A Publication for all Medicare Part B Providers

Medicare News Brief--New York

ISSUE NO. MNB-NY-2002-6

EMPIRE MEDICARE SERVICES
A Centers for Medicare & Medicaid Services Contractor

JUNE/JULY 2002

Inside

MEDICARE ON THE WORLD WIDE WEB

CMS Web Site: http://www.cms.hhs.gov

Visit our Web Site: http://www.empiremedicare.com

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins issued after November 1996 are available at no cost from our Web site at *www.empiremedicare.com*

The Medicare News Brief Is Changing

In an effort to better serve our providers in New Jersey and New York, Empire Medicare Services is making a change to *The Medicare News Brief*. Beginning with the August/September 2002 issue, New Jersey and New York information will be included in the same publication. In addition, local medical review policies (LMRP) will be published in a separate, combined publication three times per year. Watch for the new policy cover beginning with the first issue, June 2002.

The new schedule is as follows:

Regular Combined Issues:
August/September 2002 (mail date 8/30)
October/November 2002 (mail date 10/31)
December/January 2003 (mail date 12/31)
February/March 2003 (mail date 2/28)
April/May 2003 (mail date 4/30)
June/July 2003 (mail date 5/30)

Policy Combined Issues:
June 2002 (mail date 5/31)
October 2002 (mail date 9/30)
February 2003 (mail date 1/31)

Fees Combined Issue:
2002 (mail date 11/29)

Providers will continue to see the same informative articles in the new format that they did previously. Information that is exclusive to New Jersey or New York will be easily identifiable throughout the new publication. Look for this new cover beginning in August/September!

Contents

Important Telephone Numbers and Addresses

Telephone Numbers

Automated Response Unit (ARU)	(877) 869-6504
Claim Entry (MTCE)	(631) 244-5300
Claim Entry (MTCE) Information	(212) 476-7934
Claim Status and Information	
Part A	(877) 567-7205
Part B	(877) 869-6504
Durable Medical Equipment	(866) 419-9458
EMC Marketing	
Medicare Telephone	(212) 476-7952
Health Professional Shortage Area (HPSA) and EMC Audit	(315) 442-4600
IES Technical Help Desk	(315) 448-0080
Limiting Charge/Fee Schedule	(877) 869-6504
Medicare Fraud Information Specialist	(315) 442-4126
Reimbursement	(877) 869-6504
Status of Provider Enrollment Application (individual or group)	(877) 869-6504
UPIN Number Information	(877) 869-6504
UPIN Fax Number	(914) 248-2816

Addresses

Provider Changes
Provider Enrollment
Empire Medicare Services
Reimbursement Department
P.O. Box 1200
Crompond, NY 10517-1200

Fair Hearing Requests
Empire Medicare Services
P.O. Box 1206
Crompond, NY 10517-1206

Mail Assigned Claims to:
Empire Medicare Services
P.O. Box 100
Yorktown Heights, NY 10598

Non-assigned Claims to:
Empire Medicare Services
P.O. Box 355
Crompond, NY 10517

Health Professional Shortage Area (HPSA) and EMC Audit
Empire Medicare Services
P.O. Box 4716
Syracuse, NY 13221-4716

UPIN Directories (CD/ROM version)
Quality Assurance and Coordination Dept.
P.O. Box 1201
Crompond, NY 10517

Back Issue Requests
Empire Medicare Services
Mail Drop 3-1
P.O. Box 4846
Syracuse, NY 13221-4846

Part B Appeals & Correspondence
Empire Medicare Services
P.O. Box 2280
Peekskill, NY 10566

The Medicare News Brief *in Portable Document Format (PDF)*

Empire Medicare Services is offering providers a new option for receiving *The Medicare News Brief*. Rather than sending you hard copies of each issue, we will notify you via E-mail that the most recent issue is available to be downloaded from our Web site in the form of a PDF (Portable Document Format) file.

There are several benefits to electronic *News Briefs*:

- Receive information 2-3 weeks earlier than the hard copy;
- Choose the information you want to view and/or print;
- Reduce the amount of paper you receive in your office.

In order to view the *News Brief* as a PDF file, you must have Acrobat Reader installed on your computer. You can **download it for free off the Internet at:** http:\\www.adobe.com. Just click on the "Get Acrobat Reader" icon for easy-to-follow instructions.

To begin receiving this service, complete the form below and return it to the address indicated.

Release Statement

I _____, agree to discontinue receiving *The Medicare News Brief*, the Part B provider bulletin, in hardcopy form. I wish to begin to receive my copy in PDF format and agree to complete the confirmation form prior to downloading.

Empire Medicare Services agrees to notify the requester via E-mail that the file is available.

The requester may, at any time, for whatever reason, return to receiving a hardcopy by notifying us. We will institute the hardcopy with the next mailing. Should the requester decide to discontinue the PDF notification, the requester must send an E-mail to:

ltaylor@empirebcbs.com

Please print and mail this completed form to:

Empire Medicare Services
Medicare Communications Department
Mail drop 3-1
P.O. Box 4846
Syracuse, NY 13221-4846

Provider Name:	_____
Provider Number (If applicable):	_____
E-mail Address:	_____
Telephone Number:	_____
Date	Signature

Medicare Part B Seminars

INTRODUCTION TO MEDICARE NO FEE
This seminar is designed for providers and their staff members who are new to the Part B program.The program features an overview of the Medicare program as well as a coding and claim filing workshop. Emphasis is placed on the completion of the CMS-1500 claim form. **9:30 a.m. - 12:30 p.m.**

CMS-1500 CLAIM FORM $35 FEE
This seminar offers an in-depth review of the CMS-1500 claim form for both electronic and paper submitters. Emphasis is directed towards proper CPT/HCPCS code selection and the relativity of the ICD-9-CM code for the service rendered. Additional featured topics are the correct use of modifiers and how to translate the Medicare remittance statement.

COMPLIANCE/MEDICARE INTEGRITY PROGRAM $35 FEE
This seminar reviews the OIG Compliance Program Guidelines for individual and small group practices and provides information on how providers can protect their practice and safeguard the Medicare program.

ADVANCED MEDICARE $50 FEE
This seminar is intended for providers and their staff who have a basic knowledge of the Part B program.Topics included are Modifiers, Evaluation & Management Guidelines, General Medical Policy, General Surgery Concepts, Appeals Process, Correct Coding and Drugs & Biologicals. Medicare compliance is also a featured topic. **9:30 a.m. - 3:00 p.m.**

TOPICS/SPECIALTY $35 FEE
This seminar offers education and training related to specific Medicare topics (e.g., Modifiers, Evaluation and Management, etc.) or to specific provider specialties (e.g., Anesthesiology, Cardiology, Ophthalmology, etc.). Additionally, limited licensed practitioner seminars are offered (e.g., Chiropractor, Psychologist/Social Worker).

UPDATES NO FEE
These seminars are offered to provide information regarding all new and revised policies, procedures, and guidelines as they pertain to the Medicare Part B program. Information is generally updated every 3 to 4 months or on an "as needed" basis.

Note

Registration form *must* be received in our office five business days prior to the seminar you wish to attend in order to reserve your space.

Checks will NOT be accepted at the door.

SEATING IS VERY LIMITED!

For more information, please call (914) 248-2819 for *Yorktown Heights* (631) 244-5410 for *Manhattan/Long Island*

Locations and Directions

MANHASSET
North Shore University Hospital
(Conference Room #5)
300 Community Drive
Manhasset, NY 11030
(Exit 33 off the LIE)

MANHATTAN
800 Second Avenue, 3rd Floor
New York, NY 10017
(Between 42nd and 43rd Streets)

OCEANSIDE
South Nassau Communities Hospital
2445 Oceanside Road
Oceanside, NY 11572

STONY BROOK
University Hospital & Medical Center
at Stony Brook Health Sciences Center
4th Floor, OVP Conference Room
Stony Brook, NY 11790
(Exit 62 N. off the LIE)

YORKTOWN HEIGHTS
Taconic Corporate Park
2651 Strang Boulevard
Yorktown Heights, NY 10598
(Route 202, off Taconic Parkway,
near Franklin D. Roosevelt Park)

SEMINAR TIMES

Specialty Seminars indicating *a.m.* are from 9:30 a.m. - 12:30 p.m.
Specialty Seminars indicating *p.m.* are from 1:30 - 4:30 p.m.
Specialty p.m. Seminars MANHATTAN ONLY 1:00 - 4:00 p.m.

Introduction to Medicare Seminars 9:30 a.m. - 12:30 p.m.
Advanced Medicare Seminars are from 9:30 a.m. - 3:00 p.m.

Compliance/MIP Seminars indicating *a.m.* are from 9:30 a.m - 12:30 p.m.
Compliance/MIP Seminars indicating *p.m.* are from 1:30 - 4:30 p.m.

Provider Education and Training Seminar Schedule

July through September 2002

LONG ISLAND

Oceanside

p	July 16	Chiropractic - a.m.
p	August 20	Orthopedic Surgery - a.m.
p	September 17	General Medical Practices - a.m.

Stony Brook

p	July 11	Introduction to Medicare
p	August 8	General Surgery - a.m.
p	September 12	General Medical Practices - a.m.

Manhasset

p	July 31	Evaluation & Management - a.m.
p	August 28	Gynecology - a.m.
p	September 25	Private Practice Physical/Occupational Therapy - a.m.

YORKTOWN

p	July 16	Advanced Medicare
p	July 30	Oncology - a.m.
p	July 30	General Surgery - p.m.
p	August 27	Preventive - a.m.
p	August 27	Mental Health - p.m.
p	September 10	Chiropractic - a.m.
p	September 10	Private Practice Physical/Occupational Therapy - p.m.

MANHATTAN

800 2nd Avenue

p	July 9	Chiropractor - a.m.
p	July 9	Compliance - p.m.
p	July 10	Oncology - a.m.
p	July 10	General Surgery - p.m.
p	July 17	Advanced Medicare
p	July 18	Gastroenterology - a.m.
p	July 18	Modifier/Correct Coding - p.m.
p	July 23	Evaluation & Management - a.m.
p	July 23	Introduction to Medicare - p.m.
p	July 24	Urology - a.m.
p	July 24	Anesthesia - p.m.
p	August 7	Introduction to Medicare - a.m.
p	August 7	Compliance - p.m.
p	August 13	Podiatry - a.m.
p	August 13	Dermatology - p.m.
p	August 15	Orthopedic Surgery - a.m.
p	August 15	Gynecology - p.m.
p	August 21	Preventive Medicine - a.m.
p	August 21	Mental Health - p.m.
p	August 27	Advanced
p	September 12	Physical Medicine & Rehabilitation - a.m.
p	September 12	Evaluation & Management - p.m.
p	September 18	Advanced Medicare
p	September 19	Compliance - a.m.
p	September 19	CMS-1500 Claim Form - p.m.
p	September 24	Private Practice Physical/Occupational Therapy - a.m.
p	September 24	Introduction to Medicare - p.m.
p	September 26	General Medical Practices - a.m.
p	September 26	Cardiology - p.m.

a.m. seminars are 9:30 a.m. to 12:30 p.m.
p.m. seminars are 1:30 to 4:30 p.m.
Manhattan ONLY p.m. seminars are 1:00 - 4:00 p.m.

Please check the box for the appropriate seminar(s) above and enclose a check or money order made payable to Empire Medicare Services. You will receive confirmation via telephone upon receipt of this registration form and payment.

Seats can NOT be reserved without your payment!

ATTENDEE NAME & JOB TITLE _____

ATTENDEE NAME & JOB TITLE _____

PROVIDER NAME OR NUMBER _____

BUSINESS TELEPHONE *(Required for confirmation)* _____

BUSINESS ADDRESS _____

EMAIL ADDRESS (*To receive notification of future seminars*) _____

Yorktown Seminars

Mail To:
Empire Medicare Services
P.O. Box 1200
Crompond, NY 10517-1200

Fax:
(914) 248-3782

Long Island and Manhattan Seminars

Mail To:
Empire Medicare Services
P.O. Box 407
Bohemia, NY 11716

Fax:
(631) 244-5310

EMC Claim Submission Seminars

Introduction to Electronic Claims Seminars

At this seminar, we explore the many options available to your practice for electronic submission, learn how to automate your practice, and see demonstrations of Empire's Electronic Claim Product: PC-ACE ™ PRO32.

Electronic Claim Submitter User Group

These seminars are designed for medical practices that currently submit Medicare Part B and Empire Blue Cross Blue Shield claims electronically. At these seminars, we discuss the EMC enrollment process, review confirmation and validation reports, and discuss the most common error messages and claim submission exclusions.

EMC Seminar Locations

Bohemia
25 Orville Drive
Bohemia, NY 11716
(off Veterans Highway)

New York City
800 Second Avenue, 3rd Floor
New York, NY 10017
(Between 42nd and 43rd Streets)

Yorktown Heights
Taconic Corporate Park
2651 Strang Boulevard
Yorktown Heights, NY 10598
(Rt. 202, off Taconic Parkway, across from Franklin D. Roosevelt Park)

Registration form must be received in our office five business days before the seminar you wish to attend in order to reserve your space.

Your reservation will be confirmed with a telephone call from our office.

We reserve the right to cancel due to insufficient enrollment.

All a.m. seminars are from 9:30 a.m. to 12:30 p.m.
All p.m. seminars are from 1:00 to 4:00 p.m.

Electronic Claim Submission
Seminar Registration Form

Please place a **4** in the session(s) you wish to attend.

July through September 2002

Introduction to
Electronic Claims

New York City
- ❑ July 16 - a.m.
- ❑ August 1 - a.m.
- ❑ September 17 - a.m.

Yorktown Heights
- ❑ July 17 - a.m.
- ❑ August 14 - p.m.
- ❑ September 18 - a.m.

Bohemia
- ❑ July 18 - a.m.
- ❑ August 7 - a.m.
- ❑ September 11 - a.m.

Submitter/User
Group Seminars

New York City
- ❑ July 11 - a.m.
- ❑ August 22 - a.m.
- ❑ September 25 - a.m.

Yorktown Heights
- ❑ July 17 - p.m.
- ❑ August 14 - a.m.
- ❑ September 18 - p.m.

Bohemia
- ❑ July 24 - a.m.
- ❑ August 28 - a.m.
- ❑ September 19 - a.m.

All a.m. seminars are from 9:30 a.m. to 12:30 p.m.
All p.m. seminars are from 1:00 to 4:00 p.m.

Please print the following information:

Attendee Name and Job Title

Attendee Name and Job Title

Provider Name or Number

Business Telephone (Required for Confirmation)

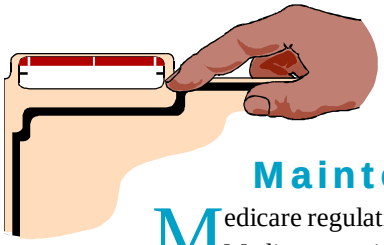
Business Address

Copy, complete and mail to:

Empire Medicare Services
Attn: EMC Seminars
800 Second Avenue, 3rd Floor
New York, NY 10017

FAX: (212) 476-7110 **Telephone: (212) 476-7952**

Provider Enrollment



Provider File Maintenance

Medicare regulations indicate that the Medicare carrier is responsible for maintaining accurate files on all providers who submit claims to the Medicare program.

Section 1001.2 of the Medicare Carriers Manual instructs the carrier to inactivate provider records if no claims have been submitted within one year.

Beginning October 1999, providers who have not submitted claims in the previous twelve months will be deactivated. Before billing, providers are required to re-enroll in the Medicare program by completing the CMS-855I or CMS-855B, as applicable, General Enrollment application if their provider number has been deactivated.

Group practices are responsible for informing the carrier of any changes to their practice. This includes adding a new member, or letting us know when a member leaves your employ. This is accomplished by submitting the CMS-855R form to us. Changes in the authorized representative/ delegated official must also be reported to us using the CMS-855B. All changes must be reported within 30 days of the effective date of the change.

Any group provider who did not enroll using the 855 enrollment application will be required to complete the CMS-855B application before any additional changes are made to your practice (i.e., adding new members).

Changes to the Provider Enrollment Process

While the new regulations governing the enrollment of a provider into the Medicare Part B program became effective July 1, 2001, the new applications became available on November 1, 2001. These applications are being used for providers who wish to enroll in the Medicare program, to reactivate an inactive provider number or to make changes to their currently active provider number. **We can no longer accept the old version of the applications (i.e., HCFA-855, HCFA-855C, HCFA-855R) .**

As a result of the new regulations in the enrollment process, some changes have taken place. Some of these changes are:

CHANGES OF INFORMATION MUST BE SUBMITTED ON THE APPROPRIATE CMS-855I OR CMS-855B FORM. Please complete the applicable section of the application, sign and date the certification statement and return ONLY THOSE SECTIONS to us.

The effective date of your Medicare Part B provider number will be the date you started practicing at the location where you are enrolling. Prior to July 1, 2001, your effective date was the date you became a licensed provider in New York State, or the date your specialty was covered under Medicare, which ever was later.

To expedite our requests for additional information, we will be calling you (or the person you have indicated as the contact person) to let you know that we need some additional information. We will be asking you to complete only the missing information, and re-sign and date the certification statement. Whenever possible, we will fax the section of the application to you, but you must return it to us through the postal service.

Certain sections of every enrollment form are required, and the forms cannot be processed if these fields are left blank.

Please be sure to check the instructions indicated throughout the form to make sure you are completing the required fields.

Please remember that our goal in the enrollment process is to ensure that only qualified and eligible individuals are enrolled in the Medicare program and receive reimbursement for services furnished to beneficiaries. We are also working to make sure that all changes made to our existing provider files are requested and authorized by you, our customer. That is why we make every attempt to speak directly to you to validate changes of information.

The new provider enrollment forms for Part B providers are:

- ✓ **CMS-855I** This form is used to enroll individual providers, reactive an inactive individual provider number, and to make changes to your current provider file.
- ✓ **CMS-855B** This form is used to enroll suppliers and organizations (Ambulance suppliers, Independent Diagnostic Testing Facilities, Ambulatory Surgery Centers, group

providers, etc.), reactivate an inactive provider/supplier number and to make changes to existing records.

✓ **CMS-855R** This form is used by individual providers who wish to reassign their Medicare benefits to their employer.

Electronic Medicare Provider/ Supplier Enrollment Forms

Empire Medicare Services (EMS), in conjunction with the Centers for Medicare & Medicaid Services (CMS), announces the availability of electronic Medicare Provider/Supplier Enrollment forms. These forms can be accessed at www.hcfa.gov/medicare/enrollment/forms on the CMS Web site. For your convenience, a comprehensive user guide providing detailed instructions on how to download these applications is also available. These forms can be completed on the computer, saved as a file and printed for submission; **however, they cannot be sent electronically due to the requirement of original signatures.**

Form Names and Usage:

- Application for Individual Health Care Practitioners (855I) – Individual enrollment, re-enrollment and changes
- Application for Health Care Suppliers That Will Bill Medicare Carriers (855B) – Group or organization enrollment, re-enrollment and changes
- Application for Individual Health Care Practitioners to Reassign Medicare Benefits (855R) – Adding or deleting group affiliation of an individual

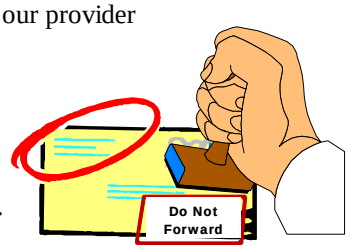
Completed forms should be mailed to:

Empire Medicare Services
Part B NY
P.O. Box 1200
Crompond, NY 10517-1200

If you have any questions, please contact our Provider Inquiry Department at 1-877-869-6504, or visit our Web site at www.empiremedicare.com.

Do Not Forward Initiative Expanded

On July 1, 2000, Empire Medicare Services discontinued the practice of forwarding Medicare checks to locations other than those recorded on our provider files.



Beginning October 1, 2002, this initiative is being expanded to include remittances as well as checks. When the post office returns a remittance advice to us due to an incorrect address, your provider file will be "flagged," and we will not be able to send any checks or remittance advice until your provider file is updated. This will also apply to providers who are paid through EFT (Electronic Funds Transfer).

Changes to your provider file can only be made when you submit the applicable sections of the CMS-855I or CMS-855B, depending on your provider type.

These forms can be accessed at www.hcfa.gov/medicare/enrollment/forms, or you can request the forms through our Provider Inquiry Department at (877) 869-6504.

Please be sure to notify us of any changes to your provider file within 30 days of the change.

Frequently Asked Questions

Most Frequently Asked Questions

1. **What information is required to obtain patient eligibility information from the Provider Customer Service area?**

Ans. 1 Provider's name and provider number
2 Beneficiary's last name and first initial
3 Beneficiary's date of birth
4 Beneficiary's Health Insurance Claim (HIC) number
5 Beneficiary's gender

**These items must match our files exactly.

2. How long do I have to submit a claim to Medicare?

Ans. Claims must be submitted no later than 15 months after the end of the federal fiscal year in which the service occurred. The federal fiscal year starts on October 1 and ends on the following September 30. There is a window of 15 to 27 months to file a claim, depending on when the service was rendered in the fiscal year. However, after 12 months, a 10 percent late filing fee reduction will be applied.

3. I just received a letter stating my provider number was terminated. Why?

Ans. The Medicare Carriers manual instructs the carrier to inactivate provider records if no claims have been submitted within one year. Providers who have not submitted claims in the previous twelve months will be deactivated.

4. What do I need to do to reactivate my provider number?

Ans. Before billing, providers are required to re-enroll in the Medicare program by completing the CMS-855I or CMS-855B.

5. I saw the patient in the hospital for a consultation and decided the patient needed surgery. Can I get paid for the consultation?

Ans. Evaluation and management services on the day before **major surgery** or on the day of **major surgery** that result in the initial decision to perform the surgery **are not included in the global surgery payment for the major surgery**, and, therefore, may be billed and paid separately. Physicians are instructed to use modifier 57 (decision for **major** surgery) to identify a visit which resulted in the initial decision to perform **major** surgery.

6. If a claim was returned/rejected for missing or invalid information and it needs to be resubmitted with the correct information, will it just deny as a duplicate?

Ans. No. If a claim has been returned/rejected and a corrected claim is received, it will not deny as a duplicate. The only claims that Medicare would deny as duplicates are those that have previously been paid or those that are currently still in process.

7. How do I bill Medicare when I need to use more than 2 modifiers?

Ans. When the procedure code requires more than two modifiers, you would use modifier 99 on the specific line of coding and list all modifiers that apply in Box 19 on the CMS-1500 form. If you bill electronically, you would list the modifiers in the narrative record.

8. Why are my chemotherapy administration codes being denied as "not medically necessary" when they are submitted with a payable diagnosis code?

Ans. Claims for chemotherapy administration submitted without a chemotherapy drug on the same day/same claim or without the name of the chemotherapy drug being infused accompanying the claim, will be denied as not medically necessary.

9. What does it mean when the ARU says "We do not have a record of any claim for the date you entered?"

Ans. It means we did not receive a claim from you for that date of service. If it was a paper claim and it has been more than four weeks since you sent it in, or if it was sent electronically and it's been more than three billing days, you should resubmit.

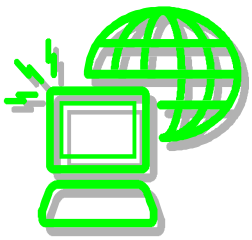
10. Why are my claims for CLIA waived tests being denied?

Ans. Even though the test you are billing for is a CLIA waived test, the CLIA number must be submitted on your claim.

11. I billed a claim for an inpatient hospital visit and an emergency room visit. I entered the hospital information in Box 32 of the CMS-1500 form. Why was my claim rejected?

Ans. Claims submitted for services rendered in a setting other than the provider's office, or the beneficiary's home must have the name and full address (including the zip code) of the facility where the services were rendered. When billing for different places of service and each place requires the facility information in Box 32, a separate claim must be submitted for each service with the appropriate information in Box 32.

New Source of Provider Information Available on the CMS Web Site



The Centers for Medicare & Medicaid Services (CMS) released the first issue of *The CMS Quarterly Provider Update* on April 22, 2002. Future issues will be released the first work day of each subsequent calendar quarter. These quarterly *Updates* will include all changes to Medicare instructions that affect providers, or may be of interest to them. They will provide a single source for national Medicare provider information and give providers advance notice of upcoming instructions and regulations.

The first release is a Web-based document and is available at http://www.cms.hhs.gov/providerupdate. For ease of use by individual providers, regulations and instructions are collated and sorted based on the interests of the user.

Each *Update* will include the full text of instructions to be implemented 90 or more days after its release. For example, instructions included in the April *Update* will have an implementation date of July 1, 2002 or later. The listings of regulations will be presented in two parts. One part will list all regulations CMS plans to publish within the next 90 days. The second part will include hyperlinks to the text of all regulations published in the previous quarter.

CMS's goal is to make it easier for providers to understand and comply with Medicare regulations and instructions and to give them time to review and react to upcoming program changes. To improve future issues of the *Update* and ensure they are responsive to provider needs, a feedback form will be included with each issue. CMS encourages anyone accessing the *Update* to use the feedback form to forward comments on its utility, organization, and format.

Forms and Publications

The November/December Issue of *The Medicare News Brief*, MNB-NY-2001-11, advised that the Health Care Financing Administration (HCFA) had changed their name to the Centers for Medicare & Medicaid Services (CMS). As part of this transition to their new name, CMS is updating forms and publications with a new prefix, i.e., the HCFA-1500 is now the CMS-1500.

Since the change will occur in phases, you will continue to see the use of the HCFA prefix on some forms and publications. The form number and the name of the form or publication will remain the same. The HCFA prefix versions are still valid until CMS completes the conversion.

Sanctioned and Reinstated Providers

We will be publishing a list of sanctioned and reinstated providers for the State of New York in our bulletin routinely. By publishing this list, it is our intention to keep the provider community advised of those providers who have been excluded from the Medicare program. This list is also intended to inform you when a provider has been reinstated.

We will deny payment to any excluded provider for items or services furnished, ordered or prescribed by a provider, facility or supplier on or after the effective date of the exclusion.

Sanctioned Providers:

Name/Specialty/Address	Effective Date	Reason for Exclusion
Aubrey Ku, General Practice New York, New York	4/18/2002	1128(a)(1)
Niels Lauersen, Gynecologist Brooklyn, New York	4/18/2002	1128(a)(1)
Richard E. Pearl, Orthopedist Brooklyn, New York	4/18/2002	1128(a)(1)
David Rosenberg, Podiatrist Atlantic Beach, New York	4/18/2002	1128(b)(4)
Mindy L. Scott, Chiropractor Huntington, New York	4/18/2002	1128(a)(1)
Marc M. Waldman, Podiatrist Bronx, New York	4/18/2002	1128(b)(14)

Reasons for Exclusion:

1128(a)(1) Convicted of a crime involving the Medicare, Medicaid, maternal and child health services block grant or block grants to states for social services programs
1128(a)(2) Convicted of a crime related to patient abuse or neglect
1128(a)(3) Felony conviction relating to health care fraud
1128(a)(4) Felony conviction relating to controlled substance violations
1128(b)(2) Conviction relating to obstruction of an investigation
1128(b)(3) Conviction relating to controlled substances
1128(b)(4) License revocation or suspension
1128(b)(5) Suspension or exclusion under a Federal or State health care program.
1128(b)(6) Excessive claims or furnishing of unnecessary or substandard items or services
1128(b)(7) Fraud, kickbacks and other prohibited activities
1128(b)(8) Entities owned or controlled by a sanctioned individual
1128(b)(14) Default on health education loan or scholarship obligations

Reinstated Providers

No reinstated providers.

Reporting the Obligated to Accept as Payment in Full (OTAF) Amount on the ANSI X12N 837 Version 4010 as Adopted Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for Medicare Secondary Payer (MSP) Claims

Utilizing the X12N 837 (Version 4010) When Submitting Medicare Secondary Payer (MSP) Claims

Effective October 16, 2002, Part B physicians and suppliers must submit all electronic MSP claims data to Medicare using the ANSI X12N 837 (version 4010), unless physicians and suppliers request a one-year extension to comply with HIPAA version 4010 under the provisions of the Administrative Simplification Compliance Act. Currently, there are fields to identify the other payer's allowed and paid amount on the 837, however, there is no field on the 837 to specifically identify the OTAF amount. The OTAF amount is a payment (which is less than your charges) that you are obligated to accept or agreed to accept as payment in full satisfaction of the patient's payment obligation. On most claims, the OTAF amount is greater than the amount the primary payer actually paid on the claim. The Medicare program uses the OTAF amount(s) when calculating its secondary liability on such claims when services are paid on other than a reasonable charge basis.

When you migrate to the X12N 4010 837, you must use the line level contract information (CN1) segment to report the OTAF. Report the OTAF in CN102 (Contract Amount) with a qualifier of "09" (Other) in CN101. If MSP data is received at the claim level, report the OTAF in 2300 CN102. If MSP data is received at the line level, report the OTAF in 2400 CN102. The X12N 4010 837 Professional Implementation Guide allows for claim level OTAF reporting using the CN1 segment as described above, as well as line level reporting using the line level CN1 segment. Furnish line level primary payer data, including the OTAF amount, when available.

The chart on the next page identifies the segments and data elements that you must use to report: (1) the submitted charges, (2) the primary payer paid amount, (3) the primary payer allowed amount, and (4) the OTAF amount at the claim and the service line levels.

	837/3051	NSF	837 v 4010	Comments
Claim Total Submitted Charge	2-130-CLM02	XA0-12	2300 CLM02	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or supplier.
Claim Primary Payer Paid Amount	2-300-AMT02 AMT01 = D	DA1-14	2320 AMT02 AMT01 = D	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim Primary Payer Allowed Amount	2-300-AMT02 AMT01= B6	DA1-11	2320 AMT02 AMT01 = B6	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim OTAF Amount			2300 CN102 CN101=09, if 2400 CN101=09 is not available	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or supplier. The claim level CN1 should be used only when the service line CN1 is not available.
Line Submitted Charge	2-370-SV102	FA0-13	2400 SV102	None
Line Primary Payer Paid Amount	2-475-AMT AMT01 = D	FA0-35	2430 SVD02	None

For more information on the 837 HIPAA version 4010, see the following issues of the *Medicare News Brief*: MNB-NY 2002-1, 2001-10, and 2001-11, or visit our Web site at: www.empiremedicare.com/hipaa/hipaaindex.htm.

Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Claims Status Request/Response Transaction Standard 276/277

Trading Partner Agreement for 276/277 ASC X12N Version 4010

This Trading Partner Agreement (TPA) provides instructions on Medicare requirements for their implementation of version 4010 of the Accredited Standards Committee (ASC) X12N 276/277 health care claims status request and response format as established in the 004040X093 Implementation Guide (IG). In order to implement the HIPAA administrative simplification provisions, the 276/277 has been named under part 162 of title 45 of the Code of Federal Regulations as the electronic data interchange (EDI) standard for Health Care Claim Status Request/Response. All other EDI formats for health care claim status request and response become obsolete October 16, 2003.

The version 4010 implementation guide for the 276/277 standard may be found at the following Web site: www.wpc-edi.com/HIPAA. The 276/277 is a "paired" transaction (the 276 is an inbound claim status request and the 277 is an outbound claims status response).

- EDI requests for claim status must be submitted via a 276 version 4010 query effective October 2003, and that each valid 276 will be issued a 277 version 4010 response. Prior claims status formats will be discontinued effective October 2003, although the information will still be available via DDE, ARU, or other non-EDI method a contractor has elected to continue to support.

- A provider that prefers to obtain claim status data in an EDI format but who does not choose to support the 276/277 may contract with a clearinghouse to translate the information on their behalf; however, that provider would be liable for those clearinghouse costs.

- The version 4010 276/277 implementation guide can be downloaded without charge from www.wpc-edi.com/HIPAA.

- Providers, agents, and clearinghouses are not required, in most cases, to be tested on their 276/277 interface prior to initial submission of a 276 or request for receipt of a 277, although they are required to notify Empire Medicare Services (EMS) when they plan to begin submitting 276 version 4010 queries. Those who prefer advance testing, to assure system compatibility of version 4010 of the 276/277, must schedule testing with EMS.

- There is no Medicare charge for this system testing.

- Although Medicare will furnish providers with basic information on the HIPAA standard transaction requirements to enable providers to make educated and timely decisions to plan for use of a HIPAA standard, Medicare will not furnish in-depth training on the use and interpretation of the standards implementation guides. Providers who feel they have a need to obtain such in-depth training for their staff are expected to obtain training of that nature from commercial vendors, their clearinghouse, or through standards development organizations.

The Health Insurance Portability and Accountability Act (HIPAA) commissioned the use of the American National Standards Institute (ANSI) 276/277 Health Care Claim Status Request and Response transaction set version 4010 as the standard mode for Electronic Data Interchange (EDI). The above information is intended to serve as a companion document to the to the HIPAA ANSI X12N Version 4010 Implementation Guide. The use of these documents is solely for the purpose of clarification. This information describes specific requirements to be used for processing the 4010 in the Empire Medicare Services Part B. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Changes may be made on an as need basis, especially in the beginning of the HIPAA Implementation. Updates can be found on our Web site: www.empiremedicare.com.

Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes

Peripheral neuropathy with loss of protective sensation (LOPS), secondary to diabetes, is a localized illness of the feet and falls within the regulation's exception to the general exclusionary rule (see 42 C.F.R. §411.15(l)(l)(i)). Foot examinations for people with diabetic peripheral neuropathy with LOPS are reasonable and necessary to allow for early intervention in serious complications that typically afflict diabetics with the disease.

Effective for services furnished on or after July 1, 2002, coverage as a physician service, an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, will be made as long as the beneficiary has not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. Five sites should be tested on the plantar surface of each foot, according to the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. The areas must be tested randomly since the loss of protective sensation may be patchy in distribution, and the patient may get clues if the test is done rhythmically. Heavily callused areas should be avoided. As suggested by the American Podiatric Medicine Association, an absence of sensation at two or more sites out of five tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament must be present and documented to diagnose peripheral neuropathy with loss of protective sensation.

For services furnished on or after July 1, 2002, the following three (3) HCPCS codes should be reported for LOPS:

G0245 Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include:

1. the diagnosis of LOPS;
2. a patient history;
3. a physical examination that consists of at least the following elements:
   a) visual inspection of the forefoot, hindfoot, and toe web spaces,
   b) evaluation of a protective sensation,
   c) evaluation of foot structure and biomechanics,
   d) evaluation of vascular status and skin integrity,
   e) evaluation and recommendation of footwear, and
4. patient education.

NOTE: Payment will be issued only once to the same provider or group practice for HCPCS code G0245 for the same beneficiary.

G0246 Follow-up evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following:

1. a patient history;
2. a physical examination that includes:
   a) visual inspection of the forefoot, hindfoot, and toe web spaces,
   b) evaluation of protective sensation,
   c) evaluation of foot structure and biomechanics,
   d) evaluation of vascular status and skin integrity,
   e) evaluation and recommendation of footwear, and
3. patient education.

G0247 Routine foot care of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include, if present, at least the following:

1. local care of superficial wounds;
2. debridement of corns and calluses; and
3. trimming and debridement of nails.

NOTE: HCPCS code G0247 must be billed on the same date of service with either HCPCS code G0245 or G0246 in order to be considered for payment.

Please refer to the reimbursement section of this news brief for fee information on HCPCS codes G0245, G0246, and G0247.

Providers should report one of the following diagnosis codes in conjunction with this benefit:

250.60 Diabetes with neurological manifestations type II (non-insulin dependent type) (NIDDM type) (adult-onset type) or unspecified type, not stated as uncontrolled

250.61 Diabetes with neurological manifestations type I (insulin dependent) (IDDM) (juvenile type), not stated as uncontrolled

250.62 Diabetes with neurological manifestations type II (non-insulin dependent type) (NIDDM type) (adult-onset type) or unspecified type, uncontrolled

250.63 Diabetes with neurological manifestations type I (insulin dependent type) (IDDM) (juvenile type) or unspecified type, uncontrolled

357.2. Polyneuropathy in diabetes

Any Medicare provider who is legally authorized in their state to perform such services may bill for these HCPCS codes.

Coverage and Billing for Home Prothrombin Time International Normalized Ratio (INR) Monitoring for Anticoagulation Management

Use of the INR allows physicians to determine the level of anticoagulation in a patient independent of the laboratory reagents used. The INR is the ratio of the patient's prothrombin time compared to the mean prothrombin time for a group of normal individuals.

For services furnished on or after July 1, 2002, Medicare will cover the use of home prothrombin time INR monitoring for anticoagulation management for patients with mechanical heart valves on warfarin. The monitor and the home testing must be prescribed by a physician, and the following patient requirements must be met:

- Must have been anticoagulated for at least three months prior to use of the home INR device;
- Must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home; and
- Self testing with the device is limited to a frequency of once per week.

Applicable HCPCS Codes for Home Prothrombin Time INR Monitoring:

G0248 Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician. Includes demonstration use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results and documentation of a patient ability to perform testing.

Short Description Demonstrate use home INR mon

G0249 Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests.

Short Description Provide test material, equipm

G0250 Physician review, interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service)

Short Description MD review interpret of test

Applicable ICD-9-CM Code for Home Prothrombin Time INR Monitoring:

- ICD-9 V43.3, Organ or tissue replaced by other means; heart valve, applies.

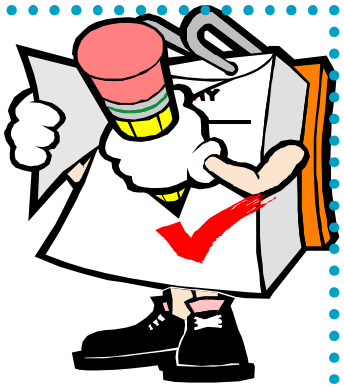
NOTE: Porcine valves are not covered, so Medicare will not make payment on Home INR Monitoring for patients with porcine valves.

Note that this is a CLIA waived diagnostic test, and it is not covered as durable medical equipment. Therefore, claims submitted to DMERCs will not be paid. It is covered under

the physician fee schedule. Also note that the cost of the device and supplies are included in the payment for G0249 and therefore not separately billed to Medicare. Additionally, for G0250, since this code descriptor is per 4 tests, this code should only be billed no more than once every 4 weeks.

- Enter the appropriate HCPCS procedure in Block 24d on health insurance claim Form CMS-1500 or electronic equivalent.

Corporate Holiday Schedule



Our office will be closed for observance on the following holidays:

2002

Holiday	Date Observed
Memorial Day	Monday, May 27
Independence Day	Thursday, July 4
Labor Day	Monday, September 2
Thanksgiving Day	Thursday, November 28
Day after Thanksgiving Day	Friday, November 29
Christmas Day	Wednesday, December 25

2003

New Year's Day	Wednesday, January 1

Notification of Updates to Coding Files on CMS Web Site for Skilled Nursing Facility (SNF) Consolidated Billing (CB)

The SNF CB coding files on the Centers for Medicare & Medicaid Services Web site at www.hcfa.gov/medlearn/refsnf.htm have been updated to reflect a number of corrections and policy changes. These code changes will be effective with the April 2002 implementation of CR 1764, Program Memorandum (PM) AB-01-159, dated November 1, 2001, Common Working File (CWF) Reject and Utilization Edits and Carrier Resolution for Consolidated Billing for SNF Residents, which implements the CWF edits.

Listed below are the changes for CWF effective April 1, 2002.

Update to Coding Files

Part A Stay, Always Submit to Carrier/DMERC - PCTC0

A4651	A4709	A4725	A4911	G0124
A4652	A4719	A4726	A4928	G0141
A4656	A4720	A4736	A4929	G0245
A4657	A4721	A4737	E1500	G0246
A4706	A4722	A4766	E1637	G0247
A4707	A4723	A4801	E1638	P3001
A4708	A4724	A4802	E1639	V5299

Part A Stay, Always Submit to Carrier/DMERC - PCTC0

G0117	G0197	83020	86255	87207	96003
G0118	G0198	83912	86256	88371	97601
G0121	G0199	84165	86320	88372	
G0193	G0200	84181	86325	89060	
G0194	G0201	84182	86327	95833	
G0195	J3370	85390	86334	95834	
G0196	L5669	85576	87164	96002	

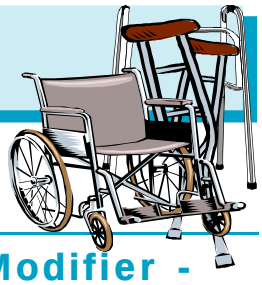
Part A Stay, Only Submit to Carrier with a 26 Modifier - PCTC1

G0131	83912	86256	88371
G0132	84165	86320	88372
76075	84181	86325	89060
76977	84182	86327	93770
78890	85390	86334	94150
78891	85576	87164	
83020	86255	87207	

Add to file: Part B Stay Only, Always Consolidated - Rehab B

G0193	G0198	95834	97601
G0194	G0199	96000	
G0195	G0200	96001	
G0196	G0201	96002	
G0197	95833	96003	

DME Issues



New Permanent Modifier - KX

Effective for dates of service on or after July 1, 2002, a new Level II national modifier has been created:

KX - Specific Required Documentation on File

The KX modifier will replace the local modifier ZX currently used in local medical review policies (LMRPs). The new modifier is required when an LMRP directs the use of a modifier to indicate "specific required documentation on file." Use of this modifier constitutes a statement to the effect that the supplier actually has the documentation on file that the LMRP requires for the particular item or service. The following LMRPs are affected by this change:

- Epoetin (Erythropoetin)
- External Infusion Pumps
- Home Blood Glucose Monitors
- Negative Pressure Wound Therapy
- Orthopedic Footwear
- Osteogenesis Stimulators
- Pressure Reducing Support Surfaces-Group 1
- Pressure Reducing Support Surfaces-Group 2
- Refractive Lenses
- Respiratory Assist Devices
- Speech Generating Devices
- Therapeutic Shoes for Diabetics
- Urological Supplies
- Walkers

Under the standard grace period, modifier ZX will continue to be accepted on claims with dates of service on or after July 1, 2002 that are received by September 30, 2002. Claim lines with modifier ZX with dates of service on or after July 1, 2002, that are received on or after October 1, 2002, will be rejected or denied as invalid coding.

Reimbursement

2002 Quarterly Drug Fee Updates

The revised fees for the drugs listed below will be implemented on July 1, 2002.

Code		Par Fee	Non-Par Fee
90746		54.94	52.19
90747		109.88	104.39
J0207		427.34	405.97
J0635		13.82	13.13
J0698		10.45	9.93
J0850		702.33	667.21
J1190		199.22	189.26
J1327		12.35	11.73
J1630		7.25	6.89
J2260		51.58	49.00
J2352	10 mg	1,458.50	1,385.58
J2352	20 mg	1,675.01	1,591.26
J2352	30 mg	2,294.88	2,180.14
J2352	40 mg	3,350.02	3,182.52
J2355		256.63	243.80
J3265		1.42	1.35
J3305		142.50	135.38
J7501		59.84	56.85
J9015		699.20	664.24
J9031		171.48	162.91
J9211		466.59	443.26
J9266		1,321.65	1,255.57
J9310		475.00	451.25
J9320		120.47	114.45
J9355		54.95	52.20

Billing of Therapy Services for SNF Patients

Claims submitted to Medicare for services to patients in skilled nursing facilities (SNFs) should be coded with a place of service code "31" if furnished during a covered Part A portion of their stay. The place of service code "32" should be used when submitting claims for those patients who have exhausted their SNF benefits or, for other reasons, are in a SNF stay not covered by Part A. Claims for patients in adult or assisted living facilities should be coded with place of service code "33" (custodial care facility).

Under SNF consolidated billing, rehabilitation services (physical, occupational, and speech-language therapy services) should not be billed to the Medicare Part B Carrier. Services considered as therapy and subject to consolidated billing are listed in the chart below. Providers should access the CMS Web site for updates in this listing (http://www.hcfa.gov/medlearn/snfcode.htm), and select "PART B STAY ONLY - ALWAYS CONSOLIDATED." Therapy services must be billed to the SNF for reimbursement, regardless of whether the beneficiary is in a covered Part A stay or not. The SNF may, in turn, submit a bill for services in a non-Part A covered stay to the Fiscal Intermediary. This is an exception to the general rule that professional services for patients in a non-Part A covered SNF stay may be billed to the Part B Carrier. Claims submitted to the Medicare Part B Carrier for therapy services furnished to patients in a SNF, whether in a covered Part A stay or not, will be denied. Empire Medicare Services' local medical review policies for any services impacted by this change will be updated.

90901	90911	92506	92507	92508	92510	92526	95831	95832	95833
95834	95851	95852	96000	96001	96002	96003	96105	96110	96111
96115	97001	97002	97003	97010**	97012	97014	97016	97018	97020
97022	97024	97026	97028	97032	97033	97034	97035	97036	97039
97110	97112	97113	97116	97124	97139	97140	97150	97504	97520
97530	97532	97533	97535	97537	97542	97545	97546	97601	97602
97703	97750	97799	G0192†	G0193	G0194	G0195	G0196	G0197	G0198
G0199	G0200	G0201	V5362	V5363	V5364				

*29065	*29075	*29085	*29105	*29125	*29126	*29130	*29131	*29200	*29220
*29240	*29260	*29280	*29345	*29365	*29405	*29445	*29505	*29515	29520
29530	*29540	*29550	*29580	*29590	*64550				

* For Part B, these codes are defined as therapy when rendered by a therapist. When they are rendered by physicians (including nurse practitioners, clinical nurse specialists, or physician assistants), they are defined as surgery and may be billed by the rendering provider.

** Payment for code 97010 is bundled with other rehabilitation services. It may be bundled with any therapy code.

† G0192 is not covered by Medicare.

2002 DMEPOS Fee Schedule Update

Jurisdiction for the code listed below has changed from DMERC to Local Carrier. This fee is effective for services rendered on or after January 1, 2002.

Code	**Fee**
E0749RR	227.53

Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Second Update to the 2002 Medicare Physician Fee Schedule Database (MPFSDB)

The changes listed in this section are effective for claims with dates of service on or after January 1, 2002, unless otherwise stated.

Bilateral Surgery

The bilateral indicator for the following codes is changing from '1' to '0.' This means that the 150% payment adjustment for bilateral procedures no longer applies.

19000 19001 19120 19125 19290

The bilateral indicator for the following codes is changing from '0' to '1.' This means that the 150% payment adjustment for bilateral procedures applies.

37609 63030

Procedure Code Status

The status for the following code is changing from 'N' to 'B.' This means that payment for this service is always bundled into payment for other services not specified. No separate payment is ever made.

90887

New Procedure Codes

The following new HCPCS code has been established effective for services performed on or after **April 1, 2002**. The status for this procedure code is 'I.' This means that this code is invalid for Medicare purposes.

G0251 Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment.

The following new HCPCS codes have been established effective for services performed on or after **July 1, 2002**. The status for these procedure codes is 'R.' This means that coverage will be on a restrictive basis.

G0245 G0246 G0247 G0248 G0249 G0250

Multiple Procedure Indicator

The multiple procedure indicator for the following code is changing from '2' to '0.' This means that standard payment adjustment rules for multiple procedures do **not** apply.

50320

FEES

The fees for the codes listed below are effective for services rendered on or after July 1, 2002.

Code	Loc.	Par Fee	Non-Par	Lmt. Chrg.
G0245	1	75.53	71.75	82.51
G0245*	1	54.01	51.31	59.01
G0245	2	72.42	68.80	79.12
G0245*	2	52.50	49.88	57.36
G0245	3	64.48	61.26	70.45
G0245*	3	47.36	44.99	51.74
G0246	1	44.95	42.70	49.11
G0246*	1	27.34	25.97	29.87
G0246	2	42.81	40.67	46.77
G0246*	2	26.51	25.18	28.96
G0246	3	38.02	36.12	41.54
G0246*	3	24.01	22.81	26.23

Code	Loc.	Par Fee	Non-Par	Lmt. Chrg.
G0247	1	49.72	47.23	54.31
G0247*	1	33.58	31.90	36.69
G0247	2	47.77	45.38	52.19
G0247*	2	32.83	31.19	35.87
G0247	3	42.01	39.91	45.90
G0247*	3	29.17	27.71	31.87
G0248	1	138.03	131.13	150.80
G0248	2	127.96	121.56	139.79
G0248	3	109.81	104.32	119.97
G0249	1	97.92	93.02	106.97
G0249	2	90.82	86.28	99.22
G0249	3	77.90	74.01	85.11
G0250	1	11.64	11.06	12.72
G0250	2	11.29	10.73	12.34
G0250	3	10.16	9.65	11.10

*** These amounts apply when service is performed in a facility setting.**

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