

# Intermediary NEWS



OCTOBER 2001

**THIS PUBLICATION  
SHOULD BE SHARED WITH  
ALL HEALTH CARE  
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## Billing for Blood *and applying the Blood Deductible*

### Blood Deductible (Part A and Part B)

Medicare does not pay for the first 3 units of whole blood or units of packed red cells that are furnished under Part A or Part B in a calendar year. However, payment may be made for blood processing (i.e. administration, storage) beginning with the first pint or unit in a benefit period.

The Part B blood deductible is reduced to the extent that a blood deductible has been applied under Part A.

### When blood is not covered

Under Part A, blood is not covered and does not count toward the blood deductible when furnished to an inpatient after a person with Medicare has exhausted their benefit days in a benefit period, or where the individual has elected not to use lifetime reserve days. However, where the person with Medicare is discharged on his first day of entitlement or on the provider's first day of participation, the provider is permitted to submit a bill with no accommodation charge, but with ancillary charges including blood.

Under Part B, payment for blood can only be made when furnished in an outpatient setting. Therefore, it is important to note that payment for blood may be made to a hospital under Part B only when furnished for outpatient services (i.e. cannot be billed on a 12X type of bill).

### Other Blood Components

Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the blood deductible. However, these components of blood are covered as biologicals.

### Revenue Codes

380 - 382	Blood and packed red blood cells:	Apply to deductible
383 - 389	Components of blood:	Do not apply to deductible

Note: HCPCS and line item dates of service are required on Part B outpatient claims.



PROVIDER RELATIONS  
TOLL FREE PHONE NUMBER

**866-488-0545**

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*“Maryland Medicare Part A publishes the Intermediary News as an informational reference source for providers furnishing services / supplies in our Medicare contract area. This information is intended to assist providers and not replace Medicare program requirements as set forth in statute, regulations and manual instructions. It is the responsibility of each provider to familiarize themselves with Medicare coverage requirements. Maryland Medicare Part A makes efforts to ensure the information in this publication is accurate and current. Please note that the Medicare program is constantly changing, therefore it is the responsibility of the provider to remain informed of the Medicare program requirements.”*

PROVIDER RELATIONS



**TOLL FREE PHONE NUMBER**

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## VALUE CODES

### 06 Medicare Blood Deductible

Enter this code to indicate the amount shown is the product of the number of unreplaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each unreplaced pint furnished. If all deductible pints have been replaced, this code is not to be used. When you give a discount for unreplaced deductible blood, show charges after the discount is applied

### 37 Pints of Blood Furnished

Enter the total number of pints of whole blood or units of packed red cells furnished, Whether or not they were replaced. Blood is reported only in terms of complete pints rounded Upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible.

### 38 Blood Deductible Pints

Enter the number of unreplaced deductible pints of blood supplied. If all deductible pints Furnished have been replaced, no entry is made.

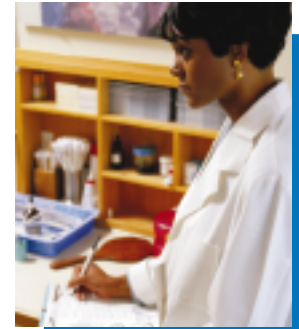
### 39 Pints of Blood Replaced

Enter the total number of pints of blood, which were donated on the patient's behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for unreplaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 39X revenue code series (blood administration) or under the 30X revenue code series (laboratory).

**Blood deductible remaining to be met should be verified on HIQA prior to billing.**



## CLAIM EXAMPLES:



*Example 1: Beneficiary receives 3 pints and all 3 pints are applied to the deductible.*

Value codes needed on the claim:

37	3.00	(Indicates 3 pints furnished)
38	3.00	(Indicates 3 pints applied to deductible)
06	xxx.xx	(Indicates dollar amount for cost of pints applied to deductible)

<u>Revenue code</u>	<u>Units</u>
38X	3

*Example 2: This example includes 3 claims for the same beneficiary. With each claim, the beneficiary receives 2 pints of blood.*

1st claim:

Value codes needed on the claim:

37	2.00	(Indicates 2 pints furnished)
38	2.00	(Indicates 2 pints applied to deductible)
06	xxx.xx	(Indicates dollar amount for cost of 2 pints applied to deductible)

<u>Revenue code</u>	<u>Units</u>
38X	2

2nd claim:

Value codes needed on the claim:

37	2.00	(Indicates 2 pints furnished)
38	1.00	(Indicates 1 pint applied to deductible, this pint satisfies the 3 pint deductible)
06	xxx.xx	(Indicates dollar amount for cost of 1 pint applied to deductible)

<u>Revenue code</u>	<u>Units</u>
38X	2

## Claim Examples: (Continued)

### 3rd claim:

Value codes needed on the claim:

37 2.00 (Indicates 2 pints furnished)

*No other value codes needed because the 3 pint deductible has been met.*

<u>Revenue code</u>	<u>Units</u>
38X	2

*Example 3: 5 pints furnished and all 5 pints replaced.*

Value codes needed on the claim:

37 5.00 (Indicates 5 pints furnished)

39 5.00 (Indicates 5 pints replaced)

*No Revenue code 38X since all pints were replaced.*

*However, as with all of these examples you could bill a revenue code 39X for blood storage or administration.*

*Example 4: 3 pints furnished and 2 pints are replaced and 1 pint is applied to the deductible.*

Value codes needed on the claim:

37 3.00 (Indicates 3 pints furnished)

38 1.00 (Indicates 1 pint applied to deductible)

06 xxx.xx (Indicates dollar amount for cost of 1 pint applied to deductible)

39 2.00 (Indicates 2 pints replaced)

<u>Revenue code</u>	<u>Units</u>
38X 1	(Do not include pints replaced in the units you bill for)

Sources:

Manual ref 3235.1 - 3235.3

MED-REG, MED-GUIDE ¶20,880.161,

42 CFR §410.161 Part B blood deductible.

42 CFR §410.161 Part B blood deductible

## Medicare Provider Instructions For Credit Balance Reporting

All providers of health care services participating in the Medicare program are required to submit a Medicare Credit Balance Report (form HCFA-838). A completed HCFA-838 is to be submitted on a quarterly basis.



Section 1866 (a) (1) (C) of the Social Security Act requires hospitals and other health care providers participating in the Medicare program to make adequate provisions to refund any monies incorrectly paid. In accordance with sections 1815 (a) and 1833 (e) of the Act, the Secretary is authorized to request information from providers, which is necessary to properly administer the Medicare program. In accordance with these provisions, form HCFA-838 must be completed by all hospitals and other health care facilities participating in the Medicare program to help assure that monies owed to the Medicare program are repaid in a timely manner.

The Form HCFA-838 is specifically used to monitor the identification and recovery of "credit balances" due the Medicare program. A credit balance is defined as an improper or excess payment made to a provider as the result of patient billing or claims processing errors. For example, if a provider is paid twice for the same service (e.g., by Medicare and another insurer), then a refund must be made to the secondary payer.

For the purpose of completing the HCFA-838 form, a Medicare credit balance is an amount determined to be refundable to the Medicare program. Generally, when a provider receives an improper or excess payment for a claim it is reflected in their accounting records (patient account receivable) as a "credit". However, Medicare credit balances include money due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. The provider is responsible for identifying and repaying all of the monies due to Medicare

To assist in the determination of whether a refund is due the Medicare program, another insurer, the patient or beneficiary, refer to the following manual sections which pertain to the eligibility and Medicare Secondary Payer (MSP) admissions procedures:

- ✓ Sections 300 and 301 of the Medicare Hospital Manual;
- ✓ Sections 400 and 401 of the Medicare Skilled Nursing Facility Manual;
- ✓ Sections 300, 302 and 341 of the Medicare Home Health Agency Manual;
- ✓ Sections 250 and 300 of the Medicare Renal Dialysis Facility Manual;
- ✓ Sections 245-251, 300 and 302 of the Medicare Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual

# Medicare Provider Instructions

## *For Credit Balance Reporting (Continued)*

### **Submitting the Form HCFA-838**

Submit a Medicare Credit Balance Report to your intermediary (FI) within 30 days after the close of each calendar quarter. The report is to include all Medicare credit balances reflected in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

### **Completing the Form HCFA-838**

The Form HCFA-838 consists of a certification page and a detail page. The certification page is to be signed and dated by an Officer or the Administrator of your facility. If no Medicare credit balances are reflected in your records for the reporting quarter, the certification page must still be signed and submitted attesting to this fact.

The detail page requires specific information on each credit balance, on a claim-by-claim basis. The detail page provides space to address 17 claims, but it may be reproduced as many times as necessary to accommodate all of the credit balances being reported.

### **Complete the Form HCFA-838 as follows:**

- ✓ The full name of the facility;
- ✓ The facility's provider number; if there are multiple provider numbers for dedicated units within the facility (e.g., Psychiatric, Physical Medicine and Rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;
- ✓ The Month, Day and Year of the reporting quarter, e.g., 10/01/01;
- ✓ An "A" if the report page(s) reflects Part A credit balances;
- ✓ The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and
- ✓ The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

### **Complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim):**

Column 1	The last name and first name of the person with Medicare. (e.g. Doe, J.)
Column 2	The Medicare Health Insurance Claim number of the person with Medicare.
Column 3	The 10-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.

- Column 4      The 3 digit number delineating the type of bill, e.g., 111 – inpatient, 131 – outpatient, 831 – same day surgery, etc. Refer to Part III; section 3871 of the Medicare Intermediary Manual, or the Uniform Billing instructions of your manual (Hospital, SNF, HHA, etc.).
  
- Column 5/6    The Month, Day and Year the beneficiary was admitted and discharged, if an inpatient claim, or "From" and "Through" dates (date service(s) were rendered) if an outpatient service. Indicate the Admission (From) and Discharge (Through) date using numerals (e.g., 01/01/01).
  
- Column 7      The Month, Day and Year (e.g., 01/01/01) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, the paid date and ICN number must correspond to the most recent payment.
  
- Column 8      An "O" if the claim is for an open Medicare cost reporting period or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one for which a NPR has not yet been issued. A cost report is not to be considered open if it was reopened for a specific issue such as graduate medical education or malpractice insurance).
  
- Column 9      The amount of the Medicare credit balance that was determined from your patient/accounting records.
  
- Column 10     The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, Medicare credit balances should be repaid at the time the Form HCFA-838 is submitted to your FI).
  
- Column 11     A "C" when a check is being submitted with the Form HCFA-838 to repay the credit balance amount shown in column 9, or an "A" if an adjustment request is being submitted.
  
- Column 12     The amount of the credit balance that remains outstanding (column 9 minus column 10). Show a zero if full payment is made.
  
- Column 13     The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer, or a "3" for "other reasons". If a "3" is indicated, a UB92 claim form must be submitted with the credit balance report indicating in red the changes that must be made.



## Medicare Provider Instructions *For Credit Balance Reporting (Continued)*

Column 14 The Value Code to which the primary payment (column 14) relates, using the appropriate two digit code as follows:

- 12 working aged
- 13 end stage renal disease
- 14 auto no-fault/liability
- 15 workers' compensation
- 16 other government program
- 41 black lung
- 42 veterans administration
- 43 disability

This column is completed only if the credit balance was caused by a payment when Medicare was not the primary payer.

Column 15 The name and address of the primary insurer identified in column 14.

**Note:** Once a credit balance is reported on the form HCFA-838, it is not to be reported on a subsequent period report.

### **Payment of Amounts Owed Medicare**

All amounts owed Medicare as shown in column 9 of the credit balance report should be paid at the time the Form HCFA-838 is submitted. Payment may be made by check or by the submission of the adjustment request. Adjustment requests may be submitted in hard copy or electronic format.

If a check is used to pay credit balances, adjustment requests must also be submitted for the individual credit balances that pertain to open cost reporting periods. Your FI will assure that monies are not collected twice.

If the amount owed Medicare is so large that immediate repayment would cause financial hardship, contact your FI regarding an extended repayment schedule.

Interest will be assessed on Medicare credit balances not timely repaid, in accordance with 42 CFR 405.376.

### **Records Supporting Form HCFA-838 Data Submissions**

Providers must develop and maintain documentation which shows that [each patient record with a credit balance](#) (transfer, holding account, etc.) was reviewed to determine credit balances attributable to Medicare and the amount owed, for the preparation of the Form HCFA-838. At a minimum, your procedures should:



1. identify whether or not the patient is an eligible Medicare beneficiary
2. identify other liable insurers and the primary payer
3. adhere to applicable Medicare reimbursement rules

Penalties may be imposed for failure to submit the Form HCFA-838, or for not maintaining documentation that adequately supports the credit balance data reported to the Medicare program. Intermediaries will review a provider's documentation during their audits/reviews performed for cost report settlement purposes.

### **Provider Based Home Health Agencies**

Provider based home health agencies are to submit their Form HCFA-838 to their Regional Home Health Intermediary, even though it may be different from the intermediary servicing the parent facility.

### **Exception for Low Utilization Providers**

Providers with extremely low Medicare utilization do not have to submit the Form HCFA-838. Low utilization is defined as a provider that files a low utilization Medicare cost report as specified in PRM-1, section 2414.B or files less than 25 Medicare claims per year.

### **Compliance with MSP Regulations**

MSP regulations 42 CFR 489.20 require providers to reimburse Medicare within 60 days from the date they receive payment from another payer (primary to Medicare) for the same service. Submission of the Form HCFA-838 and adherence to its instructions do not interfere with this rule; credit balances resulting from MSP payments must be repaid within the 60 day period.

Credit balances resulting from MSP payments must be reported on the Form HCFA-838 if they have not been repaid by the last day of the reporting quarter. When an MSP credit balance is identified and repaid within a reporting quarter, in accordance with the 60 day requirement, it would not be included in the credit balance report, i.e., once payment is made a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the Form HCFA-838 is due prior to the expiration of the 60 day requirement, it would be included in the credit balance report. However, payment of the credit balance does not have to be made at the time the Form HCFA-838 is submitted, but within the 60 days allowed.

Please submit your reports to:



**Jessica Jaworski**  
Reimbursement Technician  
Medicare Audit & Reimbursement Department  
CareFirst, INC.  
1946 Greenspring Drive  
Timonium, MD 21093-4141



If a provider fails to submit a credit balance report, the first course of action will be a 20% reduction in program payments, unless extraordinary circumstances prohibited them from doing so. Continued non-compliance could result in the full suspension of program payments, in accordance with 42 CFR 413.20 (e) and 405.370.

## **Correction to the Revision of Medicare Reimbursement for Telehealth Services**

Eliminates intermediary claims processing type of bill (TOB) 12X for telehealth benefits. Site bills originating in inpatient hospitals must be submitted on a 13X (outpatient) TOB using the date of discharge as the line item date of service. TOB 12X was incorrectly included on page 5 of Transmittal AB-01-69, Change Request 1650, dated May 1, 2001.

Q3014 is the correct HCPCS code for telehealth originating site facility fee, not Q3104 as shown one place on the same page.

(Source: Program Memorandum AB-01-120; Change Request 1827)

## **October 2001 Update to the Hospital Outpatient Prospective Payment System (OPPS)**

This instruction provides certain changes to the hospital OPPS for the October 2001 update. These changes include the following: one "new technology procedure/service," revised APCs for certain "new technology procedures/services," two new drugs eligible for pass-through payments, one new blood product reportable under OPPS, and revised payment rates for two drugs eligible for pass-through payments. **Unless otherwise indicated, the effective date for items listed below October 1, 2001.**



The OCE and PRICER currently contain the codes included in this document. However, fiscal intermediaries must add the following C-codes to the Healthcare Common Procedure Coding System (HCPCS) file in their internal claims processing systems: C9110, C9506, and C9711.

The listing of HCPCS codes contained in this instruction does not assure coverage of the specific item or service in a given case. To receive transitional pass-through payments or new technology payments, qualified items and services must be considered reasonable and necessary in a given case.

### **I. New Technology Procedure/Service Ambulatory Payment Classification (APC)**

<b>HCPCS Code</b>	<b>SI</b>	<b>APC</b>	<b>Descriptors</b>
C9711	T	978	Short Descriptor: H.E.L.P. Apheresis System Long Descriptor: H.E.L.P. Apheresis System

### **II. Revised New Technology Procedure/Service APCs**

<b>HCPCS Code</b>	<b>Old SI</b>	<b>Old APC</b>	<b>New SI</b>	<b>New APC</b>	<b>Descriptors</b>
C1050	S	976	T	978	Short Descriptor: Prosorba Column Long Descriptor: Prosorba Column
C9701	S	976	T	980	Short Descriptor: Stretta procedure Long Descriptor: Stretta procedure

**III. New Drugs Eligible for Pass-Through Payments**

HCPCS Code	SI	Descriptors	APC	Payment Rate	Min Unadj. Co-Insurance
C9110	J	Short Desc: Alemtuzumab, per 10 mg/ml Long Desc: Alemtuzumab, per 10 mg/ml	9110	\$ 486.88	\$ 69.70
J9219	J	Short Desc: Leuprolide acetate implant Long Desc: Leuprolide acetate implant, 65 mg	7051	\$ 5,399.80	\$ 773.02

CMS Pub. 60A

**IV. New Blood Product Reportable Under OPPTS**

HCPCS Code	SI	Descriptors	APC	Payment Rate	Min Unadj. Co-Insurance
C9506	K	Short Desc: Granulocytes, pheresis Long Desc: Granulocytes, pheresis, each unit	9506	\$ 1,475.00	\$ 295.00

**V. Revised Payment Rates for Two Drugs Eligible for Pass-Through Payments**

HCPCS Code	SI	Descriptors	APC	Old Payment Rate	New Payment Rate	Min Unadj. Co-Insurance
A9504	G	Short Desc: Technetium TC 99M apcitide [per vial] Long Desc: Supply of radiopharmaceutical diagnostic imaging agent, technetium TC 99M apcitide	1602	\$ 45.13	\$ 475.00	\$ 68.00
A9700	G	Short Desc: Echocardiography contrast [per 3 ml, single-dose vial] Long Desc: Supply of injectable contrast material for use in echocardiography, per study	9016	\$ 39.58	\$ 118.75	\$ 17.00

(Source: A-01-107; Change Request 1822)

**\* Special Note**

The Outpatient Code Editor & Pricer currently contain the codes included in this document. However, all of the C-codes included on this file are used exclusively for services paid under OPPTS & may not be used to bill services paid under other Medicare payment systems.

## New Temporary "Q" Codes for Splints, and Casts *Used for Reduction of Fractures and Dislocations*

### Background

In the Medicare physician fee schedule beginning in 2001, the casting supplies were removed from the practice expenses for all HCPCS codes, including the CPT codes for fracture management and for casts and splints. Thus, for settings in which CPT codes are used to pay for services, which include the provisions of a cast or splint, new temporary codes are being established to pay physicians and other practitioners for the supplies used in creating casts. The work and practice expenses involved with the creation of the cast or splint should continue to be coded using the appropriate CPT code. The use of the new temporary codes described below will replace less specific coding for the casting and splinting supplies.

### Fiscal Intermediaries Only:

The payments for casting and splinting supplies provided in hospital outpatient departments and ambulatory surgical centers are unchanged by this instruction. To the extent these services are provided by Home Health Agencies and to hospice patients for the treatment of a non-terminal illness, the payments for these services are also unchanged. These facilities continue to utilize the appropriate codes in the 2900 through 29750 series of HCPCS Level I codes. The only settings in which payments may be made on the physician fee schedule are comprehensive outpatient rehabilitation facilities (CORFs) bill type 75X and outpatient therapy facilities (ORFs) bill type 74X. The "Q" codes will be added in the October 1, 2001, version of the Outpatient Code Editor, so their use in these settings will not be implemented until that date.

The following temporary "Q" codes have been established for the supplies used by physicians and other practitioners to create splints and casts used for reduction of fractures and dislocations:

Q4001	Cast supplies, body cast adult, with or without head, plaster
Q4002	Cast supplies, body cast adult, with or without head, fiberglass
Q4003	Cast supplies, application of shoulder cast, adult (11 years +), plaster
Q4004	Cast supplies, application of shoulder cast, adult (11 years +), fiberglass
Q4005	Cast supplies, long arm cast, adult (11 years +), plaster
Q4006	Cast supplies, long arm cast, adult (11 years +), fiberglass
Q4007	Cast supplies, long arm cast, pediatric (0-10 years), plaster
Q4008	Cast supplies, long arm cast, pediatric (0-10 years), Fiberglass
Q4009	Cast supplies, short arm cast, adult (11 years +), plaster
Q4010	Cast supplies, short arm cast, adult (11 years +), fiberglass
Q4011	Cast supplies, short arm cast, pediatric (0-10 years), plaster
Q4012	Cast supplies, short arm cast, pediatric (0-10 years), fiberglass
Q4013	Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), plaster
Q4014	Cast supplies, gauntlet cast (includes lower forearm and hand) adult (11 years +) fiberglass
Q4015	Cast supplies, gauntlet cast (includes lower forearm and hand, pediatric (0-10 years), plaster

Q4016	Cast supplies, gauntlet cast (includes lower forearm and hand) pediatric (0-10 years), fiberglass
Q4017	Cast supplies, long arm splint, adult (11 years +), plaster
Q4018	Cast supplies, long arm splint, adult (11 years +), fiberglass
Q4019	Cast supplies, long arm splint, pediatric (0-10 years), plaster
Q4020	Cast supplies, long arm splint, pediatric (0-10 years), fiberglass
Q4021	Cast supplies, short arm splint, adult (11 years +), plaster
Q4022	Cast supplies, short arm splint, adult (11 years +), fiberglass
Q4023	Cast supplies, short arm splint, pediatric (0-10 years), plaster
Q4024	Cast supplies, short arm splint, pediatric (0-10 years), fiberglass
Q4025	Cast supplies, hip spica (one or both legs), adult (11 years +), plaster
Q4026	Cast supplies, hip spica (one or both legs), adult (11 years +), fiberglass
Q4027	Cast supplies, hip spica (one or both legs), pediatric (0-10 years), plaster
Q4028	Cast supplies, hip spica (one or both legs), pediatric (0-10 years), fiberglass
Q4029	Cast supplies, long leg cast, adult (11 years +), plaster
Q4030	Cast supplies, long leg cast, adult (11 years +), fiberglass
Q4031	Cast supplies, long leg cast pediatric (0-10 years), plaster
Q4032	Cast supplies, long leg cast, pediatric (0-10 years), fiberglass
Q4033	Cast supplies, long leg cylinder cast, adult (11 years +), plaster
Q4034	Cast supplies, long leg cylinder cast, adult (11 years +), fiberglass
Q4035	Cast supplies, long leg cylinder cast, pediatric (0-10 years), plaster
Q4036	Cast supplies, long leg cylinder cast, pediatric (0-10 years), fiberglass
Q4037	Cast supplies, short leg cast, adult (11 years +), plaster
Q4038	Cast supplies, short leg cast, adult (11 years +), fiberglass
Q4039	Cast supplies, short leg cast, pediatric (0-10 years), plaster
Q4040	Cast supplies, short leg cast, pediatric (0-10 years), fiberglass
Q4041	Cast supplies, long leg splint, adult (11 years +), plaster
Q4042	Cast supplies, long leg splint, adult (11 years +), fiberglass
Q4043	Cast supplies, long leg splint, pediatric (0-10 years), plaster
Q4044	Cast supplies, long leg splint, pediatric (0-10 years), fiberglass
Q4045	Cast supplies, short leg splint, adult (11 years +), plaster
Q4046	Cast supplies, short leg splint, adult (11 years +), fiberglass
Q4047	Cast supplies, short leg splint, pediatric (0-10 years), plaster
Q4048	Cast supplies, short leg splint, pediatric (0-10 years), fiberglass
Q4049	Finger splint, static
Q4050	Cast supplies, for unlisted types and material of casts
Q4051	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)

Codes A4570, A4580, A4590, L2102, L2104, L2122, and L2124, which were previously used for billing of splints and casts are invalid for Medicare use effective for intermediary processed claims October 1, 2001.

For claims with dates of service on or after July 1, 2001, jurisdiction for processing claims for splints (previously billed using A4570) will transfer from the DMERCs to local carriers. The local carriers have jurisdiction for processing claims for the new Q codes for splints and casts, which includes codes for splints that may have previously been billed to the DMERCs under code A4570. In addition, for claims with dates of service on or after July 1, 2001, jurisdiction for slings (A4565) will be jointly maintained by the local carriers (for physician claims) and the DMERCs (for supplier claims)

To assist physicians and practitioners to select the correct code for the cast and splinting supplies, the following crosswalk provides guidance as to which supply codes are applicable for the various types of casts described by Level I or CPT codes.

Level I	Level II
29000	Q4001 or Q4002
29010	Q4001 or Q4002
29015	Q4001 or Q4002
29020	Q4001 or Q4002
29025	Q4001 or Q4002
29035	Q4001 or Q4002
29040	Q4001 or Q4002
29044	Q4001 or Q4002
29046	Q4001 or Q4002
29049	Q4050
29055	Q4003 or Q4004
29058	Q4003
29065	Q4005 or Q4008
29075	Q4009 or Q4012
29085	Q4013 or Q4016
29105	Q4017 or Q4020
29125	Q4021 or Q4024

Level I	Level II
29126	Q4021 through Q4024
29130	Q4049
29131	Q4051
29305	Q4025 through Q4028
29325	Q4025 through Q4028
29345	Q4029 through Q4032
29355	Q4029 through Q4032
29365	Q4033 through Q4036
29405	Q4037 through Q4040
29425	Q4037 through Q4040
29435	Q4037 through Q4040
29440	Q4050
29445	Q4037 through Q4040
29450	Q4035, Q4036, Q4039, Q4040
29505	Q4041 through Q4044
29515	Q4045 through Q4048



## 2001 Payment Amounts

<u>HCPCS</u>	<u>Payment Amounts</u>	<u>HCPCS</u>	<u>Payment Amounts</u>
A4565	\$6.10	Q4025	\$26.86
Q4001	\$34.78	Q4026	\$83.85
Q4002	\$131.44	Q4027	\$13.43
Q4003	\$24.98	Q4028	\$41.93
Q4004	\$86.48	Q4029	\$20.53
Q4005	\$9.21	Q4030	\$54.05
Q4006	\$20.76	Q4031	\$10.27
Q4007	\$4.61	Q4032	\$27.03
Q4008	\$10.38	Q4033	\$19.15
Q4009	\$6.14	Q4034	\$47.65
Q4010	\$13.84	Q4035	\$9.58
Q4011	\$3.07	Q4036	\$23.83
Q4012	\$6.92	Q4037	\$11.69
Q4013	\$11.18	Q4038	\$29.27
Q4014	\$18.88	Q4039	\$5.85
Q4015	\$5.59	Q4040	\$14.64
Q4016	\$9.44	Q4041	\$14.21
Q4017	\$6.47	Q4042	\$24.25
Q4018	\$10.32	Q4043	\$7.10
Q4019	\$3.24	Q4044	\$12.13
Q4020	\$5.16	Q4045	\$8.25
Q4021	\$4.79	Q4046	\$13.27
Q4022	\$8.64	Q4047	\$4.12
Q4023	\$2.40	Q4048	\$6.64
Q4024	\$4.32	Q4049	\$1.50

(Source: Program Memorandum AB-01-60; Change Request 1641)

# REASONABLE CHARGE UPDATE

*for 2002 for Items and Services, Other Than Ambulance and Laboratory Services*

Where payment continues to be made on a reasonable charge basis for items and services, other than ambulance and laboratory services, carriers are to compute 2002 customary and prevailing charge updates using actual charge data from July 1, 2000, to June 30, 2001. Instructions regarding payment for ambulance and laboratory services still subject to reasonable charges will be provided under separate cover. Additional instructions regarding payment for dialysis supplies and equipment will also be provided under separate cover. All of the codes below are subject to the inflation-indexed charge (IIC). To compute their 2002 IIC screen, carriers are to increase the appropriate 2001 screen by 3.2 percent. The following are the codes subject to the reasonable charge update

Splints and Casts (Local Carrier Jurisdiction)\*

A4565 Q4001 Q4002 Q4003 Q4004 Q4005 Q4006 Q4007 Q4008 Q4009 Q4010 Q4011 Q4012 Q4013 Q4014  
 Q4015 Q4016 Q4017 Q4018 Q4019 Q4020 Q4021 Q4022 Q4023 Q4024 Q4025 Q4026 Q4027 Q4028 Q4029  
 Q4030 Q4031 Q4032 Q4033 Q4034 Q4035 Q4036 Q4037 Q4038 Q4039 Q4040 Q4041 Q4042 Q4043 Q4044  
 Q4045 Q4046 Q4047 Q4048 Q4049

Dialysis Supplies and Equipment (DMERC Jurisdiction)

A4651 A4652 A4656 A4657 A4660 A4663 A4680 A4690 A4706 A4707 A4708 A4709 A4712 A4714 A4719  
 A4720 A4721 A4722 A4723 A4724 A4725 A4726 A4730 A4736 A4737 A4740 A4750 A4755 A4760 A4765  
 A4766 A4770 A4771 A4772 A4773 A4774 A4801 A4802 A4860 A4870 A4911 A4918 A4927 A4928 A4929  
 E1500 E1510 E1520 E1530 E1540 E1550 E1560 E1570 E1575 E1580 E1590 E1592 E1594 E1600 E1610  
 E1615 E1620 E1625 E1630 E1632 E1635 E1636 E1637 E1638 E1639

Therapeutic Shoes (DMERC Jurisdiction)

A5500 A5501 A5503 A5504 A5505 A5506 A5509 A5510 A5511

Intraocular Lenses (Local Carrier Jurisdiction)

V2630 V2631 V2632

2002 Payment Amounts for Splints and Casts			
A4565	\$6.30	Q4014	\$19.48
Q4001	\$35.89	Q4015	\$5.77
Q4002	\$135.65	Q4016	\$9.74
Q4003	\$25.78	Q4017	\$6.68
Q4004	\$89.25	Q4018	\$10.65
Q4005	\$9.50	Q4019	\$3.34
Q4006	\$21.42	Q4020	\$5.33
Q4007	\$4.76	Q4021	\$4.94
Q4008	\$10.71	Q4022	\$8.92
Q4009	\$6.34	Q4023	\$2.48
Q4010	\$14.28	Q4024	\$4.46
Q4011	\$3.17	Q4039	\$6.04
Q4012	\$7.14	Q4040	\$15.11
Q4013	\$11.54	Q4041	\$14.66
		Q4042	\$25.03
		Q4043	\$7.33
		Q4044	\$12.52
		Q4045	\$8.51
		Q4046	\$13.69
		Q4047	\$4.25
		Q4048	\$6.85
		Q4049	\$1.55
		The implementation date for this instruction is January 1, 2002. (Source: Program Memorandum AB-01-118; Change Request 1803) The effective date for this instruction is January 1, 2002.	



## Annual Update of Non-Routine Medical Supply and Therapy Codes for Home Health Consolidated Billing (CB)

CMS provides annual updates to the list of non-routine medical supply and therapy codes included in home health CB to reflect the annual Healthcare Common Procedure Coding System (HCPCS) code revisions. The codes in these lists are codes that are bundled into the prospective payment system (PPS) rate. Therefore, providers and suppliers may not bill for these codes separately while a Medicare beneficiary is in an open home health episode.

The following are the changes to the non-routine medical supply list for dates of service beginning January 1, 2002:

### **New code subject to CB:**

A6010: Collagen based wound filler, dry foam

### **Discontinued code, no longer subject to CB:**

A4329: External catheter start set

There are no changes to the list of 69 therapy codes subject to CB.

(Source: Program Memorandum AB-01-128; Change Request 1854)

## Useful Lifetime Expectancy for Breast Prosthesis

### Background

Federal regulations at 42 CFR 414.229(g) state that a reasonable useful lifetime of less than 5 years for prosthetic devices can be established through program instructions. Because of this rule, in the absence of program instructions, durable medical equipment regional carriers (DMERCs) have been allowed to determine the reasonable lifetime of breast prostheses but in no case could it be less than 5 years.

### New Policy

After review of product information and in consultation with the DMERCs, CMS has determined that a period shorter than 5 years more accurately reflects the useful lifetime expectancy for a breast prosthesis. This program instruction lowers the useful lifetime expectancy for silicone breast prostheses to 2 years, the most common warranty period provided by manufacturers. For fabric, foam, or fiber filled breast prostheses, we are lowering the useful lifetime expectancy to 6 months. However, a breast prosthesis can be replaced at any time if it is lost, irreparably damaged (this does not include ordinary wear and tear), or if there is a change in the patient's medical condition necessitating a different type of item. If the patient's medical condition changes, this should be documented by the patient's physician submitting a new prescription which explains the need for a different type of breast prosthesis.

Under existing policy the Medicare program will pay for only one breast prosthesis per side. Medicare does not pay for different types of the same or similar item or for spare or back-up items. However, two prostheses, one per side, are allowed for those persons who have had bilateral mastectomies. Suppliers must use the RT and LT modifiers to delineate the side or sides being billed.

(Source: Program Memorandum AB-123; Change Request 1787)



# FRAUD & ABUSE CORNER



## SANCTIONED PROVIDER UPDATE

Sanctioned and reinstated providers from the surrounding states (Delaware, Pennsylvania and Virginia) have been added to the list for your convenience.

The Office of Inspector General (OIG) has notified us of a recent reinstatement action involving the following providers:

***Mehrdad Aalai***

Gynecologist/Obstetrician  
10524 Democracy Boulevard  
Potomac, Maryland 20854  
Effective Date: August 28, 2001

***Charles Bucklar, Jr.***

Chiropractor  
217 North 2nd Street  
Saint Clair, Pennsylvania 17970  
Effective Date: July 26, 2001

***Paul Weber Burke, Jr.***

Surgeon  
107 Oakwood Place  
Parkersburg, West Virginia 26101  
Effective Date: August 28, 2001

***Billy Wood Fisher, Jr.***

Nurse/Nurses Aide  
35 Colonnade Drive, Apartment 35  
Charlottesville, Virginia 22903  
Effective Date: July 11, 2001

***Howard D. Johnson***

Pathologist  
6 Craig Court  
Pittsburgh, Pennsylvania 15228  
Effective Date: August 7, 2001

***Micheal Merritt Kostenko***

Osteopath  
70 Brookshire Lane  
Beckley, West Virginia 25801  
Effective Date: July 26, 2001

***Walter C. Lockhart  
aka Walter C. Lockhart, Jr.***

Internist/Internal Medicine  
c/o 1616 Forest Drive, Suite 2  
Annapolis, Maryland 21403-1019  
Effective Date: July 26, 2001

***Debra S. Martini***

Nurse/Nurses Aide  
272 W. Willow Street  
Carlisle, Pennsylvania 17013  
Effective Date: August 10, 2001

***Daniel J. McCarty***

Chiropractor  
c/o 1803 N. Main Street  
Butler, Pennsylvania 16001  
Effective Date: August 28, 2001

***Frank M. O'Shea***

Family Physician/General Practitioner  
3901 Fox Hill Drive  
Ellicott City, Maryland 21042  
Effective Date: February 20, 2001

***Ronald B. Phillips***

Osteopath  
18 Todmorden Drive  
Wallingford, Pennsylvania 19086  
Effective Date: July 11, 2001

# FRAUD & ABUSE CORNER



## SANCTIONED PROVIDER UPDATE

The Office of Inspector General (OIG) has notified us of a recent administrative sanction action involving the following providers:

**Jane M. Adler  
aka Jane A. Karlsberg**

Internist/Internal Medicine  
9812 Falls Road, Suite 114  
Potomac, Maryland 20854  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(14)

**Lillian Jan Angelo**

Recipient/Beneficiary  
H C #8, Box 8601  
Blooming Grove, Pennsylvania 18428  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(1)

**Michelle Lacour Balen**

Nurse/Nurses Aide  
15 Long Lane  
Malvern, Pennsylvania 19355  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

**Ginger Short Beatley**

Nurse/Nurses Aide  
5178 Highview Avenue  
Stephens City, Virginia 22655  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

**Mary F. Bodnar**

Nurse/Nurses Aide  
752 Shadyside Drive  
W. Mifflin, Pennsylvania 15122  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

**Laurie H. Bowles**

Nurse/Nurses Aide  
604 Elliott Avenue  
Charlottesville, Virginia 22902  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

**David C. Allen**

Internist/Internal Medicine  
44830 Shady Hollow Lane  
California, Maryland 20619  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

**Robert Anthony Angelo, Jr.**

Recipient/Beneficiary  
P.O. Box 200, SCI  
Camp Hill, Pennsylvania 17001  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(1)

**Marvin H. Balistocky**

Ophthalmologist  
1601 Northview Boulevard  
Plymouth, Pennsylvania 19462  
Effective Date: February 21, 2001  
Type of Action: 1128(b)(7)

**Sarah Beddoe**

Nurse/Nurses Aide  
3799 Snakepath Road  
Blairs, Virginia 24527  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

**Body Energetics, Inc.**

Chiropractic Practice  
9051 Baltimore National Pike, Suite 3E  
Ellicott City, Maryland 21042-3927  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(8)

# FRAUD & ABUSE CORNER



## SANCTIONED PROVIDER UPDATE

### **Gina Gloria Caselli**

Dentist  
223 Pine Street  
Philadelphia, Pennsylvania 19106  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(14)

### **Audrey Waunell Bat Coulter aka Audrey Waunell Kline**

Nurse/Nurses Aide  
5045 Glenwood Way  
Virginia Beach, Virginia 23456  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### **Christine Dececco Diluca**

Nurse/Nurses Aide  
3006 Woodrow Street  
McKeesport, Pennsylvania 15133  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

### **Carol Ann Knabb Fafinski**

Nurse/Nurses Aide  
8201 Woodyard Road  
Clinton, Maryland 20735-1969  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

### **Thomas E. Finucan, Jr.**

Family Physician/General Practitioner  
3 Mauldin Avenue  
Northeast, Maryland 21901  
Effective Date: May 20, 2001  
Type of Action: 1128(b)(4)

### **Denice Karkalla Gallagher**

Nurse/Nurses Aide  
2504 Berg Place  
Pittsburgh, Pennsylvania 15210  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### **Oleg Genis**

Dentist  
45 Joshua Drive  
Richboro, Pennsylvania 18954  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(14)

### **Tyrone Cook**

Nurse/Nurses Aide  
5603 Chester Avenue  
Philadelphia, Pennsylvania 19147  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

### **Eugene Sloan Craig, Jr.**

Internist/Internal Medicine  
2822 Harview Avenue  
Baltimore, Maryland 21234-7109  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(14)

### **Vicki A. Dinitto**

Nurse/Nurses Aide  
R R 1, Box 413A  
Draper, Virginia 24324  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### **John Joseph Fingal**

Owner/Operator  
10803 Kencrest Drive  
Mitchellville, Maryland 20721  
Effective Date: September 20, 2001  
Type of Action: 1128(a)(1)

### **Deidre E. Fitzpatrick**

Nurse/Nurses Aide  
66 Brestle Cove  
Bear, Delaware 19701  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(2)

### **Sheri L. Gazes**

Nurse/Nurses Aide  
46100 Ingomar Terrace, #100  
Sterling, Virginia 20166  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(1)

### **Alan S. Greenberg**

Neurologist  
1537 Jarrettsville Road  
Jarrettsville, Maryland 21084  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

# FRAUD & ABUSE CORNER



## SANCTIONED PROVIDER UPDATE

### ***Tina R. Crawford Gusovius***

Nurse/Nurses Aide  
206 E. Southwerk Street  
Winchester, Virginia 22601  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### ***Jane Delbaugh Hart***

Nurse/Nurses Aide  
Muncy Valley, Pennsylvania 17758  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### ***Robin L. Helsel***

Nurse/Nurses Aide  
94 E Oakland Avenue  
Doylestown, Pennsylvania 18901  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### ***Alfredo J. Herrera***

Pediatrician  
2971 Poland Springs Drive  
Ellicott City, Maryland 21042  
Effective Date: September 20, 2001  
Type of Action: 1128(a)(1)

### ***Sarah May Hill aka Sarah F. May***

Nurse/Nurses Aide  
5501 Jessup Road  
Richmond, Virginia 23234  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### ***Michael J. Horan***

Family Physician/General Practitioner  
12307 Braxfield Court, #13  
Rockville, Maryland 20852  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(3)

### ***Gerald Anthony Harden***

Family Physician/General Practitioner  
16829 Cashell Road  
Onley, Maryland 20832  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(14)

### ***Judith Louise Hatch aka Judith H. Frey aka Judith L. Frey***

R R #1, Box 4  
Chiropractor  
1220 E W Highway  
Apartment 1012  
Silver Spring, Maryland 20910  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(14)

### ***Lachelle Henderson***

Nurse/Nurses Aide  
P.O. Box 888  
Kilmarnock, Virginia 22482  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

### ***Sharon Higgins***

Nurse/Nurses Aide  
261 Frieden Manor  
Schuylkill Haven, Pennsylvania 17972  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

### ***Berrie Johnson Hoover***

Nurse/Nurses Aide  
7935 Bethelen Woods Lane  
Springfield, Virginia 22153  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### ***Julian E. Jenkins***

Podiatrist  
36 Meadow Brook  
North Wales, Pennsylvania 19454  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(14)

# FRAUD & ABUSE CORNER



## SANCTIONED PROVIDER UPDATE

### **Robert J. Kay**

Chiropractor  
9051 Baltimore National Pike  
Ellicott City, MD 21042-3927  
Effective Date: July 19, 2001  
Type of Action: 1128(b)(14)

### **Yung M. Lee**

Anesthesiologist  
4414 Langtry Drive  
Glen Arm, Maryland 21057  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

### **Walter Cornell Lockhart Jr.**

Internist/Internal Medicine  
1616 Forest Drive, Suite 2  
Annapolis, MD 21403-10191  
Effective Date: July 19, 2001

### **Clinton E. McGregor**

Nurse/Nurses Aide  
7930 Brock Bridge Road  
Jessup, Maryland 20794  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(2)

### **Loretta T. Miles aka L. Tracey Miles**

Internist/Internal Medicine  
518 6th Avenue  
Bethlehem, Pennsylvania 18018  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(14)

### **Joseph E. Moran**

Chiropractor  
640 N. Washington Street  
Wilkes Barre, Pennsylvania 18705  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(14)

### **Linda Forney Kraft**

Nurse/Nurses Aide  
2296 Franklin Road  
Columbia, Pennsylvania 17512  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### **Gloria Jean Liskey**

Nurse/Nurses Aide  
317 High Street  
Bridgewater, Virginia 22812  
Effective Date: September 20, 2001  
Type of Action: 1128(a)(2)

### **Abbie Bedilion Logsdon**

Nurse/Nurses Aide  
21 Aistrop Lane  
Faber, Virginia 22938  
Type of Action: 1128(b)(4)

### **Pamela Jean Merritt**

Dentist  
4521 Brambleton Avenue  
Roanoke, Virginia 24014  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(14)

### **Edwin R. Miller**

Private Citizen  
4601 East Monument Street  
Baltimore, Maryland 21205  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(1)

### **Paul A. Mullan**

Pediatrician  
107 W. Lake Avenue  
Baltimore, Maryland 21210  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

# FRAUD & ABUSE CORNER



## SANCTIONED PROVIDER UPDATE

### **James J. Musto**

Chiropractor  
52 Shoemaker Street  
Forty Fort, Pennsylvania 18704  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(14)

### **Optimumcare Medical Center, LLC**

Clinic  
444 N. Frederick Avenue  
Gaithersburg, Maryland 20877  
Effective Date: September 20, 2001  
Type of Action: 1128(a)(1)

### **Sandra Brager Pirillo**

Nurse/Nurses Aid  
2274 Avella Road  
Avella, Pennsylvania 15312  
Effective Date: September 20, 2001  
Type of Action: 1128(a)(2)

### **Dianna L. Rafferty**

Chiropractor  
17 Enamel Street  
Uniontown, Pennsylvania 15401-2311  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(14)

### **Nancy A. Rosen**

Officer/Board Member  
8380 Greensboro Drive, #423  
McLean, Virginia 22102  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(1)

### **Frank J. Nelson**

Pharmacist  
7174 Jackson Street  
Philadelphia, Pennsylvania 19135  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

### **Francine Barton Packer**

Nurse/Nurses Aide  
114 Richland Road  
Petersburg, Virginia 23805  
Effective Date: September 20, 2001  
Type of Action: 1128(a)(2)

### **Arnold Payne, Jr.**

Pharmacist  
3549 Greenmount Avenue, #2  
Baltimore, Maryland 21203  
Effective Date: May 20, 2001  
Type of Action: 1128(a)(4)

### **Psychological Connections**

Clinic  
6024 Western Avenue  
Chevy Chase, Maryland 20815  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(8)

### **Bannister Lee Raines**

Family Physician/General Practitioner  
2350 Sundew Terrace  
Baltimore, Maryland 21209  
Effective Date: May 20, 2001  
Type of Action: 1128(b)(4)

### **Joseph M. Rukse, Jr.**

Pharmacist  
P.O. Box 1000, FCI  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(1)

# FRAUD & ABUSE CORNER



## SANCTIONED PROVIDER UPDATE

**Bethanne L. Sanders  
aka Bethanne L. Moore**

Family Physician/General Practitioner  
Chevy Chase, MD 20815  
Effective Date: July 19, 20011  
Type of Action: 1128(b)(14)

**Tracie Summerville**

Nurse/Nurses Aide  
2627 Yale Court, B1  
Chesapeake, Virginia 23324  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(2)

**Alswell Umechuruba**

Health Care Aide  
7742 Finns Lane, #C2  
Lanham, Maryland 20706  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(2)

**Steven Wayne Walter**

Internist/Internal Medicine  
27 Kanawha Trail  
Lewisburg, West Virginia 24901  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

**Kathe L. Wright**

Nurse/Nurses Aide  
1406 Elmira Street  
Williamsport, Pennsylvania 17701  
Effective Date: September 20, 20011  
Type of Action: 1128(b)(4)

**Walter M. Strine, Jr.**

Owner/Operator  
173 Rose Valley Road  
Media, Pennsylvania 19063  
Effective Date: July 11, 2001  
Type of Action: 1128(b)(6)

**Sabrina Taylor**

Nurse/Nurses Aide  
19 Sandalwood Drive, #2  
Newark, Delaware 19713  
Effective Date: August 20, 2001  
Type of Action: 1128(a)(3)

**Ronald G. Verrilla**

Podiatrist  
190 Sycamore Drive, #114  
Penn Hills, Pennsylvania 15235  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(14)

**Maritza T. Williams**

Nurse/Nurses Aide  
702 Chestnut Street  
Sunbury, Pennsylvania 17801  
Effective Date: September 20, 2001  
Type of Action: 1128(b)(4)

**Hope W. Yaeger**

Nurse/Nurses Aide  
1316 S. 10th Street, Apartment 2  
Allentown, Pennsylvania 18103  
Effective Date: August 20, 2001  
Type of Action: 1128(b)(4)

**Bashir A. Yousufzai**

Pharmacist  
500 1st Street  
Du Bois, Pennsylvania 15801  
Effective Date: September 20, 2001  
Type of Action: 1128(a)(2)

**An employer of a sanctioned provider can not be reimbursed under Medicare or Medicaid for the salary paid to a sanctioned provider nor can an employer bill either program for services rendered to Medicare and Medicaid beneficiaries by this provider. In addition, a provider who hires a sanctioned individual without making the proper inquiries may be subject to Civil Monetary Penalty Law (CMPL) action by the OIG. Direct questions or inquiries to the Maryland Medicare Part A Fraud and Abuse Unit at 410-561-4111.**



# FRAUD & ABUSE CORNER



## SANCTIONED PROVIDER UPDATE

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<b>1128(a)(1)</b>	<b><i>Program-related conviction</i></b>
<b>1128(a)(2)</b>	<b><i>Conviction relating to patient abuse or neglect</i></b>
<b>*1128(a)(3)</b>	<b><i>Felony conviction relating to health care fraud</i></b>
<b>*1128(a)(4)</b>	<b><i>Felony conviction relating to controlled substance violations</i></b>
<b>1128(b)(1)</b>	<b><i>Conviction relating to fraud</i></b>
<b>1128(b)(2)</b>	<b><i>Conviction relating to obstruction of an investigation</i></b>
<b>1128(b)(3)</b>	<b><i>Conviction relating to controlled substances</i></b>
<b>1128(b)(4)</b>	<b><i>License revocation or suspension</i></b>
<b>1128(b)(5)</b>	<b><i>Suspension or exclusion under a Federal or State healthcare program</i></b>
<b>1128(b)(6)</b>	<b><i>Excessive claims or furnishing of unnecessary or substandard items or services</i></b>
<b>1128(b)(7)</b>	<b><i>Fraud, kickbacks, and other prohibited activities</i></b>
<b>1128(b)(8)</b>	<b><i>Entities owned or controlled by a sanctioned individual</i></b>
<b>1128(b)(9)</b>	<b><i>Failure to disclose required information</i></b>
<b>1128(b)(10)</b>	<b><i>Failure to supply requested information on subcontractors and suppliers</i></b>
<b>1128(b)(11)</b>	<b><i>Failure to provide payment information</i></b>
<b>1128(b)(12)</b>	<b><i>Failure to grant immediate access</i></b>
<b>1128(b)(13)</b>	<b><i>Failure to take corrective action</i></b>
<b>1128(b)(14)</b>	<b><i>Default on health education loan or scholarship obligation</i></b>
<b>1128(b)(15)</b>	<b><i>Individuals controlling sanctioned entities</i></b>
<b>1128Aa</b>	<b><i>Imposition of a civil monetary or assessment</i></b>
<b>1156(b)</b>	<b><i>Peer Review Organization recommendation</i></b>

***\*Expansion of authority under the Health Insurance Portability and Accountability Act of 1996.***

# A SPECIAL ADVISORY BULLETIN

## PRACTICES OF BUSINESS CONSULTANTS

*Excerpts from A Message from the Office of Inspector General (June 2001)*

The Office of Inspector General (OIG) recently published the following bulletin as part of their commitment to alerting providers to certain marketing and other practices used by some independent consultants that should concern providers and may put the Medicare and Medicaid programs at increased risk of abuse. While some of the practices described in this bulletin may not themselves rise to the level of fraud and may not be illegal in all cases, all of the practices increase the risk of abuse of the Medicare and Medicaid programs. The OIG encourages providers to recognize and protect themselves and the Federal programs against these questionable practices.

"To safeguard themselves, providers engaging the services of consultants should be alert to the following questionable practices:

**Illegal or Misleading Representations.** Consultants may make illegal or misleading statements or representations about their relationship with the Medicare program, the Centers for Medicare and Medicaid Services (CMS), or the OIG. For example, consultants may misrepresent that they have inside or special access to the OIG or to OIG materials. In other cases, consultants may misrepresent that their services or products are approved, certified, or recommended by Medicare, CMS, the Department of Health or Human Services, or the OIG. Such claims are misleading and potentially harmful to well-meaning providers. Illegal or misleading statements or representations include, for example:

- ❑ An educational consultant misrepresenting that its Medicare reimbursement seminars are mandatory for obtaining or maintaining a Medicare provider number. Although such training may be valuable, the Medicare program does not require a provider to attend training courses in order to participate in the Medicare program.
- ❑ A consultant misrepresenting that a provider that fails to attend its Medicare-sanctioned seminars will be subject to government penalties. In truth, the government does not penalize providers for such conduct.
- ❑ A consultant improperly using Federal program logos or symbols on its marketing materials.
- ❑ A consultant claiming that it is recommended by the OIG. The OIG does not recommend or endorse particular consultants or particular consultants services.
- ❑ A compliance consultant falsely asserting or implying that it offers recognized accreditation or certification for compliance programs or compliance officers.

**Promises and Guarantees.** Consultants may explicitly or implicitly promise or guarantee specific results that are unreasonable or improbable. In some cases, consultants may resort to improper means to effectuate these promises or guarantees, such as submitting false claims or preparing false cost reports on behalf of a client. This misconduct potentially subjects both the consultant and the provider to liability under the False Claims Act. Problematic promises would include, for example:

- ❑ A valuation consultant promising or assuring a client that its appraisal of a physician's practice will yield a fair market value that satisfies the client's need for a particular valuation, regardless of the actual value of the practice.
- ❑ A billing consultant promising a prospective client that its advice or services will produce a specific dollar or percentage increase in the client's Medicare reimbursements. The consultant's fee is often based on a percentage of this increased reimbursement.

**Encouraging Abusive Practices.** Some consultants may knowingly encourage abuse of the Medicare or Medicaid programs. In some cases, reimbursement specialists or other consultants advocate that their clients engage in aggressive billing schemes or unreasonable practices that are fraudulent or abusive to the Medicare or Medicaid programs. This conduct potentially subjects both the consultant and the client to liability under the False Claims Act. For example:

- ❑ A reimbursement specialist may suggest that a client use inappropriate billing codes in order to elevate reimbursement and may describe methods to avoid detection.
- ❑ A consultant may encourage a client to modify or customize a routine medical supply in an insignificant manner to justify billing the supply as a device that generates higher reimbursement.
- ❑ A reimbursement specialist may advise a client to bill for an expensive item or service with a high reimbursement rate when a less expensive item or service with a lower reimbursement rate was actually provided to the patient.
- ❑ A consultant may advise a client to adopt a patently unreasonable interpretation of a reimbursement law, regulation, or rule to justify substantially greater reimbursement.
- ❑ A consultant may promise to increase Medicare revenues for laboratory services by showing its clients how to disguise double billings and claims for medically unnecessary services.
- ❑ A consultant may suggest the creation of deceptive documentation in order to mislead potential reviewers.

**Discouraging Compliance Efforts.** Some consultants may make absolute or blanket statements that a client should not undertake certain compliance efforts (such as retrospective billing reviews) or cooperate with payer audits, regardless of the client's circumstances. As reflected in the OIG's compliance guidances, the OIG believes that voluntary compliance efforts, such as internal auditing and self-review, are important tools for doing business with the Federal health care programs. Left undetected and therefore, unchecked and uncorrected, improper billing or other conduct may exacerbate fraud and abuse problems for a provider in the future.

## CONCLUSION

Consultants who abuse their position of trust pose a risk to their provider clients, to the Federal health care programs, and to themselves. While most consultants are honest and provide valuable services to their clients, a small minority engage in questionable practices or promote abuse of the Federal health care programs. In general, if a consultant's advice seems too good to be true, it probably is. We urge providers to be vigilant and to exercise judgment when selecting and relying on consultants."

The OIG's compliance guidance's are available at <http://www.hhs.gov/oig>.



## **MEDICARE SECONDARY PAYER FREQUENTLY ASKED QUESTIONS AND ANSWERS FROM ATTORNEYS**

Q. How do I notify Medicare of a possible lien or other MSP situation?

A. When reporting an MSP situation, you should notify the Coordination of Benefits Contractor (COBC) at the address or phone number below. The COBC will add an MSP auxiliary record to the beneficiary's Medicare records, and determine which Medicare contractor will take lead responsibility for handling the case.

Medicare – Coordination of Benefits Contractor  
MSP Claims Investigation Project  
P.O. Box 125  
New York, New York 10274-0125  
1-800-999-1118

Q. What should be included in the letter to Medicare?

- A.
- Your Name
  - The Medicare beneficiary's name
  - The Medicare beneficiary's Health Insurance Claim Number (HICN)
  - Date of Accident
  - Type of accident (i.e. slip and fall, auto accident, etc.)
  - Status of case
  - Projected time frame for settlement
  - Description of your client's injuries
  - Signed Letter of Representation
  - Signed Release of Information Agreement

Q. What would happen if I did not notify Medicare of a possible lien situation?

A. Section 1862(b) of the Social Security Act grants Medicare a priority right of recovery. This section also gives the Medicare program the right of subrogation for any amounts payable to the program under Section 1862 of the Act. In order to recover the conditional payment, Medicare may bring direct action in its own right against the entity responsible or required to pay Medicare, or against any other entity that has received payment. In addition, Medicare has, under subrogation law, a right to recover its payment from an individual or other entity that received payment from a third party payer.

Q. What is the difference between Part A and Part B?

A. Part A is a Medicare beneficiary's hospital insurance.  
Part B is a Medicare beneficiary's medical insurance, which provides partial reimbursement for physician office visits and certain other services.

Q. Does Medicare reduce its claim by the attorneys' fees and costs?

A. Medicare may reduce the amount it is owed by a pro rata share of the procurement costs in liability cases. The formula for this reduction can be found at 42 C.F.R. Section 411.37.

Q. Is Medicare willing to waive its claim amount entirely/partially?

A. Medicare contractors have the authority to consider a Medicare beneficiary's request for waiver on behalf of HCFA, under 1870(c) of the Social Security Act. HCFA may waive all or part of its recovery in cases where an overpayment under Title XVIII has been made with respect to a Medicare beneficiary:

- (a) Who is without fault, AND
- (b) When adjustment or recovery would either:
  - (1) Defeat the purpose of Title II or Title XVIII of the Act, OR
  - (2) Be against equity and good conscience.

Waiver requests must be submitted in writing to the designated lead contractor. Upon receipt of your request, the lead contractor will send you an Overpayment Recovery Questionnaire (HCFA Form 632-BK). This form must be filled out in its entirety, include supporting documentation, and submitted to the lead contractor for consideration. Waivers cannot be requested until Medicare has determined the total Medicare amount (both Part A and Part B) and your claim against the third party has been finally resolved

Q. What does Medicare need from my client in order to process the waiver?

A. Waiver requests must be submitted in writing to the designated lead contractor. Upon receipt of your request, the lead contractor will send you an Overpayment Recovery Questionnaire (HCFA Form 632-BK). This form must be filled out in its entirety, include supporting documentation, and submitted to the lead contractor for consideration. Waivers cannot be requested until Medicare has determined the total Medicare amount (both Part A and Part B) and your claim against the third party has been finally resolved.

The Medicare beneficiary must submit supporting documentation for:

- a) procurement costs;
- b) accident-related out-of-pocket medical expenses incurred; and
- c) expenses and income information which demonstrates financial hardship (if the Medicare beneficiary is alleging financial hardship)

Q. How long will it take for the waiver decision?

A. Waiver cases must be processed within 120 days of receipt of the fully completed request (including a fully documented form 632-BK).

Q. Is it necessary to write separate checks to all the Medicare contractors involved?

A. No, you only need to issue one check and Medicare will notify the other Medicare contractors and make appropriate allocations.

Q. Who do I make the check payable to and where do I send it?

A. Make the check payable to the "Medicare Trust Fund" and mail it to the Medicare contractor processing the case (i.e. the lead contractor).

Q. What do I do when my client believes Medicare claims included in the repayment settlement are not related to the accident/injury giving rise to Medicare's claim?

A. Notify the lead contractor and submit documentation (e.g. medical records, a letter from the attending physician stating the services were not related to the injury, etc.). The contractor will review your request and make a determination based upon the available documentation.

Q. Why is documentation needed to have unrelated claims removed from Medicare's claims list?

A. Medicare cannot make a fully informed decision unless complete and accurate information is submitted. Medicare retains the necessary documentation to provide an audit trail and ensure quality controls are met.

Q. Will my client's Medicare coverage be affected in anyway?

A. Once the case has been settled and Medicare has been refunded its claim amount, Medicare will pay as primary payer on accident-related claims with dates of services (DOS) after the date of settlement. Medicare is NOT the primary payer for accident-related claims with DOS prior to the settlement date, even if the claims are submitted to Medicare after the date of settlement.

Q. What is Medicare's Tax ID number?

A. #52-1385894

Q. How long does Medicare have to recoup money from my client?

A. Under the statute of limitations (28 U.S.C. 2415), Medicare has six (6) years and three (3) months to recover Medicare's claim. The statute of limitations begin at the time Medicare is made aware that the overpayment exists.

Q. Can I request an appeal if I am not satisfied with a waiver decision?

A. Once a waiver decision is reached, you may, within 60 days of the date of the waiver decision, request a reconsideration of the waiver decision. In this instance someone new will review the case. If you are still not satisfied, you may request an appeal and have an administrative law judge (located offsite) review your appeal. You only have 60 days after the date of the decision to request an appeal.

Q. Can Medicare reduce its claim further after the procurement process has been completed?

A. The only other reduction after the procurement process is through the waiver process discussed above.

Q. I have already settled the case and disbursed funds and now I learn from Medicare that I need to reimburse Medicare for claims. What am I supposed to do now?

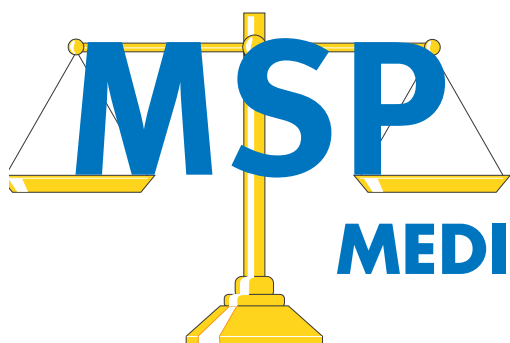
A. Because you are required to notify Medicare prior to settlement, you should supply Medicare with the settlement information and contact your client to inform him/her that Medicare should have been reimbursed. Medicare will send notification to you and your client that Medicare must be reimbursed with the funds received in the settlement. Medicare will research all claims paid related to the accident/injury, reduce its claim by the attorney's costs and fees, and inform the person with Medicare of the repayment amount. If needed, Medicare will set up an installment payment plan for the person with Medicare to relieve some of the burden of repaying Medicare.

Q. What do I do when the settlement amount does not cover Medicare's repayment request?

A. You must request a waiver in writing.

Q. I need a total claim amount from Medicare. How long will this take since I am ready to settle or go to trial?

A. The lead contractor is responsible for obtaining paid-claim information from all Medicare contractors that made payments for accident-related services. Requests for claim information should be submitted as soon as possible, as it may take 6 to 12 weeks to obtain Medicare's total claim amount. Some claim information can be obtained from the Medicare beneficiary's Explanation of Benefits and the hospital/provider/physician who rendered the services. However, we advise that you wait for Medicare's official notice before settling a case, to ensure that Medicare's claim is fully taken into account. Section 1862(b) of the Social Security Act grants Medicare a priority right of recovery, and also gives Medicare the right of subrogation.



**MEDICARE SECONDARY PAYER**

# BENEFICIARY

## FREQUENTLY ASKED QUESTIONS

Q. Please explain the Medicare Summary Notice?

A. The Medicare Part A Summary Notice (MSN) is an explanation of the services that you receive from your doctor, supplier, hospital, or other health care provider. It is not a bill.

The MSN will show some important information such as: the name and address of the provider of care, dates of service, and any amounts that you may be billed.

Q. Where may I get a duplicate MSN?

A. You may call your local Medicare office to get a copy of a duplicate MSN.

Q. Please explain what Medicare A and B covers?

A. Medicare Part A (Hospital insurance), covers services that you receive as an inpatient in a hospital, skilled nursing facility, hospice or home health. Medicare Part B (medical insurance) covers doctor services, durable medical equipment, and some home health services.

Q. I lost my Medicare card. Where can I get another one?

A. You may call the Social Security Administration at 1-800-772-1213 or you may order a new Medicare card on line at [www.medicare.gov](http://www.medicare.gov).

Q. What does MSP stand for?

A. Medicare Secondary Payer. This means that Medicare is the secondary insurance to any employer Group Health plan, auto/liability insurance, Workers compensation plan, or black lung policy.

Q. What is a deductible?

A. A deductible is an amount that you must pay before Medicare will begin to pay for your services. Medicare has two deductibles. The Part A inpatient deductible is \$792.00 per benefit period. This means that the inpatient deductible can be applied every 60 days. The Part B deductible is \$100 dollars every calendar year. The provider of care may bill you directly for the Medicare deductibles unless you have a secondary insurance.



Q. How do I change my address?

A. Contact the Social Security Office at 1-800-772-1213. You must also contact your local Medicare office to change your address on their files.

Q. I received an MSN for services that I did not receive. What should I do?

A. You should first contact the provider/supplier of care and advise them that you did not receive the services. Allow the provider time to research the issue. If the provider does not correct the billing, you may contact your local Medicare office and advise them that you did not receive the services.

Q. Does Medicare cover prescription drugs.

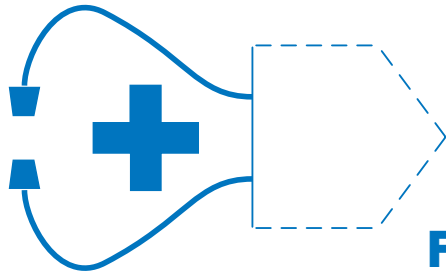
A. At this time Medicare does not cover prescription drugs

Q. Does Medicare cover my care in a nursing home?

A. Medicare does not cover custodial care in a nursing home. Custodial care is care that helps you with usual daily activities like walking eating, or bathing. Medicare does cover skilled care. Skilled care is health care that is given by licensed medical professionals such as a registered nurse, or physical therapist. Examples of skilled care include, physical, occupational and speech therapy..

Q. Was my claim forwarded to my other insurer?

A. Medicare Part A does forward your claim to some secondary insurance's. To find out if your secondary insurance is one that we forward to, please contact our office at 1-800-655-1636 or (410) 252-5310.



## PROVIDER'S FREQUENTLY ASKED QUESTIONS

### Q. Eligibility – HIQA is Down – What Should I Do?

A. Before calling the Provider Service Line, you should:

1. Contact Medicare's help desk to see if your password needs to be reset. The phone number is 410-998-6400.
2. If the problem is with dialing or network connection you need to Contact your local IT department.
3. All other problems contact Medicare's IT department at 410-561-4122, 410-561-4299, or 410-561-4145

### Q. Overlapping Claims – What Medicare Provider is causing the overlap?

A. Per CMS's Privacy Act, Medicare can only speak with providers about his/her claims. We cannot discuss other provider's claims. We suggest:

1. Checking the patient's medical records, doctors or nurses notes
2. Contacting the patient and/or family member.
3. Refer to the July 2001 Intermediary Newsletter.

### Q. Who is Primary Payer?

A. It is the provider's responsibility to obtain the primary payer information when the beneficiary receives service. It is vital that this information is shared with the billing staff to identify the primary payer. The billing staff needs to:

A. Use information obtained from the MSP questionnaire and code your claim accordingly.

Examples:

1. If the patient states they or their spouse are not working, record the retirement date using the occurrence code 18 for the date the patient retired and/or 19 for the date of their spouses' retirement.
2. Code the claim using the correct condition codes to Indicate Medicare is Primary.
  - 08 – Beneficiary would not provide information concerning insurance
  - 09 – Neither patient nor spouse is employed.
  - 10 – Patient or spouse is employed but no EGHP coverage exists.
  - 11 – Disabled Beneficiary but no LGHP
3. If Medicare is secondary Per the MSP Questionnaire:
  - A. Make sure the correct payer code is used
    1. "A" Working Age
    2. "B: ESRD
    3. "C" Conditional Payment
    4. "D" Auto no Fault
    5. "E" Workers Compensation
    6. "G" Disable

- B. Make sure the correct value code is used
  - 1. "12" Working Age
  - 2. "13" ESRD
  - 3. "14" Auto no Fault
  - 4. "15" Worker's Compensation
  - 5. Insurer's completed name and address
- C. Use the remarks area to give any additional information helpful to update or correct the MSP files shown on HIQA. Also record why the other payer did not make payment when billing for Conditional payment.

## Return to Provider (RTP) Report

Are you looking for a way to better manage your receivables? We have the answer you are looking for. A report is available that will give you the total number of times that claims were returned to your provider, by reason code, on a monthly basis. This will allow you to educate your staff and/or make corrections to your system, so that your claims will come in as clean as possible. If you would like to receive a copy of this report, please contact your assigned provider representative and they will send one out to your office.

## Can I adjust or cancel my claim when services are rejected or denied?

When your claim is fully or partially rejected or denied it affects your ability to adjust or cancel your claim. Here are the guidelines for getting your claim adjusted or cancelled:

**First, determine why the charges were in non-covered.**

This can be done by reviewing the current version of the remittance notice or through DDE.

**In DDE:**

Go to page 2 of DDE and using the tab key, go to the line that is in non-covered and press the F2 key. The bottom of the screen will display the non-covered charges and the "denial reason" code.

For an explanation of the denial code, tab to the SC field and enter 17, then enter the denial code.

The reason for charges being in non-covered will be displayed. To return to the claim press F3.

### **If the claim is a Partial Reject (claim status PB9997) with Line item(s) rejected:**

- ▶ You can adjust but must delete the entire line and re-key it below the total charges line.
- ▶ You can cancel the claim following your normal procedures.

### **If the claim is a Partial Denial (PB9997) with Line item(s) denied (reason code 5XXXX):**

- ▶ To adjust something other than the denied charge: you must submit a hardcopy adjustment with the changes marked in red and remarks indicating what is to be adjusted.
- ▶ To adjust something related to the denied charge, you must submit an appeal.
- ▶ To cancel the claim you must submit a hardcopy request with remarks indicating why you want the claim cancelled.

### **If the claim is a Full Reject (RB9997)**

- ▶ You cannot adjust or cancel.
- ▶ If the claim is posted to the Common Working File any adjustment must be done by the FI.
- ▶ If the claim is not posted to the Common Working File, you can resubmit the claim.

### **If the claim is a Full Denial (DB9997):**

- ▶ You cannot adjust or cancel.
- ▶ You must appeal.

### Canceling a Claim

Requests for claims to be canceled with medical review denials will no longer be accepted over the phone. To identify a claim with a medical review denial, you need to go to page 2 on the DDE claim inquiry screen (option 12). Find the line that has non-covered charges. Next, place your cursor on that line and press "F2". If the denial reason code, located at the bottom of the page, begins with a "5" (e.g.-56900), that is a medical review denial. If you need to cancel a claim that has any charges within the claim denied by medical review, you must send the claim along with an explanation for the cancel on the claim form to the following address.

CareFirst of MD, Inc.  
Medicare A – Claims Department  
1946 Greenspring Drive  
Timonium, MD 21093

### WEB LINKS

[WWW.HCFA.GOV/MEDICARE/HOPSMAIN.HTM](http://WWW.HCFA.GOV/MEDICARE/HOPSMAIN.HTM) – Outpatient Prospective Payment System

[WWW.LMRP.NET](http://WWW.LMRP.NET) - Local Medical Review Policies

[WWW.HCFA.GOV/MEDICARE/EDO/EDO3.HTM](http://WWW.HCFA.GOV/MEDICARE/EDO/EDO3.HTM) – Medicare EDI (Electronic Data Interchange) Formats

[WWW.HCFA.GOV/MEDLEARN](http://WWW.HCFA.GOV/MEDLEARN) – Medicare Learning Network

[WWW.HIPAA.COM](http://WWW.HIPAA.COM) – Health Insurance Portability and Accountability Act

[WWW.HCFA.GOV/AUDIENCE/PLANPROV.HTM](http://WWW.HCFA.GOV/AUDIENCE/PLANPROV.HTM) – Program Memorandums/Manuals

[WWW.HCFA.GOV/MEDICARE/PFSMAIN.HTM](http://WWW.HCFA.GOV/MEDICARE/PFSMAIN.HTM) – Physician Fee Schedules

[WWW.HCFA.GOV/MEDLEARN/TOLLNUMS.HTM](http://WWW.HCFA.GOV/MEDLEARN/TOLLNUMS.HTM) – Medicare Contractors, Phone Numbers

[WWW.HCFA.GOV/MEDICARE/COB](http://WWW.HCFA.GOV/MEDICARE/COB) – Coordination of Benefits Contractor



PROVIDER RELATIONS  
TOLL FREE PHONE NUMBER

866-488-0545

M E D I C A R E P R O V I D E R N E W S L E T T E R

Intermediary  
NEWS

HCFA