One-Time Notification

Pub. 100-04	Transmittal: 10	Date: October 17, 2003	Change Request 2958

SUBJECT: BILLING INSTRUCTIONS FOR CLAIMS FOR VENTRICULAR ASSIST DEVICES (VADS) FOR BENEFICIARIES IN A MEDICARE+CHOICE (M+C) PLAN

I. GENERAL INFORMATION

A. Background: This One-Time Notification provides billing instructions for claims for ventricular assist devices (VADs) for beneficiaries in a Medicare+Choice (M+C) Plan.

The Centers for Medicare and Medicaid Services (CMS) has recently expanded coverage for ventricular assist devices (VADs) (see **National Coverage Determination (NCD) manual section 20.9).** Until Medicare capitation rates to M+C organizations are adjusted to account for this expanded VADs coverage, Medicare will pay providers on a fee-for-service basis for VADs that fall under the new indication for destination therapy (see **NCD manual section 20.9).**

B. Policy: The fee-for-service claims processing system automatically excludes claims for services provided for risk M+C beneficiaries except in certain circumstances for which editing has been created (e.g. NETT claims, clinical trials claims).

This one-time notification instructs physicians/practitioners to use the modifier KZ (new coverage not implemented by managed care) and hospitals to use condition code 78 (new coverage not implemented by HMO) when billing for services for VADs for beneficiaries in an M+C plan when conditions fall under the new indications for destination therapy, which are effective October 1, 2003.

Until the new capitation rates to M+C organizations are in effect to include the cost of this expanded coverage, payment for VADs furnished to beneficiaries enrolled in risk M+C plans should be determined according to the applicable fee-for-service rules, except that beneficiaries are not responsible for the Part A and Part B deductibles (i.e. assume the Part A or Part B deductible has been met). M+C enrollees are liable for the coinsurance amounts applicable to services paid under Medicare fee-for service rules.

> **NOTE**: Claims for M+C organizations' beneficiaries with existing covered indications (see **NCD manual section 20.9**) should NOT be billed with the condition code or modifier since the existing covered indications are currently included in the M+C plan's capitated rates.

C. Provider Education: Contractors (Carriers and FIs) shall inform affected providers by posting either a summary or relevant portions of this document on their Web upon receipt of this instruction. Also, contractors shall publish this same information in their next regularly scheduled bulletin. If they have a listserv that targets affected providers, they shall use it to notify subscribers that information about billing instructions for claims for ventricular assist devices (VADs) for beneficiaries in a Medicare+Choice (M+C) Plan is available on their Web site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
1	Medicare carriers shall pay fee-for service for any line item services that contain the KZ modifier for risk M+C beneficiaries with dates of service on or after October 1, 2003, with procedure code 33975 or 33976.	Carriers
1.1	Medicare fiscal intermediaries shall pay fee-for service for any claims that contain the condition code 78 for risk M+C beneficiaries for discharges on or after October 1, 2003, with ICD-9-CM procedure code 37.66.	FISS/APASS
2	Medicare contractors shall hold claims for risk M+C beneficiaries that fall under the new indications for VADs submitted with modifier KZ (procedure code 33975 or 33976) and Condition Code 78 (ICD-9-CM procedure code 37.66) for dates of service October 1, 2003, through December 31, 2003.	Carriers FISS/APASS/FIs
3	Contractors shall release claims for payment, including any applicable interest, on or after January 5, 2004.	Carriers FISS/APASS/FIs
3.1	FIs shall enter Condition Code 15 when releasing held claims for payment.	FISS/APASS/FIs
4	Contractors shall not apply Part B deductible for claims containing the procedure codes 33975 or 33976 when billed with modifier KZ.	Carriers
4.1	Contractors shall not apply Part A deductible for claims containing the ICD-9-CM procedure codes 37.66 when billed with Condition Code 78.	FISS/APASS/FIs
5	Contractors shall apply applicable coinsurance for risk M+C beneficiaries who receive VADs.	Carriers FISS/APASS/FIs
6	Contractors shall publish provider education language on their websites as soon as possible, but no later than 2 weeks from the issuance date of this instruction.	Carriers/FIs
6.1	Contractors shall publish provider education in their next regularly scheduled bulletin.	Carriers/FIs
6.2	Contractors who have a listserv that targets the affected provider communities shall use their listservs to notify subscribers that information about claims processing for VADs appears on the contractor's web site.	Carriers/FIs

6.3	Contractors shall educate providers that only claims for patients with indications that are effective for coverage beginning October 1, 2003, should include modifier KZ and condition code 78. Claims for non-risk managed care beneficiaries with existing covered indications should NOT be billed with the modifier, as they are currently included in the capitated rates.	Carriers/FIs

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	**Instructions**
1.1	Applicable bill type is 11X.

B. Design Considerations:

X-Ref Requirement #	***Recommendation for Medicare System Requirements***
4 and 4.1	Standard systems should not create any front-end edits for requirements. Standard systems should only react to claims rejected by CWF that contain Condition code 78 or modifier KZ.

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2003 **Implementation Date: January 5, 2004** **Pre-Implementation Contact(s):** Yvette Cousar (410) 786-2160 (Carrier claims processing), Sarah Shirey (410) 786-0187 (FI claims processing), JoAnna Farrell (410) 786-7205 (Coverage policy), Terese Klitenic (410) 786-5942 (M+C plans) **Post-Implementation Contact(s):** Appropriate Regional Office	**These instructions should be implemented within your current operating budget.**