Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-03-134 **Date: AUGUST 22, 2003**

CHANGE REQUEST 2880

SUBJECT: Modifier and Condition Code for Providers to Use When Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare+Choice Plan

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) has recently expanded coverage on implantable automatic defibrillators. See information in the Coverage Issues Manual (CIM) section 35-85 for more information on this expanded coverage policy. Until Medicare capitation rates to Medicare +Choice (M+C) organizations are adjusted to account for this expanded implantable automatic defibrillators coverage, Medicare will pay providers on a fee-for-service basis for implantable automatic defibrillators that fall under the new indications (See CIM 35-85.A4-5).

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

This program memorandum instructs physicians/practitioners to use modifier KZ (New coverage not implemented by managed care) when billing for services for implantable defibrillators for patients in a M+C plan when the conditions fall under the new indications, which are effective October 1, 2003. Those providers billing fiscal intermediaries (FIs) for these services must use condition code 78 (New coverage not implemented by HMO).

The Common Working File (CWF) must accept the new modifier KZ and Condition Code 78 for these services beginning January 5, 2004. (See CIM section 35-85.A.4-5 for these new indications.)

Medicare contractors are also being requested to provide education on the specific use of the modifier and condition code by using the provider education article that is attached.

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

NOTE: Claims for M+C organizations' beneficiaries with existing covered indications (CIM35-85A. 1,2,3) should NOT be billed with the condition code or modifier since the existing covered indications are currently included in the M+C plan's capitated rates.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
2880.1	Medicare carriers shall recognize new modifier KZ (new coverage not implemented by managed care). The use of this modifier for the new indications is effective for dates of services on or after October 1, 2003.	CWF/Carriers
2880.2	CWF shall recognize modifier KZ in order to bypass risk HMO editing and pay expanded implantable automatic defibrillator services based on fee-for-service for claims submitted by Medicare carriers. Because of the systems changes involved, CWF shall recognize this new modifier beginning January 5, 2004.	CWF
2880.3	FIs and CWF shall recognize condition code 78 (new coverage not implemented by HMO). The use of this condition code for the new indications is effective for dates of services on or after October 1, 2003.	CWF/FIs
2880.4	CWF shall recognize condition code 78 in order to bypass risk HMO editing and pay expanded implantable automatic defibrillator services based on fee-for-service for claims submitted by FIs.	CWF
2880.5	CWF shall modify edits to not apply the deductible for claims of risk M+C beneficiaries when the claim contains modifier KZ or condition code 78.	CWF
2880.6	CWF shall create a new edit and reject the claim when the beneficiary is not in a risk M+C plan and the claim contains modifier KZ or condition code 78.	CWF
2880.6.1	CWF shall create a new error code message for the new edit explained in requirement 2880.6. Contractors shall deny the services that are rejected by CWF with the new error code.	CWF/FIs/ Carriers
2880.7	Carriers shall pay fee-for-service for any line item services that contain the KZ modifier for risk M+C beneficiaries with dates of service on or after October 1, 2003, that are submitted with any of the procedure codes listed in Attachment 2.	Carriers
2880.8	CWF shall modify the M+C Informational Unsolicited Response process to not generate a response when modifier KZ or condition code 78 is present on claim.	CWF
2880.9	CWF shall not generate an Unsolicited Response for Home Health claims when condition code 78 is present.	CWF
2880.10	FIs shall pay fee-for-service for risk M+C claims containing condition code 78 for expanded coverage.	FIs
2880.11	FIs shall pay fee-for-service for outpatient prospective payment system (OPPS) claims with condition code 78 for services related to implantable automatic defibrillators on the same date of service.	FIs
2880.12	FIs shall pay fee-for-service for inpatient hospital claims with condition code 78 for discharges on or after October 1, 2003.	FIs

2880.12.1	CWF shall apply the current editing for risk M+C basing on admit date and then follow the requirement in 2880.4.	CWF
2880.13	Contractors shall hold claims for risk M+C beneficiaries that fall under the new indications for an implantable automatic defibrillator service submitted with modifier KZ or condition code 78 and any of the attached procedure codes for dates of services October 1, 2003, through December 31, 2003.	Carriers/FIs
2880.14	Contractors shall release the claims for payment, including any applicable interest, on or after January 5, 2004.	Carriers/FIs
2880.15	FIs shall enter condition code 15 when releasing held claims for payment.	FIs
2880.16	FIs shall not apply Part A deductible for claims containing the procedure codes listed on Attachment 2 when billed with condition code 78. **See Design Considerations for processing instructions.**	FIs
2880.16.1	Carriers shall not apply Part B deductible for claims containing the procedure codes listed on Attachment 2 when billed with modifier KZ. **See Design Considerations for processing instructions.**	Carriers
2880.17	Contractors shall apply applicable coinsurance for risk M+C beneficiaries who receive implantable automatic defibrillators.	Carriers/FIs
2880.18	Contractors shall educate their provider communities using the provider education language attached to this PM.	Carriers/FIs
2880.18.1	Contractors shall publish provider education language on their web site as soon as possible but no later than 2 weeks from the issuance date of this instruction.	Carriers/FIs
2880.18.2	Contractors shall publish provider education information in their next regularly scheduled bulletin.	Carriers/FIs
2880.18.3	Contractors who have a listserv that targets the affected provider communities shall use their listserv to notify subscribers that information about claims processing for implantable automatic defibrillators appears on the contractor's web site.	Carriers/FIs
2880.18.4	Contractors shall educate providers that only claims for patients with indications that are effective for coverage beginning October 1, 2003, should include modifier KZ or condition code 78. Claims for non-risk managed care beneficiaries with existing covered indications should not be billed with the condition code or modifier, as they are currently included in the capitated rates.	Carriers/FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Req. #	Instructions
2880.3	Applicable bill types are 11X, 13X, and 85X.
2880.11	Applicable bill types are 11X, 13X, and 85X.

B. Design Considerations:

X-Ref Req. #	Recommendation for Medicare System Requirements
2880.16	Standard systems should not create any front-end edits for requirements 2880.16 and 2880.16.1. Standard systems should only react to claims rejected by CWF that contain condition code 78 or modifier KZ.

C. Interfaces: N/A
D. Contractor Financial Reporting /Workload Impact: N/A
E. Dependencies: N/A
F. Testing Considerations: N/A
G. Attachment(s): 1-- Provider Education Article

Implementation Date: January 1, 2004 **Discard Date**: January 1, 2005 **Post-Implementation Contact:** Appropriate Regional Office	**Effective Date**: October 1, 2003 **Funding**: These instructions should be implemented within your current operating budget. **Pre-implementation Contacts:** Part B:Cynthia Glover (410) 786-2589 Part A:Joey Bryson (410) 786-2986

Attachment 1

From the Medicare Learning Network @ CMS

Provider Education Article
National Coverage Determination -- Implantable Automatic Defibrillators

This provider education article discusses the background of the National Coverage Determination (NCD) to expand coverage of implantable automatic defibrillators for services rendered on or after October 1, 2003, coverage guidelines, billing instructions for providers who render services to managed care patients, and billing instructions for providers who render services to fee-for-service patients.

Background

The NCD will be effective on October 1, 2003, to expand coverage of implantable automatic defibrillators for Medicare managed care and fee-for-service patients. Providers will be reimbursed for services provided to managed care patients for implantable automatic defibrillators that fall under the expanded coverage indications effective October 1, 2003, according to the NCD on a fee-for-service basis until capitation rates are adjusted to account for this expanded coverage.

Coverage Guidelines

The following services are covered when rendered on or after July 1, 1991:

- Documented episode of cardiac arrest due to ventricular fibrillation (VF), not due to a transient or reversible cause;
- Documented sustained ventricular tachyarrhythmia (VT), either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute myocardial infarction (MI) and not due to a transient or reversible cause;
- Documented familial or inherited indications with a high risk of life-threatening VT, such as long QT syndrome or hypertropic cardiomyopathy;

As stated in the NCD, the following indications will be covered when rendered on or after October 1, 2003:

- Coronary artery disease with a documented prior MI, a measured left ventricular ejection fraction ≤ 0.35, and inducible, sustained VT or VF at EP study. (The MI must have occurred more than 4 weeks prior to defibrillator insertion. The EP test must be performed more than 4 weeks after the qualifying MI.);
- Documented prior MI and a measured left ventricular ejection fraction ≤ 0.30 and a QRS duration of > 120 milliseconds. Patients must not have:
    a) New York Heart Association classification IV;
    b) Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;
    c) Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within past 3 months;
    d) Had an enzyme-positive MI within past month;
    e) Clinical symptoms or findings that would make them a candidate for coronary revascularization; or

f) Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year.

As stated in the NCD, effective October 1, 2003, the following additional coverage guidelines apply:

- All patients considered for implantation of a defibrillator must not have irreversible brain damage, disease, or dysfunction that precludes the ability to give informed consent;

- MIs must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography; and

- All other indications remain noncovered except in Category B IDE clinical trials (60 CFR 48417) or as a routine cost in clinical trials defined under CIM 30-1.

NOTE: Refer to Coverage Issues Manual, Section 35-85 (revisions effective October 1, 2003).

Billing Instructions for Providers Who Render Services to Managed Care Patients

The following instructions apply to providers who render expanded implantable automatic defibrillator services to managed care patients:

- Providers are encouraged not to submit claims for services rendered on or after October 1, 2003, because Medicare will not be able to process the claims until January 5, 2004.

- Physicians must use modifier KZ (new coverage not implemented by managed care) when billing for services rendered on and after October 1, 2003.

- Providers billing fiscal intermediaries on or after October 1, 2003, must use condition code 78 (payment for coverage not implemented by HMO).

- Providers who are paid under the Outpatient Prospective Payment System (OPPS) must bill all services related to this expanded coverage on one claim and for the same date of service, using condition code 78.

- Providers billing carriers and providers who are paid under the OPPS must split the bills if they overlap September 2003 and October 2003.

- Patients who receive these services must pay any applicable coinsurance amounts.

- For services rendered to managed care patients whose indications fall outside this expanded coverage, providers must not bill using condition code 78 or modifier KZ.

Billing Instructions for Providers Who Render Services to Fee-for-Service Patients

The following instructions apply to providers who render expanded implantable automatic defibrillator services to fee-for-service patients:

- Claims for these services cannot be billed using modifier KZ, condition code 78, or for services outside of this expanded coverage.

Attachment 2

Procedure Codes

- 33240
- 33245
- 33246
- 33249
- ICD-9-CM Procedure Code 37.94 (for 11X TOBs)