



## July 15, 2005 Newsletter

*In This Issue....*

	<b>Audit &amp; Reimbursement</b>	
H	Update - Long Term Care Hospital Prospective Payment System (LTCH PPS) for Rate Year 2006	3
	<b>Claims</b>	
A	Anti-Cancer Chemotherapy for Colorectal Cancer	5
A	Mass Adjustment of Certain Transplant Claims	8
A	Non-Physician Practitioner Questions and Answers	9
A	Reminder Regarding Medicare Billing Rules for Ambulance Services Rendered to Medicare Patients During an Inpatient Hospital Stay	14
	<b>Claims Appeals</b>	
A	MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries (CR Title- Appeals Transition – BIPA 521 Appeals)	15
	<b>General Information</b>	
A	Posters Now Available!	22
	<b>Medical Review</b>	
A	Comprehensive Error Rate Testing (CERT) Findings Regarding Responses Received by the CERT Contractor with Improper Documentation	22
A	Autologous Stem Cell Transplantation	24
A	Radiation Therapy	26
H	<b>MIP Tip</b> - The Provider Based Attestation Process	32

### **KEY**

- A** All Providers
- H** Hospital Providers
- S** Skilled Nursing Facility (SNF) Providers
- O** Comprehensive Outpatient Rehabilitation Facility (CORF) And Outpatient Physical Therapy (OPT) Providers
- C** Community Mental Health Center (CMHC) Providers
- R** Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers
- E** End-Stage Renal Disease (ESRD) Providers
- P** Hospice Providers
- M** Home Health Providers

If you have any questions regarding this newsletter, please contact your Customer Service Representative. However, some articles may contain a specific telephone number to contact for assistance.

Mutual of Omaha Insurance Company  
Medicare Area

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## **Update - Long Term Care Hospital Prospective Payment System (LTCH PPS) for Rate Year 2006**

**Related Change Request (CR) #:** 3884      **Medlearn Matters Number:** MM3884

**Related CR Release Date:** June 10, 2005

**Related CR Transmittal #:** 578

**Effective Date:** July 1, 2005

**Implementation Date:** July 5, 2005

### **Provider Types Affected**

Long Term Care Hospitals paid under the LTCH PPS by Medicare Fiscal Intermediaries (FIs).

### **Provider Action Needed**

This article is based on information from Change Request (CR) 3884 which updates the changes to LTCH PPS for Rate Year 2006 (July 1, 2005 - June 30, 2006). The final rule for LTCH PPS was published on May 6, 2005 and may be viewed at: [www.cms.hhs.gov/providerupdate/regs/cms1483F.pdf](http://www.cms.hhs.gov/providerupdate/regs/cms1483F.pdf) on the Centers for Medicare & Medicaid Services (CMS) web site.

***CR3884 provides updates to rates, budget neutrality factors, wage indexes, etc., for the new rate year for LTCH PPS.***

See the Background Section of this article to find out further details regarding these changes.

### **Background**

CMS implemented a prospective payment system for Long Term Care Hospitals (LTCHs) under the Medicare program on October 1, 2002, in accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

***Payments under this system are made on a per discharge basis, using Long-Term Care Diagnosis-Related Groups (LTC-DRGs) that take into account differences in resource use of long-term care patients and the most recently available hospital discharge data. CMS is required to update the payments made under this prospective payment system annually. However, there are two significant updates for LTCH Prospective Payment System (PPS):***

- The Rate Year update, which occurs in July of each year, and
- The Diagnosis Related Groups (DRGs), which are updated in October of each year.

### **Rate Year Updates**

The following PRICER Updates are for LTCH PPS rate year (RY) 2006, (July 1, 2005 – June 30, 2006):

- The standard Federal rate is \$38,086.04,
- The fixed loss amount is \$10,501.00,
- The budget neutrality adjustment is 0 percent. (The PRICER payment amount will include the adjustment factor as 1.00.),
- The labor-related share is 72.885 percent,
- The non-labor related share is 27.115 percent,

- The short-stay outlier percentage for “subsection II” LTCHs is 165 percent for this 3rd transition year; and
- Core-Based Statistical Area (CBSA) designations will be used for assigning a wage index value for discharges occurring on or after July 1, 2005. There will be no transition blend under LTCH PPS for conversion to the CBSA labor market areas.

***The wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2005 is 4/5ths (80 percent). The wage index table in the Pricer will include three columns listed in the table below:***

Column	Pertaining to	Instructions
2/5ths	Discharges occurring in the LTCH cost report periods beginning Fiscal Year 2004 (October 1, 2003 – September 30, 2004)	Which will be 2/5ths of the Core Based Statistical Area (CBSA) wage index (not the MSA wage index)
3/5ths	Discharges occurring in the LTCH cost report periods beginning Fiscal Year 2005 (October 1, 2004 – September 30, 2005)	Which will be 3/5ths of the CBSA wage index (not the MSA wage index)
4/5ths	Discharges occurring in the LTCH cost report periods beginning Fiscal Year 2006 (October 1, 2005 – September 30, 2006)	Which will be 4/5ths of the CBSA wage index (not the MSA wage index)

### **LTCH Notification Requirement**

Within thirty days of the start of their cost reporting period (and whenever any change occurs during a cost reporting period), LTCHs and satellites of LTCHs must notify their FI and CMS of the name, address, and provider number of any Medicare providers with whom they are co-located, including:

- Acute Care Hospitals,
- Inpatient Rehabilitation Facilities,
- Inpatient Psychiatric Facilities, and
- Skilled Nursing Facilities (SNFs).

Note that a co-located (or onsite) facility means a hospital, unit, or SNF that occupies space 1) in a building used by another hospital or unit or 2) in one or more buildings on the same campus (250 yards from the LTCH), as buildings used by another hospital or unit.

CR3884 instructs your FIs to pay claims with LTCH PPS Pricer Version 060 for discharges/through dates on or after July 1, 2005, and this Pricer will include all Rate Year 2006 updates. In addition, FIs shall maintain and update records on facilities that are co-located.

### **Implementation**

The implementation date for this instruction is July 5, 2005.

### **Additional Information**

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

***From that web page, look for CR3884 in the CR NUM column on the right, and click on the file for that CR.***

If you have any questions regarding the information in this article, please contact the audit supervisor that is assigned to your facility.

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## **Anti-Cancer Chemotherapy for Colorectal Cancer**

**Related Change Request (CR) #:** 3742

**Related CR Release Date:** June 17, 2005

**Related CR Transmittal #:** 38 and 588

**Effective Date:** January 28, 2005

**Implementation Date:** April 18, 2005 for Medicare carriers

On or before July 5, 2005 for Medicare Fiscal Intermediaries

**Medlearn Matters Number:** MM3742

**Revised**

**Note:** This article was revised on June 21, 2005, to reflect a revision to CR3742. The CR was revised to show that Medicare fiscal intermediaries (FIs) will implement the change on or before July 5, 2005, instead of April 18, 2005. The effective date of CR3742 and all other information remains the same, but providers should take note that their Medicare FI may not be ready to process claims in accordance with CR3742 until July 5, 2005.

### **Provider Types Affected**

Providers and suppliers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs), and fiscal intermediaries (FIs) for anti-cancer chemotherapy

### **Provider Action Needed**

This article is based on information contained in Change Request (CR) 3742, which states that the Centers for Medicare & Medicaid Services (CMS) will cover the off-label use of Oxaliplatin (Eloxatin™), Irinotecan (Camptosar®), Cetuximab (Erbix™), or Bevacizumab (Avastin™) in clinical trials identified by CMS and sponsored by the National Cancer Institute (NCI).

This national coverage decision does not:

- Modify existing requirements for coverage of these and other anti-cancer chemotherapeutic agents for FDA-approved indications or for off-label indications listed in an approved compendium; or
- Change existing coverage for any off-label uses of these drugs provided outside the clinical trials identified.

Medicare carriers, DMERCs, and intermediaries will continue to make local coverage determinations for medically accepted uses of off-label indications based on guidance provided by the Secretary of the Department of Health and Human Services (DHHS).

### **Background**

On January 28, 2005, CMS announced a National Coverage Determination (NCD) covering the off-label use of certain colorectal anti-cancer drugs in identified clinical trials of colorectal cancer

and other cancer types. These clinical trials study the use of one or more off-label uses of these four drugs in colorectal and other cancer types.

**Note:** The clinical trials for which these drugs and other items and services are covered appear in Appendix A in the NCD at <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90> on the CMS web site.

Anti-cancer chemotherapeutic agents are eligible for coverage in a clinical trial setting when the following occurs:

- They are used in accordance with Food and Drug Administration (FDA)-approved labeling;
- Their use is supported in one of the authoritative drug compendia; or
- The Medicare contractor (carriers, Fiscal Intermediaries (FIs), DMERCs) determines an off-label use is medically accepted based on guidance provided by Secretary of DHHS.

Effective for services provided on or after January 28, 2005, CMS covers the following anti-cancer chemotherapeutic agents, which have been approved by the FDA for the treatment of colorectal cancer, when used in clinical trials identified by CMS and sponsored by the National Cancer Institute:

- Oxaliplatin (Eloxatin™)
- Irinotecan (Camptosar®)
- Cetuximab (Erbix™)
- Bevacizumab (Avastin™)

Under the concept of linking Medicare coverage determinations to clinical studies, the investigational items and services provided in qualified scientific studies are covered (including clinical trials, practical trials, and systematic data collection systems) when:

- They provide for the accrual of supporting evidence of medical necessity; and
- They collect data to support decisions about whether or not a technology is reasonable and necessary.

**Note:** The list of identified clinical trials for which the routine costs of the items and services are covered appears in the Clinical Trials section, at <http://www.cms.hhs.gov/coverage> on the CMS web site.

Non-routine clinical costs include items and services that are provided in either the investigational or the control arms of a clinical trial specified by CMS for coverage. The following non-routine items and services **are not covered** and include items and services:

- Provided solely to satisfy data collection, and that are not used in the direct clinical management of the patient;

- Provided solely to determine trial eligibility;
- Customarily provided by the research sponsors free-of-charge for any enrollee in the trial;
- That are statutorily excluded from Medicare coverage; or
- That do not fall into a benefit category.

This NCD, issued on January 28, 2005, does not withdraw Medicare coverage for items and services that may be covered according to the existing national coverage policy for Routine Costs in a Clinical Trial (See National Coverage Determination Manual, Section 310.1 at [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103index.asp](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp) on the CMS web site.

**Note:** The existing requirements for coverage of oxaliplatin, irinotecan, cetuximab, bevacizumab, or other anticancer chemotherapeutic agents for FDA-approved indications or for indications listed in an approved compendium are not modified.

Medicare contractors will continue to make reasonable and necessary coverage determinations under the Social Security Act (Section 1861(t)(2)(B)(ii)(II)) based on guidance provided by CMS for medically accepted uses of off-label indications of Oxaliplatin, Irinotecan, Cetuximab, Bevacizumab, or other anticancer chemotherapeutic agents provided outside of the identified clinical trials appearing on the CMS website noted previously.

Some important points to remember when billing Medicare for these anti-cancer drugs are as follows:

- FIs will accept claims for these drugs on types of bill (TOB) 11x, 12x, 13x, 18x, 21x, 22x, 23x, and 85x. Use revenue code 0636 used for anti-cancer drugs furnished during a clinical trial for outpatient claims and use revenue code 0250 for inpatient claims.
- When billing carriers, DMERCs and FIs, on a claim other than an inpatient claim, include the QR modifier to show the drug was furnished during a clinical trial.
- Claims submitted to FIs should also contain an ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position to show that the claim involves a clinical trial.
- When using the QR modifier, also be sure to include a HCPCS code of J9035, J9055, J9206, J9263, J8520, J8521, J9190, or J9201, as appropriate for the anti-cancer drug being billed.
- Providers are also to include a QR modifier when billing for nonroutine costs associated with these clinical trials.
- DMERCs will accept claims with HCPCS codes of J8520 and J8521 as clinical trial codes for **oral anticancer** drugs, when accompanied by the QR modifier to show use in a clinical trial.
- When billing for covered routine costs associated with clinical trials as described in section 310 of the NCD Manual, be sure to include a QV modifier on the claim.

- Submit an appropriate cancer diagnosis code for the clinical trial on the claim.

**Note:** While this NCD is effective as of January 28, 2005, Medicare systems will be unable to process claims containing the QR modifier received before April 1, 2005. For that reason, do not send in claims for drugs or other nonroutine services covered under this NCD until April 1, 2005. Do not hold claims for nonroutine services containing the QV modifier associated with this NCD.

### **Additional Information**

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction includes the NCD section 110.17 and it may be viewed by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

From that web page, look for CR 3742 in the CR NUM column on the right, and click on the file for that CR. You should see two versions of CR 3742 on this web site. The version of CR 3742 with a transmittal number of R38NCD will contain the NCD information and the version with a transmittal number of R588CP will contain the Medicare claims processing instructions.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>

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## **Mass Adjustment of Certain Transplant Claims**

**Related Change Request (CR) #:** N/A

**Medlearn Matters Number:** SE0539

### **Provider Types Affected**

Hospitals that submitted claims for certain transplants paid under the Inpatient Prospective Payment System (IPPS) by Medicare Fiscal Intermediaries (FIs)

### **Background**

The Centers for Medicare & Medicaid Services (CMS) has discovered that certain transplant claims paid under the IPPS by Medicare FIs may have been processed incorrectly; i.e. overpaid. Specifically, acquisition charges related to heart, liver, intestine, lung, and pancreas transplants (diagnosis-related groups (DRGs) 103, 480, 495, and 513) were being passed with all other charges on the claim to the IPPS PRICER and were, therefore, used in calculating the outlier. However, acquisition charges are considered **pass-throughs** and should **not** be included in the outlier calculation.

CMS has directed Medicare FIs to adjust claims with discharge dates on or after August 8, 2003, containing DRGs 103, 480, 495, or 513 that were paid an outlier. This adjustment will occur automatically without any action required by the provider. CMS will determine at a later date if they need to go back further than August 8, 2003 and will notify you if a decision is made.



Medicare FIs must complete these mass adjustments by **December 31, 2005**.

### **Additional Information**

Additional information on inpatient hospital billing for transplants can be found in the Medicare Claims Processing Manual, Chapter 3 (Inpatient Hospital Billing), Section 90, at [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c03.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c03.pdf) on the CMS web site.

For additional information relating to this issue, please contact local FI at their toll-free number which may be found at <http://www.cms.hhs.gov/medlearn/tollnums.asp> on the CMS web site.

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## **Non-Physician Practitioner Questions and Answers**

**Related Change Request (CR) #:** N/A

**Medlearn Matters Number:** SE0418

**Related CR Release Date:** N/A

**Revised**

**Effective Date:** N/A- This is informational only.

**Note:** This article was revised on June 14, 2005. The only change was the answer (A5) to question 5 (Q5) on page 2. All other information remains the same.

### **Provider Types Affected**

Non-Physician Practitioners (NPPs), physicians, suppliers, and providers

### **Provider Action Needed**

Be sure to understand the policies related to services for Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) as they relate to Non-Physician Practitioners.

### **Background**

The Balanced Budget Act of 1997 modified the way the Medicare program pays for Non-Physician Practitioner (NPP) services. Prior to January 1, 1998, these services were reimbursed by Medicare Part B only in certain geographical areas and health care settings. The Balanced Budget Act removed the restrictions on settings and effective January 1998, payment is allowed for non-physician practitioner services in all geographic areas and health care settings permitted under State licensing laws.

On November 13, 2003, CMS issued the Survey & Certification letter (S&C-04-08), which addresses the differences in requirements concerning the delegation of physician tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) from a survey and certification perspective. Please note that reimbursement requirements for NPPs may differ from the survey and certification requirements. The following questions (Q1 through Q17) have been asked by NPPs, and each question has been answered (A1 through A17) by the Centers for Medicare & Medicaid Services (CMS).

***Q1. Why do new regulations from CMS governing physician delegation of services differ between Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)?***

**A1.** The requirements addressing physician delegation of services are not new. The distinction made between the delegation of physician visits and tasks between SNFs and NFs is mandated by Congress in the law.

The original authority for 42 Code of Federal Regulations (CFR) section 483.40 was the sentence in section 1819(b)(6)(A) of the Social Security Act requiring that every SNF resident's medical care be under the supervision of a physician (the same sentence appeared in section 1919(b)(6)(A) of the Social Security Act for NFs). The requirements contained in 42 CFR, section 483.40, include a prescribed visit schedule and the requirement for the physician to perform the initial visit personally.

Section 483.40 of the CFR originally applied these same standards uniformly in both SNFs and NFs. However, in section 4801(d) of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress subsequently amended the Medicaid provisions of the law (section 1919(b)(6)(A) of the Social Security Act) to allow, at the option of the State, all physician tasks (including the initial visit) to be delegated to physician extenders who are not employed by the facility but who are working in collaboration with the physician. In response, CMS amended the regulations to reflect this broader authority for delegating physician tasks in NFs (see section 483.40(f)). Since Congress declined to make a similar change in the statutory requirements for SNFs at section 1819(b)(6)(A) of the Social Security Act, the corresponding SNF requirements in section 483.40(c) and (e) remain unchanged.

**Q2. When may non-physician practitioners (NPPs) begin to bill for medically necessary visits that occur prior to the initial comprehensive visit in a SNF and in a NF?**

**A2.** CMS defined "initial comprehensive visit" in the November 13, 2003 S&C-04-08 and stated that NPPs may perform any medically necessary visits even if they occur prior to the initial comprehensive visits in both SNFs and NFs. Medically necessary visits that NPPs perform on or after November 13, 2003, may be billed to the carrier when collaboration and billing requirements are met in the SNF and NF setting. The Survey & Certification letter S&C-04-08, may be found at:

<http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp>

**Q3. If State regulations require a physician co-signature for orders and/or notes written by an NPP, may the physician bill for this action?**

**A3.** No. CMS only pays for medically necessary face-to-face visits by the physician or NPP with the resident. Since the NPP is performing the medically necessary visit, the NPP would bill for the visit.

**Q4. If State regulations require more frequent visits than those that are federally mandated, are NPPs able to bill for those visits?**

**A4.** CMS only reimburses physicians and NPPs for medically necessary visits and federally prescribed visits. Visits required to fulfill or meet State requirements are considered administrative requirements and are not medically necessary for the resident. Medicare pays for services that are reasonable and medically necessary for the treatment of illness or injury only, as stated in the Social Security Act, section 1862(a)(1)(A).

**Q5. May NPPs who are employed by the facility bill for medically necessary visits?**

**A5.** Payment may be made for the services of Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) who are employed by a SNF or NF when their services are rendered to facility residents. If NPs and CNSs employed by a facility opt to reassign payment for their professional services to the facility, the facility can bill the appropriate Medicare Part B carrier

under the NPs' or CNSs' UPINs for their professional services. Otherwise, the NPs or CNSs who are employed by a SNF or NF bill the carrier directly for their services to facility residents.

On the other hand, Physician Assistants (PAs) who are employed by a SNF or NF cannot reassign payment for their professional services to the facility because Medicare law requires the employer of a PA to bill for the PA's services. Hence, the facility must always bill the Part B carrier under the PA's UPIN for the PA's professional services to facility residents.

***Q6. May NPPs employed by the NF perform the initial comprehensive visit, sign initial orders, or perform other federally required visits in NFs?***

**A6.** No. The statute specifies that the NPPs are prohibited from providing these services when **employed** by the facility. The Social Security Act states at section 1919(b)(6)(A) that the health care of every resident must be provided under the supervision of a physician or under the supervision of an NPP **not** employed by the facility who is working in collaboration with a physician.

***Q7. May NPPs perform the initial comprehensive visit in SNFs?***

**A7.** No. The Social Security Act states at Section 1819(b)(6)(A) "that the medical care of every resident must be provided under the supervision of a physician." Congress did not extend this benefit to NPPs in an SNF as was done under 1919(b)(6)(A).

***Q8. When may NPPs sign the initial orders for a SNF resident?***

**A8.** NPPs may not sign initial orders for an SNF resident. However, they may write initial orders for a resident (only) when they review those orders with the attending physician in person or via telephone conversation and have the orders signed by the physician.

***Q9. Must a physician verify and sign orders written by an NPP who is employed by the NF?***

**A9.** Yes. The regulation at 42 CFR, section 483.40(b)(3) states, the physician must "Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

In accordance with 42 CFR, Section 483.40(f), required physician tasks, such as verifying and signing orders in an NF, can be delegated under certain circumstances to a physician assistant, nurse practitioner, or clinical nurse specialist who is **not** an employee of the facility but who is working in collaboration with a physician. Therefore, in order to comply with survey and certification requirements, the physician must sign all orders written by an NPP who **is** employed by the NF.

***Q10. Why must a physician verify and sign orders written by an NPP in the SNF?***

**A10.** 42 CFR, Section 483.40(e)(2), which applies to physician delegation of tasks in SNFs, states "A physician may not delegate a task when regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies." Therefore, in accordance with 42 CFR, section 483.40(b)(3), the physician must "Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

***Q11. Referring to S&C –04-08 issued on November 13, 2003, the chart under the "Other Medically Necessary Visits and Orders" column, it specifies the ability of the NPP to***

***perform AND sign but in the column for “Other Required Visits” it does not address signing. Does CMS require a physician’s signature in such cases?***

**A11.** ‘Other Required Visits’ refers to the federally required visits. During these required visits, it is not always necessary to write orders. However, during a “Medically Necessary Visit,” which is when the resident’s condition may have changed, thus, warranting a visit outside the federally required schedule, the resident is exhibiting signs and/or symptoms that require medical attention. In these cases, CMS believes orders will often be required and, thus, expect orders to address the resident’s change in condition. Therefore, an NPP may sign the medically required orders. Please remain mindful that the survey and certification requirement that the physician must sign and date all orders remains in effect. (See Q&As 9 & 10.)

***Q12. Why can’t a PA, regardless of employment, sign certifications/re-certifications for SNF residents?***

**A12.** Congress amended section 1814(a)(2) of the Social Security Act in 1989. The Social Security Act **specifies** that NPs and CNSs who are not employed by the facility may certify (and recertify) that the services the beneficiary requires may only be performed in the SNF. They did not extend this benefit to PAs. Therefore, by statute, PAs may not sign SNF certifications/re-certifications.

***Q13. If a physician extender is not employed by the NF but is employed by an organization related to the NF, may he/she still provide services in the nursing home?***

**A13.** The requirement in 42 CFR, section 483.40(f), is specific in that the physician tasks may be performed by a NP, PA, or CNS “who is not an employee of the facility.” In this case, the NPP is not an employee of the NF and, thus, can perform physician tasks as long as they work in collaboration with the physician.

***Q14. If an NP or CNS is not employed by the SNF but is employed by an organization related to the SNF, may he/she sign the certification and re-certifications?***

**A14.** The requirement in 42 CFR section 424.20(e) is specific in that an NP or CNS “neither of whom has a direct or indirect employment relationship with the facility” may sign the certifications and re-certifications. In this case, the NP or CNS is not an employee, but has an indirect employment relationship and, thus, are not permitted to sign the certifications and re-certifications. (Social Security Act section 1814(a)(2))

***Q15. If physician delegation responsibilities are based on payment source, what are the physician delegation responsibilities for private pay resident, VA contracts or managed care?***

**A15.** If the resident’s stay is being paid for by a source other than Medicare or Medicaid AND the resident is residing in a Medicare/Medicaid dually-certified facility, follow the most stringent requirement. If the resident is residing in a Medicare only or a Medicaid only certified facility, then follow the requirements for that specific certified facility.

***Q16. Are NPPs allowed to certify/recertify therapy plans of care under Medicare Part B?***

**A16.** 42 CFR section 424.24(c)(3) states that if a physician or NPP establishes the plan of care, he/she must also certify the plan of care. If the plan of care is established by a physical or occupational therapist or speech language pathologist, a physician or NPP who has knowledge of the case must sign the plan of care. (This Q&A was **not** addressed in the November 13, 2003, Survey & Certification letter, S&C-04-08.)

Should you have any questions concerning this article, please submit your inquiry via the CMS Web site as follows:

1. Click on Feedback in top tool bar of <http://www.cms.hhs.gov> (from Home page or any page on cms.hhs.gov).
2. Select and click "Site Feedback" in last paragraph.
3. User should:
  - a. Enter his/her email address;
  - b. At Category, select "Providers" from the drop down menu;
  - c. At the sub-category, select Nursing Home Quality Initiative;
  - d. Enter feedback in space provided; and
  - e. Submit feedback.

### **Related Instructions**

The CMS Web site contains considerable information regarding SNF billing procedures and NPP billing processes. Some of the specific sites are as follows:

The *Medicare Claims Processing Manual, Pub. 100-04, Chapter 7 (SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule))* can be found at the following CMS Website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c07.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c07.pdf)

The *Skilled Nursing Facility Manual, Chapter V (Billing Procedures)* is located at the following CMS Website: [http://www.cms.hhs.gov/manuals/12\\_snf/sn500.asp](http://www.cms.hhs.gov/manuals/12_snf/sn500.asp)

The Home Health Agency Manual, Chapter IV (Billing Procedures) Website is located at: [http://www.cms.hhs.gov/manuals/11\\_hha/hh400.asp](http://www.cms.hhs.gov/manuals/11_hha/hh400.asp).

### **Additional Information**

The CMS Quarterly Provider Update Websites for Non-Physician Practitioners (NPPs) for 2004 can be found at:

<http://www.cms.hhs.gov/providerupdate/january2004/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/april2004/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/July2004/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/october2004/nonphys.asp>

In addition, the CMS Quarterly Provider Update Websites for NPPs for 2003 can be found at:

<http://www.cms.hhs.gov/providerupdate/january2003/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/april2003/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/july2003/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/october2003/nonphys.asp>

Acronyms	
CFR = Code of Federal Regulations	OBRA '90 = Omnibus Budget Reconciliation Act of 1990
CMS = Centers for Medicare & Medicaid Services	PA = Physician Assistant
CNS = Clinical Nurse Specialist	S&C = Survey & Certification
NF = Nursing Facility	SNF = Skilled Nursing Facility
NP = Nurse Practitioner	VA = Veterans Administration
NPP = Non-Physician Practitioner (NPs, CNSs, & PAs are considered NPPs)	

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## Reminder Regarding Medicare Billing Rules for Ambulance Services Rendered to Medicare Patients During an Inpatient Hospital Stay

Related Change Request (CR) #: N/A  
Related CR Release Date: N/A

Medlearn Matters Number: SE0536

### Provider Types Affected

Suppliers of ambulance services billing Medicare carriers for services provided to Medicare patients during an inpatient hospital stay.

### Provider Action Needed

#### Impact to You

The purpose of this Special Edition is to remind ambulance service suppliers of the rules regarding payment for certain services provided to Medicare patients in an inpatient hospital stay.

#### What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) will add an edit in the Medicare's claims processing systems to prevent payment by carriers for services that are bundled in the hospital's payment under the applicable inpatient Prospective Payment System (PPS).

#### What You Need to Do

Please see the Background and Additional Information Sections of this article for further details.

### Background

The Social Security Act (Section 1886(d) and (g)) established several Prospective Payment Systems (PPS) for inpatient services furnished to Medicare beneficiaries, and under the inpatient PPSs, Medicare Fiscal Intermediaries (FIs) reimburse hospitals a predetermined amount for services furnished to Medicare beneficiaries based on the beneficiary's condition and severity of treatment modalities. All services received by hospital inpatients must be supplied by the hospital either directly or under arrangements. With the exception of the days of

admission and discharge, costs for transportation of a hospital inpatient by ambulance (to and from another hospital, freestanding facility, or physician's office) to receive specialized services, and costs for radiology services (including computed tomography scans) furnished to inpatients by a physician's office, another hospital or a radiology clinic are not payable by Medicare.

CMS will add an edit in its claims processing systems to prevent payment by carriers for services that are bundled to the hospital. As an initial implementation of this policy, Medicare will cease making payments to independent suppliers of ambulance services for beneficiaries in an inpatient hospital stay.

#### **Additional Information**

As a reminder, all Medicare claims processing information is in the Medicare Claims Processing Manual. This manual may be viewed at [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp) on the CMS web site.

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

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## **MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries (CR Title-Appeals Transition – BIPA 521 Appeals)**

**Related Change Request (CR) #:** 3530

**Medlearn Matters Number:** MM3530

**Related CR Release Date:** March 25, 2005

**Related CR Transmittal #:** 146

**Effective Date:** Varied, as noted in article

**Implementation Date:** April 25, 2005

#### **Provider Types Affected**

All Medicare providers who submit claims to Medicare Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs)

#### **Provider Action Needed**

There is now a new level of the appeals process for Medicare Part A and Part B claims submitted to Medicare fiscal intermediaries (FIs). This new second level of appeal process is called a **reconsideration** (not to be confused with the previous first level of appeal for Part A claims). These new "reconsiderations" will be processed by Qualified Independent Contractors (QICs).

This change in the appeals process was governed by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 Section 521 and the Medicare Modernization Act Sections 933, 939, 940. Parties to Part A and Part B redeterminations issued by FIs on or after May 1, 2005 will have the right to appeal to a QIC. All redeterminations issued before May 1, 2005 will have appeal rights to the Administrative Law Judge (ALJ) for Part A claims and to the hearing officer (HO) for Part B claims.

For specific information pertaining to this change, please refer to the background and additional information sections. A copy of the new Medicare Appeal Decision letter accompanies this article.

## **Background**

**Note:** These revisions do not apply to claims submitted to Medicare carriers and/or redeterminations processed by carriers. In addition to the new level of appeal, there are a number of other changes that will affect the process providers and FIs use for appeals of claim decisions made by FIs. This article will summarize those changes. Providers seeking full details may wish to review the official instruction (CR 3530) that Medicare issued to the FIs. That instruction is available at:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R146OTN.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf)

The key changes are as follows:

### ***1. New Language for Redetermination Letters***

For redetermination decisions issued on or after May 1, 2005, FIs will change the Medicare Redetermination Notice (MRN) as follows:

- Language on the first page of the MRN regarding the amount in controversy will be deleted as there is no longer a minimum amount in controversy required to move to the next appeal level, i.e., the QIC.
- The MRN will show that if providers disagree with the redetermination decision, they have 180 days to appeal to a QIC and such appeal must be filed in writing. (Under special circumstances, you may ask for more time to request an appeal.)
- The MRN will include a form to use in requesting the reconsideration by the QIC. The form presents all the information required to submit an appeal. If you do not use the form in CR3530 to request the appeal, you must be sure to include the required information in your letter requesting the appeal, including the name of the contractor that made the redetermination.
- The MRN will include specific language about what providers must include in their request for a reconsideration by the QIC. Providers must pay special attention to the instructions on the MRN related to submission of evidence to support their appeal. All evidence must be presented before the reconsideration is issued. If a provider does not submit all evidence at this stage, they will not be able to submit any new evidence in subsequent appeal levels unless they demonstrate good cause for not presenting evidence to the QIC.
- The MRN will contain revised language to reflect the new level of appeal.

### ***2. Redetermination Letters for Fully Favorable Decisions***

Previously, some FIs elected to notify providers of a fully favorable decision through a Remittance Advise (RA) that reflected the processed claim, instead of issuing an MRN. (Beneficiaries were advised via the Medicare Summary Notice (MSN).) However, the revised process requires FIs to issue an MRN on all redeterminations, favorable and unfavorable, within 60 days if the RA or MSN cannot be sent within 60 days. Fully favorable decisions are those where the Medicare approved amount minus any cost sharing (coinsurance, deductibles, etc.)

has been found payable. In these instances, which apply to all redetermination requests received by the FI on or after May 1, 2005, the FI will issue the MRN explaining that the decision is favorable and a remittance advice will follow. Exhibit 2 of CR3530 contains a model of such a favorable MRN; however, your FI may choose to include additional information on their MRN.

### ***3. An Extension to the 60-day Decision-Making Time Frame***

Should a provider submit additional evidence after filing the request for redetermination, the FI's 60 day decision-making time frame may be extended for 14 calendar days. This applies to redetermination requests received on or after May 1, 2005.

### ***4. Telephone Requests for Redeterminations of Initial Determinations Made On or After May 1, 2005***

Section 937 of the Medicare Modernization Act (MMA) provides that in the case of minor errors or omissions, providers must be given the opportunity to correct such errors/omissions without the need to initiate an appeal. Consistent with that section, the Centers for Medicare & Medicaid Services (CMS) requires the FIs to conduct reopenings rather than redeterminations to correct such errors and omissions. CMS has modified the reopening regulations to allow FIs and providers to make these corrections through the reopening process and these reopening requests may be made over the telephone. However, actual redetermination requests made on all initial determinations rendered on or after May 1, 2005 must be in writing.

### ***5. Additional Information Requirements for Written Redetermination Requests Effective with Initial Determinations Made On or After May 1, 2005***

Chapter 29, Sections 40.2.1(C) and 50.2.1(B) of the Medicare Claims Processing Manual contain the requirements for provider appeal requests. This manual may be found on the CMS web site at:

[http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp)

Note that for all requests for redeterminations received on or after May 1, 2005, the providers do not need to specify the date of the initial determination in their requests.

### ***6. Consolidating Requests for Multiple Parties on Redetermination Requests Received On or After May 1, 2005***

If more than one party files a redetermination request (e.g. both the beneficiary and the provider file requests) on the same claims before the FI makes a redetermination on the first request, the FI will consolidate the separate requests into one proceeding and issue one redetermination. In such cases, the 60-day decision-making time frame begins with the receipt of the second request.

Where the second request is received after a redetermination has already been made, the second request will be treated as an inquiry and the FI will inform the second requestor of the redetermination already made. The FI will also inquire, in these instances, if the party wishes to file a request for an appeal to the next level. Should the party wish to file such appeal, the FI will provide instructions for doing so.

### ***7. Filing Reconsideration Requests on Redeterminations Issued On or After May 1, 2005***

## **Where Appellants Should Send Requests for Reconsideration**

There are two QICs to handle reconsideration requests of redeterminations made by FIs, based on two QIC jurisdictions, east and west. The two QICs are Maximums and First Coast Service Options. Parties must request a reconsideration at the QIC with jurisdiction for the appeal. FIs with multiple states may have both QICs handling requests and therefore must make certain to refer the appellant to the correct QIC. In most instances, the jurisdiction for all Part A and Part B of A QIC appeals is dependent upon the state where the service or item was rendered, with the exception of providers with multiple locations in different states (i.e., chain providers). Chain providers have the ability to select the FI that will process its claims regardless of the state where the service or items was rendered. In such cases, the state where the FI processes the claim will dictate the QIC jurisdiction. For claims processed by Mutual of Omaha, the jurisdiction is dependent upon the state where the service or item was rendered, with no exception for chain providers.

The following are the QIC jurisdictions for the East and West:

The East QIC jurisdiction is comprised of the following states: Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, and Washington DC. The QIC for the east jurisdiction is Maximus.

The West QIC jurisdiction is comprised of the following states: Washington, Idaho, Montana, North Dakota, South Dakota, Iowa, Missouri, Kansas, Nebraska, Wyoming, Utah, Arizona, Nevada, California, Alaska, Hawaii, Oregon, Kentucky, Ohio, Indiana, Illinois, Minnesota, Michigan, Wisconsin, Guam, Northern Mariana Islands, and American Samoa. The QIC for the west jurisdiction is First Coast Service Options.

The address for the appropriate QIC will be located in the redetermination notice.

## **Requirements for Reconsideration Requests**

Only the QIC has the authority to dismiss a request for a reconsideration. This applies even when it appears that the request does not meet the requirements for requesting a reconsideration (e.g., the timely filing requirements do not appear to have been met). Even though the FI cannot dismiss a reconsideration request that does not meet the requirements, it should be aware of these requirements so that it can inform providers (and States) of the requirements. A provider (or State) request for a reconsideration must either be made on a standard CMS form which will be available on the CMS website or as shown in CR3530 or must contain:

- The beneficiary's name;
- Medicare health insurance claim number;
- The specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service;
- The name and signature of the party or representative of the party making the request; and
- The name of the FI that made the redetermination.

**8. Effectuation of QIC Decisions**  
**(Effective Date: All Redeterminations Issued On or After May 1, 2005)**

In many cases, the QIC's decision will require effectuation action by the FI. The FI will not effectuate based on correspondence from any party of the Reconsideration, but instead takes an effectuation action only in response to a formal decision from the QIC. "Effectuate" means that the FI takes the necessary actions to issue payment (i.e., make payment on the claim). The FI will obtain written assurance from the provider if necessary. If the QIC's decision is favorable to the appellant and specifies an amount to be paid, the FI effectuates within 30 calendar days of the date of the QIC's decision or from the date written assurance from the provider is received. If the decision is favorable, but the contractor must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the QIC's decision (or date of receipt of written assurance from the provider has been obtained).

**9. New Appeal Rights for Medicare Providers & New Assignment Rights for Medicare Providers (Effective Date: May 1, 2005)**

**A. New Appeal Rights for Medicare Providers**

Previously, providers could only appeal a claim determination when the determination involved a finding that:

- (1) The item or service was not covered because it constituted custodial care, was not reasonable and necessary, or for certain other reasons; and
- (2) The provider knew or could reasonably be expected to know that the service in question was not covered under Medicare (that is, a finding with respect to the limitation of liability provision under section 1879 of the Act).

For initial determinations made on or after May 1, 2005, providers who submit claims to FIs will have the same right to appeal claims as beneficiaries. Accordingly, FIs will no longer use RA remark code MA44 for initial determinations made on or after May 1, 2005. This means FIs will no longer need to determine whether a provider submitting an appeal has the right to appeal. Also, FIs will no longer need to evaluate appointment of representative forms submitted by providers representing beneficiaries.

**B. New Assignment Rights for Medicare Suppliers**

Historically, non-participating suppliers accessed the appeals process by acting as the beneficiary's appointed representative in situations where they otherwise would not have had appeal rights. Section 1869(b)(1)(C) permits a beneficiary to assign his or her appeal rights with respect to an item or service to a provider or supplier. Such an assignment of appeal must be made using a standard form developed by CMS. This form will be made available at:

<http://www.cms.hhs.gov/forms/>

**10. New Appeal Rights for Overpayments and Reopenings**

**(Effective Date: Revised initial determinations issued on or after May 1, 2005)**

Previously, revised initial determinations had appeal rights to the hearing officer for part B claims where over \$100 remained in controversy and appeal rights to the review level for part B claims where under \$100 remained in controversy. For Part A claims with revised initial determinations, appeal rights were provided at the reconsideration level. For all revised initial determinations issued on or after May 1, 2005, the first level of appeal will be a redetermination. Your FI will change appeals language in all demand letters or other notices of revised initial determinations (including Remittance Advice (RA) notices and Medicare Summary Notices (MSN) if used) in accordance with this section. Additional instructions regarding changes to the MSN and RA remarks will be forthcoming (e.g., revising the terminology for the levels of appeal and time frames to appeal).

## **11. New Appeal Rights for Dismissals** **(Effective Date: All redeterminations issued on or after May 1, 2005)**

### **A. Appealing a Dismissal**

For redeterminations issued on or after May 1, 2005, parties to the redetermination will have the right to appeal a dismissal of a redetermination request to the QIC. A party to the redetermination may appeal the dismissal if they believe the dismissal is incorrect. The reconsideration request must be filed at the QIC within 60 days of the date of the dismissal. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the FI incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the FI for reopening. It is mandatory for the FI to reopen any case that is remanded to it and issue a new decision. A QIC's reconsideration of an FI's dismissal of a redetermination request is final and not subject to any further review.

### **B. Vacating a Dismissal**

A party to the redetermination may also request the FI to vacate its dismissal if good and sufficient cause is established. The FI determines if there is good and sufficient cause and if there is, the contractor reopens the dismissal and issues a new decision. If a QIC reconsideration has been requested, the contractor no longer has jurisdiction and cannot vacate a dismissal unless directed to do so through a QIC remand.

### **C. Dismissal Letters**

For any dismissal issued on or after May 1, 2005, your FI will include the following information or similar language in dismissal letters (also see the model dismissal letter in exhibit 4 of CR 3530):

If you disagree with this dismissal, you have two options:

1. If you think you have good and sufficient cause, you may ask your FI to vacate their dismissal. The FI will vacate the dismissal if it determines that you have good and sufficient cause. If you would like to request the FI to vacate this dismissal, you must file a request within six months of the date of this notice. In your request, please explain why you believe you have good and sufficient cause. Your FI will provide the address to which such a request should be sent.
2. If you think the FI has incorrectly dismissed your request, you may request a reconsideration of the dismissal by a QIC. Your request must be filed within 60 days of receipt of this letter. The QIC will have 60 days to complete the reconsideration. In your request, please explain why you believe the dismissal was incorrect. Please note that the QIC will not consider any evidence for

establishing coverage of the claims(s) being appealed. Their examination will be limited to whether the dismissal was appropriate.

#### **D. Incomplete Requests**

The requirements for written requests for redeterminations are included in the Medicare Claims Processing Manual, Chapter 29, sections 40.2.1 and 50.3.1. As noted previously, this manual may be found on the CMS Web site at:

[http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp)

For all redetermination requests received on or after May 1, 2005, providers (and States) no longer are required to include the date of initial determination in their requests. Previously, FIs were instructed to return requests that did not meet the manual requirements for a complete request. For redetermination requests received on or after May 1, 2005, FIs must handle and count incomplete redetermination requests as dismissals. The above requirements under (C) for vacating and appealing dismissals apply to incomplete requests as well. Parties to the redetermination also have the option to refile their request if any time remains in the filing period (i.e., 120 days of receipt of the initial determination). When a request is refiled that meets the requirements, the previous dismissal is vacated and reopened. FIs must notify parties of their options in the dismissal notice. (Please see the model dismissal notice for an incomplete request in Exhibit 3 in CR 3530.)

#### **12. Preparing Case Files for Administrative Law Judge (ALJ) Hearings (Effective Date: All redeterminations issued on or after May 1, 2005)**

For Part A and Part B redeterminations issued before May 1, 2005, FIs will continue to be responsible for accepting ALJ hearing requests and for preparing case files for the hearing. FIs will continue to follow instructions in the Medicare Claims Processing Manual, Chapter 29, §§ 50 and 60 in preparing case files. For redeterminations issued on or after May 1, 2005, the QIC will be responsible for accepting ALJ hearing requests and for preparing case files for the hearing.

#### **13. Effectuation of ALJ Decisions**

In many cases, the ALJ's decision will require an effectuation action on the FI's part. As with QIC decisions, the FI does not effectuate based on correspondence from any party of the ALJ hearing. It takes an effectuation action only in response to a formal decision by the ALJ. The FI will obtain written assurance from the provider if necessary. If the ALJ's decision is favorable to the appellant and gives a specific amount to be paid, the FI effectuates within 30 calendar days of the date of the ALJ's decision or from the date written assurance from the provider is received. If the decision is favorable but the FI must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the ALJ's decision (or date of receipt of written assurance from the provider).

#### **14. Redetermination Acknowledgement Letters (Effective Date: All redeterminations received on or after May 1, 2005)**

FIs are not required to send or mail acknowledgment letters for redetermination requests received on or after May 1, 2005.

### **Additional Information**

The official instruction (CR 3530) issued to your FI regarding this change may be found by going to:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R146OTN.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf)

If you have any questions regarding these changes, please contact your FI at their toll free number which may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>

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### **Posters Now Available!**

Posters titled "Have Limited Income? Social Security Can Help with Prescription Costs" can be ordered free of charge on the Centers for Medicare & Medicaid Services' (CMS) website. The posters are suitable for display in a physician's, provider's, or supplier's office, a pharmacy, or other health care setting where Medicare beneficiaries will see this information. The posters direct Medicare beneficiaries with limited income to a toll free number where they can find out if they are eligible for help with prescription drug costs. Flat posters are suitable for wall display. Easel posters are suitable for counter display. Order the size and style appropriate for your use. Artwork cannot be specified as posters will be sent based on availability at the time the order is received. To view and order the posters, go to the Medlearn Prescription Drug Coverage web page located at: <http://www.cms.hhs.gov/medlearn/drugcoverage.asp> on the CMS website. We need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

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### **Comprehensive Error Rate Testing (CERT) Findings Regarding Responses Received by the CERT Contractor with Improper Documentation**

We have noted a concern regarding our providers' inability to find medical records for claims billed to Mutual of Omaha – Medicare. We would like to remind our providers that any services billed to Medicare may at any time be medically reviewed. When a claim is chosen for medical review by the CERT Contractor or Mutual of Omaha – Medicare, documentation must be submitted to support ALL services billed. Examples of provider responses to requests for medical records that the CERT Contractor has received and noted are as follows:

**Provider Response:** "Claim archived no changes"

**Tip:** It is the responsibility of the provider to submit medical records when a request is made from Medicare either via CERT or Mutual of Omaha - Medicare

**Provider Response:** "Patient did not have a CXR done on that date"

**Tip:** If a provider is unable to provide documentation for the dates of service billed, recoupment of payment will be made and the provider should notify CERT of such

circumstances. However, a provider should be able to submit medical documentation for services billed to Mutual of Omaha – Medicare.

**Provider Response:** “Received documentation of cancelled procedure”.

**Tip:** If a procedure was cancelled, the service should not to be billed to Medicare. In this case, if a provider cannot submit documentation for the service(s) billed, recoupment of payment will be made and it is correct to notify CERT of such circumstance.

**Provider Response:** “We have searched for this patient by all means that you provided to no avail. This patient is not in our system”

**Tip:** If a provider is unable to submit documentation for the dates of service billed, recoupment of payment will be made and the provider should notify CERT of such circumstances.

**Provider Response:** “Services were billed in 2003 but the documentation submitted was for 2002”

**Tip:** When submitting medical documentation for review, it is very important that the documentation is for the correct dates of service requested. When documentation is received for incorrect service dates, payment for these services will be denied and payment will be recouped.

**Provider Response:** “Need record of release filled out”

**Tip:** A record release is not needed to submit medical records to a Medicare Contractor including Mutual of Omaha – Medicare and the CERT program. The release of the medical records is not in violation to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. HIPAA permits disclosure of personal health information to carry out treatment, payment or health care operations. When Medicare beneficiaries enroll in the program they are informed of Medicare's use of their personal health information to carry out health care operations. Providing the requested documentation does not violate the minimum necessary provision of the HIPAA Privacy Rule and does not require beneficiary authorization.

**Provider Response:** “Records can't be retrieved from the cardiology dept. due to computer problems”

**Tip:** In a situation such as equipment failure, we suggest that the provider wait until the problem is corrected or retrieve the records manually. If there is an issue with meeting the time frame required, the provider must telephone the CERT contractor or Mutual of Omaha – Medicare's CERT coordinator explaining the situation for a possible extension.

**Provider Response:** “We are returning the enclosed documentation received for a patient who could not be identified”

**Tip:** If a provider is unable to identify the patient for which a request for medical records is being made recoupment of payment will be made for services billed. All efforts should

be made to attempt identify the requested documentation. The provider may choose to call our CERT coordinator for assistance in this matter.

**Provider Response:** "SS# is for another patient and we have no listing for the name given"

**Tip:** In a case similar to this, it would be suggested to call Mutual of Omaha – Medicare's CERT coordinator to assist in attempting to find the correct patient information for the request.

If your facility is delayed in responding to a medical record request this may cause recoupment of payments previously made. All attempts must be made to submit correct and adequate documentation to the CERT contractor and/or Mutual of Omaha – Medicare.

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## **Autologous Stem Cell Transplantation**

**Related Change Request (CR) #:** CR3797

**Medlearn Matters Number:** MM3797

**Related CR Release Date:** April 15, 2005

**Related CR Transmittal #:** 32

**Effective Date:** March 15, 2005

**Implementation Date:** May 16, 2005

### ***Updated Requirements for Autologous Stem Cell Transplantation (AuSCT) for Amyloidosis***

#### **Provider Types Affected**

Physicians and providers billing Medicare carriers and intermediaries for AuSCT

#### **Provider Action Needed**

This article is based on information contained in Change Request (CR) 3797, which informs physicians and providers that, effective for services on or after March 15, 2005, High Dose Mephalan (HDM) and Autologous Stem Cell Transplantation (AuSCT) is reasonable and necessary for all Medicare beneficiaries with primary Amyloid Light chain (AL) amyloidosis who meet the following criteria:

- 1) Amyloid deposition in two or fewer organs; and
- 2) Cardiac left ventricular ejection fraction (EF) greater than 45 percent.

Primary AL amyloidosis is covered for all beneficiaries who meet the above criteria regardless of age. All forms of non-primary (AL) amyloidosis remain non-covered.

#### **Background**

Stem cell transplantation is a process by which stem cells are harvested from either a patient's or a donor's bone marrow (or peripheral blood) for intravenous infusion. Autologous Stem Cell Transplantation (AuSCT) is a technique for restoring a patient's stem cells using the patient's own previously stored cells (ICD-9-CM procedure code 41.01, 41.04, 41.07, and 41.09 and CPT-4 code 38241).

AuSCT **must** be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (High Dose Chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies. Allogeneic stem cell transplant may also be used to restore function in recipients who have an inherited or acquired deficiency or defect.

### **Coverage Policy Changes**

For Medicare beneficiaries age 64 years or older who have primary Amyloid Light chain (AL) amyloidosis (ICD-9-CM 277.3), the Centers for Medicare & Medicaid Services (CMS) previously had a national non-coverage policy for High-Dose Melphalan (HDM), together with Autologous Stem Cell Transplantation (AuSCT). This non-coverage policy was based on the lack of sufficient data to establish definitive conclusions regarding the efficacy of AuSCT, and for those beneficiaries age 63 years or younger, coverage of HDM/ AuSCT was left to the local Medicare carrier's/intermediary's discretion.

However, CR3797 informs physicians, providers, and suppliers that (effective for services on or after March 15, 2005) when recognized clinical risk factors are employed to select patients for transplantation, HDM together with AuSCT is reasonable and necessary for Medicare beneficiaries of **any age group** with primary AL amyloidosis who meet the following criteria:

- Amyloid deposition in 2 or fewer organs; and
- Cardiac left ventricular Ejection Fraction (EF) greater than 45 percent.

Primary AL amyloidosis is covered for all beneficiaries who meet the above criteria regardless of age, and all forms of non-primary (AL) amyloidosis remain noncovered.

To clarify existing coverage, AuSCT must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies. Please refer to the National Coverage Determinations Manual (Pub. 100-03), Section 110.8.1 for complete coverage guidelines; and the Medicare Claims Processing Manual (Pub. 100-04), Chapter 3, Section 90.3.2 (FI), plus Chapter 32, Section 90-90.6 (Carrier) for complete claims processing guidance.

### **Updates to Medicare Claims Processing Manual**

CR3797 updates the Medicare Claims Processing Manual (Pub.100-04), Chapter 3, Section 90.3.2 (FI claims) and Chapter 32, Section 90.3 (carrier claims) with the new coverage guidelines for primary amyloid light chain (AL) amyloidosis for high-dose melphalan together with autologous stem cell transplantation (HDM/ AuSCT).

The criteria for multiple myeloma (Durie-Salmon) within the Fiscal Intermediary (FI) section is also revised to coincide with the Nation Coverage Determination Manual (NCD) (Pub. 100-03), Section 110.8.1 and the non-coverage guidelines have been updated to remove the age requirement language to in Chapter 32, Section 90.3.2.

In addition, CMS removed reference to revenue code 0891 in the Medicare Claims Processing Manual (Pub. 100-04, Chapter 3, Section 90.3.3), since that revenue code no longer exists. CMS also removed the reference to physicians that does not belong in the hospital chapter. All other information within the claims processing manual remains the same.

### **Implementation**

The implementation date for this instruction is May 16, 2005.

### **Additional Information**

For complete details (including the manual updates listed in the previous section), please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to:

**[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)**

From that web page, look for CR3797 in the CR NUM column on the right, and click on the files for that CR. Please note that there will be two files representing CR3797 on this web page. One file will contain the National Coverage Determination manual changes and the other will contain the changes to the Medicare Claims Processing Manual.

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>**

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## **Radiation Therapy**

Radiation therapy is a treatment modality often utilized in the medical discipline of Oncology that employs high-energy ionizing radiation in the treatment of both malignant and certain non-malignant neoplasms. A few specific techniques employed in treatment protocols and regimens are brachytherapy, teletherapy, hyperthermia, and stereotactic radiation.

The purpose of this article is to highlight the documentation guidelines associated with radiation therapy. Comprehensive Error Rate Testing (CERT) reviewer comments have identified a significant issue related to the denial of claims submitted for medical review. Specifically, documentation was not received to support the medically reasonable and or necessary nature of the services provided. The documentation that is submitted for any medical review should include all information relevant to the services billed by the provider. The information should support all services rendered, particularly through the dates of service on the request. When there is no documentation to support charges, the prevailing indication is that the services were not provided.

The article provides a practical review for clinical and clerical personnel, identifying information required by the Centers for Medicare & Medicaid Services (CMS) and Mutual of Omaha-Medicare (Fiscal Intermediary) for the determination of coverage for medically reasonable and necessary services.

General Documentation Requirements:

- Radiation Oncology services are considered medically reasonable and necessary when the following conditions are indicated and documented in the patient's medical records:
- Documentation of comprehensive history that substantiates the conditions being treated
- Documentation of physician involvement to the "incident to" requirements

- Physician orders for treatment including current dosage
- Documentation to support all services billed
- Documentation that is legible and justifies the medical necessity of each treatment billed and adherence to coverage guidelines
- A detailed itemization for all services billed
- A copy of radiological report or physician's interpretation
- A copy of physician's treatment management plan
- Documentation of any contrast material provided

## **Current Procedural Terminology (CPT) Documentation and Billing Tips**

### **RADIATION ONCOLOGY – DOSIMETRY AND PORT PLANNING**

#### **77300 Basic Radiation Dosimetry Calculation:**

Documentation of basic radiation dosimetry calculation, central axis depth dose, Time Dose Fractionation (TDF), Nominal Standard Dose (NSD), gap calculation, off axis factor, tissue inhomogeneity factors, as required during course of treatment, only when prescribed by the treating physician. Any changes in dosimetry calculations and change in radiation treatment and frequency must be documented. The physician and the physicist must sign each dosimetry.

This service is considered to be medically necessary for each treatment port and if a patient has any other situation requiring individual point calculations of radiation dosage.

This procedure need not be routinely performed each time the patient is treated, but calculations may be reported as many times as the calculations are performed.

#### **77305-77315 Teletherapy Isodose Plan:**

The physician's documentation must be specific to the number of volumes of interest. The specific location of tumor(s) to be treated must be documented as well as the specific number of ports involved with each volume of interest treated. Usually there is only one isodose plan for a course of therapy to a treatment area. Usually only one plan per volume of interest will be sufficient, though some patients may require multiple teletherapy plans during the course of therapy. An additional teletherapy dose plan may be allowed in special circumstances. Full documentation must include an explanation for the need of a subsequent isodose plan during the course of treatment. All isodose plans must be checked and signed by the medical radiological physicist and the radiation oncologist.

The billing of 77295 precludes the use of 77305, 77310, 77315.

The typical course of radiation therapy will require from one to three isodose plans.

#### **77321 Special Teletherapy Port Plan:**

Documentation must include the need and the reasonableness for the use of special beam and be made available to the Medicare contractor upon request. This service is considered medically necessary only when a plan for a special beam consideration is required for the treatment of a neoplasm, such as the use of electrons or heavy particles.

Only one set of treatment plans should be billed per treatment course regardless of the number of times that the special beam is utilized.

If the special teletherapy port plan code is used, codes 77305, 77310, 77315, are not to be billed for that volume of interest.

This service is considered medically necessary only when a plan for a special beam consideration is required for the treatment of a neoplasm, such as the use of electrons or heavy particles.

A special isodose plan may be involved with a special teletherapy port plan.

**77331 Special Dosimetry:**

Physician documentation must be specific to the number of volumes of interest, location of tumor(s) to be treated as well as the specific number of involved ports with each volume of interest.

This service is considered medically necessary once per port when the physician determines that it is necessary to have a measurement of the amount of radiation that a patient has actually received at a given point with the final results being utilized to accept or modify the current treatment plan. This procedure is not routinely performed each time the patient is treated.

The physician must specify the type of special dosimetry.

**77301 Intensity Modulated Radiation Therapy (IMRT) plan:**

This service is considered per session and includes dose-volume histograms for target and critical structure partial tolerance specifications.

CPT codes 77261 through 77295 and 77300 through 77370 are subject to Correct Coding Initiative (CCI) edits and as such are components of this comprehensive code and not separately reimbursable.

**G0242 Multi-Source Photon Stereotactic Radiosurgery or Linear Accelerator Stereotactic Radiosurgery (SR) plan:**

CPT codes 77280 through 77295, 77300, and 77300 through 77328, 77332 through 77370 are included in the Ambulatory Payment Classification (APC) payment for IMRT and SR planning and not separately billable. These codes should not be billed in addition to G0242. This technical charge can be billed once per treatment course.

Payment for IMRT and SR planning does not include payment for services described by CPT codes 77331. When provided, these services should be billed in addition to the IMRT and SR planning codes 77301, G0242.

CPT code G0243 should be billed for multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions.

## **RADIATION ONCOLOGY TREATMENT MANAGEMENT**

### **77427 Radiation treatment management, five treatments:**

Is billable only to the Carrier and should not be billed with CPT code 77470

### **77431 Radiation therapy management with complete course of therapy consisting of one or two fractions only:**

Is billable only to the Carrier

### **77432 Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session):**

Billable only to the Carrier

### **77470 Special treatment procedure (e.g., total body irradiation, hemibody irradiation, per oral, endocavitary or vaginal cone irradiation):**

This code covers the additional physician effort and work required for the special procedures of hyperfractionation or other deviation from standard, total body irradiation, per oral or transvaginal cone use, brachytherapy, concurrent hyperthermia, planned combination with chemotherapy or other combined modality therapy, stereotactic radiosurgery, intra-operative radiation therapy, and any other special time consuming treatment plan. This code is not intended to be used because a patient has another ongoing medical diagnosis such as diabetes, Chronic Obstructive Pulmonary Disease (COPD) or hypertension. It is considered acceptable standards of practice for this code to be reported only once during a treatment course, and may be billed with the weekly management codes. For the remaining treatment course, a physician should use the appropriate weekly radiation therapy management code.

## **RADIATION ONCOLOGY; TREATMENT DEVICES AND RADIATION PHYSICS**

### **77332-77333 Treatment Devices, Designs, and Construction:**

Legible documentation in the patient's medical record must include an explanation of the need for treatment devices and must be made available to Medicare upon request.

### **77332 Treatment devices, design and construction; simple (simple block, simple bolus)**

### **77333 Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)**

### **77290 and 77334 Therapeutic radiology simulation-aided field setting; complex Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts):**

The selection of these treatment devices are considered to be reasonable and necessary in documented cases of neoplasm and some selected cases of benign conditions in patients where a treatment course needs to be established. Multiple treatment devices may be charged during a course of therapy if documentation substantiates multiple volumes of interest/ports, the use of custom-made devices, and/or the necessity of replacement devices.

Documentation for CPT codes 77290 and 77334, respectively, should include the dated form for therapeutic radiology simulation aided field setting. In addition the documentation should show what date the blocks were constructed. For example: If simulation was done on 9/1/04 and the blocks were constructed the same day either the form or the Staff Communication Notes on 9/1/04 should indicate that new blocks were constructed. The therapeutic radiology simulation

aided field setting form supports the charge for CPT code 77290 and the notation on the form or in the staff notes supports the charge for CPT code 77334. The biller should bill the services on the actual date the services were provided.

**77336 Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy:**

This is a weekly code that describes ongoing medical physics assessment. It is reported once for each week of radiation treatment in which at least three fractions have been given. This code can also be reported once for each five treatments in the event that more than one treatment is given per day. This code may also be used to report radiation therapy that is not administered in five weekly fractions, (e.g., brachytherapy or stereotactic radiosurgery), or for a course of radiation therapy that consist of one or two fractions.

Documentation for CPT code 77336 should reflect assessment of treatment parameters, quality assurance of dose delivery and review of patient treatment documentation in support of the radiation oncologist. Service should be done weekly and biller must bill the service on the date the service was provided. Initialing the radiation treatment log is not sufficient documentation for this service.

CPT code 77336 includes a documented weekly check of a patient's radiation treatment chart by a, (or under the supervision of), a qualified medical physicist. This is to assure that the treatment delivered conforms to that prescribed by the radiation oncologist. Verification of accurate dose calculations, accurate data entry in the patient's chart, proper patient positioning and beam orientation, patient radiation safety, and correct summation of dose at the conclusion of treatment. In order to assure that the placement of the wedges or other beam modifiers are correct; an examination of the patient setup may be required.

Included in this service are the initial acceptance testing and commissioning and ongoing review of the performance of treatment equipment (Computerized Tomography (CT) and conventional simulators), linear accelerators, treatment device manufacturing equipment, and treatment planning computers. Performance of these tasks, by a qualified medical physicist, is essential in order to ensure that the course of radiation therapy being given follows that which is prescribed by the physician. Documentation of the physics services performed is essential. The calibration and maintenance of radiation therapy equipment is also documented but not considered part of the treatment chart and not considered special physics consultations and not billable as such.

**77370 Special Medical Radiation Physics Consultation:**

CPT code 77370 is used when the radiation oncologist directly requests the qualified medical physicist for a special consultative report or for specific physics services pertaining to an individual patient. Such a request may be indicated when the complexity of the treatment plan requires a thorough written analysis that addresses a specific problem or the expertise of a qualified medical physicist is required in order for the service to be performed. Documentation of the clinical indications that supports this request must be included as part of the medical record. It is also necessary to provide documentation of the physician's order and the physics report as well as the physician's review of the report. Verification of calculations performed by others or performing the duties of other members of the treatment team (e.g., dosimetrists) are not considered a special physics consultations and are therefore not billable as such.

CPT codes 77336 and 77370 are technical services only. These services are payable as Medicare Part B services and are considered separately identifiable procedures.

Continuing medical radiation physics assessment and special medical radiation physics consultation are considered distinct and independent services provided during the course of radiation therapy. These services require a detailed written report describing the nature of the problem by the requesting physician. This service includes a documented review of the patient's treatment chart and record to verify that the patient received the prescribed radiation dosage, appropriate positioning, beam orientation, and radiation safety.

These services require full documentation to include, but not limited to specifications of the prescribing physician, which include:

- Review of patient's treatment chart and record
- Adequate documentation of prescribed radiation dosage
- Appropriate positioning
- Beam orientation
- Radiation Safety

To our providers....keep informed of Medicare Integrity Program issues as they arise by reading the MIP Tip in every issue.

### "MIP Tip"

This tip is brought to you from our Audit and Reimbursement Department.

#### **The Provider Based Attestation Process**

Regulations in 42 Code of Federal Regulations (CFR) §413.65 describe the criteria and procedures for determining whether a facility or organization is provider-based. The Medicare Hospital Inpatient Prospective Payment System final rule published on August 1, 2002 (67 FR 50078) revised those regulations effective on October 1, 2002. The revised regulations may also be found in Transmittal A-03-030 (CR 2411).

The four types of facilities for which provider-based determinations are made include departments of a provider, provider-based entities, remote locations of a hospital, and satellite facilities.

CMS defines a *department of a provider* as a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider. The term "department of a provider" does not include an RHC.

A *provider based entity* is a provider of health care services, or an RHC that is created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from the main provider.

A *remote location of a hospital* is a facility or organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider.

A *satellite facility* is part of a hospital or of a hospital unit that provides services in a building also used by another hospital, or in one or more buildings on the same campus as buildings used by another hospital. A satellite facility always involves co-location with another hospital.

***Although the provider-based attestation process is voluntary (meeting provider-based regulations is not voluntary), it is generally beneficial to attest in order to receive a provider-based determination for approval from CMS. In addition, a provider that receives a provider-based denial from CMS and has not attested is generally subject to a greater amount of overpayment recovery than a provider that has attested.***

In order to receive a provider-based determination from CMS, you must first complete the voluntary provider-based attestation. There is not a required provider-based attestation format, but Mutual of Omaha has a sample provider-based attestation located at [http://www.mutualmedicare.com/audit\\_reimbursement/provider\\_enrollment/index.html](http://www.mutualmedicare.com/audit_reimbursement/provider_enrollment/index.html).

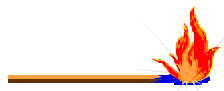
Once you have fully completed the provider-based attestation, please forward the original provider-based attestations to Mutual of Omaha and copy the applicable CMS Regional Office based on your State location. It is suggested that you address the letter to Mutual of Omaha and include the appropriate CMS RO as the cc: at the bottom of the letter so both organizations understand they were copied appropriately. If you need assistance in obtaining the appropriate CMS RO contact and/or address, please feel free to contact us.

The original provider-based attestation forms may be sent to one of the following addresses:

Delivery/Overnight Service:  
Mutual of Omaha  
Medicare Audit & Reimbursement  
Attn: Provider Enrollment Area – LL2  
Mutual of Omaha Plaza  
Omaha, NE 68175

Regular Mail Service:  
Mutual of Omaha  
Medicare Audit & Reimbursement  
Attn: Provider Enrollment Area – LL2  
P.O. Box 1604  
Omaha, NE 68101

Mutual of Omaha staff will review the provider-based attestation, request any additional information, and write a letter of recommendation to the CMS Regional Office. The CMS Regional Office will then issue a formal provider-based determination and notify the provider and fiscal intermediary. For any questions, please call Carey Miller at 1-866-734-9444 x 2178 or Krystal Wyatt at 1-866-734-9444 x 6238.



**Please stay tuned for more hot tips!**