OIG Alert about Charging Extra for Covered Services

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0421
Release Date: N/A

Provider Types Affected
Physicians, suppliers, and providers

Provider Action Needed
Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees should be mindful that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.

Background
On March 31, 2004, the Office of the Inspector General (OIG) issued an Alert that focused on physicians charging extra for services covered by Medicare. The Alert noted that these extra contractual charges beyond Medicare’s deductible and coinsurance constituted a potential assignment violation.

In the Alert, the OIG reminded Medicare participating physicians of the potential liabilities posed by billing Medicare patients for services that are already covered by Medicare. Charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid for by Medicare.

Medicare participating providers can charge Medicare beneficiaries extra for items and services that are not covered by Medicare. In addition, participating providers may charge beneficiaries for any Medicare deductibles and coinsurance without violating the terms of their assignment agreements.

However, when participating providers request added payment for covered services from Medicare patients, they are liable for substantial penalties and exclusion from Medicare and other federal health care programs. The special services for added payment are known by various names and may include “concierge care,” “boutique medicine,” “retainer practice,” or “platinum practice.”
For example, the OIG recently alleged that a physician violated his assignment agreement when he offered his patients, including Medicare beneficiaries, a “Personal Health Care Medical Care Contract” that required payment of an annual $600 fee. The physician characterized the services to be provided under the contract as “not covered” by Medicare, and the services offered under this contract included:

- Coordination of care with other providers;
- A comprehensive assessment and plan for optimum health; and
- Extra time spent on patient care.

The OIG alleged that based on the specific facts and circumstances of this case, at least some of these contracted services were already covered and reimbursable by Medicare. Therefore, OIG alleged that each contract presented to this physician’s Medicare patients constituted a request for payment for already covered services, other than the coinsurance and deductible, and was therefore a violation of the physician’s assignment agreement. To resolve these allegations, the physician agreed to pay a settlement amount to the OIG, and to stop offering these contracts to his patients.

Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees are reminded that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.

Note that a participating provider is a provider of Medicare covered items and services who agrees to accept the Medicare-approved charge for all covered services to Medicare patients. A participating provider “accepts assignment” for all Medicare-payable services.

Also note that non-participating providers may also be subject to penalties and exclusion for overcharging beneficiaries for covered services. This is true whether the provider accepts assignment for a given service or not, in which case the provider's charge is limited to the “limiting charge.”

**Related Instructions**


**Additional Information**

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Section 1: General Information

Comprehensive Error Rate Testing (CERT) FAQs

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does the acronym CERT stand for?</td>
<td>CERT stands for Comprehensive Error Rate Testing.</td>
</tr>
<tr>
<td>Who is responsible for administering the CERT Program?</td>
<td>AdvanceMed is the Payment Safeguard Contractor responsible for administering the CERT Program.</td>
</tr>
<tr>
<td>Who is responsible for communicating with the CERT contractor for the Region C DMERC?</td>
<td>Palmetto GBA, for DMERC Region C, is responsible for reporting all CERT related activities within Region C to AdvanceMed.</td>
</tr>
<tr>
<td>How are suppliers alerted that one or more of their claims has been selected for review in the CERT Program?</td>
<td>AdvanceMed will send an initial request letter to each supplier followed by a series of letters and phone calls to the supplier if they do not receive the requested documentation within 25 days of the initial letter.</td>
</tr>
<tr>
<td>What documentation should suppliers send to AdvanceMed?</td>
<td>Suppliers should send all records, including medical records that support the payment of the item(s) billed on the claim.</td>
</tr>
<tr>
<td>Where should suppliers send the documentation that is requested by AdvanceMed?</td>
<td>Suppliers can mail the documentation to:</td>
</tr>
</tbody>
</table>
|                                                                          | AdvanceMed  
1530 East Parham Road  
Richmond, VA 23228                                                                                                                                                                                |
|                                                                          | The best way to submit the documentation for CERT claims is to fax it to AdvanceMed at the following fax numbers:                                                                                      |
|                                                                          | (804) 864-9980 and (804) 264-3268.                                                                                                                                                                    |
| How does AdvanceMed log and track the claims they review?               | Every claim sampled in the CERT Program is assigned a Claim Identification Number referred to as a CID.                                                                                                  |
Comprehensive Error Rate Testing (CERT) FAQs, cont.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the significance of the barcode sheet?</td>
<td>The barcode sheet is just another way of identifying a claim selected in the CERT program. The barcode sheet that suppliers receive with the CERT documentation request should be returned to AdvanceMed when a supplier submits their documentation to AdvanceMed.</td>
</tr>
<tr>
<td>What if a claim is determined by CERT to have been paid incorrectly?</td>
<td>Overpayments will be recouped for those claims that the CERT program determined to have been paid incorrectly. Suppliers will follow normal procedures for submitting appeals.</td>
</tr>
<tr>
<td>What do providers risk in not responding to the request made by AdvanceMed?</td>
<td>Suppliers that do not respond to the CERT request will receive an &quot;error&quot; and will be assessed an overpayment. Suppliers who repeatedly do not respond to a CERT request for documentation are considered &quot;recalcitrant&quot;. Recalcitrant suppliers with a claim line total or claim total of $40.00 or more in question will be referred to the OIG for action.</td>
</tr>
</tbody>
</table>

Coordination of Benefits Agreement (COBA)

The Centers for Medicare and Medicaid Services (CMS) is implementing a new initiative known as the "Coordination of Benefits Agreement (COBA) consolidated crossover process." COBA will streamline the claims crossover process and consolidate the claims crossover function under one contractor, the Medicare Coordination of Benefits Contractor (COBC).

This program will offer an automatic crossover service to other insurers, or trading partners, that may pay benefits after the Medicare claim has been processed. The trading partner is charged a fee-per-claim that is crossed by Medicare. COB trading partners include:

- Medicare supplemental insurers (i.e., non-Medigap plans);
- Title XIX State Medicaid Agencies; and
- Medigap insurers.

COB trading partners, who are eligible to receive Medicare claim information directly from CMS for purposes of calculating their secondary liability, will no longer have to sign separate agreements with individual Medicare Contractors. Instead, each COB trading partner will:

- Enter into one national Coordination of Benefits Agreement (COBA) with CMS’ consolidated claims crossover contractor (COBC); and
- No longer need to prepare and send separate eligibility files to Medicare Contractors, nor receive numerous crossover files. Instead, trading partners will submit one eligibility file to COBC based on the terms of their COBA and will regularly receive a consolidated file of claims for their eligible beneficiaries.

These changes are the result of input from affected stakeholders in the health insurance industry and will result in a more effective implementation of the COBA process. Also, this will be a more effective process for Medicare providers and suppliers to receive claim payments that are secondary to Medicare benefits. Additionally, the revised COBA process will ensure that CMS fulfills the requirements imposed by the HIPPA ANSI-X12 85 (Electronic Remittance Advice (ERA)) Implementation Guide with respect to
Coordination of Benefits Agreement (COBA), cont.

communication of crossover information to its Medicare providers and suppliers.

For an eligibility file-based crossover, the COBA ID of the trading partner, along with all other eligibility file data elements associated to an individual beneficiary, will be stored in Medicare's Common Working File (CWF) in the recently established Beneficiary Other Insurance (BOI) auxiliary record. CWF will also house the COBA Insurance file that will contain specific information associated to the trading partner that is identified on the BOI auxiliary record. As Medicare claims are processed, CWF will apply each COB trading partner’s claims selection criteria against the Medicare claims. CWF will provide information to the Medicare Contractor to enable them to place appropriate crossover remark codes on the HIPAA ANSI X12N 835 Electronic Remittance Advice sent to providers and suppliers.

For those Medigap and Medicaid insurers that do not provide COB eligibility files, identifying beneficiaries that are insured by their plans, a claim-based crossover process will be implemented. Unique five-digit COBA IDs will be assigned by the COBC to Medigap and Medicaid insurers that do not provide eligibility files to the COBC. Medicare providers and DME suppliers will receive a listing of all Medigap and Medicaid insurers that have been assigned unique claim-based COBA IDs. Providers and suppliers will be responsible for entering the unique COBA IDs on each claim submitted to a Medicare Contractor to initiate the crossing over of claims to the Medigap or Medicaid insurer for review to determine if a supplemental payment should be made to the provider or supplier.

Medicare claims processing systems will be modified to house Medigap and Medicaid claim-based COBA IDs and the associated Medigap or Medicaid information necessary for the Medicare contractor to prepare an ERA and send the claim to the COBC so that it can be sent to the Medigap or Medicaid insurer. The Part B provider or DME supplier is required to include a claim-based COBA ID on incoming Medicare claims where:

- The beneficiary presents (or has presented) some evidence of his/her coverage under a Medigap plan or eligibility for Medicaid benefits and a corresponding COBA ID for the identified Medigap insurer or State Medicaid Agency can be located on CMS’ COBA claim-based ID listing;
- The provider or supplier participates in the Medicare Program. Note that this condition applies both to Medigap and Medicaid claim-based crossover; and
- The beneficiary assigns (or has assigned) his/her Medigap benefits to the provider or supplier.

Because of the impact on providers and suppliers, Medicare Contractors will not be required to implement the COBA claim-based crossover requirements until a date to be determined. Upon the announcement of an effective date, all participating Part B providers and DME suppliers will cease including the Palmetto GBA OCNA number on incoming claims. Instead, when Part B providers or DME suppliers check the claim-based COBA ID listing and locate the beneficiary’s identified Medigap plan; they shall include the Medigap claim-based COBA ID on the incoming claim if:

1) The provider or supplier participates in the Medicare Program; and

2) The beneficiary assigns (or has assigned) his/her rights to benefits to the provider or supplier.
Use of Group Health Plan Payment System for Medicare Disease Management Demonstration Serving Medicare Fee-for-Service Beneficiaries

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0425
Effective Date: N/A

Provider Types Affected
All Medicare providers

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) has begun a four-state Medicare Disease Management Demonstration to improve care for chronically ill Fee-for-Service Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The Disease Management Programs that are currently enrolling beneficiaries are: CorSolutions in Louisiana; XLHealth in Texas; and HeartPartners in California and Arizona.

These Disease Management Organizations are not HMOs, but are being paid, using the CMS Group Health System, a fixed monthly payment for disease management services as an "Option 1" cost plan. All Fee-for-Service claims will continue to be processed under traditional Medicare payment rules. Beneficiaries enrolled in these demonstrations will be considered covered under the traditional Medicare Fee-for-Service program. Participants in the demonstration are not restricted in any way as to how they receive their other Medicare services.

The Medicare beneficiaries participating in the Medicare Disease Management Demonstration are NOT enrolled in an HMO; they should be treated as traditional Fee-for-Service beneficiaries. No referrals for care are needed and all Fee-for-Service claims will be processed under traditional Medicare payment rules.

Background
The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 mandated this demonstration to evaluate how disease management services, combined with a prescription drug benefit, can improve the health outcomes of Medicare beneficiaries diagnosed with advanced-stage illness from congestive heart failure, diabetes, or coronary heart disease.

Up to 30,000 eligible Medicare Fee-for-Service beneficiaries will be enrolled in the treatment arm of the study during the three-year project in California, Arizona, Louisiana, and Texas.

The project will help Medicare:

- Find better ways to improve the quality of life for people with diabetes and chronic heart disease;
- Determine the benefits of disease management programs for chronically ill persons; and
- Find ways to make these services available to people with Medicare.

Participants will be assigned to either a disease management group or a usual care group. The disease management group will receive disease management services and prescription drug benefits in addition to their usual Medicare benefits at no additional cost except for a modest co-payment for prescription drugs. All participants remain in the traditional Fee-for-Service Medicare program under the care of their own doctor. The program is voluntary and the decision whether or not to participate does not affect Medicare benefits.

Demonstration Locations
Louisiana - CorSolutions will be providing services to 5,000 Medicare beneficiaries with congestive heart failure (CHF), diabetes, and/or coronary heart disease residing in the Shreveport – New Orleans corridor of Louisiana. (Questions? Call 1-800-917-2204).

Texas - XLHealth will be providing services to 10,000 Medicare beneficiaries with congestive heart failure (CHF), cardiovascular disease (CVD), or diabetes with co-morbidities of CHF, CVD or lower extremity complications in Texas. (Questions? Call 1-888-284-0001).
Use of Group Health Plan Payment System for Medicare Disease Management Demonstration Serving Medicare Fee-for-Service Beneficiaries, cont.

California and Arizona - HeartPartners SM (collaboration among PacifiCare Health Systems, Qmed, and Alere Medical) will be providing services to 15,000 Medicare beneficiaries with congestive heart failure (CHF) in California and Arizona. (Questions? Call 1-866-242-3432).

Medicare Common Working File Inquiry Screens
When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, the Common Working File screens will display a line item indicating enrollment in an “Option 1” HMO Cost Plan. The definition of “Option 1” means that Medicare is still primary and Fee-for-Service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional Fee-for-Service program.

Use of Group Health Plan Payment System for Demonstrations Serving Medicare Fee-for-Service Beneficiaries

Related Change Request (CR) #: 3283
Medlearn Matters Number: MM3283
Related CR Release Date: May 14, 2004
Related CR Transmittal #: 4

Effective Date: October 4, 2004
Implementation Date: October 4, 2004

Provider Types Affected
All Medicare providers.

Provider Action Needed
No action needed.

Background
The Centers for Medicare & Medicaid Services (CMS) is conducting several large coordinated care and disease management demonstrations under which private organizations will contract with CMS to provide disease management services to beneficiaries enrolled in the traditional Medicare Fee-for-Service program. In a previous Medlearn Matters article published on 5/13/2004 (SE0425), a summary of the Medicare Disease Management Demonstration was provided with an instruction to treat participants in the demonstration as traditional Fee-for-Service beneficiaries.

The Medicare beneficiaries participating in these demonstrations are NOT enrolled in an HMO. The Disease Management Organizations are being paid using the CMS Group Health Plan System as an “Option 1” cost plan. All Fee-for-Service claims will continue to be able to be processed under traditional Medicare payment rules and beneficiaries enrolled in these demonstrations will be considered covered under the traditional Medicare Fee-for-Service program.

Beneficiaries will only receive coordinated care/disease management services from these special demonstration plans. They are not restricted in any way as to how they receive their other Medicare services.

In order to avoid confusion about a beneficiary’s access to services when providers or others check beneficiary eligibility on certain standard system screens, the related CR 3283 directs CWF to suppress any reference to HMO information on certain screens for beneficiaries enrolled in these demonstrations.
MMA - Clarification for CR 3064 - MSP Policy for Hospital Reference Lab Services and Independent Reference Lab Services

Related Change Request (CR) #: 3267
Medlearn Matters Number: MM3267
Related CR Release Date: July 16, 2004
Related CR Transmittal #: 17

Effective Date: December 8, 2003
Implementation Date: August 16, 2004

Provider Types Affected
Hospitals, Critical Access Hospitals (CAHs), and Independent Reference Laboratories

Provider Action Needed
STOP: Impact to You
Hospitals are no longer required to collect MSP information where there is no face-to-face encounter with a beneficiary because independent reference laboratories no longer need the information to bill Medicare for reference laboratory services.

CAUTION: What you need to know
This clarification of CR3064 and Medlearn Matters article MM3064 provides additional information regarding preparation of the CMS-1500 claim form. Compliance with this instruction will help assure prompt and correct processing of reference laboratory claims.

GO: What you need to do
Affected providers should ensure that billing staff enter “None” in Block 11 of the CMS-1500 when filing claims to Medicare for reference laboratory services when there is not a face-to-face encounter with the Medicare beneficiary.

Background
Section 943 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that:

“(T)he Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare Secondary Payer provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.”

Prior to the enactment of MMA, hospitals were required to collect MSP information every 90 days in order to bill Medicare for reference lab services.

Further, those providers billing carriers are reminded to enter “None” in Block 11 of the CMS-1500 claim form for reference laboratory services in order to bill Medicare for the reference laboratory services, as described in Section 943(b).

Additional Information
Because of these policy changes, Medicare intermediaries have been instructed not to include claims for reference laboratory services, as described in Section 943(b) of MMA, in the sample of claims that are reviewed during MSP hospital audits. This is effective for reference laboratory service claims with dates of service of December 8, 2003 and later.

To view the actual instruction issued to your carrier/intermediary, go to:
http://www.cms.hhs.gov/manuals/transmittals/com_m_date_dsc.asp

Once at that site, scroll down the right hand CR NUM column to CR3267 and click on the link for that CR.
CMS Manual System - Payment to Bank

Related Change Request (CR) #: 3079
Medlearn Matters Number: MM3079
Related CR Release Date: June 25, 2004
Related CR Transmittal #: 213

Effective Date: July 25, 2004
Implementation Date: July 25, 2004

Provider Types Affected
Providers and suppliers.

Provider Action Needed
Become familiar with the revised policy regarding Medicare payments to be sent to a bank in the name of a provider/supplier.

STOP: Impact to You
There is a change in the policy allowing Medicare to send a payment to an individual provider or supplier’s bank account for deposit.

CAUTION: What you need to know
If certain conditions are met, payments from Medicare to a provider or supplier may be sent to the provider’s bank (or similar financial institution) for deposit into the provider’s account. Please refer to the Background section for a review of these conditions.

GO: What you need to do
Follow these revised criteria if you want Medicare to deposit payments directly into your bank account.

Background
Medicare payments may be sent to a bank (or similar financial institution) to be deposited into a provider/supplier’s account so long as the following requirements are met:

• The bank may provide financing to the provider/supplier as long as the bank states in writing, in the loan agreement, that it waives its right of offset. (This allows the bank to lend money to the provider as well as deposit money from Medicare into the provider/supplier’s account.)

• The bank account is in the provider/supplier’s name and only the provider/supplier may issue instructions on that account. The bank should only be bound by the provider/supplier’s instructions.

• No other agreement that a provider/supplier has with a third party can have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier’s account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier’s agreement with the financing entity.

Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier’s Medicare receivables.

Additional Information
If you have any questions, please contact your carrier at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp
Procedures for Re-issuance and Stale Dating of Medicare Checks

Related Change Request (CR) #: 2951
Medlearn Matters Number: MM2951
Related CR Release Date: July 16, 2004
Related CR Transmittal #: 49

Effective Date: August 16, 2004
Implementation Date: August 16, 2004

Provider Types Affected
Physicians, suppliers, and providers

Provider Action Needed

STOP: Impact to You
The Centers for Medicare & Medicaid Services (CMS) is clarifying the policy for re-issuing, stale dating, and reporting outstanding Medicare checks.

CAUTION: What you need to know
This instruction updates the Medicare Financial Management Manual (Pub. 100-06) and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding CMS procedures for re-issuance and stale dating of Medicare checks.

GO: What you need to do
Be aware of these instructions in the event you have a problem in the future regarding lost, stolen, defaced, mutilated, destroyed, forged, or uncashed checks from your Medicare carrier/intermediary.

Background
This instruction updates the Medicare Financial Management Manual (Pub. 100-06) and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding the CMS procedures for re-issuance and stale dating of Medicare checks, which expired in September 2002. Legal authority for the CMS re-issuance and stale dated check policy is contained in Medicare regulations published at 42 CFR 424.352.

Introduction
As part of the CMS effort to improve financial reporting, CMS is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

Re-issuing Medicare Checks
In December 1993, CMS issued 42 Code of Federal Regulations (CFR) Subpart M – Replacement and Reclamation of Medicare Payments 424.352: Intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. All Medicare contractors must re-issue checks in accordance with 42 CFR 424.352.

The provisions of this regulation require that a Medicare contractor (fiscal intermediary or carrier) perform certain tasks upon notification by a payee that a check has been lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. These tasks are as follows:

A. The Medicare contractor must contact the financial institution on which the check was drawn to determine whether the check has been negotiated.

B. If the check has been negotiated:
   1. The Medicare contractor will provide the payee with a copy of the check and other pertinent information (such as a claim form, affidavit, or questionnaire to be completed by the payee) required to pursue the claim in accordance with State law and commercial banking regulations.
   2. To pursue the claim, the payee must examine the check and certify (by completing the claim form, affidavit, or questionnaire) that the endorsement is not the payee’s.
   3. The claim form and other pertinent information are sent to the Medicare contractor for review and processing of the claim.
   4. The Medicare contractor reviews the payee’s claim. If the Medicare contractor determines that the claim appears to be valid, it forwards the claim and a copy of the check to the issuing bank. The Medicare contractor takes further action to recover the proceeds of the check in accordance with state law and regulations.
Procedures for Re-issuance and Stale Dating of Medicare Checks, cont.

5. Once the Medicare contractor recovers the proceeds of the initial check, the Medicare contractor issues a replacement check to the payee.

6. If the bank of first deposit refuses to settle on the check for good cause, the payee must pursue the claim on his or her own, and the Medicare contractor will not re-issue the check to the payee.

C. If the check has not been negotiated:

1. The Medicare contractor arranges with the bank to stop payment on the check; and

2. Except as provided in paragraph (D) of 42 CFR 424.352, the Medicare contractor re-issues the check to the payee.

D. No check may be reissued under (C)(2) unless the claim for a replacement check is received by the contractor no later than one year from the date of issuance of the original check, unless state law (including any applicable federal banking laws or regulations that may affect the relevant state proceeding) provides a longer period, in which case that state law will apply.

Medicare contractors may receive requests for re-issuance of Medicare checks that are older than one year. Based on 42 CFR 424.352 (summarized above), Medicare contractors should inform beneficiaries and providers/physicians/suppliers regarding the possibility that state law may provide a more favorable time frame for re-issuance. Requests for re-issuance based on state law should be forwarded by Medicare contractors to their Regional Office. The Regional Office will work with the Regional Office General Counsel to resolve these requests on a case-by-case basis.

Medicare contractors regularly receive requests for re-issuance of Medicare checks that are older than one year. Under 42 CFR 424.352 many of these requests must be denied. However, 42 CFR 424.352 applies only to checks that have been lost, stolen, defaced, mutilated, destroyed, or paid on a forged endorsement. Accordingly, Medicare checks that are in the physical possession of the payee, have not been defaced or mutilated, and have not been negotiated are not subject to the one-year time limit for re-issuance required by 42 CFR 424.352 (d). Therefore, if the criteria below are met, such checks may be re-issued by the Medicare contractor even if they are older than one year. The criteria are:

1. The payee (beneficiary, physician, supplier, provider, etc.) and/or authorized representative can present the physical check;
2. The Medicare contractor can confirm that the check was not previously reissued; and
3. Re-issuance is not barred by a federal and/or state statute of limitations.

Any questions that the Medicare contractors have regarding application of the above criteria should be forwarded to their Regional Office. The Regional Office will work with the Regional Office General Counsel to resolve the questions.

Stale Dating of Checks

Medicare contractors are expected to continuously review all outstanding checks, take the appropriate action to stale date checks in conformance with federal and/or state/local banking regulations, and adjust financial reporting for these actions. Medicare contractors must advise their financial institution of the change in the status of a check.

Outstanding checks are checks that have been issued as payment for Medicare benefits and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Checks are “voided” by rendering them non-negotiable either physically or by placing a stop payment on them.

Stale dated checks are checks that have reached a specific age from date of issue (e.g., one year from the date of issuance) and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Additionally, once a check has been stale dated and is no longer negotiable, the financial institution must be notified in writing.

Undeliverable Checks

Medicare providers, physicians, suppliers, and beneficiaries are responsible for providing their Medicare contractor with their current and accurate mailing address.
Procedures for Re-issuance and Stale Dating of Medicare Checks, cont.

The Medicare contractors must comply with the policy established by the “Do Not Forward (DNF) Initiative.” This policy requires Medicare contractors to re-issue the check based on the receipt of updated verified address information per Form CMS-855; and if no updated address information has been submitted, then Medicare contractors must void any returned checks. Checks voided due to DNF may be re-issued in accordance with the instructions in the preceding section titled “Re-issuing Medicare Checks.”

Implementation
The implementation date for this instruction is August 16, 2004.

Related Instructions

Section 420-Procedures for Re-issuance and Stale Dating of Medicare Checks) is new. These updated manual instructions will be incorporated into the new Internet-only Office of Financial Management Manual, but are available now as part of the official instruction issued to your carrier/intermediary. This instruction (CR2951) can be found by going to: http://www.cms.hhs.gov/manuals/transmittals/com_m_date_dsc.asp.

From that Web page, look for CR2951 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnumsa.asp.

Revised Fact Sheets on Long Term Care Hospital Prospective Payment System

Revised fact sheets on Long Term Care Hospital Prospective Payment System are now available on the Medicare Learning Network Web site at www.cms.hhs.gov/medlearn/ltchpps.asp. The fact sheets are:

Updated Final Rule Fact Sheet
Short-Stay Outliers Fact Sheet
Interrupted-Stay Fact Sheet
High Cost Outliers Fact Sheet

New Rural Health Fact Sheets

Four new fact sheets that contain rural health information, definitions, helpful rural health resources, and Medicare Prescription Drug, Improvement and Modernization Act of 2003 enhancements are now available on the Medicare Learning Network Web site at www.cms.hhs.gov/medlearn/pubs.asp. The Fact Sheets are entitled:

Rural Health Clinic
Sole Community Hospital
Federally Qualified Health Center
Critical Access Hospital Program

These updated fact sheets provide clarification for the above provider types based on the MMA.
Wheelchair Seating - Policy Revision

A revision of this policy is included in the Autumn 2004 Region C DMERC DMEPOS Supplier Manual update.

As a result of the 2004 ICD-9 update, pressure ulcers are coded with five-digit codes effective for dates of service on or after October 1, 2004. For skin protection seat cushions, the acceptable diagnoses will include 707.03, 707.04 and 707.05 - pressure ulcer of the lower back, hip, and buttock, respectively. These changes are included in the revised LCD (Local Coverage Determination). Suppliers are reminded that there is no grace period for the use of the previous ICD-9 code (707.0). However, it should continue to be used on claims with dates of service prior to October 1, 2004, regardless of the date of claim submission.

The Policy Article clarifies the distinction between seat inserts and solid support bases.

Suppliers are reminded that the grace period for use of previous HCPCS codes for wheelchair seat and back cushions ends with claims with dates of service on or after July 1, 2004 that are submitted on or after October 1, 2004. The new HCPCS codes for prefabricated seat cushions (K0650-K0657), prefabricated back cushions (K0660-K0665), and brand name custom fabricated seat and back cushions (K0658, K0666) may not be billed until the HCPCS code for the product that was provided has been confirmed in a written coding verification review from the SADMERC. The results of these are posted on the SADMERC Web site. If a supplier chooses to submit a claim for a cushion before this has been obtained, HCPCS code K0669 must be used and it will be denied as not medically necessary.
Clarification to CR 3069 – New “K” Codes for Wheelchair Cushions

Related Change Request (CR) #: 3289  
Medlearn Matters Number: MM3289  
Related CR Release Date: May 14, 2004  
Related CR Transmittal #: 179

Effective Date: July 1, 2004  
Implementation Date: July 6, 2004

Provider Types Affected  
Durable medical equipment (DME) suppliers and Home Health Agencies

Provider Action Needed

STOP: Impact to You  
Medicare may not reimburse you correctly for ordering or supplying wheelchair cushions for your Medicare patients if you don’t use the correct HCPCS codes on your claim.

CAUTION: What you need to know  
As previously published in CR 3069, The Centers for Medicare & Medicaid Services (CMS) has established twenty new HCPCS “K” codes for wheelchair cushions. Further, these new HCPCS codes will be replacing 11 HCPCS “E” codes and three HCPCS “K” codes that CMS is discontinuing on July 1, 2004. You will be granted a 90-day grace period (from July 1, 2004 to September 30, 2004) to begin using the correct HCPCS codes.

GO: What you need to do  
Make sure that your billing staffs are aware of these new and discontinued HCPCS codes for wheelchair cushions you provide on or after July 1, 2004.

Background  
This Change Request updates a previous one (CR 3069) that addressed HCPCS codes for ordering or supplying wheelchair cushions. CMS has established twenty new HCPCS “K” codes for wheelchair cushions. Effective July 1, 2004, the HCPCS codes shown in the following table will be added to the system.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0650</td>
<td>General use wheelchair seat cushion, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>K0651</td>
<td>General use wheelchair seat cushion, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>K0652</td>
<td>Skin protection wheelchair seat cushion, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>K0653</td>
<td>Skin protection wheelchair seat cushion, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>K0654</td>
<td>Positioning wheelchair seat cushion, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>K0655</td>
<td>Positioning wheelchair seat cushion, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>K0656</td>
<td>Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>K0657</td>
<td>Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>K0658</td>
<td>Custom fabricated wheelchair seat cushion, any size</td>
</tr>
<tr>
<td>K0659</td>
<td>Wheelchair seat cushion powered</td>
</tr>
<tr>
<td>K0660</td>
<td>General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware</td>
</tr>
</tbody>
</table>

Short Descriptor

- Gen w/c cushion width < 22”
- Gen w/c cushion width > 22”
- Skin protect w/c cushion width < 22”
- Skin protect w/c cushion width > 22”
- Position w/c cushion width < 22”
- Position w/c cushion width > 22”
- Skin protect w/c cushion width < 22”
- Skin protect w/c cushion width > 22”
- Custom fabricated w/c cushion
- Powered w/c cushion
- Gen use back cushion width < 22”
Clarification to CR 3069 – New “K” Codes for Wheelchair Cushions, cont.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0661</td>
<td>General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware</td>
<td>Gen use back cushion width &gt; 22&quot;</td>
</tr>
<tr>
<td>K0662</td>
<td>Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware</td>
<td>Position back cushion width &lt; 22&quot;</td>
</tr>
<tr>
<td>K0663</td>
<td>Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware</td>
<td>Position back cushion width &gt; 22&quot;</td>
</tr>
<tr>
<td>K0664</td>
<td>Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware</td>
<td>Position back post/lat width &lt; 22&quot;</td>
</tr>
<tr>
<td>K0665</td>
<td>Positioning wheelchair back cushion, posterior-lateral width 22 inches or greater, any height, including any type mounting hardware</td>
<td>Position back post/lat width &gt; 22&quot;</td>
</tr>
<tr>
<td>K0666</td>
<td>Custom fabricated wheelchair back cushion, any size, including any type mounting hardware</td>
<td>Custom fab w/c back cushion</td>
</tr>
<tr>
<td>K0667</td>
<td>Mounting hardware, any type, for seat cushion or seat support base attached to a manual wheelchair or lightweight power wheelchair, per cushion/base</td>
<td>Mount hardware man or light power w/c</td>
</tr>
<tr>
<td>K0668</td>
<td>Replacement cover for wheelchair seat cushion or back cushion, each</td>
<td>Replacement cover w/c seat cush each</td>
</tr>
<tr>
<td>K0669</td>
<td>Wheelchair seat or back cushion, no written coding verification from SADMERC</td>
<td>W/c seat/back no CVR SADMERC</td>
</tr>
</tbody>
</table>

Additionally, HCPCS codes E0176, E0177, E0178, E0179, E0192, E0962, E0963, E0964, E0965, E1012, E1013, K0023, K0024 and K0114 are being eliminated and will be invalid for submission to Medicare on or after July 1, 2004.

You will be granted a 90-day grace period (from July 1, 2004 to September 30, 2004) to begin using the correct HCPCS codes.

Additional Information

You can read this Change Request on the CMS Web site at this address:
http://www.cms.hhs.gov/manuals/transmittals/com_m_date_dsc.asp

Once at that site, look for CR3289 in the right hand column, CR NUM, and click on the files for that CR.
Orthoses/Prostheses - Coding for Professional Services/Fabrication Supplies

HCPCS codes L4205 (Repair of orthotic device, labor component, per 15 minutes) and L7520 (Repair of prosthetic device, labor component, per 15 minutes) may only be billed for time involved with the actual repair of an orthosis or prosthesis, respectively, or for medically necessary adjustments made more than 90 days after delivery.

HCPCS codes L4205 and L7520 must not be used to bill for time involved with other professional services including, but not limited to:

- Evaluating the patient
- Taking measurements, making a cast, making a model, use of CAD/CAM
- Making modifications to a prefabricated item to fit it to the individual patient
- Follow-up visits
- Making adjustments at the time of or within 90 days after delivery

Reimbursement for these services is included in the allowance for the HCPCS codes which describe the orthosis/prosthesis.

Similarly, HCPCS codes L4210 (Repair of orthotic device, repair or replace minor parts) and L7510 (Repair of prosthetic device, repair or replace minor parts) must not be used for casting supplies or other materials used in the fitting or fabrication of an orthosis/prosthesis.

If a supplier decides to submit a claim for services/items that are included in the allowance for the orthosis/prosthesis, HCPCS code L9900 (Orthotic and prosthetic supply, accessory and/or service component of another HCPCS L code) must be used. HCPCS code L9900 is denied as not separately payable.

Services or supplies associated with the provision of plaster or fiberglass casts or splints are in the jurisdiction of the local carriers and fiscal intermediaries. Claims for these items may not be submitted to the DMERC.

Knee Orthoses - Correct Coding - Kneecap

HCPCS codes L2795 (Addition to lower extremity orthosis, knee control, full kneecap) and L2800 (Addition to lower extremity orthosis, knee control, kneecap, medial or lateral pull) describe anterior knee pads that help to control movement of the knee during ambulation. These HCPCS codes must not be used to describe components of orthoses used to treat contractures or other orthoses intended for use by patients when they are nonambulatory. If the supplier chooses to bill separately for a kneepad in these situations, HCPCS code L9900 (Orthotic and prosthetic supply, accessory and/or service component of another HCPCS L code) must be used and it will be denied as not separately payable.
DME Supplier BiPAP Alert

There has been extremely high utilization of HCPCS code E0471 in certain sectors of Region C. In an effort to stem the tide of inappropriate payments made on this HCPCS code, many of the ordering physicians are being interviewed with regards to their orders. It appears that the majority of these physicians were either under the impression they were ordering simple CPAPs, or denied having ordered any such equipment at all.

Once these physicians have attested to one of the above, Palmetto GBA will no longer pay the claims. If suppliers are getting denials on their E0471 claims, they should communicate first with the referring (or ordering) physician regarding their understanding of what they were ordering.

Often suppliers may not understand the differences between the types of equipment that are represented by the HCPCS codes E0471, E0461, E0460, and E0601. Continuing education should be sought from a licensed professional facility, or a professional organization such as the state Respiratory Board, so that suppliers improve their expertise regarding the equipment they supply. Other sources of continuing education for suppliers would include the manufacturers and national professional organizations such as the American Association for Respiratory Care, which in fact publishes clinical practice guidelines for all respiratory equipment.

Since the Supplier Standards require that suppliers be in compliance with State licensure and regulatory requirements, they may want to ensure that the polysomnogram (done to determine the need for the equipment being ordered) was done in a facility licensed by the state to do these studies. The treating physician who orders an E0471 should, as per the medical policy, be ‘qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of respiratory assist devices.’ Suppliers should be encouraged to inquire about the ordering physician’s training and experience with this equipment and in the treatment of sleep disorders. Physicians who carry the qualification of being sleep specialists should still offer the supplier their credentials for verification.

Any questions about denied RAD claims should be addressed to your assigned multifunctional team (see Chapter 13 of the Region C DMERC DMEPOS Supplier Manual). If further orientation is required with regards to the RAD Policy, contact your ombudsman.

Pancreatic Islet Cell Transplants - Change in National Coverage Determination

Effective for dates of service on or after October 1, 2004, Medicare will cover pancreatic islet cell transplants when conducted as part of a National Institutes of Health (NIH)-sponsored clinical trial. Medicare will pay for the routine costs, as well as transplantation and appropriate related items and services, for Medicare beneficiaries participating in an approved clinical trial. The term “routine costs” means reasonable and necessary routine patient care costs, including immunosuppressive drugs and other follow-up care, as defined in section 310.1 of the National Coverage Determination (NCD) Manual.

Specifically, Medicare will cover transplantation of pancreatic islet cells, the insulin producing cells of the pancreas. Coverage will include the costs of acquisition and delivery of the pancreatic islet cells, as well as clinically necessary inpatient and outpatient medical care and immunosuppressants. For these patients, Question 4 on the Immunosuppressive Drugs DMERC Information Form (DIF) should be answered “Yes” and in Question 5, enter “8”.

Immunosuppressive drugs used following partial pancreatic tissue transplantation or islet cell transplantation performed outside the context of a clinical trial will continue to be noncovered. In these situations, question #4 must be answered “No” and in question #5, enter “8”.

Bulletins issued after October 1, 1999 are available at no cost from our Web site at www.PalmettoGBA.com.
Pancreatic Islet Cell Transplants - Change in National Coverage Determination, cont.

Further details may be found in the Centers for Medicare & Medicaid Services (CMS) Internet-only manual Pub. 100-3, Section 260.3.1. This change will also be incorporated into an upcoming revision of the Immunosuppressive Drugs local coverage determination.
Medicare Contractor Annual Update of the ICD-9-CM

Related Change Request (CR) #: 3303
Medlearn Matters Number: MM3303
Related CR Release Date: June 18, 2004
Related CR Transmittal #: 210

Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Provider Types Affected
Physicians, suppliers, and providers

Provider Action Needed
STOP: Impact to You
Medicare will soon issue the annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2004.

CAUTION: What you need to know
Remember that, as of October 1, 2004, Medicare no longer can provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes.

GO: What you need to do
Be ready to use the updated codes on October 1, 2004. Refer to the Background and Additional Information sections of this article for further details regarding this instruction.

Background
This instruction is a reminder that Medicare carriers and intermediaries will use the annual International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding update effective for:

- Dates of service on or after October 1, 2004; and
- Discharges on or after October 1, 2004 for institutional providers.

The Centers for Medicare & Medicaid Services (CMS) has been evolving the use of ICD-9-CM codes as follows:

- Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on Form CMS-1450.
- On April 1, 1989, the use of ICD-9-CM codes became mandatory for all physician services submitted on Form CMS-1500.
- Effective October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (Specialty Type 59) (see Change Request (CR) 2725, dated June 6, 2003, at http://www.cms.hhs.gov/manuals/pm_trans/B03045.pdf).
- Effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The
Medicare Contractor Annual Update of the ICD-9-CM, cont.


Updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment System and are effective each October first. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004.

After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following Web site: http://www.cms.hhs.gov/medlearn/icd9code.asp

The update should be available at this site in June.

Implementation
The implementation date for this instruction is October 4, 2004.

Related Instructions
The Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service) has been revised. The updated manual instructions are included in the official instruction issued to your carrier, and it can be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web site, look for CR3303 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

Additional Information
The new, revised, and discontinued ICD-9-CM diagnosis codes are posted annually on the following CMS Web site: www.cms.hhs.gov/medlearn/icd9code.asp.

Providers can view the new updated codes at this Web site in June and providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

In addition, the National Center for Health Statistics (NCHS) also will place the new ICD-9-CM Addendum on their Web site (www.cdc.gov/nchs/icd9.htm) in June, which is also available for providers to visit.

SNF Consolidated Billing L HCPCS Codes

Related Change Request (CR) #: 3295
Medlearn Matters Number: MM3295
Related CR Release Date: May 28, 2004
Related CR Transmittal #: 191

Effective Date: June 28, 2004
Implementation Date: June 28, 2004

Provider Types Affected
Skilled Nursing Facilities (SNFs) and suppliers

Provider Action Needed
STOP: Impact to You
As of April 1, 2004, suppliers cannot get paid for HCPCS codes L5673 and L5679 for services provided to a beneficiary in a Part A SNF stay. These HCPCS codes have replaced HCPCS codes K0557 and K0558. HCPCS codes L5673 and L5679 were inadvertently left off the April 2004 quarterly update edits for SNF consolidated billing.

CAUTION: What you need to know
Once corrected, these HCPCS codes will allow separate payment by Medicare Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal Intermediaries (FI) outside the perspective payment rate for Medicare beneficiaries in Part A SNF stays. These HCPCS codes will be added to the October quarterly update. When claims for HCPCS codes L5679 and L5673 are rejected, the
SNF Consolidated Billing L HCPCS Codes, cont.

Following incorrect messages will appear on your statement: Remittance Advice American National Standards Institute (ANSI) Reason Code 109, “Claims not covered by this payer/contractor. Claims must be sent to the correct payer/contractor;” and Remark Code MA101, “A SNF is responsible for payment of outside providers who furnish these services/ supplies under arrangement to its residents.” Since these codes were mistakenly not added to the edits for services that are separately payable outside of consolidated billing and the PPS rate, the provider or supplier should not contact the SNF for payment on these claims.

**GO: What you need to do**

If your claim for HCPCS code L5679 or L5673 services is not paid from April 1 through September 30, 2004, notify your DMERC or intermediary and request they re-open the claim and use the appropriate override code to process your claim for payment.

**Background**

Due to an inadvertent programming error, Medicare systems will not process payments for HCPCS codes L5673 and L5679 as of April 1, 2004. These HCPCS codes are described as follows:

- **L5673** - Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism, effective January 1, 2004.

- **L5679** - Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism, effective January 1, 2004.

- **HCPCS codes L5673 and L5679 replaced HCPCS codes K0557 and K0558, which were terminated as of December 31, 2003.**

HCPCS codes K0557 and K0558 are defined as follows:

- **K0558** - Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use HCPCS code K0556 or K0557), terminated December 31, 2003.

Where appropriate, Medicare has instructed your DMERC or intermediary to pay interest for delayed payments.

**Additional Information**

If you have any questions regarding this issue, please contact your DMERC or intermediary at their toll free number. If you do not have that number, you may find it at: [http://www.cms.hhs.gov/medlearn/tollnums.asp](http://www.cms.hhs.gov/medlearn/tollnums.asp)

To view the instruction issued to your carrier/intermediary regarding this issue, please visit: [http://www.cms.hhs.gov/manuals/transmittals/com_m_date_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/com_m_date_dsc.asp)

Scroll down the CR NUM column on the right and click on CR3295.
October 2004 Quarterly Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement

Related Change Request (CR) #: 3348  
Medlearn Matters Number: MM3348  
Related CR Release Date: July 9, 2004  
Related CR Transmittal #: 224

Effective Date: October 1, 2004  
Implementation Date: October 4, 2004

Provider Types Affected
Institutional providers billing claims to the Medicare Fiscal Intermediaries (FIs). Physicians, practitioners, and suppliers billing Medicare carriers for services.

Provider Action Needed
STOP: Impact to You
HCPCS codes are being added to or removed from the SNF consolidated billing enforcement list.

CAUTION: What you need to know
Services included on the SNF consolidated billing enforcement list will be paid to SNF Medicare providers only. Services excluded from the SNF consolidated billing enforcement list may be paid to Medicare providers other than SNFs. See Background and Additional Information sections for further explanation.

GO: What you need to do
Be aware of the requirements explained below and how they can impact your Medicare payment.

Background
The Centers for Medicare & Medicaid Services (CMS) periodically updates the list of HCPCS codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (SNF PPS). Services appearing on this list submitted on claims to Medicare Fiscal Intermediaries (FIs) and Carriers, including Durable Medical Equipment Regional Carriers (DMERCs) will not be paid to any Medicare providers, other than a SNF, when included in SNF consolidated billing.

For non-therapy services, the SNF consolidated billing applies only when the services are furnished to a SNF resident during a covered Part A stay. However, the SNF consolidated billing applies to physical, occupational, or speech-language therapy services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services excluded from the SNF consolidated billing may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay.

Section 1888 of the Social Security Act codifies SNF PPS and consolidated billing. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates. New updates are required by changes to the coding system, not because the services subject to the SNF consolidated billing are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

The codes below are listed as being added or removed from the annual update, mentioned above. Deletions from Major Category I F, below, specifically HCPCS code 36489, are being removed because the HCPCS code was discontinued as of December 31, 2003. Additions to what is noted as Major Category III below means these services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing. Additions to therapy inclusions, Major Category V below, mean SNFs alone can bill and be paid for these services when delivered to beneficiaries in a SNF, whereas codes being removed from this therapy inclusion list now can be billed and potentially paid to other types of providers for beneficiaries NOT in a Part A stay or in a SNF bed receiving ancillary services billed on TOB 22x.

Outpatient Surgery and Related Procedures  
(Major Category I F., FI Annual Update, INCLUSION)
Remove 36489 - Placement of cv catheter

Note on HCPCS code above:

Customized Prosthetic Devices  
(Major Category III, FI Annual Update, EXCLUSION)
For FI claims processing, remove HCPCS codes K0556*, K0557*, K0558*, K0559* - Addition to lower extremity, below knee/above knee, custom fab. For carrier claims processing, these
October 2004 Quarterly Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement, cont.

HCPCS codes will remain payable for dates of service prior to January 1, 2004.

Add L5673** - addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism

Add L5679** - addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism

Chemotherapy Administration (Major Category III, FI Annual Update, EXCLUSION)
Remove 36489*** - Placement of cv catheter

Notes on HCPCS codes above:
* HCPCS codes were replaced by L5673, L5679, L5681 and L5683.
** HCPCS codes are added to exclusion list retroactive to January 1, 2004.

Therapies (Major Category V, FI Annual Update, for FI billing use revenue codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)

Remove G0295^ Electromagnetic stimulation, to one or more areas (Not covered by Medicare) (This HCPCS code was not previously included on carrier coding files.)

Remove G0237^^ - Therapeutic proc strg endur
Remove G0238^^ - Oth resp proc, indiv
Remove G0239^^ - Oth resp proc, group
Remove G0302^^ - Pre-op LVRS service
Remove G0303^^ - Pre-op service LVRS 10-15dos
Remove G0304^^ - Pre-op service LVRS 1-9dos
Remove G0305^^ - Post-op service LVRS min 6dos

Add G0329 ^^^- Electromagnetic therapy, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

Notes on HCPCS codes above:
^ This HCPCS code was erroneously added to file. HCPCS code was not previously included on carrier coding files.
^^ These HCPCS codes are not considered therapy codes and are not payable to a SNF. They were inadvertently added to the table.
^^^ This HCPCS code was added to the therapy inclusion list effective July 1, 2004. (Information concerning this HCPCS code was not received in time to issue a July 2004 update.)

Additional Information
Each January, separate instructions are published for FIs, Carriers and DMERCs for the annual notice on SNF consolidated billing. The 2004 Annual Updates for FIs can be found on the CMS Web site at: www.cms.hhs.gov/manuals/pm_trans/R19CP.pdf

This instruction is referred to as CR2926.

Overall information regarding SNF consolidated billing can be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp

Quarterly updates now apply to FIs, Carriers and DMERCs. There has been one joint FI/Carrier/DMERC quarterly update published subsequent to the 2004 Annual Updates. This update can be found at: www.cms.hhs.gov/manuals/pm_trans/R92CP.pdf

That instruction is also known as CR3070. The official instruction issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3348 in the CR NUM column on the right, and then click on the file for that CR.
October Quarterly Update for 2004 DMEPOS Fee Schedule

Related Change Request (CR) #: 3377
Medlearn Matters Number: MM3377
Related CR Release Date: August 10, 2004
Related CR Transmittal #: 272

Effective Date: January 1, 2004 for revised 2004 fee schedule amounts
Implementation Date: October 4, 2004

Provider Types Affected
Physicians, providers, and suppliers

Provider Action Needed
This instruction provides information for updating and implementing the October Quarterly 2004 fee schedule amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). It implements fee schedule amounts for new HCPCS codes and revises any fee schedule amounts for existing HCPCS codes that were calculated in error.

Background
Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings (Social Security Act, Sections 1834(a), (h), and (i)). In addition, payment on a fee schedule basis is required for Parenteral and Enteral Nutrition (PEN) by regulations contained in 42 CFR 414.102.

This instruction implements fee schedule amounts for new HCPCS codes, deletes certain HCPCS codes, and revises any fee schedule amounts for existing HCPCS codes that were calculated in error in prior updates. Specifically, the changes for this update are as follows:

- HCPCS codes A4363, E1400 through E1404, K0137 through K0139, K0168 through K0181, K0190 through K0192, K0277 through K0279, K0284, K0400, K0417, K0419 through K0439, and K0530 were deleted from the Healthcare Common Procedure Coding System (HCPCS) effective 12/31/1999. These HCPCS codes were inadvertently included in the 2004 fee schedule file, and they are being removed with this update.
- HCPCS codes E1019 and E1021 are also being removed as they are not valid 2004 HCPCS codes.
- The 2004 Puerto Rico schedule amounts for HCPCS codes A4351 and A4352 were based on incorrect pricing information. The Durable Medical Equipment Regional Carriers (DMERCs) must revise the base fee schedule amounts for these codes as part of the October quarterly update.
- HCPCS codes K0630 through K0649, representing Lumbar Sacral Orthosis products were added to the HCPCS effective April 1, 2004 and their fee schedule amounts were implemented on July 1, 2004. However, the Centers for Medicare & Medicaid Services has determined that the fee schedule amounts for HCPCS codes K0630, K0631, K0632, K0634, K0635, K0636, K0637, K0639, K0640, K0642, K0644, K0645, and K0646 were based on incorrect pricing information and has recalculated those fee schedule amounts. The revised amounts will be implemented on October 4, 2004 as part of this update.
- HCPCS codes K0650 thru K0669 were added to the HCPCS effective July 1, 2004. Because data is not yet available, implementation of the fee schedule amounts for these items will be delayed until the January 2005 update.

Implementation
The implementation date for this instruction is October 4, 2004.

Additional Information
To view the official instruction issued to your DMERC or intermediary on this issue, please see: http://www.cms.hhs.gov/manuals/pm_trans/R272C_P.pdf

Also, the quarterly update process for the DMEPOS fee schedule is located in Section 60 of Chapter 23 of the Medicare Claims Processing Manual, which may be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

If you have any questions, please contact your DMERC or intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
2004 Fourth Quarter Fee Updates

The Centers for Medicare & Medicaid Services (CMS) provided revised fees for the following HCPCS codes.

The following new fees are effective for claims processed on or after August 16, 2004.

<table>
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<tr>
<th>HCPCS Code</th>
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2004 Fourth Quarter Fee Updates, cont.

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The following HCPCS codes are individually considered (IC). You will need to send product information with suggested retail price for the item being billed.

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Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.
2004 Urinary Catheter Fee Revisions for Puerto Rico

Due to the variance in fees between Puerto Rico and national fees, Palmetto GBA was requested to review the HCPCS codes listed below.

Our review indicated that the base fee allowances for the HCPCS codes listed were cross-walked from a deleted HCPCS code in error. In order to correct the fees, we have gap-filled fees using a neighboring carrier, the Virgin Islands. Revisions will be implemented October 1, 2004.

**A4351** - Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.) each

**A4352** - Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.) each

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2004 Third Quarter Oral Anti-Cancer Drug Fee Update

Due to the enactment of section 626(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA) on December 8, 2003, Oral Anti-Cancer Drug (OACD) pricing will remain unchanged throughout calendar year 2004; however, we will continue to provide new and deleted sources quarterly.

There are no new or deleted sources for the July 2004 update.
Section 4: HIPAA Information

Reporting MSP Information on HIPAA X12N 837, Created via the Free Billing Software

Update of Health Care Claims Status Codes and Health Care Claims Status Category Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

Reporting MSP Information on HIPAA X12N 837, Created via the Free Billing Software

Related Change Request (CR) #: 3284
Medlearn Matters Number: 3284
Related CR Release Date: May 28, 2004
Related CR Transmittal #: 84

Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Provider Types Affected
All providers who use free billing software from Medicare for HIPAA 837.

Provider Action Needed
STOP: Impact to You
All providers who use free (or low cost) billing software from Medicare for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 837 must receive a software upgrade related to Medicare Secondary Payer (MSP) from their carrier, durable medical equipment regional carrier, or intermediary. Changes included in the updated software will be required for electronic submission of such claims (when there is one primary payer to Medicare). Note that the HIPAA 837 does not accommodate the data Medicare needs when there is more than one primary payer. Providers must submit these types of MSP claims to Medicare on paper.

CAUTION: What you need to know
Please be sure to submit claims in the correct format to avoid delays in claims processing.

GO: What you need to do
If you use the billing software supplied by a Medicare carrier or intermediary, please obtain the required software upgrade after October 4, 2004 from your carrier/intermediary to ensure accurate electronic claims processing.

Additional Information
If you have questions regarding this issue, contact your carrier or intermediary on their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, the toll free number for your carrier/intermediary may be found online at: http://www.cms.hhs.gov/providers/edi/anum.asp

If you bill for Medicare Part B services, the toll-free number may be found at: http://www.cms.hhs.gov/providers/bnum.asp

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR NUM 3284, at: http://www.cms.hhs.gov/manuals/transmittals/com_date_dsc.asp

Once at that page, scroll down the CR NUM column on the right to find CR3284 and click on the file for that CR.
Update of Health Care Claims Status Codes and Health Care Claims Status Category Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

Related Change Request (CR) #: 3361  
Medlearn Matters Number: MM3361  
Related CR Release Date: July 23, 2004  
Related CR Transmittal #: 230

Effective Date: January 1, 2005  
Implementation Date: January 3, 2005

Provider Types Affected  
All providers

Provider Action Needed  
STOP: Impact to You
The Health Insurance Portability and Accountability Act (HIPAA) requires all payers to use the applicable health care claims status category codes and health care claim status codes.

CAUTION: What you need to know
Medicare carriers and intermediaries must periodically update their claims system with the most current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277.

GO: What you need to do
Providers will need to be aware of the new codes that may appear on their response to a claims status inquiry.

Background
Medicare carriers and intermediaries must periodically update their claims system with the most current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277. Under HIPAA, all payers must use health care claims status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee.

At each X12 trimester meeting (generally held in the months of February, June and October) the Committee may update the claims status category codes and health care claim status codes. Included in the code list are specific details, such as the date a code was added, changed, or deleted.

Per HIPAA (1996), health plans must be able to conduct the standard electronic transactions mentioned in the regulation. The named HIPAA transaction for claims status is the ASC X12N 276/277.4010A1 Health Care Claim Status Request and Response. The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes.

Medicare contractors are already using these code sets because of prior instructions. However, recently some new codes and code changes were made with the designation “new as of 2/04.” Medicare carriers and intermediaries will start using the “new as of 2/04” codes as of January 3, 2005.

Additional Information
Claims Status codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-2, STC10-2 and STC11-2 composite elements. They indicate the detail about the general status communicated in the Claims Status Category Codes carried in STC01-1, STC10-1 and STC11-1.

Claims status codes communicate information about the status of a claim, i.e., whether it’s been received, pended, or paid.

For users who are new to the Claim Status transaction, please review the 276/277 Implementation Guide for using claim status codes.

The Claim Status transaction is not used as a financial transaction.

Claim Status Category codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-1, STC10-1 and STC11-1 composite elements. They indicate the general category of the status (accepted, rejected, additional information requested, etc.), which is then further detailed in the Claim Status Codes carried in STC01-2, STC10-2 and STC11-2.

The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes found at: http://www.wpc-edi.com/codes/codes.asp
Update of Health Care Claims Status Codes and Health Care Claims Status Category Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277, cont.

By January 3, 2005, Medicare carriers and intermediaries must have all applicable code changes and new codes that are posted on the Web site with the “new as of 2/04” designation and prior dates available for use in production.

The official instruction issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/com_m_date_dsc.asp

From that Web page, look for CR 3361 in the CR NUM column on the right, and click on the file for that CR.
### Team Tips

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<tr>
<th>Topic</th>
<th>Tip</th>
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<tbody>
<tr>
<td><strong>Beneficiary Address Changes/CMNs</strong></td>
<td>When a beneficiary’s address changes to reflect a new region, the supplier/provider should submit a copy of all Certificates of Medical Necessity (CMNs) from the previous region to the new carrier with the initial claim for those items.</td>
</tr>
<tr>
<td><strong>Beneficiary Call Center</strong></td>
<td>Do not give the Palmetto GBA provider/supplier telephone number to beneficiaries. Instead, instruct beneficiaries to call 1-800-MEDICARE.</td>
</tr>
</tbody>
</table>
| **Medicare Secondary Payer (MSP)** | Help yourself and the MSP team to keep claims and correspondence flowing. Failure to adhere to the following guidelines slows down processing as keyers and MSP Specialists struggle to read documentation:  
  * Do not highlight documents. When we image the document, highlighted areas can become distorted or black. Use an asterisk (*) at the beginning and ending of any line you wish us to focus on.  
  * Include the name of the primary insurer and the insurer’s address on the claim in Item 11 as stipulated in the directions for completing the CMS-1500 claim form when this information is not included on the remittance advice or explanation of benefits.  
  * Do not use a letter from the primary insurer as an explanation of benefits or remittance advice. Only documents that are date specific, service specific, and cost specific — in other words, documents that mimic the actual remittance advice or explanation of benefits — are acceptable.  
  * Call (866) 650-9129 for general MSP inquiries, and use the following address for claim reconsiderations:  
    Palmetto GBA  
    Medicare Secondary Payer  
    P.O. Box 100209  
    Columbia, SC  29202-3209  
  * Make sure that if the services are denied by the primary insurer that you include the section of the remittance that contains the explanation. |
**Team Tips**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Tip</th>
</tr>
</thead>
</table>
| Medicare Secondary Payer (MSP), cont. | - For overpayments based on MSP, please include a copy of the primary insurer’s remittance advice or explanation of benefits.  
- If your beneficiary has a Pharmacy Benefit, make sure that Medicare is not primary for all other services. Remember, Medicare is either 100% primary or 100% secondary. The following are the only instances when Medicare can pay as primary when it is secondary:  
  - When the beneficiary policy does not cover the product  
  - When the necessary medical documents were provided but the beneficiary does not meet the primary insurer’s medical criteria for coverage (this does not include failure to obtain prior authorization)  
  - When the beneficiary no longer is covered by another insurer |

| Remittance Notices - Denial Reasons | For denied claims, the main denial reason for is located in the REM (remark code) field directly below the provider number on each remittance notice. A detailed explanation of the denial reason is located in the Glossary section at the bottom of the remittance notice. |

<table>
<thead>
<tr>
<th>Telephone Resources</th>
<th>The following telephone numbers may be helpful resources for your Medicare questions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region C DMERC Voice Response Unit (VRU)</td>
<td>(866) 238-9650</td>
</tr>
<tr>
<td>Technology Support Center (EDI)</td>
<td>(866) 749-4301</td>
</tr>
<tr>
<td>Medicare Secondary Payer (MSP)</td>
<td>(866) 650-9129</td>
</tr>
<tr>
<td>Social Security Administration (SSA)</td>
<td>(800) 772-1213</td>
</tr>
<tr>
<td>National Supplier Clearinghouse (NSC)</td>
<td>(866) 238-9652</td>
</tr>
<tr>
<td>Medicare Customer Service Center (MCSC)/Beneficiary Call Center</td>
<td>(800) 583-2236</td>
</tr>
<tr>
<td>Railroad Medicare</td>
<td>(877) 288-7600</td>
</tr>
</tbody>
</table>

For other resources, see Chapter 75 of the Region C DMEPOS Supplier Manual.

| Voice Response Unit (VRU) | Region C DMERC’s VRU allows suppliers to obtain detailed information on claims status via telephone, either voice activated or keypad directed. To ensure the best customer service to Region C suppliers, the DMERC recommends that you use the VRU to request routine claims, pricing, appeals, and payment information. Use of the VRU frees our customer service representatives to work with supplier who have more difficult claims issues. For the most current VRU user guide, see Chapter 13 of the Region C DMEPOS Supplier Manual. To contact the VRU, you must use the telephone number (866) 238-9650. If you use the live customer service telephone number, (866) 270-4909, to reach a Customer Service Representative (CSR), the CSR cannot transfer you to the line for the VRU. Likewise, the VRU line cannot transfer you to a CSR. |
Quarterly Provider Update

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

• Inform providers about new developments in the Medicare program;

• Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;

• Ensure that providers have time to react and prepare for new requirements;

• Announce new or changing Medicare requirements on a predictable schedule; and

• Communicate the specific days that CMS business will be published in the Federal Register.

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

The Quarterly Provider Update can be accessed at http://www.cms.gov/providerupdate. We encourage you to bookmark this Web site and visit it often for this valuable information.

The SADMERC is pleased to provide DMECS (Durable Medical Equipment Coding System), an online application that provides Healthcare Common Procedure Coding System (HCPCS) coding assistance and national pricing information 24 hours a day. DMECS is designed to help Medicare providers and suppliers quickly classify durable medical equipment, prosthetics/orthotics, and supplies (DMEPOS) by combining information from a variety of sources to make HCPCS coding determinations for claim submission to the DMERCs easier. Currently, DMECS includes a HCPCS and fee schedule look-up with capabilities to print or download information. Future enhancements will include SADMERC Classification Lists, sample product pictures, and a coding navigator tool that categorizes and combines HCPCS codes in a format that allows you to easily determine how to code your product.

You may access DMECS by selecting SADMERC from the Palmetto GBA home page at www.PalmettoGBA.com. From the SADMERC home page, click on the link for “Durable Medical Equipment Coding System (DMECS)” in the menu on the left side of the screen. Your feedback is vital to the success of this tool. Please e-mail us your feedback by selecting Contact Us from our Web site.
Palmetto GBA Online Learning

Via our Online Learning Center, Palmetto GBA offers Web-based tutorials, online workshops and learning materials designed to enhance knowledge of Medicare billing and coverage issues. Palmetto GBA’s Online Learning Center allows providers and suppliers to experience instructor-led courses over the Internet, or to take Web-based tutorials on their own. In online workshops, course attendees are able to interact with the instructor and with other attendees via microphone or text chatting, provide feedback on workshops and ask direct questions to complement their learning experience. Web-based tutorials allow providers and suppliers to take a course whenever their schedule allows.

Online workshops are conducted each month to cover a variety of topics helpful to the supplier community. Suppliers must register to attend each course separately. Registration can occur at any time prior to the scheduled date and time.

How do I register for online learning?
To register for online learning via Centra, access the Palmetto GBA Web site at www.PalmettoGBA.com.

1. Under Providers, click on Learning & Education.
2. Select Online Learning on the left hand menu.
3. Click the Login button. (This will take you to the Palmetto GBA Online Training Home Page).
4. Select Click Here to Register a New User.
5. Complete the New User form and click Submit. (You will receive a message that states that your new user name and password have been accepted).
6. To log in, return to the Online Learning page and log in using your new user name and password.

Remember! Your new user name and password are case-sensitive. You must enter them in the same format used to create them.

How do I locate and register for courses?
Workshops and tutorials are listed in Centra according to presentation style and by line of business.

1. Select the Catalog tab to see a list of learning resources.
2. Choose the Category that pertains to your line of business (e.g. DMERC).
3. Upon selecting the category, a list of workshops and learning resources will display alphabetically. Scroll through the list and place a check mark beside each course you would like to attend. Once you complete your selection, scroll back to the top of the page and click on the Add to My Learning button on the right hand side of the category listing.
4. A pop-up window will appear with a list of all of the classes you have selected. Check your selections carefully and then click the Submit button.
bulletin to enroll in the course(s).

5. Click on the My Learning tab to ensure that all workshops have been added to your schedule.

Don’t forget to mark your calendar if you have registered for a scheduled online workshop!

Attending a course
1. Log in to Palmetto GBA’s Online Learning Center.
2. Click on the My Learning tab to view courses.
3. Select the course you want to attend.
4. Click Attend to join the session.

To begin a tutorial, follow steps 1-3, then click on Start to begin.

Helpful hints for online workshop attendance
• The tools at the top of the screen are for responding to prompts from the course instructor. Tools include buttons to Raise your Hand and answer Yes and No.

• The Text Chat feature allows the attendees to ask questions. Simply click on the Text Chat button (keyboard with a bubble) to participate.

Enter the text in the Message window and click Send.

Using a microphone
We recommend you use a headset with a microphone when participating in online workshops. A microphone allows course attendees to speak directly with the instructor throughout the workshop.

During the workshop, you will not be able to speak unless granted a microphone by the course leader. You may raise your hand to signal to the instructor that you would like to have a microphone granted to you. Once the microphone has been granted, click on the Lock to talk button in the top left hand corner.

Please Note: You must release the Lock to talk button to allow the instructor to respond to you.

System requirements
Before attending an online workshop, test your system to make sure your computer can support the actual session. Click on the My Learning button at the top of the page. Toward the top right on the following screen, click on the System Check button (it looks like a computer) to test your system. The minimum system requirements are listed below:

• Windows 98, 2000, XP
• Internet Explorer 5.0 and later. Netscape 4.5x, 4.7x, 7.0 or later (SSL events require IE 5.01 or later)
• 28.8 kbps or faster Internet connection
• P133+ MHz, 64+ MB memory
• 800x600 or higher display resolution
• Sound card, speakers/microphone or headset

Follow the instructions in the System Check pop-up box. After completing the system check, you may exit the Online Learning section.
Register on the Palmetto GBA Web Site Listserv

Are you keeping up to date on the latest Medicare publications and information? By registering on the Palmetto GBA Web site (www.PalmettoGBA.com) and completing a user profile, you can be notified by e-mail when new or important information is added to our Web site. You only need to register once. It is quick and easy. You do NOT have to register to use our Web site, but registering lets you:

- Receive weekly e-mail notification of Medicare news and updates.
- Know when the next online workshop will be offered.
- Update your e-mail profile at any time.

To register, access the DMERC section of the Palmetto GBA Web site. From the Web site home page, select DMERC (under Providers). From the top of the screen, select the login option. Follow the on-screen instructions. Here are some helpful tips:

1. Note your User name and Password, as these items are case-sensitive.

2. Be sure to fill out all required fields, and check the boxes in the lower portion of the form for the topics in which you are interested.

3. After you register, you only need to log in when you want to update your profile.

If you have questions about this process, please use the Contact Us button (located at the top of your screen) to send an e-mail to Palmetto GBA via our Web site. Once on the Contact Us page, select DMERC (Region C), then “E-mail Palmetto GBA” for technical assistance (at the bottom). At the bottom of the page you will provide your name, e-mail address and nature of your concern.
Region C Directory

Please retain this list as your new DMERC telephone directory.

### Palmetto GBA Contacts

<table>
<thead>
<tr>
<th>Mailing address</th>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Integrity Unit</strong></td>
<td>(877) 867-4852</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100236</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3236</td>
<td></td>
</tr>
<tr>
<td><strong>Multifunctional Teams/DMERC General Information</strong></td>
<td>(866) 270-4909</td>
</tr>
<tr>
<td><strong>DMERC Interactive Voice Response Unit</strong></td>
<td>(866) 238-9650</td>
</tr>
<tr>
<td><strong>Medicare Customer Service Center (Beneficiary Call Center)</strong></td>
<td>(800) 583-2236</td>
</tr>
<tr>
<td><strong>Technology Support Center (Formerly EDI Help Desk)</strong></td>
<td>(866) 749-4301</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100145</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3145</td>
<td></td>
</tr>
<tr>
<td><strong>Hearings Department</strong></td>
<td>(866) 238-9650</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100249</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202</td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Secondary Payer</strong></td>
<td>(866) 650-9129</td>
</tr>
<tr>
<td>Palmetto GBA</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100209</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202</td>
<td></td>
</tr>
<tr>
<td><strong>ADMC Department</strong></td>
<td>FAX: (803) 424-2622</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100235</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3235</td>
<td></td>
</tr>
<tr>
<td><strong>Professional Relations Department</strong></td>
<td>(803) 763-5744</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100141</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3141</td>
<td></td>
</tr>
</tbody>
</table>

*Inquiries regarding hearings or Advance Determination of Medicare Coverage should be directed to the Dedicated Work Teams.

### National Contacts

<table>
<thead>
<tr>
<th>Mailing address</th>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Security Administration (SSA)</strong></td>
<td>(800) 772-1213</td>
</tr>
<tr>
<td><strong>National Supplier Clearinghouse (NSC)</strong></td>
<td>(866) 238-9652</td>
</tr>
<tr>
<td>P.O. Box 100142</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3142</td>
<td></td>
</tr>
<tr>
<td><strong>Region A DMERC</strong></td>
<td>(866) 419-9458</td>
</tr>
<tr>
<td><strong>Region B DMERC</strong></td>
<td>(877) 299-7900</td>
</tr>
<tr>
<td><strong>Region D DMERC Interactive Voice Response Unit</strong></td>
<td>(877) 320-0390</td>
</tr>
<tr>
<td><strong>Region D DMERC Customer Service Representatives</strong></td>
<td>(866) 243-7272</td>
</tr>
<tr>
<td><strong>Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)</strong></td>
<td>(877) 735-1326</td>
</tr>
<tr>
<td>Mail code: AG-370</td>
<td></td>
</tr>
<tr>
<td>2300 Springdale Drive, Bldg. One</td>
<td></td>
</tr>
<tr>
<td>Camden, SC 29020</td>
<td></td>
</tr>
<tr>
<td><strong>Railroad Medicare</strong></td>
<td>(877) 288-7600</td>
</tr>
</tbody>
</table>
Ombudsmen Addresses and Territories

**Alabama**
Lia Bunch  
PMB 425  
459 Main Street, Suite 101  
Trussville, AL  35173  
(205) 661-6988

**Arkansas/Oklahoma**  
Kendra Kerley  
1050 E. 2nd Street, #356  
Edmond, OK  73034  
(405) 277-3875

**Colorado/New Mexico**  
Eric Carlson  
P.O. Box 2027  
Littleton, CO  80161-2027  
(720) 493-5301

**Florida (south)**  
(Takes in southern Florida including Manatee, Hardee, Highlands, Okeechobee and Indian River counties)  
Teresita Ortiz  
934 N. University Dr., #447  
Coral Springs, FL  33071  
(561) 997-9210

**Florida (north)**  
(Takes in northern Florida including Pinellas, Hillsborough, Polk, Osceola and Brevard counties)  
Keith Smith  
PMB 112  
11111-70 San Jose Blvd.  
Jacksonville, FL  32223-7946  
(904) 886-2887

**Georgia**  
Sharon Briggman  
8200 Mall Pkwy. #135 - 304  
Lithonia, GA  30058  
(770) 388-7380

**Kentucky**  
James Owens  
P.O. Box 224  
Albany, KY  42602  
(606) 387-4672

**Louisiana/Mississippi**  
Bobby Smith  
P.O. Box 9225  
Jackson, MS  39286  
(601) 856-8468

**North Carolina**  
Makisha Pressley-Callaham  
P.O. Box 5323  
Concord, NC  28027  
(704) 782-9600

**Out of Region C**  
Deidre Bibbs  
P.O. Box 100141, AG-520  
Columbia, SC  29202-3141  
(803) 763-5170

**Puerto Rico/Virgin Islands**  
Carmen Soto-Ortiz  
P.O. Box 100141, AG-520  
Columbia, SC  29202-3141  
(803) 763-5857

**South Carolina**  
Elizabeth Ullman  
P.O. Box 100141, AG-520  
Columbia, SC  29202-3141  
(803) 763-5920

**Tennessee**  
Ronja F. Roland  
5341 Mt. View Rd., PMB 122  
Antioch, TN  37013  
(615) 793-6873

**Texas (south)**  
(Denotes area codes 210, 254, 325, 361, 432, 512, 830, 915 and 956)  
Dana Causey  
PMB 604  
20475 Highway 46 W, Suite 180  
Spring Branch, TX  78070-6124  
(830) 980-7749

**Texas (north)**  
(Denotes area codes 214, 281, 409, 469, 713, 806, 817, 832, 903, 936, 940, 972 and 979)  
Peggy Miller  
2601 Cartwright Rd., Suite D392  
Missouri City, TX  77459  
(281) 416-9688

Ombudsmen investigate complaints, report findings and facilitate problem solving through training and education of the supplier community.