Medicare Informa
División Medicare / Parte B

¡Qué Bueno Que Preguntó!

ATENCIÓN A TODOS LOS NEFRÓLOGOS

Nuevos Códigos para Servicios Relacionados con Enfermedad Renal Terminal

Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) crearon códigos temporeros, conocidos como códigos G, que describen procedimientos o servicios cuando pacientes de diálisis visitan al médico una vez al mes, 2-3 veces al mes o cuatro o más veces al mes, con un aumento en pago de acuerdo al número de visitas. El pago total por estos servicios es lo que actualmente se paga por los códigos CPT 90918 a 90921. Estos códigos tienen estatus I = código inválido, esto significa que no se les aplicará el período de gracia. Por lo tanto, a partir del 1 de enero de 2004 no se podrá utilizar los códigos 90918 a 90921.

Cont. en la página 4

We Are Glad You Asked!

ATTENTION TO ALL NEPHROLOGIST

New Codes for End Stage Renal Disease Related Services

For dialysis patients seeing the doctor, The Centers for Medicare and Medicaid Services (CMS) created separate temporary codes that describe procedures or services, known as G codes, for 1 physician visit per month, 2-3 visits per month, and 4 or more visits per month, with payment increasing with the number of visits. The aggregate payments for these services are approximately equal to current payments for CPT codes 90918 to 90921, these codes have status I = invalid code, which means that the grace period will not apply. As of January 1, 2004 and thereafter, codes 90918 to 90921 cannot be used.

Cont. on page 4

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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!

Viene de la Portada...

Se crearon también unos códigos G para el manejo de pacientes de diálisis en el hogar para diferentes grupos clasificados por edad. Además, se crearon cuatro nuevos códigos G para pacientes de diálisis en el hogar que son hospitalizados durante el mes. Estos códigos se utilizarán para informar el manejo diario de pacientes de diálisis en el hogar en los días que el paciente no estuvo hospitalizado. La siguiente tabla muestra la transferencia de archivos de los códigos CPT actuales a los códigos G:

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From the Cover Page...

New G codes were also created for the management of home dialysis patients in each of the age groups. In addition, four new G codes were also created for home dialysis patients who are hospitalized during the month. These codes are to be used to report daily management of home dialysis patients for the days the patient was not in the hospital. Following is the crosswalk from the current CPT codes to the G codes.

Pacientes de Diálisis que no sean Pacientes de Diálisis en el Hogar
Patients Other than Home Dialysis

Código CPT *CPT Code*	Edad del Paciente *Age of Patient*	Nuevo Código G *New G Codes*	Número de Visitas *Number of Visits*
90918	< 2	G0308 G0309 G0310	4+ 2 to 3 Una visita / *One visit*
90919	2 to 11	G0311 G0312 G0313	4+ 2 to 3 Una visita / *One visit*
90920	12 to 19	G0314 G0315 G0316	4+ 2 to 3 Una visita / *One visit*
90921	20+	G0317 G0318 G0319	4+ 2 to 3 Una visita / *One visit*

Pacientes de Diálisis en el Hogar (mes completo)
Home Dialysis Patients (entire month)

Código CPT *CPT Code*	Edad del Paciente *Age of Patient*	Nuevo Código G *New G Codes*	Lugares de Servicio Válidos *Valid Place of Service*
Ningún Código CPT Definido *No distinct CPT Codes*	< 2	G0320	11 (Office), 12 (Home), 22 (Outpatient Hospital, and 65 (Dialisis Facility)
	2 to 11	G0321	
	12 to 19	G0322	
	20+	G0323	

Pacientes de Diálisis en el Hogar (sólo mes parcial – por día)
Home Dialysis Patients (partial month only - per day)

Código CPT *CPT Code*	Edad del Paciente *Age of Patient*	Nuevo Código G *New G Codes*	Lugares de Servicio Válidos *Valid Place of Service*
90922	< 2	G0324	11 (Office), 12 (Home), 22 (Outpatient Hospital, and 65 (Dialisis Facility)
90923	2 to 11	G0325	
90924	12 to 19	G0326	
90925	20+	G0327	

¡Qué Bueno Que Preguntó!

PROCESO DE CONTRATACIÓN DEL PROVEEDOR

En los pasados meses han surgido algunas preguntas de parte de la comunidad médica relacionadas al proceso de contratación de proveedor a Medicare. Por tal razón, preparamos las siguientes preguntas con sus contestaciones para aclararle el desarrollo asociado a este proceso.

1. **¿Por qué los proveedores y suplidores experimentan atrasos en el procesamiento de su solicitud de proveedor de Medicare?**

   El 3 de noviembre de 2003 los contratistas de Medicare comenzaron a utilizar una base de datos electrónica para guardar la información relacionada a la solicitud de contratación de los proveedores/suplidores. Esta base de datos se conoce como PECOS (Provider Enrollment, Chain and Ownership). El sistema PECOS es la implantación electrónica de una decisión que CMS tomó en 1995, como resultado de una iniciativa contra el fraude y el abuso, para crear un procedimiento nacional uniforme para la contratación del proveedor/suplidor a Medicare.

   El sistema PECOS se implantó para los contratistas de Medicare el 3 de noviembre de 2003; los intermediarios fiscales comenzaron a usar el sistema en julio de 2002. Hasta ese momento los contratistas tenían instrucciones de procesar cualquier solicitud nueva de contratación o hacer cualquier cambio en la solicitud a través del sistema PECOS. Mientras que algunos contratistas tienen casos atrasados que deben disminuir, otros contratistas manejaron la transición al sistema PECOS sin mucha dificultad.

   Además de los asuntos relacionados directamente a la implantación del sistema PECOS, existen otros asuntos sobre la infraestructura del centro de información

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PROVIDER ENROLLMENT PROCESS

During the last few months some questions regarding the Medicare provider enrollment process have been raised by members of the healthcare community. Therefore, we have prepared two questions and answers, which we believe, will clarify developments associated with provider enrollment.

1. ***Why are providers and suppliers experiencing delays associated with processing their provider/supplier applications?***

   On November 3, 2003, CMS' Medicare carriers began using a new electronic database for recording and retaining enrollment data for providers/suppliers. This electronic database is known as the Provider Enrollment, Chain and Ownership System (PECOS). The PECOS system is the electronic implementation of a policy decision made by CMS in 1995, as a result of a CMS fraud and abuse initiative, "Operation Restore Trust", to create a national, uniform business process for provider/supplier enrollment.

   AThe PECOS system was implemented for Medicare carriers on November 3, 2003; fiscal intermediaries began using the system in July 2002. As of this date carriers were instructed to process any new enrollments and any changes in enrollment applications through PECOS. While some carriers have backlogs that must be reduced, other carriers have handled the transition to PECOS with less difficulty.

   In addition to issues directly related to PECOS implementation, there have been unanticipated CMS data center infrastructure issues that have caused

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¡Qué Bueno Que Preguntó!

de CMS que han ocasionado averías en el sistema. Estas averías imprevistas han provocado que el sistema PECOS estuviera inaccesible para el contratista por cierto tiempo.

Otro factor es el proceso de aprendizaje de los empleados de nuestros contratistas. Este proceso nuevo es diferente a la manera en que anteriormente los contratistas procesaban las solicitudes de contratación de los proveedores. CMS ha desarrollado adiestramientos y ha dado apoyo, pero, como cualquier cambio de esta magnitud, se anticipan reducciones en la producción por un tiempo.

Otro factor que ha ocasionado atrasos es el proceso de presupuesto. Para este año fiscal la asignación de presupuesto para CMS se demoró en el Congreso. Como resultado, CMS y sus contratistas de Medicare manejaron sus operaciones bajo un decreto presupuestario hasta principios de este año natural.

2. **¿Qué está haciendo CMS para resolver los atrasos asociados al proceso de contratación de los proveedores/ suplidores?**

Recientemente, CMS reunió un equipo de altos ejecutivos que tienen la responsabilidad de resolver estos atrasos. Este equipo se concentra en solucionar rápidamente los atrasos en las solicitudes de contratación de los proveedores. Se tomarán medidas para dirigir el trabajo atrasado y se considerarán todas las alternativas.

Equipos con representantes de CMS Oficina Central y de las Oficinas Regionales y los desarrolladores del sistema PECOS se establecieron y desde el 1 de marzo de 2004 comenzaron a visitar a cada contratista de Medicare. Estos equipos tendrán la responsabilidad de proveer servicio a los contratistas para resolver

We Are Glad You Asked!

system outages. These unanticipated outages have made PECOS inaccessible to carrier staffs for certain periods of time.

Another factor is the learning curve staff is experiencing at our carriers. This is a new, uniform business process, most times different from the way carriers processed provider enrollment applications in the past. Ongoing training and support has been provided by CMS but, as with any change of this magnitude, it is anticipated that slowdowns in work processing will occur for a time.

Another factor that has caused delays is the budget process. This fiscal year, CMS' appropriation was held up in Congress. As a result, CMS and its Medicare contractors were operating at a prior year continuing resolution levels until earlier this calendar year.

2. ***What is CMS doing to resolve the delays associated with processing provider/supplier applications?***

CMS recently assembled a senior leadership team with accountability for resolving these delays. This team is focusing on expeditiously resolving delays in processing provider enrollment applications. Steps are being taken to address the backlogs and all options are being considered.

Teams of representatives from CMS headquarters and regional offices and the PECOS system developers have been assembled and began conducting site visits to each Medicare carrier beginning the week of March 1, 2004. These teams will have direct responsibility to provide on-site focused customer service to individual carriers to expeditiously resolve any issues related to PECOS and the provider enrollment business process so that delays in processing can be reduced or eliminated.

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¡Qué Bueno Que Preguntó!

rápidamente cualquier asunto relacionado al sistema PECOS y al proceso de contratación del proveedor con el propósito de reducir o eliminar los atrasos.

CMS está trabajando diligentemente para solucionar asuntos relacionados a sus sistemas de infraestructura que están ocasionando problemas para acceder al sistema PECOS. Además, CMS está en el proceso de dirigir cualquier restricción de fondos para que los contratistas tengan los recursos necesarios para atender los atrasos y reducir sus inventarios.

La meta de CMS es reducir el inventario de casos atrasados para el verano de 2004.

We Are Glad You Asked!

On the CMS infrastructure front, CMS is working diligently to resolve CMS data system infrastructure issues that are causing outages in access to PECOS. CMS is also in the process of addressing any current funding constraints so that carriers have the necessary resources to address the delays and reduce their inventories.

The goal of CMS senior leadership is to have the backlog inventories reduced by the summer of 2004.

JSM-160/March 5, 2004/DMG

ACTUALIZACIÓN EXPEDIENTES DE PROVEEDORES

Durante el mes de mayo todos los médicos que ofrecen servicios a los beneficiarios del Programa Medicare y que reciben pago por los servicios prestados recibirán una notificación de la Oficina de Contratos de Triple-S, Inc./Medicare. En la misma le solicitamos nos sometan antes del 31 de julio de 2004 evidencia de la Certificación y Registro de Educación Médica para el trienio 1 de julio de 2004 al 30 de junio de 2007 que otorga el Tribunal Examinador de Médicos de Puerto Rico.

Es importante que sometan esta información a la Oficina de Contratos Medicare. De esta manera nos aseguraremos de cumplir con la regulación de Medicare y a la misma vez mantener sus expedientes al día.

UPDATE OF MEDICARE PROVIDER FILES

During the month of May all physicians that render services to beneficiaries of the Medicare Program and receive payment for the services rendered will be receiving a written communication from the Contract Section. In that letter we are requesting to submit before July 31, 2004 evidence of the Certification and Registration from the Puerto Rico Medical Board of Examiners, for the period July 1, 2004 to June 30, 2007.

It is very important that you submit this information to our Contract Section. This way we would be sure and could comply with Medicare Regulations and at the same time have all your files updated.

SS/Contract Section/March, 2004

ESPECIALIDADES QUE OPTAN POR NO PERTENECER

ATENCIÓN MÉDICOS Y PROFESIONALES DE LA SALUD DEL PROGRAMA MEDICARE

Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) añadieron las siguientes especialidades de la medicina a la definición/lista de médicos que pueden optar por no pertenecer al Programa Medicare y firmar acuerdos privados con beneficiarios:

- Doctores en Osteopatía
- Doctores en Cirugía Dental
- Doctores en Medicina Dental
- Doctores en Podiatría
- Doctores en Optometría

Los siguientes profesionales de la salud pueden también optar por no pertenecer al Programa Medicare:

- Médico Asistente*
- Enfermera Practicante*
- Enfermera Clínica (especialista)*
- Enfermera Anestesista Certificada*
- Enfermera Partera Certificada*
- Psicólogo Clínico
- Trabajador Social Clínico

***Estas especialidades se cubren en las Islas Vírgenes, pero en Puerto Rico no están autorizadas.**

La ley de "opt-out" (optar por no pertenecer) no incluye en su definición de "médico" a los quiroprácticos; por lo tanto, éstos no podrán optar por no pertenecer al Programa Medicare y entrar en acuerdos privados con beneficiarios. Igualmente, los terapistas físicos y ocupacionales en práctica privada no podrán optar por no pertenecer, ya que no se incluyen en la definición de "médico" o "profesionales de la salud".

OPT-OUT SPECIALTY LIST

ATTENTION PHYSICIANS/ PRACTITIONERS IN THE MEDICARE PROGRAM

The Centers for Medicare and Medicaid Services (CMS) added the following group of specialties to the definition/list of physicians who may opt-out of the Medicare program and thus, enter into private contracts with beneficiaries:

- *Doctors of osteopathy*
- *Doctors of dental surgery*
- *Doctors of dental medicine*
- *Doctors of podiatric medicine*
- *Doctors of optometry*

The practitioners, who may opt-out as well, are:

- *Physician assistant**
- *Nurse practitioner**
- *Clinical nurse specialist**
- *Certified registered nurse anesthetist**
- *Certified nurse midwife**
- *Clinical psychologist*
- *Clinical social worker*

These specialties are covered in the U.S. Virgin Islands, but not in Puerto Rico.

The opt-out law does not define "physician" to include chiropractors; therefore, they may not opt-out of Medicare and provide services under private contract. Physical therapists in independent practice and occupational therapists in independent practice cannot opt-out because they are not within the opt-out law's definition of either a "physician" or "practitioner".

CR3016/Pub. 100-02/Transmittal 4/January 2, 2004/els

Health Insurance Portability and Accountability Act (HIPAA)

MODIFICACIÓN AL PLAN DE CONTINGENCIA DE MEDICARE PARA LA IMPLEMENTACIÓN DE HIPAA

Proveedores Afectados:

Todos los proveedores y suplidores de servicios de Medicare que facturan en formato electrónico.

Acción necesaria de parte del Proveedor:

Comenzando el 1 de julio de 2004 Medicare modificará el Plan de Contingencia de HIPAA. La modificación continuará permitiendo el envío de reclamaciones electrónicas en formato que no cumple con los requisitos de HIPAA; sin embargo, el pago de estas reclamaciones tomará 13 días adicionales. Esto significa que a partir del 6 de julio de 2004 Medicare tomará más tiempo en emitir pagos por toda reclamación sometida en formato que no cumple con los requisitos de HIPAA.

Le exhortamos a que envíe reclamaciones que cumplan con los requisitos de HIPAA. Si actualmente somete reclamaciones en el formato requerido por HIPAA, es decir el formato **4010A1** X12N, o espera utilizar este formato antes del 6 de julio de 2004, entonces este cambio al Plan de Contingencia no le aplica.

Trasfondo:

Actualmente Medicare paga las reclamaciones electrónicas 14 días luego de la fecha de recibo (13 días de período de espera). Las reclamaciones no electrónicas (en papel) se pagan 27 días luego de la fecha de recibo (26 días de período de espera).

HIPAA establece que a partir del 16 de octubre de 2003 las reclamaciones electrónicas deben cumplir con los estándares adoptados para uso nacional.

"The Administrative Simplification and Compliance Act"(ASCA) requiere que las reclamaciones sometidas a Medicare desde el 16 de octubre de 2003 sean en formato electrónico, salvo algunas excepciones.

MODIFICATION OF CMS' MEDICARE CONTINGENCY PLAN FOR HIPAA IMPLEMENTATION

Providers Affected:

All Medicare physicians, providers, and suppliers who submit electronic claims to Medicare.

Provider Action Needed:

Effective July 1, 2004, Medicare is modifying its Health Insurance Portability and Accountability Act (HIPAA) contingency plan. The modification continues to allow submission of non-compliant electronic claims. However, the payment of electronic claims that are not HIPAA compliant will take thirteen additional days.

*While the contingency plan remains in place, the submission of non-HIPAA electronic claims to Medicare after July 6, 2004, means that Medicare will take longer to pay such claims. Submit HIPAA compliant claims. If you are already submitting HIPAA compliant claims, **4010A1** X12N format, or will do so on or before July 6, 2004, then this change does not apply to you.*

Background:

Currently, Medicare pays electronic media claims (EMC) no earlier than the 14th day after the date of receipt (13-day waiting period). Non-electronic claims cannot be paid earlier than the 27th day after the date of receipt (26-day waiting period).

HIPAA requires that claims submitted electronically, effective October 16, 2003, be in a format that complies with the appropriate standard adopted for national use.

The Administrative Simplification and Compliance Act (ASCA) requires claims to be submitted to Medicare electronically, with some exceptions, effective October 16, 2003.

Health Insurance Portability and Accountability Act (HIPAA)

Basado en recomendaciones del Departamento de Salud y Servicios Humanos, Medicare implementó un Plan de Contingencia para que de forma temporera se aceptarán reclamaciones electrónicas en formato pre-HIPAA para mantener el flujo de efectivo en la industria del cuidado de la salud luego del 16 de octubre del 2003 y, dado el hecho de que sólo 33% de las reclamaciones de Medicare cumplían con el formato requerido por HIPAA. Este plan de contingencia provee tiempo adicional a aquellas entidades cubiertas que han demostrado un esfuerzo por cumplir con los requisitos de HIPAA.

Bajo la modificación al Plan de Contingencia las reclamaciones electrónicas sometidas en formato HIPAA, formato 4010A X12N, continuarán con el período de pago de 14 días luego de la fecha de recibo. En cambio, a las reclamaciones electrónicas recibidas en formato pre-HIPAA se les aplicará un período de pago de 27 días luego de la fecha de recibo. **A manera de ejemplo, reclamaciones en formato HIPAA recibidas el 1 de julio de 2004 pueden pagarse tan pronto como el 15 de julio de 2004. Sin embargo, reclamaciones en formato pre-HIPAA recibidas el 1 de julio de 2004 se pagarán no antes del 28 de julio de 2004.**

Medicare continuará aceptando reclamaciones en formato pre-HIPAA por tiempo limitado para no interrumpir los pagos a proveedores. Este cambio al Plan de Contingencia debe servir de incentivo para moverse al formato requerido por HIPAA. Esta medida va encaminada a eventualmente eliminar el plan de contingencia para todas las reclamaciones.

Fechas Importantes:

Medicare instruyó a los Intermediarios y Contratistas a aplicar este reglamento el 6 de julio de 2004. Esta regla aplicará a todas las reclamaciones recibidas del 1ero de julio de 2004 en adelante.

Información Adicional:

Los Contratistas de Medicare ofrecen un programa de facturación gratis o a bajo costo que cumple con los requisitos de HIPAA. Llame a nuestro Departamento de EMC al (787) 749-4949, extensión 2381, para obtener copia del programa.

Based on guidance issued by the Department of Health and Human Services to maintain cash flow in the health care industry beyond October 16, 2003 and the fact that only 33 per cent of Medicare's electronic claims were in HIPAA formats as of that date, Medicare implemented a contingency plan to temporarily allow electronic claims to continue to be submitted in a pre-HIPAA format. This was done to provide those members of the healthcare community, who demonstrate a good faith effort to comply, additional time to become HIPAA compliant.

*Under the subject modification to the October 16, 2003, contingency plan, those claims submitted electronically **and** in a HIPAA-compliant format, **4010A1** X12N format, will continue to be considered as eligible for Medicare payment on the 14th day after the date of receipt. Claims submitted electronically in a pre-HIPAA format under a Medicare contingency plan, will be considered as eligible for Medicare payment on the 27th day after the date of receipt. **As an example, HIPAA compliant claims received on July 1, 2004, can be paid as early as July 15, while a claim that is not HIPAA compliant and is received electronically on July 1, 2004, can be paid no earlier than July 28.***

Medicare is continuing to allow claims to be submitted in a pre-HIPAA format for a limited time to maintain provider payments, but this modification of the contingency plan should provide an incentive for moving to HIPAA formats quickly. This is a measured step toward ending the contingency plan for all incoming claims.

Important Dates:

Medicare has instructed its carriers and intermediaries to begin enforcing these rules on July 6, 2004 and the rules will apply to claims received on or after July 1, 2004.

Additional Information:

CMS has instructed its Medicare carriers and intermediaries to make available free/low cost software that will enable submission of HIPAA compliant claims electronically. Contact your

Health Insurance Portability and Accountability Act (HIPAA)

Para facturación de reclamaciones Medicare Parte B visite: http://www.cms.hhs.gov/providers/edi/bnum.asp.

Para información adicional de HIPAA visite: http://www.cms.hhs.gov/hipaa/hipaa2/default.asp.

Para ver la sección revisada del manual sobre el recibo de reclamaciones puede dirigerse al Capítulo 1, Sección 80.2.1.2 que encontrará en la Publicación 100-04, Manual del Procesamiento de Reclamaciones de Medicare en:http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp.

Para ver las instrucciones emitidas por los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) a los Intermediarios y Contratistas visite:http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

Una vez entre a la página diríjase a la columna con título "CR NUM" y haga clic en el archivo con nombre **2981**.

CR2981/Trans. 114/Pub. 100-04 MCP/02-27-04/S/els

carrier or intermediary in order to obtain this software at their special EDI number. For those billing Medicare Part A (including hospital outpatient services), a list of these numbers by State is available at: http://www.cms.hhs.gov/providers/edi/anum.asp.

For those billing Medicare Part B, you may find those numbers listed by State at: http://www.cms.hhs.gov/providers/edi/bnum.asp.

For additional information on HIPAA, visit the CMS Web site at: http://www.cms.hhs.gov/hipaa/hipaa2/default.asp.

To view the revised manual chapter for the claims receipt rules, see Chapter 1, Section 80.2.1.2, which can be found in Pub 100-04, the Medicare Claims Processing Manual. This can be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp.

To view the actual instruction issued by CMS to your carrier or intermediary, visit: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

*Once at that site, scroll down the CR NUM column to **2981** and click on that file.*

HIPAA X12N 837 COMPANION DOCUMENT

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically from the following Web site http://www.wpcedi.com. The following information is intended to serve only as a companion document to the HIPAA X12N 837 implementation guides. The use of this document is solely for the purpose of clarification. The information describes specific requirements to be used for processing data in the VMS system of Triple-S Contractor number 00973. The information in this document is subject to change. Changes will be communicated in the standard Medicare ListServ monthly news bulletin and on Triple-S Web site: www.triples-med.org . This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

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Interchange Control Header				
	ISA06	Interchange Sender ID	Triple-S will reject an interchange (transmission) that does not contain a valid ID in ISA06	B.4
	ISA08	Interchange Receiver ID	Triple-S will reject an interchange (transmission) that does not contain 00973.	B.5
Loop	**Transaction Set**			
1000A	NM109	Submitter ID	Triple-S will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission	69
2000B	SBR02, SBR09	Subscriber Information	Subscriber Information R For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used	111
2010BD		Credit/Debit Card Information	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop)	150
Loop	**Claim Information**			
2300	CLM02	Total Submitted Charges	Negative values submitted in CLM02 [will/may] not be processed and will result in the claim being rejected	172
2300	CLM02	Total Submitted Charges	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102)	172
2300	CLM05-3	Claim Frequency Type Code	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" may be rejected	173
2300	CLM20	Delay Reason Code	Data submitted in CLM20 will not be used for processing	179
2300	AMT01	Credit/Debit Card Maximum Amount	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop)	219
2300	AMT02	Patient Amount Paid	Negative values submitted in the following fields will not be processed and may result in the claim being rejected: AMT02	220
2300	AMT02	Total Purchased Service Amount	Negative values submitted in the following fields will not be processed and may result in the claim being rejected: AMT02	221
2300	CR102, CR106	Ambulance Transport Information	Negative values submitted in the following fields will not be processed and may result in the claim being rejected: CR102, CR106	249, 250
2300	HI	Health Care Diagnosis Code	Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes	265
2300	HI	Health Care Diagnosis Code	You may send up to eight diagnosis codes per claim. If diagnosis codes are submitted, you must point to the primary diagnosis for each service line.	265
2320	AMT02	Coordination of Benefits Amounts	Negative values submitted in the following fields will not be processed and may result in the claim being rejected: AMT02	332, 333

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Loop	Claim Information			
2400	SV104	Professional Service	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes may be rejected. (SV104)	403
2400	SV104	Professional Service	SV104 (Service unit counts) (units or minutes) cannot exceed 999.9	403
2400	SV104	Professional Service	Negative values submitted will not be processed and may result in the claim being rejected. (SV104)	403
2400	PS102	Purchased Service	Negative values submitted in PS102 will not be processed and may result in the claim being rejected	490
997 – Acknowledgement Report				
			We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission	B.15
			Triple-S will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997	
			Dates that are submitted on an inbound 837 transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit valid calendar dates will result in the rejection of the applicable interchange (transmission)	

997 – Acknowledgement Report Additional Requirements Unique to Triple-S, Inc. Medicare	Descriptions
	The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 may be rejected
	Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. In certain circumstances, the percent can be less than two positions to the left or the right. Percent amounts that exceed their COBOL PIC clause will be rejected
	Triple-S will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case
	Only loops, segments, and data elements valid for the HIPAA Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected
	The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^, |, and :. Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected

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997 – Acknowledgement Report Additional Requirements Unique to Triple-S, Inc. Medicare	Descriptions
	You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set may cause the interchange (transmission) to be rejected at the carrier translator.
	Medicare does not require taxonomy codes be submitted in order to adjudicate claims, but will accept the taxonomy code, if submitted. However, taxonomy codes that are submitted must be valid against the taxonomy code set published at www.wpc-edi.com/codes. Claims submitted with invalid taxonomy codes will be rejected
	All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission)
	Triple-S may reject an interchange (transmission) submitted with more than 9,999 loops
	Triple-S will reject an interchange (transmission) submitted with more than 9,999 segments per loop
	Triple-S will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction
	Compression of files is not supported for transmissions between the submitter and Triple-S
	Only valid qualifiers for Medicare should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing may cause the claim or the transaction to be rejected
	You may send up to four modifiers; however, the last two modifiers may not be considered. The Triple-S processing system may only use the first two modifiers for adjudication and payment determination of claims.

CR2900/12-20-03/js

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

Las tablas que aparecen en las páginas 14 y 15 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 14 and 15 identifies those providers and billing software vendors that have successfully completed “HIPAA X12N 837 Professional” testing with Triple-S, Inc. / Medicare Division. Their programs may be used by Medicare providers to submit X12N electronic claims.

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Vendor Name and Program Name	Claims Type Tested	Address and Telephones	837 Production Version	Certification Date of HIPAA Tests
MASS: Medical Accounting VisualMass 7.0	- Visit/Consultation - Laboratory Procedure - Surgery Procedure	PO Box 397 Manatí, PR 00674 787-854-8638 787-884-7214	004010X098	9/12/2002
Medical Computer System Medical Biller V7	- UPIN - Visit/Consultation - Diagnostic Tests - Laboratory Procedure	4 Calle Barcelona URB Torrimar Guaynabo PR 00966 medbiller@coqui.net 787-793-8833 Fax:787 793-8299	004010X098	10/25/2002
Structured Systems Corp Medical Practice 6.2	- Visit/Consultation - Diagnostic Tests - Referring Provider/UPIN - Surgery Procedure - Procedimientos de	PO Box 50335 Levittown, PR 00950 787-795-5072	004010X098 004010X098A1	9/20/2002 9/15/2003
TurboMed, Inc. TurboMed ver. 1.01	- Visit/Consultation - Diagnostic Tests - Referring Provider/UPIN	Box 1811 Arecibo, PR 00613 787-898-1437	004010X098 004010X098A1	9/25/2002 9/23/2003
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	10/9/2002
Advance Data Support MedOne Ver. 2.0	- Visit/Consultation	PO Box 8512 Bayamón, PR 00960 787-269-3830 787-269-5620 787-841-0396	004010X098	10/11/2002
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	11/6/2002
Air Information Systems Medi+2000	- Visit/Consultation - Diagnostic Tests - UPIN - Ambulancia	PO Box 270152 San Juan, PR 00927-0152 Tel.: 787-294-1161 787-793-0046 Fax: 787-775-4123	004010X098 004010X098A1	4/24/2003 9/15/2003
The Right Answer TRA Medical Billing System	- 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 Tel. 787-272-8787 787-643-3738 FAX: 787-272-6106	004010X098	4/15/2003
Lab Warehouse, Inc. Best 2000 Ver. 20030520	- Laboratory Procedures	13 Calle 65 de Infantería Esq. Calle Concordia Lajas, PR 00667 Tel. 787-899-2900	004010X098	4/16/2003
WebMD	- Radiology Services - UPIN	26 Century Boulevard Nashville TN 37214	004010X098	6/30/2003
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 787-763-1262 FAX	004010X098 004010X098A1	6/27/2003 9/23/2003

Vendor Name and Program Name	Claims Type Tested	Address and Telephones	837 Production Version	Certification Date of HIPAA Tests
Lamars Computerized 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	6/11/2003 9/15/2003
Computer Softek Inc. WinMBS Versión: 3.0	- Visit/Consultation - UPIN	POBox 190408 San Juan, PR 00919-0408 787-751-5196 787-565-8514 www.winmbs.com softek@prtc.net	004010X098	6/27/2003
JCL Systems, Inc. Med Center	-Visit/Consultation -Laboratory Procedure -Surgery Procedure	Box 144 53 Ave. Esmeralda Guaynabo PR 00969 787-630-7881	004010X098 004010X098A1	2/24/2003 9/15/2003
Simplesoft PR Inc. Medical Orders System	- Visit / Consultation - UPIN - MSP Claims	210 Sol San Juan PR 00901 787-696-4594	004010X098	7/28/2003
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	10/6/2003
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	10/15/2003
OFFI-PLUS, INC OFFI-MED 7.02	- Visit / Consultation - Surgery	PO Box 1132 Trujillo Alto, PR 787-283-0804 PCS 787-642-9035 FAX: 787-292-0222 offiplus@prtc.net	004010X098A1	10/15/2003
Aranay Interactive Systems InstantMed Version 7.0	- Anesthesia Procedure - UPIN	609 Miramar Ave. Suite 101 787-225-4466 apinzon@aranay.com	004010X098A1	10/22/2003
Multi Soft Developers, MSD WABS MEDICAL BILLING	- Radiology Services - UPIN	Ave. Americo Miranda #1110 787 793-5725 787 783-3266 www.genius-msd.com	004010X098A1	10/22/2003
Infomedika, Inc. IUHP ver. 3	- Visit / Consultation - UPIN	http://www.infomedika.com/ ctorres@infomedika.com 787-620-2474	004010X098A1	10/22/2003
MCPC	- Visit / Consultation - UPIN	787-765-3638	004010X098A1	12/26/2003
Inmediata	- Visit / Consultation	636 San Patricio Ave. San Juan, PR 00920 (787) 774-6969 (787) 277-0980 www.inmediata.com	004010X098A1	2/6/2004

Updated: March 12, 2004

Health Insurance Portability and Accountability Act (HIPAA)

MANDATORY ELECTRONIC SUBMISSION OF MEDICARE CLAIMS

Section 3 of the Administrative Simplification Compliance Act (ASCA), requires that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, except from small providers and other limited exceptions. Initial claims are those claims submitted to a Medicare fee-for-service carrier, DMERC, or intermediary for the first time, including resubmitted previously rejected claims, demand bills, claims where Medicare is secondary and there is only one primary payer, and non-payment claims. Initial claims do not include adjustments submitted to intermediaries on previously submitted claims or appeal requests.

Medicare will not cover claims submitted on paper that do not meet the limited exception criteria. Claims denied for this reason will contain claim adjustment reason code 96 (None covered charge(s)) and remark code M117 (Not covered unless submitted via electronic claim).

Claims required to be submitted electronically effective October 16, 2003 and thereafter must comply with the appropriate claim standards adopted for national use under HIPAA or with standards supported under the Medicare HIPAA contingency plan during the period that the plan is in effect. The mandatory electronic claim submission requirement does not apply to claims submitted by providers that only furnish services outside of the United States, Puerto Rico and U.S. Virgin Islands, claims submitted to Medicare Managed Care Plans, or to health plans other than Medicare.

Providers that do not qualify for a waiver as small and that do not meet any of the remaining exception or waiver criteria must submit their claims to Medicare electronically.

Small Providers

A “small provider” is:

- A provider of services with fewer than 25 Full-Time Equivalent (FTE) employees; or
- A physician, practitioner, facility or supplier that is not otherwise a provider under section 1861(u) of the Social Security Act with fewer than 10 FTEs.

To simplify implementation, Medicare will consider all providers that have fewer than 25 FTEs and that are required to bill a Medicare intermediary to be small; and will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier or DMERC to be small.

Full Time Equivalent Definition and Calculation Methodology

The ASCA law and regulation do not modify pre-existing laws or employer policies defining full time employment. **Each employer has an established policy, subject to certain non-Medicare State and Federal regulations, that define the number of hours employees must work on average on a weekly, biweekly, monthly, or other basis to qualify for full-time benefits.** Some employers do not grant full-time benefits until an employee works an average of 40 hours a week, whereas another employer might consider an employee who works an average of 32 hours a week to be eligible for full-time benefits. An employee who works an average of 40 hours a week would always be considered full time, but employees who work a lesser number of hours weekly on average could also be considered full time according to the policy of a specific employer.

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Health Insurance Portability and Accountability Act (HIPAA)

Everyone on staff for whom a health care provider withholds taxes and files reports using an Employer Identification Number (EIN) is considered an employee, including if applicable, a physician(s) who owns a practice and provides hands on service and those support staff who do not furnish health care services but do retain records of, perform billing for, order supplies related to, provide personnel services for, and otherwise perform support services to enable the provider to function. Unpaid volunteers are not employees. Individuals that perform services for a provider under contract, such as individuals employed by a billing agency or medical placement service, for whom a provider does not withhold taxes, are not considered members of a provider's staff for FTE calculation purposes when determining whether a provider can be considered as "small" for electronic billing waiver purposes.

Medical staff sometimes work part time, or may work full time but their time is split among multiple providers. Part-time employee hours must also be counted when determining the number of FTEs employed by a provider. For example, if a provider has a policy that anyone who works at least 35 hours per week on average qualifies for full-time benefits, and has 5 full-time employees and 7 part-time employees, each of whom works 25 hours a week, that provider would have 10 FTEs (5+(7 x 25 = 175 divided by 35=5). **The provider is the one that determines if an employee is a full-time or part-time employee regardless of the hours worked up to a maximum of 40 hours per week.**

Nevertheless, small providers are encouraged to submit as many of their claims electronically as possible.

Exceptions

In some cases, it has been determined that due to limitations in the claims transaction formats adopted for national use under HIPAA, it would not be reasonable or possible to submit certain claims to Medicare electronically. Providers are to self-assess to determine if they meet these exceptions. At the present time, only the following claim types are considered to meet this condition:

1. Roster billing of vaccinations covered by Medicare - Although flu shots and similar covered vaccines and their administration can be billed to Medicare electronically, one claim for one beneficiary at a time, in the past, some providers have been allowed to submit a single claim on paper with the basic provider and service data to which was attached a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. The claim implementation guides adopted under HIPAA can submit single claims to payer for single individuals, but cannot be used to submit a single claim for multiple individuals.

   Flu shots are often administered in senior citizen centers, grocery stores, malls and other locations in the field. It is not always reasonable or hygienic to use a laptop computer to register all necessary data to enable a HIPAA-compliant claim to be submitted electronically in such field situations. Due to the low cost of these vaccinations, it is not always cost effective to obtain all of the data normally needed for preparation of a HIPAA-compliant claim. Such providers rarely have a long-term health care relationship with their patients and do not have a need for the extensive medical and personal history routinely collected in most other health care situations.

   It is in the interest of Medicare and public health to make it as simple as possible for mass immunization activities to continue. Although providers are encouraged to submit these claims to Medicare electronically, one claim for one beneficiary at a time, this is not required. In the absence of an electronic format that would allow a single claim for the same service to

be submitted on behalf of multiple patients using abbreviated data, providers currently allowed to submit paper roster bills may continue to submit paper roster bills for vaccinations. Providers that furnish vaccinations and other medical services or supplies must bill those other medical services or supplies to Medicare electronically though unless the provider qualifies as "small" or meets other exception criteria.

This vaccination waiver applies only to injections such as flu shots frequently furnished in non-traditional medical situations, and does not apply to injections furnished in a traditional medical setting such as a doctor's office or an outpatient clinic when supplied as a component of other medical care or examination. In traditional medical situations where the provider is required to bill the other services furnished to the patient electronically, the flu shot or other vaccination is also to be included in the electronic claim sent to Medicare for the patient.

2. Claims for payment under a Medicare demonstration project that specifies paper submission-by their nature, demonstration projects test something not previously done, such as coverage of a new service.

3. Medicare Secondary Payment Claims (MSP) - The claim formats adopted for national use under HIPAA include segments for provider or payer use to submit secondary claims. Nonetheless, the claim formats adopted under HIPAA do not currently contain the ability to report individual service level payments made by more than one primary payer.

   The paper claim format has no fields for reporting of any primary payment data when Medicare is secondary. When paper claims are submitted, a copy of the primary plan's Explanation of Benefits (EOB) must always be attached if there is one or more payers that pay prior to Medicare. Since the HIPAA claim formats do allow service level data to be submitted electronically when there is only one payer primary to Medicare, those claims can be sent to Medicare electronically. When more that one payer is primary, the formats cannot accommodate this additional reporting and the only alternative is for providers to submit those claims to Medicare on paper with copies of the EOBs/Remittance Advices (RAs).

   The payment segments of the claim formats adopted under HIPAA include fields for reporting of the identity of the primary payer, service procedure code, allowed amount, payment amount and claim adjustment reason codes and amounts applied by the other payer when the billed amount of the service was not paid in full. These segments correspond to segments reported in the X12 835 remittance advice format. Since the HIPAA requirements apply only to electronic transactions, and not to paper transactions such as paper EOBs or RA notices, there is no requirement that payers use the same codes in their paper EOBs or RAs as in their electronic RAs. Medicare uses the same code set in both paper and electronic RAs, but other payers may not. Payers can elect to use different code sets in their paper transactions than their electronic transactions, r to use text messages in their paper transactions and not use codes at all. Payers that do not use the standard claim adjustment reason codes in their paper EOBs or RAs, generally use proprietary codes or messages for which there is no standard crosswalk to the 835 claim adjustment reason codes.

   Providers that receive those paper EOBs/RAs cannot reasonably furnish standard claim adjustment reason codes for use in the HIPAA claim and COB formats. As a result, when there is only one payer primary to Medicare and those claims must be sent to Medicare electronically, those providers cannot complete the situational CAS segment for those claims. The coordination of benefits implementation guide adopted under HIPAA does not require that this

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segment be completed in this situation. Although this will prevent the primary payer data in the claim from balancing, akin to balancing when the data is reported in an 835 transaction that is acceptable. There is no requirement in the implementation guide that these payment segments balance in a claim transaction. Providers should not try to convert non-standard messages or codes to standard claim adjustment reason codes to submit these claims to Medicare electronically. Medicare does not use the CAS segment data elements to calculate the Medicare payment in any case. Providers must, however, still report the primary's allowed, contract amount when Obligation to Accept in Full (OTAF) applies, and payment amounts for the individual services to enable Medicare to calculate payment.

4. Claims submitted by Medicare beneficiaries.
5. **Sending Attachments for Electronic Claims-**Presently, our free billing software does not provide technical support for claim attachments. Therefore, a paper claim should be submitted for those services where attachments are required.

"Unusual Circumstance" Waivers

Congress granted the Secretary considerable discretion to decide what other circumstance should qualify as "unusual circumstance" for which a waiver of the electronic claim submission requirement would be appropriate. The Secretary delegated that authority to The Centers for Medicare and Medicaid Services (CMS). In the event it is determined that enforcement of the electronic claim submission requirement would be against equity and good conscience as result of an "unusual circumstance," CMS will waive the electronic claim submission requirement for temporary or extended periods. In those situations, providers are encouraged to file claims electronically where possible, but electronic filing would not required.

CMS has in turn delegated certain authority to the Medicare contractors (carrier, DMERC, or intermediary) to determine whether an "unusual circumstance" applies. Providers who feel they should qualify for a waiver as result of an "unusual circumstance" must submit their waiver request to the Medicare carrier, DMERC or intermediary to whom they submit their claims. Waiver requests submitted by providers should include the: providers' name, address, contact person, the reason for the waiver, why she/he considers enforcement of the electronic billing requirement to be against equity and good conscience, and any other information that the contractor would deem appropriate for evaluation of the waiver request.

In some cases, an "unusual circumstance" or the applicability of one of the other exception criteria may be temporary; in which case, the related waiver would also be temporary. Once the criteria no longer applied, that provider would again be subject to the requirement that claims be submitted to Medicare electronically. Likewise, some exception and waiver criteria apply to only a specific type of claim, such as secondary claims when more than one other payer is primary. Other claim types not covered by an exception or waiver must still be submitted to Medicare electronically, unless the provider is small or meets other unusual circumstance criteria.

To request a waiver, please submit your request to:

Waiver for Unusual Circumstance
Systems Department
Medicare Division/Triple-S Inc.
PO Box 71391
San Juan, PR 00939-1391

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Health Insurance Portability and Accountability Act (HIPAA)

Unusual Circumstance Waivers Subject to Provider Self-Assessment

The following circumstances always meet the criteria for waiver. Providers that experience one of the following "unusual circumstance" are automatically waived from the electronic claim submission requirement. A provider is expected to self-assess when one of these circumstances applies, rather than apply for contractor or CMS waiver approval. A provider may continue to submit claims to Medicare on paper when one of these circumstances applies. A provider is not expected to pre-notify their Medicare contractor that one of the circumstances applies as a condition of paper submission.

1. Dental claims-Medicare does not provide dental benefits. Medicare does cover certain injuries of the mouth that may be treated by dentists, but those injury treatments are covered as medical benefits. Less than .01 percent of Medicare expenditures were for oral and maxillofacial surgery costs in the calendar year 2002. The X12 837 professional implementation guide standard for submission of medical claims requires submission of certain data that is not traditionally reported in a dental claim but which is needed by payers to adjudicate medical claims. As a result, Medicare contractors have not implemented the dental claim standard adopted for national use under HIPAA. Due to the small number of claims they would ever send to Medicare, most dentists have not found it cost effective to invest in software they could use to submit medical claims to Medicare electronically. For these reasons, dentists will not be required to submit claims to Medicare electronically. They can continue to submit claims, when appropriate, to Medicare on paper.
2. Disruption in electricity or phone/communication services—In the event of a major storm or other disaster outside of a provider's control, a provider could lose the ability to use personal computers, or transmit data electronically. If such a disruption is expected to last more than 2 business days, all of the affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be 2 business days or less, providers should simply hold claims for submission when power and/or communication are restored.
3. A provider is not small based on FTEs, but submits fewer than 10 claims to Medicare per month on average (not more than 120 claims per year). This would generally apply to a provider that rarely deals with Medicare beneficiaries.
4. Non-Medicare Managed Care Organizations that are able to bill Medicare for co-payments may continue to submit those claims on paper. These claims cannot be processed by the MSPPay module and must be manually adjudicated by Medicare contractors.

Unusual Circumstance Waivers Subject to Medicare Contractor Approval

Medicare contractors may at their discretion approve a single waiver for up to 90 days after the date of the decision notice for a provider if the contractor considers there to be "good cause" that prevents a provider to submit claims electronically for a temporary period. "Good cause" would apply if a provider has made good faith efforts to submit claims electronically, but due to testing difficulties, or a similar short-term problem that the provider is making reasonable efforts to rectify, the provider is not initially able to submit all affected claims electronically effective October 16, 2003.

Cont. on next page

Health Insurance Portability and Accountability Act (HIPAA)

In the event that a provider cites an inability to submit certain primary or secondary claims to Medicare electronically as a result of the inability of their commercial HIPAA-compliant software to submit these claims, Medicare contractors may approve a single waiver for up to 180 days after the date of the decision notice to allow adequate time for the provider to obtain and install an upgrade from their vendor, or to transition to software from another vendor that can submit these claims electronically.

Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision

A provider may submit a waiver request to their Medicare contractor in the following "unusual circumstances." It is the responsibility of the provider to submit documentation appropriate to establish the validity of the waiver request in these situations. Requests received without documentation to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied.

1. Provider alleges that the claim transaction implementation guides adopted under HIPAA do not support electronic submission of all data required for claim adjudication. (If a waiver is approved in this case, it will apply only to the specific claim type(s) affected by the implementation guides deficiency.)
2. A provider is not small, but all those employed by the provider have documented disabilities that would prevent their use of a personal computer for electronic submission of claims.
3. Any other unusual situation that is documented by a provider to establish that enforcement of the electronic claim submission requirement would be against equity and good conscience.

Electronic and Paper Claims Implications of Mandatory Electronic Submission

Medicare carriers, DMERCs, and intermediaries will assume, for processing purposes, that claims submitted by a provider on paper October 16, 2003 and thereafter are submitted by providers that are small or that do meet exception criteria, barring information received from other sources to the contrary. Submission of a paper claim October 16,2003 and thereafter will be considered an attestation by a provider that waiver criteria are met at the time of submission.

In the event contractor staff members realize that a particular provider does not meet any of the exception criteria, paper claims submitted by that provider may be rejected in the mailroom without entry of those claims.

Enforcement will be conducted on a post-payment basis and will entail targeted investigation of providers that appear to be submitting extraordinary numbers of paper claims. If an investigation establishes that a provider incorrectly submitted paper claims, the provider will be notified that Medicare will deny any paper claims submitted after a certain date (a reasonable period will be allowed for implementation of necessary provider changes).

CR 2966/ Transmittal 44/December 19, 2003/dg/els

Health Insurance Portability and Accountability Act (HIPAA)

ACTUALIZACIÓN DEL PAGO DE RECLAMACIONES POR JURISDICCIÓN

Para reclamaciones recibidas del 1ro de abril de 2004 en adelante el pago jurisdiccional de los servicios sujetos a las Tarifas fijas para Médico y los servicios de anestesia se determinarán conforme al código postal donde se ofreció el servicio.

- Un proveedor que presta servicios ena localidad fuera de su jurisdicción tendrá que inscribirse con el contratista que tiene esa jurisdicción y reunir todos los criterios de inscripción con ese contratista.
- Cuando se facture por pruebas compradas en el Formulario CMS-1500, cada prueba debe someterse por separado. De esta manera, el código postal adecuado y el precio de compra de cada prueba se someterán y el contratista podrá pagar la tarifa correcta.
- El encasillado 32 del Formulario CMS-1500 se limita al nombre y la dirección del lugar de servicio. En muchos casos, cuando se compra una prueba, la misma se prestará en un lugar de servicio diferente de donde se realizó la interpretación. Por lo tanto, el médico solamente puede facturar en la misma reclamación por una prueba comprada y la interpretación cuando los servicios son ofrecidos en la misma fecha del servicio y en el mismo lugar de servicio.
- Para que los contratistas determinen donde los servicios se prestaron y así poder pagar correctamente las tarifas conforme a la localidad, el proveedor no debe anotar más de un nombre, dirección y código postal en el encasillado 32 del Formulario CMS-1500.
- Las reclamaciones electrónicas por servicios comprados se pueden someter con la interpretación y la producción de la prueba en la misma reclamación. No obstante, la información sobre el lugar de

CLAIM JURISDICTION PAYMENT UPDATE

Effective for claims received on April 1, 2004 and thereafter, jurisdictional payment of services paid under the Medicare Physician Fee Schedule and anesthesia services will be made based on the zip code of where the service is provided.

- *A provider that renders services in a locality outside of the carrier's jurisdiction will have to enroll with the carrier that has that jurisdiction and meet all the enrollment criteria with that carrier.*
- *When billing for purchased tests on the Form CMS-1500 paper claim form, each test must be submitted on a separate claim form. In this way, the appropriate service facility location zip code and the purchase price of each test will be submitted and the carrier will be able to pay the correct reimbursement rates.*
- *Item 32 on the Form CMS-1500 paper claim is limited to one service facility location name and address. In most cases when a test is purchased, it has been rendered at a different service facility location from where the interpretation is performed. Therefore, a physician may only bill for a purchased test and an interpretation on the same claim when the services are rendered on the same date of service and at the same service facility location, and are submitted with the same place of service codes.*
- *In order for carriers to correctly determine where services were provided and pay correct locality rates, no more than one name, address, and zip code may be entered in Item 32 of the Form CMS-1500.*
- *Electronic claims submitted for purchased services may be submitted with the interpretation and the test on the*

servicio deberá indicarse en cada línea de la reclamación de manera que el contratista adjudique correctamente el pago. Si la información no se somete, el contratista presumirá que los servicios se prestaron en el mismo lugar de servicio.

- Las reclamaciones por múltiples pruebas compradas pueden someterse por medios electrónicos mientras la información del lugar de sercivio sea sometida cuando los servicios son ofrecidos en diferentes lugares y la cantidad de los servicios comprados es sometida para cada prueba comprada.

- De acuerdo a la guía de implementación de la versión 4010/4010A1 del formato ANSI X12N837, se acepta que las reclamaciones contengan el código para el lugar de servicio (POS, por sus siglas en inglés) y cualquier número de códigos adicionales de lugar de servicio. Si se usan códigos de lugares de servicio diferentes para servicios en la reclamación, la localidad y la dirección del lugar de servicio deben añadirse para cada servicio en cada línea de la reclamación, si la localidad es diferente al proveedor que factura, al proveedor que se le paga o el lugar de servicio de la reclamación.

- Para determinar la información relacionada al lugar donde se ofreció un servicio, puede referirse a la implantación de la guía actual del formato ANSI X12N837. De acuerdo a la documentación, aunque la dirección no debe aparecer en el "loop" titulado "dirección del lugar de servicio", la información debe continuar disponible en la reclamación en un "loop" relacionado.

- Sea la reclamación en papel o electrónica, los proveedores no deben someter el código global del servicio cuando un componente del servicio haya sido comprado. Para que los contratistas

same claim. In order for the carrier to pay the correct locality based fee, appropriate service facility service location information must be submitted at the line level when services are rendered at different locations. If line item data is not submitted, it will be assumed by the carrier that the services were rendered at the same service facility location.

- *Multiple purchased tests may be submitted on electronic claims as long as appropriate service facility location information is submitted when services are rendered at different locations and the appropriate total purchased service amounts are submitted for each purchased test.*

- *Per the implementation guide of the 4010/4010A1 version of the ANSI X12N 837, it is acceptable for claims to contain the code for place of service "home" and any number of additional place of service code (POS). If different POS codes are used for services on the claim, a corresponding service facility location and address must be entered for each service at the line level, if that location is different from the billing provider, pay-to-provider, or claim level service facility location.*

- *Refer to the current implementation guide of the ANSI X12N 837 to determine how information concerning where a service was rendered, the service facility location, must be entered on a claim. Per the documentation, though an address may not appear in the loop named "service facility address," the information may still be available on the claim in a related loop.*

- *Providers may not submit a global billing code on paper or electronic claims when one component of the service has been purchased. In order for carriers to determine payment jurisdiction and price services correctly, the technical and*

determinen correctamente la jurisdicción del pago y el precio de los servicios, los componentes técnico y profesional deben someterse en líneas separadas.

Todas las instrucciones mencionadas anteriormente aplican a las reclamaciones sometidas en papel y a las sometidas electrónicamente en el formato ANSI X12N; las reclamaciones en el Formato Estándar Nacional (NSF, por sus siglas en inglés) pueden facturarse como de costumbre.

professional components of the service must be submitted on separate lines of the claim.

All the above instructions apply to paper claims and ANSI X12N claims, claims in NSF shall be billed as usual.

Pub. 100-04/MCP/Trans. 6/CR 2912/ Oct. 17, 2003/FMR/dg
Pub. 100-04/MCP/Trans. 67/CR 3039/Jan. 16, 2004/JS

X12N 835 HEALTH CARE REMITTANCE ADVICE REMARK CODES UPDATE

The Centers for Medicare and Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list. The remittance advice code list is referenced in the 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.

CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities, and these additions and modifications may not impact Medicare. The list is updated three times a year. By April 1, 2004 the latest approved remark codes will be used in the 835 version 4010A1 and subsequent versions, the corresponding standard paper remittance advice transactions, and any other ANSI X12 transaction where these codes might be used. The complete list of remark codes is available at: http://www.wpc-edi.com/codes/Codes.asp and http://www.cms.hhs.gov/providers/edi/hipaadoc.asp.

Pub. 100-04 MCP/Tran. 93/CR-3122/February 6, 2004/JS

Medicare+Choice (M+C) Program

NEW ENROLLEE RIGHTS, NEW PROVIDER RESPONSIBILITIES IN M+C PROGRAM

Beginning on January 1, 2004, enrollees of Medicare+Choice (M+C) plans will have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their M+C plan's decision that Medicare coverage of their services from a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) should end. This new right stems originally from the Grijalva lawsuit and was established in regulations in a final rule published on April 4, 2003 (68 FR 16652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

What is "Grijalva"?

"Grijalva" is Grijalva v. Shalala – a class action lawsuit that challenged the adequacy of the Medicare managed care appeals process. The plaintiffs claimed that beneficiaries in Medicare managed care plans were not given adequate notice and appeal rights when coverage of their health care services were denied, reduced or terminated. Following extended legal negotiations - and significant changes to appeal procedures that resolved many issues - CMS reached a settlement agreement with plaintiffs and published a proposed rule based on that agreement in January 2001, and the final rule in April 2003.

New Regulations

Based on the provisions of the April 2003 final rule, SNFs, HHAs, and CORFs must provide an advance notice of Medicare coverage termination to M+C enrollees no later than 2 days before coverage of their services will end. If the patient does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in that State and the enrollee's M+C plan must furnish a detailed notice explaining why services are no longer necessary or covered. The review process generally will be completed within less than 48 hours of the enrollee's request for a review.

The new SNF, HHA, and CORF notification and appeal requirements distribute responsibilities under the new procedures among four parties:

1. The *M+C organization* generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. (In some cases, M+C organizations may choose to delegate these responsibilities to their contracting providers.)
2. The *provider* is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to all enrollees no later than 2 days before their covered services end.
3. The *patient/M+C enrollee* (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.
4. The *QIO* is responsible for immediately contacting the M+C organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end.

Again, these new notice and appeal procedures go into effect on January 1, 2004. You should be aware that the Medicare law (section 1869(b)(1)(F) of the Social Security Act) establishes a parallel right to an expedited review for "fee-for-service" Medicare beneficiaries, and we expect to implement similar procedures for these beneficiaries later in 2004.

Medicare+Choice (M+C) Program

What Do the New SNF, HHA, and CORF Notification Requirements Mean for Providers?

Notice of Medicare Non-Coverage (NOMNC)

The NOMNC (formerly referred to as the Important Medicare Message of Non-Coverage) is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS is developing a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider. The NOMNC essentially includes only two variable fields (i.e., patient name and last day of coverage) that the provider will have to fill in.

When to Deliver the NOMNC

Based on the M+C organization's determination of when services should end, the provider is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a 2-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. We encourage providers to work with M+C organizations so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

How to Deliver the NOMNC

The provider must carry out "valid delivery" of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

Expedited Review Process

If the enrollee decides to appeal the end of coverage, he or she must contact the QIO by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform the M+C organization and the provider of the request for a review and the M+C organization is responsible for providing the QIO and enrollee with a detailed explanation of why coverage is ending. The M+C organization may need to present additional information needed for the QIO to make a decision. Providers should cooperate with M+C organization requests for assistance in getting needed information. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

Importance of Timing/Need for Flexibility

Although the regulations and accompanying CMS instructions do not require action by any of the four responsible parties until 2 days before the planned termination of covered services, we want to emphasize that whenever possible, it's in everyone's best interest for an M+C organization and its providers to work together to make sure that the advance termination notice is given to enrollees as early as possible. Delivery of the NOMNC by the provider as soon as it knows when the M+C organization will terminate coverage will allow the patient more time to determine if they wish to appeal. The sooner a patient contacts the QIO to ask for a review, the more time the QIO has to decide the case, meaning that a provider or M+C organization may have more time to provide required information.

We understand the challenges presented by this new process and have tried to develop a process that can accommodate the practical realities associated with these appeals. With respect to weekends, for example, many QIOs are closed on weekends (except for purposes of receiving expedited review requests), as are the administrative offices of M+C organizations and providers. Thus, to the extent possible, providers should try to deliver termination notices early enough in the week to minimize the possibility of extended liability for weekend services for either M+C enrollees or M+C organizations, depending on the QIO's decision.

Similarly, SNF providers may want to consider how they can assist patients that wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to accumulate liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance and, thus, facilitate a faster and more simple discharge. We strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible.

We recognize that these new requirements will be a challenge—at least at first – and that there may be unforeseen complications that will need to be resolved as the process evolves. We intend to work together with all involved parties to identify problems, publicize best practices, and implement needed changes.

More Information

Further information on this process, including the NOMNC and related instructions can be found on the CMS website at: www.cms.hhs.gov/healthplans/appeals. (Also, see regulations 42 CFR 422.624, 422.626, and 489.27 and Chapter 13 of the M+C Manual.)

CR3044/Transmittal 41/Pub.100-20 OTN/January 9, 2004/els

CÓDIGO PARA DISPOSITIVO DE ASISTENCIA EN CONTRACCIÓN VENTRICULAR (VADS) PARA BENEFICIARIOS EN UN PLAN DE CUIDADO COORDINADO

Hacemos referencia al artículo publicado en el Volumen 76 del boletín Medicare Informa, página 38, en relación a la Cubierta Extendida para los Dispositivos de Asistencia en Contracción Ventricular.

Queremos indicarle que el código CPT para este servicio es el 33979, el cual describe correctamente el servicio como está implantado en el VAD intracorporeal.

CODE FOR VENTRICULAR ASSIST DEVICES (VADS) FOR BENEFICIARIES IN A MEDICARE + CHOICE PLAN

We make reference to the article published in Volume 76 of the Medicare Informa bulletin, page 38, in regard to the Expanded Coverage for Ventricular Assist Devices.

We want to indicate that the CPT code for this service is 33979, which correctly describes the service as implanting an intracorporeal VAD.

Pub. 100-04 MCP/Tran. 64/January 16, 2004/CR-3068/2985

ESTAFA AL PROGRAMA DE DESCUENTOS DE MEDICAMENTOS DE MEDICARE

Un beneficiario del Programa Medicare informó sobre supuestos representantes de Medicare que estaban realizando visitas de puerta en puerta orientando sobre el Programa de Descuentos de Medicamentos de Medicare. De acuerdo a la información suministrada, estos individuos representan falsamente a Medicare por teléfono y mediante visitas a las residencias de los beneficiarios para obtener información o identificación personal. En un caso particular, el falso representante tenía la información personal que identificaba al beneficiario y preguntó “el color de su casa” para asegurarse de que fue a la dirección correcta. El falso representante no dejó un nombre, número de teléfono ni tarjeta del negocio.

Es importante que los beneficiarios de Medicare no ofrezcan información personal ni muestren su identificación a individuos que se representen a sí mismos como oficiales de Medicare. El Programa Medicare no ha comenzado aún esfuerzos para inscribir, mercadear u ofrecer charlas sobre el Programa de Descuento de Medicamentos Recetados. Por tal razón, solicitamos la ayuda de aquellas personas que tengan conocimiento de que este tipo de actividad está ocurriendo en su área e informen los detalles a la siguiente dirección:

MEDICARE DISCOUNT DRUG PROGRAM SCAM

A Medicare beneficiary reported that supposed Medicare representatives were going door-to-door discussing the Medicare Discount Drug Program. According to the information provided, these individuals are misrepresenting Medicare over the telephone and on visits to Medicare beneficiary homes to obtain personal identifying information from the beneficiaries. In one particular case, the false representative had the beneficiary’s personal identifying information and asked for “the color of her house” to make sure he or she went to the correct address. The false representative did not leave a name, telephone number, or the business card.

It is important that Medicare beneficiaries should not be releasing their personal identifying information to individuals representing themselves as Medicare officials. The Medicare Program has not yet begun its enrollment, marketing, or outreach efforts for the Prescription Discount Drug Program. For that reason, we are asking for assistance from individuals who may be aware of this activity occurring in their areas by reporting it to the Medicare contractor to the following address:

Triple-S, Inc./Medicare Division
Community Relations Department
P.O. Box 71391
San Juan, PR 00936-1391

February, 2004/Stephen Quindoza/Tri-Centurion, LLC./RG

Proceso de Transferencia de Reclamaciones

CAMBIOS AL PROCESO DE TRANSFERENCIA DE ARCHIVOS PARA LOS SOCIOS DE NEGOCIO DE COORDINACIÓN DE BENEFICIOS

Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) decidieron facilitar el proceso de transferencia de archivos para propósitos de coordinación de beneficios entre Medicare y los Aseguradores Suplementarios (“crossover”). Los Aseguradores Suplementarios a Medicare tales como las Pólizas Complementarias (no-Medigap), Agencias Estatales de Servicios Medicaid (Titulo XIX) y los Seguros Medigap, conocidos colectivamente como Socios de Negocios para la Coordinación de Beneficios (COB, por sus siglas en inglés), elegibles a recibir directamente de CMS información de reclamaciones pagadas por Medicare para propósitos de calcular su obligación secundaria, no tendrán que firmar acuerdos individuales con cada contratista de Medicare.

Los Aseguradores pasarán en transición del proceso actual de Acuerdos de Socios de Negocios “Crossover” al nuevo acuerdo que se conoce como Acuerdos de Coordinación de Beneficios (COBA, por sus siglas en inglés). Los cambios en sistema y el período de pruebas comenzaron el 1 de enero de 2004. Durante este tiempo el Contratista de Coordinación de Beneficios (COBC, por sus siglas en inglés) y los Socios de Negocios “Crossover” estarán en transición al COBA. Estos acuerdos se ejecutarán directamente entre CMS y los Socios de Negocios COBA, los negociará el COBC y permitirán que cada Socio de Negocio COBA envíe al COBC un solo archivo nacional que incluya información de elegibilidad de cada beneficiario que asegura. Asimismo, cada Socio de Negocio COBA no tendrá que preparar ni enviar archivos de elegibilidad por separado al Contratista de Medicare ni recibirá numerosos archivos “crossover”. El COBC recaudará en nombre de CMS los honorarios de “crossover”

Claims Crossover Process

UPCOMING CHANGES TO THE TRADING PARTNERS CROSSOVER PROCESS

The Centers for Medicare and Medicaid Services (CMS) have decided to streamline the claims crossover process. Medicare Complementary Insurers, such as non-Medigap Plans, Title XIX State Medicaid Agencies and Medigap Plans, collectively known as Coordination of Benefits (COB) Trading Partners, that are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability, will no longer have to sign separate agreements with individual Medicare carriers.

Insurer entities will be transitioned from the current trading partner agreement process to new agreements called Coordination of Benefits Agreements (COBA). The systems changes and testing period will take place starting January 1, 2004. During which time the Coordination of Benefits Contractor (COBC) and the trading partners will transition to COBA. These agreements will be entered into directly between CMS and the COBA partners. These agreements will be negotiated by the COBC and will provide for each COBA partner to send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. Likewise, each COB Trading Partner will no longer need to neither prepare and send separate eligibility files to Medicare carriers nor receive numerous crossover files. The COBC will collect crossover fees from all COB Trading Partners (except for Title XIX State Medicaid Agencies which are exempt from such fees) on behalf of CMS.

Cont. on next page

Proceso de Transferencia de Reclamaciones

de todos los Socios de Negocio de COB (excepto de las Agencias Estatales de Servicios Medicaid (Título XIX) que están exentas de dichos honorarios).

A partir del 1 de enero de 2004 todos los aseguradores que interesen negociar Acuerdos de Coordinación de Beneficios pueden comunicarse con el Contratista de Coordinación de Beneficios al 1-800-999-1118. Mientras tanto, los Contratistas de Medicare continuarán llevando a cabo acuerdos con los **nuevos** Socios de Negocios "Crossover" hasta que todos entren en transición exitosa a los COBA.

Claims Crossover Process

*Starting January 1, 2004 all insurers willing to negotiate crossover agreements may contact the Coordination of Benefits Contractor at 1-800-999-1118. Meanwhile, Medicare contractors will continue to execute Trading Partner Agreements (TPA) with **new** trading partners until all trading partners have successfully transitioned to a COBA.*

CR2961-2962/Trans. 28 & 29/Pub. 100-04/11-7-2003/CG/els
JSM-RO-2399/December 23, 2003/els

NÚMERO DE TELÉFONO PARA PROVEEDORES

Recuerde que el número de teléfono de Medicare Parte B para Puerto Rico e Islas Vírgenes es el 1-877-715-1921. El número de teléfono local, (787) 749-4232, no estará disponible próximamente.

Comm. Relations/February, 2004/MMM

PROVIDERS TELEPHONE NUMBER

Remember that the Medicare Provider telephone number for Puerto Rico, St. Thomas, and St. Croix is 1-877-715-1921. The local number (787) 749-4232 will not be available soon.

Medlearn Matters
Information for Medicare Providers
CMS

EDICIÓN ESPECIAL

Anunciando el nuevo *"Medlearn Matters"...* Información para los Proveedores Medicare

RECURSO EDUCATIVO PARA LOS PROVEEDORES MEDICARE

Proveedores Afectados:

Todos los Proveedores de Medicare

Acción necesaria de parte del Proveedor:

Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) están comprometidos a colaborar con los médicos, proveedores y suplidores de Medicare para que los servicios que reciben los beneficiarios de Medicare estén a tiempo y sean de alta calidad. Una forma de proveer servicios de alta calidad a los pacientes de Medicare es asegurando que los proveedores tengan las reglas de coberturas y reembolsos más recientes y las políticas en una forma resumida, acertada y en un formato fácil de entender.

CMS reconoce que para los proveedores de Medicare esto es un poco difícil de lograr debido al número, frecuencia y complejidad de los cambios de Medicare. CMS también agradece la reacción de aquellos proveedores que han indicado a Medicare que las reglas y los cambios no siempre han sido trasmitidos de manera fácil, a tiempo y consistente.

Para dirigir estos asuntos, CMS implantó una nueva iniciativa dirigida a la "Consistencia en el Material a ser Enviado al Contratista de Medicare" designada a proveer información oportuna en los cambios de Medicare. El resultado de este esfuerzo es *Medlearn Matters....Information for Medicare Providers*, una serie de artículos preparados por médicos clínicos y expertos facturadores. Los artículos publicados en el

PREMIER EDITION

Announcing the New *Medlearn Matters...Information for Medicare Providers*

EDUCATIONAL RESOURCE FOR MEDICARE PROVIDERS

Provider Types Affected:

All Medicare providers.

Provider Action Needed:

The Centers for Medicare & Medicaid Services and your Medicare Learning Network introduces Medlearn Matters…Information for Medicare Providers, a new educational resource for Medicare Providers. Medlearn Matters… Information for Medicare Providers is designed to inform you of important changes to the Medicare system in a user-friendly format that will accommodate your busy schedule.

Please let us know if these articles help you understand these changes more readily. Provide us with suggestions for improvements to articles. If there is a special topic of interest that you believe warrants an article, let us know and we will consider a special edition for that topic. To provide feedback, please go to: http://www.cms.hhs.gov/medlearn/suggestform.asp. Bookmark this page, use it frequently, and let us know how best to continue providing good service to you.

The Centers for Medicare & Medicaid Services (CMS) is committed to partnering with the Medicare physician, provider, and supplier communities so services to Medicare beneficiaries can be timely and of the highest quality. One way of providing the best services to Medicare patients is assuring that the providers of care have ready access to Medicare's latest coverage and reimbursement rules and policies in a brief, accurate, and easy-to-understand format.

Medlearn Matters....Information for Medicare Providers están hechos en contenido y lenguaje para proveedores específicos afectados por los cambios en Medicare.

Anteriormente, cada contratista e intermediario de Medicare era responsable de crear artículos educativos casi al mismo tiempo de la publicación de los cambios de Medicare. Con este esfuerzo, el contratista o el intermediario fiscal de Medicare será responsable de ofrecer educación al proveedor. Sin embargo, ellos se beneficiarán de la disponibilidad de los artículos del *Medlearn Matters....Information for Medicare Providers* para apoyar sus esfuerzos. Estos artículos son fáciles de acceder de la página electrónica de *Medlearn,* la cual también provee acceso a otra información de Medicare.

Poder contar con la pericia de profesionales para desarrollar estos artículos y proveyéndolos a una localidad en particular resultará en una información más consistente, acertada y oportuna que en el pasado. Esta iniciativa completa y puede mejorar la habilidad de su contratista o intermediario para proveerle un mejor servicio.

Aquellos de ustedes que han dependido de los *"Program Memorandums y Manual Transmittals"* de Medicare que aparecen en la página electrónica, deben estar familiarizados con los documentos del *Change Request (CR)* y sus números. Sabemos que algunos proveedores acceden los CRs para obtener la más reciente información relacionada con los cambios futuros. No obstante, estos documentos no siempre son claros de entender para el proveedor.

Una de las razones es que esos *CRs* se escribieron para proveer instrucciones para los contratistas de Medicare, intermediarios y las personas que actualizan los sistemas de Medicare. Por eso, el enfoque del mensaje era muy diferente y probablemente contenía

CMS recognizes that the Medicare provider communities have been hampered by the number, frequency, and complexity of Medicare changes. CMS also appreciates the feedback from those same providers who indicate that Medicare rules and changes are not always relayed to them in an easy, timely, and consistent manner.

To address those issues, CMS has implemented a new initiative - "Consistency in Medicare Contractor Outreach Material" or CMCOM, designed to provide more timely information on Medicare changes. The product of this effort, Medlearn Matters…Information for Medicare Providers, is a series of articles prepared by actual clinicians and billing experts. Medlearn Matters…Information for Medicare Providers articles are tailored, in content and language, to the specific provider types who are affected by Medicare changes.

Previously, each Medicare carrier and intermediary was responsible for crafting educational articles within days of release of the related Medicare change. With this new effort, the Medicare carrier or fiscal intermediary will still be responsible for local provider education. However, they will benefit from the availability of Medlearn Matters…Information for Medicare Providers articles to support their efforts. These articles are easily accessible from the Medlearn Web site, which providers already access for other Medicare information.

Enlisting the expertise of medical professionals to develop these articles and providing them from a single location will result in more consistent, accurate, and timely information than in the past. This initiative supplements and should improve the ability of your carrier or intermediary to provide better service to you.

Those of you who have relied on Medicare Program Memorandums or Manual Transmittals on the Web, may be familiar with the Change Request (CR) documents and

más información de la que el proveedor necesitaba saber. La intención de los artículos en el *Medlearn Matters...Information for Medicare Providers* es ayudar a enfocar la información hacia los proveedores, dar solamente la información que necesita y ahorrarle tiempo en la búsqueda.

Los artículos se pondrán en la página electrónica de *Medlearn.* Cada número de los artículos corresponderá al número del "Change Request" (CR) que oficialmente anuncia el cambio, pero el número será presidido por las letras MM para indicar que está relacionado con el artículo del *Medlearn Matters...Information for Medicare Providers.* Hay excepciones designadas como Ediciones Especiales. Estos artículos serán numerados de manera distinta, como "SEyyn" donde "SE" significa Edición Especial, las "yy" son los dos dígitos de cuando se publicó el artículo y las "nn" es el número de la edición especial de ese año. Así que, el número de este primer artículo es SE0301.

Para poder ver todos los artículos disponibles, favor de visitar: http://www.cms.hhs.gov/medlearn/matters.

Esperamos que este nuevo medio sea de ayuda para usted y le invitamos a que nos deje saber su opinión.

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their accompanying CR numbers. Since you may have used the original CRs to get early information on upcoming changes, we think you will agree that those documents were not always clear as to provider impact and action needed.

One reason is that those CRs were written to provide instructions to Medicare carriers, intermediaries, and Medicare system maintainers. Thus, the focus of the message was quite different and probably contained more information than providers needed to know. The intent of Medlearn Matters…Information for Medicare Providers articles is to help focus the information more toward providers, to give you only the information you need and thus reduce the amount of time you need to spend on that information. The articles will be placed on the Medlearn Web site on the new Medlearn Matters…Information for Medicare Providers page. Each article's number will usually correspond to the number of the Change Request (CR) that officially announced the change, but the number will be preceded by MM to show it is a related Medlearn Matters…Information for Medicare Providers article. There are exceptions, designated as Special Editions. These articles will be numbered in a distinctive manner, as "SEyynn" where "SE" stands for Special Edition, the "yy" is the two-digit year the article was released, and "nn" is the number of the special edition for that year. Thus, this first Special Edition article is numbered as SE0301.

To view all the articles available , please visit: http://www.cms.hhs.gov/medlearn/matters

We hope you find this new vehicle of assistance to you and we invite your feedback.

"Disclaimer
Medlearn Matters articles are prepared as a service to the public and are not intended to grant rights or impose obligations. Medlearn Matters articles may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents".

Nuevas Páginas de Internet en CMS

ACTUALIZACIÓN A LAS PÁGINAS DEL WEB PARA PROVEEDORES/ SUPLIDORES

Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) comunican las nuevas direcciones electrónicas y las valiosas herramientas para proveedores en la página de Internet de los Centros para Servicios de Medicare & Medicaid (CMS) (http://www.cms.hhs.gov/). CMS desea asegurar que los proveedores y profesionales de la salud tengan acceso rápido y preciso de la información del Programa Medicare. Para mantener esta meta, las páginas en la Red específicas para proveedores-suplidores en la lista que se incluye más adelante son un recurso de una sola parada ("one-stop") enfocado en las necesidades de información e intereses de los proveedores de Medicare, incluyendo médicos y otros profesionales de la salud.

Las páginas de la Red específicas para proveedores-suplidores pueden accederse desde http://www.cms.hhs.gov/providers o http://www.cms.hhs.gov/suppliers. Desde la página principal de CMS seleccione "*Providers" desde la barra de navegación de la izquierda bajo "Topics"* o busque bajo el tabulador de "*Professionals"* o el menú hacia abajo ("drop-down menu").

La información especializada en estas páginas de una "sola parada" incluye enlaces con las Regulaciones y Avisos Federales, Peticiones de Transmisiones/Cambios y Preguntas Frecuentes. La información General incluye enlaces para Cubierta, Codificación, Integridad del Programa/Revisión Médica y otros asuntos que puedan ser de interés para todos los públicos. Cada página tiene también una sección de "*Highlights" para enfatizar información importante y oportuna tal como regulaciones* pertinentes, instrucciones o conferencias. Los proveedores, médicos y suplidores pueden ir a http://www.cms.hhs.gov/mailinglists para subscribirse a listas de servicios ("listservs") para varios públicos o categorías.

New Web Pages at CMS

NEW PROVIDER/SUPPLIER WEB PAGES

The Centers for Medicare & Medicaid Services' (CMS) announces the new Web page URL addresses and the valuable provider Web tools on the Centers for Medicare & Medicaid Services' (CMS) Web site (http://www.cms.hhs.gov/). CMS wants to ensure providers and health care practitioners have quick access to accurate Medicare program information. In keeping with this goal, the provider and supplier-specific Web pages listed below are a one-stop resource focused on the informational needs and interests of Medicare providers, including physicians and other practitioners.

Provider and supplier-specific Web pages can be accessed from http://www.cms.hhs.gov/providers or http://www.cms.hhs.gov/suppliers. From the CMS Home page, click on Providers *from the left navigation bar under* Topics *or search under the* Professionals *tab or drop-down menu.*

Specialized information on these one-stop resource pages includes links to Federal Regulations and Notices, Transmittals/ Change Requests, and Frequently Asked Questions. General information includes links for Coverage, Coding, Program Integrity/ Medical Review and a wealth of other subjects that would be of interest to all audiences. Each page also has a Highlights *section to emphasize important and timely information such as pertinent regulations, instructions, or conferences. Providers, physicians, and suppliers can now go to http://www.cms.hhs.gov/mailinglists to subscribe to listservs for various Medicare audiences or categories.*

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Las NUEVAS Páginas del Web para Proveedor/Suplidor incluyen:	
Tratamiento Médico de Emergencia & Ley del Trabajo (EMTALA) – El contenido incluye Política, Regulaciones, Manuales, Preguntas Frecuentes y más.	http://www.cms.hhs.gov/providers/emtala
Fuente de Información sobre Fallo Permanente del Riñón (ESRD) – El contenido incluye Regulaciones, Cubierta, Facturación, Demostraciones, CROWN, Formularios, Organizaciones en la Red, Archivos para el Uso Público, Publicaciones, Comparación de Centros de Diálisis y más.	http://www.cms.hhs.gov/providers/esrd.asp
Fuente de Información para Medicare sobre Prácticas de Administración – El contenido incluye información actualizadas y herramientas relacionadas a Administradores, Codificadores, Personal de Facturación y otras fuera del rol del proveedor tradicional.	http://www.cms.hhs.gov/providers/pair
Centros Ambulatorios de Cirugía (ASC) – El contenido incluye información sobre Inscripción/ Participación, Tarifas de Pago, Regulaciones y más.	http://www.cms.hhs.gov/suppliers/asc
Centros de Salud Certificados por el Gobierno Federal (FQHC) – El contenido incluye Regulaciones, HIPAA, Inscripción, Preguntas Frecuentes, Formularios, Manuales, Publicaciones y más.	http://www.cms.hhs.gov/providers/fqhc
Equipo Médico Duradero, Prostético, Ortótico, y Suministros (DMEPOS) – El contenido incluye Instrucciones para Facturar, Codificación, Pago, información sobre Revisión Médica y más.	http://www.cms.hhs.gov/suppliers/dmepos
Agencias de Salud en el Hogar (HHA) – El contenido incluye Regulaciones, Codificación, Facturación, Información sobre Evaluación y Resultados (OASIS) y Mejoras de Calidad basados en Resultados Obtenidos (OBQI) y más.	http://www.cms.hhs.gov/providers/hha
Hospicio – El contenido incluye Certificación, Artículos Educacionales, Preguntas Frecuentes, Información sobre Investigaciones y Estadísticas y más.	http://www.cms.hhs.gov/providers/hospiceps
Sistema de Pago Probable (Futuro) (PPS) por Internados en Instituciones Psiquiátricas (IPF) -- El contenido incluye información útil relacionada al desarrollo de un "PPS" para Medicare para servicios psiquiátricos a internados, que incluye información sobre Trasfondo y Codificación, la Regulación y Herramienta de Evaluación Contínua propuesta y más.	http://www.cms.hhs.gov/providers/ipfpps
Servicios de Mamografía – El contenido incluye Codificación, Políticas/ Regulaciones, Recursos prácticas y más.	http://www.cms.hhs.gov/suppliers/mammography
Clínicas Rurales de Salud – El contenido incluye Regulaciones, Inscripción, Cubierta, Publicaciones, Formularios, Manuales y más.	http://www.cms.hhs.gov/providers/rh
Instituciones de Enfermería Especializada (SNF) PPS – El contenido incluye Regulaciones, Publicaciones, Tarifas e Índices, MDS, "Swing Bed", Preguntas Frecuentes y más.	http://www.cms.hhs.gov/providers/snfpps

NEW Provider/ Supplier Web Pages include:	
Emergency Medical Treatment & Labor Act (EMTALA) -- Content includes Policy, Regulations, Manuals, Frequently Asked Questions and more.	http://www.cms.hhs.gov/providers/emtala
End-Stage Renal Disease (ESRD) Information Resource -- Content includes Regulations, Coverage, Billing, Demonstrations, CROWN, Forms, Network Organizations, Public Use Files, Publications, Dialysis Facility Compare, and more.	http://www.cms.hhs.gov/providers/esrd.asp
Practice Administration Information Resource for Medicare -- Content includes up-to-date information and tools as they relate to Administrators, Coders, Billing Personnel, and others outside the traditional provider role.	http://www.cms.hhs.gov/providers/pair
Ambulatory Surgical Centers (ASC) -- Content includes information on Enrollment/ Participation, Payment Rates, Regulations, and more.	http://www.cms.hhs.gov/suppliers/asc
Federally Qualified Health Centers (FQHC) -- Content includes Regulations, HIPAA, Enrollment, Frequently Asked Questions, Forms, Manuals, Publications and more.	http://www.cms.hhs.gov/providers/fqhc
Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) -- Content includes Billing Instructions, Coding, Payment, Medical Review information and more.	http://www.cms.hhs.gov/suppliers/dmepos
Home Health Agencies (HHA) -- Content includes Regulations, Coding, Billing, Outcome and Assessment Information Set (OASIS) and Outcome-Based Quality Improvement (OBQI), and more.	http://www.cms.hhs.gov/providers/hha
Hospice -- Content includes Certification, Educational Articles, Frequently Asked Questions, Research and Statistics information and more.	http://www.cms.hhs.gov/providers/hospiceps
Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) -- Content includes useful information related to the development of a PPS for Medicare inpatient psychiatric services, including Background and Coding information, the proposed Regulation and Assessment Tool and more.	http://www.cms.hhs.gov/providers/ipfpps
Mammography Services – Content includes Coding, Policies/ Regulations, helpful Resources and more.	http://www.cms.hhs.gov/suppliers/mammography
Rural Health Clinics -- Content includes Regulations, Enrollment, Coverage, Publications, Forms, Manuals, and more.	http://www.cms.hhs.gov/providers/rh
Skilled Nursing Facilities (SNF) PPS -- Content includes Regulations, Publications, Rates and Indices, MDS, Swing Bed, Frequently Asked Questions and more.	http://www.cms.hhs.gov/providers/snfpps

Las NUEVAS Páginas-Herramientas para Proveedores incluyen:	
Búsqueda Lista de Tarifas de Medicare ("Physician Fee Schedule Lookup") – Vea información sobre servicios médicos, índices de costo para práctica por área geográfica y política de pago.	http://www.cms.hhs.gov/physicians/mpfsapp
Éditos de Iniciativa Nacional para Codificación Correcta (NCCI) – La NCCI promueve la uniformidad en la interpretación de las políticas de pago de Medicare entre los contratistas que procesan las reclamaciones de Medicare. Los éditos son pares de servicios que normalmente no deben facturarse el mismo día por el mismo proveedor para el mismo paciente.	NCCI Edits for Physicians -- http://www.cms.hhs.gov/physicians/cciedits NCCI Edits for Hospital Outpatient Departments -- http://www.cms.hhs.gov/providers/hopps/cciedits
"Medlearn Matters"…Información para Proveedores de Medicare -- Esta página incluye enlaces con artículos educacionales y las Peticiones de Cambios relacionadas, a fin de presentar información consistente a los proveedores.	http://www.cms.hhs.gov/medlearn/matters

NEW Provider Web Tools include:	
Medicare Physician Fee Schedule Lookup -- View physician service information, geographic practice cost indices and payment policy.	http://www.cms.hhs.gov/physicians/mpfsapp
National Correct Coding Initiative (NCCI) Edits -- The NCCI promotes uniformity among the contractors that process Medicare claims in interpreting Medicare payment policies. The edits are pairs of services that normally should not be billed by the same provider for the same patient on the same day.	NCCI Edits for Physicians -- http://www.cms.hhs.gov/physicians/cciedits NCCI Edits for Hospital Outpatient Departments -- http://www.cms.hhs.gov/providers/hopps/cciedits
Medlearn Matters…Information for Medicare Providers -- This page includes links to educational articles and related Change Requests, in order to present consistent information to providers.	http://www.cms.hhs.gov/medlearn/matters

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Revisión Médica

ACLARACIÓN PARA LOS PROVEEDORES DE SERVICIOS DE LABORATORIOS SOBRE LA UTILIZACIÓN DE CÓDIGOS DE PRUEBAS DE SANGRE OCULTA FECAL Y DE CERNIMIENTO DE CÁNCER COLORECTAL

En el análisis de revisión médica del segundo semestre del año 2003 se reveló una tendencia en aumento en la utilización del código 82274 (sangre oculta por determinación de hemoglobina fecal a través de inmunoensayo cualitativo, en heces fecales, 1-3 determinaciones simultaneas), ver gráfica. En ese mismo período de tiempo se evidenció una disminución en la utilización del código 82270 (prueba de sangre oculta en heces fecales por metodología Guaiac).

Medicare quiere aclararle a la comunidad de proveedores de servicios de laboratorios que estos códigos no son intercambiables. Cuando una prueba de sangre oculta en heces fecales es hecha con la metodología de peroxidasa (Guaiac FOBT, por sus siglas en inglés), el código a facturar es 82270 (prueba cualitativa de sangre oculta por actividad de peroxidasa (guaiac) heces fecales, 1-3 determinaciones simultáneas.

El código 82274 debe usarse exclusivamente para pruebas de sangre oculta en heces fecales realizadas por metodología de inmunoensayo. La manera correcta de codificar la prueba de cernimiento para cáncer colorectal por metodología guaiac para detectar sangre oculta en heces fecales, es con el código G0107 (cernimiento cáncer colorectal; 1-3 determinaciones simultáneas).

La manera correcta de codificar pruebas de cernimiento de cáncer colorectal por metodología de inmunoensayo es utilizando el código G0328 (cernimiento cáncer colorectal; Inmunoensayo de sangre oculta en heces fecales, 1-3 determinaciones simultáneas).

Medical Review

CLARIFICATION FOR LABORATORY PROVIDERS OF THE CORRECT UTILIZATION OF CODES FOR FECAL OCCULT BLOOD TESTS AND COLORECTAL CANCER SCREENING

Medical review analysis of the second semester of the year 2003, revealed an increasing trend in the utilization of code 82274 (Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative; feces, 1-3 simultaneous determinations), see graph. In that same period of time there was a decrease in the utilization of code 82270 (Guaiac based stool for occult blood).

Medicare wants to clarify to the laboratory provider community that these codes are not interchangeable. When a stool for occult blood is done with the peroxidase methodology (Guaiac FOBT) the code that must be billed is code 82270 (Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, 1-3 simultaneous determinations).

Code 82274 must be used exclusively for the immunoassay-based stool for occult blood. The correct coding for screening of colorectal cancer with the Guaiac based FOBT is code G0107 (Colorectal Cancer Screening; 1-3 simultaneous determinations).

The correct coding for screening of colorectal cancer with the immunoassay-based test is with the utilization of code G0328 (Colorectal Cancer Screening; Immunoassay, Fecal-Occult Blood Test, 1-3 Simultaneous Determinations).

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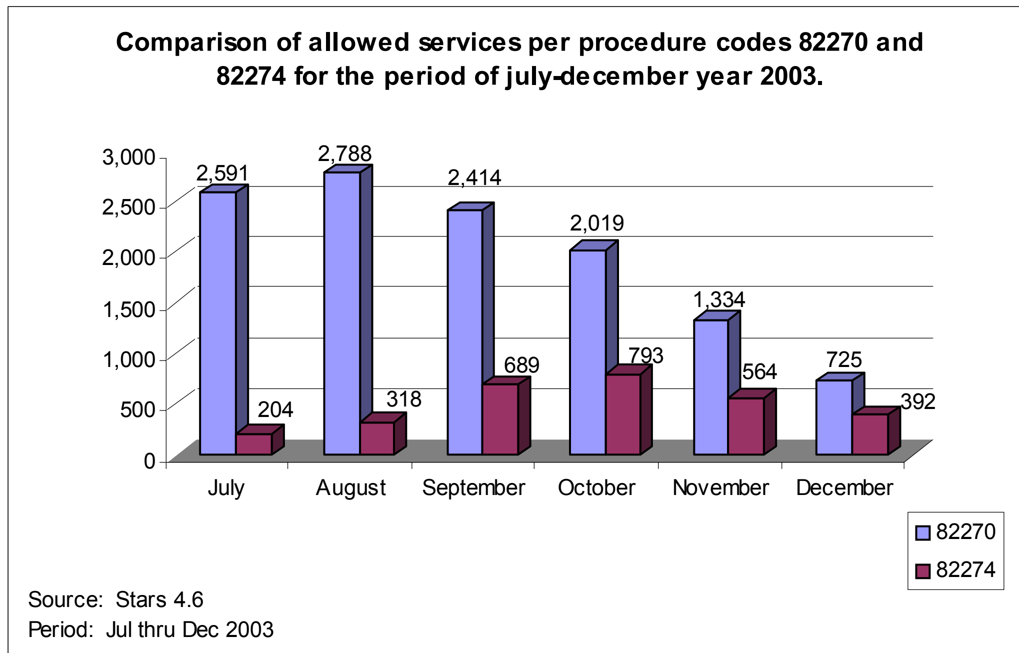
Aumento en la Utilización del Código 82274
Increasing Utilization of Code 82274



Ref. CPT 2004, American Medical Association/ Stars 4.6 for the period July through December 2003/jsp-006

REQUISITOS DE LA FIRMA DEL PROVEEDOR

La Reglamentación de Medicare establece que para poder determinar el pago apropiado de los servicios es necesario identificar claramente la firma del proveedor que prestó u ordenó el servicio. Existen diferentes métodos para firmar, tales como firma de su puño y letra, firma electrónica o sello gomígrafo. Por lo tanto, una reclamación de servicios no puede denegarse por el tipo de firma utilizada.

Sin embargo, queremos mencionar que el proveedor debe estar consciente de que cuando se utilizan métodos distintos a la firma en original existe un potencial de abuso y mal uso de dichos métodos. Además, al figurar su nombre en dicha firma asume la responsabilidad de que la información provista sea correcta. Le recomendamos que consulte con su abogado y con la compañía de seguros que le provee la cubierta de responsabilidad profesional sobre el uso de métodos alternos de firma.

SIGNATURE REQUIREMENTS

The Medicare Regulations establishes that a legible identify for services provided or ordered is needed in order to determine the appropriateness of payments. Different methods can be used, such as hand written, electronic, or signature stamp to sign an order or other medical record. Therefore, a claim can not be denied on the sole basis of type of signature submitted.

Nevertheless, we would like to mention that as a provider you have to recognize that there is a potential for misuse or abuse when in using alternative signature methods (e.g. a signature stamp). Also, that the individual whose name is on the alternate signature method bears the responsibility for the authenticity of the information being attested to. It is recommended that you check with your attorneys and malpractice insurers in regard to the use of alternative signature methods.

Pub. 100-08/ MPI Trans. 59/CR-2937/11-28-03/MR Dept.

MEDICAL POLICY

CHANGE IN CODING ON MEDICARE CLAIMS FOR DARBEPOETIN ALFA (TRADE NAME ARANESP) AND EPOETIN ALPHA (TRADE NAME EPOGEN, EPO, PROCRIT)

Darbepoetin Alfa:

Effective January 1, 2004 the HCPS code J0880 (Darbepoetin Alfa 5mcg) will be billable when administered in a physician's office to non-ESRD patients not on dialysis.

Code Q0137 (injection darbepoetin alfa 1mcg, non-ESRD use) will remain active in all non ESRD settings.

Code Q4054 (injection darbepoetin alfa 1mcg, for ESRD patients) should continue to be used for ESRD patients on dialysis treated in a physician's office. The claims with code Q4054 must include the patient's hematocrict or will be denied due to lack of documentation.

Epoetin Alfa:

Effective January 1, 2004 codes Q9920 through Q9940 for injection of epoetin alpha 1,000 units linked to the patients hematocrict will be deleted and substitute by the new code Q4055 (Injection, epoetin alfa 1,000 units for ESRD on dialysis).

Non Coverage:

Billing on the same date of service is not allowable for codes J0880 and Q0137 for non-ESRD use.

Billing on the same date of service is not allowed for codes J0880 and Q4054 for ESRD use.

Since there is currently no payment rate for Darbepoetin Alfa, the Centers for Medicare & Medicaid Services (CMS) has determined that new code Q4054 should be paid based on the Single Drug Pricer payment amount. This payment rate will be in effect until CMS determines an appropriate conversion factor for Darbepoetin Alfa.

CR#3037/Trans. 36/Dec 24, 2003/jlsp / CR#2963/Trans. 39/Jan. 9, 2004/jlsp

TREATMENT OF CERTAIN DENTAL CLAIMS AS A RESULT OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

Provider Types Affected:

Dentists

Provider Action Needed:

Providers who submit dental claims for services provided to Medicare beneficiaries need to be aware of the new law related to claims submissions to supplemental or other group health insurers of Medicare beneficiaries.

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MEDICAL POLICY

As of February 8, for **outpatient** dental services that are not covered by Medicare, you do not need to submit a claim to Medicare and receive a denial if the beneficiary has group secondary or supplemental coverage. Group health plans are prohibited from requiring such determinations as of February 8 for such services.

A group health plan may continue to require such determinations in cases involving or appearing to involve inpatient dental hospital services, or other dental services covered by Medicare.

Please amend your procedures regarding dental service claims for Medicare patients as reflected by the new legislation. See the Additional Information section for further illumination.

Background:

Under present law, the Medicare benefit does not include coverage of most dental services. Some insurers have required dentists to receive a claim denial from Medicare before they will process a claim from the dentist for a Medicare beneficiary holding coverage from that group health insurer. Under section 950 of the Medicare Prescription Drug, Improvement, and Modernization act of 2003, a group health plan providing supplemental or secondary coverage to Medicare beneficiaries cannot require dentists to obtain a claim denial from Medicare for dental services that are not covered by Medicare before paying the claim.

However, a claims determination, i.e., a submission of a claim to Medicare, **may be required** for inpatient dental hospital services or dental services **specifically covered** by Medicare. (Payment may be made under part A for these services.)

This section of the new legislation is to be effective 60 days after enactment of the legislation, which was enacted on December 8, 2003. Thus, this provision is effective as of February 8, 2004.

Additional Information

For your convenience, the actual text of Section 950 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reads as follows:

"Sec. 950. Treatment of Certain Dental Claims

(a) In General—Section 1862 (42 U.S.C. 1395y) is amended by adding at the end, after the subsection transferred and redesignated by section 948 (a), the following new subsection:

(k) (1) Subject to paragraph (2), a group health plan (as defined in subsection (a) (1) (A) (v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a Medicare claims determination under this title for dental benefits specifically excluded under subsection (a) (12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act."

MEDICAL POLICY

EXPANDED COVERAGE FOR COLORECTAL CANCER SCREENING

MEDICARE COVERAGE IS BEING EXPANDED FOR SCREENING FOR EARLY DETECTION OF COLORECTAL CANCER BY ADDING AN ADDITIONAL FECAL OCCULT BLOOD TEST (iFOBT, IMMUNOASSAY-BASED) THAT CAN BE USED AS AN ALTERNATIVE TO THE EXISTING gFOBT, GUAIAC-BASED TEST. MEDICARE COVERAGE CONTINUES TO ALLOW FOR ONE FOBT PER YEAR FOR BENEFICIARIES AGED 50 AND OVER.

Background

Section 4104 of the Balanced Budget Act of 1997 provides for coverage of screening colorectal cancer procedures under Medicare Part B. Medicare currently covers:(1) annual fecal occult blood tests (FOBTs); (2) flexible sigmoidoscopy over 4 years; (3) screening colonoscopy for persons at average risk for colorectal cancer every 10 years, or for persons at high risk for colorectal cancer every 2 years; (4) barium enema every 4 years as an alternative to flexible sigmoidoscopy, or every 2 years as an alternative to colonoscopy for persons at high risk for colorectal cancer; and, (5) other procedures the Secretary finds appropriate based on consultation with appropriate experts and organizations. Coverage of the above screening examinations was implemented in regulations through a final rule that was published on October 31, 1997 (62 FR 59079), and was effective January 1, 1998.

FOBTs are generally divided into two types: immunoassay and guaiac types. Immunoassay (or immunochemical) fecal occult blood tests (iFOBT) use “antibodies directed against human globin epitopes. While most iFOBTs use spatulas to collect stool samples, some use a brush to collect toilet water surrounding the stool. Most iFOBTs require laboratory processing.

Guaiac fecal occult blood tests (gFOBT) use a peroxidase reaction to indicate presence of the heme portion of hemoglobin. “Guaiac” turns blue after oxidation by oxidants or peroxidases in the presence of an oxygen donor such as hydrogen peroxide. Most FOBTs use sticks to collect stool samples and may be developed in a physician’s office or a laboratory.

Expanded Coverage:

Effective for services furnished on or after January 1, 2004, screening FOBT, (code G0328 - Colorectal Cancer Screening; Immunoassay, Fecal-Occult Blood Test, 1-3 Simultaneous Determinations) may be paid as an alternative to G0107 (Colorectal Cancer Screening; Fecal-Occult Blood Test, 1-3 Simultaneous Determinations) for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either G0107 or G0328, but not both) at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed). Screening FOBT, immunoassay, includes the use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, as determined by the individual manufacturer’s instructions. This screening requires a written order from the beneficiary’s attending physician. (The term “attending physician” is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary’s medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary’s specific medical problem).

Noncovered Indications:

All other indications for colorectal cancer screening not otherwise specified above remain noncovered.

(This NCD last reviewed December 2003.) CR# 2996/Trans. 3, 5 & 52/Dec. 19, 2003/jlsp

REVISION OF NATIONAL COVERAGE DETERMINATION ON THORACIC ELECTRICAL BIOIMPEDANCE

Background

Cardiac output monitoring by Electrical Bioimpedance, a form of plethysmography, has been covered, for certain indications, effective for services furnished on or after July 1, 1999, CMS (HCFA) Change Request #827 (CIM, Section 50-54) effective July 1, 1999 (Coverage). Electrical Bioimpedance measures changes in Electrical resistance (impedance) associated with fluctuations of blood volume (mostly H20) in the Thoracic great vessels. Blood volume, and therefore, impedance, varies with the cardiac cycle. Impedance variations consistently correlate with cardiac output, thoracic fluid volume, cardiac index, stroke volume, stroke volume index, and systemic vascular resistance.

The test is performed similar to an ECG. Electrical leads are attached to the upper and lower thorax and connected to a computer. Software analyzes the raw electrical data and reports information in a clinically useful format. The information is similar to that obtained from an invasive pulmonary artery catheter study.

In January 23, 2004, Section 20.16 of Pub. 100-03, Medicare National Coverage Determinations Manual (NCDM), was revised in response to a request for reconsideration to offer more explicit guidance and clarification for coverage of Thoracic Electrical Bioimpedance (TEB) based on a complete and updated literature review. Effective for services performed on or after January 23, 2004, TEB is covered for specific indications as outlined in 20.16 of Pub. 100-03. This revision to 20.16 of Pub. 100-03 is a National Coverage Determination.

Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)

Thoracic electrical bioimpedance (TEB) devices, a form of plethysmography, monitor cardiac output by no invasively measuring homodynamic parameters, including: stroke volume, systemic vascular resistance, and thoracic fluid status. Under the previous coverage determination, effective July 1, 1999, use of TEB was covered for the “noninvasive diagnosis or monitoring of hemodynamics in patients with suspected or known cardiovascular disease.” In reconsidering this policy, CMS concluded that this use was neither sufficiently defined nor supported by available clinical literature to offer the guidance necessary for practitioners to determine when TEB would be covered for patient management. Therefore, CMS revised its coverage policy language in response to a request for reconsideration to offer more explicit guidance and clarity for coverage of TEB based on a complete and updated literature review.

I. Covered Indications

A. TEB is covered for the following uses:

1. Differentiation of cardiogenic from pulmonary causes of acute dyspnea when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.

2. Optimization of atrioventricular (A/V) interval for patients with A/V sequential cardiac pacemakers when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.

3. Monitoring of continuous inotropic therapy for patients with terminal congestive heart failure, when those patients have chosen to die with comfort at home, or for patients waiting at home for a heart transplant.

4. Evaluation for rejection in patients with a heart transplant as a predetermined alternative to a myocardial biopsy. Medical necessity must be documented should a biopsy be performed after TEB.

5. Optimization of fluid management in patients with congestive heart failure when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.

II. Contractors have discretion to determine whether the use of TEB for the management of drug-resistant hypertension is reasonable and necessary. Drug resistant hypertension is defined as failure to achieve goal BP in patients who are adhering to full doses of an appropriate three-drug regimen that includes a diuretic.

A. Noncovered Indications

1. TEB is noncovered when used for patients:

a. With proven or suspected disease involving severe regurgitation of the aorta;

b. With minute ventilation (MV) sensor function pacemakers, since the device may adversely affect the functioning of that type of pacemaker;

c. During cardiac bypass surgery; or

d. In the management of all forms of hypertension (with the exception of drug- resistant hypertension as outlined above).

2. All other uses of TEB not otherwise specified remain non-covered.

(This NCD last reviewed January 2004.)

Billing Instructions

For TEB services supplied, report CPT code 93701, Bioimpedance, Thoracic, electrical. Report the ICD-9-CM code that reflects the reason for the test.

References

- CMS (HCFA) CR 827 (CIM, Section 50-54) effective July 1, 1999 (Coverage)
- CMS CR 2689 (NCDM, Section 20.16) effective January 23, 2004 (Coverage)

Pub. 100-03 MNCD Trans. 6/CR 2689/Jan. 23, 2004/JLSP

MEDICAL POLICY

VENTRICULAR ASSIST DEVICES (VADS) FOR DESTINATION THERAPY

For services on October 1, 2003 and thereafter coverage has been expanded for Ventricular Assist Devices (VADs) when used as destination therapy under the following conditions:

- The VAD has 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.

NOTE: All other indications for the use of VADs remain as described in our article "Expanded Coverage for Ventricular Assist Devices (VADs) and Billing Instructions for Claims for Beneficiaries in a Medicare+Choice (M+C) Plan", which you can find at: http://www.triples-med.org under Most Recent Articles or in our **Medicare Informa**, volume 76, October, November, December 2003 issue.

VAD Claims Processing Information

Services Provided to Medicare+Choice (M+C) Patients

- Until Medicare capitation rates to M+C organizations are adjusted to account for expanded VAD coverage, providers will be paid on a fee-for-service basis for VAD services that fall under the new indication for destination therapy.
- Medicare will not have systems changes in place to pay claims for risk M+C patients until January 5, 2004.
- Medicare contractors will hold claims for risk M+C patients that fall under the new indications for VADs submitted with modifier KZ or condition code 78 from October 1, 2003 until December 31, 2003.
- Medicare contractors shall release these claims for payment with any applicable interest on January 5, 2004 and thereafter.

VAD Information Resources

http://www.cms.hhs.gov/manuals/cmsindex.asp

Pub. 100-03 – Medicare National Coverage Determination Manual, Section 20.9

CR-2985//Pub.100-03 Transmittal 4/November 7, 2003/els
CR-2958/Pub.100-04 Transmittal 10/Pub.100-03 Transmittal 2/dmg/lc

Políticas de Pago

RESUMEN DE LOS CAMBIOS A LA TARIFA FIJA DE MEDICARE PARA EL 2004

A continuación el resumen de los cambios a la Tarifa Fija con vigencia el 1 de enero de 2004:

- La actualización a la Tarifa Fija para el 2004 es de 1.5 por ciento. El factor de cambio es $37.3374.
- El factor de cambio para anestesia es $17.50, el **promedio nacional** para el 2004. El factor de cambio del 2004 para anestesia en Puerto Rico es $15.71 y $17.56 para Islas Vírgenes.
- El pago para el código HCPCS "Q3014, Telehealth originating site facility fee" es 80 por ciento del menor del cargo actual o $21.20.
- En aquellos casos donde el profesor anestesiólogo esté ocupado con dos anestesias simultáneas con anestesiólogos residentes, el profesor anestesiólogo puede facturar las unidades base usuales y tiempo de anestesia por el tiempo que ella/él esté con el anestesiólogo residente. El anestesiólogo puede facturar unidades base si ella/él está presente con el anestesiólogo residente de principio a fin del cuidado pre y post anestesia. El anestesiólogo debe usar el modificador "AA" para informar dichos casos. El profesor anestesiólogo debe documentar su participación en los casos de los anestesiólogos residentes. La documentación debe sustentar el pago de la tarifa y estar disponible para revisión al solicitarse.
- El Contratista continuará pagando el componente técnico (TC, por sus siglas en inglés) por los servicios de patología médica cuando un laboratorio independiente preste este servicio a un paciente hospitalizado o ambulatorio de un hospital que tenga cubierta.

Billing Policies

SUMMARY OF 2004 MEDICARE PHYSICIAN FEE SCHEDULE ANNUAL CHANGES

The following is a summary of the Medicare Physician Fee Schedule changes that became effective January 1, 2004.

- *The fee schedule update for 2004 is 1.5 percent. The conversion factor is $37.3374.*
- *The 2004 **national average** anesthesia conversion factor is $17.50. The 2004 anesthesia conversion factor for Puerto Rico is $15.71 and $17.56 for the U.S. Virgin Islands.*
- *The payment amount for HCPCS code "Q3014, Telehealth originating site facility fee" is 80 percent of the lesser of the actual charge or $21.20.*
- *In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time she/he is present with resident. The anesthesiologist can bill base units if she/he is present with the resident throughout pre-and post- anesthesia care. The anesthesiologist should use the "AA" modifier to report such cases. The teaching anesthesiologist must document his/her involvement in cases with residents. The documentation must be sufficient to support the payment of the fee and available for review upon request.*
- *The Medicare carrier will continue to pay for the technical component (TC) of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.*

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Políticas de Pago

- Se mantendrán los valores actuales para Lesiones de la Piel, Benigna y Maligna (serie de códigos CPT 11400 y 11600).
- Se añadió a dentistas, optómetras y podiatras a la lista de médicos que pueden firmar acuerdos privados con beneficiarios.
- Hay una nueva definición de diabetes en el "Code of Federal Regulations" (CFR) 410.141 para el Adiestramiento del Auto Manejo de la Diabetes (DSMT, por sus siglas en inglés) y Terapia Médica de Nutrición (MNT, por sus siglas en inglés). Además, la definición de DSMT sustituye los criterios de elegibilidad del beneficiario de la vieja reglamentación.
- Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) crearon códigos temporeros, conocidos como códigos G, que describen procedimientos o servicios cuando pacientes de diálisis visitan al médico una vez al mes, 2-3 veces al mes o cuatro o más veces al mes, con un aumento en pago de acuerdo al número de visitas. El pago total por estos servicios es lo que actualmente se paga por los códigos CPT 90918 a 90921. Estos códigos tienen estatus I = código inválido, esto significa que no se les aplicará el período de gracia. Por lo tanto, a partir del 1 de enero de 2004 no se podrá utilizar los códigos 90918 a 90921.
- Se crearon también unos códigos G para el manejo de pacientes de diálisis en el hogar para diferentes grupos clasificados por edad. Además, se crearon cuatro nuevos códigos G para pacientes de diálisis en el hogar que son hospitalizados durante el mes. Estos códigos se utilizarán para informar el manejo diario de pacientes de diálisis en el hogar en los días que el paciente no estuvo hospitalizado. La siguiente tabla muestra la transferencia de archivos de los códigos CPT actuales a los códigos G:

Billing Policies

- *Current values will be maintained for Skin Lesions, Benign and Malignant (CPT codes 11400 and 11600 series).*
- *The list of physicians who can enter into private contracts with beneficiaries is expanded to include dentists, optometrists, and podiatrists.*
- *There is a new definition of diabetes for diabetes self-management training (DSMT) and medical nutritional therapy at CFR 410.141. In addition, the DSMT definition replaces the beneficiary's eligibility criteria in the old regulation.*
- *For dialysis patients seeing the doctor, The Centers for Medicare and Medicaid Services (CMS) created separate temporary codes that describe procedures or services, known as G codes, for 1 physician visit per month, 2-3 visits per month, and 4 or more visits per month, with payment increasing with the number of visits. The aggregate payments for these services are approximately equal to current payments for CPT codes 90918 to 90921, these codes have status I = invalid code, which means that the grace period will not apply. As of January 1, 2004 and thereafter, codes 90918 to 90921 cannot be used.*
- *New G codes were also created for the management of home dialysis patients in each of the age groups. In addition, four new G codes were also created for home dialysis patients who are hospitalized during the month. These codes are to be used to report daily management of home dialysis patients for the days the patient was not in the hospital. Following is the crosswalk from the current CPT codes to the G codes.*

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Pacientes de Diálisis que no sean Pacientes de Diálisis en el Hogar
Patients Other than Home Dialysis

Código CPT *CPT Code*	Edad del Paciente *Age of Patient*	Nuevo Código G *New G Codes*	Número de Visitas *Number of Visits*
90918	< 2	G0308 G0309 G0310	4+ 2 to 3 Una visita / *One visit*
90919	2 to 11	G0311 G0312 G0313	4+ 2 to 3 Una visita / *One visit*
90920	12 to 19	G0314 G0315 G0316	4+ 2 to 3 Una visita / *One visit*
90921	20+	G0317 G0318 G0319	4+ 2 to 3 Una visita / *One visit*

Pacientes de Diálisis en el Hogar (mes completo)
Home Dialysis Patients (entire month)

Código CPT *CPT Code*	Edad del Paciente *Age of Patient*	Nuevo Código G *New G Codes*	Lugares de Servicio Válidos *Valid Place of Service*
Ningún Código CPT Definido *No distinct CPT Codes*	< 2	G0320	11 (Office), 12 (Home), 22 (Outpatient Hospital, and 65 (Dialisis Facility)
	2 to 11	G0321	
	12 to 19	G0322	
	20+	G0323	

Pacientes de Diálisis en el Hogar (sólo mes parcial – por día)
Home Dialysis Patients (partial month only - per day)

Código CPT *CPT Code*	Edad del Paciente *Age of Patient*	Nuevo Código G *New G Codes*	Lugares de Servicio Válidos *Valid Place of Service*
90922	< 2	G0324	11 (Office), 12 (Home), 22 (Outpatient Hospital, and 65 (Dialisis Facility)
90923	2 to 11	G0325	
90924	12 to 19	G0326	
90925	20+	G0327	

- Se revisaron algunas de las políticas de pago para los servicios de quimioterapia de la Sección 303 del "Medicare Prescription Drug, Improvement and Modernization Act (MMA)" del 2004. Para servicios prestados el 1 de enero de 2004 en adelante, CMS permitirá que el código 96408 se informe más de una vez por día por cada medicamento que se suministre.

- *For chemotherapy administration, Section 303 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) revises some of the Medicare physician payment policies for chemotherapy services. For services furnished on January 1, 2004 and thereafter, CMS will allow code 96408 to be reported more than once per day for each drug administered.*

Políticas de Pago

- CMS añadió la unidad de valor relativo del trabajo por .17 a los siguientes servicios de administración de medicamentos: códigos CPT 90780-90781, 90782-90788, 96400, 96408-96425, 96520 y 96530.
- Para servicios prestados el 1 de enero de 2004 en adelante, CMS no permitirá que se facture el código CPT 99211 el mismo día que se facture un código de administración de medicamento que tenga una unidad de valor relativo. CMS continuará permitiendo que se facturen otras visitas médicas el mismo día que se dé el servicio de administrar medicamento con modificador 25 indicando que se proveyó por separado un servicio de administración y evaluación identificable.

Billing Policies

- *CMS added the physician work relative value units of .17 to the following drug administration services: CPT codes 90780-90781, 90782-90788, 96400, 96408-96425, 96520 and 96530.*
- *For services furnished on January 1, 2004 and thereafter, CMS will not allow CPT code 99211 to be billed on the same day as a drug administration code that has a work relative value unit. CMS will continue to allow other office visits to be billed on the same day as a drug administration service with modifier 25 indicating that a separately identifiable evaluation and management service was provided.*

CR3028/Transmittal 34/Pub.100-20 OTN/December 24, 2003/els

CORRECCIÓN A LAS RECLAMACIONES DE TERAPIA FÍSICA, SERVICIOS DE TERAPIA OCUPACIONAL Y PATOLOGÍA DEL HABLA

La recién creada ley *"Medicare Prescription Drug and Modernization"* de 2003 renovó la moratoria en los pagos para las reclamaciones recibidas desde el 8 de diciembre de 2003 hasta el 31 de diciembre de 2005 para servicios de terapia física, patología del habla y terapia ocupacional. Los sistemas para procesar reclamaciones se programaron para cumplir con la ley al 8 de diciembre de 2003.

Sin embargo, el sistema que apoya el procesamiento de reclamaciones de Triple-S, Inc. generó pagos reducidos o denegados en reclamaciones procesadas después del 8 de diciembre de 2003 que incluyeron servicios de terapia. Esta situación se identificó el 7 de enero de 2004 y se corrigió el 16 de enero de 2004. En ese momento Triple-S, Inc. liberó las reclamaciones afectadas. Los pagos para las reclamaciones procesadas que se habían denegado o reducido por error se ajustaron automáticamente. Disculpen cualquier inconveniente que este problema pudo ocasionarle.

CORRECTION OF CLAIMS IMPACTED BY THE THERAPY LIMIT ON PHYSICAL THERAPY, SPEECH-LANGUAGE PATHOLOGY AND OCCUPATIONAL THERAPY SERVICES

The recently enacted Medicare Prescription Drug and Modernization Act of 2003 renewed the moratorium on physical therapy, speech-language pathology, and occupational therapy services payment caps for claims received from December 8, 2003 through December 31, 2005. Claims processing systems were programmed to comply with the law as of December 8, 2003.

However, the system supporting Triple-S, Inc. claims processing system generated in error reduced or denied claim payment amounts on claims processed after December 8, 2003 that included therapy services. This situation was identified on January 7, 2004 and corrected on January 16, 2004. At that time Triple-S, Inc. released the therapy claims being held. These claims were automatically adjusted. We apologize for any inconvenience you may have experienced related to this problem."

Ref. JSM-48 RO-2422/Jan. 15, 2004/dmg

Políticas de Pago

MORATORIA PARA LAS LIMITACIONES FINANCIERAS

El Congreso de los Estados Unidos reinició la moratoria a las limitaciones financieras de servicios de terapia a pacientes no hospitalizados (terapia física, patología del habla y terapia ocupacional). La misma está vigente desde el 8 de diciembre de 2003 hasta el 31 de diciembre de 2005. Sin embargo, el uso de los modificadores de terapia queda en efecto.

Modificadores de terapia:

GN - servicios ofrecidos bajo un plan de cuidado de patología del habla a pacientes no hospitalizados

GO - servicios ofrecidos bajo un plan de cuidado de terapia ocupacional para pacientes no hospitalizados

GP - servicios ofrecidos bajo un plan de cuidado de terapia física para pacientes no hospitalizados

Códigos Aplicables de Terapia:

Los Centros de Servicio de Medicare para Medicaid (CMS, por sus siglas en inglés) identificaron los siguientes códigos como servicios de terapia. Los códigos sin el signo + siempre requieren modificadores de terapia. Los códigos con el signo + necesitan modificadores cuando representan servicios de terapia.

Billing Policies

FINANCIAL LIMITATIONS MORATORIUM

The United States Congress re-enacted the financial limitations moratorium for outpatient therapy services (Physical Therapy, which includes outpatient Speech-Language Pathology; and Occupational Therapy) on December 8, 2003 and extends it through December 31, 2005. Nonetheless, the use of the therapy modifiers remains in effect.

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.*

Applicable Therapy Codes:

CMS identifies the following codes as therapy services. Codes without + signs always require therapy modifiers. Codes with +sign need modifiers when they represent therapy services.

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+	97602****	97703
97750	97755	97799*	G0279+***	G0280+***	G0281
G0283	0020T+***	0029T+***			

Políticas de Pago

*El Manual de Tarifas Fijas de Médicos no tiene precio para los códigos 96110 y 97799; éste lo determina el contratista. A partir del 1 de enero de 2004 el código 96110 será un código activo en el Manual de Tarifas fijas para Médicos.

**El código 97504 no debe reportarse con el código 97116. Sin embargo, si el código 97504 se realizó en una extremidad superior y el código 97116 (adiestramiento de marcha) también se realizó, ambos códigos pueden facturarse con el modificador 59 para indicar un lugar anatómico separado.

***Los códigos 97010 y 97602 se consideran parte de todo servicio de terapia y nunca se pagan por separado.

+Los códigos identificados con + y todos los códigos mencionados en la lista anterior representan siempre servicios de terapia cuando los realizan los terapistas. Los códigos marcados con + no son servicios de terapia cuando no se realizaron bajo un plan de cuidado de terapia y se facturaron por proveedores de servicio que no son terapistas. Los códigos identificados con + en la lista anterior no deben usarse por médicos practicantes no terapistas sin un modificador de terapia en situaciones donde el servicio realizado es esencial a un servicio de terapia de rehabilitación para un paciente no hospitalizado.

"Terapia de rehabilitación para pacientes no hospitalizados" se refiere a servicios especializados de terapia física, terapia ocupacional y patología del habla realizados con el propósito de rehabilitar al paciente e implica tratamientos en curso requiriendo las destrezas de personal profesional capacitado como terapistas físicos, terapistas ocupacionales o patólogos del habla. A diferencia, un servicio de no-terapia es un servicio realizado por profesionales de la salud, sin metas o planes de rehabilitación. Ej. Aplicación del yeso para estabilizar y proteger una fractura.

Billing Policies

The physician fee schedule does not contain a price for codes 96110 and 97799 they are carrier priced. Effective January 1, 2004, 96110 will be an active code on the physician fee schedule. Carriers shall no longer price this code.

*** 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 price for codes G0279, G0280, 0020T, 0029T since they are priced by the carrier. In addition, the carrier determines coverage for these codes.*

*****Codes 97010 and 97602 are bundled. They are bundled with any therapy code and are never separately paid.*

+ Codes marked + and all codes on the above list always represent therapy services when performed by therapists. Codes marked + are not therapy services when they are not done under a therapy plan of care and they are billed by providers of services who are not therapists. The Codes marked + on the above list may not be used by non-therapist practitioners without a therapy modifier in situations where the service provided is integral to an outpatient rehabilitation therapy service.

"Outpatient rehabilitation therapy" refers to skilled PT, OT and SLP services, requiring the skills of qualified professional personnel such as physical therapists, occupational therapists or speech-language pathologists, performed for restorative purposes and generally involving ongoing treatments. In contrast, a non-therapy service (usually a onetime service) is a service performed by non-therapist practitioners, without a rehabilitative plan or goals, e.g., application of a cast to stabilize and protect a fracture.

CR#3005/ Transmittal 42/Dec.8, 2003/dmg / CR3045/MedLearn Matters #MM3005

Políticas de Pago

NUEVAS GUÍAS PARA EL MÉTODO DE PAGO DE MEDICAMENTOS BAJO LA PARTE B DE MEDICARE

A partir del 1 de enero de 2004 el "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" (MMA), estableció los límites de pago para medicamentos de Medicare ofrecidos del 1 de enero al 31 de diciembre de 2004 que no se pagan basándose en el pago prospectivo. Estos se basarán en el 85 por ciento del Precio Promedio de Venta al Por Mayor (AWP, por sus siglas en inglés) del 1 de abril de 2003.

Las excepciones a la regla general antes mencionada son las siguientes:

- Los límites de pago para los factores de la coagulación de la sangre son el 95 por ciento del AWP reflejados en el compendio publicado el 1 de septiembre de 2003.
- Para medicamentos nuevos el límite es el 95 por ciento del AWP reflejado en el compendio publicado el 1 de septiembre de 2003. El límite de pago para un medicamento nuevo que no esté en la lista de AWP del compendio publicado el 1 de septiembre de 2003 se pagará basándose en el 95 por ciento del AWP reflejado en el compendio publicado el primero del mes que se determine el límite del pago del medicamento.
- Para propósitos de esta instrucción, se define como un medicamento nuevo aquel que no tiene un código HCPCS asignado y la Administración de Drogas y Alimentos (FDA, por sus siglas en inglés) lo aprobó luego del 1 de abril de 2003. Un medicamento no se considera como un medicamento nuevo si:
  - la marca o el manufacturero del medicamento cambió,
  - si se crea un tamaño nuevo de vial, o
  - si el medicamento recibe nuevas indicaciones

Billing Policies

NEW BASIS FOR MEDICARE DRUG PAYMENT AMOUNTS UNDER PART B

As of January 1, 2004, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides that the Medicare payment limits for most drugs and biological not paid on a prospective payment basis, furnished on January 1, 2004 through December 31, 2004, are based on 85 percent of the April 1, 2003 Average Wholesale Price (AWP).

The exceptions to the general rule stated above are as described below:

- *The payment limits for blood clotting factors are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.*
- *The payment limits for new drugs or biological is 95 percent of the AWP reflected in the published compendia as of September 1, 2003. The payment limits for new drugs or biological without AWP listings in the published compendia as of September 1, 2003, are based on 95 percent of the AWP reflected in the published compendia as of the first of the month the payment limit for the drug or biological is determined.*

  For the purposes of this instruction, a new drug is one not correctly covered by a HCPCS code and was approved by the Food and Drug Administration (FDA) subsequent to April 1, 2003. A drug is not considered to be a new drug if:

  - *the brand or manufacturer of the drug changes*
  - *a new vial size is developed*
  - *or the drug receives a new indication.*

Cont. on next page

Políticas de Pago

- Los límites de pago para las vacunas de influenza, neumococo y hepatitis B son el 95 por ciento del AWP reflejados en el compendio publicado el 1 de septiembre de 2003.
- Los límites de pago para los siguientes medicamentos bajo estudio por la Oficina del Inspector General (OIG, por sus siglas en inglés) y la Oficina General de Contabilidad del Gobierno de los Estados Unidos (GAO, por sus siglas en inglés) están basados en los por cientos del AWP reflejados en el compendio publicado el 1 de abril de 2003. Estos se especifican en la Tabla 1, Sección 20 del Capítulo 17 del Manual de Procesamiento de Reclamaciones Medicare, Publicación 100-04.

Billing Policies

- *The payment limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.*
- *The payment limits for the following drugs studied by the Office of the Inspector General (OIG) and U.S. General Accounting Office (GAO) are based on the percentages of the AWP reflected in the published compendia as of April 1, 2003 specified in Table 1 in §20 of Chapter 17 of the Medicare Claims Processing Manual, Publication 100-04.*

Código HCPCS HCPCS Code	***Por Ciento que Aplica Applicable Percentage***	***Código HCPCS HCPCS Code***	***Por Ciento que Aplica Applicable Percentage***
J0640	80	J7631	80
J1100	86	J7644	80
J1260	80	J9000	80
J1440	81	J9045	81
J1441	81	J9170	80
J1561/J1563	80	J9201	80
J1626	80	J9202	80
J1642	80	J9206	80
J2405	87	J9217	81
J2430	85	J9265	81
J2820	80	J9310	81
J7320	82	J9350	84
J7517	86	J9390	81
J7608	80	Q0136	87
J7619	80		

- A partir del 1 de enero de 2004, el límite de pago para medicamentos de Infusión prestados a través de equipo o aparatos cubiertos de Equipo Médico Duradero (DME, por sus siglas en inglés), está al 95 por ciento del AWP reflejados en el compendio publicado el 1 de octubre de 2003, sin tener en cuenta que el implante se realizará o no.

- *The payment limits for infusion drugs supplied through a covered item of durable medical equipment (DME) on January 1, 2004 and thereafter, are 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted.*

Cont. on next page

Políticas de Pago

- Los límites de pago para los medicamentos suplidos con relación a diálisis y facturados por instalaciones independientes de diálisis se basan en 95 por ciento del AWP reflejados en el compendio publicado el 1 de septiembre de 2003.
- Los medicamentos que no están descritos, como se indica anteriormente, se pagarán al 85 por ciento del AWP reflejado en el compendio publicado el 1 de abril de 2003.

Los límites de pago para medicamentos que no se pagan basándose en el pago prospectivo, prestados antes del 1 de enero de 2004, serán el 95 por ciento del AWP.

Los límites de pago aquí establecidos no se actualizarán durante el 2004.

La inclusión o exclusión en estos archivos de un código HCPCS y su límite de pago correspondiente no es indicio de cubierta bajo el Programa Medicare. Igualmente, la inclusión de un límite de pago dentro de una columna en específico no es indicio de cubierta del medicamento en dicha categoría. El Contratista local de Medicare que procesa la reclamación será el que tome estas determinaciones.

Para información adicional puede ir al: http://cms.hhs.gov/providers/drugs/default.asp. ("MMA Drug Payment Limits Pricing Files for Dates of service 1/1/2004 and after – Revised").

La página electrónica de los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) provee a los proveedores y beneficiarios de Medicare y público en general información relacionada a medicamentos. Una vez este en la página electrónica, el enlace al archivo de "MMA Pricing" es:

Medicare Drugs Information Resource/ Drug Pricing Files/Medicare Prescription Drug, Improvement, and Modernization Act (MMA)/MMA Drug Payment Limits Pricing Files for Dates of Service 1/1/2004 and After – Revised 1/30/04.

Billing Policies

- *The payment limits for drugs or biological supplied in connection with dialysis and billed by independent dialysis facilities are based on 95 percent of the AWP reflected in the published compendia as of September 1, 2003.*
- *Drugs and biological not described above are paid at 85 percent of the AWP as reflected in the published compendia as of April 1, 2003.*

The Medicare payment limit for drugs and biological not paid on a prospective basis and furnished prior to January 1, 2004 is 95 percent of AWP.

Payment limits determined under this instruction will not be updated during 2004.

The absence or presence of a HCPCS code and its associated payment limit in these files does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

For additional information you may go to: http://cms.hhs.gov/providers/drugs/default.asp. (MMA Drug Payment Limits Pricing Files for Dates of service 1/1/2004 and after – Revised).

The Centers for Medicare and Medicaid Services (CMS) web page provides drug-related information to Medicare providers, physicians and other suppliers, Medicare beneficiaries and to the general public. Once at the website, the path to the MMA pricing file is:

Medicare Drugs Information Resource/ Drug Pricing Files/Medicare Prescription Drug, Improvement, and Modernization Act (MMA)/MMA Drug Payment Limits Pricing Files for Dates of Service 1/1/2004 and After – Revised 1/30/04.

CR3022/Transmittal 54/Pub.100-04 MCP/12-24-03/dmg
CR3105/Transmittal 75/Pub.100-04 MCP/1-30-04/els
MM3105/3-10-04/els

Políticas de Pago

Billing Policies

MEDICAMENTOS NO CLASIFICADOS

Los siguientes medicamentos inyectables no tienen un código establecido por los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés), pero pueden facturarse al Programa Medicare al utilizar el código J3490 para la primera tabla y el código J9999 para la segunda tabla. Las tarifas están vigentes desde el 1 de enero de 2004.

UNCLASSIFIED DRUGS

The following injectable drugs do not have a permanent billing code established by the Centers for Medicare and Medicaid Services (CMS), but the Medicare Program can be billed using code J3490 for the first table codes and J9999 for the second table code. These fees are effective as of January 1, 2004.

CÓDIGO / *CODE* J3490		
Medicamentos ***Drugs***	**Dosis** ***Dosage***	**Tarifa / *Fee*** **(85% of the April 1, 2003 AWP)**
Cimetidine(Tagamet)	150mg/ml	$ 1.27
Cimetidine(Tagamet)	300mg/ml	$ 2.65
Famotidine (Pepcid)	10mg/ml	$ 1.60
Nitroglycerin (Tridil)	5mg/ml	$ 0.42
Sincalide (Kinevac)	5mcg	$29.41
Verapamil HCL (Isoptin)	5mg/2ml	$ 0.98

CÓDIGO / CODE J9999		
Medicamentos ***Drugs***	**Dosis** ***Dosage***	**Tarifa / *Fee*** **(85% of the April 1, 2003 AWP)**
Peginterfero alfa-2a (Pegasys)	1ml single dose vial	$296.82

Para facturar estos medicamentos es necesario que se indique en la reclamación (forma CMS 1500) en el encasillado 19 o su equivalente en el formato de facturación electrónica la siguiente información:

a. Nombre del medicamento

b. Concentración y dosis administrada

A continuación los códigos HCPCS asignados a los siguientes medicamentos previamente clasificados como nuevos. Estos códigos están vigentes desde el 1 de enero de 2004.

J2505=Pegfilgrastim G-CSF (Neulasta) 6 mg

J9395 = Fulvestrant 25 mg (Faslodex)

J9263 = Oxaliplatin .5 mg (Eloxadin)

When you submit a claim for any of these drugs, it is necessary that you specify on the claim form (CMS 1500) in block 19 or its equivalent in electronic claims format the following information:

a. Name of the drug

b. Concentration and dose administered

The following HCPCS codes were assigned to the previously unlisted drugs mentioned below. These codes are effective as of January 1, 2004:

J2505=Pegfilgrastim G-CSF (Neulasta) 6 mg

J9395=Fulvestrant 25 mg (Faslodex)

J9263=Oxaliplatin .5 mg (Eloxadin)

CR3022/Trans. 34/Pub.100-20 OTN/December 24, 2003/ERO/els

Políticas de Pago

CORRECCIÓN A LA 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 el ambiente institucional, las reclamaciones a los contratistas de la Parte B por servicios que figuren en esta lista no se pagarán cuando los servicios facturados fueron prestados en las fechas en que un beneficiario se encontraba en un episodio de servicios de salud en el hogar. Medicare reembolsará solamente a la agencia primaria de servicios de salud en el hogar que haya 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 (Ej. códigos K) a través del año natural. Los nuevos códigos identificados en cada actualización describen los servicios utilizados para determinar la tarifa aplicable a los pagos de HHPPS. Estas actualizaciones no añaden ni delimitan categorías de servicios sujetos a la facturación consolidada de servicios de salud en el hogar.

Billing Policies

CORRECTION TO THE JANUARY 2004 ANNUAL UPDATE OF HCPCS CODES USED FOR HOME HEALTH CONSOLIDATED BILLING ENFORCEMENT

The Centers for Medicare and Medicaid Services (CMS) periodically update 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 agency that has 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. These updates do not add services or redefine categories of services subject to HH consolidated billing.

Cont. on next page

Políticas de Pago

Los siguientes códigos no se añadirán a la facturación consolidada de servicios de salud en el hogar:

A7525 Tracheostomy mask, each

A7526 Tracheostomy tube collar/holder, each

La lista actualizada con estos códigos sujetos a la facturación consolidada de servicios de salud en el hogar está disponible en: www.cms.hhs.gov/providers/hhapps/#billing.

Billing Policies

The following codes will not be added to HH consolidated billing enforcement:

A7525 Tracheostomy mask, each

A7526 Tracheostomy tube collar/holder, each

This correction is reflected in the HH consolidated billing master code list available at: www.cms.hhs.gov/providers/hhapps/#billing.

Pub. 100-04 MCP/Transmittal 62/CR 3024/January 16, 2004/els

CÓDIGOS DE EQUIPO MÉDICO DURADERO, PROTÉSICO, ORTÓTICO Y SUMINISTROS (DMEPOS) SUJETOS A JURISDICCIÓN LOCAL PARA EL 2004

La siguiente tabla incluye los códigos DMEPOS sujetos a la jurisdicción local:

2004 DMEPOS CODES SUBJECT TO LOCAL CARRIER JURISDICTION

The following are the DMEPOS codes subject to local carrier jurisdiction:

CODIGO HCPCS ***HCPCS CODE***	**CATEGORIA** ***CATEGORY***
E0749RR	Capped Rental
E0616	Inexpensive or Routinely Purchased DME
E0782NU	Inexpensive or Routinely Purchased DME
E0782UE	Inexpensive or Routinely Purchased DME
E0782RR	Inexpensive or Routinely Purchased DME
E0783NU	Inexpensive or Routinely Purchased DME
E0783RR	Inexpensive or Routinely Purchased DME
E0785	Inexpensive or Routinely Purchased DME
E0786	Inexpensive or Routinely Purchased DME
L8600	Prosthetic / Orthotic
L8603	Prosthetic / Orthotic
L8610	Prosthetic / Orthotic
L8612	Prosthetic / Orthotic
L8613	Prosthetic / Orthotic
L8614	Prosthetic / Orthotic
L8619	Prosthetic / Orthotic
L8630	Prosthetic / Orthotic
L8641	Prosthetic / Orthotic
L8642	Prosthetic / Orthotic
L8658	Prosthetic / Orthotic
L8670	Prosthetic / Orthotic

** La inclusión o exclusión de una tarifa fija para un articulo o servicio no implica cubierta de algún seguro de salud.
*** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.*

CR3020/Trans. 35/December 24, 2003/ERO / CR 2378/AB-02-152/October 25, 2003/mm

Políticas de Pago

PRIMERA ACTUALIZACIÓN A LA BASE DE DATOS DE LAS TARIFAS FIJAS DEL 2004 PARA MÉDICOS

Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) notificó la primera actualización a la base de datos de las Tarifas Fijas del 2004 para Médicos (MPFSDB por sus siglas en inglés).

Los cambios de esta actualización se implementarán el 5 de abril de 2004. Estos serán vigentes para reclamaciones con fechas de servicio del 1 de abril de 2004 en adelante, excepto aquellos que indiquen otra fecha de vigencia en este artículo.

Los cambios incluidos en esta primera actualización son los siguientes:

Código HCPCS	Nuevo Estatus de Procedimiento
*A4644	E
*A4645	E
*A4646	E
A9525	I
47133	X

Cambios de Estatus en Códigos de Procedimientos

*Estos códigos se eliminaron en el HCPCS del 2004 y se incluirán nuevamente a partir del 1 de abril de 2004.

Definiciones de los Estatus de Procedimientos Mencionados Arriba

E =excluidos del manual de tarifa fija por regulación (no aplican los RVU's)

I =código no es válido para propósitos de Medicare; no le aplica período de gracia

X = exclusión estatutoria

Billing Policies

FIRST UPDATE TO THE 2004 MEDICARE PHYSICIANS FEE SCHEDULE DATABASE

The Centers for Medicare & Medicaid Services (CMS) notified the first Medicare Physicians Fee Schedule Database (MPFSDB) update for 2004.

These changes will be implemented on April 5, 2004 for claims with dates of services April 1, 2004 and thereafter (except the ones that have a different effective date indicated in this articles).

Changes included in this first update are as follows:

Procedure Code Status Changes

HCPCS Codes	*New Procedure Status*
**A4644*	*E*
**A4645*	*E*
**A4646*	*E*
A9525	*I*
47133	*X*

**These codes were deleted with the 2004 HCPCS and are being reinstated on April 1, 2004.*

Procedure Status Definitions:

E=excluded from physician fee schedule by regulation (Not RVU's applicable)

I=code not valid for Medicare purposes; no grace period apply

X=statutory exclusion

Cont. on next page

Políticas de Pago

Cambios en Indicadores Bilaterales

Código HCPCS	*Indicador Bilateral*
*0037T	indicador de cirugía bilateral = 1
47525	indicador de cirugía bilateral = 1
63048	indicador de cirugía bilateral = 1
73720	indicador de cirugía bilateral = 0
73720-26	indicador de cirugía bilateral = 0
73720-TC	indicador de cirugía bilateral = 0
92136-26	indicador de cirugía bilateral = 3

*Este cambio aplica a servicios prestados del 1 de enero de 2003 en adelante.

Cambios en Indicador de Procedimientos Múltiples

Código HCPCS	Indicador de Procedimiento Múltiples
52001	3
52005	3
52234	3
52235	3
52240	3
52400	3

Cambios en otros Indicadores

- El indicador de tipo de servicio para el código G0268 cambió a 2. **Esto será vigente desde el 1 de enero de 2003.**
- El código 52000 se utilizará como código base de endoscopia para los siguientes códigos de procedimientos: 52001, 52234, 52235, 52240, 52400
- Para el código 76950-TC el indicador de supervisión diagnóstica cambió a 1 (procedimiento debe realizarse bajo la supervisión general de un médico).
- Los códigos 76070, 76070-26 y 76070-TC son válidos para Medicare desde la implementación del MPFSDB del 1 de marzo de 2003.

Billing Policies

Changes in Bilateral Indicators

HCPCS Codes	*Indicator Bilateral*
**0037T*	*bilateral surgery indicator = 1*
47525	*bilateral surgery indicator = 1*
63048	*bilateral surgery indicator = 1*
73720	*bilateral surgery indicator = 0*
73720-26	*bilateral surgery indicator = 0*
73720-TC	*bilateral surgery indicator = 0*
92136-26	*bilateral surgery indicator = 3*

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

Changes in Multiple Procedure Indicator

HCPCS Code	*Multiple Procedure Indicator*
52001	*3*
52005	*3*
52234	*3*
52235	*3*
52240	*3*
52400	*3*

Other Indicator Changes

- *Type of Service Indicator for the code G0268 changed to 2.* ***This change is effective January 1, 2003.***
- *The code 52000 will be used as endoscopic base code to the following procedure codes: 52001, 52234, 52235, 52240, 52400*
- *The Diagnostic Supervision Indicator changes to 1 for the code 76950-TC (procedure must be performed under the general supervision of a physician).*
- *Codes 76070, 76070, 76070-TC and 76070-26 became valid for Medicare with the implementation of the 2003 MPFSDB on March 1, 2003.*

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Definiciones de los Indicadores de Proceso

Indicadores	Definiciones
Códigos con Estatus C	contratista establece precio
Códigos con Estatus A	código activo
PC/TC = 0	este indicador identifica códigos que describe los servicios médicos
Lugar de servicio = 1 (SOS)	servicio está sujeto a un ajuste de pago basado en lugar de servicio
Indicador de procedimiento múltiple = 0	No aplica regla de ajuste de pagos para procedimiento múltiples
Indicador de procedimiento múltiple = 3	una regla especial aplica para los procedimientos múltiples de endoscopia; cuando procedimientos de endoscopia son facturados con otro procedimiento
Indicador de procedimiento bilateral = 0	150 por ciento de ajuste de pago para procedimiento bilateral aplica
Indicador de procedimiento bilateral = 1	150 por ciento de ajuste de pago para procedimiento bilateral no aplica
Indicador de asistente de cirugía = 0	restricción en el pago para los asistentes en esta cirugía es aplicado; al menos que sometan documentación que justifique la necesidad médica
Indicador de co-cirugía = 0	co-cirujano no es permitido para este procedimiento
Indicador de cirugía en equipo = 0	equipo de cirujanos no es permitido para este procedimiento

Processing Indicators Definitions

Indicators	Definitions
Code with Status C	carrier price
Code with Status A	active code
PC/TC = 0	this indicator identifies codes that describe physicians service
Site of Service = 1 (SOS)	service subject to payment adjustment based on site of service
Multiple Procedure Indicator = 0	No payment adjustment rules apply
Multiple Procedure Indicator = 3	special rules apply for multiple endoscopic procedures when endoscopic procedure are billed with other endoscopic procedure in the same family
Bilateral Procedure Indicator = 0	the 150 percent payment adjustment for bilateral procedures does not apply.
Bilateral Surgery Indicator = 1	this means that the 150 percent payment adjustment apply
Assistant at Surgery Indicator = 0	payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity
Co-Surgeons Indicator = 0	co-surgeons not permitted for this procedure
Team Surgeons Indicator = 0	team surgeons not for this procedure

Cont. on next page

Políticas de Pago

Cambios para Códigos Vigentes desde el 1 de enero de 2004

89220 Estatus de Procedimiento = A
Non-facility Practice Expense RVU = .40
Facility Practice Expense RVU = .40
RVU de Impericia Médica = .02
PC/TC= 3
SOS = 1
Indicador de Procedimiento Múltiple = 0
Indicador de Procedimiento Bilateral = 0
Indicador de Asistente de Cirugía = 0
Indicador de Co-cirugía = 0
Indicador de Cirugía en Equipo = 0

89230 Estatus de Procedimiento = A
Non-facility Practice Expense RVU = .44
Facility Practice Expense RVU = .44
RVU de Impericia Médica = .02
PC/TC= 3
SOS = 1
Indicador de Procedimiento Múltiple = 0
Indicador de Procedimiento Bilateral = 0
Indicador de Asistente de Cirugía = 0
Indicador de Co-cirugía = 0
Indicador de Cirugía en Equipo = 0

89240 Estatus de Procedimiento = C
PC/TC= 0
SOS = 1
Indicador de Procedimientos Múltiples = 0
Indicador de Procedimiento Bilateral = 0
Indicador de Asistente de Cirugía = 0
Indicador de Co-cirugía = 0
Indicador de Cirugía en Equipo = 0

Billing Policies

Change in Codes Effective January 1, 2004

89220 Procedure Status = A
Non-facility Practice expense RVU = .40
Facility Practice Expense RVU = .40
Malpractice RVU = .02
PC/TC= 3
SOS = 1
Multiple Procedure Indicator = 0
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 0
Co-surgery = 0
Team Surgery Indicator = 0

89230 Procedure Status = A
Non-facility Practice expense RVU = .44
Facility Practice Expense RVU = .44
Malpractice RVU = .02
PC/TC= 3
SOS = 1
Multiple Procedure Indicator = 0
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 0
Co-surgery = 0
Team Surgery Indicator = 0

89240 Procedure Status= C
PC/TC = 0
SOS = 1
Multiple Procedure Indicator = 0
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 0
Co-surgery = 0
Team Surgery Indicator = 0

Cont. on next page

Políticas de Pago

Cambios en las Unidades de Valor Relativo (RVU)

Los siguientes códigos sufrieron cambios en las unidades de Valor Relativo:

Billing Policies

Relative Value Units (RVU) Changes

The Relative Units changed for the following codes:

Codes	Non-facility PE RVU	Facility PE RVU	Malpractice RVU	Work RVU	Fees Puerto Rico	Fees U.S. Virgin Islands
76511	1.83	1.83			$84.65	$108.37
76511-TC	1.43	1.43			$38.72	$57.24
76512	1.75	1.75			$72.27	$95.61
76512-TC	1.45	1.45			$39.55	$59.13
76513	1.84	1.84			$74.66	$99.04
76513-TC	1.54	1.54			$41.94	$62.57
76516	1.20	1.20			$59.51	$78.54
76516-TC	1.45	1.45			$32.60	$48.46
76519	1.54	1.54			$61.90	$81.98
76519-TC	1.29	1.29			$34.99	$51.89
76529	1.40	1.40			$59.40	$78.13
76529-TC	1.15	1.15			$31.37	$46.92
89220	0.40	0.40	0.02		$10.83	$16.03
89230	0.44	0.44	0.02		$11.90	$17.56
94240	0.70	0.70			$28.92	$38.69
94240-TC	0.62	0.62			$16.98	$25.55
96412				0.17	$35.27	$49.14

CR3128/Transmittal 105/February 20, 2004/ERO

FACTURACIÓN CORRECTA PARA MATERIAL DE CONTRASTE DE BAJA OSMOLARIDAD

Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) decidieron no eliminar los códigos de material de contraste de baja osmolaridad A4644 al A4646, sino invalidar el nuevo código A9525 efectivo el 1 de abril de 2004.

Los productos Iso-osmolares deben continuar facturándose usando el código adecuado de baja osmolaridad A4644, A4645 ó A4646.

CORRECT CODING FOR LOW OSMOLAR CONTRAST MATERIAL

The Centers for Medicare and Medicaid (CMS) decided not to eliminate low osmolar contrast material codes A4644 thru A4646 and rather invalid effective April 1, 2004 new HCPCS code A9525.

Iso-osmolar products should continue to be coded using the appropriate low osmolar code A4644, A4645, or A4646.

Pub. 100-20/Trans. 45/Jan 23, 2004/CR3053/dmg

Políticas de Pago

FACTURACIÓN PARA PRUEBAS REFERIDAS POR LABORATORIOS

Definiciones:

1. Medicare define una prueba referida de laboratorio clínico como un servicio realizado por un laboratorio a petición de otro laboratorio.
2. Laboratorio que refiere se define como el laboratorio que refiere una muestra para prueba a otro laboratorio.
3. Laboratorio de referencia se define como el laboratorio que recibe una muestra de otro laboratorio y que realiza una o más pruebas de esa muestra.

Las siguientes instrucciones aclaran el modo en que usted debe facturar por servicios de laboratorios clínicos referidos en reclamaciones en papel y en reclamaciones electrónicas.

Reclamaciones en papel:

Los proveedores que someten reclamaciones en papel (Formulario CMS 1500) no deben combinar en el mismo formulario CMS 1500 los servicios que ellos mismos realizaron y aquellos que refirieron a otro laboratorio. Si el laboratorio que factura realiza algunas pruebas y refiere el resto de las pruebas a otro laboratorio, la facilidad (instalación de salud) debe separar la reclamación y someter dos reclamaciones por separado. En cada reclamación el número de CLIA del laboratorio que realiza la prueba debe informarse en el encasillado 23 del formulario CMS 1500. En el encasillado 24 usted debe identificar la prueba referida con el modificador 90. Solamente se permiten reclamaciones por pruebas referidas a los laboratorios clínicos facturando independientemente, especialidad 69. El nombre y la dirección del laboratorio que realiza las pruebas debe anotarse en el encasillado 32 del formulario CMS 1500 indicando donde se llevó a cabo el servicio (la prueba).

Billing Policies

LABORATORIES BILLING FOR REFERRED TEST

Definitions:

1. *Medicare defines a referred clinical diagnostic laboratory service or test as a service performed by one laboratory at the request of another laboratory.*
2. *Referring laboratory is defined as the laboratory that refers a specimen to another laboratory for testing.*
3. *Reference laboratory is defined as the laboratory that receives a specimen from another laboratory and that performs one or more tests on such specimen.*

The following instructions clarify the way you should bill for referred clinical diagnostic laboratory services on paper and electronic claims.

Paper claims:

Providers that submit paper claims (CMS 1500 claim form) may not combine on the same claim services that they performed with those they referred to another laboratory. If a billing laboratory performs some tests and refers the remaining tests to another laboratory to perform, the facility must split the claim and submit two separate claims. On each claim, the CLIA number of the laboratory that is performing the tests must be reported in item 23 of the CMS 1500 form. Item 24 should indicate the referred test (CPT code) with modifier 90. Referral laboratory claims are permitted only for independently billing clinical laboratories specialty 69. The performing laboratory's name and address must be reported in item 32 of the CMS-1500 form to show where the service (test) was actually performed.

Cont. on next page

Políticas de Pago

Las reclamaciones sometidas en papel se devolverán como no procesables si los facturadores combinan en el mismo formulario CMS 1500 servicios de laboratorio clínico realizados por ellos mismos con cualquier servicio referido a otro laboratorio.

Reclamaciones en formato electrónico:

Los proveedores que someten reclamaciones en formato electrónico ANSI pueden combinar en la misma reclamación electrónica los servicios que ellos mismos realizaron y aquellos que refirieron a otro laboratorio. Los números CLIA para el laboratorio que factura y del laboratorio que refiere deben estar en la reclamación. El servicio referido tiene que identificarse con el modificador 90.

Para una reclamación en formato electrónico ANSI, el número de CLIA del laboratorio que realiza la prueba debe anotarse en el formato **4010A1** X12 837 (versión HIPAA) loop 2300, REF02. REF01 = F4. Una reclamación electrónica para pruebas de laboratorio requiere el nombre y la dirección del laboratorio que realiza y del laboratorio que la factura. El encasillado con el modificador 90 requiere información del proveedor en el formato X12N 837 en Loop 2400, REF02. REF01=4.

Los proveedores que sometan reclamaciones en formato electrónico NSF no pueden combinar en la misma reclamación servicios que ellos mismos hayan realizado y los que hayan referido a otro laboratorio. En una reclamación NSF el número de CLIA del laboratorio de referencia debe anotarse en FAO-34.0 y la dirección debe anotarse en los siguientes campos de NSF:

EA0 – Campo 39/Instalación de salud/ Nombre del laboratorio

EA1 – Campo 06/Instalación de salud/ Dirección 1 del laboratorio

EA1 – Campo 07/Instalación de salud/ Dirección 2 del laboratorio

EA1 – Campo 08/Instalación de salud/ Pueblo del laboratorio

Billing Policies

Paper claims will be returned as unprocessable if the billing providers combines clinical laboratory services performed themselves and any referred to another laboratory on the same CMS 1500 form.

Electronic claims:

Providers that submit claims in the electronic format (ANSI) can combine services that they performed and those that they referred to another laboratory on the same electronic claim. CLIA numbers for both the billing and reference laboratory must be on the claim. The referred service must to be identified with modifier "90".

*For an ANSI electronic claim the CLIA number of the laboratory performing the test should be entered on "**4010A1** X12 837 (HIPAA version) loop 2300, REF02.REF01 = F4. An electronic claim for laboratory tests requires the presence of the performing and billing laboratory's name and address. The line item with modifier "90" requires provider information on X12N 837 in Loop 2400, REF 02. REF01 = F4.*

Providers that submit claims in an electronic format (NSF) may not combine services that they performed with those that they referred to another laboratory on the same NSF form. In the NSF claim the CLIA number for the laboratory performing the test should be entered on FA0 – 34.0 and reference laboratory address should be submitted on the following NSF records and fields:

EA0 Field 39 Facility/Lab Name

EA1 Field 06 Facility/Lab ADDR1

EA1 Field 07 Facility/Lab ADDR2

EA1 Field 08 Facility/Lab City

EA1 Field 09 Facility/Lab State

EA1 Field 10 Facility/Lab Zip Code

Cont. on next page

EA1 – Campo 09/Instalación de salud/País del laboratorio

EA1 – Campo 10/Instalación de salud/ Código postal del laboratorio

En una reclamación separada el laboratorio podrá indicar la prueba referida del laboratorio con el modificador 90 y podrán someter los siguientes campos de NSF: FAO-34.0 (CLIA de un laboratorio de referencia).

Nota: El número CLIA del laboratorio de referencia y el modificador 90 identificando los servicios referidos es importante para procesar estas reclamaciones.

Este artículo sustituye el que aparece en nuestra página electrónica bajo el CR-2193.

In a separate claim the laboratory should indicate the referral laboratory test with modifier 90 and should be submitted the following NSF records and fields; FAO-34.0 (CLIA from reference lab).

***Note:** The CLIA number of the reference laboratory and modifier "90" identifying referred services are important to process these claims.*

This article supersedes the one posted at our webpage under CR-2193.

Pub. 100-04 MCP/Trans. 85/CR-3090/Feb. 6, 2004/ICR

CRITERIOS PARA EL USO DEL MODIFICADOR "CB"

La disposición de Facturación Consolidada para los Centros de Enfermería Especializada (SNF CB, por sus siglas en inglés) requiere a estos centros incluir en la factura a la Parte A de Medicare casi todos los servicios que sus residentes reciben durante una estadía cubierta. No obstante, existen ciertas categorías de servicios que la ley (§1888 (e)(2)(A)(ii) del Seguro Social) excluye de esta disposición y pueden ser facturadas separadamente a la Parte B de Medicare por el suplidor externo que los provea. Una de las categorías excluidas abarca aquellos artículos y servicios que son parte del beneficio de la Parte B que cubre diálisis crónica para beneficiarios con Enfermedad Renal terminal (ESRD, por sus siglas en inglés).

Proveedores y suplidores deben utilizar Modificador **CB** para los servicios ordenados por un médico del centro de diálisis como parte de los beneficios de diálisis del paciente ESRD y que no son parte de la tasa compuesta y son reembolsables separadamente. No es

CRITERIA FOR USING THE CB MODIFIER

The Skilled Nursing Facility (SNF) Consolidated Billing (CB) provision requires a SNF to include in its Part A bill almost all of the services that its residents receive during the course of a covered stay. However, there are several categories of services that the law (§1888 (e)(2)(A)(ii) of the Social Security Act) specifically excludes from this provision and these excluded services remain separately billable under Part B by the outside supplier that provided them. One of the excluded categories is for those items and services that cover chronic dialysis for beneficiaries with End Stage Renal Disease (ESRD).

*Providers and suppliers should use Modifier **CB** for services ordered by a dialysis facility physician as part of the ESRD beneficiary's dialysis benefit that are not part of the composite rate and are reimbursable separately. It is not necessary to include modifier **CB** in every single service; however, the provider or supplier must be aware that SNF CB editing will be applied if the line item does not contain the modifier.*

Cont. on next page

Políticas de Pago

necesario incluir el Modificador **CB** en todos los servicios; sin embargo, aquellos servicios que no incluyan el modificador se considerarán parte del SNF CB.

Los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) actualizaron las instrucciones para que los proveedores y suplidores puedan utilizar el modificador "**CB**" sólo cuando se ha determinado que:

a. el beneficiario tiene derecho como ESRD;

b. la prueba está relacionada al tratamiento de diálisis para paciente ESRD;

c. la prueba es ordenada por un médico que provee el cuidado de salud a los pacientes en el centro de diálisis; y

d. la prueba no está incluida en el pago compuesto a los centros de diálisis

CMS identificó las siguientes pruebas diagnósticas como pruebas comúnmente suministradas a beneficiarios ESRD y que no son parte de la tasa compuesta. Cuando estos servicios se facturen con el Modificador **CB** se considerarán para pago.

La lista en las páginas 68 a la 70 no abarca todas las pruebas diagnósticas que Medicare considera como pruebas cubiertas para pacientes ESRD. Puede que existan pruebas diagnósticas adicionales relacionadas al tratamiento/cuidado del paciente ESRD; no obstante, si dichas pruebas no se incluyen en la siguiente lista, el contratista puede requerir documentación médica.

CR2906/Trans. 69/Pub.100-04 MCP/23 de enero de 2004/ICR/els
CR2475/Trans. AB-02-175/December 13, 2002/ICR/els

Billing Policies

*The Centers for Medicare and Medicaid Services (CMS) have modified the instructions so that a provider or supplier may use the "**CB**" modifier only when it has determined that:*

a. the beneficiary has ESRD entitlement;

b. the test is related to the dialysis treatment for ESRD;

c. the test is ordered by a doctor providing care to patients in the dialysis facility; and

d. the test is not included in the dialysis facility's composite rate payment

*CMS has identified the following diagnostic services as being commonly furnished to ESRD beneficiaries and payable outside the composite rate. When billed using the "**CB**" modifier, these services will bypass our SNF CB edits.*

The list on pages 68 to 70 was not designed as an all-inclusive list of Medicare covered diagnostic services. Additional diagnostic services related to the beneficiary's ESRD treatment/care might be considered ESRD-related; however, if these services are not included in the following list, the carrier may require supporting medical documentation.

Cont. on next page

Code	Diagnostic	Code	Diagnostic
75790	Visualize A-V shunt	87517	Hepatitis B, dna, quant
7579026	Visualize A-V shunt	87520	Hepatitis C, rna, dir probe
75790TC	Visualize A-V shunt	87521	Hepatitis C, rna, amp probe
75893	Venous sampling by catheter	87522	Hepatitis C, rna, quant
7589326	Venous sampling by catheter	87525	Hepatitis G, dna, dir probe
75893TC	Venous sampling by catheter	87526	Hepatitis G, dna, amp probe
75894	X-rays, transcath therapy	87527	Hepatitis G, dna, quant
7589426	X-rays, transcath therapy	93307	Echo exam of heart
75894TC	X-rays, transcath therapy	9330726	Echo exam of heart
75896	X-rays, transcath therapy	93307TC	Echo exam of heart
7589626	X-rays, transcath therapy	93308	Echo exam of heart
75896TC	X-rays, transcath therapy	9330826	Echo exam of heart
75961	Retrieval, broken catheter	93308TC	Echo exam of heart
7596126	Retrieval, broken catheter	93922	Extremity study
75961TC	Retrieval, broken catheter	9392226	Extremity study
75962	Repair arterial blockage	93922TC	Extremity study
7596226	Repair arterial blockage	93923	Extremity study
75962TC	Repair arterial blockage	9392326	Extremity study
75964	Repair artery blockage, each	93923TC	Extremity study
7596426	Repair artery blockage, each	93925	Lower extremity study
75964TC	Repair artery blockage, each	9392526	Lower extremity study
76070	Ct bone density, axial	93925TC	Lower extremity study
7607026	Ct bone density, axial	93926	Lower extremity study
76070TC	Ct bone density, axial	9392626	Lower extremity study
76075	Dexa, axial skeleton study	93926TC	Lower extremity study
7607526	Dexa, axial skeleton study	93930	Upper extremity study
76075TC	Dexa, axial skeleton study	9393026	Upper extremity study
76080	X-ray exam of fistula	93930TC	Upper extremity study
7608026	X-ray exam of fistula	93931	Upper extremity study
76080TC	X-ray exam of fistula	9393126	Upper extremity study
78351	Bone mineral, dual photon	93931TC	Upper extremity study
80048	Basic metabolic panel	93965	Extremity study
80051	Electrolyte panel	9396526	Extremity study
80053	Comprehen metabolic panel	93965TC	Extremity study
80069	Renal function panel	G0008	Admin influenza virus vaccines
80074	Acute hepatitis panel	G0009	Admin pneumococcal vaccine
80076	Hepatic function panel	G0010	Admin Hepatitis B vaccine
80410	Calcitonin stimul panel	G0015	Post symptom ECG tracing
82040	Assay of serum albumin	G0202	Screening mammography digital
82108	Assay of aluminum	G020226	Screening mammography digital
82306	Assay of vitamin D	G0202TC	Screening mammography digital
82307	Assay of vitamin D	71010	Chest x-ray
82308	Assay of calcitonin	7101026	Chest x-ray
82310	Assay of calcium	71010TC	Chest x-ray
82330	Assay of calcium	71015	Chest x-ray
82379	Assay of carnitine	7101526	Chest x-ray
82435	Assay of blood chloride	71015TC	Chest x-ray
82565	Assay of creatinine	71020	Chest x-ray
82570	Assay of urine creatinine	7102026	Chest x-ray
82570	Assay of urine creatinine	71020TC	Chest x-ray
82585	Assay of cryofibrinogen	71021	Chest x-ray
82800	Blood pH	7102126	Chest x-ray

Code	Diagnostic	Code	Diagnostic
82803	Blood gases: pH, pO2 & pCO2	71021TC	Chest x-ray
82805	Blood gases W/02 saturation	71022	Chest x-ray
82810	Blood gases, O2 sat only	7102226	Chest x-ray
82945	Glucose other fluid	71022TC	Chest x-ray
82947	Assay, glucose, blood quant	71030	Chest x-ray
82947	Assay, glucose, blood quant	7103026	Chest x-ray
82948	Reagent strip/blood glucose	71030TC	Chest x-ray
83540	Assay of iron	71035	Chest x-ray
83550	Iron binding test	7103526	Chest x-ray
83970	Assay of parathormone	71035TC	Chest x-ray
83986	Assay of body fluid acidity	73120	X-ray exam of hand
83986	Assay of body fluid acidity	75710	Artery x-rays, arm/leg
84100	Assay of phosphorus	7571026	Artery x-rays, arm/leg
84132	Assay of serum potassium	75710TC	Artery x-rays, arm/leg
84134	Assay of prealbumin	75716	Artery x-rays, arms/legs
84155	Assay of protein	7571626	Artery x-rays, arms/legs
84160	Assay of serum protein	75716TC	Artery x-rays, arms/legs
84295	Assay of serum sodium	75774	Artery x-ray, each vessel
84520	Assay of urea nitrogen	7577426	Artery x-ray, each vessel
84525	Urea nitrogen semi-quant	75774TC	Artery x-ray, each vessel
84540	Assay of urine/urea-n	75820	Vein x-ray, arm/leg
84545	Urea-N clearance test	7582026	Vein x-ray, arm/leg
85002	Bleeding time test	75820TC	Vein x-ray, arm/leg
85004	Automated diff WBC count	75822	Vein x-ray, arms/legs
85007	Bl smear w/diff WBC count	7582226	Vein x-ray, arms/legs
85008	Bl smear w/o diff WBC count	75822TC	Vein x-ray, arms/legs
85009	Manual diff WBC count b-coat	75898	Follow-up angiography
85013	Spun microhematocrit	7589826	Follow-up angiography
85014	Hematocrit	75898TC	Follow-up angiography
85014	Hematocrit	75901	Remove cva device obstruct
85018	Hemoglobin	7590126	Remove cva device obstruct
85018	Hemoglobin	75901TC	Remove cva device obstruct
85021	Automated hemogram	75902	Remove cva lumen obstruct
85022	Automated hemogram	7590226	Remove cva lumen obstruct
85023	Automated hemogram	75902TC	Remove cva lumen obstruct
85024	Automated hemogram	76092	Mammogram, screening
85025	Complete CBC w/auto diff WBC	7609226	Mammogram, screening
85027	Complete CBC, automated	76092TC	Mammogram, screening
85031	Manual hemogram, CBC	76778	US exam kidney transplant
85032	Manual cell count, each	7677826	US exam kidney transplant
85041	Automated RBC count	76778TC	US exam kidney transplant
85044	Manual reticulocyte count	78070	Parathyroid nuclear imaging
85045	Automated reticulocyte count	7807026	Parathyroid nuclear imaging
85046	Reticyte/Hgb concentrate	78070TC	Parathyroid nuclear imaging
85048	Automated leukocyte count	80061	Lipid panel
85049	Automated platelet count	80061	Lipid panel
85345	Coagulation time	80197	Assay of tacrolimus
85347	Coagulation time	81000	Urinalysis, nonauto w/scope
85348	Coagulation time	81001	Urinalysis, auto w/scope
85590	Platelet count, manual	81002	Urinalysis nonauto w/o scope
85595	Platelet count, automated	81003	Urinalysis, auto, w/o scope
85610	Prothrombin time	81003	Urinalysis, auto, w/o scope

Code	Diagnostic	Code	Diagnostic
85610	Prothrombin time	81005	Urinalysis
85611	Prothrombin test	81007	Urine screen for bacteria
85730	Thromboplastin time, partial	81015	Microscopic exam of urine
85732	Thromboplastin time, partial	82009	Test for acetone/ketones
86645	CMV antibody, IgM	82010	Acetone assay
86687	Htlv-i antibody	82010	Acetone assay
86688	Htlv-ii antibody	82017	Acylcarnitines, quant
86689	HTLV/HIV confirmatory test	82247	Bilirubin, total
86692	Hepatitis, delta agent	82248	Bilirubin, direct
86701	HIV-1	82575	Creatinine clearance test
86702	HIV-2	82728	Assay of ferritin
86703	HIV-1/HIV-2, single assay	83937	Assay of osteocalcin
86704	Hep B core antibody, total	84300	Assay of urine sodium
86705	Hep B core antibody, igm	84315	Body fluid specific gravity
86706	Hep B surface antibody (HBsAB)	84450	Transferase (AST) (SGOT)
86707	Hep be antibody (HBeAb)	84460	Alanine amino (ALT) (SGPT)
86803	Hepatitis C antibody	84460	Alanine amino (ALT) (SGPT)
86804	Hep C ab test, confirmatpry Test	85520	Heparin assay
86812	HLA typing, A, B, or C	85652	RBC sed rate, automated
86813	HLA typing, A, B, or C	86590	Streptokinase, antibody
86816	HLA typing, DR/DQ	87198	Cytomegalovirus antibody dfa
86817	HLA typing, DR/DQ	87199	Enterovirus antibody, dfa
86900	Blood typing, ABO	87205	Smear, gram stain
86903	Blood typing, antigen screen	93000	Electrocardiogram, complete
86904	Blood typing, patient serum	93005	Electrocardiogram, tracing
86905	Blood typing, RBC antigens	93010	Electrocardiogram report
86906	Blood typing, Rh phenotype	93040	Rhythm ECG with report
87070	Culture, bacteria, other	93041	Rhythm ECG, tracing
87071	Culture bacteri aerobic othr	93042	Rhythm ECG, report
87073	Culture bacteria anaerobic	93970	Extremity study
87075	Culture bacteria anaerobic	9397026	Extremity study
87076	Culture anaerobe ident, each	93970TC	Extremity study
87077	Culture aerobic identify	93971	Extremity study
87077	Culture aerobic identify	9397126	Extremity study
87081	Culture screen only	93971TC	Extremity study
87084	Culture of specimen by kit	ATP02	Auto.Test Pane Pricing Code, 1-2 Tests
87086	Urine culture/colony count	ATP03	Auto.Test Panel Pricing Code, 3 Tests
87088	Urine bacteria culture	ATP04	Auto.Test Panel Pricing Code, 4 Tests
87181	Microbe susceptible, diffuse	ATP05	Auto.Test Panel Pricing Code, 5 Tests
87184	Microbe susceptible, disk	ATP06	Auto.Test Panel Pricing Code, 6 Tests
87185	Microbe susceptible, enzyme	ATP07	Auto.Test Panel Pricing Code, 7 Tests
87186	Microbe susceptible, mic	ATP08	Auto.Test Panel Pricing Code, 8 Tests
87187	Microbe susceptible, mlc	ATP09	Auto.Test Panel Pricing Code, 9 Tests
87188	Microbe suscept, macrobroth	ATP10	Auto.Test Panel Pricing Code, 10 Tests
87190	Microbe suscept, mycobacteri	ATP11	Auto.Test Panel Pricing Code, 11 Tests
87197	Bactericidal level, serum	ATP12	Auto.Test Panel Pricing Code, 12 Tests
87340	Hepatitis B surface antigen	ATP16	Auto Test Panel Pricing Code 13-16 Test
87341	Hepatitis B surface, neutralization	ATP18	Auto Test Panel Pricing Code, 17-18 Test
87350	Hepatitis Be Ag,	ATP19	Auto Test Panel Pricing Code, 19 Tests
87380	Hepatitis delta agent	ATP20	Auto Test Panel Pricing Code, 20 Tests
87390	HIV-1 Ag	ATP21	Auto Test Panel Pricing Code, 21 Tests
87391	HIV-2 Ag	ATP22	Auto.Test Panel Pricing Code, 22+ Tests
87515	Hepatitis B, dna, dir probe	G0001	Drawing blood for specimen
87516	Hepatitis B, dna, amp probe	P9615	Urine specimen collect mult

Políticas de Pago

NUEVAS PRUEBAS AL CERTIFICADO DE DISPENSA

La Administración Federal de Drogas y Alimentos aprobó las siguientes pruebas como pruebas de dispensa bajo el Clinical Laboratory Improvement Amendments (CLIA). Para que dichas pruebas se reconozcan como pruebas de dispensa, los códigos CPT para las mismas deberán venir acompañados del modificador QW.

Billing Policies

NEW TESTS TO THE WAIVED CERTIFICATE

The following are the latest approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments (CLIA). To be recognized as a waived test, the CPT codes for these new tests must have the modifier QW.

CÓDIGO *CODE*	FECHA DE EFECTIVIDAD *EFFECTIVE DATE*	DESCRIPCIÓN *DESCRIPTION*
87899-QW	8/21/2003	Binax NOW RSV Test
87899-QW	8/29/2003	Integrated Biotechnology Quick Lab RSV Test
86701-QW	9/30/2003	OraSure OraQuick Rapid HIV-1 Antibody Test - fingerstick and venipuncture whole blood
82274-QW G0328-QW	10/16/2003 1/1/2004	Enterix InSure Fecal Immunochemical Test
87880-QW	10/21/2003	Germaine Laboratories Strep AIM Tower

El nuevo código de dispensa, 87899QW, se asignó para la pruebas “*Binax NOW RSV*” e “Integrated Biotechnology Quick Lab RSV”. Se añadió el código G0328QW para las pruebas “Enterix InSure Fecal Immunochemical” y “Enterix InSure™ Fecal Occult Blood”.

The new waived code, 87899QW, has been assigned for the Binax NOW RSV test and the Integrated Biotechnology Quick Lab RSV Test. The new code G0328QW has been added for the Enterix InSure Fecal Immunochemical Test and the Enterix InSure™ Fecal Occult Blood Test.

CR-3061/Trans. 102/February 20, 2004/MRM

ACTUALIZACIÓN DE LOS ÉDITOS CCI (CORRECT CODING INITIATIVE), VERSIÓN 10.1

La actualización más reciente al “Correct Coding Initiative” (CCI, por sus siglas en inglés), Versión 10.1 con vigencia el 1 de abril de 2004, está disponible en la página electrónica de los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en ingés): http://www.cms.hhs.gov/physicians/cciedits/default.asp.

La Versión 10.1 incluye todas las versiones y actualizaciones previas comenzando con la del 1 de enero de 1996 al presente. Estas están organizadas en dos tablas: Columna 1/Columna 2 “Correct Coding Edits” y “Mutually Exclusive Code (MEC) Edits”.

QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI) EDITS, VERSIÓN 10.1

The latest package of Correct Coding Initiative (CCI) edits, Version 10.1, effective April 1, 2004, is available at the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.hhs.gov/physicians/cciedits/default.asp.

Version 10.1 will include all previous versions and updates from January 1, 1996, to the present and will be organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits.

CR2997/Transmittal 66/Pub.100-04 MCP/January 16, 2004/els

Laboratorio

NUEVA POLÍTICA DE PAGO PARA EL SERVICIO DE PRUEBAS COMPRADAS POR UN LABORATORIO INDEPENDIENTE

Trasfondo:

Actualmente las reclamaciones para el servicio de pruebas compradas son adjudicadas a base de la política establecida en la Sección 15048 del *Medicare Carriers Manual*. Esta establece que si un médico o laboratorio factura por una prueba de laboratorio prestada por un suplidor externo, el reembolso por las pruebas compradas será igual a lo menor de la tarifa fija del médico o el laboratorio o del precio pagado por el servicio.

Política:

Para servicios ofrecidos desde el 1 de abril de 2004 en adelante, se añadió una nueva política a la Publicación 100-04, Capítulo 16, Sección 40.2, que aclara los requisitos para que un laboratorio independiente facture por una prueba de laboratorio ofrecida por un suplidor externo.

Esta nueva política, la cual se explica más adelante, aplica solamente a laboratorios independientes:

Cuando un laboratorio independiente factura por el componente técnico (TC) de un servicio médico patológico comprado por un médico o suplidor externo, la cantidad a pagarse por el componente técnico se basa en el menor de los cargos facturados o la tarifa del Manual de Tarifas Fijas de Medicare. El pago para la prueba diagnóstica comprada no aplica; por lo tanto, la información del servicio comprado no debe añadirse en la reclamación.

Todos los servicios diagnósticos comprados se basan en el Manual de Tarifas Fijas de Medicare y están sujetos a las normas que rigen dicho Manual.

Los laboratorios independientes deben realizar al menos uno de los componentes de servicio. Si compran ambos servicios, el técnico y el profesional, solamente puede facturar el médico o el suplidor que lleve a cabo esos servicios.

Esta nueva política se implantará el 5 de abril de 2004.

Laboratory

NEW POLICY FOR PURCHASED DIAGNOSTIC SERVICES BY AN INDEPENDENT LABORATORY

Background:

Currently claims for purchased diagnostic services are adjudicated based on a policy established in MCM Section 15048. This Section established that if a physicians or laboratory bills for a laboratory test performed by an outside supplier, the fee schedule amount for the purchased service equals the lower of the billing physicians or laboratory's fee schedule or the price paid for the service.

New Policy:

Effective for services provided on or after April 1, 2004, a new policy is being added to Publication 100-04 Chapter 16 Section 40.2 that clarifies the requirements for when an independent laboratory bills for a laboratory test performed by an outside supplier.

This new policy, which is detailed below, applies to independent laboratories only:

When an Independent Laboratory (IL) bills for the technical component (TC) of a physician pathology service purchased from a separate physician or supplier, the payment amount for the TC is based on the lower of the billed charge or the Medicare Physician Fee Schedule. The purchase diagnostic test payment provision does not apply, thus, the purchase service information shall not be entered on the claim.

All purchased diagnostic services are based on the Medicare Physician Fee Schedule and are subject to the jurisdiction rules for that fee schedule.

The Independent Laboratories must perform at least one of the component services. If they purchase both the PC and the TC services, only the physician or supplier that performed those services may bill.

This new policy will be implemented on April 5, 2004.

CR2919/Transm. 16/October 31, 2003/ERO

Laboratorio

CAMBIOS A LA DETERMINACIÓN DE LA CUBIERTA NACIONAL PARA LABORATORIOS

De acuerdo al memorando publicado el 30 de octubre de 2003 en Internet (http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=99), CMS añadió los siguientes códigos de diagnósticos para los estudios de hierro en sangre.

Laboratory

CHANGES TO THE LABORATORY NATIONAL COVERAGE DETERMINATION (NCD)

In accordance with the decision memorandum published on the coverage Internet site on October 30, 2003 (see http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=99), CMS added the following diagnosis codes for the serum iron studies.

- 403.01 = Hypertensive renal disease, malignant, with renal failure
- 403.11 = Hypertensive renal disease, benign, with renal failure
- 403.91 = Hypertensive renal disease, unspecified, with renal failure
- 404.02 = Hypertensive renal disease, malignant, with renal failure
- 404.03 = Hypertensive heart and renal disease, malignant, with heart and renal failure
- 404.12 = Hypertensive heart and renal disease, benign, with renal failure
- 404.13 = Hypertensive heart and renal disease, benign, with heart and renal failure
- 404.92 = Hypertensive heart and renal disease, unspecified, with renal failure
- 404.93 = Hypertensive heart and renal disease, unspecified, with heart and renal failure

Estos códigos se cubrirán para servicios prestados del 5 de abril de 2004 en adelante.

These codes will be covered for services furnished on April 5, 2004 and thereafter.

CR3032 & 3072/Pub. 100-04 MCP/Trans. 71/January 23, 2004

Centros de Cirugía Ambulatoria (ASC)

CAMBIOS EN LOS PAGOS PARA EL AÑO FISCAL 2004

Este artículo indica los cambios en el pago por servicios prestados en Centros de Cirugía Ambulatoria durante el año fiscal 2004. Esta información sustituye la Carta Circular #M03-08-006 publicada el 27 de agosto de 2003. Los cambios son como resultado de la nueva ley establecida; *Section 626(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) on December 8, 2003.*

Estas nuevas tarifas son vigentes para los servicios prestados del 1 de abril de 2004 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*). El grupo de tarifas de pago utilizado para los Centros de Cirugía Ambulatoria fue el que se implantó el 1 de octubre de 2002.

En la primera tabla identificada como **TARIFAS DE PAGO ASC ABRIL 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 se incluyen en la segunda tabla identificada como **Áreas Urbanas**.

Ambulatory Surgical Centers (ASC)

CHANGES IN PAYMENT RATES UPDATES FOR FY-2004

This article describes changes in payment for services furnished in Ambulatory Surgical Centers during fiscal year 2004. The information in this notification supersedes Circular Letter #M03-08-006 that was issued on August 27, 2003. It reflects changes resulting from enactment of Section 626(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA) on December 8, 2003.

These new fees are effective for services rendered April 1, 2004 and thereafter. The wage index values used for urban and rural areas are part of fiscal year 2004 update for the hospital inpatient prospective payment system (PPS). The ASC payment group rates used were the fees implemented effective October 1, 2002.

*The first table identified as **ASC PAYMENT RATES April 2004** includes the new payment rates arranged by group (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 in the second table identified as **Urban Areas**.*

TARIFAS DE PAGO ASC - ABRIL, 2004 / *ASC PAYMENT RATES APRIL, 2004*

GRUPO *GROUP*	TARIFA *FEE*	I 0.4289	II 0.4138	III 0.4184	IV 0.4776	V 0.4689	VI 0.4880	VII 0.4002
1	333.00	$ 267.48	$ 265.75	$ 266.28	$ 273.07	$ 272.07	$ 274.26	$ 264.19
2	446.00	$ 358.25	$ 355.93	$ 356.64	$ 365.73	$ 364.40	$ 367.33	$ 353.84
3	510.00	$ 409.66	$ 407.01	$ 407.82	$ 418.22	$ 416.69	$ 420.05	$ 404.62
4	630.00	$ 506.05	$ 502.77	$ 503.77	$ 516.62	$ 514.73	$ 518.88	$ 499.82
5	717.00	$ 575.93	$ 572.20	$ 573.34	$ 587.96	$ 585.81	$ 590.53	$ 568.85
6	826.00	$ 693.00	$ 689.48	$ 690.56	$ 704.34	$ 702.32	$ 706.76	$ 686.32
7	995.00	$ 799.24	$ 794.06	$ 795.64	$ 815.93	$ 812.95	$ 819.50	$ 789.40
8	973.00	$ 811.08	$ 806.80	$ 808.10	$ 824.89	$ 822.42	$ 827.84	$ 802.94
9	1,339.00	$ 1,075.56	$ 1,068.59	$ 1,070.72	$ 1,098.02	$ 1,094.01	$ 1,102.82	$ 1,062.32

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

Cont. on next page

Centros de Cirugía Ambulatoria (ASC)

Ambulatory Surgical Centers (ASC)

AREAS 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

Transmittal AB-03-116/CR 2871/August 8, 2003/ERO
Transmittal 51/CR 3082/February 6, 2004/ERO

Ambulancia

CORRECCIÓN EN TARIFA RURAL 18 MILLAS EN ADELANTE

En nuestra carta del 3 de marzo de 2004 relacionada al "Informe de los Cargos Razonables del 2004'' involuntariamente indicamos una tarifa incorrecta para el millaje en área rural 18 millas en adelante.

La siguiente tabla sustituye la enviada con dicha carta:

Ambulance

CORRECTION TO THE RURAL RATE GREATER THAN 18 MILES

In our letter of March 3, 2004 regarding the "2004 Reasonable Charge Disclosure" we inadvertently indicated an incorrect fee for the rural mileage rate greater than 18 miles.

The following table substitutes the one sent with said letter.

TARIFAS URBANAS Y RURALES PARA PUERTO RICO

CÓDIGO	TARIFA URBANA	TARIFA RURAL
A0425	$5.65	1-17 millas 8.48(5.65x1.50)=8.48 **18 millas en adelante = $5.65**
A0435	$6.78	$10.17(aumento 50% a la tarifa fija sin ajustar)
A0436	$18.07	$27.11(aumento 50% a la tarifa fija sin ajustar)
A0426	$168.66	N/A
A0427	$267.05	N/A
A0428	$140.55	N/A
A0429	$224.88	N/A
A0430	$2,045.08	$3,067.62(aumento 50% a la tarifa fija sin ajustar)
A0431	$2,377.70	$3,566.55(aumento 50% a la tarifa fija sin ajustar)
Q3019	$224.88	$224.88
Q3020	$140.55	$140.55

URBAN AND RURAL RATES FOR VIRGIN ISLANDS

CODES	URBAN RATE	RURAL RATE
A0425	$5.65	1-17 miles(5.65x1.50)=8.48 **greater than 18 miles = $5.65**
A0435	$6.78	$10.17(50% increase of the unadjusted base rate)
A0436	$18.07	$27.11(50% increase of the unadjusted base rate)
A0426	$214.65	N/A
A0427	$339.86	N/A
A0428	$178.87	N/A
A0429	$286.20	N/A
A0430	$2,416.58	$3,624.88(50% increase of the unadjusted base rate)
A0431	$2,809.63	$4,214.45 (50% increase of the unadjusted base rate)
Q3019	$286.20	$286.20
Q3020	$178.87	$178.87

Ambulancia

Conforme a nuestra publicación en el "**Medicare Informa**" de octubre-diciembre 2003 (página 66) y notificado en nuestra página de Internet en la sección de Ambulancia (Ajuste en la Tarifa de Millaje de Área rural para Servicios de Ambulancia Terrestre), estas tarifas están vigentes desde el 1 de enero de 2004.

Ambulance

*As published in our October – December 2003 "**Medicare Informa**" (page 66) and posted under the Ambulance Section of our Webpage (Adjustment to the Rural Mileage Payment Rate for Ground Ambulance Services) these fees are effective January 1, 2004.*

CR2212,Trans. B-02-048/July, 2002

MÉTODO DE PAGO PARA LOS NUEVOS PROVEEDORES DE SERVICIOS DE AMBULANCIA

Los servicios de ambulancia cubiertos por Medicare actualmente se pagan tomando en consideración el cargo razonable y la tarifa fija que se publicó en el **Registro Federal**, Volumen 67, Número 39. Este pago combinado se escalonó en un período de cinco años durante el cual Medicare establece el reembolso según la porción del cargo razonable del proveedor combinado con la tarifa fija. Para su beneficio, la siguiente tabla indica éstas cantidades:

PAYMENT FOR AMBULANCE SERVICES FURNISHED BY NEW PROVIDERS

*Medicare covered ambulance services are presently paid based on a blend of fees, which was published in the **Federal Register**, Volume 67, Number 39. This payment blend is phased in over a five-year transition period during which the Medicare payment allowance is based on the provider's reasonable charge and the new fee schedule amount. To aid you, the following table indicates these amounts:*

Year	Reasonable Charge Percent	Fee Schedule Percent
Year One (4/2002-12/2002)	80	20
Year Two (CY 2003)	60	40
Year Three (CY 2004)	**40**	**60**
Year Four (CY 2005)	20	80
Year Five (CY 2006)	0	100

Para un nuevo proveedor de ambulancia, el cargo razonable a usarse es el menor entre lo sometido por los proveedores, el percentil 50 del cargo prevaleciente y el índice de inflación prevaleciente (IIC, por sus siglas en inglés). Usualmente, el percentil 50 prevaleciente se convierte en el cargo del proveedor ya que éste no tiene un cargo razonable establecido. Se utilizará el cargo razonable combinado con la tarifa fija del año correspondiente para determinar el pago.

For a new ambulance service provider, the reasonable charge to be used is the lower of the provider's submitted charge, the 50th percentile prevailing charge, and the prevailing IIC (inflation indexed charge). The prevailing 50th percentile becomes a provider's default customary charge for the purpose of calculating the provider's reasonable charge. This reasonable charge and the fee schedule amount for the corresponding year are used to determine the fee to be adjudicated.

Cont. on next page

Ambulancia

Un **nuevo** proveedor de ambulancia incluye:

1. Una entidad que se estableció como proveedor de ambulancia luego que se eliminara el proceso de creación de perfil;
2. Un proveedor que nunca ha facturado a Medicare y comienza a prestar servicios y a facturar por los servicios de ambulancia por primera vez y luego de que se eliminó el proceso de creación de perfil;
3. Un proveedor que comienza a prestar servicios en otra área geográfica; o
4. Un proveedor que comienza a prestar un tipo de servicio que no había prestado anteriormente. Por ejemplo, una ambulancia que sólo prestaba servicios BLS y comienza a prestar servicios ALS.

Ambulance

*A **new** ambulance provider includes:*

1. *An entity that was established as an ambulance provider when the profile charges process was no longer in place;*
2. *A provider that had never billed Medicare and began furnishing and billing for Medicare ambulance services for the first time after it could no longer establish a customary charge because profile charges were no longer allowed;*
3. *A provider that begins furnishing services in another geographic area; or*
4. *A provider that begins furnishing a service that it did not previously supply. For example, an ambulance provider that formerly furnished only BLS services and begins to furnish ALS services as well.*

CR2700/Transmittal 23/November 21, 2003/ERO/els/dg

NUEVO CÓDIGO HCPCS PARA EL CARGO DIFERENCIAL POR SERVICIOS NOCTURNOS DE AMBULANCIA

A pesar de que los Centros de Servicio para Medicare y Medicaid (CMS, por sus siglas en inglés) implantó un nuevo código HCPCS, A0800, para los proveedores de ambulancia elegibles a facturar por separado el cargo diferencial por servicios nocturnos de ambulancia, éste no aplica a Puerto Rico e Islas Vírgenes.

El método de pago para Puerto Rico e Islas Vírgenes es el método dos, el cual paga por separado **sólo** el millaje. Por lo tanto, toda reclamación por el cargo diferencial por servicios nocturnos de ambulancia se denegará.

NEW HCPCS CODE FOR AMBULANCE NIGHT DIFFERENTIAL CHARGES

Even though the Centers for Medicare and Medicaid Services (CMS) established a new HCPCS code, A0800, for ambulance providers eligible to bill separately for ambulance night differential charges, this does not apply to Puerto Rico or U.S. Virgin Islands.

*Puerto Rico and the U.S. Virgin Islands pay for method two, which means that **only** mileage, is paid separately. Therefore, claims received for ambulance night differential charges will be denied.*

CR 3035/Transmittal 59/January 2, 2004/ERO/els

Ambulancia

FACTOR DE INFLACIÓN DE AMBULANCIA PARA EL 2004

La Sección 1834(l)(3)(A) del Acta del Seguro Social establece la base para la actualización del límite de pago para los servicios de ambulancia. Específicamente, esta sección provee para una actualización en los pagos del 2004 igual al por ciento de aumento en el índice de precios del consumidor. Este por ciento se conoce como Factor de Inflación de Ambulancia (AIF, por sus siglas en inglés).

Durante el período de transición, el AIF es 2.1 por ciento para el año natural 2004, éste se aplica a la porción de la tarifa fija y a la porción del cargo razonable que componen la tarifa combinada de cada suplidor de ambulancia. La combinación en las tarifas para el año natural 2004 es 40 por ciento del cargo razonable y 60 por ciento de la tarifa fija.

Recuerden que los servicios de transportación en ambulancia están sujetos al deducible y coaseguro de la Parte B.

Ambulance

2004 AMBULANCE INFLATION FACTOR

Section 1834(l)(3)(A) of the Social Security Act provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2004 that is equal to the percentage increase in the consumer price index. This percentage is referred to as the Ambulance Inflation Factor (AIF).

During the transition period, the AIF for calendar year (CY) 2004 is 2.1 percent, which is applied to both the fee schedule portion and to the reasonable charge portion of the blended payment amount for each ambulance supplier. The blended payment amounts for CY 2004 ambulance services are 40 percent of the reasonable charge and 60 percent of the ambulance fee schedule.

Remember, ambulance services are subject to Part B coinsurance and deductible requirements.

CR 3000/Transmittal 56/December 24, 2004/ERO/els/dg

ENFERMERIA ESPECIALIZADA

CAMBIOS A LA ACTUALIZACIÓN ANUAL DE LOS CÓDIGOS HCPCS USADOS PARA LA FACTURACIÓN CONSOLIDADA DE CENTROS DE ENFERMERÍA ESPECIALIZADA A ENERO DE 2004

Para las reclamaciones con fecha de servicio del 1 de abril de 2004 en adelante, los códigos 92613 y 92615 se eliminaron de la lista de códigos de terapia. Los códigos 92597 y 0020T se añadieron a la lista de códigos de terapia que pueden consolidarse y no pueden pagarse separadamente por los contratistas de la Parte B.

Usted puede revisar la lista de códigos sujetos a la facturación consolidada de Centros de Enfermería Especializada (SNF, por sus siglas en inglés) vigente a partir del 1 de abril de 2004 en: www.cms.hhs.gov/medlearn/snfcodes.asp.

SKILLED NURSING FACILITY

UPDATE TO THE JANUARY 2004 ANNUAL UPDATE OF HCPCS USED FOR SNF CONSOLIDATED BILLING ENFORCEMENT

Effective for claims with date of service April 1, 2004 and thereafter, codes 92613 and 92615 has been deleted from the list of therapy codes. Codes 92597 and 0020T were added to the list of therapy codes that shall be consolidated and shall not be paid separately by Part B carriers.

You can review the coding file for SNF consolidated billing updated effective April 1, 2004 at: www.cms.hhs.gov/medlearn/snfcodes.asp.

CR-3070/Trans. 92/02-06-2004/ICR

Contrato

PROVEEDORES SANCIONADOS

Proveedores sancionados son aquellos que han violado las obligaciones de su contrato con Medicare o Medicaid. A estos proveedores no se les permite facturar al Programa Medicare. 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 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, on next pages we have included the list of excluded providers to the Medicare Program:

Cont. on next page

Proveedores Excluídos del programa Medicare *Providers Excluded from the Medicare Program*		
NOMBRE ***NAME***	**DIRECCION** ***ADDRESS***	**FECHA EFECTIVIDAD** **EFFECTIVE DATE**
Alvarado Sánchez, Mayda C.	56 Georgetti St. Comerío, PR 00782	September 3, 1997
Alvarez Valentin, Mario	Urb. Valencia 1 52 Calle Pedro Cruz-Marg Juncos, PR 00777	July 18, 2002
Arce Forestier, Nestor	3 Muñoz Rivera St. Camuy, PR 00627	August 20, 1998
Arrillaga, Abenamar	Ext. Hermanas Davila 23 - J St. Bayamón, PR 00959	May 18, 2000
Atocha Sánchez, José M.	720 Ponce De León Ave. San Juan, PR 00918	April 29, 1996
Baco Cuebas, German A.	Urb. Ponce De Leon 11 Calla Granada Mayaguez, PR 00680	January 20, 2003
Baez López, Roberto	Calle Victor Salaberry #32 Guanica, PR 00653	February 20, 2003
Bailey, Colin D H	227 Golden Rock Dev Est Christiansted St. croix, VI 008204	April 1, 1992
Canabal Enriquez, Jose M	170 Calle Luna San German, PR 00683	April 20, 2003
Caro Acevedo, Eduardo	Santa Rosa Mall Suite 201 - Segundo Nivel Bayamon, PR 00959	March 20, 2002
Cruz Baez, Edgar A	Hospital Dr. Pila - Ave. Las Americas Ponce, PR 00731	February 20, 2003
Davila Aponte, Wanda E	63 Calle Nogal Monte Casino Toa Alta, PR 00953	May 20, 2002
Escalante Santos, Gilberto	Urb. Summit Hills 596 Torrecillas St. Rio Piedras, PR 00920	June 10, 1994
Francis Ambulance	99 Manolo Flores St. Fajardo, PR 00738	August 20, 2000
Garcia Medina, Benjamin A	Calle Aibonito 1468 Santurce, PR 00907	April 20, 2003
Grana Díaz, Roberto	Urb Sagrado Corazón 1616 Calle Sta Eduviges San Juan, PR 00926	May 20, 2001
Jimenez Casso, José	Urb. Santa Rosa 51-37 Ave. Main Bayamón, PR 00959	January 20, 2002
Kutcher Olivo, Roberto	Calle Betances 80 Canóvanas, PR 00629	March 20, 2001
López Morales, Angel	Ave. A Buenas Bloque 20 #31 Urb. Santa Rosa Bayamón, PR 00959	January 20, 2002
Maisonet Correa, Carlos	61 Marginal Urb. Santa Rosa Bayamón, PR 00960	September 20, 2001
Mercado Franci, José A.	Villa Clarita 2 6 St. # 46 Fajardo, PR 00738	August 20, 2000

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

Transferencia Electrónica de Fondos

TRANSFERENCIA ELECTRÓNICA DE FONDOS (DEPÓSITO DIRECTO)

El método de pago directo a través de transferencia electrónica (EFT, por sus siglas en inglés) permite que Medicare 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.

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.

Es importante que una vez el formulario CMS 588 esté completado envíe el mismo a:

Medicare/Triple-S, Inc.
PO Box 71391
San Juan, PR 00936-1391

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

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

Electronic Funds Transfer

ELECTRONIC FUNDS TRANSFER (DIRECT DEPOSIT)

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

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

We include CMS Form 588, which should be completed in order to participate of 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.

It is important that once the CMS Form 588 is complete same is sent to:

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

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

System/Budget EFT 2003/ic-fc/January, 2004/FC/els

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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0626. The time required to complete this information collection is estimated to average 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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/.

NOTES

MEDICARE INFORMA

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SAN JUAN, PR 00936

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