 2003/mm/nls

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MAMOGRAFÍA EXPLORATORIA Y DIAGNÓSTICA

Esta instrucción cambia la facturación de los códigos de detección computadorizada (CAD por sus siglas en inglés) en conjunto con servicios de mamografía al eliminar dos códigos existentes y reemplazarlos con otros dos códigos.

Sec. 4601.1 Examinación de Mamografía Exploratoria

Desde el 1 de enero de 1999 la Parte B de Medicare cubre la mamografía exploratoria para mujeres. La sección 4101 del Balanced Budget Act (BBA) de 1997 ofrece una mamografía exploratoria para mujeres mayores de 39 años; en este caso no aplica el deducible de la Parte B de Medicare. La cubierta aplica de la siguiente manera:

- Entre 35-39 años: el período de cubierta de mamografía "Baseline'' sólo cubre una exploración para las mujeres que estén en ese grupo.
- Mayores de 39 años: cubre anualmente (tiene que pasar un lapso de 11 meses para hacerse una mamografía a partir del mes siguiente al que se hizo la prueba)

Sec. 4601.2 Identifica las reclamaciones de mamografía exploratoria y diagnóstica:

- Comenzando el 1 de octubre de 2003 no se permitirá añadir un código ICD-9 para una mamografía exploratoria cuando la reclamación de ésta no tenga un código de diagnóstico. Las reclamaciones asignadas de mamografía exploratoria que no tengan un código de diagnóstico se devolverán como no procesables. Por otro lado, las reclamaciones no asignadas serán denegadas.

Códigos de detección computadorizada *(CAD por sus* siglas en inglés) usados como códigos para reclamaciones con fechas de servicio de 1/1/02-12/31/03

- **76085** '' Digitization of film radiographic images with computer analysis for lesion detection and further physician review for

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SCREENING AND DIAGNOSTIC MAMMOGRAPHY

This instruction changes the billing of computer aided detection devices (CAD) in conjunction with mammography services by deleting the two existing CAD codes and replacing them with two new codes.

Section 4601.1 *Screening Mammography Examinations:*

Beginning January 1, 1991, Medicare provides Part B coverage of screening mammographies for women. Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over 39 and apply the Medicare Part B deductible. The coverage is the following:

- *Age 35-39 Baseline (only one screening allowed for women in this age group)*
- *Over age 39 Annual (11 full months must have elapsed following the month of last screening)*

Section 4601.2 *Identifying a Screening and Diagnostic Mammography Claim:*

Beginning October 1, 2003, carriers are no longer permitted to plug the ICD-9 code for a screening mammography when the claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.

Computer- Aided Detection (CAD) codes used as Add-On Codes for claims with date of service January 1, 2002 – December 31, 2003:

- ***76085*** *''Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure)''. List the CAD code*

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interpretation, screening mammography (List separately in addition to code for primary procedure)''. Los CAD deben indicarse por separado cuando facturen los códigos primarios de mamografía exploratoria. **Este código se eliminará el 31 de diciembre de 2003.**

- **G0236** ''Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure). Este código add-on se creó para los servicios de mamografía diagnóstica, el mismo debe incluirse además del código de procedimiento de diagnóstico primario. **Este código se eliminará el 31 de diciembre de 2003.**

Instrucciones de facturación para CAD para reclamaciones con fecha de servicio del 1 de enero de 2002- 31 de diciembre de 2003.

- Mamografía diagnóstica – el código G0236 (CAD para mamografía diagnóstica) se añadió como un código add-on. Este debe ser facturado en una línea separada con el código primario de mamografía diagnóstica, 76090 ó 76091.

Nota: Para las reclamaciones con fecha de servicio del 1 de abril de 2003 hasta el 31 de diciembre de 2003 se añadieron los códigos G0204 y G0206 a la lista de códigos a facturarse con el código G0236 (mamografía diagnóstica).

- Mamografía exploratoria; utilizar el código 76092 con el 76085 (CAD).

Nota: Para las reclamaciones con fecha de servicio del 1 de abril de 2003 hasta el 31 de diciembre de 2003 se añade el código G0202 a la lista de códigos a facturarse en conjunto con el código 76085 (mamografía exploratoria).

No aplica el deducible de la Parte B de Medicare. Sin embargo, el coaseguro se aplica.

Instrucciones de facturación para CAD, para reclamaciones con fecha de servicio del 1 de enero de 2004 en adelante:

- Mamografía Diagnóstica – el nuevo código 76082 para servicios de detección computadorizada ha sido establecido para

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separately when billing screening mammography primary codes. ***This code will be deleted as of December 31, 2003.***

- ***G0236*** *''Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure). List add-on codes separately in addition to code for primary diagnostic procedure.* ***This code will be deleted as of December 31, 2003.***

Billing Instructions for CAD Codes, Effective for Claims With Dates of Service Beginning January 1, 2002 through December 31, 2003:

- *Diagnostic Mammography – code G0236 (CAD code for diagnostic mammography) as an add-on code. G0236 must be billed as a separate line in conjunction with the primary services diagnostic mammography code 76090 or 76091.*

Note: Claims with Date of Service (DOS) April 1, 2003 – December 31, 2003, add G0204 and G0206 to the list of codes to be billed in conjunction with G0236 (diagnostic mammography).

- *Screening Mammography ; use code 76092 with CAD code 76085.*

Note: Claims with DOS April 1, 2003– December 31, 2003, add G0202 to the list of codes to be billed in conjunction with 76085 (screening mammography).

There is no Part B deductible. However, coinsurance is applicable.

Billing Instructions for CAD Codes, effective for Claims With DOS January 1, 2004 and later:

- *Diagnostic Mammography – the new code 76082 for CAD services is established for diagnostic mammography CAD services. List this new code separately*

Cont. on next page

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servicios de detección computadorizada para mamografía diagnóstica. Este nuevo código se añade a la lista de los códigos que se facturan con el procedimiento primario de la mamografía diagnóstica.(76090, 76091, G0204, G0206). **El CAD G0236 no podrá usarse después del 31 de diciembre de 2003**.

- Mamografía Exploratoria – el nuevo código 76083 se estableció para los servicios de detección computadorizada para servicios de CAD de mamografía exploratoria. Este nuevo código se añade a la lista de los códigos que se facturan con el procedimiento primario 76092 y G0202. Deben añadir a la lista los nuevos códigos además de los códigos primarios. **El CAD 76085 se eliminará el 31 de diciembre de 2003**.

A esto no le aplica el deducible de la Parte B de Medicare. Sin embargo, el coaseguro aplica.

Nota: El código *add-on* no puede ser facturado solo. Las reclamaciones sometidas con un solo código *"add-on''* serán denegadas. Estos códigos deben ser facturados con los códigos primarios de mamografía.

Sección 4601.6 Mamografías exploratorias y diagnósticas realizadas con nuevas tecnologías

Las mamografías diagnósticas y exploratorias están sujetas a la certificación del FDA. Sin embargo, el equipo de CAD no requiere esta certificación. La mamografía utiliza una placa de rayos x tomada directamente de la mama. En contraposición el procedimiento de CAD utiliza un haz de rayos láser para interpretar la placa convencional convirtiéndola en datos digitales para la computadora. No se requiere que el paciente esté presente en el proceso de CAD.

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in addition to code for primary diagnostic mammography procedure (76090, 76091, G0204, G0206). ***CAD code G0236 is deleted as of December 31, 2003.***

- *Screening Mammography – the new code 76083 for CAD services is established for screening mammography CAD services. List this new code separately in addition to code for primary screening mammography procedure (76092 and G0202).* ***CAD code 76085 is deleted as of December 31, 2003.***

There is no Part B deductible. However, coinsurance is applicable.

Note: The add-on code can't be billed alone. Deny the claim if only the add-code is billed. Must list these codes separately with primary mammography codes.

Section 4601.6 *Diagnostic and Screening Mammograms Performed with New Technologies*

Screening and diagnostic mammographies (film and digital) are subject to FDA certification. However, CAD equipment does not required FDA certification. Mammography utilizes a direct x-ray of the breast. By contrast, The CAD process uses laser beam to scan the mammography film from a film (analog) mammography, converts it into digital data for the computer, and analyzes the video display for areas suspicious for cancer. The CAD process used with digital mammography analyzes the data from the mammography on a video display for suspicious areas. The patient is not required to be present for the CAD process.

CR2632/TRANSM. 1814/ August 8, 2003/ERO
CR2932/November 28, 2003

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

Los Centros para Servicios de Medicare y Medicaid (CMS, por sus siglas en inglés) establecieron el proceso de actualización periódica de las listas de códigos pertenecientes al Healthcare Common Procedure Coding System (HCPCS, por sus siglas en inglés) sujetos a la disposición de facturación consolidada del Sistema de Pago Prospectivo de Servicios de Salud en el Hogar (HHPPS, por sus siglas en inglés). Con la excepción de terapias realizadas por los médicos, suministros incidentales a los servicios médicos y suministros utilizados en un marco institucional, las reclamaciones por servicios que figuren en esta lista que sean sometidas a los contratistas de la Parte B no serán pagadas cuando los servicios facturados hayan sido prestados en las fechas en que un beneficiario se encuentre en un episodio de servicios de salud en el hogar (por ejemplo, bajo un plan cuidado de salud en el hogar administrado por una agencia de salud en el hogar). Medicare reembolsará solamente a las agencias primarias de servicios de salud en el hogar que hayan iniciado servicios durante este período.

La lista de los códigos de facturación consolidada de servicios de salud en el hogar se actualiza anualmente para reflejar los cambios anuales de los códigos HCPCS. Trimestralmente pueden ocurrir actualizaciones adicionales para reflejar la creación de códigos HCPCS temporeros a través del año natural (ejemplo códigos 'K').

Pub. 100-4 MCP/Transm. 8/CR 2931/Oct. 17, 2003/icr/nls

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

The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list, which are submitted on claims to Medicare contractors will not be paid separately 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.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Code Changes for January 2004 Annual Update of Medicare HH Consolidated Billing Code Lists

New & Deleted Codes for HH CB			
Code	**Description**	**Action**	**Replacement Code or Code Being Replaced**
Non-Routine Supplies			
K0581	Ost pch clsd w barrier/filtr	Delete	Replacement Code: A4416
K0582	Ost pch w bar/bltinconv/fltr	Delete	Replacement Code: A4417
K0583	Ost pch clsd w/o bar w filtr	Delete	Replacement Code: A4418
K0584	Ost pch for bar w flange/flt	Delete	Replacement Code: A4419
K0585	Ost pch clsd for bar w lk fl	Delete	Replacement Code: A4420
K0586	Ost pch for bar w lk fl/fltr	Delete	Replacement Code: A4423
K0587	Ost pch drain w bar & filter	Delete	Replacement Code: A4424
K0588	Ost pch drain for barrier fl	Delete	Replacement Code: A4425
K0589	Ost pch drain 2 piece system	Delete	Replacement Code: A4426
K0590	Ost pch drain/barr lk flng/f	Delete	Replacement Code: A4427
K0591	Urine ost pouch w faucet/tap	Delete	Replacement Code: A4428
K0592	Urine ost pouch w bltinconv	Delete	Replacement Code: A4429
K0593	Ost urine pch w b/bltin conv	Delete	Replacement Code: A4430
K0594	Ost pch urine w barrier/tapv	Delete	Replacement Code: A4431
K0595	Os pch urine w bar/fange/tap	Delete	Replacement Code: A4432
K0596	Urine ost pch bar w lock fln	Delete	Replacement Code: A4433
K0597	Ost pch urine w lock flng/ft	Delete	Replacement Code: A4434
A4416	Ost pch clsd w barrier/filtr	Add	Replaces Code: K0581
A4417	Ost pch w bar/bltinconv/fltr	Add	Replaces Code: K0582
A4418	Ost pch clsd w/o bar w filtr	Add	Replaces Code: K0583
A4419	Ost pch for bar w flange/flt	Add	Replaces Code: K0584
A4420	Ost pch clsd for bar w lk fl	Add	Replaces Code: K0585
A4423	Ost pch for bar w lk fl/fltr	Add	Replaces Code: K0586
A4424	Ost pch drain w bar & filter	Add	Replaces Code: K0587
A4425	Ost pch drain for barrier fl	Add	Replaces Code: K0588
A4426	Ost pch drain 2 piece system	Add	Replaces Code: K0589
A4427	Ost pch drain/barr lk flng/f	Add	Replaces Code: K0590
A4428	Urine ost pouch w faucet/tap	Add	Replaces Code: K0591
A4429	Urine ost pouch w bltinconv	Add	Replaces Code: K0592
A4430	Ost urine pch w b/bltin conv	Add	Replaces Code: K0593
A4431	Ost pch urine w barrier/tapv	Add	Replaces Code: K0594
A4432	Os pch urine w bar/fange/tap	Add	Replaces Code: K0595
A4433	Urine ost pch bar w lock fln	Add	Replaces Code: K0596
A4434	Ost pch urine w lock flng/ft	Add	Replaces Code: K0597
A4319	Sterile H2O irrigation solution	Delete	Replacement codes: A4216 & A4217
A4323	Saline irrigation solution	Delete	Replacement codes: A4216 & A4217
A4216	Sterile water/saline up to 10 ml	Add	Replaces A4319 & A4323
A4217	Sterile water/saline 500 ml	Add	Replaces A4319 & A4323
A4712	Sterile water injection, per 10 ml	Delete	
A4622	Trachestomy or larngectomy	Delete	Replacement codes: A7520, A7521, & A7522
A7520	Tracheostomy/larynectomy tube, non-cuffed	Add	Replaces code: A4622
A7521	Tracheostomy/larynectomy tube, cuffed	Add	Replaces code: A4622
A7522	Tracheostomy/larynectomy tube, stainless steel	Add	Replaces code: A4622
A7523	Tracheostomy shower protector, each	Add	From or related to discontinued code, A4622 and/or A4623: Tracheostomy
A7524	Tracheostomy stent/stud/button, each	Add	From or related to discontinued code, A4622 and/or A4623: Tracheostomy

New & Deleted Codes for HH CB			
Code	**Description**	**Action**	**Replacement Code or Code Being Replaced**
Non-Routine Supplies			
A7526	Tracheostomy tube collar/holder, each	Add	Replaces code: A4623
K0621	Gauze, non-impreg packing strip	Delete	Replacement code: A6407
A6407	Packing strips, non-impregnated, up to 2 inches,	Add	Replaces: K0621
A4248	Chlorhexidine containing anticeptic, 1 ml	Add	
A4366	Ostomy vent, any type, each	Add	
A6025	Gel sheet for dermal or epidermal application (e.g. Silicone, hydrogel, other)	Add	
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard	Add	
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	Add	
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	Add	
A6444	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard	Add	
A6445	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard	Add	
A6446	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	Add	
A6447	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard	Add	
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard	Add	
A6449	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	Add	
A6450	Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard	Add	
A6451	Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	Add	
A6452	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	Add	

New & Deleted Codes for HH CB			
Code	**Description**	**Action**	**Replacement Code or Code Being Replaced**
Non-Routine Supplies			
A6455	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard	Add	
A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	Add	
Therapies			
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes	Add	

Pub. 100-4 MCP/Transm. 8/CR 2931/Oct. 17, 2003/icr/nls

USO DEL MODIFICADOR GY PARA SERVICIOS DE LABORATORIOS CLÍNICOS QUE NO ESTÁN CUBIERTOS POR MEDICARE

En noviembre de 2002 Medicare implementó 23 cubiertas nacionales para servicios de laboratorios clínicos (NCDs, por sus siglas en inglés). Estas políticas incluyen un grupo de diagnósticos que están cubiertos y otro grupo que no está cubierto por Medicare. Los proveedores de servicios de laboratorio pueden cobrarle al beneficiario por servicios que no están cubiertos por Medicare sin proveerle una Nota al Beneficiario(ABN), siempre y cuando la denegación no sea por necesidad médica.

A partir del 1 de enero de 2004, los laboratorios clínicos deberán utilizar el modificador GY para aquel servicio donde el diagnóstico indicado está en el grupo de los diagnósticos no cubiertos por Medicare.

USE OF GY MODIFIER TO IDENTIFY CLINICAL DIAGNOSTIC LABORATORY SERVICES THAT ARE NOT COVERED BY MEDICARE

In November 2002, Medicare implemented 23 national coverage determinations (NCDs) for clinical diagnostic laboratory services. These NCDs included lists of ICD-9-CM codes that are covered and those that are not covered by Medicare. Laboratories are permitted to bill beneficiaries for services that are not covered by Medicare for reasons other than medical necessity without providing for an Advance Beneficiary Notice (ABN).

As of January 1, 2004, the clinical diagnostic laboratory should append modifier GY to the CPT procedure codes for any service where the appropriate diagnosis is on the list of diagnoses that are not covered by Medicare.

Pub. 100-01 MCP/Trans. 11/Oct. 24/2003/CR 2933/er

Políticas de Pago

PROCESO DE PAGO DE RECLAMACIONES PARA COLONOSCOPÍA EXPLORATORIA NO COMPLETADA

Medicare cubre los procedimientos y pruebas exploratorias para la detección temprana de cáncer colorectal cuando se cumplen las condiciones de cubierta. Entre los procedimientos de colonoscopía exploratoria cubiertos están: G0105- "colorectal cancer screening, colonoscopy on an individual at high risk"; G0121- "colorectal screening, colonoscopy on an individual not meeting criteria for high risk". La cubierta de estos servicios está sujeta a ciertas limitaciones de frecuencia.

En algunos casos el proveedor puede comenzar la colonoscopía, pero por razones atenuantes, el procedimiento no puede completarse. Medicare pagará por el procedimiento de colonoscopía no completada una tarifa coincidente con la sigmoidoscopía mientras se cumplan las condiciones de cubierta para procedimientos no completados.

Cuando una colonoscopía (con cubierta) se intenta nuevamente y se completa, Medicare pagará por la colonoscopía de acuerdo a la metodología de pago para el procedimiento siempre y cuando se cumpla con las condiciones de cubierta. Esta política aplica tanto a la prueba de colonoscopía exploratoria como a la de diagnóstico.

Las reclamaciones para colonoscopía exploratoria (G0105 ó G0121) **no completada** deben ser sometidas con modificador 53 para indicar que el procedimiento fue interrumpido. Las reclamaciones para colonoscopía no completada no estarán sujetas a las limitaciones de frecuencia que se aplican a las colonoscopías **completadas**.

Los Centros de Cirugía Ambulatoria deben someter las reclamaciones de colonoscopía con el modificador 73-"Discontinued Outpatient Procedure **prior** to Anesthesia

Billing Policies

CLAIMS PROCESSING AND PAYMENT OF INCOMPLETE SCREENING COLONOSCOPIES

Medicare covers screening tests and procedures for the early detection of colorectal cancer when coverage conditions are met. Among the screening procedures covered are screening colonoscopies: G0105- Colorectal cancer screening; colonoscopy on an individual at high risk; and G0121- Colorectal screening; colonoscopy on an individual not meeting criteria for high risk. Coverage of these services is subject to certain frequency limitations.

In some instances, a provider may begin a screening colonoscopy, but, because of extenuating circumstances, be unable to complete the procedure. Medicare will pay for the incomplete colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure.

When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for the procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies.

*Claims submitted for an **incomplete** screening colonoscopy (G0105 or G0121) should be submitted with modifier 53 to indicate that the procedure was interrupted. Incomplete colonoscopy claims will not be subject to the frequency limitations that apply for a **completed** colonoscopy.*

*When submitting a claim for the facility fee associated with this procedure, Ambulatory Surgical Centers (ASCs) are to suffix the colonoscopy code with modifier 73-Discontinued Outpatient Procedure **prior** to Anesthesia Administration or 74-Discontinued Outpatient Procedure **after** Anesthesia*

Políticas de Pago

Administration" ó 74-"Discontinued Outpatient Procedure **after** Anesthesia Administration", según le aplique, para el pago del procedimiento en dicho lugar. Los pagos para las colonoscopías exploratorias cubiertas, incluyendo la tarifa relacionada al Centro de Cirugía Ambulatoria, cuando aplique, serán coincidentes con el pago de las colonoscopías diagnósticas independientemente que el procedimiento se complete o no.

El proveedor debe conservar la información necesaria en el expediente del paciente en caso de que se necesite documentar el procedimiento no completado.

Billing Policies

Administration. Payment for covered screening colonoscopies, including that for the associated ASC facility fee when applicable, shall be consistent with payment for diagnostic colonoscopies, whether the procedure is complete or incomplete.

Providers must maintain adequate information in the patient's medical record in case it is needed to document the incomplete procedure.

CR2822/Transm. AB-03-114/August 1,2003/ERO/els
CR2932/November 28, 2003

VACUNA CONTRA LA INFLUENZA

Nuevo Código para Reclamaciones

Todos los que suministran la Vacuna de Influenza; proveedores institucionales, médicos Parte B, profesionales de la salud y suplidores, deben usar el nuevo código de diagnóstico ICD-9-CM, V04.81, en las reclamaciones con fecha de servicio del 1 de octubre de 2003 en adelante.

Aumento en el Pago

También vigente el 1 de octubre de 2003, Medicare Parte B aprobó la tarifa de $9.95 para el pago de la vacuna de influenza. Esta nueva tarifa aplicará a servicios prestados con fecha del 1 de septiembre de 2003 en adelante.

Al igual que para la temporada de influenza del 2002, el "*Whole Virus Vaccine*" *(código 90659)* no se elaboró para la temporada del 2003. La vacuna de influenza debe facturarse con el código **90658.**

Para su beneficio, incluimos el código y tarifa para la administración de esta vacuna:

INFLUENZA VIRUS VACCINE

New Diagnosis Code for Claims

All Medicare institutional providers, Part B physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccine must use the new diagnosis code ICD-9-CM, V04.81, for claims with dates of service of October 1, 2003 and thereafter.

Payment Increase

Also, effective October 1, 2003, the Medicare Part B payment allowance for the Influenza Virus Vaccine increased to $9.95. This new fee is effective for services rendered September 1, 2003 and thereafter.

*The same as for the 2002 flu season, the Whole Virus Vaccine (code 90659) was not produced for the 2003 season. The influenza vaccine should be billed using code **90658.***

To aid you, we are also including the code and fee for the administration of this vaccine:

Código *Code*	**Descripción** *Description*	**Tarifas / *Fees*** *Puerto Rico*	*Virgin Islands*
G0008	Administration of influenza virus vaccine	$5.34	$7.89

Si tiene alguna duda sobre este asunto, llámenos al 1-877-715-1921.

JSM-2139/10-15-03/nls & JSM-2119B/09-23-03/els
CR 2918/Transmittal 3/September 12, 2003

If you have any questions on this matter, please contact us at 1-877-715-1921.

CMS-Joint Signature Letter/October 25, 2002/mm/els
CR2530/B-03-001/01-17-03/DG

Políticas de Pago

PAGO PARA EL EXAMEN DE LEUCOCITOS DE HECES FECALES BAJO EL CERTIFICADO DE MICROSCOPIA REALIZADOS POR PROVEEDORES DE CLIA

Para servicios del 1 de enero de 2003 hasta el 31 de diciembre de 2003 el código HCPCS Q0111 ("Wet mounts, including preparations of vaginal, cervical or skin specimens") podrá utilizarse por instalaciones o proveedores con un certificado válido de "Provider Performed Microscopy" (PPM, por sus siglas en inglés) para facturar el examen de leucocitos de heces fecales.

Comenzando el 1 de enero de 2004 las instalaciones y proveedores con un certificado válido de PPM deben facturar con el código HCPCS 89055 ("Leukocyte assessment, fecal, qualitatitive or semi quantitative") para el examen de leucocitos de heces fecales.

La regulación de CLIA requiere, además, que las instalaciones o proveedores estén debidamente certificados para cada una de las pruebas que ellos realicen. Para asegurar que Medicare y Medicaid sólo pague por pruebas de laboratorios aprobadas en las categorías de PPM o de dispensa bajo CLIA, las reclamaciones serán debidamente editadas en el ámbito de la certificación de CLIA.

Billing Policies

PAYMENT FOR THE FECAL LEUKOCYTE EXAMINATION UNDER CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 CLIA PERFORMED MICROSCOPY PROCEDURES

For services January 1, 2003 until December 31, 2003, HCPCS code Q0111 (Wet mounts, including preparations of vaginal, cervical or skin specimens) can be used by facilities and providers with a valid certificate for Provider Performed Microscopy (PPM) for the billing of fecal leukocyte examination.

Effective January 1, 2004 facilities and providers with a valid certificate for Provider Performed Microscopy (PPM) should bill HCPCS code 89055 (Leukocyte assessment, fecal, qualitative or semi quantitative) for fecal leukocyte examination.

The CLIA regulations also require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as provider-performed microscopy (PPM) procedures or waived complexity under CLIA in facilities having a valid CLIA certificate for PPM procedures, laboratory claims are currently edited at the CLIA certificate level.

CR2843/Transmittal AB-03-127/August 22, 2003/ICR
CR2924/Transmittal 12/October 24, 2003/els

Centros de Cirugía Ambulatoria (ASC)

ACTUALIZACIÓN A LOS CÓDIGOS Y PAGOS PARA CENTROS DE CIRUGÍA AMBULATORIA

Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) notificaron los códigos nuevos y los que se eliminarán de la lista de códigos de procedimientos de los Centros de Cirugía Ambulatoria.

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

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

La siguiente tabla incluye los códigos que se eliminarán, así como los códigos que los sustituyen.

Códigos Eliminados *Deleted Codes*	Códigos que Sustituyen *Replace Codes*	Grupo *Group*
36488	36555	*1*
36489	36556	*1*
36490	36557	*2*
36491	36558	*2*
36530	36560	*3*
36531	36561	*3*
36532	36563	*3*
36533	36565	*3*
36534	36566	*3*
36535	36568	*1*

La tabla que sigue incluye los códigos nuevos que serán vigentes para servicios prestados a partir del 1 de enero de 2004.

CÓDIGO *CODE*	GRUPO *GROUP*	CÓDIGO *CODE*	GRUPO *GROUP*	CÓDIGO *CODE*	GRUPO *GROUP*	CÓDIGO *CODE*	GRUPO *GROUP*
36555	1	36563	3	36571	3	36582	3
36556	1	36565	3	36575	2	36583	3
36557	2	36566	3	36576	2	36584	1
36558	2	36568	1	36578	2	36585	3
36560	3	36569	1	36580	1	36589	1
36561	3	36570	3	36581	2	36590	1

CR 2890/Transmittal AB-03-137/August 29,2003/ERO/els

Ambulatory Surgical Centers (ASC)

CODES AND PAYMENT UPDATES FOR AMBULATORY SURGICAL CENTERS

The Centers for Medicare & Medicaid Services (CMS) notified the additions and deletions from the Ambulatory Surgical Centers (ASCs) procedure code list.

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

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

The following table includes the deleted codes with their respective replace codes:

The table that follows includes the new codes which will be effective for services performed starting January 1, 2004 and thereafter:

Centros de Cirugía Ambulatoria (ASC)

ACTUALIZACIÓN DE TARIFAS PARA LOS CENTROS DE CIRUGÍA AMBULATORIA

Conforme a la Sección 1833 (1)(2)(C) del Acta del Seguro Social, los Centro de Servicios Medicare & Medicaid (CMS) autorizaron la actualización de tarifas de pago a los Centros de Cirugía Ambulatoria. Estas nuevas tarifas son vigentes para los servicios prestados del 1 de octubre de 2003 en adelante. El índice de los valores utilizado en áreas urbanas y rurales es parte de la actualización para el año fiscal 2004 del Sistema de Pagos Prospectivos de Hospitales (Hospital Prospective Payment System).

En la primera tabla, **TARIFAS DE PAGO ASC 2003-2004** se incluyen las nuevas tarifas por categoría y área geográfica. Los números romanos presentados en la tabla de tarifas indican las áreas y los cargos que aplicarán a cada una de éstas. Dichas áreas están descritas en la segunda tabla titulada **Áreas Urbanas**.

Ambulatory Surgical Centers (ASC)

PAYMENT RATES UPDATES FOR AMBULATORY SURGICAL CENTERS

As stated in Section 1833 (1)(2)(C) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has authorized the Ambulatory Surgical Centers payment rates update. These new fees are effective for services rendered October 1, 2003 and thereafter. The wage index values used for urban and rural areas are part of fiscal year 2004 update of the hospital inpatient prospective payment system (PPS).

*The first table identified as **ASC PAYMENT RATES 2003-2004** includes the new payment rates arranged by category and geographic areas. The roman numerals presented in the payment rate table indicate the areas and the charge that will apply to each one of these. These areas are detailed on the second table titled **Urban Areas**.*

ASC PAYMENT RATES
TARIFAS DE PAGO ASC
2003-2004

GROUP/ GRUPO	FEE TARIFA	I 0.4289	II 0.4138	III 0.4184	IV 0.4776	V 0.4689	VI 0.4880	VII 0.4002
1	340.00	$ 273.11	$ 271.34	$ 271.88	$ 278.81	$ 277.79	$ 280.03	$ 269.75
2	455.00	$ 365.48	$ 363.11	$ 363.84	$ 373.12	$ 371.75	$ 374.75	$ 360.98
3	520.00	$ 417.69	$ 414.99	$ 415.81	$ 426.42	$ 424.86	$ 428.28	$ 412.55
4	643.00	$ 516.49	$ 513.15	$ 514.17	$ 527.28	$ 525.35	$ 529.59	$ 510.14
5	731.00	$ 587.18	$ 583.38	$ 584.54	$ 599.44	$ 597.25	$ 602.06	$ 579.95
*6	840.00	$ 704.25	$ 700.66	$ 701.75	$ 715.82	$ 713.75	$ 718.30	$ 697.42
7	1,015.00	$ 815.30	$ 810.02	$ 811.63	$ 832.33	$ 829.29	$ 835.97	$ 805.27
*8	989.00	$ 823.93	$ 819.57	$ 820.90	$ 838.01	$ 835.49	$ 841.01	$ 815.64
9	1,366.00	$ 1,097.25	$ 1,090.14	$ 1,092.31	$ 1,120.17	$ 1,116.07	$ 1,125.06	$ 1,083.74

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

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

Trans.AB-03-116/ CR 2871/August 8, 2003

ACTUALIZACIÓN TRIMESTRAL DE PRECIOS MEDICAMENTOS

CAMBIO EN EL MÉTODO DE PAGO DE TARIFAS DE MEDICAMENTOS

A partir del 1 de enero de 2004, las Tarifas de Medicamentos publicadas trimestralmente estarán vigentes para las fechas de servicio que correspondan al término de la publicación. Por ejemplo; la actualización de enero de 2004 aplica a las reclamaciones con fechas de servicio del 1 de enero al 31 de marzo de 2004 y así subsiguientemente como sigue:

QUARTERLY PRICING UPDATE FOR DRUGS

CHANGES IN THE SINGLE DRUG PRICING PAYMENT METHOD

Starting January 1, 2004 the Single Drug Pricer (SDP) published quarterly will be effective for dates of service that belong to the period of publication. For example; the January 2004 drug fee update will apply to claims with dates of service January 1 to March 31, 2004 and so forth as described below:

ACTUALIZACIÓN *UPDATE*	**FECHA DE SERVICIO** *DATE OF SERVICE*
January – enero	January – March /enero-marzo
April – abril	April – June /abril-junio
July – julio	July – September /julio-septiembre
October – octubre	October– December/octubre-diciembre

Puede dirigirse a nuestra página electrónica en: www.triples-med.org bajo la sección "Tarifas Fijas de 2004" y "Estandarización de Precios para Medicamentos Cubiertos por Medicare" para la actualización trimestral. Los precios indicados tendrán vigencia el 1 de enero de 2004.

You can find the quarterly pricing update for drugs at our Web page: www.triples-med.org under the section "2004 Fee Schedules", "Standardizing for Medicare Covered Drugs". The stated fees will be effective on January 1, 2004.

CR2381/AB-02-174/12-03-02/SDP/10-03/mm/els
CR2755/B-03-059/08-08-03/ero/els
CR2950/Pub.100-20/Trans.22/11-21-03/dg/els

Ambulancia

RECORDATORIO DEL ITINERARIO DE TRANSICIÓN AL SISTEMA DE PAGO PARA SERVICIOS DE AMBULANCIA

El 1 de abril de 2002 los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) implementaron un nuevo sistema de pago para todos los servicios de ambulancia. Estos incluyen servicios voluntarios, municipales, privados, independientes y proveedores institucionales tales como Hospitales y Centros de Enfermería Especializada. El itinerario de las tarifas fijas está escalonado en un período de cinco años. Cuando el período de implantación termine, las tarifas fijas sustituirán el sistema actual de pago por cargo razonable a los proveedores de ambulancia.

Este es el itinerario de tarifas fijas de ambulancia sujeto al período de transición de cinco años:

Ambulance

REMINDER NOTICE OF THE IMPLEMENTATION OF THE TRANSITIONAL AMBULANCE FEE SCHEDULE

On April 1, 2002 the Centers for Medicare and Medicaid Services (CMS) implemented a new fee schedule for all ambulance services. These include volunteer, municipal, private, independent, and institutional providers, i.e. hospitals, and skilled nursing facilities. The fee schedule will be phased over a five-year period. When fully implemented, the fee schedule will replace the current reasonable charge system for ambulance suppliers.

The following is the ambulance fee schedule subject to the five-year transition period:

Year	Fee Schedule Percentage	Cost/Charge Percentage
Year 1 (4/1/02-12/31/02)*	20%	80%
Year 2 (CY 2003)*	40%	60%
Year 3 (CY 2004)	60%	40%
Year 4 (CY 2005)	80%	20%
Year 5 (CY 2006 and thereafter	100%	0%

***Por cientos previos y del año actual**

Ajuste a la Tarifa de Millaje de Área Rural:

A partir del 1 de enero de 2004 la tarifa de millaje por servicios de ambulancia terrestre originados en áreas rurales continuará siendo el 150 por ciento de la tarifa de millaje de área urbana para las primeras 17 millas. La tarifa de millaje por servicios de ambulancia terrestre de 18 a 50 millas, inclusive, será equivalente al millaje de área urbana, no aplicará el ajuste rural. La nueva tarifa aplica a todas las reclamaciones de servicios de ambulancia terrestre con fecha de servicio del 1 de enero de 2004 en adelante.

***Previous and current year percentages**

Adjustment to the Rural Mileage Payment Rate:

Effective January 1, 2004 the mileage rate for ground ambulance services originating in rural areas remains 150 percent of the urban mileage rate for the first 17 miles; the payment rate for ground ambulance miles 18 to 50, inclusive, will be equivalent to the urban mileage rate with no rural adjustment. The new payment rate for ground ambulance miles applies to all ground ambulance service claims with dates of service of January 1, 2004 and thereafter.

CR 2834/Transmittal AB-03-146/September 26, 2003/ERO/els
CR 2767/Transm AB-03-110/August 1, 2003/ERO/els/dg

Transferencia Electrónica de Fondos

TRANSFERENCIA ELECTRÓNICA DE FONDOS

El método de pago directo a través de transferencia electrónica (EFT por sus siglas en inglés) permite que Medicare le deposite sus pagos a su cuenta bancaria. Muchos de nuestros proveedores ya han comprobado que este método mejora la seguridad de sus pagos y elimina muchos de los problemas y costos asociados a la pérdida de cheques.

Los depósitos que Medicare efectúe a su cuenta bancaria se le informarán en los estados de cuenta que cada mes le envía su banco.

Le incluimos el formulario CMS 588 que debe completar para acogerse a las conveniencias de EFT. Deberá incluir cheque cancelado si es una cuenta de cheque y copia del estado de cuenta si es de ahorros. Asegúrese de eliminar toda información personal, excepto el nombre y el número de cuenta.

Nota: CMS modificó el formulario CMS 588, ahora el mismo también debe completarse para notificar cambios en la información y cancelaciones.

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

Electronic Funds Transfer

ELECTRONIC FUNDS TRANSFER

The Electronic Funds Transfer (EFT) payment method allows Medicare to deposit payments directly to your bank checking or savings account. Many of our providers have confirmed that the EFT method represents a more secure method of payment flow and eliminates problems associated to the processing of lost checks.

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

We include CMS Form 588, which should be completed in order to enjoy the advantages EFT provides. You must enclose a cancelled check, if it's a checking account or copy of the bank statement, if it's a saving account. Please, make sure that you have removed all personal information, except your name and account number.

Note: CMS modified CMS Form 588, now it should also be used to inform changes and request information.

For more information, please call us at 1-877-715-1921.

November 2003/FC

Form Approved
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

Reason for Submission:
- ❑ New EFT Authorization
- ❑ Revision to Current Authorization *(i.e. account or bank changes)*
- ❑ EFT Termination Request

Chain Home Office:
- ❑ Check here if EFT payment is being made to the Home Office of Chain Organization *(Attach letter Authorizing EFT payment to Chain Home Office)*

Physician/Provider/Supplier Information

Physician's Name _____

Provider/Supplier Legal Business Name _____

_____

Chain Organization Name _____

Home Office Legal Business Name *(if different from Chain Organization Name)* _____

_____

Tax ID Number: *(Designate SSN* ❑ *or EIN* ❑*)* ___ ___ ___ ___ ___ ___ ___ ___ ___

Doing Business As Name _____

Medicare Identification Number (*OSCAR, UPIN, or NSC only)* _____

Depository Information (Financial Institution)

Depository Name _____

Account Holder's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number *(nine digit)* ___ ___ ___ ___ ___ ___ ___ ___ ___

Depositor Account Number _____

Type of Account *(check one)* ❑ Checking Account ❑ Savings Account

Please include a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead with this agreement for verification of your account number.

Authorization

I hereby authorize the Medicare contractor, _____, hereinafter called the COMPANY, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the said Physician/Provider/Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it. The COMPANY will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the COMPANY an updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name *(Print)* _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature_____Date_____

PRIVACY ACT ADVISORY STATEMENT

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

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

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

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

Instructions for Completing the Authorization Agreement for EFT

The following instructions will guide you through the EFT Authorization process. If you are submitting multiple requests, a separate Authorization Agreement must be completed for each provider identification number (OSCAR, UPIN, or NSC). All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made. In the meantime, all payments will be mailed via hard copy checks directly to the "Pay To" address that the Medicare contractor currently has on file. Please contact the Provider Enrollment Unit to verify the "Pay To" address. This agreement must be completely filled out. Omission of any information will delay the processing of your request. If you have any questions, please contact your Medicare contractor. For a list of contractors see www.cms.hhs.gov/providers/enrollment/contacts/.

Please indicate your reason for completing this form: New EFT authorization; Change to your account information; or Termination of your EFT authorization.

If you are authorizing EFT payments to the Home Office of a Chain Organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the Home Office of the Chain Organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

Enter the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier as reported to the Internal Revenue Service (IRS). The account to which EFT payments are made must exclusively bear the Name of the Physician or Individual Practitioner, or the Legal Business Name of the person or entity enrolled with Medicare.

For EFT payments to the Home Office of a Chain Organization, the depository account must be established in the legal business name of the Home Office, and must match the Home Office name provided above on this form, as well as the Home Office name provided in the appropriate sections of the relevant Form CMS-855 (Provider/Supplier Enrollment Application).

Enter your Tax Identification Number as reported to the IRS. If the business is a corporation, provide the Federal Employer Identification Number (EIN), otherwise provide your SSN.

Enter your Medicare Identification Number. If you are a Part A Provider, or certified Supplier this will be your 6-digit OSCAR number. If you are enrolled as an individual practitioner or a group practice this will be the 6-position alphanumeric UPIN. If you are enrolled as a supplier of durable medical equipment, this will be the 10-digit National Supplier Clearinghouse number.

Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds), address, name of a contact person, and contact person's telephone number.

Enter your electronic Routing Transit Number, Account Number, and the type of account in which deposits will be made (Checking or Saving). Attach a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead for verification of your account number. The documentation on bank letterhead should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature.

If you do not submit this information, your EFT Authorization Agreement will be returned without further processing.

Read the Authorization carefully. By your signature on this form you are certifying:

1. That the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier;
2. The Physician/Provider/Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions;
3. That all arrangements between the depository and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions;
4. The effective date of the EFT authorization; and
5. That you will notify the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on Form CMS-855 which the Medicare contractor has on file.

Mail this form with the original signature (no Fax signatures can be accepted) to the Medicare Contractor that services your geographical area. For a listing of contractors, see www.cms.hhs.gov/providers/enrollment/contacts/.

Read the Authorization carefully. By your signature on this form you are certifying:

1. That the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier;
2. The Physician/Provider/Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions;
3. That all arrangements between the depository and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions;
4. The effective date of the EFT authorization; and
5. That you will notify the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on Form CMS-855 which the Medicare contractor has on file.

Mail this form with the original signature (no Fax signatures can be accepted) to the Medicare Contractor that services your geographical area. For a listing of contractors, see www.cms.hhs.gov/providers/enrollment/contacts/.

RECLAMACIONES

ACTUALIZACIÓN A LA DISPOSICIÓN DE MEDICARE COMO PAGADOR SECUNDARIO

Una ley federal reciente define cónyuge en el contexto de estatutos federales y reglamentaciones como "una persona del sexo opuesto quien es esposo(a)" (P.L. 104-199). Bajo esta ley, un compañero consensual no es reconocido como esposo(a) y, por lo tanto, Medicare como pagador secundario para beneficiarios de 65 años de edad o más que aún trabajan no aplica en situaciones donde no se cumple con la definición federal de "esposo(a)".

La nueva política no aplica a las disposiciones de Medicare como Pagador Secundario para beneficiarios incapacitados ni de enfermedad renal terminal.

A continuación un resumen de situaciones para las cuales la disposición de Medicare como pagador secundario para beneficiarios de 65 de edad o más que aún trabajan no aplica:

- Personas que solamente tengan Parte B;
- Personas que tengan la Parte A basada en una prima mensual. Cualquier persona menor de 65 años de edad (Medicare es secundario para planes de salud grupales que cubren al menos un patrono con 100 o más empleados para personas incapacitadas menores de 65 años);
- Personas cubiertas por otro seguro médico (Ej. Un seguro privado que la persona haya comprado sin ser miembro de un grupo y cuyo pago no se haga a través de un patrono);
- Menos de 20 empleados en una empresa cubiertos por un seguro médico sencillo. Miembros de seguros de muchos patronos aprobados por CMS para la "exención de múltiples patronos" a quien el seguro identificó como empleado de patronos de menos de 20 empleados;
- Beneficiarios retirados cubiertos por seguros de salud grupales de su empleo anterior y quienes no tienen cubierta de seguros de salud grupales como resultado de su empleo actual o el de su esposo(a).

CLAIMS

UPDATE TO MEDICARE SECONDARY PAYER PROVISION FOR THE WORKING AGED

A recent Federal law defines spouse in the context of all Federal statutes, rulings, and regulations as "a person of the opposite sex who is a husband or a wife" (P.L.104-199). Under this law, a domestic partner cannot be recognized as a spouse, and therefore, the Medicare secondary payer provisions for the working aged do not apply in situations where the Federal definition of "spouse" is not met.

The new policy does alter neither MSP disability nor end-stage renal disease provisions.

The following summarizes situations where the MSP working aged provision does not apply:

- *Individuals enrolled in Part B only;*
- *Individuals enrolled in Part A on the basis of a monthly premium. Anyone who is under age 65. (Medicare is secondary to large group health plans that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.);*
- *Individuals covered by a health plan other than an GHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer;*
- *Employees of employers of fewer than 20 employees who are covered by a single employer plan. Members of multi-employer plans, which have been approved by CMS for the "multi-employer exemption", whom the plan identified as employees of employers with fewer than 20 employees;*
- *Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status;*

RECLAMACIONES

- Personas en un seguro de salud grupal sencillo de patronos con menos de 20 empleados; o
- Miembros de seguros multi-patronales a quien el seguro identificó como empleado de un patrono con menos de 20 empleados, proporcionándoles el seguro elegido (Ver Sección 10.4) para eximir al seguro de pagar por los empleados y esposos(as) de los empleados de patronos identificados con menos de 20 empleados.
- Compañeros consensuales a quienes el plan de salud grupal le ha dado una cubierta como "cónyuge". La ley federal define "cónyuge" como una persona del sexo opuesto quien es un esposo(a). De modo que un compañero consensual no se reconoce como un esposo(a).

CLAIMS

- *Individuals enrolled in single employer GHPs of employers of fewer than 20 employees; or*
- *Members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected (see §10.4) to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees.*
- *Domestic partners who are given "spousal" coverage by the group health plan. Federal law defines spouse as a person of the opposite sex who is a husband or a wife. Thus a domestic partner cannot be recognized as a spouse.*

Pub 100-5 MSP/Trans. 2/CR 2252/Oct. 17, 2003/fa/nls

SOMETER LA SOLICITUD DE PAGO

Los Centros de Servicios para Medicare y Medicaid (CMS, por sus siglas en inglés) actualizaron las Secciones 3000 a 3004.2 del Manual del Contratista de Medicare. Estas secciones definen los procedimientos para someter jurisdicción y cambios en las reclamaciones por servicios o suministros a Medicare Parte B. Algunos de los temas presentados son:

- Definición de una Reclamación Medicare
- Someter reclamaciones de Médicos y suplidores a Medicare Parte B
- Someter reclamaciones adecuadamente

Para información completa sobre esta actualización, puede dirigirse a la siguiente dirección electrónica de CMS: http://www.cms.hhs.gov/manuals/pm_trans/R1818B3.pdf.

FILING THE REQUEST FOR PAYMENT

CMS issued updates to Sections 3000 through 3004.2 for the Medicare Carrier Manual. These sections define the Medicare Part B Claim, Filing, Jurisdiction and Development procedures. Some of the topics you will find covered are:

- *Definition of a Medicare Claim*
- *Filing Part B Claims for Physician and Suppliers*
- *Timely Claim Submission*

For detailed information on these changes visit the following CMS address http://www.cms.hhs.gov/manuals/pm_trans/R1818B3.pdf.

Trans. 1818 CR2815/ 8-29-03/DG

Laboratorio

CAMBIOS EN LOS ÉDITOS DE LA CUBIERTA NACIONAL PARA LABORATORIOS

A continuación los cambios a la Cubierta Nacional de laboratorios que entrarán en vigor el 1 de enero de 2004:

1. De acuerdo con la decisión publicada el 17 de septiembre de 2003 en la página de Internet sobre cubiertas (http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=97), añadimos los siguientes códigos de diagnóstico a la lista de diagnósticos cubiertos por Medicare para la cubierta nacional de tiempo de protrombina (PT) y sangre oculta en heces fecales:
   - 863.91 = pancreas head with open wound into cavity;
   - 863.92 = pancreas body with open wound into cavity;
   - 863.93 = pancreas tail with open wound into cavity;
   - 863.94 = pancreas multiple and unspecified sites with open wound into cavity;
   - 863.95 = appendix with open wound into cavity; and,
   - 863.99 = other gastrointestinal sites with open wound into cavity.
2. Conforme con la decisión publicada el 23 de septiembre de 2003, en la página de Internet sobre cubiertas (http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=93), eliminamos los siguientes códigos de diagnóstico a la lista de diagnósticos cubiertos por Medicare para la cubierta nacional de tiempo de protrombina (PT) y tiempo parcial de protrombina (PTT):
   - V72.81 = pre-operative cardiovascular examination (from PTT);

Laboratory

CHANGES TO THE LABORATORY NATIONAL COVERAGE DETERMINATION (NCD)

The following changes to the National Coverage Determination will be effective January 2004:

1. *In accordance with the decision memorandum published on the coverage Internet site on September 17, 2003 (see http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=97),we are adding the following diagnosis codes to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) and fecal occult blood test (FOBT) NCDs:*
   - *863.91 = pancreas head with open wound into cavity;*
   - *863.92 = pancreas body with open wound into cavity;*
   - *863.93 = pancreas tail with open wound into cavity;*
   - *863.94 = pancreas multiple and unspecified sites with open wound into cavity;*
   - *863.95 = appendix with open wound into cavity; and,*
   - *863.99 = other gastrointestinal sites with open wound into cavity.*
2. *In accordance with the decision memorandum published on the coverage Internet site on September 23, 2003 (see http://cms.hhs.gov/mcd/viewdecisionmem.asp?id=93), we are deleting the following diagnosis codes from the list of ICD-9-CM codes covered by Medicare for PT and partial thromboplastin time (PTT) NCDs:*
   - *V72.81 = pre-operative cardiovascular examination (from PTT);*

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Laboratorio

- V72.83 = other specified pre-operative examination (from PTT); and,
- V72.84 = pre-operative examination, unspecified (from PT and PTT).

3. Anteriormente CMS anunció la inclusión del código de diagnóstico 401.1 a la lista de diagnósticos cubiertos para "lipid testing". Sin embargo, olvidamos anunciar el cambio en la narrativa de la cubierta nacional para el lipid. Por tal razón, notificamos un cambio en la narrativa de la cubierta nacional del lipid publicada el 17 de julio de 2003 en la página de Internet sobre cubiertas (http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=94). El tercer punto en las indicaciones de esta cubierta nacional fue enmendado para que lea:

   "Any form of atherosclerotic disease, or any disease leading to the formation of atherosclerotic disease."

4. CMS también anunció la eliminación de varios códigos de diagnósticos en la actualización del 1 de octubre de 2003. Se proveyó un período de gracia de 90 días a todos los laboratorios y proveedores para adaptarse a estos cambios. Aunque anunciamos estos cambios, no realizamos ningún cambio en nuestros éditos para denegar las reclamaciones donde se utilizaban estos códigos eliminados. Sin embargo, el período de gracia expiró con la actualización de enero y los siguientes códigos de diagnóstico se denegarán: 282.4, 331.2, 348.3, 530.2, 600.0, 600.1, 600.9, 767.1, 790.2, V04.8, V43.2, V53.9, V54.0, V65.1.

Pub. 100-20/OTN/Trans. 10/Oct. 24/2003/CR 2940/er

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- *V72.83 = other specified pre-operative examination (from PTT); and,*
- *V72.84 = pre-operative examination, unspecified (from PT and PTT).*

3. *Previously CMS announced the addition of diagnosis code 401.1 (benign essential hypertension) to the list of covered diagnoses for lipid testing. However, we neglected to announce the corresponding change to the narrative of the lipid NCD that authorizes this code. By inclusion in this transmittal, we are announcing a change to the narrative of the lipid NCD that was included in the July 17, 2003 decision memorandum posted on the Internet at http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=94. The third bullet listed in the lipid NCD indications section is amended to read:*

   "Any form of atherosclerotic disease, or any disease leading to the formation of atherosclerotic disease."

4. *CMS had also announced a number of ICD-9-CM codes that were deleted by the update in ICD-9-CM codes that became effective October 1, 2003. We provided for a 90-day grace period for the provider and laboratory community to adapt to these changes. Thus, while we announced the changes in CR 2814, we did not alter the software to deny claims when these codes were used. However, the grace period expires with the January update of the software and the following ICD-9-CM codes will be denied: 282.4, 331.1, 348.3, 530.2, 600.0, 600.1, 600.2, 600.9, 767.1, 790.2, V04.8, V43.2, V53.9, V54.0, V65.1.*

ENFERMERIA ESPECIALIZADA

GUÍA PARA LA FACTURACIÓN CONSOLIDADA DE LOS CENTROS DE ENFERMERÍA ESPECIALIZADA

La Facturación Consolidada de los Centros de Enfermería Especializada (SNF, por sus siglas en inglés) establece que éstos deben someter las reclamaciones de Medicare al Intermediario Fiscal (FI, por sus siglas en inglés) por todos los servicios de la Parte A y B que sus residentes reciben durante el período de cubierta de la estadía Parte A. Salvo un número limitado de servicios excluidos que proveedores externos deben suministrar directamente o según acuerdo con el SNF. La sección 4432(b) del "Balanced Budget Act" del 1997 (BBA, PL 105-33) excluyó categorías completas de servicios de la Facturación Consolidada de los SNFs. Los servicios excluidos deben facturarse por separado al contratista de Medicare de la Parte B y estos incluyen los servicios de médicos y ciertos profesionales de la salud.

Servicios y Suministros Incluidos en la Facturación Consolidada de los SNFs:

Los requisitos para la Facturación Consolidada de los SNFs le otorga a éstos la responsabilidad de facturar por el paquete completo de servicios que reciben sus residentes incluyendo:

- Todos los servicios y suministros recibidos durante el transcurso de una estadía cubierta Parte A (incluye terapia física, ocupacional y del habla) fuera de exclusiones reglamentarias; y
- Para residentes de SNFs en estadías no cubiertas (ejemplo, beneficios de la Parte A agotados o sin una previa hospitalización autorizada), servicios de terapia física, ocupacional y del habla.

Servicios y Suministros Excluidos de la Facturación Consolidada de los SNFs:

A. Los siguientes servicios y suministros están excluidos de la Facturación Consolidada de los SNFs y deben facturarse por separado al contratista de Medicare:

SKILLED NURSING FACILITY

GUIDELINES FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING

Skilled Nursing Facility (SNF) Consolidated Billing states that SNFs 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 limited number of specifically excluded services that must be furnished either directly or under arrangement with outside providers. Section 4432(b) of the Balanced Budget Act of 1997 (BBA, PL 105-33), mandated the exclusion of entire categories of services from SNF consolidated billing. These excluded services are separately billable to the Part B Medicare Carrier and include the services of physicians and certain other types of medical practitioners.

Services and Supplies Included in SNF Consolidated Billing:

The SNF consolidated billing requirement bestows on SNFs the billing responsibility for the entire package of services that residents receive including:

- *All services and supplies received during the course of a Part A covered stay (including physical, occupational, and speech-language therapy services), with the exception of statutory exclusions; and*
- *For SNF residents in non-covered stays (e.g., Part A benefits exhausted or no prior qualifying hospital stay), physical, occupational, and speech-language therapy services.*

Services and Supplies Excluded from SNF Consolidated Billing:

A. The following are excluded from SNF consolidated billing and must be billed separately to the Medicare Carrier:

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- El componente profesional de los servicios médicos (ver sección 1861(r) del Acta del Seguro Social para la definición de médico para propósitos de Medicare) excepto servicios de terapia física, ocupacional y del habla;
- Servicios sicológicos calificados;

Las siguientes especialidades están cubiertas en las Islas Vírgenes USA, pero no en Puerto Rico:

- Servicios de Médico Asistente, cuando éste trabaja bajo la supervisión del médico;
- Servicios de Enfermera Practicante, cuando ésta trabaja en colaboración con el médico;
- Enfermeras Clínicas Especializadas, cuando éstas trabajan en colaboración con el médico;
- Servicios de Comadrona Certificada
- Servicios de Enfermera Graduada Anestesista

NOTA: Servicios de terapia física, ocupacional y del habla incluidos en la Facturación Consolidada de los SNFs están sujetos a la Facturación Consolidada de los SNFs no importa quien los provea, aún cuando comúnmente los servicios provistos por estos profesionales están excluidos de la Facturación Consolidada de los SNFs.

B. Los siguientes servicios y suministros están excluidos de la Facturación Consolidada de los SNFs y deben facturarse por separado al contratista o al FI, según el caso:

- Viajes en ambulancia para trasladar a un paciente al SNF para el alta inicial o de un SNF después del alta (vea más adelante información adicional sobre los servicios de ambulancia);

SKILLED NURSING FACILITY

- *The professional component of physician services (see Section 1861(r) of the Social Security Act for the definition of a physician for Medicare purposes) except physical, occupational, and speech-language therapy services;*
- *Qualified psychologist services;*

The specialties that follow are covered in the U.S. Virgin Islands but not in Puerto Rico:

- *Physician assistant services, when a physician assistant is working under a physician's supervision;*
- *Nurse practitioner services, when a nurse practitioner is working in collaboration with a physician;*
- *Clinical nurse specialists, when a clinical nurse specialist is working in collaboration with a physician;*
- *Certified mid-wife services;*
- *Certified registered nurse anesthetist services.*

***NOTE**: Physical, occupational, and speech-language therapy services included in SNF consolidated billings are subject to SNF consolidated billing regardless of who provides them, even if the services normally provided by that type of practitioner are excluded from SNF consolidated billing.*

B. Excluded from SNF consolidated billing and which must be billed separately to the Medicare Carrier or FI as appropriate, are:

- *Ambulance trips that transport a patient to the SNF for initial admission or from the SNF following a final discharge (see below for additional ambulance services information);*

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- Servicios a beneficiarios de alto riesgo de las Organizaciones para el Mantenimiento de la Salud (HMO, por sus siglas en inglés);
- Servicios a residentes de la Parte A en estadías cubiertas (sólo algunos servicios de estas categorías están excluidos)

  -Algunas drogas de quimioterapia;

  -Algunos servicios de administrar la quimioterapia;

  -Algunos servicios isótopo radioactivo; y

  -Algunos dispositivos protéticos hechos a la medida

Centros Incluidos en la Facturación Consolidada de los SNFs:

- SNFs participantes del programa de Medicare, incluye secciones de los SNFs certificados por Medicare y todos los hospitales excepto Hospitales de Cuidado Agudo (CAHs, por sus siglas en inglés).

Centros Excluidos en la Facturación Consolidada de los SNFs

- Asilo de Ancianos que no están certificados por Medicare (ejemplo, no participan del programa de Medicare o Medicaid);
- Asilo de Ancianos que participan exclusivamente del programa Medicaid como Centro de Enfermería;
- Las secciones no participantes de los Centros de Enfermería que también tienen secciones certificadas por Medicare; y
- Las secciones de traslado en los Hospitales de Cuidado Agudo.

Componentes Profesional y Técnico de las Pruebas de Diagnóstico

El componente profesional (la interpretación médica de la prueba de diagnóstico) se considera un servicio médico y se factura por separado al contratista de Medicare. El componente técnico (la prueba de diagnóstico en sí) se considera

SKILLED NURSING FACILITY

- *Services to risk based HMO enrollees; and*
- *Services for residents in a Part A covered stay (only certain services in these categories are excluded):*

  -Certain chemotherapy drugs;

  -Certain chemotherapy administrative services;

  -Certain radioisotope services; and

  -Certain customized prosthetic devices.

Facilities Included in SNF Consolidated Billing:

- *Medicare participating SNFs, including Medicare-certified distinct part SNFs and swing beds in all hospitals except Critical Access Hospitals (CAHs).*

Facilities Excluded from SNF Consolidated Billing:

- *Nursing homes that have no Medicare certification (e.g., do not participate at all in either the Medicare or Medicaid program);*
- *Nursing homes that exclusively participate only in the Medicaid program as a nursing facility;*
- *The non-participating portion of a nursing home that also contains a Medicare-certified distinct part SNF; and*
- *Swing beds in CAHs.*

Professional and Technical Components of Diagnostic Tests

The professional component, or the physician's interpretation of a diagnostic test, is considered a physician service and is separately billable to the Medicare carrier. The technical component, or the diagnostic test itself, is considered a diagnostic test and is subject to consolidated billing. As an

Cont. on next page

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una prueba diagnóstica y está sujeta a la Facturación Consolidada. Ejemplo, para los servicios diagnósticos radiológicos la exclusión de los servicios médicos de la Facturación Consolidada aplica sólo al componente profesional. El componente técnico se considera una prueba diagnóstica que el SNF debe facturar al Intermediario Fiscal de Medicare y éste se incluye en el pago de la Facturación Consolidada a la Parte A para una estadía cubierta. Debido a que el componente técnico ya cae dentro del pago inclusivo por día de la Parte A al SNF por una estadía cubierta, una entidad externa que provea el componente técnico le facturará al SNF en lugar del contratista (Parte B) de Medicare.

Servicios de Ambulancia:

Fuera de algunas exclusiones específicas, la Facturación Consolidada de los SNFs incluye aquellos viajes en ambulancia que son médicamente necesarios durante una estadía Parte A. En la mayoría de los casos, cuando termina la estadía cubierta Parte A, los viajes en ambulancia están excluidos de la Facturación Consolidada de los SNFs. La compañía de ambulancia tiene entonces que facturarle al contratista o al FI de Medicare para recibir el pago. Las circunstancias específicas bajo las cuales un paciente podrá recibir servicios de ambulancia cubiertos por Medicare, pero excluidos de la Facturación Consolidada de los SNFs son:

- Un viaje en ambulancia
  - a un hospital participante del programa de Medicare o a un Hospital de Cuidado Agudo para recibir servicios de emergencia o servicios ambulatorios de hospital médicamente necesarios;
  - médicamente necesario, después del alta oficial o alguna otra salida del SNF, **a menos que** el paciente vuelva a ser admitido o regrese al SNF donde se encontraba o algún otro SNF antes de la medianoche del mismo día;
  - para recibir servicios de o servicios relacionados a diálisis;

SKILLED NURSING FACILITY

example, for diagnostic radiology services, the exclusion of physician services from consolidated billing applies only to the professional component of the diagnostic radiology service. The technical component of the diagnostic radiology service is considered a diagnostic test that must be billed to the Medicare FI by the SNF and is included in the SNF consolidated billing payment for covered Part A stays. Because the technical component is already included within Part A's comprehensive per diem payment to the SNF for the covered stay, an outside entity that actually furnishes the technical component would bill the SNF, rather than Part B, for payment.

Ambulance Services:

Except for specific exclusions, SNF consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a Part A stay. In most cases, ambulance trips are excluded from SNF consolidated billing when the covered Part A stay has ended, at which time the ambulance company must bill the Medicare Carrier or FI directly for payment. The specific circumstances under which a patient may receive ambulance services that are covered by Medicare but excluded from SNF consolidated billing are:

- *A medically necessary ambulance trip:*
  - *to a Medicare participating hospital or CAH for the specific purpose of receiving emergency or other excluded outpatient hospital services;*
  - *after a formal discharge or other departure from the SNF, **unless** the patient is readmitted or returns to that or another SNF before midnight of the same day;*
  - *to receive dialysis or dialysis-related services;*

Cont. on next page

ENFERMERIA ESPECIALIZADA

- para una alta a paciente hospitalizado en un hospital participante del programa Medicare o Hospital de Cuidado Agudo; y
- después del alta del SNF y médicamente necesario trasladar al paciente a su hogar donde ella o él recibirá servicios bajo un plan de cuidado de una agencia participante del programa de Medicare de Servicios de Salud en el Hogar.

NOTA: El traslado de un paciente de un SNF a otro antes de la medianoche del mismo día no está excluido de la Facturación Consolidada del SNF. El primer SNF es responsable de los servicios de ambulancia.

Medios de Información sobre la Facturación Consolidada de los SNF:

- Página electrónica sobre Facturación Consolidada en: www.cms.hhs.gov/medlearn/snfcode.asp provee lo siguiente:
  - Información general de Facturación Consolidada de los SNFs
  - Códigos HCPCS que el contratista de Medicare puede pagar por separado (i.e., servicios no incluidos en la Facturación Consolidada)
  - Códigos de terapia que deben consolidarse en una estadía no cubierta
  - Todas las listas de códigos están sujetas a actualizaciones trimestrales y anuales y deben analizarse periódicamente para la revisión más reciente.
- Manual Electrónico de CMS en: www.cms.hhs.gov/manuals/cmsindex.asp

  Publicación 100-4 – "Medicare Claims Processing"

  Capítulo 6 – provee Requerimientos de la Facturación Consolidada para los SNFs;

  Capítulo 7 – tiene a) Códigos HCPCS incluidos en el pago a los SNFs Parte A; b) Códigos de la Parte B que el Intermediario Fiscal puede pagarle al SNF y bajo que términos.

SKILLED NURSING FACILITY

- *an inpatient admission to a Medicare participating hospital or CAH; and*
- *the patient's home where he/she will receive services from a Medicare participating home health agency under a plan of care after discharge from a SNF.*

***NOTE**: A patient's transfer from one SNF to another before midnight of the same day is not excluded from SNF consolidated billing. The first SNF is responsible for the ambulance services.*

SNF Consolidated Billing Information Resources:

- *Consolidated Billing Web Site at: www.cms.hhs.gov/medlearn/snfcode.asp provides the following:*
  - *General SNF consolidated billing information.*
  - *HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).*
  - *Therapy codes that must be consolidated in a non-covered stay.*
  - *All code lists are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.*
- *CMS Manual System at: www.cms.hhs.gov/manuals/cmsindex.asp*

  Publication 100-4 - Medicare Claims Processing

  Chapter 6 – supplies Consolidated Billing Requirements for SNFs

  Chapter 7 – provides a) HCPCS codes included in the SNF Part A Payment; b) Codes that may be paid and on what basis to a SNF by the FI under Part B.

JSM-2088/August 29, 2003/els
CR2858 Trans. B-03-06-8/8-22-2003/els

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

Contrato | Enrollment

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

NOTES

CENTERS for MEDICARE & MEDICAID SERVICES

NOTA AL BENEFICIARIO

PRIMAS, DEDUCIBLES Y COASEGUROS DE MEDICARE PARA EL 2004

DEDUCIBLES, COASEGUROS Y PRIMAS DE MEDICARE PARTE A:

Deducible - $876 (por período de beneficio)

Coaseguros - $219 (diarios desde el día 61 al 90 de cada periodo de beneficio)

- $438 (diarios desde el día 91 al 150 por los restantes días de reserva de por vida)

- $109.50 (diarios en una facilidad de enfermería especializada desde el día 21 al 100 de cada período de beneficios)

Prima - $343 (mensual para quienes deben pagar la prima)

- $377.30 (mensual para quienes deban pagar la prima y un aumento de 10 por ciento)

- $189.00 (mensual para quienes hayan completado 30-39 trimestres de la cubierta)

- $207.90 (mensual para quienes hayan completado 30-39 trimestres de la cubierta y deban pagar un aumento de 10 por ciento)

DEDUCIBLES, COASEGUROS Y PRIMAS DE MEDICARE PARTE B:

Deducible - $100.00 per year

Coaseguro - 20%

Prima - $66.60 per month

Pub. 100-4 MCP/Trans. 21/CR 2969/Oct. 31, 2003

CENTERS for MEDICARE & MEDICAID SERVICES

MESSAGE TO THE BENEFICIARY

MEDICARE DEDUCTIBLE, COINSURANCE, AND PREMIUM RATES FOR 2004

MEDICARE PART A DEDUCTIBLE, COINSURANCE & PREMIUM AMOUNTS:

Deductible -$876 (per benefit period)

Co-Insurance -$219 (a day for 61-90 in each period)

-$438 (a day for days 91-150 for each ''Lifetime Reserve'' day used)

-$109.50 (a day in a Skilled Nursing Facility for days 21-100 in each benefit period)

Premium -$343 (per month for those who must pay a premium)

-$377.30 (per month for those who must pay both a premium and a 10 percent increase)

-$189.00 (per month for those who have 30-39 quarters of coverage)

-$207.90 (per month for those who have 30-39 quarters of coverage and must pay a 10 percent increase)

MEDICARE PART B DEDUCTIBLE, COINSURANCE & PREMIUM AMOUNTS:

Deductible - $100.00 per year

Co-Insurance - 20%

Premium - $66.60 per month

Pub. 100-4 MCP/Trans. 21/CR 2969/Oct. 31, 2003

Nuevo Director Médico

La Lcda. Gloria M. Lebrón, Vicepresidenta de la División Medicare, se complace en anunciar el nombramiento del Dr. Juan Luis Schaening-Pérez como Director Médico efectivo el 15 de diciembre de 2003.

El doctor Schaening-Pérez es graduado de Medicina Interna de la Universidad de Puerto Rico. Se ha desempeñado en funciones de Director Médico en varias organizaciones y se distingue por su experiencia en clínicas de cuidado crónico e inmunología.

El nuevo Director Médico mantendrá una comunicación abierta con la comunidad médica y los diferentes sectores con los que Medicare interacciona. Su política de puertas abiertas garantizará la atención adecuada de las inquietudes sobre Medicare en nuestra comunidad. Le damos la bienvenida y estamos confiados en que trabajaremos juntos con miras a ofrecer el mejor servicio.

New Medical Director

Gloria M. Lebrón, Esq. Vice-President of the Medicare Division is pleased to announce the appointment of Dr. Juan Luis Schaening-Perez as our Medical Director effective December 15, 2003.

Dr. Schaening-Pérez graduated in Internal Medicine from the University of Puerto Rico. He has carried out the Medical Director functions in various organizations and he is well-known for his clinical expertise in acute care and immunology.

The new Medical Director will maintain an open communication with our physician community and all other sectors that interact with Medicare. His open-door policy will guarantee that adequate attention is placed on concerns from our communities on to the Medicare Program. We welcome him and are certain that we will work together to offer the best service.

December 8, 2003/gml/dmg

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