CENTERS FOR MEDICARE AND MEDICAID SERVICES

Contractor Training Conference Call:

New Preventive Physical Examination, Cardiovascular Screening Blood Tests, and Diabetes Screening Tests

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Wednesday

January 12, 2005

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C O N T E N T S

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P R O C E E D I N G S

[1:09 p.m.]

THE OPERATOR: All lines are in a listen-only mode until the question-and-answer segment of today's conference call. Also, this call is being recorded. If you have any objection, you may disconnect at this time.

I would like to turn the call over to Ms. Robin Phillips.

Ma'am, you may begin.

Opening Remarks

Robin Phillips

MS. PHILLIPS: Thank you, Laurel.

Hi. This is Robin Phillips. I'm with the Provider Communications Group, Division of Provider Information, Planning and Development, at CMS of Baltimore.

I would like to welcome everyone to the first of two contractor education conference calls that will focus on the new preventive services covered in the MMA, the Initial Preventive Physical Examination, CR 3638, Cardiovascular Screening Blood Tests, CR 3411, and

Diabetes Screening Tests, CR 3637.

Today's call includes an overview of the three benefits presented by a panel of Central Office Subject Matter Experts. A question-and-answer session will follow the panel discussion.

A PowerPoint presentation has been prepared for today's call and can be located at www.cms.hhs.gov/medlearn/cmsinit.asp so that you may follow along with the speakers.

Before we begin, I would like to remind everyone that this call is for Medicare contractors, Central Office and Regional Office staff, and is not for providers. The call is being recorded and transcribed, so please identify yourself before you speak.

At this time, I would like to have each person in the room here at CMS in Baltimore introduce yourself and say what component or division you work with.

MS. ROULAC: Hazeline Roulac, Provider Communications Group.

MS. PARDUE: Karen Pardue with Office of Communications Group.

MS. MURPHY: Cindy Murphy, Institutional Claims Processing.

CMS PARTICIPANT: Mary Case, Provider Communication Group

MS. GREENBERG: Anita Greenberg, Payment Policy.

MS. SHAW: Betty Shaw, Coverage.

DR. SANDERS: Tiffany Sanders, Coverage and Analysis Group.

MR. LARSON: Bill Larson, Coverage and Analysis Group.

MS. ENG: Joyce Eng, Coverage and Analysis Group.

MS. PROCTOR-YOUNG: Joan Proctor-Young, Provider Billing Group.

MS. RIVERA: Taneka Rivera, Institutional Claims Processing.

MS. KERSELL: Kathy Kersell, Division of Practitioner Claims Processing.

MS. GILL: Pat Gill, the Division of Practitioner Claims Processing.

MS. SCALLY: Kit Scally, the Division of Practitioner Services, Payment Policy.

MS. PHILLIPS: Thank you.

At this time, I would like to introduce our first speaker, Bill Larson.

Initial Preventive Physical Examination (IPPE)

Bill Larson

[PowerPoint presentation.]

MR. LARSON: Thank you, Robin. We appreciate the opportunity to participate in this phone conference.

Over the next few minutes, Dr. Tiffany Sanders and I will run through slides 4 through 16. That starts with the question of "Why Cover Preventive Services?", then outlines provisions of coverage, provisions of the Initial Preventive Physical Exam benefit. We will refer to that as the IPPE, the acronym for that statutory benefit category.

So, Dr. Sanders and I had the lead in drafting the coverage provisions of these regulations, with the help of other folks in Payment and Claims Processing in doing the manual instructions, but basically, Tiffany and

I prepared the regulations with the help of our folks in the Coverage Analysis Group.

So, I'm going to start by going over slides 4 through 7. Then I will turn it over to Dr. Sanders.

So, I will just start with slide 4. I will read it fairly quickly, maybe elaborate a little bit here and there.

Why Cover Preventive Services? The simple answer, of course, is the mammography -- excuse me, the MMA legislation. In addition to that, the leaders of the administration on the Hill have all been very enthusiastic about the need to add new preventive benefits to the program and to encourage greater use of them.

Anyway, that first bullet, Medicare Prescription Drug Improvement and Modernization Act expanded Medicare's preventive coverage.

The second bullet, coverage expansion basically generally requires legislative approval. The reason for that is at the beginning of Medicare the law did not mention prevention at all. There were two statutory

exclusions, reasonable and necessary, and there was a physical check-up exclusion. Those two exclusions have been used over time to preclude coverage of preventive services unless the Congress has acted otherwise.

The first 16 years after Medicare was enacted, there was no coverage of prevention at all. The reason for this was those statutory exclusions that I just mentioned to you. The exclusions were overridden by the Congress for the first time in 1981 with the enactment of the -- Pneumococcal Vaccination Benefit.

Additional benefits have been added on a selective basis since that time. Ten new ones have been added since 1997.

The trends are important here. The Congress appears to be telling us something about the importance prevention now has in modern medicine today. So, in conclusion, the reason for increased interest in this area appears to be the result of accumulating evidence that certain preventive services can, in fact, improve the health outcome of Medicare beneficiaries.

Then, of course, the last bullet, goals of

covering preventive services include health promotion and disease prevention. Those two goals are what this legislation is intended to deal with. Although those two items were mentioned in connection with the Initial Preventive Physical Exam, in reality they really apply to all of the preventive benefits.

So next, I want to move on to slide 5, which basically is an introductory slide for the IPPE benefit. It is also known by other terms. Obviously, with the mouthful of IPPE, often people want to just refer to it as the "Welcome to Medicare Visit." I think our Medicare handbook uses a variation on that theme. The Medicare 2005 handbook basically says "Welcome to Medicare" Physical Examinations. Dr. Sanders and I plan to use the IPPE term in our remaining slides.

So next, slide 6, beneficiaries are eligible for coverage. There is a one-time benefit that when all the following criteria are met: first, the exam must be completed within six months of the effective date of the beneficiary's first Medicare Part B coverage period.

Secondly, the Part B coverage must begin on or

after January 1st, 2005. Some may have a coverage period that began before January 1st, 2005. Unfortunately, under this benefit, they would be out of luck. So this is the way the law was written, and there is not much we can do about it. Basically, I think they were concerned about the cost implications of implementation.

The next item under that is the services, in order to be covered, have to be performed by physicians -- that is, M.D.s or doctors of osteopathy -- or Qualified Non-Physician Practitioners. The law is explicit here. It specifically indicates that these can only be physician assistants, nurse practitioners, or clinical nurse specialists.

On to slide 7. This will be my last slide before I turn it over to Dr. Sanders.

This summarizes the basic seven service elements that are included in the definition of the benefit that we are talking about. There are seven of them. Three of them are specifically mandated by law: the fourth, the fifth, and the seventh, the fourth being basically the physical exam, the height, weight, blood

pressure measurements, and visual acuity screen. The performance and interpretation of the EKG was also mandated by Congress.

Finally, no. 7, education, counseling, and referral for obtaining screening and other preventive services separately covered under Medicare. This was a special provision included. I think there was concern that Medicare was not paying enough to doctors and other practitioners for counseling and education of their patients in connection with preventive services. I believe it is hoped that with the addition of this particular item that we will do a better job and you all will do a better job in getting the word out to people in getting Medicare beneficiaries educated and counseled with respect to the importance of preventive measures.

I believe I have come to the end of my slide presentation. Next, I will turn things over to Dr. Sanders.

Presentation by Dr. Tiffany Sanders

[PowerPoint presentation.]

DR. SANDERS: Thank you, Bill.

Good afternoon, everyone. I will be reviewing more specifically the service elements that Bill outlined briefly in slide 7.

Slide 8 is service element 1, and that is the review of the medical and social history. This includes review of the beneficiary's past medical and surgical history, which should include obtaining information about illnesses, hospital stays, operations, allergies, injuries, and treatments. It should also include a review of medications and supplements, including calcium and vitamins.

The thinking there for calcium and vitamins was in terms of osteoporosis and preventing osteoporosis, making sure beneficiaries have adequate calcium and Vitamin D intake.

It should also include a review of the beneficiary's family history, with particular attention to diseases that may be hereditary or place an individual at increased risk.

The next slide. Social history should include a review of alcohol, tobacco, and illicit drug use, and

diet. There we mean nutritional data, just trying to get a sense of how nutritionally healthy a beneficiary may or may not be. And also, their level of physical activity.

Slide 10 refers to service element 2. That is review of the potential risk factors for depression. Here there should be a review of the individual's potential risk factors for depression, including current or past experience with depression or other mood disorders such as bipolar disorder. We expect practitioners to use an appropriate screening instrument, and that would be for persons without a current diagnosis of depression.

We also have specifically stated that the practitioners may select from various available standardized screening tests that have been recognized by national medical professional organizations.

The next slide refers to service element 3, and that is a review of the functional ability and level of safety. That includes review or asking the beneficiary about any hearing impairment, their activities of daily living, any risk of falls, and home safety. Here again,

we have specified that appropriate screening questions or standardized questionnaires could be used and that they should be recognized by national professional medical organizations.

The next slide refers to service element 4, which is the actual physical examination portion of the IPPE, and that should include height, weight, blood pressure, visual acuity screen, and we listed other factors as deemed appropriate. There we simply mean that if other things were identified during the history that the practitioner feels should be examined, then they should feel free to do so there.

The next slide addresses service element 5, which is the EKG. The EKG is required as part of the statute under the IPPE benefit. We have specifically listed in this slide that the primary physician or Qualified NPP does not perform -- if that is not performed during the IPPE visit, the beneficiary should be referred to another physician or entity to have the EKG performed and/or interpreted, and that the IPPE and EKG must both be performed and interpreted before either

is billed.

In addition, the results must be incorporated into the beneficiary's medical records, to include the performance and interpretation, and the referring physician or Qualified NPP should ensure performing provider bills appropriately using the G code and not a CPT code. This will be discussed a little bit further in the next couple of slides.

Slide 14 refers to service element 6, and that is education, counseling, and referral. We have listed the education, counseling, and referral, as appropriate, based on the results of the first five service elements. So, for example, if during the social history you are questioning the beneficiary about their diet, you realize that they don't have very good dietary habits, some counseling could be provided in that regard, or referral to a cardiologist for an abnormal EKG, or education on other prevention initiatives, such as increasing their level of physical activity.

The next slide refers to service element 7, and that is education, counseling, and referral for other

preventive services. Here we are specifying that the beneficiaries be provided with a brief written plan, such as a checklist, for obtaining the other appropriate screening and/or other Medicare Part B preventive services. Our idea there is for beneficiaries to be active participants in their health care so that they know what services are provided by Medicare and how they can go about obtaining those services.

The next slide, slide 16, actually lists all the covered Part B benefits that may be included in the written plan and provided to the beneficiary, and I will not read those as they are listed there for your review.

At this time, I will turn it over to Kit Scally, and she will discuss further the payment and the coding for the benefits.

Presentation by Kathleen Scally

[PowerPoint presentation.]

MS. SCALLY: Thank you, Tiffany and Bill.

Good afternoon. Slide 17 refers to the procedure codes and descriptors. Now, when we published the proposed policy and the notice of proposed rulemaking

we actually had planned on one code, but based on the comments received during the NPRM comment period, it was obvious to us that there were many scenarios that could possibly take place and therefore, we needed to actually develop four codes.

So the list of the four codes is here, and these are the long descriptors. I will just go through them.

It is G0344. That is the initial preventive physical examination face-to-face visit. Service is limited to the new beneficiary during the first six months of Medicare enrollment.

Then, the next one is G0366. That is the electrocardiogram, routine ECG with at least 12 leads, with interpretation and report, performed as a component of the initial preventive examination.

G0367 is tracing only. That is without interpretation and report, performed as a component of the initial preventive physical examination.

G0368 is the code that is the interpretation and report only, performed as a component of the initial

physical preventive examination.

On to slide 18, the coding issues. A physician or a Qualified NPP performing the complete IPPE would report G0344 and G0366. That would be the entire benefit. The benefit includes both the exam and the EKG.

If the physician or Qualified NPP is not able to perform both the examination and the screening EKG at the encounter, a referral may be made to another physician or entity to complete the benefit. The referring physician/Qualified NPP would ensure the physician or entity performing the EKG bills the appropriate G code, not a CPT code, for example, a diagnostic EKG code. The law requires that it is a screening EKG code, and we did develop a code specifically for this benefit.

I will turn over the slides now to Pat Gill.

Presentation by Pat Gill

[PowerPoint presentation.]

MS. GILL: Thanks, Kit.

I will just be reading slide 19 for the moment. This has to do with the filing requirements, billing to

carriers. The claims, of course, must be submitted on a CMS-1500 form or the electronic equivalent. The appropriate G codes for the IPPE benefit or the EKG screening must be submitted.

If a separately identifiable, medically necessary evaluation and management service, and we are talking particularly about the codes 99201 through 99215, is performed at the same encounter, it should be recorded with modifier 25 appended to the E/M code.

Other covered preventive services performed may be billed in addition to the G0344 and the appropriate EKG codes.

For the next two slides, I'm going to turn it over to Taneka, who will be reading about billing to the fiscal intermediaries.

Presentation by Taneka Rivera

[PowerPoint presentation.]

MS. RIVERA: Thank you.

Slide 20, filing requirements for billing to FIs. The following types of bills may be submitted: for hospitals, 12X and 13X; for skilled nursing facilities,

22X; Rural Health Clinics, RHCs, 71X; Federally Qualified Health Centers, FQHCs, 73X; and Critical Access Hospitals, CAHs, 85X.

Slide 21. Claims must be submitted on a CMS-1450 claim form or an equivalent electronic form. Appropriate HCPCS codes for the services must be submitted. If a separate medically necessary E/M is performed, it must be reported with modifier 25.

Slide 22, special filing requirements for RHCs and FQHCs. Follow normal billing procedures. Payment will be made under the all-inclusive rate. Consider single visits if on the same day beneficiary has, one, encounters with one or more than one health profession, or two, multiple encounters with the same health professional.

Payment for the technical component of the IPPE EKG will be billed by the base provider or the individual practitioner, not the RHC or FQHC.

RHCs and FQHCs will be using Revenue Code 052X.

Now, I will turn it back over to Kit Scally.

Presentation by Kathleen Scally

[PowerPoint presentation.]

MS. SCALLY: Hello again. I will be talking about slide 23, and that is the documentation requirements. The physician or Qualified NPP must document that all required components of the service were provided or provided and referred, for example in a checklist, which would be the medical plan that would be given to the patient.

If a separately identifiable, medically necessary E/M service is also performed, at the visit the physician or Qualified NPP must document this in the medical record. The 1995 and the 1997 E/M documentation guidelines must be followed for reporting the appropriate clinical information in the beneficiary's medical record for the medically necessary E/M encounter. All referrals and a medical plan must be included in this documentation.

Now, I would like to turn it back to Pat.

Presentation by Pat Gill

[PowerPoint presentation.]

MS. GILL: Thanks, Kit.

I will be reading slide 24 regarding reimbursement. Reimbursement is made for these services under the Medicare Physician Fee Schedule. The Medicare Part B deductible and coinsurance apply, except that there is no deductible for the FQHC.

For hospital outpatient departments, G0344 will be assigned to APC 0601, G0367 will be assigned to the APC 0099. Separate payment will be paid for the physician's professional services under the Medicare Physician Fee Schedule.

Back over to Taneka.

Presentation by Taneka Rivera

[PowerPoint presentation.]

MS. RIVERA: Thank you.

Reimbursement for RHCs and FQHCs are reimbursed under the all-inclusive rate. CAHs are reimbursed at 101 percent of their reasonable cost. Maryland hospitals will be reimbursed on a claims basis, according to the Maryland State Cost Containment Plan.

Now, I will turn it back over to Pat.

Presentation by Pat Gill

[PowerPoint presentation.]

MS. GILL: Thanks, Taneka.

On slide 26, we have listed there the reasons for denial. When the exam is provided after the beneficiary has been enrolled for more than six months, or if an IPPE has already been paid, or if the beneficiary was enrolled in Part B prior to January 1st, 2005.

On the next couple slides, it talks about the Advance Beneficiary Notice, or ABN. If a second IPPE is billed for the same bene, it would be denied as a statutory denial under Section 1861(s)(2) of the Act. Since the IPPE is a one-time benefit, an ABN would not be required in order to hold the beneficiary liable for the cost of the IPPE.

On slide 28, however, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory six-month period has lapsed since, based on 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the six-month period.

Slide 29. An ABN should also be issued for an

IPPE that is conducted within the first six months but which is not reasonable and necessary for the beneficiary on the occasion in question. For example, if the beneficiary has a terminal illness, conducting an IPPE may not be appropriate.

That ends the first part of the preventive benefit slides, and we are now going to go into the Cardiovascular Screening Blood Tests. For that, I will turn it over to Joyce.

Cardiovascular Screening Blood Tests

Joyce Eng

[PowerPoint presentation.]

MS. ENG: Thank you, Pat.

Slide 30 is the title slide.

Slide 31. Cardiovascular screening blood tests detect cardiovascular disease and other abnormalities associated with the risk of heart disease and stroke. These tests determine a beneficiary's cholesterol and other blood lipid levels such as triglycerides. They are covered for all asymptomatic beneficiaries enrolled in Medicare Part B.

Slide 32. The covered tests include a total cholesterol test, a cholesterol test for high-density lipoproteins, and a triglycerides test. Tests should be ordered as a lipid panel; however, they may be individually ordered. Beneficiaries must fast for 12 hours prior to the test. Other cardiovascular screening blood tests remain non-covered.

Slide 33, coverage guidelines. These tests must be ordered by the physician or the non-physician practitioner treating the beneficiary for the purpose of early detection of cardiovascular disease. Beneficiaries must have no apparent signs or symptoms of cardiovascular disease.

Clinical laboratories must offer the ability to order the lipid panel without the low-density lipoprotein, LDL, measurement.

Frequency parameters are on slide 34. These tests are covered once every five years if performed for an asymptomatic beneficiary. Fifty-nine months must have passed following the month of the test, and the frequency limit for each test applies regardless if provided in a

panel or individually.

Now I turn this over to Joan.

Presentation by Joan Proctor-Young

[PowerPoint presentation.]

MS. PROCTOR-YOUNG: Hi. This is Joan Proctor-Young. Slide 35 talks about the CPT codes that were identified.

We have 80061, which is the lipid panel, and then we have the component parts, the other three codes that make up 80061. Those are 82465, 83718, and 84478. This allows the doctor who orders individual components to be able to order the tests individually should they so choose.

The diagnostic codes identified for billing for cardiovascular screening blood tests are V81.0, which is a special screening for ischemic heart disease; V81.1, special screening for hypertension; V81.2, special screening for other unspecified cardiovascular conditions.

Slide 37 talks about our billing requirements for carriers. The claims must be submitted on a CMS-1500

claim form or an electronic equivalent. We identified in slide 35, page 35 or slide 35, whichever you refer to, the appropriate procedure codes to be billed for these services, and/or in slide 36 we identified the screening diagnosis codes that must be in the header and pointed to the line items.

I believe that there have been some questions about this particular issue of pointing to the line items, and that is something that is specific to carrier process claims and non of us.

Now, I'm going to turn it over to Taneka, who is going to handle the FI billing requirements.

Presentation by Taneka Rivera

[PowerPoint presentation.]

MS. RIVERA: I will be working from slide 38, filing requirements for billing to fiscal intermediaries. Covered when performed on an inpatient or outpatient basis in a hospital, CAH, or SNF. Types of bills that may be submitted are: hospitals, 12X, 13X, and 14X; for SNFs, 22X and 23X; for CAHs, 85X.

Slide 39. Claims must be submitted on a CMS-

1450 claim form or an electronic equivalent and include the following: appropriate procedure codes for the services and appropriate screening ICD-9-CM codes.

Now, I will turn it back over to Joyce.

Presentation by Joyce Eng

[PowerPoint presentation.]

MS. ENG: Slide 40, documentation requirements. Must include that the tests were performed with the supporting screening ICD-9 codes and that the beneficiary had the test after a 12-hour fasting period.

Slide 41, reimbursement. There are generally no out-of-pocket costs to beneficiaries. Part B coinsurance and deductibles do not apply. These tests will be paid under the clinical laboratory fee schedule, except that Critical Access Hospitals will be reimbursed at 101 percent of the reasonable cost. Maryland hospitals will be reimbursed on claims basis, according to the Maryland State Cost Containment Plan.

Slide 42, the reasons for denial. Frequency is limited to one of each of these tests or combination as a panel once every five years.

Slide 43. An advance beneficiary notice may be issued to a beneficiary if there is sufficient doubt that a cardiovascular screening test has been provided within the last five years. Laboratories may be financially liable for the cost of the test if an ABN is not issued. The laboratory is not required to issue an ABN if a physician has already issued one to the patient.

Slide 44. Frequency limitation must be included in the ABN as the reason for which Medicare will deny coverage. Beneficiaries who receive an ABN but exceed the frequency limitations may incur out-of-pocket charges.

I now turn this over to Betty.

Diabetes Screening Tests

Betty Shaw

[PowerPoint presentation.]

MS. SHAW: Thank you, Joyce.

My name is Betty Shaw, and I will be presenting the Diabetes Screening Test slides. I will be covering slide nos. 45 through 51.

No. 45 is your lead-in slide.

On slide 46, diabetes screening tests. Beneficiaries eligible for diabetes screening tests are those that are at risk for diabetes or diagnosed with pre-diabetes. Beneficiaries who have already been diagnosed with diabetes are not eligible for the screening benefit.

Diabetes: Diabetes Mellitus is a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar resulting in readings above 126 milligrams per deciliter on two different occasions, a two-hour post-glucose challenge test resulting in a reading of 200 milligrams per deciliter on two different occasions, or a random glucose test reading above 200 milligrams per deciliter for an individual with symptoms of uncontrolled diabetes.

The risk factors for diabetes. Individuals are considered at risk if they have any of the following risk factors: hypertension, dyslipidemia, obesity, which is defined as a body mass index greater than or equal to 30 kilograms per meter squared. Risk factors for diabetes are also identified by previous identification of an

elevated impaired fasting glucose or previous identification of impaired glucose tolerance.

In addition, risk factors for diabetes can be identified if they have at least two of the following characteristics, and those are overweight, which is identified as a body mass index greater than 25 kilograms per meter squared but less than 30 kilograms per meter squared. In addition, a family history of diabetes or history of gestational diabetes mellitus or delivery of a baby weighing over nine pounds, and being 65 years of age or older.

Moving on to slide 49, pre-diabetes. Pre-diabetes is a condition of abnormal glucose metabolism that is diagnosed by using the following criteria: a fasting glucose level of 100 to 125 milligrams per deciliter or a two-hour post-glucose challenge test reading of 140 to 199 milligrams per deciliter. Some conditions implying pre-diabetes are an impaired fasting glucose or an impaired glucose tolerance test.

Covered diabetes screening tests. Covered by Medicare Part B after a referral from a physician or

Qualified non-physician provider for an individual at risk for diabetes: fasting blood glucose test and post-glucose challenge tests, but not limited to oral glucose tolerance test with a glucose challenge of 75 grams for non-pregnant adults or a two-hour post-glucose challenge test alone.

Frequency of the testing. Beneficiaries that have been diagnosed with pre-diabetes will be covered for a maximum of two screening tests within a 12-month period, but not less than six months apart. Also, a non-diabetic who has not previously been diagnosed as pre-diabetic, they may have one screening test within a 12-month period.

I will now turn it over to Joan Proctor-Young.

Presentation by Joan Proctor-Young

[PowerPoint presentation.]

MS. PROCTOR-YOUNG: This is Joan Proctor-Young. Diagnosis coding and HCPCS codes for diabetes screenings are as follows: V77.1 is the diagnosis code that is to be reported, and the HCPCS code identified of 82947, 82950, 82951.

In addition, at billing, for the pre-diabetic beneficiary claims will also include a modifier TS which is to be included in instructions released in final CR 3677, which has yet to clear the agency, for the April release.

Slide 53, filing requirements for billing to the carriers. Claims must be submitted on a 1500 claim form or an electronic equivalent. Again, the HCPCS codes and ICD-9 codes that I identified in the previous slide. In addition, the screening diagnosis codes must be reported in the header and pointed to the line items, and that is a carrier-only requirement.

Now, I'm going to turn to Taneka, who is going to handle the FI filing requirements.

Presentation by Taneka Rivera

[PowerPoint presentation.]

MS. RIVERA: Thank you.

Slide 54, filing requirements for fiscal intermediaries. The following types of bills will be submitted for diabetes screening: hospitals, 12X, 13X, and 14X; for SNFs, 22X and 23X; for CAHs, 85X.

Slide 55. Claims must be submitted on a CMS-1450 claim form or an electronic equivalent. Appropriate procedure codes for the service and ICD-9 must also be submitted. When furnished to a beneficiary in a SNF, type of bill 22X should be used.

Slide 56, Reimbursement. Deductible and coinsurance do not apply. Reimbursement is made under the clinical lab fee schedule. CAHs will be reimbursed at 101 percent of their reasonable cost. Maryland hospitals will be reimbursed according to the Maryland State Cost Containment Plan.

Slide nos. 57 through 60 are general information slides and are just FYI only.

Additional Information

Robin Phillips

[PowerPoint presentation.]

MS. PHILLIPS: This is Robin Phillips again. I will go over slide nos. 57 through 60.

Slide 58 is a slide that we put together to have all the new services put on there so you can look at it at a glance. For additional information, on slide

nos. 59 and 60, for the new preventive services under the Medicare MMA, you will find the CMS Medlearn and Medicare websites, and the 1-800-MEDICARE phone number that beneficiaries can use.

Before we begin the question-and-answer session, I would like to thank all the presenters.

I would like to remind you that this call is being recorded and transcribed, so please give us your name and tell us what organization you are with.

In an effort to get as many questions as possible, we ask that you limit your questions to one. We don't expect to be able to answer every question, so CMS has established an e-mail box where you can send in your question and it will be addressed at the next contractor training call, scheduled for February 10th at 1:00 Eastern Standard Time.

The e-mail box is contractortraining -- that is all one word -- @cms.hhs.gov.

We would also like to ask that we take the IPPE questions first, if we can do that, please. Our subject matter experts have another call that they need to go to.

Question-and-Answer Session

THE OPERATOR: At this time, if you would have a question pertaining to Initial Preventive Physical Examinations, please depress star-1. Star-1 for those questions, please.

Our first question comes from Katherine Dunsley [ph.] Your line is open, and please state your company name.

MS. DUNSLEY: Hi. This is Kathy Dunsley from New York, Empire Medicare. Just a question with regard to the seven components of the initial physical exam and sending physicians off to other specialty societies. Is there a list of those? You know, the safety factors and other depression factors. Would there be like a little list we could have compiled as to the simple steps or maybe even work towards having a simple format for doctors?

It is one benefit, and I think if we move toward a simple approach of a suggested format and not sending them all around to specialty societies would help.

Thank you.

DR. SANDERS: This is Dr. Sanders. While there is no official list, in the regulation we do list some of the societies which they could go to. Another great place is the U.S. Preventive Services Task Force website or either the book that they put out regarding clinical preventive services. Most of the information could be found right there.

This would just be two things. The other one is the CDC website, which has a lot of information about home safety and injury prevention.

So, I think going to the U.S. Preventive Services Task Force probably would be all the resource they needed.

MS. DUNSLEY: Good suggestion. Thank you.

MS. PHILLIPS: Thank you, Dr. Sanders.

Next call, please.

THE OPERATOR: Cheryl Torres, your line is open, and please state your organization.

MS. TORRES: Mutual of Omaha Medicare. I would just like to seek some clarification on slide nos. 27 and

28 where it has to do with the ABN. If they have a second IPPE for the same beneficiary, it says an ABN is not required because it is a statutory denial. How does that differ from slide 28, when it is still a statutory exclusion when they have the IPPE after the six-month period? Why is an ABN required in one and not the other?

MS. MURPHY: This is Cindy Murphy. The answer has to do with the section of the law that was modified for the benefit. On slide 28, the reference is to 1862(a)(1)(k). 1862(a)(1) lists all the services that are subject to limitation of liability and protection of the beneficiary whereas the section of the law that specifies that there is only one initial preventive physical examination is 1861(s)(2). To the best of my knowledge, that is the sole difference.

MR. LARSON: That's right. That is the basis for limited liability. It has to be under 1861.

MS. PHILLIPS: Thanks, Cindy.

MR. LARSON: 1861 is not subject to waiver.

MS. TORRES: Thank you.

THE OPERATOR: Our next question comes from

Barbara Sauls, and please state your organization.

MS. SAULS: Part B South Carolina Palmetto GBA. I have a question about the IPPE G0344 HCPCS code. Is there a list of approved screening codes, or is it just any type of screening code for that particular HCPCS?

MS. SCALLY: I'm sorry. This is Kit Scally. I don't understand your question, Barbara.

MS. SAULS: I'm sorry. Is there a particular diagnosis code, ICD-9, that you would recommend our providers to use for the screening G0344?

MS. SCALLY: We actually did not specify a specific diagnosis code, and we are telling folks to use an appropriate ICD-9 code or V code. We really want to avoid denials on this one-time benefit, so we didn't specify only one or two codes that could cause denials.

Does that help?

MS. SAULS: Yes, it does.

THE OPERATOR: Our next question comes from Anita Henderson. Please state your organization.

MS. HENDERSON: Yes, from First Coast Service Options. I have a question on slide 15, in regard to the

checklist. Is this something that the providers will be developing as part of their medical documentation to give to the patient, or is it something that CMS will be developing for the providers?

DR. SANDERS: Again, this is Tiffany Sanders. This is something that the providers will have to develop to give to the beneficiaries. The U.S. Preventive Services Task Force has information -- give me one second.

They have a section on their website called "Putting Prevention into Practice," and it actually has examples of checklists that can be used to, you know, provide to patients.

So, that is what we are sort of expecting, that physicians develop something. It doesn't have to be a lot, just so that the beneficiary will know that these are some other preventive services which they are entitled to and should have done.

MS. PHILLIPS: Thank you.

THE OPERATOR: Katie Nadu [ph], your line is open, and please state your organization.

MS. NADU: Anthem Health Plans of New Hampshire. How specific must the documentation requirements be, and would it be appropriate if there are elements missing to deny?

DR. SANDERS: This is Dr. Sanders again. The documentation elements for all of the examination, or are you referring to the part that was just discussed with reference to the checklist?

MS. NADU: Well, I was referring to the IPPE where it says documentation requirements, that, you know, they have to identify all the components of what they are doing: the physical, the history, the blood pressure, et cetera.

DR. SANDERS: Oh. What slide are you referring to?

MS. NADU: Okay. For example, if you go to no. 8, it lists they have to address the medical history, surgical history, medications. Are we expected to see documentation on each of these individual components?

MS. SCALLY: This is Kit Scally. The requirements have been basically set up by the

legislation to say that these are the elements that should be included in the IPPE. Now, it will depend on the individual physician as to how much they, you know, will be obtaining from the patient, et cetera, and what they put in the medical record.

Bear in mind that the payment for the IPPE is based on the equivalent payment of a CPT 99203, so that basically requires some detail as far as your history and your physical examination.

Now, that is to say we have never told folks that they have to put down word-by-word, you know, what it is. They should refer to the documentation guidelines, but each physician usually has their own standard of whatever way that they document. We don't tell physicians how to document. But they must have the information available in the medical record in some manner.

The same way with the medically necessary E/M visit that they provide. What other level of service that they are providing and billing for should be documented per the documentation guidelines to the level

that they are doing, whether it is a problem-focused problem which requires very limited information versus a detailed which requires detailed and specific information, or it is a comprehensive examination and therefore they would actually have to provide quite a bit of information. They would get that from the documentation guidelines.

I hope that helps.

MS. NADU: Okay. Can I just ask one more quick question? Rural Health Clinics, they historically don't bill with HCPCS codes. Are they required to bill these preventive services?

Cindy Murphy: Technically, they are required to bill a HCPCS code until April 1. Effective April 1, we have eliminated the need to report any HCPCS codes for preventive services in Rural Health Clinics and Federally Qualified Health Centers.

MS. NADU: So, until 4/1/05 they must report a HCPCS; after 4/1, there is no need?

Cindy Murphy: Certainly, after 4/1 there is no need. It is our understanding that they would be

reporting HCPCS until 4/1. If we are incorrect -- I don't want to say they are required to because we don't have a specific requirement for this benefit for RHCs and FQHCs. We have not stated that they must use a HCPCS.

MS. NADU: Okay. So therefore, there wouldn't be a HCPCS billed. There would be nothing recorded for the beneficiary that they already had this service?

Cindy Murphy: That's correct.

MS. NADU: Okay. Thank you.

THE OPERATOR: Our next question comes from Madonna Fritz [ph.] Your line is open, and please state your organization.

DR. CLARK: BlueCross BlueShield Arizona. This is Dr. Clark, the medical director. It may seem a little bit out of order, but I'm going to assume every beneficiary that applies for this is going to assume he or she will get a complete physical examination. This is not addressed. The physical exam has been almost allocated to other sources. Please explain that to me, will you? If this is an IPPE and a physical, that means a hands-on physical.

DR. SANDERS: This is Dr. Sanders. The goal of the benefit was to allow discussion, education, and information about prevention, not so much focus on a physical examination. That is why we only specified those things that were required by the statute, the height, weight, the blood pressure, the EKG, and we added one more, which was a visual acuity screen, which is recommended by the U.S. Preventive Services Task Force as an important part of prevention.

Otherwise, we left the actual physical examination up to the provider performing the benefit so that if they felt like other physical examination maneuvers didn't need to be performed at that time, more focus on other issues could be addressed.

DR. CLARK: Dr. Sanders, every beneficiary that comes into the office expecting to have an IPPE is going to expect a complete physical, and that includes the Pap smear for the female and the prostate exam for males. I don't know how you're going to avoid that without a lot of misunderstanding on their parts.

DR. SANDERS: Actually, we are not asking to

avoid that. If, as part of the preventive services, a female would like a pelvic and Pap, that is a separately covered benefit under Medicare and could be performed, you know, during that visit or subsequently. That is not an issue that that could not be performed.

DR. CLARK: If it is performed, is it billed separately?

DR. SANDERS: It would be billed separately.

DR. CLARK: A prostate exam is addressed separately from the -- also separately from the physical examination, from this?

DR. SANDERS: For the prostate exam, we will have to get back to you about that.

DR. CLARK: But, Dr. Sanders, my question is, seriously, the beneficiaries are going to expect -- historically. I have been in business a long time, and they will historically expect a physical examination when they are told they are having an initial preventive physical exam. How do you explain to them that they are not going to get the Pap smear if they are a female or a pelvic exam if they are female or a breast exam if they

are a female or a prostate exam if they are a male?

I don't mean to be difficult, but that is what is going to happen when they walk into my office.

DR. SANDERS: Again, I would just say that they are entitled to a Pap smear and pelvic exam, and that is separately covered under Medicare and billable.

Also, the idea is to get the beneficiaries excited about prevention, some of the education, some of the counseling you can provide, as opposed to actual physical examination. But again, the pelvic and such would be covered.

I will also give you an e-mail address where you can e-mail your questions and we will talk in detail with you further about that. That is contractortraining, all one word, @cms.hhs.gov.

MS. FRITZ: Did you say that they could bill those services separately from these preventive?

DR. SANDERS: Yes. The pelvic and Pap is a separately covered benefit. We are looking into the prostate examination, and we will get back to you about that on the next call.

MS. FRITZ: I have one additional question in Arizona, I'm sorry. I believe today Rural Health Clinics aren't required to HCPCS code. Do they need to at least HCPCS code these until April, or can we tell them they don't have to HCPCS at all?

DR. SANDERS: We will have to get back to you about that question, also. We apologize. We don't have someone here right this second to answer that.

MS. FRITZ: Should we just send our questions to this e-mail address?

DR. SANDERS: Yes.

MS. FRITZ: Okay. Thanks.

DR. SANDERS: Thank you.

THE OPERATOR: Jean Roberts, your line is open, and please state your organization.

MR. ROOK: Hi. Actually, this is Fred Rook [ph] from AdminiStar Federal here in Chicago. I had a question about slide nos. 27 and 28, dealing with the statutory basis for denials. It appears to me that these slides are actually in reverse with their statutory bunks here. It seems like Section 1862(a)(1)(K) deals with

limitation of liability for frequency purposes and not for time frame, and Section 1861(s)(2)(W) deals with time frame limits.

If you look inside the laws, you will see examples like immunosuppressive drugs under 1861(s)(2) that have time frames for 12-month, 36-month periods, whereas 1862, frequency, usually has to deal with other preventive services like mammographies, providing so many frequencies in time frames.

So, I think that these slides need to be taken a look at again. Cindy, if you have doubts, just let me know, but it seems like the quotes are backwards.

Dr. Sanders: Okay. Thank you. We will follow up with that.

THE OPERATOR: Our next question comes from Lori Langavan [ph.] Your line is open, and please state your organization.

MS. DEMELLO: Hi, yes, this is Carol Demello [ph] calling from Rhode Island Medicare. I'm speaking in place of Lori.

I just had a question on the EKG. Am I

understanding this that the EKG has to be done as part of the IPPE?

DR. SANDERS: Yes. This is Dr. Sanders. That is the correct understanding.

MS. DEMELLO: So there wouldn't be a case where an IPPE would be done with no EKG?

DR. SANDERS: Correct.

MS. DEMELLO: Okay. Thank you.

DR. SANDERS: Although, you do understand that if the physician performing the IPPE could not perform the EKG in his office, he can refer it out.

MS. DEMELLO: Right. But it has to be done?

DR. SANDERS: Correct.

MS. DEMELLO: Okay. Thank you.

DR. SANDERS: You're welcome.

THE OPERATOR: Roberta Finn [ph], your line is open, and please state your organization.

MS. FINN: NIHP New England. Actually, one quick comment and one question, if I could. I don't have a slide to refer back to. I'm not sure if any other participant had problems downloading the presentation,

but two people here at our site had problems downloading.

My real question is that if a beneficiary books an IPPE but can't get an appointment until after their six months, how will that be handled?

MS. GILL: This is Pat Gill. It would be denied. It has to be done within that first six months of eligibility.

MS. FINN: Thank you.

THE OPERATOR: Christine Griffith [ph], your line is open, and please state your organization.

MS. GRIFFITH: Trailblazer Health Enterprises. We had a question, and we have heard it from some of the physicians that have to do with the E/M and the 25 modifier. The question they were asking was, what portions of the IPPE, you know, would they have to take out of their other E/M, or could they be duplicating some of the services. We didn't quite know how to answer that question.

MS. SCALLY: This is Kit Scally. We actually say that in the payment policy manual piece, which is in Publication 100-04, Chapter 12, Section 30.6.1.1. We say

that when you are reporting a medically necessary E/M at the same visit, some of the components of the medically necessary E/M service, for example a portion of the history or the physical exam, may have been part of the IPPE and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary E/M service.

So, we don't want duplication there. It would be expected that the physician or QNPP would, you know, extrapolate that out and select the lower level of E/M service.

MS. GRIFFITH: Yes. I guess we had just been asked the question of how they should do that, you know. So I guess, you know, because we had pointed them to that portion of the law, the manual, but they had still asked us, you know, well, how would you do that. So, I mean, I just thought you all might have some thoughts on it. Is there a separate type of document?

MS. SCALLY: If they were duplicating what they already did in the IPPE portion, then they are getting paid for that. They would not be expected to bill and

incorporate that into the level of the E/M visit. They would perhaps bill a lower level of E/M service.

MS. GRIFFITH: Okay. That is kind of what we had told them. So, thank you.

MS. SCALLY: Sure.

MS. PHILLIPS: Hi. This is Robin Phillips again. If anyone is having trouble downloading the PowerPoint slides, please send me an e-mail and I will send them to you. My e-mail address is rphillips, P-H-I-L-L-I-P-S, @cms.hhs.gov.

Also, at this time we would like to open the questions up to other calls.

THE OPERATOR: Our next question comes from Chris Maynard [ph.] Please state your organization.

MR. MAYNARD: Palmetto GBA, Ohio. In reference to slide 13, it talks about both IPPE and the EKGs must be performed and the EKG interpreted before either is billed. What is to stop a physician from billing the IPPE service if he refers the EKG out, and will that cause a denial for the EKG once that is billed?

MS. GILL: This is Pat Gill. No, it won't

cause a denial. Our policy is trying to emphasize to the providers that they need to talk with each other and kind of correspond when those claims will be submitted. That is how our policy on this could be emphasized to the provider. If the IPPE G0344 comes in first, we will pay it, followed by the EKG, we will pay it as long as it is done within the six-month time period, or reverse.

MR. MAYNARD: Okay. Thank you very much.

THE OPERATOR: Adrian Hamilton, your line is open, and please state your organization.

MR. HAMILTON: Cahaba GBA in Georgia. My question has been asked and answered. Thank you.

THE OPERATOR: Nancy Knudsen [ph], your line is open, and please state your organization.

PARTICIPANT: Her question has been answered. Thank you.

THE OPERATOR: If anyone further would like to withdraw their question, you can just press star-2. One moment.

Our next question comes from Melinda Stanley. Your line is open, and please state your organization.

MS. VAN DENBERGEN: This is Donna Van Denbergen, BlueCross BlueShield Nebraska. I just would like some clarification and educate me as to why the LDL had been excluded under the cardiovascular screening.

MS. ENG: This is Joyce Eng. Generally, when a lipid panel is performed, you calculate an LDL. When you have high triglycerides, it is important to do a direct measurement LDL, but a direct measurement is not part of this benefit.

Does that help you?

MS. VAN DENBERGEN: Yes.

THE OPERATOR: Our next question comes from Kelly Frye [ph], and please state your organization.

MS. FRYE: Yes, Empire Medicare Services. Question back to the ABN requirements for the IPPE. In the Medlearn Matters article that has been posted, we have no notification to the providers that an ABN is required in those two situations. So, we would like to submit a request for a revision to that article for that notification to prevent calls into the call center and potential review requests.

CMS PARTICIPANT: Can you send that to us to the e-mail box, please, and we will take care of that for you?

MS. FRYE: Yes, thank you.

THE OPERATOR: Janna Rash [ph], your line is open, and please state your organization.

MS. RUTHERFORD: Hi. This is Sandra Rutherford at Trailblazer. I was wondering, in anticipation for our phone call center, can we refer the provider community to your PowerPoint that you presented today?

CMS PARTICIPANT: I don't see why they can't use it.

MS. RUTHERFORD: Okay. Thank you.

THE OPERATOR: Fran Wiley, your line is open, and please state your organization.

DR. WINTER: Hi. This is Dr. Eugene Winter with CIGNA Medicare in Nashville. I would like to draw your attention to slide 12, where the service elements for the examination are listed. As you can see, there are five, and the fifth one states "other factors as deemed appropriate."

Now, if during that IPPE some abnormality is detected, for example if that patient happens to have high blood pressure, and the provider decides to pursue this further during that very same encounter, does this become an E/M code with a modifier 25 or is there another service or another factor as deemed appropriate and the next visit becomes, for lack of a better word, the medically necessary visit?

CMS PARTICIPANT: That question will have to be sent in.

MS. PHILLIPS: Actually, if you could send that question in to our e-mail box? This is Robin Phillips.

DR. WINTER: Okay.

MS. PHILLIPS: That would be very helpful.

DR. WINTER: Now, along the same line, the question comes about EKGs and any further evaluations that might be triggered by this visit.

MS. PHILLIPS: Our initial visit subject matter experts had to go to another meeting. So, if anyone on the call can send questions to the e-mail box, that would be helpful. We will get the answers back out to you on

the February 10th call.

THE OPERATOR: Our next question comes from Barbara Sauls, and please state your organization.

MS. SAULS: South Carolina Palmetto GBA. I'm curious on the statutory exclusion for the IPPE and the ABN. Why would you not use a Notice of Exclusion of Medicare Benefits if it is statutorily excluded?

MS. PHILLIPS: I'm sorry. Again, you are going to have to submit that question to the e-mail box. Contractortraining@cms.hhs.gov.

THE OPERATOR: Our next question comes from Linda Windley [ph.] Your line is open, and please state your organization.

MS. WINDLEY: Hi. This is Linda Windley from Noridian Administrative Services. Again, this is on the ABN, slide 29. If a provider is currently seeing a patient and now they turn 65, is it mandatory that they do the IPPE if a patient wants it?

MS. ROULAC: Unfortunately, our IPPE subject matter expert had to go to another meeting. So, any questions pertaining to IPPE at this time would have to

be sent to the e-mail address, and we will follow up with you.

MS. WINDLEY: Thank you.

MS. PHILLIPS: You're welcome.

THE OPERATOR: Any further questions in queue for IPPE, please depress star-2. One moment.

Our next question comes from Madonna Fritz. Your line is open, and please state your organization.

MS. LISANBERG: This is Lisa Lisanberg [ph], BlueCross of Arizona. I just need a little clarification on slide nos. 38 and 54, the cardiovascular screening and the diabetes screening as it relates to Rural Health Clinics.

We do not list Rural Health Clinics as being those providers that can bill. Is it correct that the Rural Health Clinics can perform these services but the hospitals bill them? Is that correct? Because of the diagnostics?

MS. PHILLIPS: We would like you to send that question in to the e-mail box, please, and we will get back with you on that.

MS. LISANBERG: Sure.

MS. PHILLIPS: Thank you.

THE OPERATOR: Sherry Thompson, your line is open, and please state your organization.

MS. THOMPSON: Palmetto GBA South Carolina. My question has previously been answered.

MS. PHILLIPS: Thank you.

THE OPERATOR: Next question comes from Robin Cappello [ph.] Your line is open, and please state your organization.

MS. WEBSTER: This is Susie Webster at UGS. I have two questions. First of all, the questions that are going to this e-mail address, I keep hearing reference that they will be talked about at the next training session. Will they also be posted somewhere? Because I don't know that we will all attend the second training session.

MS. PHILLIPS: I believe that we will have them posted on the website.

MS. WEBSTER: On the Medlearn website?

MS. PHILLIPS: Yes.

MS. WEBSTER: Okay. And then, my question regarding the training itself with the cardiovascular screening blood test, slide 35, the HCPCS that are identified are HCPCS that are used now and for which there are NCDs posted. I'm kind of wondering, a curiosity question, why there weren't special screening HCPCS decided. I can foresee that there might be some problem with bills pending for edits for super-ops when they really -- you know, the lipid panel was done for the screening test but they don't have the screening test diagnosis on the bill.

MS. GREENBERG: This is Anita Greenberg. You're correct. Because these blood tests are done so often and for different patient conditions, the process of creating separate HCPCS codes is becoming more cumbersome and the laboratory industry has difficulty. So this new benefit, we have tried to streamline it where they continue to use the same CPT codes for those different blood tests but they have to use a screening diagnosis code. And it will be up to the laboratories and physicians to bill and order that properly.

MS. WEBSTER: I guess I just foresee potential problems with the reasons for denial. If, by some chance, they do a lipid panel for the cardiovascular screening purpose but don't put the code, but they also don't have the code that is required for an NCD coverage, I was wondering, will the bill be denied for the right reason, I guess.

MS. PROCTOR-YOUNG: This is Joan Proctor-Young. I think we have taken steps. There is actually a CR out there circulating to update the NCD edit module. I think the bottom line here is that providers have to be educated that they have to bill using this procedure code with this diagnosis code, because that is the way to bill for a screening for the cardiovascular.

So, that is the other part of us, you know, emphasizing that they have to report it in the header and they have to point to that line item. That is the way to bill for cardiovascular screens.

MS. WEBSTER: And then, one final question. Will CWF be tracking all of these screening tests?

CMS PARTICIPANT: Yes.

MS. WEBSTER: They will each have their separate screens so to speak, then? Or will they all be combined in the screening? Like, right now there is a screening page, if you will, on CWF. Will they all be under that screening page, or will they each have their own separate page?

MS. PROCTOR-YOUNG: I believe it's 538T is the one for cardiovascular that you can look up the documentation, but it does take in consideration all of the codes, the individual components and the actual panels. All of them are being tracked.

MS. WEBSTER: Okay. Thank you.

THE OPERATOR: Katie Nadu, your line is open, and please state your organization.

MS. NADU: Anthem Health Plans of New Hampshire. On slide 38, it states that they will be covered when performed on an inpatient or outpatient basis in a hospital, critical access, SNF, et cetera. But then, it lists the types of bills that are submitted.

Now, I guess my question is, if the patient is an inpatient, this is paid outside of the DRG or RUG

code?

MS. PHILLIPS: Would you be able to send that question in to the e-mail box, please?

MS. NADU: Certainly. Thank you.

MS. GREENBERG: If it is inpatient and they have exhausted the Part B benefit, then they might need to continue to be able to get it under their Part B but to bill for the Critical Access schedule.

MS. NADU: Right. But this implies that if they are an inpatient under the Part A benefit that it would still be paid, and that is my question: is it paid separately?

MS. GREENBERG: Well, generally, if they are an inpatient, it is bundled under the DRG, but you can send your question in and we will try to get you the citation for that.

MS. NADU: Thank you.

THE OPERATOR: Again, parties, star-1 for questions, please. Star-1.

[Pause.]

THE OPERATOR: I am showing no further

questions.

MS. PHILLIPS: Thank you, Laurel.

Well, I want to thank everyone for participating on the call. Again, I want to remind you about the upcoming call February 10th at 1:00. If you have questions that you want answered, please send them to the contractor training mail box, contractortraining, all one word, @cms.hhs.gov.

I would like to thank all of our speakers and the participants on the call.

[Whereupon, at 2:20 p.m., the teleconference was concluded.]

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