Medicare

Overview:

- **"Health Insurance for the Aged and Disabled"**, Title XVII of the Social Security Act, signed into law on July 30, 1965 by President Lindon B. Johnson
- **Covers 95 percent of our nations aged population** (Over 42 million Americans in total)
- **Now includes prescription benefits**, effective May 2006, under Medicare Part D
- Private insurance companies (known as Medicare Administrative Contractors, or MACS) work under contract with Medicare at the national level to develop medical coverage policies, administer benefits, and process fee-for-service claims at the local level
- Can be either Traditional or Managed Care (*Medicare + Choice, Medicare Part C*)

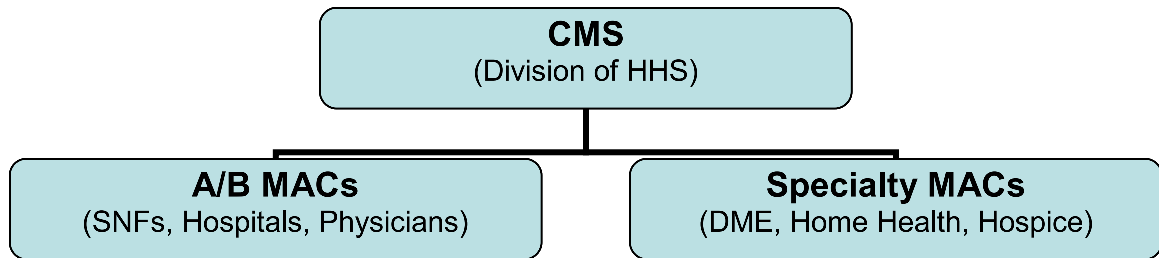
Medicare Eligibility:

- The beneficiary or spouse must have worked at least 10 years in Medicare-covered employment
- The beneficiary must either be a citizen of the United States or a permanent resident
- Those who paid Medicare taxes while working receive Part A benefits automatically when they turn 65 years of age. They do not have to pay a premium for Part A if they worked for 40 quarters of coverage.
- For those who worked 30-39 quarters paying Medicare taxes, those persons are required to pay a reduced Part A monthly premium. (amt differs each year based on inflation)
  *For 2007, the Part A reduced-rate premium is $226.00 per month
- For those who worked under 30 quarters paying Medicare taxes, the Medicare Part A premium for 2007 is $410.00 per month.

Three Main Entitlements:

- **Elderly** – Aged 65 and older
- **Disabled** – Two year wait period before eligible upon applying
- **End-Stage Renal Disease** – Medicare Part B benefit
  1.) *Dialysis patients* - up to 12 months after last routine dialysis, and
  2.) *Transplant patients* - up to 36 months post-solid organ transplant
- Certain otherwise non-covered persons who elect to buy into Medicare

The Players:



The Centers for Medicare and Medicaid Services (CMS) – A federally mandated United States Government administration working under the Department of Health and Human Services (HHS) that administers the Medicare and Medicaid programs, and establishes and enforces standards that regulate the quality of healthcare provided in nation-wide healthcare facilities

A/B MACs – Also known as *Medicare Administrative Contractors*, A/B MACs process both Medicare Part A and Part B medical claims at the local level, including all hospital, skilled nursing facility, physician office, and other institutional service claims.

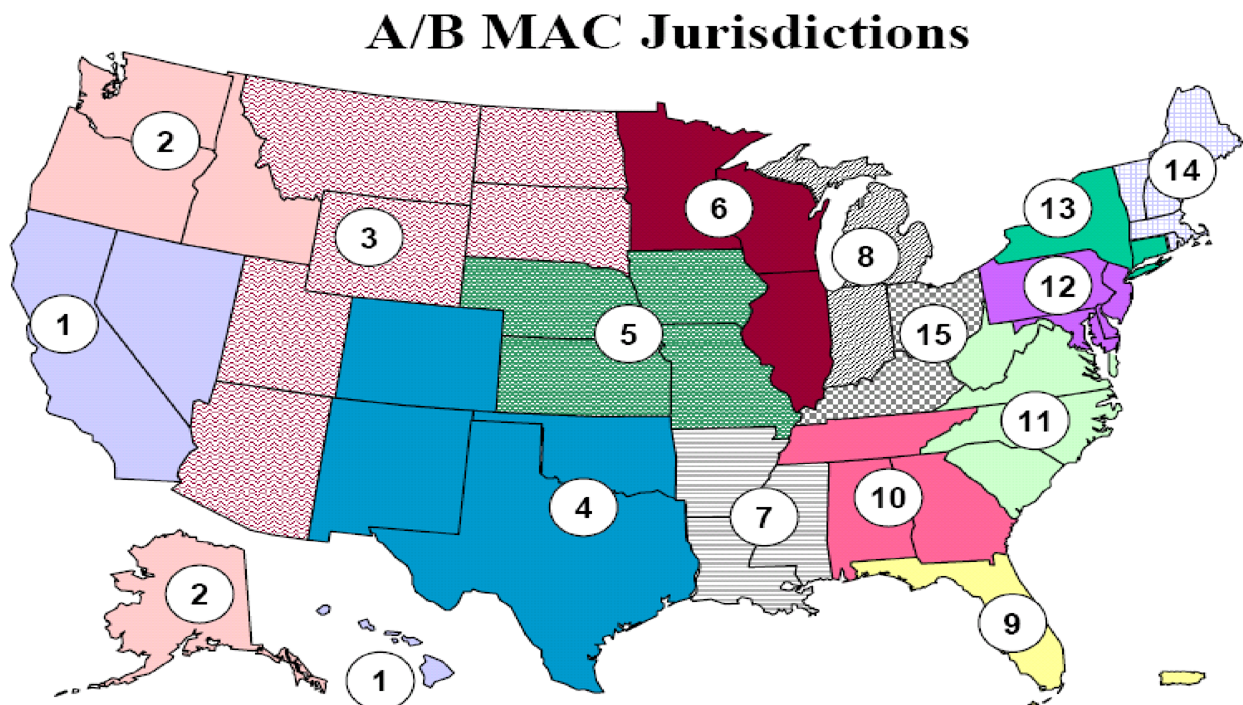
A/B MAC Responsibilities:

- Claims Processing
- Beneficiary and Provider Customer Service
- Appeals
- Provider Education
- Financial Management
- Provider Enrollment
- Reimbursement
- Payment Safeguards
- Information Systems Security

A/B MAC Jurisdictions

Jurisdiction #	States Included in Jurisdiction
1	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands
2	Alaska, Idaho, Oregon, and Washington
3	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming
4	Colorado, New Mexico, Oklahoma, and Texas
5	Iowa, Kansas, Missouri, and Nebraska
6	Illinois, Minnesota, and Wisconsin
7	Arkansas, Louisiana, and Mississippi
8	Indiana and Michigan
9	Florida, Puerto Rico, and U.S. Virgin Islands
10	Alabama, Georgia, and Tennessee
11	North Carolina, South Carolina, Virginia and West Virginia
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania
13	Connecticut and New York
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
15	Kentucky and Ohio

You can also refer to the A/B MAP Jurisdictions map below for specific state assignments.



***Information taken from CMS [Contracting Reform] data.**

Specialty MACs – Specialty MACs are responsible for processing all Medicare Part A and Part B medical claims related to Durable Medical Equipment (DME), Home Health, and Hospice at the local level.

NOTE: There are 4 assigned Specialty MACs (Regions A-D)
(Refer to the map below for individual state assignments)

*__Region A__ will be administered by the Jurisdiction 14 A/B MAC
*__Region B__ will be administered by the Jurisdiction 15 A/B MAC
*__Region C__ will be administered by the Jurisdiction 11 A/B MAC
*__Region D__ will be administered by the Jurisdiction 6 A/B MAC

Specialty MACs Responsibities:

- Claims Processing
- Beneficiary and Provider Customer Service
- Appeals
- Provider Education
- Financial Management
- Provider Enrollment
- Reimbursement
- Payment Safeguards
- Information Systems Security

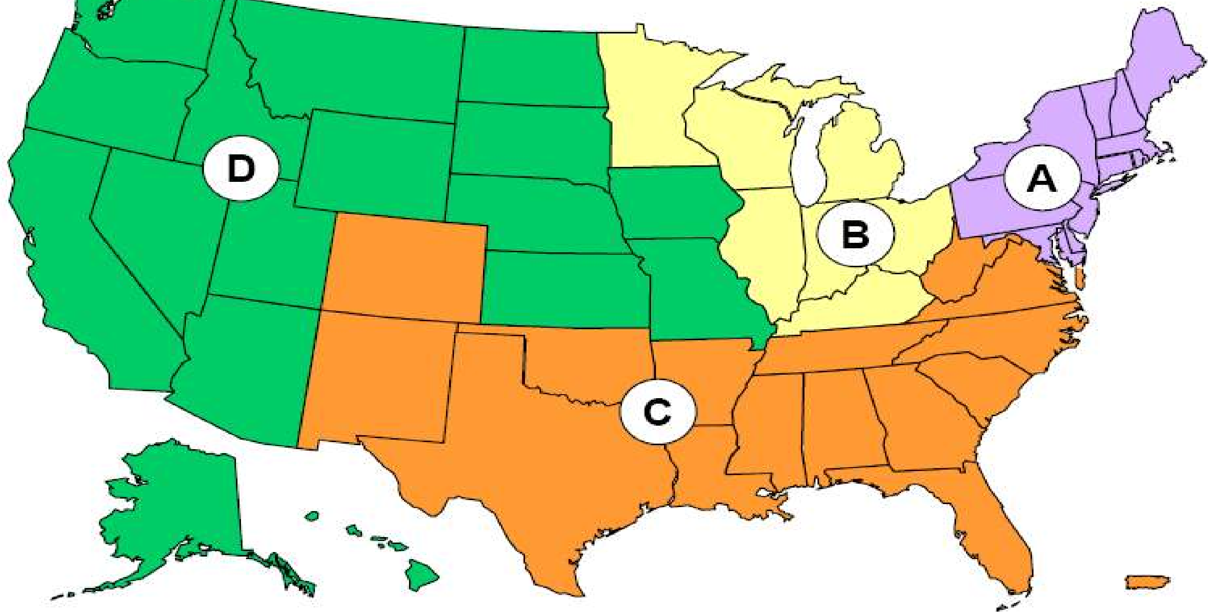
Specialty MAC Jurisdictions (DME and Home Health/Hospice)

Jurisdiction	States Included in Jurisdiction
A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin
C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia
D	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming

Durable Medical Equipment Coverage Criteria:

- Equipment withstands repeated use
- Is used primarily and customarily to serve a medical purpose
- Generally is not useful to a person in the absence of an illness or injury
- Appropriate for use in the home (e.g. wheelchairs, hospital beds, home oxygen equipment, and artificial limbs)

You can also refer to the Specialty MAC Jurisdictions map below for specific state assignments.



***Information taken from CMS [Contracting Reform] data.**

Medicare Part A (Major Medical Insurance):

Institutional services - Paid by the local A/B MAC, and billed on a UB04 (HCFA 1450) claim form.

Hospital Inpatient

- **Benefit Period -** *Measurement of time-duration for inpatient care*
  - Starts when beneficiary enters the hospital
  - Ends when a break of at least 60 consecutive days since inpatient hospital or skilled nursing facility care occurs
  - No limit to number of benefit periods covered by Medicare Part A during a beneficiary's lifetime. However, co-payments are required for inpatient stays beyond 60 days, from days 61-90. After beneficiary exhausts the 90 days of inpatient hospital care, he or she can then elect to use up to a total of 60 additional days from a non-renewable lifetime reserve.

- **Inpatient Benefits**
  - Semi-private room
  - Meals
  - Regular nursing services
  - Operating and recovery room
  - Intensive care
  - Drugs
  - Laboratory tests
  - X-rays
  - All other Medically necessary services and supplies

Skilled Nursing Facilities (SNF)

- **Benefit Period**
  - Limited number of days, up to 100 per benefit period
  - Co-payment required for days 21-100

- **SNF Benefits**
  - Medicare Fiscal Intermediary pays only if it follows within 30 days of a hospitalization of three or more days, and is certified as medically necessary.
  - Same benefits as Hospital Inpatient, but also includes rehabilitation services and appliances.

Home Health Services

- **Benefit Period**
  - Medicare will pay for some Home Health Care services under the Medicare Part A benefit, but generally, they are covered under the Medicare Part B benefit

    - The Fiscal Intermediary will only pay of there's a set plan of treatment and a periodical review by a physician. There is no time limitation.

- **HHA benefits**
    - Home Health Aide may be furnished by a Home Health Agency (HHA) in the residence of a home-bound beneficiary if intermittent or part-time skilled nursing, physical therapy, or rehabilitation care is necessary.
    - The Fiscal Intermediary will pay for the full allowed amount of the services rendered, meaning that the patient has no co-payment, and no deductible amounts
    - Full-time nursing care, food, blood, and drugs are NOT provided as HHA services

Hospice Care

Hospice Care is a service provided to those terminally ill persons with a life expectancy of six months or less who elect to forgo traditional medical treatment for the terminal illness, and to receive only limited hospice care.

- **Benefit Period**
    - Medicare will pay for all necessary-covered services to treat and comfort a patient until the patient becomes deceased

- **Hospice Benefits**
    - Pain relief
    - Supportive medical and social services
    - Physical therapy
    - Nursing services
    - Symptom management for a terminal illness
    - Beneficiary pays no deductibles, but does pay a very small co-insurance amount for drugs and the cost of respite care

Critical Access Hospitals

- **Overview**
    - New class of Medicare providers
    - Advantage: Reimbursement Structure
    - CAH status is voluntary
    - Started with the passing of the Rural Hospital Flexibility Program (FLEX) in 1997. The FLEX program adjusted rural localities reimbursement rates to help compensate for higher costs.
    - **Limited service, rural hospitals (CAH Criteria):**
        - A hospital must be classified as rural by their own state regulations, but be under government control.
        - Must be located at least 35 road miles (15 in mountainous areas) from the nearest short-term general hospital
        - Permitted to operate no more than 15 acute-care beds
        - May operate an additional 10 swing beds for long-term care (LTC) patients

- **Benefit Period**
    - Individual patient stays are limited to 4 days

- **Critical Access Hospital Benefits**
  - The covered benefits are the same as they would be in the Hospital Inpatient setting, see list above, but the **Medicare reimbursement structure and amounts differ.**
- **Critical Access Hospital Reimbursement Structure**
  - **Standard Method** – The FI will pay 80% of 101% of the reasonable costs of services provided. A physician's professional services component is billed separately to Medicare Carrier.
  - **Elective Payment Method** – The FI will pay 115% of the physician fee schedule, plus an additional 10% incentive payment for qualified, licensed physicians. Non-licensed physician/practitioners are only reimbursed at 115% of 85% of the physician fee schedule.

Medicare Part A Benefit Summary:

Setting	***Benefit Period***	***Entitled Benefits***
Hospital Inpatient	From time patient enters hospital until there's been a break of at least 60 consecutive days. There's currently NO LIMIT to the number of benefit periods during patient's lifetime.	Semi-private room, meals, regular nursing services, operating and recovery room, intensive care, drugs, lab tests, X-rays, all other medically necessary services and supplies.
Skilled Nursing Facility	Limited number of days, up to 100 per benefit period	Same benefits as Hospital Inpatient, but also includes rehabilitation services and appliances
Home Health Services	No time limitation, but patient must have a set plan of treatment, and periodic review by physician	The FI will pay for the full allowed amount (patient has no co-pay or deductible). Full-time nursing, food, blood, and drugs NOT covered.
Hospice Care	Until the patient becomes deceased	Pain relief, supportive medical and social services, physical therapy, nursing services, symptom management. Patient pays no deductibles, only small co-insurance amount for drugs and the cost of respite care.
Critical Access Hospitals	Individual patient stays are limited to 4 days	Benefits are the same as they would be in the hospital inpatient setting, see list above, but the **Medicare reimbursement structure and amounts differ.**

Medicare Part B (Supplemental Insurance):

Overview

- Is an optional supplemental insurance program where people must pay a Medicare Part B premium (currently set at $93.50/month for 2007) to be enrolled. Patient must already be enrolled in Medicare Part A, however, to be eligible to buy into Medicare Part B.
  - Premium may be higher, in some cases, if Part B enrollment did not occur during a 7-month period that begins 3 months before turning 65 years of age. The cost goes up 10% for each 12-month period that Part B enrollment does not occur. The beneficiary is required to pay this extra 10% for the remainder of his or her lifetime.
- Medicare Part B covers physician services component in all settings: hospital (inpatient and outpatient), skilled nursing facility, physician office, free-standing center, home health, etc. (billed on HCFA 1500)

Physician Office/Free-standing Facility Services – Paid for by the local A/B MAC, and billed on a HCFA 1500 claim form.

- Covered Services
  - Doctors services
  - Clinical laboratory tests
  - Flu vaccinations
  - Most supplies
  - Diagnostic tests
  - Some other therapy services
  - Most drugs, drugs which cannot be self-administered
    - Drugs that are deemed reasonable and necessary for the treatment for which it is used,
    - Drugs that are administered "incident to a physician's service", and
    - Drugs that the Food and Drug Administration (FDA) has not deemed less effective than current therapies
  - Special exception self-administered drugs (Pharmacy setting)**-** Medicare covers the following medications under the Medicare Part B benefit
    - Oral anti-cancer drugs
    - Immunosuppressives
    - Blood clotting factors for hemophelia
    - Whole blood given to a hospital outpatient
    - Antigens
    - Pneumococcal pneumonia and hepatitis B vaccinations
    - Epoetin alpha (EPO) provided to treat anemia in ESRD patients
    - Injectable osteoporosis drugs

Hospital Outpatient Setting– Paid for by the local Medicare Fiscal Intermediary, and billed on a UB04 (HCFA 1450) claim form.

- Covered Services
  - Doctors services
  - Outpatient hospital care
  - Clinical laboratory tests
  - Durable medical equipment
  - Drugs which cannot be self-administered
  - Most supplies
  - Diagnostic tests
  - Ambulance services
  - Some other therapy services
  - Blood not supplied by Part A
  - Certain other health care services

Healthcare Services NOT Covered In Any Setting – (Hospital Inpatient, Hospital Outpatient, Pharmacy, Skilled Nursing Facility, Home Health, or Physician Office/Free Standing Center)

- Medicare does NOT cover the following:
  - Long-term nursing or custodial care
  - Dentures and dental care
  - Eyeglasses
  - Hearing aides
- These are NOT a part of either the Medicare Part A, Part B, or Part D Programs, unless they are a part of a special Medicare Managed Care plan [Medicare Part C = Medicare + Choice Plan (HMO, PPO, POS, etc.)]

Medicare Part B Benefit Summary:

Setting	***Entitled Benefits/Covered Services***	***Non-Covered Medicare Services*** **NOTE: This also applies to Part A**
Physician Office/Free-Standing Center	Doctors services, clinical lab tests, flu vaccinations,most supplies,diagnostic tests,some therapy services,most drugs (NOT self-administered), and c*ertain special exception self-administered drugs (see list)*	Long-term nursing or custodial care, dentures and dental care, eyeglasses, or hearing aides
Hospital Outpatient	Doctors services, outpatient hospital care,clinical lab tests,durable medical equipment,drugs not self-administered,most supplies,diagnostic tests,ambulance services,some therapy services, blood not supplied by Part A, etc.	Same as above
Home Health Services	Same benefits as Hospital Inpatient (see hospital inpatient benefits), and some outpateint services	Same as above. Also includes full-time nursing, food, blood, and drugs NOT covered

Medicare Part D (Prescription Drugs Insurance) – Overview

As part of the Medicare Modernization Act (MMA) of 2003, and implemented in May 2006, Medicare now offers a new Part D Prescription Drugs program to provide coverage for drugs and biologicals dispensed in the pharmacy setting. Certain prescription medications may have restricted or limited Medicare coverage, however, and certain drugs might not have Medicare coverage at all, depending on the patient's individual plan, even some by statute.

*Enrolling in a Medicare Part D Prescription Drugs plan is **optional**, similar to the Part B enrollment process, but for a patient to be eligible, they must already be enrolled in Medicare Parts A & B, then pay an additional premium for Part D*

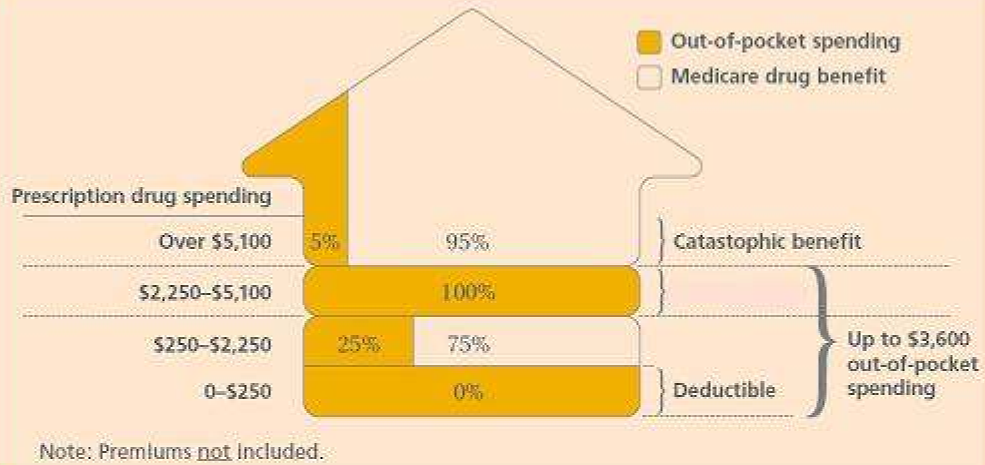
The Medicare Part D statute describes a standard benefit structure:

- $250 deductible
- 25% coinsurance on formulary drugs between the deductible and initial coverage limit;
- $2250 initial coverage limit on total drug expenses;
- $3600 out-of-pocket threshold, reached after total drug costs equal $5100;
- Catastrophic coverage of no more that 5% co-insurance for formulary drugs.

NOTE: The deductible, initial coverage limit and out-of-pocket threshold can increase each year based on increases in expenditures for Part D drugs. Part D monthly premiums can also differ for each patient, depending on the type of prescription drug plan the patient is enrolled in.

The standard statutory Part D drug benefit provides for drug coverage for formulary drugs up to an initial coverage limit of $2250. Upon reaching this coverage limit, beneficiaries fall into the Donut Hole; that is, they become responsible for the full cost of their formulary medicines. They do not get out of this coverage gap unless and until they incur $3600 in out-of-pocket costs for drugs **on their Part D formulary** – for a total of $5100 in costs for formulary drugs - in the same calendar year. They are, of course, also responsible for the full costs of non-formulary and non-covered drugs. Beneficiaries who reach $3600 in qualifying out-of-pocket expenses are eligible for catastrophic drug coverage in the form of reduced cost sharing.

***Refer to the chart below for a visual overview of the Medicare Part D structure**



*Information taken from CMS Part D Medicare Coverage data.

There have been mixed feelings from both patients and providers about this new prescription drug plan in general, as the costs are still significant to those who are subject to a limited income, but it has helped a lot of Medicare patients, overall, in being better-able to afford the costs of their prescription drugs.

Other Medicare Options:

Medicare beneficiaries typically get their Medicare in one of five ways:

1. Original Medicare only, or Original Medicare and a Medigap ('Supplement') Policy without drug coverage.
2. Original Medicare and a Medigap ('Supplement') Policy with drug coverage.
3. Retiree or union coverage. In most cases, people with good retiree or union coverage can continue to get it with new financial support from Medicare.
4. Medicare Advantage Plan (like an HMO or PPO) or other Medicare Health Plan, which already include drug coverage and other extra benefits.
5. Dual coverage from Medicare for both medical and drug coverage.

****Qualified Medicare Beneficiaries**, or Dual-Eligible QMB patients, who used to receive prescription benefits through Medicaid, are automatically enrolled in Medicare Part D, and the Medicare program pays their monthly premiums.*

Supplemental Plans - Additional coverage over and above Medicare Parts A and Parts B

Medigap Plans – Medicare supplemental insurance plans in which a regular (non-managed care) Medicare beneficiary has both Medicare Part A and Part B of the original plan, plus one of ten supplemental Medigap plans (A-J), sold by private insurance companies. These Medigap plans, A through J, provide sets of benefits determined by CMS (formerly the Healthcare Financing Administration, HCFA). Beneficiaries pay an extra premium to the private insurance company to be enrolled in the selected plan, and the company provides additional coverage according to the selected plans benefits, whether it be prescription drug coverage, deductibles, at-home recovery, or emergency foreign travel.

NOTE: A beneficiary is NOT eligible to enroll if they do NOT have both Medicare Part A and Part B.

Refer to the chart below for the various Medigap plan specifications:

Medigap Plans (A – J) Benefits overview

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-linsurance	Skilled Nursing Facility Co-linsurance	Skilled Nursing Facility Co-linsurance	Skilled Nursing Facility Co-linsurance	Skilled Nursing Facility Co-linsurance	Skilled Nursing Facility Co-linsurance	Skilled Nursing Facility Co-linsurance	Skilled Nursing Facility Co-linsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1250 Limit)	Basic Drugs ($1250 Limit)	Extended Drugs ($3000 Limit)
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

Medicare + Choice (Medicare Part C) – Optional variations to the regular Medicare plan for patients who are not on Medicare due to End-Stage Renal Disease

Private Fee-for-Service Plans – Medicare pays a set amount of money every month to the private insurance company to provide health care coverage to people with Medicare on a pay-per-visit arrangement. In a fee-for-service plan, the Medicare beneficiary must pay a premium over and above the Medicare Part B premium, but they are not restricted to network physicians or hospitals. All services normally covered under Original Medicare are provided, but extra, additional benefits may apply, such as outpatient prescription drugs.

Medicare Managed Care Plans - Are pre-paid health care plans, such as health maintenance organizations (HMOs), in which the Medicare beneficiaries receive their medical services at a comprehensive health care setting within a service area. The selected public or private organization provides health care services at a per-person payment rate that is pre-determined, regardless of frequency or extent of utilization by its enrollees. The beneficiary, however, is limited to use only the professionals and facilities affiliated with the HMO or CMP that the beneficiary has selected, except, of course, in emergency situations.

In addition to those services that are usually provided under Medicare fee-for-service plans, the managed care plans often cover other services, such as preventative care,

eyeglasses, dental care, or hearing aids. Electing to participate in a managed care plan may also serve as an alternative to purchasing Medigap insurance, which is often wanted if the beneficiary is in a traditional fee-for-service plan. Overall, despite certain restrictions and limitations, the managed care plan's larger fixed monthly premiums and smaller coinsurance payments help to provide more predictability for out-of-pocket costs for the beneficiaries who do not have Medigap insurance.

Medicare Payment Systems:

Definitions/Overview/Types:

***Prospective Payment System* –** System in which forecasting the cost of services based on a patient's diagnosis determines flat rates for the payment of those services. The federal government uses this system to reimburse hospitals for both inpatient and outpatient care delivered to Medicare subscribers.

***Bundling* –** Grouping services based on some commonality, does not distinguish between medical services and supplies.

***Fee Schedule* –** List of payment rates for services based on the codes used to categorize the service.

Codes – Alpha numeric systems that provide information to insurers (e.g. CPT, HCPCS, ICD-9). They describe medical services, supplies, and diagnoses, and are used on insurance claim forms. These codes enable insurers to process claims and pay providers. They allow consistent processing of claims and appropriate reimbursement for medical services.

Diagnosis Related Groups (DRGs) – Hospital Inpatient

A prospective payment system administered by CMS in which services are forecasted and bundled by principle diagnosis. The hospital receives a fixed payment for each type of inpatient medical procedure, regardless of whether the hospital's cost is greater or less than the payment itself. DRGs include payment for diagnosis, procedures, services, and drugs, but NOT physician services.

DRG's defined and assigned by the following factors:

- Principle diagnosis upon admission (ICD-9)
- Presence of any co-morbidities or complications (CCs)
- Surgery
- Patient's age
- Discharge status

DRG assignment is based on ICD-9 codes:

- ICD-9s provide a diagnosis code, which is used to assign DRGs
- Many different ICD-9s will be bundled into the same DRG
- Only 1 DRG per patient
- Two patients with same diagnosis may generate different payment rates due to other factors when assigning DRGs (e.g. age, sex, discharge status, etc.)

DRG Breakdown: ICD-9 → DRGs → MDCs

- ***International Classification of Diseases, 9th Edition (ICD-9) Codes*** – Thousands of codes defining diagnoses. A coding system that includes codes for both diagnoses and certain procedures. ICD-9 codes are used by all types of providers for listing their patients' diagnoses on claim forms.

- **ICD-9 Diagnosis Codes - Clinical Modification (CM)** – Administered by the National Center for Health Statistics (NCHS) and CMS, and are used exclusively by hospitals for inpatient procedures. They classify patient diagnosis by disease and injury. There are up to 5 digits to describe disease type, disease subtype, and any additional information: 3 digits (disease type), period, 1 digit (disease subtype), period (additional information).

- **ICD-9 Procedure Codes** – Used in conjunction with ICD-9-CM diagnosis codes. Hospitals use them for procedures, and they help drive DRGs.

- ***DRGs*** – Hundreds of codes defining groups of services based on diagnoses (See above)
- ***Major Diagnosic Categories (MDCs)*** – Prospective payment system that bundles services based on procedure. MDCs are 25 categories based on the body's systems, and are grouped by DRGs.

Revenue Codes: Hospitals also use Revenue Codes on claim forms to help identify specific accommodations, ancillary services, or billing calculations. They help describe items and services, and record costs. Revenue codes are administered by the American Hospital Association (AHA), and include items such as durable medical equipment, laboratory, radiology, room and board, IV therapy, anesthesia, blood, and emergency room.

Ambulatory Payment Classifications (APCs) – Hospital Outpatient

A recently implemented prospective payment system created by CMS that bundles hospital outpatient services by their clinical similarity, and hospitals are paid a lump sum/fixed payment for a variety of services, similar to DRGs. There are hundreds of HCPCS and CPT codes grouping procedures and drugs based on clinical similarity. Services for one patient may map to more than one APC.

APCs defined and assigned by the following factors:

- CPT codes are grouped into clinically similar groups, but only those applicable to the hospital outpatient setting.
- Any procedure done on an outpatient basis can be billed to its corresponding APC. (It's possible to bill more than one APC, not only per visit, but also per procedure.)

There are currently 3 major APC groups:

- Significant procedures and therapies
- Medical visits
- Ancillary services

APC Breakdown: CPT/HCPCS → APCs

- ***Current Procedural Terminology (CPT) codes (HCPCS - Level I)*** –

A coding system maintained by the American Medical Association (AMA) that is used to outline thousands of procedures or drugs, describes physician services in all settings, and is required for some hospital outpatient claims. The system includes an exhaustive list of surgical and medical procedures performed by physicians, as well as codes for consults, visits, and diagnostic tests. CPT codes are 5 digit codes, and are updated annually.

CPT codes have 2 components (to bill only one, providers must use a modifier):

- **Professional** – cognitive services
  - Modifier: *(5 digit #) – 26 means Professional Only*
- **Technical** – Supplies, equipment, capital, overhead, and malpractice insurance
  - Modifier: *(5 digit #) – TC means Technical Only*

****NOTE**:** CPT codes are often used interchangeably and synonymously with HCPCS codes, and depending on the level or category, they can even be one and the same.

3 Health Care Common Procedure Coding System (HCPCS) Code Categories/Levels:

- **Category I CPT codes –** Level I consists of CPT codes. These describe physician services in both inpatient and outpatient settings. A CPT code is a procedure or service identified with a five-digit code (e.g. 10001-99999). CPT codes are administered by the American Medical Association (AMA).
- **Category II CPT codes – (Performance Measurement)** – Level II denotes HCPCS codes. These codes are used for supplies, drugs, and miscellaneous codes not described by CPT codes, and are billing codes for most supplies, drugs, and medical items covered under Medicare. These codes begin with a single letter (A to V) followed by four numeric digits. J codes are for drugs administered other than oral.

  Category II CPT codes are intended to facilitate data collection by coding certain services and/or test results that are agreed upon as contributing to positive health outcomes and quality patient care. This category of CPT codes is a set of optional tracking codes for performance measurement. These codes may be services that are typically included in an Evaluation and Management (E/M) service or other component part of a service and are not appropriate for Category I CPT codes. The use of tracking codes for performance measures will decrease the need for record abstraction and chart review, thus minimizing administrative burdens on physicians and survey costs for health plans.

- **Category III CPT Codes (Emerging Technology)** – Level III designates alphanumeric codes issued by local carriers. The purpose of this category of codes is to facilitate data collection on and assessment of new services and procedures. These codes are intended to be used for data collection purposes to substantiate widespread usage or in the Food and Drug Administration (FDA) approval process.

HCPCS Category/Level Summary:

Category	*What are these codes used for*	*Why are they used*
Category I CPT codes (HCPCS Level I)	**CPT codes** - These codes have five digits, #00000, and are used to describe physician services and procedures in both inpatient and outpatient settings. (They often have modifiers, additional 2 numbers: 26 0r TC, if not billing for both professional and technical components)	CPT/HCPCS codes assist insurers in being able to properly identify, track, and reimburse providers appropriately for a rendered product or service
Category II CPT codes (HCPCS Level II)	**HCPCS codes** - These codes are used for supplies, drugs, and miscellaneous codes not described by CPT codes, and are billing codes for most supplies, drugs, and medical items covered under Medicare. These codes begin with a single letter (A to V) followed by four numeric digits. J codes are for drugs administered other than oral.	In addition to adequate reimbursement to providers, these codes are intended to facilitate data collection. This category of CPT codes is a set of optional tracking codes for performance measurement. The use of tracking codes for performance measures will decrease the need for record abstraction and chart review, thus minimizing administrative burdens on physicians and survey costs for health plans.
Category III CPT codes (HCPCS Level III)	Designates alphanumeric codes issued by local carriers	These codes are used to facilitate data collection on and assessment of new services and procedures, and are intended to be used for data collection purposes to substantiate widespread usage or in the Food and Drug Adminstration (FDA) approval process.

Resource-Based Relative Value Scale (RBRVS) – Free-Standing Centers/Physician Offices

Services are paid according to a fee schedule, and free-standing centers/physician offices are paid at a flat rate based on HCPCS codes. Physicians bill for procedures with CPT codes, which are then assigned a relative value unit (RVU). RBRVSs are composed of RVUs that are converted to a dollar amount for payment rates.

A fee schedule is a chart listing payment rates for procedures and drugs, and lists the maximum fees that an insurer will pay for certain services.

RBRVS is a fee schedule based on the resources associated with individual procedures. It was adopted as the basis for physician payment for Medicare Part B services, and is now also used by several other payers.

The relative value of each service is the sum of values assigned to the following:

- **Professional Component** - Physician work
- **Technical Component** - Practice expense
- **Malpractice Component** - Professional liability insurance costs
- **Geographic Modification** – Population/Standard of Living adjustment

(Work RVUs) + (Practice Expense RVUs) +(Malpractice RVUs) = Total RVUs

Each factor is adjusted for each locality by geographic adjustment factors, such as population, income per capita, etc.

RBRVS is defined and assigned by the following factors:

- Payments are determined by resource costs
- Services are assigned "value units" to which a conversion factor (CF) is applied.
  - CF is determined by CMS (formerly HCFA)
  - CF converts relative "value units" into dollars.
  - **CF for 2007 is currently set at $37.8975**

Every CPT code has a corresponding RVU, and costlier procedures are assigned higher RVUs. Also of note, not every RBRV will incorporate all three RVUs. For example, if a physician did not actually provide the service, the labor component cannot be billed.

RBRVS Breakdown: HCPCS → 106% of the drug's ASP and
CPT → Fee Schedule based on RBRVS

NOTE: Reimbursement for Medicare-covered drugs in this setting, effective as of January 2005, and based on the MMA 2003 statute, is currently based on 106% of the drug's Average Sales Price. (Prior to MMA 2003, drugs were reimbursed at 85% of the drugs Average Wholesale Price (AWP) amount.)

NDC/DMEPOS – Home Health Agencies

- **National Drug Codes (NDCs)** – Used mainly on pharmacy claims. NDCs are a unique identifier for drugs provided by the Food and Drug Administration. Drugs have unique NDCs for each strength of medication and packaging size. The code is composed of 11 digits – first 5 refers to the manufacturer, the next four refers to the drug compound, and the last two refers to dosing administration. The code is in the following format: 00000-0000-00.

  Note: Specialty Macs (for Durable Medical Equipment, DME, claims ONLY) may starting using NDC codes instead of HCPCS codes to process claims, and if they do, CMS must create a ***"crosswalk file"*** that will map existing HCPCS to the appropriate NDC. The crosswalk will include all drugs for which claims are submitted to the DME Specialty MACS. The crosswalk file must be maintained by each DME Specialty MAC.

  NDC Breakdown: HCPCS → 106% of the drug's Average Sales Price (ASP) and CPT → Fee Schedule based on RBRVS

- **Durable Medical Equipment Prosthetics/Orthotics and Supplies (DMEPOS)** – A fee schedule created by CMS that takes into consideration geographic location. Drugs are currently paid at 106% of the Average Sales Price (ASP). Claims are submitted to the appropriate DME Specialty MAC.

Clinical Laboratory Fee Schedule – Clinical Laboratory

This fee schedule created by CMS lists contains national limits and pricing amounts for each procedural code (HCPCS), and is subject to payment methodology. Medicare will reimburse tests for diagnosis, but not tests for screening purposes.

Ambulatory Surgical Center (ASC) Fee Schedule –

A fee schedule created by CMS in which CPT codes are classified into one of 8 groups, and each group receives a flat reimbursement rate. These include nursing services, supplies, equipment, and the use of the facility. Payment is also adjusted for geographical location.

Summary of Medicare's Major Payment Systems:

Setting	*Payment System*	*How it works*
Hospital Inpatient	DRGs	Bundling services based on diagnosis (ICD-9)
Hospital Outpatient	APCs	Bundling services based on clinical similarity (HCPCS)
Home Health/Free-Standing Center/Physician Office	RBRVS	Fee Schedule (HCPCS)