Medicare
Carriers Manual
Part 3 - Claims Process

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

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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NEW/REVISED MATERIAL--*EFFECTIVE DATE:* January 1, 2003
***IMPLEMENTATION DATE:* January 1, 2003**

Section 15903, Hearing Aid Exclusion, is added to clarify which devices are considered to be hearing aids and, are therefore, excluded from coverage.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER XV
FEE SCHEDULE FOR PHYSICIANS' SERVICES

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H = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the data base with the H status. (Code subject to a 90 day grace period.)

I = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

N = Non-covered service. These codes are carried on the HCPCS tape as noncovered services.

P = Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule.

If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service).

If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.

R = Restricted coverage. Special coverage instructions apply.

T = There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. (Examples are ambulances services and clinical diagnostic laboratory services.)

15902. MAINTENANCE PROCESS FOR THE MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFSDB)

The Division of Health Plan and Provider Data (DHPPD) calculates the fee schedule payment amounts and releases them to the carriers in the Medicare Physician Fee Schedule Database (MPFSDB). Carriers will implement those payment amounts on January 1 for that year. DHPPD will maintain the payment files centrally and will be responsible for recalculating any revised payment amounts. Any revisions initiated by Central Office (fee schedule amounts or payment policy indicators) will be issued to the carriers on a quarterly basis through a program memorandum.

The information for the ongoing maintenance of the MPFSDB is stated below.

o DHPPD will calculate the new fee schedule amounts. DHPPD will issue the revised data to the ROs in the same format of the MPFSDB.

o Carriers will receive a file containing data with revisions for the quarter. This file will be release electronically.

o Carriers should give providers 30 days notification before revised payment amounts are implemented. The revised payment amounts should be implemented by the beginning of the following quarter.

o DHPPD will furnish the recalculated payment amounts to the carriers in data files to ensure accuracy. If carriers overlay these files into their existing file, the potential for errors will be eliminated.

o Carriers should make adjustments on those claims that were processed incorrectly if the adjustment is requested by the biller. Adjustments should be made retroactively to January 1 of the current year, unless otherwise specified. This directive will apply in all instances unless the situation requires special consideration. In those instances, instructions on handling adjustments will be provided on a case by case basis.

o Separate instructions will be issued describing the data exchange for the fiscal intermediaries (FIs). In summary, FIs will receive the revised payment amounts two to three weeks after the carriers receive the data from DHPPD. FIs should not implement the revised payment amounts prior to the carriers' implementation date.

o Carriers will be required to furnish the revised payment information to the State Medicaid Agencies upon their request one month following receipt of the data from DHPPD. Those State agencies with Internet access capability should download the data directly from the CMS Home Page.

15903. HEARING AID EXCLUSION

Section 1862(a)(7) of the Social Security Act states that no payment may be made under part A or part B for any expenses incurred for items or services "where such expenses are for . . . hearing aids or examinations therefore. . . " This policy is further reiterated at 42 CFR 411.15(d) which specifically states that "hearing aids or examination for the purpose of prescribing, fitting, or changing hearing aids" are excluded from coverage.

At the time of passage of the hearing aid exclusion, all hearing aids utilized functional air and/or bone conduction pathways to facilitate hearing. We are clarifying that any device that does not produce as its output an electrical signal that directly stimulates the auditory nerve is a hearing aid for the purposes of Medicare payment policy. Examples of hearing aids are devices that produce air-conducted sound into the external auditory canal, devices that produce sound by mechanically vibrating bone, or devices that produce sound by vibrating the cochlear fluid through stimulation of the round window. Devices such as cochlear implants, which produce as their output an electrical signal that directly stimulates the auditory nerve, are not considered to be hearing aids for purposes of Medicare payment policy. (See Coverage Issues Manual §65-14).

Medicare contractors are to deny payment for an item or service that is associated with any hearing aid as defined above. This clarification is not meant to change policy for the medically necessary treatment of complications of implantable hearing aids, such as medically necessary removals of implantable hearing aids due to infection. See §2300.1 of Part 3 of the Medicare Carrier Manual.