Medicare Hospital Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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445 - 445	4-457 (1 p.)	4-457 - 4-485 (24 pp.)
450 - 451	4-491 - 4-492 (2 pp.)	4-491 - 4-492 (6 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: N/A
IMPLEMENTATION DATE: N/A

Section 106, Fraud and Abuse - General, has been **deleted** and moved to the Program Integrity Manual to avoid duplication.

Section 419, Focused Medical Review (FMR), has been **deleted** and moved to the Program Integrity Manual to avoid duplication.

Section 445, Billing for Part B Intermediary Outpatient Occupational Therapy (OT) Services, has been **deleted** and moved to the Program Integrity Manual to avoid duplication.

Section 450, Special Instructions for Billing Dysphagia, has been **deleted** and moved to the Program Integrity Manual to avoid duplication.

The Program Integrity Manual can be found at the following Internet address: **www.hcfa.gov/pubforms/83_pim/pimtoc.htm**.

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.

CHAPTER I
GENERAL INFORMATION ABOUT THE PROGRAM

Section

Administration of Medicare Program

Provider Participation in Medicare

Hospital Insurance

CHAPTER I
GENERAL INFORMATION ABOUT THE PROGRAM

Administration of Medicare Program

100. INTRODUCTION

The Health Insurance for the Aged and Disabled Act (title XVIII of the Social Security Act), known as "Medicare," has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the nation's elderly to meet hospital, medical, and other health costs. Health insurance coverage has also been extended to persons under age 65 qualifying as disabled and those having end-stage renal disease (ESRD). The program includes two related health insurance programs--hospital insurance (HI) (Part A) and supplementary medical insurance (SMI) (Part B).

The conduct of the program has been delegated by the Secretary of the Department of Health and Human Services (DHHS) to the Administrator of the Health Care Financing Administration (HCFA). Congress has also provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law does not permit the Federal Government to exercise supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him/her services. The responsibility for treatment and the control of care remains with the individual's physician and the hospital or other facility or agency furnishing services. The individual may keep or obtain any other health insurance he/she desires.

102. FINANCING THE PROGRAM

Part A is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are deposited to the account of the Federal Hospital Insurance Trust Fund which is used only for hospital insurance benefits and administrative expenses. The cost of providing Part A benefits to persons who are not Social Security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues or through premium payments.

Part B is financed by monthly premiums of those who voluntarily enroll in the program and by the Federal Government which makes contributions from general revenues. All premiums and Government contributions are deposited in a separate account known as the Federal Supplementary Medical Trust Fund. Money from this fund is used only to pay for Part B benefits and administrative expenses.

104. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program (e.g., hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), hospices, outpatient physical therapy (OPT), comprehensive outpatient rehabilitation facilities (CORFs), occupational therapy and speech pathology providers, and ESRD facilities) must comply with the requirements of title VI of the Civil Rights Act of 1964. Under the provisions of that Act, a participating

provider is prohibited from making a distinction on the ground of race, color, or national origin, in the treatment of patients, the use of equipment, other facilities, and the assignment of personnel to provide services.

HHS is responsible for investigating complaints of noncompliance.

106. FRAUD AND ABUSE - GENERAL

Sections 106 - 106.3 have been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

108. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

HHS has overall responsibility for administering the hospital insurance and voluntary SMI programs. Two major agencies -- HCFA and the Public Health Service are involved in specified administrative functions.

HCFA is responsible for policy formulation. The central and regional offices are responsible for the general management and operation of the program. In brief, HCFA's responsibilities include the following:

- Determining an individual's entitlement to benefits in consultation with the Social Security Administration (SSA);
- Determining the nature and duration of services for which a beneficiary's benefits may be paid;
- Establishing, maintaining, and the administrating agreements with State agencies, providers of services, and intermediaries;
- Formulating major policies regarding conditions of participation for providers (except SNFs) in consultation with the Public Health Service;
- Developing and maintaining statistical research and actuarial programs;
- Managing general finances of the program; and
- Determining reasonable costs and amounts to be paid to providers who have elected to deal directly with the Government.

CHAPTER IV
BILLING PROCEDURES

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Section

Uniform Billing

Electronic Media Claims Data

Form HCFA-1450

Billing in Situations Where Medicare Is Secondary Payer

Billing in Medicare Secondary Payer Situations

419. FOCUSED MEDICAL REVIEW (FMR)

This section has been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

445. BILLING FOR PART B INTERMEDIARY OUTPATIENT OCCUPATIONAL THERAPY (OT) SERVICES

Sections 445 - 446.1 have been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

450. SPECIAL INSTRUCTIONS FOR BILLING DYSPHAGIA

This section has been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

451. BILLING FOR MAMMOGRAPHY SCREENING

Section 4163 of the Omnibus Budget Reconciliation Act of 1990 added §1834(c) of the Act to provide for Part B coverage of mammography screening for certain women entitled to Medicare for screenings performed on or after January 1, 1991. The term "screening mammography" means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

There is no requirement that the screening mammography examination be prescribed by a physician for an eligible beneficiary to be covered. Payment may be made for a screening mammography furnished to a woman at her direct request.

Prior to October 1, 1994, if you perform screening mammographies, you must request and be recommended for certification by the State certification agency and approved by HCFA before payment is made. Effective October 1, 1994, if you perform mammography services (diagnostic and screening), you must be issued a certificate from the Food and Drug Administration (FDA) before payment is made. (See §454 for more detailed instructions.) If you arrange for another entity to perform a screening mammography for one of your patients prior to October 1, 1994, you must assure that the entity is certified to perform the screening, or on or after October 1, 1994, you must assure that the entity has been issued a certificate by FDA. Your intermediary will deny claims when it determines the entity that performed the screening is not certified. It will utilize denial language in subsection F.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over 39 and waives the Part B deductible. Coverage applies as follows:

- No payment may be made for a screening mammography performed on a woman under 35 years of age;

- You will be paid for only one screening mammography performed on a woman between her 35th and 40th birthdays (ages 35 thru 39); and

- For a woman over 39, you will be paid for a screening mammography performed after 11 full months have passed following the month in which the last screening mammography was performed.

A. Determining 11 Month Period.--To determine the 11 month period, your intermediary starts their count beginning with the month after the month in which a previous screening mammography was performed.

EXAMPLE: The beneficiary received a screening mammography in January 1991. Intermediaries start their count beginning with February 1991. The beneficiary is eligible to receive another screening mammography in January 1992 (the month after 11 full months have elapsed).

B. Payment Limitations.--There is no Part B deductible. However, coinsurance is applicable. Following are three categories of billing for mammography services:

- Professional component of mammography services (that is, for the physician's interpretation of the results of the examination),