Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

The *Medicare A Bulletin* should be shared with all health care practitioners and managerial members of the provider/supplier staff.

Publications issued after October 1, 1997, are available at no-cost from our provider website at *www.floridamedicare.com.*

Routing Suggestions:

- ☐ Medicare Manager
- ☐ Reimbursement Director
- ☐ Chief Financial Officer
- ☐ Compliance Officer
- ☐ DRG Coordinator
- ☐
- ☐
- ☐

CMS CENTERS for MEDICARE & MEDICAID SERVICES

FIRST COAST SERVICE OPTIONS, INC.
A CMS Contracted Intermediary & Carrier

Table of Contents

Medicare A Bulletin

Vol. 8, No. 7
October 2006

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The *Medicare A Bulletin* is published monthly by First Coast Service Options, Inc. Provider Outreach and Education division, to provide timely and useful information to Medicare Part A providers in Florida.

Questions concerning this publication or its contents may be directed in writing to:

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P.O. Box 45270
Jacksonville, FL
32232-5270

About the *Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive magazine published by First Coast Service Options, Inc. (FCSO) for Medicare Part A providers in Florida in accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters.

The Medicare Communication and Education Provider Publications team will begin distributing the *Medicare A Bulletin* on a monthly basis. We are making this change to better serve our customers by making valuable information available in a more timely manner. The previous quarterly publications have become too large in scope and size making it difficult to navigate through the large volume of information.

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education website *http://www.floridamedicare.com*.

In some cases, additional unscheduled special issues may also be posted and or published.

Who Receives the *Bulletin*?

Anyone may view, print or dowload the *Bulletin* from our provider education website. Providers who cannot obtain the *Bulletin* from the Internet are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form on page 90).

Distribution of the *Medicare Part A Bulletin* in hardcopy format is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed hardcopy registration form to us*.

For additional copies, providers may purchase a separate annual subscription. A subscription order form may be found at the end of the Educational Resources section in each issue. Issues published since January 1997 may be downloaded from the Internet free of charge.

We use the same mailing address for *all* correspondence, and we cannot designate that the *Bulletin* be sent to a specific person/department within a medical facility. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Registration department. Please remember that address changes must be done using the appropriate Form CMS-855.

What Is in the *Bulletin*?

The *Bulletin* is divided into sections addressing general and facility-specific information and coverage guidelines:

- The publication starts with a column by the Intermediary Medical Director.
- Following an administrative section are usually general information and coverage sections with informational and billing issues, processing guidelines, and medical coverage applicable to all Medicare Part A providers and facilities.
- Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.)
- As needed, the *Bulletin* contains Electronic Data Interchange and Fraud and Abuse sections.
- The Local Coverage Determination (LCD) section contains notification of revisions to finalized medical policies and additions, revisions, and corrections to previously published LCDs. In addition, this section may contain information on widespread probe reviews conducted by the fiscal intermediary. Whenever possible, the LCD section will be placed in the center of the *Bulletin* to allow readers to remove it separately, without disturbing the rest of the publication.
- The Educational Resources section includes educational material, such as seminar schedules, Medicare provider education website information, and reproducible forms.
- Important addresses and phone numbers are in the back of every issue.

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

Articles included in each *Medicare A Bulletin* represent formal notice that specific coverage policies have or will take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Do You Have Comments?

The publications staff welcomes your feedback on the *Bulletin* and appreciates your continued support. Please mail comments to:

Editor, *Medicare A Bulletin*
Medicare Publications – 10T
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Jacksonville, FL 32232-5270

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "***eNews***" link on the navigational menu and follow the prompts.

GENERAL INFORMATION

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Physicians, hospitals, including Medicare critical access hospitals, Indian Health Service facilities, and ambulance service providers treating patients eligible for payment of Section 1011 of the Medicare Modernization Act of 2003 (MMA).

Provider Action Needed
STOP – Impact to You

You may be eligible for reimbursement for treating certain individuals under Section 1011 of the MMA. This article help you learn more about this program.

CAUTION – What You Need to Know

As of August 2006, over 15,500 physician and provider enrollment applications have been approved nationwide to participate in the Section 1011 reimbursement process. But, the Centers for Medicare & Medicaid Services (CMS) advises that funds remain available and you may be eligible.

GO – What You Need to Do

CMS scheduled two national outreach conferences to inform providers of their potential eligibility to participate and to provide more details on how this program may help you.

Background

Section 1011 of the MMA provides up to $250 million per year for federal fiscal years 2005-2008 for payments to eligible providers for emergency services furnished to:

- Undocumented aliens
- Aliens who have been paroled into a United States port of entry for the purpose of receiving eligible services
- Mexican citizens permitted to enter the United States on a laser visa, issued in accordance with the requirements of regulations prescribed under the Immigration and Nationality Act.

The covered services are the same as those required by the Emergency Medical Treatment and Labor Act (EMTALA), as well as related hospital inpatient and outpatient services. Providers do not have to be enrolled in the Medicare program to receive Section 1011 eligibility and payments. However, you do have to enroll in the Section 1011 program by submitting an application to TrailBlazer Health Enterprises, LLC, the national contractor for the Section 1011 program.

To provide you with more details about this program, Medicare, through TrailBlazer Health Enterprises, offered two national outreach sessions for the medical community and the general public. These sessions were scheduled for September 2006 and the dates and times were announced and posted to our provider education website *http://www.floridamedicare.com* on August 31, 2006.

Additional Information

Additional information regarding the Section 1011 program may be found on the CMS website at *http://www.cms.hhs.gov/UndocAliens/*.

To enroll as a provider, or to learn more details and updates regarding provider enrollment, medical review, payment request processing, provider education, and customer service assistance related to Section 1011 program visit the TrailBlazer Health Enterprises site on the Web at *http://www.TrailBlazerhealth.com/Section1011*.

You may also reach TrailBlazer Health Enterprises by telephone at 1-866-860-1011.

MLN Matters Number: SE0662
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0662

Flu Shot Reminder

September is the perfect time to start talking with your patients about getting the flu shot. Medicare provides coverage for the flu vaccine and its administration. Influenza vaccination is a covered Part B benefit.

Note: Influenza vaccine is **NOT** a Part D covered drug.

Please encourage your Medicare patients to take advantage of this vital benefit. And don't forget – health care professionals and their staff benefit from the flu vaccine also. Protect yourself, your patients, and your family and friends. Get your flu shot! ❖

Source: CMS Provider Education Resource 200609-11

Medicare Telehealth Services

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Method II critical access hospitals (CAHs) who bill Medicare fiscal intermediaries (FIs) for telehealth services and telehealth originating sites that bill the Medicare FI.

Provider Action Needed

CR 5201, from which this article was taken announces (effective January 1, 2007) a correction to the payment amount regarding telehealth services when the distant site practitioner is located in a critical access hospital (CAH) that has elected Method II and the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, Medicare FIs will make payment for the telehealth service at 80 percent of the Medicare physician fee schedule (MPFS) and **not** according to the optional payment method as discussed in the *Medicare Claims Processing Manual*, Chapter 4, Section 250.2. This chapter of the manual is available on the CMS website at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Chapter 12 of the same manual includes further telehealth information. Also, in accordance with the Medicare telehealth originating site payment methodology, Medicare FIs will make payment to originating sites at the lesser of 80 percent of the actual charge or the originating site facility fee. The originating site facility fee was established by section 1834(m) of the Social Security Act at $20 and is adjusted annually by the Medicare economic index.

Additional Information

You may find more information about billing telehealth services, including revised portions of Chapter 12 of the *Medicare Claims Processing Manual*, by going to CR 5201, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1026CP.pdf*.

Additional telehealth instructions are available in Chapter 15, Section 270, of the *Medicare Benefit Policy Manual* on the CMS website at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

If you have any questions, please contact your FI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5201
Related Change Request (CR) Number: 5201
Related CR Release Date: August 11, 2006
Related CR Transmittal Number: R1026CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1026, CR 5201

2006–2007 Influenza (Flu) Season Resources for Health Care Professionals

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare carriers/ Medicare administrative contractors (MAC) or fiscal intermediaries (FI) for flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider Action Needed

- Keep this special edition MLN Matters article and refer to it throughout the 2006 – 2007 flu season.
- Talk with your patients about the flu virus and their risks for complications of the disease and encourage them to get the flu shot. ***(Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/ coinsurance applies.***
- Stay abreast of the latest influenza information and inform your patients.
  - Order appropriate provider resources for yourself and your staff.
  - Have appropriate literature on hand about influenza that can be handed out to your patients during the flu season.
- Don't forget to immunize yourself and your staff – Protect yourself, protect your patients, and protect your family and friends. Get Your Flu Shot.

Introduction

On average, 36,000 people in the United States die each year from influenza and complications arising from influenza. Greater than 90 percent of deaths occur in persons 65 years of age and older. Individuals with chronic medical conditions such as diabetes and heart disease are particularly at risk of influenza infection, as are people in nursing, convalescent, or other institutional settings. Historically, the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that Medicare beneficiaries are informed about this vaccine-preventable disease and get their flu shot this flu season. In addition, unvaccinated health care workers can spread influenza to patients, family, and friends. CMS encourages you and your staff to get vaccinated. Protect your patients,

2006–2007 Influenza (Flu) Season Resources for Health Care Professionals (continued)

protect your family and friends, and protect yourself. CMS has developed a variety of educational resources, listed in the next section, to ensure that Medicare FFS health care professionals have the information they need to bill Medicare correctly for the Medicare-covered vaccines and help promote increased awareness and utilization of the flu vaccine among beneficiaries, providers, and their staff.

Products

The following products have been developed by CMS to be used by the Medicare fee-for-service (FFS) health care community and are not intended for distribution to Medicare beneficiaries.

***MLN Matters* Articles**

- **MM4240 –** *Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration* *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf*
- **MM5037 –** *Reporting of Diagnosis Code V06.6 on Influenza Virus and/or PneumococcalPneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine* *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf*

MLN Flu Related Products for Health Care Professionals

- ***Quick Reference Information: Medicare Immunization Billing –*** This two-sided chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the flu, pneumococcal, and hepatitis B vaccines and their administration. This product is currently available as a download. *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.
- ***An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals –*** This educational video program provides health care professionals with an overview of Medicare-covered preventive services. The program includes a section on Medicare's coverage of flu, pneumococcal, and hepatitis B vaccines. This educational video has been approved for .1 IACET* CEU for successful completion. This video program may be ordered through the MLN Product Ordering Web page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.
- ***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals –*** This comprehensive guide to Medicare-covered preventive services and screenings is intended to give Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement to help them file claims effectively, while also giving providers information that will enable them to encourage utilization of these benefits as appropriate. Pages 97 – 104 cover the flu vaccine. Pages 117 – 119 include a discussion of mass immunizers and Roster billing. Available in print or as a download at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- ***Medicare Preventive Services Adult Immunizations Brochure –*** This two-sided tri-fold brochure gives an overview of the coverage information for flu, pneumococcal, and hepatitis B. Available in print or as a download at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization_06-08-05.pdf*.
- ***Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course –*** This course was updated August 2006 and has been approved for .1 IACET* CEU for successful completion. This WBT contains four modules that include information about Medicare's coverage of flu, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. This course may be accessed through the MLN Product Ordering web page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1*.
- ***Quick Reference Information: Medicare Preventive Services –*** This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes flu, pneumococcal, and hepatitis B. Available in print or as a download at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- ***Medicare Preventive Services Bookmark –*** This bookmark lists the preventive services and screenings covered by Medicare (including flu) and serves as a handy reminder to health care professionals about the many preventive benefits covered by Medicare. Available in print or as a download at *http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf*.
- ***2006 – 2007 Influenza (Flu) Season Educational Products and Resources PDF Document –*** This online PDF document includes links to flu-related educational products developed by CMS for provider use and links to other resources where clinicians may find useful information and tools for the 2006 – 2007 flu season. The resource document will be updated as new flu information becomes available. The ***2006 – 2007 Influenza (Flu) Season Educational Products and Resources*** online document can be accessed by going to the Downloads section of the *MLN Preventive Services Educational Products* web page, located on the CMS site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.

2006–2007 Influenza (Flu) Season Resources for Health Care Professionals (continued)

Other CMS Resources

- **CMS Adult Immunizations Web Page** *http://www.cms.hhs.gov/AdultImmunizations/*
- **2006 Administration Fees for Flu and Pneumococcal (PPV)** *http://www.cms.hhs.gov/AdultImmunizations/Downloads/0506vaccreimburs033006.pdf*
- **CMS Frequently Asked Questions** *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi*

Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2006 flu season.

- Advisory Committee on Immunization Practices *http://www.cdc.gov/nip/acip*
- American Lung Association's Influenza (Flu) Center *http://www.lungusa.org/* – This site provides a flu clinic locator *http://www.flucliniclocator.org/*.

  Individuals can enter their ZIP code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- Centers for Disease Control and Prevention *http://www.cdc.gov/flu*
- Immunization Action Coalition *http://www.immunize.org/*
- Immunization: Promoting Prevention for a Healthier Life *http://www.nfid.org/pdf/publications/naiaw06.pdf*
- Medicare Quality Improvement Community *http://www.medqic.org/*
- National Alliance for Hispanic Health *http://www.hispanichealth.org/*
- National Foundation For Infectious Diseases *http://nfid.org/influenza*
- National Immunization Program *http://www.cdc.gov/nip*
- National Network for Immunization Information *http://www.immunizationinfo.org/*
- National Vaccine Program *http://www.hhs.gov/nvpo*
- Office of Disease Prevention and Promotion *http://odphp.osophs.dhhs.gov*
- Partnership for Prevention *http://prevent.org*
- World Health Organization http://www.who.int/csr/disease/influenza/en/

MLN Matters Number: SE0667
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0667

*The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington, DC 20006. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and web-based training course was developed without any commercial support.

Introducing the Provider Outreach and Education Advisory Group

Effective October 1, 2006, the name of the Provider Communication Advisory Group (PCOM AG) has been officially changed and referred to as the Provider Outreach and Education Advisory Group (POE AG).

The primary function of the Provider Outreach and Education Advisory Groups remains the same. These groups of providers/suppliers assist the Medicare contractors with ideas and recommendations in the creation and implementation of provider education strategies and efforts. Providers interested in participating in a POE AG may access the provider education website *http://www.floridamedicare.com*. From the home page, click on the POE AG section on the left navigational bar. The POE AG page contains important information, including a membership request form and an overview of this initiative. Providers lacking Internet access and interested in becoming a POE AG member may leave a message on the provider education registration hot line 1-904-791-8103.

We look forward to hearing from you. ❖

Unsolicited/Voluntary Refunds

All Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open accounts receivable). Intermediaries generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds. The Centers for Medicare & Medicaid Services reminds providers that:

> "The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims." ❖

Source: CMS Pub 100-6 Transmittal 50, CR 3274

Laboratory Competitive Bidding Demonstration

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Physicians and all providers who bill Medicare carriers and fiscal intermediaries (FIs) for laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites

Background

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, Pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and change request (CR) 5205 provides instructions for the implementation of a laboratory competitive bidding demonstration. CR 5205 is being implemented in multiple phases. The requirements specified in this article and CR 5205 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the ZIP code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore exempt from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing are not included in the demonstration, except where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Required Bidders

Laboratory firms with $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for "demonstration tests" provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration. These laboratory firms will be referred to as "required bidders."

Passive Laboratories

Small laboratories or laboratory firms with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will not be required to bid in the demonstration. These laboratories are considered "passive" laboratories." Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of $100,000.

Passive laboratory firms exceeding the annual ceiling of $100,000 will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Winners

Both required and nonrequired bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled "winners."

Nonwinners

Both required and nonrequired bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled "nonwinners."

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Nonwinner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, nonwinner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although nonwinner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Laboratory Competitive Bidding Demonstration (continued)

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses metropolitan statistical areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's ZIP code of residence.

CMS will provide the contractors with a list of ZIP codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of Pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR 5205 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

By January 1, 2007, CMS will provide Medicare carriers and fiscal intermediaries (FIs) with a national ZIP code pricing file identifying the ZIP codes included in the first CBA. Also, by the same date, CMS will provide to the carriers/FIs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by nonwinner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (noncovered charges)
- Remark code M114 (*This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor*.)
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.)

Using these same reason and remark codes, Medicare will reject any laboratory claims with a date of service between April 1, 2007, and March 31, 2010 with a modifier of "90" submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA, regardless of the referring laboratory's participation status.

Medicare will pay claims during the demonstration period submitted by nondemonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., "snow birds") according to the laboratory competitive bidding demonstration.

Nonwinning laboratories should know that advance beneficiary notices (ABNs) and notices of beneficiary exclusion from medicare benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at nonwinner laboratories.

Line items for demonstration services and for nondemonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

The demonstration in the first CBA is scheduled to begin on April 1, 2007 and the tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember that required and nonrequired bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

The implementation date for this instruction is January 2, 2007.

Additional Information

The official instructions issued to your Medicare carrier/FI regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R49DEMO.pdf*.

If you have questions, please contact your Medicare carrier/FI at their toll-free number, which may be found on the CMS, website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.
MLN Matters Number: MM5205
Related Change Request (CR) Number: 5205
Related CR Release Date: August 1, 2006
Related CR Transmittal Number: R49DEMO
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-19, Transmittal 49, CR 5205

October 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File Update, and Revisions to Previous Drug Pricing Files

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

All Medicare providers who bill Medicare for Part B drugs

Provider Action Needed

STOP – Impact to You

Change request (CR) 5270, upon which this article is based, provides notice of the updated payment allowance limits effective October 1, 2006, and revisions to the April 2006, and July 2006 quarterly drug pricing files.

CAUTION – What You Need to Know

Be aware that certain Medicare Part B drug payment limits have been revised and that CMS updates the payment allowance on a quarterly basis. The revised payment limits included in the revised average sales price (ASP) and not otherwise classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to this document.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes.

CR 5270, upon which this article is based, provides the quarterly ASP Medicare Part B drug pricing file update for October 1, 2006, and also provides revisions to the April 2006 and July 2006 quarterly files.

Section 303(c) of the Medicare Modernization Act (MMA) of 2003 revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis; and mandated that since January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis be paid based on the ASP methodology.

In the same way in 2006, all end-stage renal disease (ESRD) drugs furnished by both independent and hospital-based ESRD facilities; specified, covered outpatient drugs; and drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS) will be paid according to this ASP methodology, which is based on quarterly data submitted to CMS by manufacturers.

Note: MMA also requires CMS to update the payment allowance limits quarterly, which CR 5270 does.

Beginning January 1, 2005, Part B drugs that are not paid on a cost or prospective payment basis have been paid based on **106 percent** of the ASP. Additionally, beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on **106 percent** of the ASP.

There are exceptions to this general rule as summarized below.

1. Blood and Blood Products

Blood and blood products furnished in the hospital outpatient department are paid under the OPPS at the amount specified for the ambulatory payment classification (APC) to which the product is assigned.

Conversely, for blood and blood products, not paid on a prospective payment basis (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner used to determine them on October 1, 2003.

The payment allowance limits for blood and blood products are **95 percent** of the average wholesale price (AWP) as reflected in the published compendia. These payment allowance limits will be updated on a quarterly basis, along with the others.

2. Infusion Drugs

The payment allowance limits for infusion drugs, furnished through a covered item of durable medical equipment, on or after January 1, 2005, will continue to be **95 percent** of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits were not updated in 2006.

The payment allowance limits for infusion drugs (unless compounded), furnished through a covered item of durable medical equipment, that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are **95 percent** of the first published AWP.

3. Influenza, Pneumococcal and Hepatitis B vaccines

The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are **95 percent** of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. In this latter instance, the vaccine is paid at reasonable cost.

4. Drugs not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified Pricing File

The payment allowance limits for drugs that are not included in the ASP Medicare Part B drug-pricing file or not otherwise classified (NOC) pricing file (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration [FDA]) are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, Medicare contractors (carriers, including durable medical equipment regional carriers [DMERCs], and fiscal intermediaries, including regional home health intermediaries [RHHIs]) follow the methodology in the *Medicare Claims Processing Manual* specified for calculating the AWP, but substitute WAC for AWP. (See Publication 100-04, Chapter 17, Drugs and Biologicals on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf*.)

The payment limit is **100 percent** of the lesser of the lowest brand or median generic WAC. And note that for 2006, when the blood-clotting factor is not included on the ASP file, the blood clotting furnishing factor of $0.146 per I.U. is added to the blood clotting factor payment amount.

October 2006 Quarterly ASP Medicare Part B Drug Pricing File Update, and Revisions to Previous Files (continued)

Your Medicare contractor may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting contractor or will post them in an MS Excel® file on the CMS website. If the payment limit is available from CMS, contractors will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.

1. New Drugs

The payment allowance limits for new drugs that are produced or distributed under a new drug application approved by the FDA and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on **106 percent** of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005. As mentioned above, for 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for a new blood clotting factor when a new blood clotting factor is not included on the ASP file.

2. Radiopharmaceuticals

The payment allowance limits for radiopharmaceuticals are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio. And your carrier/FI will determine payment limits for radiopharmaceuticals not furnished in the hospital outpatient department based on the methodology in place as of November 2003.

3. Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

CR 5270 clarifies that payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology, as described above. Your carrier or FI will develop the pricing for compounded drugs. Physicians (or a practitioner described in Section 1842(b)(18)(C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for them to perform the service. Your carrier/FI must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for: 1) The professional service of filling or refilling the implantable pump or reservoir; and 2) For drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if: 1) The medication administered is accepted as a safe and effective treatment of the patient's illness or injury; 2) There is a medical reason that the medication cannot be taken orally; and 3) The nurse's skills are needed to infuse the medication safely and effectively.

Important Points To Remember

- The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.
- Pricing for compounded drugs is performed by your carrier/FI.
- The presence or absence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.
- The October 2006 and revised April 2006 and July 2006 ASP drug pricing files for Medicare Part B drugs will be available via the CMS Data Center (CDC) for your carriers/FIs to download on or after September 19, 2006.
- You may also view the October 2006 and revised April 2006, and July 2006 ASP NOC drug pricing files for Medicare Part B drugs (on or after September 22, 2006) on the CMS website at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage*.

Note that:

- The revised April 2006 payment allowance limits apply to dates of service April 1, 2006 through June 30, 2006.
- The revised July 2006 payment allowance limits apply to dates of service July 1, 2006 through September 30, 2006.
- The October 2006 payment allowance limits apply to dates of service October 1, 2006 through December 31, 2006.

Additional Information

You can find the official instructions issued to your carrier/FI/RHHI/DMERC regarding this change by going to CR 5270, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1066CP.pdf*.

If you have any questions, please contact your carrier at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5270
Related Change Request (CR) Number: 5270
Related CR Release Date: September 22, 2006
Related CR Transmittal Number: R1066CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1059, CR 5270

2006 Hurricane Season—Are You Prepared?

Hurricane preparedness is paramount this time of the year. Whether we face an active hurricane season, like last year, or a below-normal season, the vital message for Medicare customers is to be prepared!

First Coast Service Options, Inc. (FCSO) Disaster Preparedness Task Force has been invoked to proactively assist providers.

How Can Providers Communicate with FCSO During and After an Emergency?

1. Visit our website *http://www.floridamedicare.com* for announcements.
2. Subscribe to the appropriate *general* eNews list and receive automatic notices about urgent or other critical information. By signing up, you will receive periodic messages advising you of updates to the website *http://www.floridamedicare.com*.
3. Access the interactive voice response (IVR) unit by calling the Medicare Customer Service Contact Center at the toll-free number 1-877-602-8816.

The IVR is available 24/7! Sunday thru Saturday from 6:00 a.m. to 6:00 p.m. Eastern and Central standard times. You may obtain claim specific, eligibility, or Medicare payment information. Only general information is available from 6:00 p.m. to 6:00 a.m. Eastern and Central standard times.

The Disaster Preparedness Task Force will continue to work with CMS and other federal agencies to address your concerns, *and explain any unique procedures to process and pay claims for providers impacted by a disaster*.

More To Come…Stay Tuned!

Additional information will be posted to *http://www.floridamedicare.com* as it becomes available.

Other Related Sources

Agency	Website Address
DHHS (Department of Health & Human Services) Disasters & Emergencies	*http://www.hhs.gov/emergency/*
FEMA (Federal Emergency Management Agency)	*http://www.fema.gov/*
Florida Division of Emergency Management	*http://www.floridadisaster.org/*
National Mail Service Updates	*http://www.usps.com/communications/news/serviceupdates.htm*
NOAA National Hurricane Center	*http://www.nhc.noaa.gov/*

October Quarterly Update for 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment (DME) regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), and/or fiscal intermediaries (FIs), including regional home health intermediaries, for services paid under the DMEPOS fee schedule.

Background

This article and related CR 5255 provide specific information regarding the quarterly update for the October 2006 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

Key Points

Quarterly Update

The DMEPOS fee schedules are updated on a quarterly basis to:

- Implement fee schedule amounts for new codes.
- Revise any fee schedule amounts for existing codes that were calculated in error.

Required Payment

Payment on a fee schedule basis is required for:

- Durable medical equipment, prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)).
- Parenteral and enteral nutrition (PEN) by regulations contained in the *Code of Federal Regulations* (42 CFR 414.102).

Codes Added to HCPCS

The following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) on October 1, 2006, and are effective for claims with dates of service **on or after October 1, 2006**:

- Code K0738 (Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flow meter, humidifier, cannula or mask, and tubing). This code is to be used for billing and payment for oxygen transfilling equipment used in the beneficiary's home to fill portable gaseous oxygen cylinders.
- HCPCS codes K0800 through K0802, K0806 through K0808, K0812 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, K0898 and K0899, as appropriate, for related power mobility device claims.

October Quarterly Update for 2006 DMEPOS Fee Schedule (continued)

The descriptions for these codes and other codes in this article may be found in CR 5255 on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1037.pdf*.

For power wheelchairs furnished on a rental basis with dates of service prior to October 1, 2006, use codes K0010, K0011, K0012, and K0014 as appropriate.

Claims for K0010, K0011, K0012 and K0014 with dates of service on or after October 1, 2006, if the claims are for purchase of initial rental of the item, will be rejected.

The fee schedules for HCPCS code E1238 (Wheelchair, pediatric size, folding, adjustable, without seating system) are being revised as part of this update to correct errors in calculation and are effective for dates of service on or after January 1, 2006.

Fee schedule amounts for codes E2620 and E2621 are being revised to correct fee schedule assignment errors for claims with dates of service on or after January 1, 2006.

The fee schedules for HCPCS code A7043 (Vacuum drainage bottle and tubing for use with implanted catheter) are being revised as part of this update to correct calculation errors and will be effective for dates of service on or after January 1, 2006.

Previously processed claims for codes E2620, E2621, A7043 and E1238 with dates of service on or after January 1, 2006, will be adjusted if they are resubmitted as adjustments.

The fee schedule for HCPCS code L8689 (External recharging system for implanted neurostimulator, replacement only) was revised. FIs and carriers will adjust previously processed claims for code L8689 with dates of service on or after January 1, 2006, if they are resubmitted as adjustments.

HCPCS code L8689 should only be used for external systems that recharge implanted batteries (i.e., external recharging of batteries that area inside the patient). Claims for replacements for other types of implanted neurostimulator battery charging systems should be submitted using L8699.

The fee schedules for HCPCS code L2232 (Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only) are added to the fee schedule file on October 1, 2006, and are effective for new claims with dates of service on or after January 1, 2005.

Codes H0049 (Alcohol and/or drug screening) and H0050 (Alcohol and/or drug services, brief intervention, per 15 minutes) are being added to the HCPCS on June 30, 2006, and will be available on January 1, 2007, for assignment by insurers in accordance with their programs and policies.

Implementation

The implementation date for the instruction is October 2, 2006.

Additional Information

For complete details, please see the official instruction issued to your Medicare carrier, FI, RHHI, DMERC, or DME/MAC regarding this change. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1037CP.pdf*.

If you have questions, please contact your Medicare carrier, DMERC, DME MAC, FI, or RHHI at their toll-free number, which may be found on the CMS website at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5255
Related Change Request (CR) Number: 5255
Related CR Release Date: August 25, 2006
Related CR Transmittal Number: R1037CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1037, CR 5255

Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: CMS has revised this MLN Matters article on September 13, 2006, to reflect changes made to CR 5243 indicating that this issue does not apply to claims billed to regional home health intermediaries and to correct the definition of the 2000A loop. The article was also revised to reflect the new CR transmittal number, CR release date, and the Web address for accessing CR 5243. All other information remains the same. This article was originally published in the September 2006 Medicare A Bulletin (pages 6-7).

Provider Types Affected

Institutional providers who bill Medicare fiscal intermediaries (FIs) for their services

Provider Action Needed
STOP – Impact to You

Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a **taxonomy code** on all claims submitted to their FI.

Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims (continued)

CAUTION – What You Need to Know

Please use the attachment to CR 5243 (supplied in the *Background* section of this article) to crosswalk the OSCAR (online survey certification and reporting) system number to the appropriate taxonomy code for your type of facility. The taxonomy code will assist Medicare in cross walking from the national provider identifier (NPI) of the provider to each of its subparts in the event that the provider chooses not to apply for a unique NPI for each of its subparts individually.

GO – What You Need to Do

Refer to the *Background* section of this article for additional crosswalk information.

Background

Regulations implementing the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 require the use of national provider identifiers (NPIs) by covered health care providers and health plans (other than small plans) **effective May 23, 2007.** (45 CFR Part 162, Subpart D (162.402-162.414)

The Centers for Medicare & Medicaid Services (CMS) will use a Medicare provider identifier crosswalk between NPIs and legacy identifiers (such as OSCAR numbers) to validate NPIs received in transactions, assist with the population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. (See MM4023 at the link provided below for more information on CMS' implementation of the NPI.) The crosswalk detailed in CR 5243 between the provider's OSCAR number and the appropriate taxonomy code will assist in this process.

Attachment to CR 5243: Reporting of Taxonomy Codes (Institutional Providers)

The following chart supplies the crosswalk from the OSCAR number to the appropriate taxonomy code based on the provider's facility type.

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Short-term (general and specialty) hospitals	0001-0879 *****positions 3-6 of the OSCAR number	282N00000X
Critical access hospitals	1300-1399*****	282NC0060X
Long-term care hospitals (LTCH swing beds submitting with type of bill (TOB) 18x must use the LTCH taxonomy code)	2000-2299*****	282E00000X
Hospital-based renal dialysis facilities	2300-2499*****	261QE0700X
Independent-renal dialysis facilities	2500-2899*****	261QE0700X
Rehabilitation hospitals	3025-3099*****	283X00000X
Children's hospitals	3300-3399*****	282NC2000X
Hospital-based satellite renal dialysis facilities	3500-3699	TOB 72x and taxonomy code of 261QE0700X and a ZIP code different than any renal dialysis facility issued an OSCAR number that is located on that hospital's campus
Psychiatric hospitals	4000-4499*****	283Q00000X
Organ procurement organization (OPO)	P in third position of the OSCAR number	335U00000X
Psychiatric unit	M or S in third Position	273R00000X
Rehabilitation unit	R or T in third Position	273Y00000X
Swing-bed unit/facility	U, W, Y, or Z in third position	TOB X8X with one of the following to show type of facility in which the swing-bed is located: 275N00000X short term hospital (U); 282E00000X long-term care hospital (W); 283X00000X rehabilitation facility (Y); or 282NC0060X critical access hospital (Z)

Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims (continued)

Be sure to follow the following billing instructions contained in CR 5243:

- Report the service facility locator loop (2310E) in an 837-I claim whenever the service was furnished at an address other than the address reported on the claim for the billing or pay to provider.
- Input the taxonomy code in the 837-I provider loop 2000A (billing or pay to provider).
- Submit separate batches of claims for each subpart identified by a different taxonomy code.
- Providers submitting claims for their primary facility and its subparts must submit a nine-digit ZIP code on their claims.
- CMS recommends submitting both the OSCAR number and the NPI on claims submitted through May 22, 2007. (Note that failure to report and OSCAR number that corresponds to your NPI could result in a payment delay.)

Implementation Date

The implementation date for this instruction is January 2, 2007.

Additional Information

MM4023 "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms" is located on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf*.

CR 5243 is the official instruction issued to your Medicare FI/RHHI regarding changes mentioned in this article. CR 5243 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1054CP.pdf*.

If you have questions, please contact your local Medicare FI/RHHI at their toll-free number, which may be found on the CMS web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5243 – Revised
Related Change Request (CR) Number: 5243
Related CR Release Date: September 8, 2006
Related CR Transmittal Number: R1054CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1054, CR 5243

Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: CMS has revised this MLN Matters article on August 28, 2006, to reflect revisions made to change request (CR) 5105, which CMS released on August 25, 2006. The transmittal number, CR release date, and Web address for accessing CR 5105 have been changed. All other information remains the same. The first revision to this article was published in the August 2006 Medicare A Bulletin (pages 15-16).

Provider Types Affected

Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare advantage (MA) organizations.

Impact on Providers

This article is based on CR 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR 5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in an MA organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

Background

The Centers for Medicare & Medicaid Services (CMS) pays for a beneficiary's medical services more than once when a specific set of circumstances occurs.

When CMS data systems recognize a beneficiary has enrolled in a MA organization, the MA organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

The result is that Medicare may pay for the services rendered during a specific period twice:

- First, for the specific service which was paid by the fee-for-service Medicare contractor to the provider.
- Second, by the MA payment systems in the monthly capitation rate paid to the MA plan for the beneficiary.

Overview of the Medicare Advantage Plan Enrollment Process

When an MA plan enrollment is processed retroactively:

- Fee-for-service claims with dates of service that fall under the MA plan enrollment period are identified by Medicare's common working file (CWF) system.
- An informational unsolicited response (IUR) record is created.

Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment (continued)

In essence, the retroactive enrollment triggers a search for fee-for-service claims that were incorrectly paid for services rendered when the beneficiary was covered by the MA plan. If such claims are found, the system generates an adjustment and initiation by Medicare systems of overpayment recovery procedures. The current policy/procedures, as outlined in CR 2801 (Transmittal AB-03-101, dated July 18, 2003) and CR 5105, dictates that:

- Claims paid in error (due to enrollment or disenrollment corrections) will be adjusted.
- Medicare contractors will initiate overpayment recovery procedures.

Note: CR 2801 (Transmittal AB-03-101, dated July 18, 2003) may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/Downloads/AB03101.pdf*.

Because of the inherent retroactivity in the enrollment process, (e.g., beneficiaries can enroll in plans up to the last day of the month, and the effective date would be the first of the following month), the CWF may receive this information after the enrollment is effective. For this reason, these kinds of adjustments occur routinely.

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. For details of the impact of this synchronization on providers, please see *MLN Matters* article, SE0638, which is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0638.pdf*.

When claims are identified as needing payment recovery, the related remittance advice for the claim adjustment will indicate reason code 24, which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." Upon receipt, providers are to contact the MA plan for payment.

- Providers who bill carriers will be alerted by their carrier (via letter or alternate method) of the following:
  - That the beneficiary was in a MA plan on the date of service
  - That the provider should bill the managed care plan
  - What the plan identification number is
  - Where to find the plan name and address associated with the plan number on the CMS website.
- For providers who bill FIs, the adjustment will occur automatically and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

Note: To associate plan identification numbers with the plan name, go to the CMS website *http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage*.

In summary, CMS issued CR 5105 to:

- Ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the Medicare contractors (carriers, DMERCs, FIs, and RHHIs) for overpayments
- Instruct Medicare contractors to follow the instructions outlined in the *Medicare Financial Management Manual* (Pub.100-06, Ch. 3, Section 190), which is included as part of CR 5105. Instructions for accessing CR 5105 are in the *Additional Information* section of this article.

Implementation

The implementation date for the instruction is June 26, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R106FM.pdf*.

Also, if you have any questions, please contact your carrier/DMERC/intermediary/RHHI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5105 – Second Revision
Related Change Request (CR) Number: 5105
Related CR Release Date: August 25, 2006
Related CR Transmittal Number: R106FM
Effective Date: October 1, 2003
Implementation Date: June 26, 2006

Source: CMS Pub. 100-06, Transmittal 106, CR 5105

MEDICARE SECONDARY PAYER

National Recovery Contractor for New Medicare Secondary Payer Recovery Claims

The Centers for Medicare & Medicaid Services (CMS) has awarded a contract for a national Medicare Secondary Payer Recovery Contractor (MSPRC) to Chickasaw Nation Industries, Inc. – Administration Services, LLC (CNI). This contract will be implemented **on October 2, 2006.**

Please read the sections immediately below to determine how the change to a national MSPRC will affect you, as some existing MSP recovery claims will remain the responsibility of the claim processing contractors.

What Does Implementation of the MSPRC Mean for You if You Are a Provider, Physician, or Other Supplier?

The recovery of provider, physician or other supplier MSP recovery claims will continue to be the responsibility of the contractor that processed the underlying Medicare claim. Consequently, providers, physicians, and other suppliers should not see any changes in CMS' processes for recovering debts where the provider, physician, or other supplier is overpaid due to receiving a duplicate payment from both an insurer or workers' compensation carrier and Medicare.

What Does Implementation of the MSPRC Mean for You if You Are:

(a) An employer, insurer, group health plan (GHP), third party administrator, or other plan sponsor subject to the MSP GHP provisions of the Social Security Act;
(b) A workers' compensation plan/carrier or a liability or no-fault insurer; or
(c) A beneficiary (or the representative of a beneficiary)?

For all **new** MSP initial recovery demand letters issued **on or after the implementation date for the MSPRC (October 2, 2006),** you should respond to the entity that issues the recovery demand letter to you. Except for provider, physician, or other supplier MSP recovery claims and a limited number of GHP debts in certain states, this will routinely be the MSPRC.

General Rules

The MSPRC will have responsibility for all **new** MSP recovery demand letters issued on or after the implementation date for the MSPRC (October 2, 2006), as well as all subsequent CMS actions on those recovery claims. Two exceptions to these general rules are:

- Recovery demand letters issued by the MSP recovery audit contractors (RACs) implemented as a demonstration project under the Medicare Modernization Act (MMA) of 2003.
  The following three RACs will continue to have responsibility for certain MSP GHP based recovery demands for the respective states:
  - Diversified Collection Systems – California
  - Public Consulting Group – Florida
  - Public Consulting Group – New York
- MSP recovery demand letters issued by the claim processing contractors to providers, physician, and other suppliers.

Note: The responsibility for all pending MSP recovery cases where a recovery demand letter has not yet been issued will, aside from the two exceptions noted in the preceding paragraph, be the responsibility of the MSPRC. (Please note that a letter providing the amount of Medicare's conditional payments in connection with a workers' compensation or liability or no-fault insurance case is not a recovery demand letter.) This responsibility is in line with the MSPRC's responsibility for the issuance of all new MSP recovery demand letters issued on or after October 2, 2006 (again, with the two exceptions noted in the preceding paragraph).

Due to systems issues, the Medicare contractors listed immediately below will continue to have responsibility for all further CMS collection activities with respect to MSP recovery claims where the initial recovery demand letter was issued **prior to the implementation date of the MSPRC (October 2, 2006).** This includes responsibility for the "Notice of Intent to Refer Debt to the Department of Treasury" letters where a recovery claim is not repaid timely. The RACs will also continue to have this responsibility for all RAC-initiated MSP recovery claims.

- Empire – Syracuse NY or Harrisburg PA
- First Coast Service Options, Inc. (FCSO) – Jacksonville FL
- Mutual of Omaha – Omaha NE
- Palmetto – Augusta GA or Columbia SC or Columbus OH
- Trailblazer – Denison TX

The MSPRC will have responsibility for all further CMS collection actions for MSP recovery demand letters issued **before** the implementation date for the MSPRC (October 2, 2006) **unless** the recovery demand letter was: 1) issued by one of the Medicare contractors listed immediately above; 2) issued by one of the RACs; or 3) issued to a provider, physician, or other supplier.

Once a recovery claim is referred to the Department of the Treasury, the contractor that issued the recovery demand letter and the notice of intent to refer the debt to the Treasury letter will make no further collection attemps. You should direct any further correspondence to the Department of the Treasury (or its contractor if you have received

National Recovery Contractor for New Medicare Secondary Payer Recovery Claims (continued)

correspondence from an entity working under contract to the Department of the Treasury).

Contact Information for the MSPRC

MSPRC telephone access will **not** be available **before October 2, 2006**. The number for the MSPRC's dedicated call center will be 1-866-MSP-RC20 (1-866-677-7220), available from 8:00 a.m. to 8:00 p.m. Eastern Standard Time, Monday through Friday, with the exception of holidays.

The MSPRC will **not** accept mail **until September 25, 2006.** Mailing information for the MSPRC will be available on CMS' website after September 22, 2006.

The MSPRC is a recovery contractor.

Two Important Points

- The appropriate contact for reporting changes in group health plan (GHP) insurance coverage, or reporting non-GHP claims (workers' compensation, liability insurance (including self-insurance), or no-fault insurance) remains CMS' Coordination of Benefits Contractor (COBC). Initial contact for parties wishing to propose a workers' compensation Medicare set-aside amount also remains with the COBC. See *http://www.cms.hhs.gov/COBGeneralInformation/* for further information about the COBC, including contact information, attorney information, etc. The COBC's toll-free line is 1-800-999-1118 (TTY/TDD 1-800-318-8782 for the hearing and speech impaired).
- The CMS Medicare claims processing contractors continue to be responsible for claims processing for Medicare billing involving Medicare as a secondary payer. ❖

Source: CMS Joint Signature Memorandum 06686, September 21, 2006

NATIONAL PROVIDER IDENTIFICATION

Modification of National Provider Identifier Editing Requirements in CR 4023 and an Attachment to CR 4320

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Medicare carriers including durable medical equipment regional carriers (DMERCs) (or durable medical equipment Medicare administrative contractors (DME MACs) if appropriate)

Provider Action Needed

STOP – Impact to You

This article is based on CR 5229, which corrects certain business requirements from CR 4023 that relate to edits for national provider identifiers (NPIs) and provider legacy identifiers when reported on claims, particularly for **referring/ordering or other secondary providers**, effective October 1, 2006 and later. Additionally, CR 5229 revises Attachment 1 to CR 4320.

CAUTION – What You Need to Know

Some of those business requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare Provider Identifier Crosswalk. This is not always the case. CR 5229 modifies those business requirements.

GO – What You Need to Do

These modifications will enable correct processing of affected claims in October 2006 and later, and will avoid the unnecessary rejection of many claims that involve a referring/ordering or other secondary provider. Please refer to the *Background* section of this article and to CR 5229 for additional important information regarding these modifications.

Background

The Medicare Learning Network (MLN) articles, MM4023 and MM4320, which are based on CR 4023 and CR 4320 respectively, contain important information about the stages of the NPI implementation process. Some of this information is updated in the current article. The links to these articles are located in the *Additional Information* section of this article.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414). To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs on May 23, 2005. Applications may be made by mail and online at *https://nppes.cms.hhs.gov*.

During Stage 2 of the NPI implementation process (October 2, 2006 – May 22, 2007), Medicare will utilize a Medicare Provider Identifier Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions.

Primary and Secondary Providers

Providers, for NPI provider identifier editing purposes, are categorized as either "primary" or "secondary" providers. Primary providers include billing, pay-to, and rendering providers. Primary providers are required to be enrolled

Modification of NPI Editing Requirements in CR 4023 and an Attachment to CR 4320 (continued)

in Medicare for the claim to qualify for payment.

Secondary providers are all other providers for which data could be reported on an institutional (837-I) or professional (837-P), free billing software or direct data entry (DDE) claim, or on a revised CMS-1500 or a UB-04 (once those paper claims are accepted by Medicare). Since the UB-92, the currently used CMS-1500, and the HIPAA NCPDP format do not allow reporting of both NPIs and legacy identifiers, information on secondary providers in those claims is not included in the following requirements. **Secondary providers may be enrolled, but are not required to be enrolled in Medicare** (unless they plan to bill or be paid by Medicare for care rendered to Medicare beneficiaries).

Secondary Provider Claims
Claims Submitted with NPI and Medicare Legacy Identifier:

During Stage 2, claim submitters should submit a provider's Medicare legacy identifier whenever reporting an NPI for a provider. Failure to report a Medicare legacy number for a provider enrolled in Medicare could result in a delay in processing of the claim. When an NPI and a legacy identifier are reported for a provider, Medicare contractors will apply the same edits to those numbers that would have been applied if that provider was a primary provider. (See MM4023.)

There are two exceptions:

1. A Medicare contractor cannot edit a surrogate unique provider identification number (sometimes called a dummy UPIN, such as OTN000). Despite its name, a surrogate is not actually unique for a specific provider.
2. Only a national supplier clearinghouse (NSC) identification number or a UPIN should ever be reported as the legacy numbers on a claim sent to a DMERC/DME MAC. If a carrier provider identification number (PIN) is reported as a legacy identifier with an NPI, DMERCs/DME MACs will edit as if the NPI was the only provider identifier reported for that provider.

Claims Submitted with NPI Only

The NPI is edited to determine if it meets with the physical requirements of the NPI (10 digits, begins with a 1, 2, 3, or 4, and the check digit in 10th position is correct), and whether there is a Medicare provider identifier crosswalk entry for that NPI.

If the NPI is located in the crosswalk:

- The taxpayer identification number (TIN) (employer identification number (EIN) or social security number (SSN) and legacy identifier will be sent to the trading partner in addition to the NPI if coordination of benefits (COB) applies.
- However, only the TIN will be forwarded to the COB payer if there is more than one legacy identifier associated with the same NPI in the Medicare Provider Identifier Crosswalk because it may be difficult to know which Medicare legacy identifier applies to that claim.

If the NPI is not located in the crosswalk:

- No supplemental identifier can be reported to a COB payer.
- However, the claim **will not be rejected** if the NPI for a referring/ordering provider or another secondary provider cannot be located in the Medicare Provider Identifier Crosswalk, with one exception. Reporting of a Medicare legacy identifier other than a surrogate UPIN signifies a provider is enrolled in Medicare. If a Medicare legacy identifier is reported and cannot be located in the Crosswalk, the claim will be rejected, regardless of whether an NPI was reported for that provider.

Claims (including UB-92 or the current CMS-1500 paper claims) submitted with Medicare legacy identifier only

- A Medicare contractor may, but is not required to check a legacy number against the Medicare Provider Identifier Crosswalk.
- As at present, claims will be rejected if any Medicare legacy identifier reported on a claim does not meet the physical requirements (length, if numeric or alphanumeric as applicable) for that type of Medicare provider identifier.

COB and Medigap Trading Partners

Legacy identifiers will not be reported to these trading partners for secondary providers if they are not submitted on the claim sent to Medicare, are surrogate UPINs or if the provider is not enrolled in Medicare. If not enrolled, a legacy identifier or a TIN cannot be sent for a "secondary" provider because Medicare would not have issued a legacy identifier to or collected a TIN from that provider.

837-I or 837-P version 4010A1 Claims

Attachment 1 to CR 4320 which is being revised as part of CR 5229 addresses (among other issues), the identification of secondary providers for which the 837-I or 837-P version 4010A1 implementation guides only require reporting of an NPI or other identifier "if known." Unless there is a pre-existing Medicare instruction that mandates the reporting of a specific identifier for those "if known" types of providers, there is no requirement for entry of any identifier for those entities/individuals. If there is no such requirement, claims received that lack an identifier for those types of providers will not be denied.

Note that "secondary" providers such as a referring/ordering physician are not required to be enrolled in Medicare as a **condition for payment** of the services or supplies they order, furnish, supervise delivery of, etc. for beneficiaries **when those services are billed, paid-to or rendered by "primary" providers**. For example, Medicare could pay:

- A hospital for services ordered for a patient for inpatient hospital care when the admitting or attending physician is not enrolled in Medicare;
- Hospital surgery costs when the surgeon is not enrolled in Medicare; or
- A hospital when services are purchased from another provider "under arrangements" even if that other provider is not enrolled in Medicare.

Modification of NPI Editing Requirements in CR 4023 and an Attachment to CR 4320 (continued)

Implementation Date

The implementation date for this instruction is October 2, 2006.

Additional Information

CR 4320, issued February 1, 2006, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" is located on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf*.

The associated MLN article (with the same title) MM4320, may be found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf*.

CR 4023, dated November 3, 2005, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms" is located on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf*.

MM4023, the associated MLN article, is located on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf*.

CR 5229 is the official instruction issued to your Medicare carrier/DMERC (DME MAC if appropriate), FI/RHHI regarding changes mentioned in this article. CR5229 may be found on the CMS website at *http://ww.cms.hhs.gov/Transmittals/downloads/R234OTN.pdf*.

If you have questions, please contact your local Medicare carrier/DMERC (DME MAC if appropriate), or FI/RHHI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5229
Related Change Request (CR) Number: 5229
Related CR Release Date: August 18, 2006
Related CR Transmittal Number: R234OTN
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-20, Transmittal 234, CR 5229

Change in Online Availability of NPI Application/Update Form (CMS-10114)

National Provider Identifier: Get It. Share It. Use It.

Beginning on September 20, 2006, the PDF version of the NPI Application/Update Form (CMS-10114) will no longer be available for download on the CMS forms website, and there will not be a link to that form from the NPPES page (*https://nppes.cms.hhs.gov/NPPES/Welcome.do*).

Health care providers can still, however, apply for National Provider Identifiers (NPI) in one of these three ways:

1. For the most efficient application processing and the fastest receipt of NPIs, health care providers should consider using the web-based NPI application process. They can log onto the National Plan and Provider Enumeration System (NPPES) and apply on line at https://nppes.cms.hhs.gov/NPPES/Welcome.do.
2. Health care providers can agree to have an electronic file interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
3. Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:

   Phone: 1-800-465-3203 or TTY 1-800-692-2326

   E-mail: customerservice@npienumerator.com

   Mail: NPI Enumerator
   P.O. Box 6059
   Fargo, ND 58108-6059

Getting an NPI is free – not having one can be costly. ❖

Source: CMS Provider Education Resource 200609-06

Requirements for Use and Editing of National Provider Identifier Numbers

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: CMS has revised this MLN Matters article on August 25, 2006, by adding this statement directing readers to view article MM5060 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf* for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR 5060, which is available at *http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf*. All other information remains the same. This article was originally published in the Second Quarter 2006 *Medicare A Bulletin* (pages 18-20).

Provider Types Affected

Physicians, providers, and suppliers who submit claims for services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), to include regional home health intermediaries (RHHIs)

Provider Action Needed

The requirements for stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in stage 2 is October 1, 2006.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005.

Applications may be made by mail and also online at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.

NPI and Legacy Identifiers

The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. **Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers.**

Legacy provider identifiers include:

- Online survey certification and reporting (OSCAR) system numbers
- National supplier clearinghouse (NSC) numbers
- Provider identification numbers (PINs)
- Unique physician identification numbers (UPINs) used by Medicare.

They **do not** include taxpayer identifier numbers (TINs) such as:

- Employer identification numbers (EINs)
- Social security numbers (SSNs).

Primary and Secondary Providers

Providers are categorized as either "primary" or "secondary" providers:

- ***Primary providers*** include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- ***Secondary providers*** include supervising physicians, operating physicians, referring providers, and so on.

Crosswalk

During stage 2, Medicare will utilize a crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this crosswalk include the following:

- Each primary provider's NPI reported on an inbound claim or claim status query will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI, and from NPI to a legacy identifier.
- The Medicare crosswalk will be updated daily to reflect new provider registrations.

NPI Transition Plans for Medicare FFS Providers

Medicare's implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as shown in the table on the next page:

Requirements for Use and Editing of National Provider Identifier Numbers (continued)

Stage	Medicare Implementation
May 23, 2005 – January 2, 2006	Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.
January 3, 2006 – October 1, 2006	Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
October 2, 2006 – May 22, 2007 (*This is stage 2, the subject of CR 4023)*	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.
May 23, 2007 – Forward	CMS systems will **only** accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

Claim Rejection

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
  - X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only)
  - National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only)
  - Claims submitted using Medicare's free billing software
  - Electronic claim status request received via X12 276 or DDE screen
  - Non-X12 electronic claim status queries
- An NPI reported cannot be located in Medicare files.
- The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI.
- Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare's free billing software.

Note: If only provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.

Additional Information

X12 837 Incoming Claims and COB

During stage 2, an X12 837 claim may technically be submitted with only an NPI for a provider, **but you are strongly encouraged to also submit the corresponding Medicare legacy identifier for each NPI** in X12 837 Medicare claims.

Use of both numbers could facilitate investigation of errors if one identifier or the other cannot be located in the Medicare validation file. When an NPI is reported in a claim for a billing or pay-to provider, a TIN must also be submitted in addition to the provider's legacy identifier as required by the claim implementation guide.

National Council of Prescription Drug Plans (NCPDP) Claims

The NCPDP format was designed to permit a prescription drug claim to be submitted with either **an NPI or a legacy identifier, but not more than one identifier** for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

- For stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.
- During stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician's NPI) in their claims.

Requirements for Use and Editing of National Provider Identifier Numbers (continued)

When an NPI is submitted in an NCPDP claim, it will be edited in the same way as an NPI submitted in an X12 837 version 4010A1 claim. The retail pharmacy will be considered the primary provider and the prescribing physician as the secondary provider for NPI editing purposes.

Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006 and end February 28, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

Pending the start of submission of the revised CMS-1500 and the UB-04, providers must continue to report legacy identifiers, and not NPIs, when submitting claims on the nonrevised CMS-1500 and the UB-92 paper claim forms.

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. "Old" form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI.

Or, if they are not rejected—since some legacy identifiers were also ten-digits in length—could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

Standard Paper Remits (SPRs)

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider's NPI and legacy identifier when both are available in Medicare's files. If a provider's NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was not reported for the billing/pay-to, or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR 4023:

- CR 4023 Attachment 1: FI standard paper remit (SPR) amended format for stage 2
- CR 4023 Attachment 2: carrier/DMERC SPR amended stage 2 Format.

Remit Print Software

The 835 PC-Print and Medicare remit easy print software will be modified by October 2, 2006, to enable either the NPI or a Medicare legacy number, or both, if included in the 835, to be printed during stage 2.

Free Billing Software

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim, and to identify whether an entered identifier is an NPI or a legacy identifier.

In-Depth Information

Please refer to CR 4023 for additional detailed NPI-related claim information about the following topics:

- Crosswalk
- X12 837 Incoming Claims and COB
- Non-HIPAA COB Claims
- NCPDP Claims
- DDE Screens
- Paper Claim Forms
- Free Billing Software
- X12 276/277 Claim Status Inquiry and Response Transactions
- 270/271 Eligibility Inquiry and Response Transactions
- 835 Payment and Remittance Advice Transactions
- Electronic Funds Transfer (EFT)
- Standard Paper Remits (SPRs)
- Remit Print Software
- Claims History
- Proprietary Error Reports
- Carrier, DMERC, and FI Local Provider Files, including EDI System Access Security Files
- Med A and Med B Translators
- Other Translators
- Stages 3 and 4

CR 4023, the official instruction issued to your FI/regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to CMS website *http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf*.

You may also wish to review *Medlearn Matters* article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *Medlearn Matters* Articles on NPI-Related Activities," which is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0555.pdf*.

This article contains further details on the NPI and how to obtain one.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find their toll free phone number, go to CMS website *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Medlearn Matters Number: MM4023 – Revised
Related Change Request (CR) Number: 4023
Related CR Release Date: November 3, 2005
Related CR Transmittal Number: 190
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Source: CMS Pub. 100-20, Transmittal 190, CR 4023

GENERAL COVERAGE

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2006

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers and fiscal intermediaries (FIs) for clinical diagnostic laboratory services provided for Medicare beneficiaries

Impact on Providers

This article is based on change request (CR) 5293, which announces the changes that will be included in the October 2006 release of the edit module for clinical diagnostic laboratory services.

Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Subsequently, the Centers for Medicare & Medicaid Services (CMS) contracted for nationally uniform software to be developed and incorporated into its shared systems so that laboratory claims subject to one of the 23 NCDs can be processed uniformly throughout the nation effective January 1, 2003. The 23 national coverage determinations are listed below:

1. Culture, Bacterial, Urine
2. Human Immunodeficiency Virus Testing (Prognosis including monitoring)
3. Human Immunodeficiency Virus Testing (Diagnosis)
4. Blood Counts
5. Partial Thromboplastin Time
6. Prothrombin Time
7. Serum Iron Studies
8. Collagen Crosslinks, Any Method
9. Blood Glucose Testing
10. Glycated Hemoglobin/Glycated Protein
11. Thyroid Testing
12. Lipids
13. Digoxin Therapeutic Drug Assay
14. Alpha-fetoprotein
15. Carcinoembryonic Antigen
16. Human Chorionic Gonadotropin
17. Tumor Antigen by Immunoassay - CA125
18. Tumor Antigen by Immunoassay CA 15-3/CA 27.29
19. Tumor Antigen by Immunoassay CA 19-9
20. Prostate Specific Antigen
21. Gamma Glutamyl Transferase
22. Hepatitis Panel/Acute Hepatitis Panel
23. Fecal Occult Blood

The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* (Pub.100-4), Chapter 16, section 120.2, *http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf*).

CR 5293 informs your Medicare carrier and FI about changes in the laboratory NCD code lists for October 2006, that require updating of the laboratory edit module. These changes become effective for services furnished on or after October 1, 2006.

Changes are being made to the NCD code lists for services furnished on or after October 1, 2006, are as follows:

190.12 – Urine Culture, Bacterial

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the urine culture, bacterial (190.12) NCD:

- ICD-9-CM codes 288.00, 288.01, 288.02, 288.03, 288.04, 288.09, 608.20, 608.21, 608.22, 608.23, 608.24, 616.81, 616.89, 780.96, 780.97, 788.64 and 788.65.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the urine culture, bacterial (190.12) NCD:

- ICD-9-CM codes 288.0, 608.2 and 616.8.

190.14 – Human Immunodeficiency Virus (HIV) Testing (Diagnosis)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the human immunodeficiency virus (HIV) testing (diagnosis) (190.14) NCD:

- ICD-9-CM codes 052.2, 053.14, 054.74, 288.00, 288.01, 288.02, 288.03, 288.04, 288.09, 288.4, 288.50, 288.51, 288.59, 288.60, 288.61, 288.62, 288.63, 288.64, 288.65, 288.69, 289.53 and 331.83.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the human immunodeficiency virus (HIV) testing (diagnosis) (190.14) NCD:

- ICD-9-CM code 288.0.

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2006 (continued)

190.15 – Blood Counts

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes that do not support medical necessity for the blood counts (190.15) NCD:

- ICD-9-CM codes 338.0, 338.11, 338.12, 338.18, 338.19, 338.21, 338.22, 338.28, 338.29, 338.4, 389.15, 389.16, 478.11, 478.19, 521.81, 521.89, 525.60, 525.61, 525.62, 525.63, 525.64, 525.65, 525.66, 525.67, 525.69, 526.61, 526.62, 526.63, 526.69, 608.20, 608.21, 608.22, 608.23, 608.24, 618.84, V26.34, V26.35, V45.86, V72.11 and V72.19.
- ICD-9-CM codes 521.8 and V72.1 are **deleted** from the list of codes that do not support medical necessity for the blood counts (190.15) NCD.

190.16 – Partial Thromboplastin Time (PTT)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT)(190.16) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 277.30, 277.31, 277.39, 289.81, 649.30, 649.31, 649.32, 649.33, 649.34, 649.50, 649.51, 649.53, 998.12, 995.20, 995.21, 995.27, and 995.29.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT)(190.16) NCD:

- ICD-9-CM codes 238.7, 277.3 and 995.2.

190.17 – Prothrombin Time (PT)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 277.30, 277.31, 277.39, 289.81, 649.30, 649.31, 649.32, 649.33, 649.34, 649.50, 649.51, 649.53, 995.20, 995.21, 995.27, and 995.29.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD:

- ICD-9-CM codes 238.7, 277.3 and 995.2.

190.18 – Serum Iron Studies

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, and 238.79.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD:

- ICD-9-CM code 238.7.

190.20 – Blood Glucose Testing

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the blood glucose testing (190.20) NCD:

- ICD-9-CM codes 331.83, 528.00, 528.09, 649.20, 649.21, 649.22, 649.23, 649.24 and 780.32.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the blood glucose testing (190.20) NCD:

- ICD-9-CM code 528.0.

190.22 – Thyroid Testing

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the thyroid testing (190.22) NCD:

- ICD-9-CM codes 331.83, 780.96 and 780.97.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the thyroid testing (190.22) NCD:

- ICD-9-CM code 793.9.

190.23 – Lipids Testing

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the lipids testing (190.23) NCD:

- ICD-9-CM codes 277.30, 277.31 and 277.39.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the lipids testing (190.23) NCD:

- ICD-9-CM code 277.3.

190.24 – Digoxin Therapeutic Drug Assay

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the digoxin therapeutic drug assay (190.24) NCD:

- ICD-9-CM codes 995.20, 995.21, 995.27 and 995.29.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the digoxin therapeutic drug assay (190.24) NCD:

- ICD-9-CM code 995.2.

190.25 – Alpha-fetoprotein

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the alpha-fetoprotein (190.25) NCD:

- ICD-9-CM codes V86.0, V86.1, 795.89 and 338.3.

190.26 – Carcinoembryonic Antigen

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the carcinoembryonic antigen (190.26) NCD:

- ICD-9-CM codes 795.81, 795.89 and 338.3.

190.27 – Human Chorionic Gonadotropin

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the human chorionic gonadotropin (190.27) NCD:

- ICD-9-CM codes 795.89 and 338.3.

190.28 – Tumor Antigen by Immunoassay CA 125

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the tumor antigen by immunoassay CA 125 (190.28) NCD:

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2006 (continued)

- ICD-9-CM codes 795.82, 795.89 and 338.3.

190.29 – Tumor Antigen by Immunoassay CA 15-3/ CA27.29

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the tumor antigen by immunoassay CA 15-3/CA27.29 (190.29) NCD:

- ICD-9-CM codes 338.3 and 795.89.

190.30 – Tumor Antigen by Immunoassay CA 19.9

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the tumor antigen by immunoassay CA 19.9 (190.30) NCD:

- ICD-9-CM codes 338.3 and 795.89.

190.31 – Prostate Specific Antigen (PSA)

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the prostate specific antigen (PSA) (190.31) NCD:

- ICD-9-CM codes 600.00, 600.10, 600.11, 600.21, 788.64 and 788.65.

190.32 – Gamma Glutamyl Transferase (GGT)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (GGT) (190.32) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 277.30, 277.31 and 277.39.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (GGT) (190.32) NCD:

- ICD-9-CM codes 238.7 and 277.3.

190.33 – Hepatitis Panel/Acute Hepatitis Panel

The following ICD-9-CM code of 780.32 is being **added** to the list of ICD-9-CM codes covered by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.

190.34 – Fecal Occult Blood Test (FOBT)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the fecal occult blood test (FOBT) (190.34) NCD:

- ICD-9-CM codes 284.2 and 338.3.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the fecal occult blood test (FOBT) (190.34) NCD:

- ICD-9-CM code 995.2.

List of Denied ICD-9-CM Codes for All NCDs

The following ICD-9-CM codes are being **added** to the list of denied ICD-9-CM codes for all NCDs:

- ICD-9-CM codes V18.51, V18.59, V82.71 and V82.79.
- ICD-9-CM code V18.5 is **deleted** from the list of denied ICD-9-CM codes for all NCDs.

Implementation

The implementation date for CR5293 is October 2, 2006.

Additional Information

To see the official instruction issued to your carrier/ intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/ Transmittals/downloads/R1050CP.pdf*.

If you have any questions, please contact your carrier/ intermediary at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/ MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5293
Related Change Request (CR) Number: 5293
Related CR Release Date: September 7, 2006
Related CR Transmittal Number: R1050CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1050, CR 5293

Clarification on Billing Requirements for Percutaneous Transluminal Angioplasty Concurrent with Placement of an FDA-approved Carotid Stent

CMS has issued the following "MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: CMS has revised this MLN Matters article on August 25, 2006, to reflect changes made to CR 5022, which CMS re-issued on August 25. The transmittal number, CR release date, and Web address for accessing CR 5022 were changed. All other information remains the same. This article was originally published in the July 2006 *Medicare A Bulletin* (page 31-32).

Provider Types Affected

Providers, physicians, and suppliers that bill Medicare contractors (fiscal intermediaries (FIs) and carriers) for their services

Key Points

- This article is based on CR 5022, which contains instructions (summarized below) that must be implemented to correctly process carotid stenting claims.
- The Centers for Medicare & Medicaid Services (CMS) has additionally updated the carotid artery stenting (CAS) facilities "approved facilities" website link in Publication 100-03, *The National Coverage Determinations Manual*. The list is now available on the CMS website at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp*.
- Claims that are being billed for category B investigational device exemption (IDE) studies and post-approval studies, per CR 1660 (effective July 1, 2001) and CR 3489 (effective October 12, 2004), respectively, are not subject to the same billing requirements as indicated in CR 3811 (effective March 17, 2005). The links to CR 1660 and the Medicare Learning Network (MLN) articles relating to CR 3489 and CR 3811 may be found in the *Related Links* section below.
- CMS created a new section in the *Medicare Claims Processing Manual* specific to carotid stents. Please refer to this new section in the manual attachment to CR 5022, (Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 32, Sections 150.1-150.3) for more information about PTA for implanting the carotid stent. (This includes information on CR [1]660, CR 3489 and CR 3811.)

Background

Percutaneous transluminal angioplasty (PTA) involves inserting a balloon catheter into a narrow or occluded blood vessel to recanalize and dilate the vessel by inflating the balloon. The objective of PTA is to improve the blood flow through the diseased segment of a vessel so that vessel patency is increased and embolization is decreased. With the development and use of balloon angioplasty for treatment of atherosclerotic and other vascular stenoses, PTA (with and without the placement of a stent) is a widely used technique for dilating lesions of peripheral, renal, and coronary arteries.

Please refer to the manual attachment to CR 5022, Transmittal 53, (Publication 100-03, *The Medicare National Coverage Determinations Manual*, Chapter 1, Part 1, Section 20.7) for more information about the nationally covered indications for PTA concurrent with carotid stent placement, and for facilities accepted for services related to CAS with embolic protection. This is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf*.

Category B IDE Study Claims and Post-approval Study Claims

Effective for dates of service on or after March 17, 2005, the following claims are not subject to the approved facility list. These are CAS claims:

- Billed under a category B IDE study (identified by a six-digit IDE number preceded by a "G," i.e., G123456); or
- Billed under an FDA-approved post-approval study (identified by a six-digit PMA (pre-market approval) number preceded by a "P," i.e., P123456),
- Previously denied due to the unintended application of the "approved" facility edit created per CR 3811 that are brought to your FI's or carrier's attention will be adjusted (per CR 1660 for category B IDE study laims, and CR 3489 for post-approval study claims).

CAS with Embolic Protection Claims

- Effective for dates of service on or after March 17, 2005, CAS with embolic protection claims will be paid only if they are from facilities listed on the approved list (see *http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp*). CAS with embolic protection claims from nonapproved facilities will be rejected rather than denied. (CR 3811)
- Effective for dates of service on or after March 17, 2005, CAS **with** embolic protection claims that contain *CPT code 37216 (transcatheter placement of intravascular stent(s) without distal embolic protection)* will **not** be paid. CMS has deemed *CPT* code *37216* a noncovered service for Medicare purposes.

Related Links

CR 1660, *Claims Processing Instructions for Clinical Trials on Carotid Stenting With Category B Investigational Device Exemptions (IDEs)* may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/Downloads/AB0174.pdf*.

MM3489, *Percutaneous Transluminal Angioplasty (PTA)* may be found on the CMS website at the following link *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf*.

MM3811, *Expansion of Coverage for Percutaneous Transluminal Angioplasty (PTA)* is located on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf*.

Clarification on Billing Requirements for PTA Concurrent ... (continued)

CR 5022 is the official instruction issued to your FI or carrier regarding changes mentioned in this article, MM5022. CR 5022 may be found by going to Transmittal [1042]CP on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1042CP.pdf* for the claim processing instructions and to transmittal 53NCD for the NCD Manual section, which is at *http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf*.

Please refer to your local FI or carrier if you have questions about this issue. To find their toll-free phone number, go to the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5022 – Revised
Related Change Request (CR) Number: 5022
Related CR Release Date: August 25, 2006
Related CR Transmittal Number: R1042CP and R53NCD
Effective Date: March 17, 2005
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1042, CR 5022

LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from the provider education website *http://www.floridamedicare.com*. Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part A section under the Part A Medical Coverage section.

This section of the *Medicare A Bulletin* features summaries of new and revised LCDs developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the fiscal intermediary's medical policies and review guidelines are consistent with accepted standards of medical practice.

Effective and Notice Dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the provider education website is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It is very easy to do; simply sign on to the provider education website, *http://www.floridamedicare.com*; click on the *eNews*" link on the navigational menu and follow the prompts.

More Information

If you do not have Internet access, contact the Medical Policy and Procedures department at:

Medical Policy and Procedures – 19T
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048

Local Coverage Determination Table of Contents

Additions/Revisions to Existing LCDs

Correction to Previous Article

Additional Medical Information

This Bulletin Should Be Shared with All Health Care Practitioners and Managerial Members of the Provider Staff. Bulletins Are Available at no Cost from Our Provider Education Website at *http://www.floridamedicare.com*.

ADDITIONS/REVISIONS TO LCDS

A93965: Non-Invasive Evaluation of Extremity Veins—Addition to the LCD

The local coverage determination (LCD) for noninvasive evaluation of extremity veins was last updated on April 11, 2006. Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to include ICD-9-CM code 451.2 (phlebitis and thrombophlebitis of lower extremities, unspecified) as medically necessary.

Effective Date

This addition to the LCD is effective for services provided **on or after October 5, 2006.**

The full text for this LCD (L937) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ABotulinum Toxins—Revision to the LCD

The local coverage determination (LCD) for botulinum toxins was last revised on May 11,2006. Since that time, the LCD has been revised to delete the following statements from the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD:

> Off-label indications for botulinum toxin type B (Myobloc®): The use of Myobloc may be considered a medically necessary off-label indication for spasticity caused by stroke or brain injury.

This revision has been implemented as the result of a USPDI (United States Pharmacopoeia Drug Information) revision dated December 5, 2005, reversing the decision to allow treatment of spasticity caused by stroke or brain injury listing under "Acceptance not established." The USPDI revision further states, "The data describing the treatment of botulinum toxin type B for upper limb spasticity are limited and inconclusive. In a single, randomized, placebo-controlled trial, BTX-B did not demonstrate a benefit in reducing muscle tone in the elbow, wrist or finger flexors in post-stroke patients. However, improvements in upper limb spasticity were reported in a few small open-labeled trials presented in abstract and/or poster forms". Therefore, First Coast Service Options, Inc. (FCSO) will no longer allow this indication. In this regard, the "Sources of Information and Basis for Decision" section has been revised accordingly.

In addition, the following ICD-9-CM codes **will no longer be allowable** for HCPCS code J0587:

342.10–342.12	344.00–344.09	344.1
344.2	344.30-344.32	344.40-344.42
344.5	438.20-438.22	438.30-438.32
438.40-438.42	754.1	

This notification serves, as a 45-day notice that the above revisions for HCPCS code J0587 will be **effective** for services provided **on or after November 1, 2006.**

Also, in order to indicate a higher degree of specificity when billing for HCPCS code J0585 – botulinum toxin type A (Botox®), the following ICD-9-CM codes have been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD:

344.5	438.21	438.22	438.31
438.32	438.41	438.42.	

This addition is effective for services provided **on or after September 28, 2006.**

The full text for this LCD (L1382) is available through the provider education website *http://www.floridamedicare.com* on or after these effective dates. ❖

AEPO: Epoetin alfa—Revision to the Coding Guideline

The coding guideline for the local coverage determination (LCD) for epoetin alfa was last updated on October 1, 2006. Since that time, the coding guideline has been revised based on instruction from change request 5251. The definition of modifier GS has been revised to read as follows:

GS Dosage of EPO or Darbepoetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level

Effective Date

This revision to the LCD is effective for services provided **on or after October 1, 2006.**

The full text for this LCD (L895) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ1950: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs—Revision to the LCD and Coding Guideline

The local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs and coding guideline were last updated on August 7, 2006. Since that time, the following revisions have been made. Because of different payment methodologies for Medicare Part A, the least costly alternative (LCA) policy will not be implemented for Medicare Part A. The "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD was revised to remove all references to the LCA policy. The coding guideline was also revised to remove all instructions related to the LCA policy.

Effective Date

These revisions to the LCD are effective for services provided **on or after August 7, 2006.**

The full text for this LCD (L1416) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ANESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—Revision to the Coding Guideline

The coding guideline for the local coverage determination (LCD) for darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) was last updated on October 1, 2006. Since that time, the coding guideline has been revised based on instruction from change request 5251. The definition of modifier GS has been revised to read as follows:

GS Dosage of EPO or Darbepoetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level

Effective Date

This revision to the LCD is effective for services provided **on or after October 1, 2006.**

The full text for this LCD (L13796) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ATHERSVCS: Therapy and Rehabilitation Services—Addition to the LCD

The local coverage determination (LCD) for therapy and rehabilitation services was last updated on April 6, 2006. Since that time, the LCD has been revised. Change Request 4364, dated February 13, 2006, states that contractors shall require providers to document services in accordance with the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM), Pub 100-2, Medicare Benefit Policy, Chapter 15, Section 220.3 and Pub 100-4, Medicare Claim Processing, Chapter 5, Section 10.2. The language from these IOMs appears under the "Documentation Requirements" section of the LCD. Further revision was completed to remove references related to weekly documentation requirements found under the heading "Progress Notes".

Effective Date

These revisions to the LCD are effective for claims processed on or after May 10, 2006 for services provided **on or after January 1, 2006.**

The full text for this LCD (L1125) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy—Correction to Previously Published Article

An article was published in the September 2006 *Medicare A Bulletin* (page 31) revising the local coverage determination (LCD) for diagnostic and therapeutic esophagogastroduodenoscopy by adding ICD-9-CM code V55.1 (Attention to artificial openings, gastrostomy) to the"ICD-9 Codes that Support Medical Necessity" section of the LCD, expanding the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to include follow-up for removal of the PEG, and updating the "Utilization Guidelines" section of the LCD to include indications regarding provider qualification requirements when rendering this service.

Correction to the Effective Date

The article indicated effective date for **services provided** on or after August 24, 2006. However, the effective date applies to **claims processed on or after August 24, 2006**.

The full text for this LCD (L3016) is available through the provider education website *http://www.floridamedicare.com*. ❖

ADDITIONAL MEDICAL INFORMATION

2007 ICD-9-CM Local Coverage Determination Changes

The 2007 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2006. Providers are required to use the 2007-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring **on or after October 1, 2006.**

Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the outpatient prospective payment system (OPPS) used the appropriate ICD-9-CM coding. Other providers that code diagnoses and procedures (non-OPPS providers) are also affected. In addition, the new diagnosis coding is used in hospital outpatient billing.

Florida Medicare has revised the LCDs, for *CPT*/HCPCS codes with specific diagnosis criteria that are affected by the 2007 ICD-9-CM update. The following table lists the LCDs affected and the specific conditions revised as a result of the 2007 ICD-9-CM update:

LCD Title	2007 Changes
ABOTULINUM TOXINS – Botulinum Toxins	• Change descriptor for diagnosis 333.6 for HCPCS code J0585 • Add diagnosis 333.71 for HCPCS code J0585.
AEPO – Epoetin alfa	• Change descriptor for diagnoses 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, and 404.93 for HCPCS code J0885. • Add diagnoses 995.20 and 995.29 for HCPCS code J0885. • Change diagnosis range 284.0-284.9 to 284.01-284.9 for HCPCS code J0885. • Add diagnoses 238.72, 238.73, 238.74 and 238.75 for HCPCS code J0885 (Coding Guideline only). • Remove diagnoses 585.4 and 585.5 for HCPCS code J0886.
AG0104 – Colorectal Cancer Screening	• Add diagnosis range V18.51 – V18.59 for HCPCS codes G0105 and G0120.
AJ0640 – Leucovorin (Wellcovorin®)	• Add diagnoses 995.20 and 995.29 for HCPCS code J0640.
AJ1440 – G-CSF (Filgrastim, Neupogen®)	• Add diagnoses 238.72, 238.73, 238.74, 238.75, 288.00-288.09, 995.20, and 995.29 for HCPCS codes J1440 and J1441.
AJ1566 – Intravenous Immune Globulin	• Add diagnosis 288.09 for HCPCS codes J1566 and J1567.
AJ2505 – Pegfilgrastim (Neulasta™)	• Add diagnoses 995.20 and 995.29 for HCPCS code J2505.
AJ9000 – Antineoplastic Drugs	• Add diagnosis range 238.71-238.79 for HCPCS codes J9181, J9182, and J9350.
ANESP – Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	• Add diagnoses 995.20 and 995.29 for HCPCS code J0881. • Add diagnoses 238.72, 238.73, 238.74 and 238.75 for HCPCS code J0881 (Coding Guideline only). • Change diagnosis range 284.0-284.9 to 284.01-284.9 for HCPCS code J0881. • Remove diagnoses 585.4 and 585.5 for HCPCS code J0882.
APULMDIAGSVCS – Pulmonary Diagnostic Services	Add diagnosis range 519.11-519.19 for *CPT* codes *93720*, *93721*, *93722*, *94010*, *94060*, *94070*, *94150*, *94200*, *94240*, *94250*, *94260*, *94350*, *94360*, *94370*, *94375*, *94620*, *94621*, *94720*, *94725*, and *94750*.
A43235 – Diagnostic and Therapeutic Esophagogastroduodenoscopy	• Add diagnoses 538, 784.91-784.99, and V18.51-V18.59 for *CPT* codes *43235*, *43236*, *43237*, *43238*, *43239*, *43241*, *43243*, *43244*, *43245*, *43246*, *43247*, *43248*, *43249*, *43250*, *43251*, *43255*, and *43258*.

2007 ICD-9-CM Local Coverage Determination Changes (continued)

LCD Title	2007 Changes
A44388 – Diagnostic Colonoscopy	• Add diagnosis range V18.51-V18.59 for *CPT* codes *44388*, *44389*, *44390*, *44391*, *44392*, *44393*, *44394*, *44397*, *45355*, *45378*, *45379*, *45380*, *45381*, *45382*, *45383*, *45384*, *45385*, *45386*, *45387*, *45391*, and *45392*.
A70540 – Magnetic Resonance Imaging of the Orbit, Face, and Neck	• Add diagnosis ranges 379.60-379.63 and 478.11-478.19 for *CPT* codes *70540, 70542, and 70543.*
A70544 – Magnetic Resonance Angiography (MRA)	• Change descriptor for diagnoses 403.00-403.91 and 404.00-404.93 for *CPT*/HCPCS codes *74185*, C8900, C8901, and C8902. • Add diagnosis 171.5 for *CPT*/HCPCS codes *74185*, C8900, C8901, and C8902. (Not new diagnosis for 2007 ICD-9-CM update.)
A73218 – Magnetic Resonance Imaging of Upper Extremity	• Add diagnoses 238.71-238.79, 729.71, and 958.91 for *CPT* codes *73218, 73219, 73220, 73221, 73222,* and *73223.*
A78460 – Myocardial Perfusion Imaging	• Add diagnoses 995.20 and 995.29 for *CPT* codes *78460*, *78461*, *78464*, *78465*, *78478*, and *78480.*
A82310 – Total Calcium	• Add diagnoses 519.11 and 519.19 for *CPT* code *82310.*
A83735 – Magnesium	• Add diagnosis 995.29 for *CPT* code *83735.*
A83880 – B-Type Natriuretic Peptide (BNP)	• Change descriptor for diagnoses 404.01, 404.03, 404.11, 404.13, 404.91, and 404.93 for *CPT* code *83880.*
A84100 – Serum Phosphorus	• Change descriptor for diagnoses 403.01, 403.11, 404.02, 404.03, 404.12, and 404.13 for *CPT* code *84100.*
A86706 – Hepatitis B Surface Antibody and Surface Antigen	• Change descriptor for diagnoses 403.01, 403.11, 404.02, 404.03, 404.12, and 404.13 for *CPT* codes *86706* and *87340*.
A93000 – Electrocardiography	• Add diagnoses 277.30 and 277.39 for *CPT* codes *93000*, *93005*, and *93010*.
A93303 – Transthoracic Echocardiogram	• Change descriptor for diagnosis range 404.00-404.93 for *CPT* codes *93307* and *93308.* • Add diagnoses 277.30, 277.39, 770.88, 995.20, and 995.29 for *CPT* codes *93307* and *93308.*
A93350 – Stress Echocardiography	• Add diagnoses 995.20 and 995.29 for *CPT* code *93350.*
A93701 – Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	• Change descriptor for diagnoses 403.00-403.01, 403.11, 403.91, 404.00-404.03, 404.11, 404.12, 404.13, 404.91, 404.92, and 404.93 for *CPT* code *93701*. • Add diagnoses 429.83 and 518.7 for *CPT* code *93701.*
A93975 – Duplex Scanning	• Add diagnoses 288.60 and 608.20 for *CPT* codes *93975 and 93976.*
A95900 – Nerve Conduction Studies	• Add diagnoses 729.71 and 729.72 for *CPT* codes *95900*, *95903*, and *95904.*

J2354: Octreotide Acetate Injection (Sandostatin®) Removed from Self-administered Drug (SAD) List

HCPCS code J2354 (Octreotide acetate injection (Sandostatin®), nondepot form for subcutaneous or intravenous injection 25 mcg, was placed on the self-administered drug (SAD) list for a 45 day notice period beginning July 18, 2006, with an effective date of September 1, 2006.

During the 45-day notice period, it was determined that due to local medical standards of practice the placement of octreotide acetate injection on the SAD list may not be in the best interest for providing access of care to beneficiaries undergoing chemotherapy and experiencing the severe side effects that would require octreotide acetate injection. The administration of octreotide acetate injection for these beneficiaries is for an acute episode of illness and is administered in the physician's office more than 51 percent of the time or it is administered over a two-week period as a prelude to placing the patient on the once per month administration of the long-acting form of this medication.

Therefore, octreotide acetate injection is being removed from the SAD list prior to its implementation date of September 1, 2006. ❖

Administration of Certain Biological Response Modifiers

According to the 2006 edition of the Current Procedural Terminology (CPT) professional edition, ***chemotherapy administration codes*** *96401-96549 apply to parenteral administration of non-radionuclide* ***anti-neoplastic drugs****; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g, cyclophosphamide for auto-immune conditions) or to substances such as* ***monoclonal antibody agents****, and other* ***biologic response modifiers.*** *Any physician can provide these services. Chemotherapy services are typically highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician about these issues.*

Biological response modifiers ***(***BRMs) are agents that modify the relationship between micro-organisms and hosts by changing the host's biological response resulting in a desired therapeutic effect. BRMs are also referred to as immunotherapy or immune therapy. First Coast Service Options, Inc. (FCSO) will allow the use of chemotherapy administration codes for *certain biological response modifiers* when it is evident that requirements are demonstrated as specified in the *CPT* description for chemotherapy administration codes. It should be documented that the administration of the BRM requires advanced practice, training and competency of the staff that provide the service; special considerations for preparation, dosage or disposal; and significant patient risk that requires frequent monitoring.

Currently, FCSO considers the following BRMs for payment using a chemotherapy administration code:

- Monoclonal antibodies
- Tumor necrosis factors
- Interleukins
- Certain fusion proteins

Payment of a chemotherapy administration code will not be allowed when administering the following (**not an inclusive list**):

- Colony stimulating factors
- Erythroid stimulating agents (EPO, DPA,etc.)
- Leucovorin
- Growth factors
- Vitamins
- Nesiritide
- Vaccines
- Immunoglobulins, IVIG
- Steroids. ❖

HOSPITAL SERVICES

Change in Revenue Codes for Blood Products on Outpatient Prospective Payment System Claim Lines

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 3681 instructing providers how to billed for blood and blood products under the hospital outpatient prospective payment system (OPPS). Instructions related to CR 3681 were published in the Third Quarter 2005 *Medicare A Bulletin* (pages 118-119). Effective for dates of service on or after July 1, 2005, blood charges are to be reported on revenue codes 038x (Blood) and 039x (Blood storage/ processing) so that proper payment and blood deductible could be applied.

CMS has learnt of a discrepancy between the OPPS PRICER output and the common working file (CWF) editing. Currently, there is a CWF edit (61#8) that ensures that blood deductible is only applied to revenue code lines 0380-0382. Because the OPPS PRICER applies blood deductible to all 038x revenue code lines, some OPPS claims are editing with reason code E61#8 when blood deductible is applied to revenue code lines 0383-0389.

CMS will disable CWF edit 61#8 on January 1, 2007, effective for services provided **on or after July 1, 2005.** Fiscal intermediaries will identify OPPS claims that edit with reason code E61#8 and return the claims to the provider for resubmitting using revenues codes 0380-0382.

Action Required by Providers

Until the CWF edit is disabled on January 1, 2007, providers may resubmit these claims by changing revenue code lines 0383-0389 to one of the following revenue code lines: **0380, 0381, or 0382.** By doing so, the resubmitted claim will price the same and avoid the unintentional CWF edit until the edit is disabled.

Note: This action will not have any impact on CMS ability to apportion cost data for the particular revenue codes. CMS performs cost analysis based on all 038x lines, and not for individual revenue code lines**.** ❖

Source: CMS Joint Signature Memorandum 06640, August 24, 2006

Medicare Code Editor Issue with Bilateral Knee Replacement Procedures

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries (FIs) of an editing error in the Medicare code editor (MCE) system affecting bilateral procedures for inpatient knee replacement claims.

CMS has instructed FIs to manually override MCE edits W1445 and W1446 for ICD-9-CM procedure codes 00.81, 00.82, 00.83, 00.84 and 81.55 **with a discharge date of October 1, 2005.**

CMS will be correcting this editing problem in the next release of the MCE version 23.0 (for fiscal year 2007) scheduled for October 2006. The above ICD-9-CM procedure codes do not affect the diagnosis related group (DRG) assignment or payment.

Action Required by Providers

Hospitals that have claims for bilateral knee replacement procedures **with a discharge date of October 1, 2005,** returned to them with reason codes W1445 and W1446 should contact First Coast Service Options, Inc. Medicare Part A Customer Service Center toll-free number 1-877-602-8816, to request a manual override of these edits. ❖

Source: CMS Joint Signature Memorandum 06623, August 18, 2006

Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: CMS has revised this MLN Matters article on August 30, 2006, to provide a more efficient address for accessing the inpatient psychiatric facilities prospective payment system (IPF PPS) final rule published on May 9, 2006. All other information remains the same. This article was previously published in the August 2006 Medicare A Bulletin (pages 30-34).

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) for inpatient psychiatric services furnished to Medicare beneficiaries

Impact on Providers

This article is based on change request (CR) 5129 which informs your intermediary that changes are required as part of the annual inpatient psychiatric facilities prospective payment system (IPF PPS) update for rate year 2007. These changes include the following:

Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update (continued)

- Market basket update
- New CBSA designations used for assigning a wage index value.
- The PRICER update.

Background

On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published a final rule in the *Federal Register* (*http://www.access.gpo.gov/su_docs/fedreg/a041115c.html*) establishing the prospective payment system for inpatient psychiatric facilities under the Medicare program (in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balance Budget Refinement Act of 1999 [BBRA]).

Payments to IPFs under the IPF PPS are based on a federal per-diem base rate that:

- Includes inpatient operating and capital-related costs (including routine and ancillary services).
- Excludes certain pass-through costs (i.e., bad debts, and graduate medical education).

CMS is required to make updates to the IPF PPS annually. In addition:

- The rate year update is effective July 1 – June 30 of each year; while
- The diagnosis related groups (DRGs) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes are updated on October 1 of each year.

Note: This is the first rate year update to the IPF PPS.

CR 5129 announces that, effective July 1, 2006, all IPFs (freestanding psychiatric hospitals and distinct part units of acute care hospitals and critical access hospitals) must meet the physician certification requirements specified in 42 CFR 424.14. Certification is required at the time of admission or as soon thereafter as is reasonable and practicable.

The first re-certification is required as of the 12th day of hospitalization and subsequent re-certifications are required at intervals established by the utilization review committee (on a case-by-case basis, if it so chooses), but no less than every 30 days. The physician must also re-certify that the patient continues to need, on a daily basis, active inpatient psychiatric treatment furnished directly by or requiring the supervision of IPF personnel.

Also, CR 5129 identifies changes that are required as part of the annual IPF PPS update from the rate year 2007 IPF PPS final rule published on May 9, 2006. This final rule is available at *http://frwebgate.access.gpo.gov/cgi-bin/multidb.cgi?WAISdbName=2006_register+Federal+Register%2C+Volume+71+%282006%29&WAISqueryRule=%28%24WAISqueryString%29&WAISqueryString=%22IPF+PPS%22&WAIStemplate=multidb_results.html&WrapperTemplate=fr_wrapper.html&WaismaxHits=40*.

These changes are **applicable to IPF discharges** occurring during the rate year beginning on July 1, 2006, through June 30, 2007. These changes include the following:

1. **Market Basket Update**
   CMS is now using the new rehabilitation/psychiatric/long-term care (RPLTC) market basket to update the IPF PPS portion of the blended payment rate (that is, the federal per-diem base rate).
   A re-based, 2002-excluded hospital market basket is used to update the cost-based portion (TEFRA). It is effective for cost reports periods beginning on or after October 1 of each year and is applied to the TEFRA target amount.

2. **PRICER Updates for IPF PPS Rate Year 2007, (July 1, 2006 – June 30, 2007)**
   - The federal per-diem base rate is $595.09.
   - The fixed-dollar loss threshold amount is $6,200.
   - The revised standardization factor is 82.54 percent.
   - The IPF PPS transition blend percentage for cost reporting periods beginning on or after January 1, 2006, but before January 1, 2007, is 50 percent PPS and 50 percent TEFRA.
   - The transition blend percentage for cost reporting periods beginning on or after January 1, 2007, but before January 1, 2008, is 75 percent PPS and 25 percent TEFRA.
   - Core-based statistical area (CBSA) designations will be used for assigning a wage index value for discharges occurring on or after July 1, 2006. There will be no separate transition blend under IPF PPS for conversion to the CBSA based labor market areas.
   - The labor-related share is 75.665 percent.
   - The nonlabor related share is 24.335 percent.
   - The electroconvulsive therapy (ECT) rate is $256.20.

Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update (continued)

3. **Teaching Status Adjustment**
   The teaching adjustment is made on a claim basis as an interim payment and the final payment in full for the claim is made during the final settlement of the cost report. The difference between those interim payments and the actual teaching adjustment amount computed in the cost report is adjusted through lump sum payments/recoupments when the cost report is filed and later settled.

4. **Electroconvulsive Therapy (ECT) Update**
   The new update methodology for the ECT rate is to use the CY 2005 ECT rate as a base and update that amount by the market basket increase each rate year.
   This methodology is consistent with the methodology CMS uses to update the federal per-diem base rate because CMS will use the rehabilitation, psychiatric and long-term care market basket increase to increase both rates. The ECT adjustment per treatment is $256.20 for RY 2007.

5. **Diagnosis Related Group (DRG) Adjustment Update**
   The IPF PPS has DRG specific adjustments for 15 DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or in the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of the identified 15 psychiatric DRGs, the IPF receives the federal per-diem base rate and all other applicable adjustments.
   Table 1 below lists the new FY 2006 ICD-9-CM diagnosis codes that are classified to one of the 15 DRGs that are provided a DRG adjustment in the IPF PPS. When coded as a principal diagnosis, the IPF receives the correlating DRG adjustment.
   This table is only a listing of new codes and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

TABLE 1. FY 2006 New Diagnosis Codes

ICD-9-CM Diagnosis Code	Description	DRG
291.82	Alcohol induced sleep disorders	521, 522, 523
292.85	Drug induced sleep disorders	521, 522, 523
327.00	Organic insomnia, unspecified	432
327.01	Insomnia due to medical condition classified elsewhere	432
327.02	Insomnia due to mental disorder	432
327.09	Other organic insomnia	432
327.10	Organic hypersomnia, unspecified	432
327.11	Idiopathic hypersomnia with long sleep time	432
327.12	Idiopathic hypersomnia without long sleep time	432
327.13	Recurrent hypersomnia	432
327.14	Hypersomnia due to medical condition classified elsewhere	432
327.15	Hypersomnia due to mental disorder	432
327.19	Other organic hypersomnia	432

Table 2 below lists ICD-9-CM diagnosis codes whose titles have been modified in FY 2006. Title changes do not impact the DRG adjustment. When used as a principal diagnosis, these codes still receive the correlating DRG adjustment. This table is only a listing of FY 2006 changes and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

TABLE 2. Revised Diagnosis Code Titles

ICD-9-CM Diagnosis Code	Description	DRG
307.45	Circadian rhythm sleep disorder of nonorganic origin	432
780.52	Insomnia, unspecified	432
780.54	Hypersomnia, unspecified	432
780.55	Disruption of 24 hour sleep wake cycle, unspecified	432
780.58	Sleep related movement disorder, unspecified	432

Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update (continued)

For discharges occurring during the RY July 1, 2006, through June 30, 2007, the DRG adjustment factors, the ICD-9-CM coding changes, and the DRG classification changes, are shown below in Table 3. Please note these are the same adjustment factors that are currently in effect, since implementation.

TABLE 3. FY 2006 DRGs and Adjustment Factor

DRG	DRG Definition	Adjustment Factor
424	O.R. Procedure with principal diagnosis of mental illness	1.22
425	Acute adjustment reaction & psychosocial dysfunction	1.05
426	Depressive neurosis	0.99
427	Neurosis, except depressive	1.02
428	Disorders of personality & impulse control	1.02
429	Organic disturbances & mental retardation	1.03
430	Psychoses	1.00
431	Childhood mental disorders	0.99
432	Other mental disorder diagnoses	0.92
433	Alcohol/drug abuse or dependence, leave against medical advice (LAMA)	0.97
521	Alcohol/drug abuse or dependence with CC	1.02
522	Alcohol/drug abuse or dependence with rehabilitation therapy without CC	0.98
523	Alcohol/drug abuse or dependence without rehabilitation therapy without CC	0.88
12	Degenerative nervous system disorders	1.05
23	Non-traumatic stupor & coma	1.07

In order to maintain consistency with the IPPS, for discharges occurring on or after October 1, 2005, ICD-9-CM diagnosis code 305.1 for tobacco use disorder, will not be a covered principal diagnosis under the IPF PPS.

Note: All IPFs must follow the ICD-9-CM official guidelines for coding and reporting, including code first. The ICD-9-CM Official Guidelines for Coding and Reporting may be found at *http://www.cdc.gov/nchs/data/icd9/icdguide.pdf*.

6. Comorbidity Adjustment Update

The IPF PPS has 17 comorbidity groupings, each containing ICD–9-CM codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category.

IPFs must enter the full ICD-9-CM codes for up to eight additional diagnoses if they coexist at the time of admission or develop subsequently.

Comorbidities are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Comorbid conditions must coexist at the time of admission, develop subsequently, affect the treatment received, affect the length of stay (LOS) or affect both treatment and LOS.

CMS is using the FY 2006 GROUPER, version 23.0, effective for discharges occurring on or after October 1, 2005. Table 4 lists the updated FY 2006 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. Table 4 only lists the FY 2006 new codes and does not reflect all of the currently valid ICD-9-CM codes applicable for the IPF PPS comorbidity adjustment.

TABLE 4. FY 2006 New ICD-9-CM Codes Applicable for the Comorbidity Adjustment

ICD-9-CM Diagnosis Code	Description	DRG	Comorbidity Category
585.3	Chronic kidney disease, Stage III (moderate)	315 – 316	Renal failure, chronic
585.4	Chronic kidney disease, Stage IV (severe)	315 – 316	Renal failure, chronic
585.5	Chronic kidney disease, Stage V	315 – 316	Renal failure, chronic
585.6	End stage renal disease	315 – 316	Renal failure, chronic
585.9	Chronic kidney disease, unspecified	315 – 316	Renal failure, chronic
V46.13	Encounter for weaning from respirator [ventilator]	467	Chronic obstructive pulmonary disease
V46.14	Mechanical complication of respirator [ventilator]	467	Chronic obstructive pulmonary disease

Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update (continued)

Since the purpose of the comorbidity adjustment is to account for the higher resource costs associated with comorbid conditions that are expensive to treat on a per-diem basis, CMS is not providing a comorbidity adjustment for the following ICD-9-CM codes:

ICD-9-CM Code	Description
585.1	Chronic kidney disease, Stage I
585.2	Chronic kidney disease, Stage II (mild)

These conditions (585.1 and 585.2) are less costly to treat on a per-diem basis because patients with these conditions are either asymptomatic or may have only mild symptoms.

Table 5 lists the invalid ICD-9-CM codes no longer applicable for the comorbidity adjustment. This table does not reflect all of the currently valid ICD-9-CM codes applicable for the IPF PPS comorbidity adjustment.

TABLE 5. FY 2006 Invalid ICD-9-CM Codes No Longer Applicable for the Comorbidity Adjustment

ICD-9-CM Diagnosis Code	Description	DRG	Comorbidity Category
585	Chronic renal failure	315 – 36	Renal Failure, Chronic

CMS is aware that ICD-9-CM code 404.03 (hypertensive heart and renal disease, malignant, with heart failure and renal failure) has caused confusion, since this ICD-9-CM code is currently used to code an adjustment in two separate IPF comorbidity categories, (that is, both "Renal Failure, Chronic" and "Cardiac Conditions").

It more appropriately corresponds to the "Cardiac Conditions" comorbidity than to the "Renal Failure, Chronic" comorbidity. Therefore, to be more clinically cohesive and to eliminate confusion, CMS:

- Removed ICD-9-CM code 404.03 from the comorbidity adjustment category "Renal Failure, Chronic," but
- Retained ICD-9-CM code 404.03 in the "Cardiac Conditions" comorbidity category.

For discharges occurring during the RY July 1, 2006, through June 30, 2007, the Comorbidity Category factors, the ICD-9-CM coding changes, and Comorbidity Category classification changes that are **currently** being paid are shown below in Table 6. Please note these are the same adjustment factors in place since implementation.

TABLE 6. FY 2006 Diagnosis Codes and Adjustment Factors for Comorbidity Categories

Description of Comorbidity	ICD-9-CM	Code Adjustment Factor
Developmental disabilities	317, 3180, 3181, 3182, and 319	1.04
Coagulation factor deficits	2860 through 2864	1.13
Tracheostomy	51900 through 51909 and V440	1.06
Renal failure, acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585	1.11
Renal failure, chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V451, V560, V561, and V562	1.11
Oncology treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled diabetes-mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe protein calorie malnutrition	260 through 262	1.13
Eating and conduct disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or alcohol induced mental disorders	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic obstructive pulmonary disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial openings – digestive and urinary	56960 through 56969, 9975, and V441 through V446	1.08

Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update (continued)

Description of Comorbidity	ICD-9-CM	Code Adjustment Factor
Severe musculoskeletal and connective tissue diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

7. Payment Rate

Payments to IPFs under the IPF PPS are based on a federal per-diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services) but excludes certain pass-through costs (i.e., bad debts, and graduate medical education).

Per-diem Rate

Federal per-diem base rate $595.09
Labor share (0.75665)$450.27
Nonlabor share (0.24335) $144.82

The rates for RY 2007 were published in the final rule and may also be found on the CMS website at *http://www.cms.hhs.gov/InpatientPsychFacilPPS*.

8. The National Urban and Rural Cost to Charge Ratios for the IPF PPS RY 2007

Cost to Charge Ratio	Median	Ceiling
Urban	0.55	1.7179
Rural	0.71	1.7447

CMS is applying the national median cost-to-charge ratios (CCRs) to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR may be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- IPFs whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

Implementation

The implementation date for CR 5129 is July 3, 2006.

Additional Information

For complete details, please see the official instruction (CR 5129) issued to your intermediary regarding this change. There are two transmittals associated with CR 5129. The first transmittal contains information on the physician certification requirements and is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R39GI.pdf*.

The second transmittal includes claims processing information and is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R978CP.pdf*.

If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5129 – Revised
Related Change Request (CR) Number: 5129
Related CR Release Date: June 9, 2006
Related CR Transmittal Number: R39GI and R978CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-01, Transmittal 39, CR 5129

Update to Repetitive Billing Instructions in Medicare Claim Processing Manual

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on September 11, 2006, to correct Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same. This article was published in the Second Quarter 2006 *Medicare A Bulletin* (pages 47-50).

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for repetitive Part B services, including inpatient hospital Part B and outpatient prospective payment system (OPPS) services, and repetitive hospice Part A services

Provider Action Needed

This article is based on change request (CR) 4047, which updates repetitive billing instructions in the *Medicare Claims Processing Manual* (Pub. 100-04). It is intended to be informational only to convey the clarifications made in CR 4047.

Background

CMS issued CR 3633 (Transmittal 407, "Hospital Billing for Repetitive Services," dated December 17, 2004) with an effective date of January 1, 2005. Soon after the release of CR 3633, CMS became aware of difficulties that may arise from instructions contained in CR 3633. Therefore, CMS reevaluated the policy of repetitive billing and provided clarifications in CR 4047.

CR 3633 may be found on the CMS website at *http://www.cms.hhs.gov/transmittals/Downloads/R407CP.pdf*.

A Medlearn Matters article (MM3633) is also available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3633.pdf*.

General Billing Requirements

Frequency of Billing to Fiscal Intermediaries for Outpatient Services

Repetitive Part B services furnished to a single individual by providers who bill FIs should be billed monthly (or at the conclusion of treatment).

Note: These instructions (which were taken from CR 4047) also apply to hospice services billed under Part A, and they do not apply to home health services.

By consolidating repetitive services into a single monthly claim, CMS processing costs will be reduced for:

- Relatively small claims; and
- Instances where bills are held for monthly review.

Services are defined as repetitive services if they are repeated over a span of time and billed with the following revenue codes:

Type of Service	Revenue Code(s)
DME Rental	0290 – 0299
Respiratory Therapy	0410, 0412, 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech Pathology	0440 – 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943

One bill for repetitive services will be submitted for the entire month (during a period of repetitive outpatient services) for cases in which there is:

- An inpatient stay; or
- Outpatient surgery; or
- Outpatient hospital services subject to OPPS.

The provider will use an occurrence span code 74 (Leave of Absence) on the repetitive bill to encompass the:

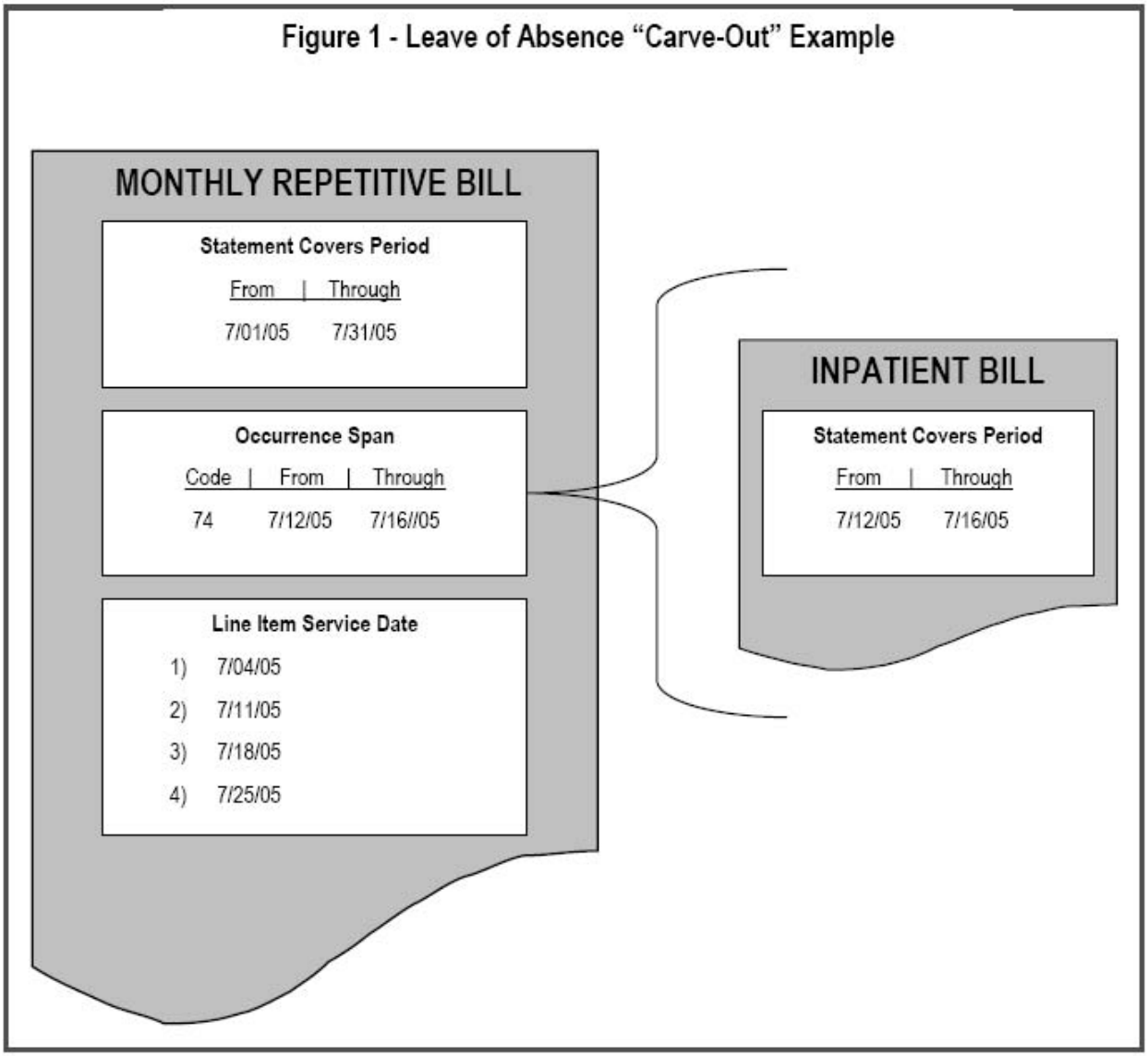
- Inpatient stay
- Day of outpatient surgery; or
- Outpatient hospital services subject to OPPS.

This permits submission of a single bill for the repetitive services for the month and simplifies FI review of these bills.

Note: This is in addition to the bill for the inpatient stay or outpatient surgery.

Update to Repetitive Billing Instructions in Medicare Claim Processing Manual (continued)

This is shown in Figure 1 below.



Any items and/or services in support of the repetitive service will be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list.

Note: Supporting items and/or services are those needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs, or equipment used to furnish the repetitive service.

To facilitate ambulatory payment classification (APC) recalibration, do not report unrelated, one-time nonrepetitive services that have the same date of service as a repetitive service (even if both the nonrepetitive service and the repetitive service are paid under OPPS). If a nonrepetitive OPPS service is provided on the same date as a repetitive service, report on a separate OPPS claim:

- The nonrepetitive OPPS services; and
- Any packaged and/or services related to the nonrepetitive OPPS service.

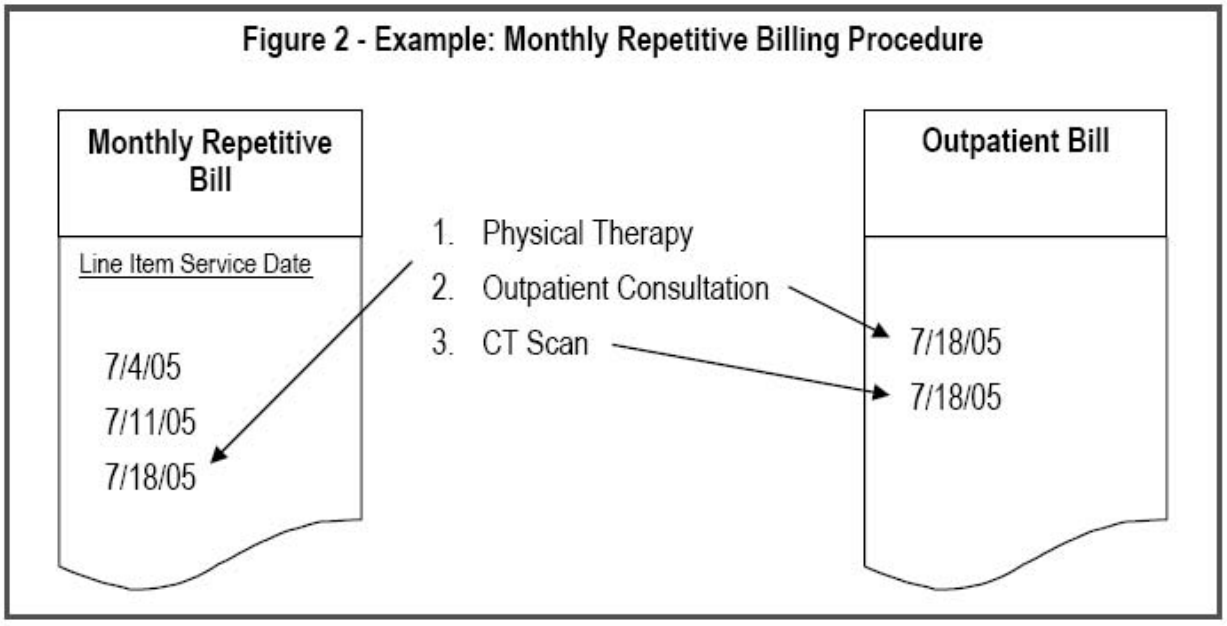
For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, then report the chemotherapy drug, its administration, its related supplies, and so on, on a separate claim from the monthly repetitive services claim. Similarly, as shown in Figure 2, "Example: Monthly Repetitive Billing Procedure," the following occurs on the same day:

- A physical therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service list) is administered;
- An outpatient consultation is furnished; and
- A CT scan is furnished.

Update to Repetitive Billing Instructions in Medicare Claim Processing Manual (continued)

In this case, report the physical therapy service on the claim with the other physical therapy services provided during the applicable month, and report the visit for the consultation and the CT scan on a separate claim.

Figure 2 - Example: Monthly Repetitive Billing Procedure



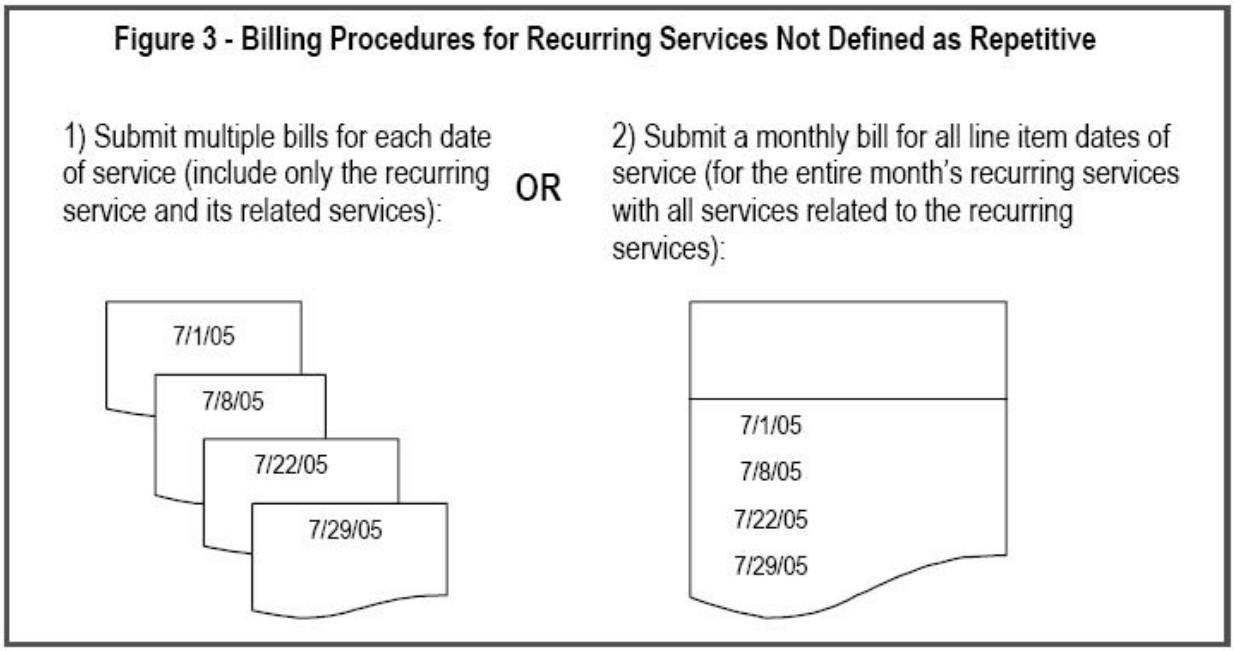
Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service.

However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, nonrepetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill. The services may be billed:

- On the same claim; or
- Separately (by date of service).

This is shown in Figure 3 below:

Figure 3 - Billing Procedures for Recurring Services Not Defined as Repetitive



Update to Repetitive Billing Instructions in Medicare Claim Processing Manual (continued)

Part B Hospital (Including Inpatient Hospital Part B and OPPS)
Hospital and Community Mental Health Center (CMHC) Reporting Requirements for Services Performed on the Same Day

When reporting a Healthcare Common Procedure Coding System (HCPCS) code for a separately payable, nonrepetitive hospital OPPS service, report charges for all services and supplies associated with that service that were furnished on the same date. (Services subject to the three-day payment window are an exception to this OPPS policy.)

When a hospital provides electroconvulsive therapy (ECT) on the same day as partial hospitalization services, both the ECT and partial hospitalization services should be reported on the same hospital claim. In this instance, the claim should contain condition code 41. Report charges for all services and supplies associated with the ECT service that was furnished on the same date(s) on the same claim.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change.

That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R763CP.pdf*.

If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Medlearn Matters Number MM: 4047 – Second Revision
Related Change Request (CR) Number: 4047
Related CR Release Date: November 25, 2005
Related CR Transmittal Number: 763
Effective Date: N/A
Implementation Date: N/A

Source: CMS Pub. 100-4, Transmittal 763, CR 4047

ESRD SERVICES

Revisions to the Epoetin (EPO) and Aranesp® Monitoring Policy

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Renal dialysis facilities billing Medicare fiscal intermediaries (FIs) for services related to erythropoietin (EPO) and darbepoetin (Aranesp) for ESRD patients

Background

Change request (CR) 4135 titled, "National Monitoring Policy for Erythropoietin (EPO) and Aranesp® for End Stage Renal Disease (ESRD) Patients Treated in Renal Dialysis Facilities," inadvertently did not exempt claims for method 2 home dialysis patients who self-administer EPO or Aranesp®. Consequently, some claims for home dialysis patients may receive an inappropriate 25 percent reduction in payment. Claims for home dialysis patients who self-administer these drugs in the home ***should not*** have been included in the requirements for CR 4135. Claims for patients who normally perform home dialysis and self-administration of EPO or Aranesp® and who need to receive back-up services in-facility should also be exempt. In addition, CR 4135 announced that Medicare would not apply a 25 percent payment reduction on claims for EPO or Aranesp® when a GS modifier was reported on the claim. The GS modifier was defined as *"Dosage of EPO or Darbepoetin Alfa has been reduced 25 percent of preceding month's dosage."* This definition of the GS modifier precluded providers from informing Medicare when they made a dose reduction in EPO or darbepoetin alfa but the total billed EPO or darbepoetin alfa reported was not 25 percent less than the preceding month's billed units.

Key Points

- CR 4135 is to be applied to patients who receive their EPO or Aranesp® in the renal dialysis center.
- CR 4135, effective for services furnished on or after April 1, 2006, implemented a national claim monitoring policy for EPO and Aranesp® in the Medicare ESRD in-facility dialysis population.
- For dates of service April 1, 2006, and later, claims for patients who have opted to receive home dialysis under method 1 or method 2 and are self-administering the EPO or Aranesp® in their home are exempt from the policy and therefore, are not subject to automatic monitoring or the automatic 25 percent payment reduction as described in CR 4135.
- Providers should report condition code 70 on claims to identify home dialysis patients who self-administer EPO or Aranesp® and condition code 76 for the home dialysis patients who received back-up services in the facility.
- Upon implementation of this instruction **on January 1, 2007,** providers may request claim adjustments for home dialysis claims that received an inappropriate 25 percent reduction in payment.
- Medicare requested and received a revised definition of the GS modifier to enable providers to inform Medicare when a hematocrit or hemoglobin level responsive dose reduction occurred and was maintained.
- Effective October 1, 2006, the revised definition of the GS modifier is, *"Dosage of EPO or Darbepoetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level."*
- Providers should include the GS modifier on the claim when the reported hematocrit level is above 39.0 percent (hemoglobin 13.0g/dL) and a corresponding dose reduction was made and maintained.

Implementation

The implementation date for this instruction is October 2, 2006 for the new modifier definition; January 1, 2007 for the method one exclusion.

Additional Information

For complete details, please see the official instruction issued to your FI regarding this change. The revised coverage rules for EPO are explained in the CMS Pub.100-02, *Medicare Benefit Policy Manual*, Chapter 11, Section 60.4, which is included in the official instruction attachment. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1043CP.pdf.*

If you have questions, please contact your Medicare FI, at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5251
Related Change Request (CR) Number: 5251
Related CR Release Date: August 25, 2006
Related CR Transmittal Number: R1043CP
Effective Date: October 1, 2006 for new modifier definition; April 1, 2006 for method one exclusion
Implementation Date: October 2, 2006 for new modifier definition; January 1, 2007 for method one exclusion.

Source: CMS Pub. 100-04, Transmittal 1043

Change in HCPCS Code for Renal Dialysis Facilities and Hospitals Billing for ESRD Related Epoetin Alfa Effective January 1, 2007

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: CMS has revised this MLN Matters article on September 19, 2006, to reflect changes made to CR 5216, which was re-issued on August 25. Originally, CR 5216 changed the revenue code that hospitals reported EPO to 0636. However, 0636 is not to be used for this purpose. Hospitals should continue to use revenue codes 0634/0635 as they currently do. In addition to this change, the article was revised to reflect a new CR release date, transmittal number, and a new Web address for accessing CR 5216. All other information remains the same. This article was originally published in the September 2006 *Medicare A Bulletin* (page 39).

Provider Types Affected

Renal dialysis facilities and hospitals billing Medicare fiscal intermediaries (FIs) for renal dialysis services

Provider Action Needed

STOP – Impact to You

Effective for services on or after January 1, 2007, you must include the new Healthcare Common Procedure Coding System (HCPCS) code Q4081 (Injection, epoetin alfa, 100 units [for ESRD on dialysis]) when you bill for an injection of epoetin alfa (EPO) for your ESRD patients on dialysis.

CAUTION – What You Need to Know

A new HCPCS code (Q4081) has been established for the injection of epoetin alfa, 100 units (for ESRD patients on dialysis), submitted on bill type 72x, 12x, 13x and 85x, effective January 1, 2007. Renal dialysis facilities and hospitals previously billing for ESRD related EPO with the 1000 unit code J0886 should begin using the new 100-unit code effective January 1, 2007.

GO – What You Need to Do

Make sure that your billing staffs are aware of the requirement to use this new HCPCS code for the use of 100 units of epoetin alfa by injection, effective January 1, 2007.

Background

CR 5216, upon which this article is based, provides that a new HCPCS code has been established for an injection of epoetin alfa, 100 units (for ESRD patients on dialysis). The new code, Q4081, will be effective for services on or after January 1, 2007 when submitted on bill type 72x, 12x, 13x and 85x (see Table 1, below).

Renal dialysis facilities and hospitals previously billing for ESRD related EPO with the 1000 unit code J0886 **should begin using the new 100-unit code for all claims with dates of service on or after January 1, 2007.**

Billing and payment instructions for renal dialysis facilities previously applicable to J0886, as defined in the *Medicare Claims Processing Manual* (publication 100-4), Chapter 8, Section 60, will be applicable to Q4081. There are no other billing or payment changes for renal dialysis facilities.

Change in Revenue Code Reporting for Hospitals

Hospitals and renal dialysis facilities will report Q4081 for the appropriate bill types 12x, 13x, 72x and 85x.

Table 1. Epoetin Alfa Injection HCPCS Codes, Descriptions, and Applicable Billing Periods

HCPCS Codes	HCPCS Description	Applicable Billing Period
Q4055	Injection, epoetin alfa, 1,000 units (for ESRD on dialysis)	January 1, 2004 through December 31, 2005
J0886	Injection, epoetin alfa, 1,000 units (for ESRD on dialysis)	January 1, 2006 through December 31, 2006
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)	January 1, 2007 and after

Additional Information

You may find more information about new HCPCS code (Q4081) for the injection of epoetin alfa, 100 units (for ESRD patients on dialysis) by going to CR 5216, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1041CP.pdf*.

CR 5216 includes the revised pages of the *Medicare Claims Processing Manual* affected by the change request. Those pages also manualize instructions released in CR 2503 for those who wish a refresher on those instructions.

If you have any questions, please contact your FI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5216 – Revised
Related Change Request (CR) Number: 5216
Related CR Release Date: August 25, 2006
Related CR Transmittal Number: R1041CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1041, CR 5216

Clarification of Billing for Separately Billable End-Stage Renal Disease Drugs

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: CMS has revised this MLN Matters article on August 24, 2006, to delete mention in the "Caution" section regarding payment methodology. For payment information, please see CR 3451 on the CSM website at *http://www.cms.hhs.gov/Transmittals/downloads/R318CP.pdf*. All other information remains the same. This article was originally published in the Fourth the Fourth Quarter 2004 *Medicare A Bulletin* (page 62-63).

Provider Types Affected

Hospital-based and independent dialysis facilities

Provider Action Needed

STOP – Impact to You

This instruction clarifies the billing procedures for separately billable end-stage renal disease (ESRD) injectable drugs and administration-supply charges. It also includes a correction to the provider series numbers for dialysis providers: 3300-3399 (children's hospitals excluded from PPS).

CAUTION – What You Need to Know

Separately billable drugs furnished in ESRD dialysis centers must be of the appropriate category of drugs, and the most appropriate method of administration supply will be paid for these separately billable injectable drugs.

GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections of this article for further details regarding these changes.

Background

Multiple categories of drugs are not included in the ESRD composite rate. These drugs are considered to be separately billable drugs when used to treat the patient's renal condition. The separately billable injectable drugs allow for an administration-supply charge. The allowable administration-supply charges are determined by the most appropriate method of administration.

This instruction clarifies the billing procedures for separately billable ESRD injectable drugs and administration-supply charges. Separately billable drugs furnished in ESRD dialysis centers must be of the appropriate category of drugs, and the most appropriate method of administration-supply will be paid for these separately billable injectable drugs. The instruction also includes corrections to the provider series numbers for dialysis providers: 3300-3399 (children's hospitals).

Separately Billable ESRD Drugs

The following categories of drugs are separately billable when furnished in hospital-based facilities or independent dialysis facilities to treat the patient's renal condition:

- Antibiotics
- Analgesics
- Anabolics
- Hematinics
- Muscle relaxants
- Sedatives
- Tranquilizers
- Thrombolytics: used to declot central venous catheters.

Note: Erythropoietin replacement therapies are separately billable and paid at established rates through appropriate billing methodology: epotein (EPO) alfa (Epoetin®) and darbepoetin alfa (Aranesp®) (see the *Medicare Claims Processing Manual, Pub. 100-04, Sections 60.4* and *60.7*). Also, note that there is an exception for separate payment for antibiotics. Antibiotics are included in the composite rate when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis. These separately billable drugs may only be billed by an ESRD facility if they are actually administered in the facility by the facility staff. Staff time used to administer separately billable drugs is covered under the composite rate and may not be billed separately. However, the supplies used to administer these drugs may be billed in addition to the composite rate and paid on a reasonable cost basis.

Drugs Furnished in Dialysis Facilities

Payment is made for drugs furnished in independent dialysis facilities and paid outside the composite rate, based on:

- The lower of billed charges; or
- Ninety five percent average wholesale price (AWP) for the calendar year 2004.

Coinsurance and deductible are applied to billed charges. Hospital-based facilities are paid at cost with applicable coinsurance and deductibles.

The *Medicare Benefit Policy Manual, Chapter 11* provides a description of drugs that are part of the composite rate and when other drugs may be covered. Except for epoetin alfa (Epogen, EPOGEN®) and darbepoetin alfa (Aranesp®, DPA), drugs and biologicals, such as blood, may be covered in the home dialysis setting only if the "incident to a physician's services" criteria are met (i.e., it is not covered under the composite rate).

Normally, a physician is not in the patient's home when the drugs or biologicals are administered, and therefore, drugs and biologicals generally are not paid in the home setting.

Billing Procedures for Drugs for Facilities

The following billing procedures apply to independent and hospital-based facilities. Facilities identify and bill for drugs by HCPCS code, along with revenue code 0636, "Drugs Requiring Specific Information." The example below includes the Healthcare Common Procedure Coding System (HCPCS) code and indicates the dosage amount specified in the descriptor of that code. Facilities use the 'units' field as a multiplier to arrive at the dosage amount.

Example 1: HCPCS – J3360, Drug – Valium, Dosage (lowest denominator) – 5mg, Amount - $200.

Actual dosage: 10 mg

On the bill, the facility shows J3360 and 2 in the 'units' field (2 x 5 mg = 10 mg). For independent facilities, fiscal intermediaries (FIs) compare the price of $4.00 (2 x $2.00) to the billed charge and pay the lower, subject to coinsurance and deductible.

Note:

- When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units.

Clarification of Billing for Separately Billable End Stage Renal Disease Drugs (continued)

- When the dosage amount is less than the amount indicated for the HCPCS code, use one (1) as the unit of measure.

In the above example, if the dosage were 7 mg, the facility would show 2 in the 'unit' field, if the dosage were 3 mg, the facility would show one (1) in the 'units' field. Facilities bill for supplies used to administer drugs with revenue code 0270, "Medical/Surgical Supplies." The number of administrations is shown in the 'units' field.

Example 2: Revenue Code - 0270, Units - 3
The number of units for supply codes billed should match the number of injections billed on the claim form. Appropriate HCPCS codes for administration-supply of separately billable drugs would include:

- **A4657:** Injection Administration-supply Charge: include the cost of alcohol swab, syringe, and gloves.
- **A4913:** IV Administration-supply Charge: include the cost of IV solution administration set, alcohol swab, syringe, and gloves. This code should only be used when an IV solution set is required for a drug to be given. This rate will not be paid for drugs that only require a syringe for administration.

Drug Payment Amounts for Facilities

Hospital-based facilities are paid at cost with applicable coinsurance and deductibles. Independent facilities are paid based on the lower of billed charges or 95 percent AWP for the calendar year 2004: coinsurance and deductibles are applied to billed charges. Payment for separately billable ESRD drugs is subject to the Medicare policy that the program does not pay for items that are not medically necessary, or pay for the cost of luxury items beyond the basic item required to treat the patient's medical condition.

Therefore, payment is limited to the reimbursement that would be made for the generic form of the drug or the lowest cost-equivalent drug. Payment for the additional price of a brand name drug in excess of the price of the generic drug may be made only if the FI determines that the brand name drug is medically necessary.

Dialysis Provider Number Series

There are multiple facilities that provide dialysis services to ESRD beneficiaries. To ensure that provider data is correct, facilities are required to use a provider number based on facility type issued by the Centers for Medicare & Medicaid Services (CMS).

The provider number series for dialysis providers are as follows:

2300-2499 – Chronic renal dialysis facility (hospital–based)

2500-2899 – Non-hospital renal facility

2900-2999 – Independent special purpose renal dialysis facility

3300-3399 – Children's hospitals (excluded from PPS)

3500-3699 – Renal disease treatment centers (hospital satellite)

3700-3799 – Hospital-based special purpose renal dialysis facilities.

All facilities should use their appropriately assigned provider numbers on type of bill 72x. In the event that a facility changes from one type to another, the provider number must reflect the facility's present provider type. Listings of the transplant centers may be found on the CMS website at *http://www.cms.hhs.gov/ESRDGeneralInformation/downloads/trancenterslist_23dec2005.pdf*.

Implementation

The implementation date for this instruction is October 4, 2004.

Related Instructions

Transmittal 39 (change request [CR] 2963) dated January 6, 2004, Change in Coding on Medicare Claims for Darbepoetin Alfa (trade name Aranesp®) and Epoetin Alfa (trade name Epogen®, EPOGEN®) for Treatment of Anemia in End Stage Renal Disease (ESRD) Patients on Dialysis, may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R39OTN.pdf*.

Also, Transmittal 118 CR 2984) dated March 5, 2004, Frequency Limitations for Darbepoetin Alfa (trade name Aranesp®) for Treatment of Anemia in End Stage Renal Disease (ESRD) Patients on Dialysis, may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R118CP.pdf*.

Additional Information

As a result of these changes, the following sections are being revised or added to the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims):

10.9 – Dialysis Provider Number Series – revised
60.2 – Drugs Furnished in Dialysis Facilities – revised
60.2.1 – Billing Procedures for Drugs for Facilities – revised
60.2.1.1 – Separately Billable ESRD Drugs – new
60.2.2 – Drug Payment Amounts for Facilities – revised.

These revised manual sections may be viewed as an attachment to CR 3176. The official instruction issued to your FI regarding this change may be found by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R146CP.pdf*.

If you have questions, please contact your Medicare FI, at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816. ❖

MLN Matters Number: MM3176 – Revised
Related Change Request (CR) Number: 3176
Related CR Release Date: April 23, 2004
Related CR Transmittal Number: 146
Effective Date: October 1, 2004
Implementation Date: April 3, 2006

Source: CMS Pub. 100-04, Transmittal 146, CR 3176

SKILLED NURSING FACILITY SERVICES

Mass Adjustment for Type of Bills 22x & 23x with Healthcare Common Procedure Coding System Codes G0008, G0009 and G0010

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Skilled nursing facilities (SNFs) that bill Medicare fiscal intermediaries (FIs) for influenza and pneumococcal pneumonia virus (PPV) vaccines

What You Need To Know

CR 4240, (implemented on July 3, 2006) entitled "Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus (PPV), Influenza Virus, and Hepatitis B Virus)," provided guidelines for Medicare FI payment for these vaccines and for their administration.

In making this change in Medicare's Fiscal Intermediary Standard System (FISS), the appropriate pricing change needed for HCPCS codes G0008, G0009 & G0010 when submitted on type of bills (TOBs) 22x & 23x was omitted.

Therefore, your FIs will perform a mass adjustment to correct the payment of your claims for these vaccines once the FISS correction is implemented on October 2, 2006. Please note again that the mass adjustment will pertain to TOBs 22x & 23x that contain HCPCS G0008, G0009 & G0010 with dates of service between **July 1, 2006, and September 30, 2006.** You need **not** take any action to adjust these claims.

Additional Information

If you have any questions, please contact your FI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: SE0661
Related Change Request (CR) Number: 4240
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0661

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 2006 Outpatient Prospective Payment System Outpatient Code Editor Specifications—Version 7.3

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs) for services paid under the outpatient prospective payment system (OPPS)

Impact on Providers

This article is based on change request (CR) 5244, which informs your FI that the October 2006 OPPS outpatient code editor (OCE) specifications have been updated with new additions, deletions, and changes.

Background

This article is based on CR 5244, which reflects specifications that were issued for the July revision of the OPPS OCE (version 7.2).

CR 5244 provides the revised OPPS OCE instructions and specifications that will be utilized under the OPPS for hospital outpatient departments, community mental health centers (CMHCs) and for limited services provided in a home health agency (HHA) not under the home health PPS or to a hospice patient for the treatment of a nonterminal illness.

Attachment A of CR 5244 contains specifications issued for the October 2006 OCE (version 7.3), and all shaded material in Attachment A reflects changes from the prior release, which have been incorporated into the July 2006 version of the OPPS OCE (version 7.2).

The modifications of the OCE/APC (ambulatory payment classification) for the October 2006 release (V7.3) are detailed in the tables within CR 5244, and that CR is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1045CP.pdf*.

You should also read through the specifications attached to CR 5244 and note the highlighted sections, which indicate change from the prior release of the OPPS OCE software.

Note also that some of these modifications have an effective date earlier than October 1, 2006, and such dates are reflected at the beginning of each table in CR 5244.

The following is an excerpt of one table in CR 5244 (Attachment A, Appendix L). It summarizes the key modifications of the OCE/APC for the October 2006 release (V7.3).

	Mod. Type	Effective Date	Edit	
1.	Logic	October 1, 2006	74	**New edit 74** – Units greater than one for bilateral procedure billed with modifier 50…**Return to Provider.** For any code on the conditional or independent bilateral list that is submitted with modifier 50 and units of service greater than one on the same line (Appendix A).
2.	Logic	April 1, 2005		Modify appendix F to bypass edits 8, 9, 11, 12, 44, 50, 53, 54, 55, 59 & 69 for bill types 71x and 73x. Modify appendix E to reflect the changes made in appendix F.
3.	Logic	October 1, 2006		Modify appendix D to apply bilateral procedure discounting to nontype T procedures that are on the conditional bilateral list, when submitted with modifier 50. [The bilateral indicator to supersede the SI, to determine discounting].
4.	Content			Make HCPCS/APC/SI changes, as specified by CMS.
5.	Content	July 1, 2006	19, 20, 39, 40	Implement version 12.2 of the NCCI file, removing all code pairs which include anesthesia (*00100-01999*), E&M (*92002-92014, 99201-99499*), or MH (*90804-90911*); and the following drug admin code pairs: C8950-C8952, C8953-C8950, C8953-C8952, C8954-C8950, C8954-C8952, C8954-C8953.
6.	Content	October 1, 2006	1	Update valid diagnosis code lists with ICD-9-CM changes.
7.	Content	October 1, 2006	2,3	Update diagnosis/age and diagnosis/sex conflict edits with MCE changes.
8.	Content	January 1, 2005	22	Add new *CPT* modifiers (genetic testing category) to global 'valid modifier' list.
9.	Content	January 1, 2006	71	Update procedure/device edit list.

October 2006 Outpatient PPS Outpatient Code Editor Specifications—Version 7.3 (continued)

Note: Some OCE/APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the "Effective Date" column.

Implementation

The implementation date for CR 5244 is October 2, 2006.

Additional Information

If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5244
Related Change Request (CR) Number: 5244
Related CR Release Date: September 1, 2006
Related CR Transmittal Number: R1045CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1045, CR 5244

ELECTRONIC DATA INTERCHANGE

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), Medicare carriers, including durable medical equipment regional carriers (DMERCs) and durable medical equipment medicare administrative contracts (DME MACs)

Provider Action Needed

STOP – Impact to You

The November 2005 through February 2006 updates have been posted for the X12N 835 Health Care Remittance Advice Remark codes (RARCs) and the X12N 835 Health Care Claim Adjustment Reason codes (CARCs).

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has developed a new website located at *http://www.cmsremarkcodes.info/* on the CMS website, to provide information and help navigate the RARC database more easily. A helpful search tool is provided at this site if you need to find a specific category of code. This new website does not replace the Washington Publishing Company (WPC) website, *http://www.wpc-edi.com/codes*, as the official site where the most current RARC list resides. Use the list posted at the **WPC website** if there are any discrepancies between code text listed either on the new website or in this article, and the code text provided on the WPC website.

GO – What You Need to Do

Please refer to the *Background* section of this article for a summary of the RARC and CARC code text changes.

Background

Among the codes sets mentioned in the *Implementation Guide* for transaction 835 (Health Care Claim Payment/ Advice), the following two code sets must be used to report payment adjustments and related information for transaction 835 and the standard paper remittance advice for Medicare:

- Claim Adjustment Reason Code (CARC)
- Remittance Advice Remark Code (RARC).

Additionally, for the coordination of benefits (COB) transaction (837), the CARC must be used.

Both of these code sets are updated three times a year, and Medicare issues recurring change requests (CRs) that capture the changes in these code sets that have been approved in the previous four months.

Summary of Current Updates (November 1, 2005 – February 28, 2006 Changes)

Remark Code (RARC) Changes

The following codes reflect **new** remark codes:

New Code	Current Narrative
N365	This procedure code is not payable. It is for reporting/information purposes only.
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
N367	The claim information has been forwarded to a Health Savings Account processor for review.
N368	You must appeal the determination of the previously adjudicated claim.
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/ regulation.

Modified: Remark code **MA02** was modified effective December 29, 2005. Its modified narrative is:

> "If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days."

This modification is effective January 1, 2006, and was implemented on or before May 17, 2006.

Deactivated: Code **MA03** was deactivated effective October 1, 2006. Remark code MA02 may be used instead.

Reason Code (CARC) Changes

New: The following reflects new reason codes:

New Code	Current Narrative
193	Original payment decision is being maintained. This claim was processed properly the first time. New as of: February 2006
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician. New as of: February 2006
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/ service. New as of: February 2006

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

Implementation Date

These code changes will be applied by your Medicare carrier/DMERC/FI/RHHI by October 2, 2006.

Additional Information

CR 5212 is the official instruction issued to your Medicare carrier/DMERC/FI/RHHI regarding changes mentioned in this article. CR 5212 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1031CP.pdf*.

For more information on the process used to update these two codes sets, see the *MLN Matters* article, MM4314, available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4314.pdf*.

If you have questions please contact your local Medicare carrier/DMERC/FI/RHHI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5212
Related Change Request (CR) Number: 5212
Related CR Release Date: August 18, 2006
Related CR Transmittal Number: R1031CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1031, CR 5212

MSP Claims—More than One Primary Payer and More Than One Allowed Amount

When submitting an MSP claim, Medicare needs to use a primary payer's allowed and paid amounts to calculate the supplemental amount that can be paid by Medicare. In some cases, a beneficiary may have coverage by more than one other primary payer. Each of those other payers must complete adjudication before Medicare can process those claims. The ASC X12 837 version 40101A1 IG permits reporting of payment information from more than one other payer, but not for reporting of separate allowed amounts at the line or claim level for more than one payer.

As a result of this limitation, when there is more than one primary payer, and the allowed amounts differ, a provider is permitted to submit the claim to Medicare on paper, attaching the remittance advice/explanation of benefits from each of the primary payers.

Unless a provider meets **one** of the exceptions listed below, no other types of MSP claims (e.g. when there is only one primary payer) may be submitted to Medicare on paper. These exceptions are:

- Obligated to accept as payment in full amount (OTAF) claims when there is also more than one primary payer.
- The provider meets the criteria for a "small provider".
- The provider meets one of the temporary exception criteria (e.g. disruption of electricity, communications, etc.). ❖

Source: CMS Internet Only Manual, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 24, Section 90.2
CMS Pub. 100-04, Transmittal 952, CR 5068

EDUCATIONAL RESOURCES

An Overview of Medicare Preventive Services Video

The ***Medicare Learning Network*** is pleased to announce the availability of the latest provider education resource on Medicare's coverage of preventive benefits, ***An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*** **video program.**

This educational video program provides an overview of preventive services covered by Medicare including the newest preventive services that became effective January 2005 as a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This program provides information on risk factors associated with various preventable diseases and highlights the importance of prevention, detection, and early treatment of disease. The information presented in this program is useful for physicians, providers, suppliers, and other health care professionals involved in providing preventive services to Medicare beneficiaries. The program runs approximately 75 minutes in length.

The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington, DC 20006.

CMS has awarded for this educational video program 0.1 of CEUs (continued education units) to participants who successfully complete this program. This program is appropriate for use by a single individual or may be shown to a large group. Credit expires July 4, 2009. The authors of this program have no conflicts of interest to disclose. This course was developed without the use of any commercial support.

The video program may be accessed at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

Flu Season Resources for Health Care Professionals

The ***Medicare Learning Network*** has developed the ***2006 – 2007 Influenza (Flu) Season Educational Products and Resources*** online PDF document. This online document includes links to flu-related educational products developed by CMS for provider use and links to other resources where clinicians may find useful information and tools for the 2006 – 2007 flu season. The resource document will be updated as new flu information becomes available.

The 2006 – 2007 Influenza (Flu) Season Educational Products and Resources

Online document may be accessed by going to the Downloads section of the MLN Preventive Services Educational Products Web page, located at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*. ❖

Source: CMS Provider Education Resource 200609-08

PREVENTIVE SERVICES

September is Prostate Cancer Awareness Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting awareness of prostate cancer and the prostate cancer screening benefit covered by Medicare.

Prostate cancer is the second most common type of cancer and the second leading cause of cancer-related deaths among men in the US. According to the American Cancer Society, approximately 234,460 new cases and 27,350 deaths are expected in 2006. All men are potentially at risk; however, the incident of prostate cancer rises dramatically with increasing age. The risk of prostate cancer is significantly higher among African-American men, and men who have a family history of the disease are also at increased risk.

Medicare began providing coverage of prostate cancer screening tests/procedures for the early detection of prostate cancer January 1, 2000. Medicare provides coverage of a digital rectal examination (DRE) and a prostate specific antigen (PSA) blood test once every 12 months for all men with Medicare over the age of 50 for the early detection of prostate cancer.

PSA and DRE screening can detect prostate cancer in its early stages. However, while the U.S. Preventive Services Task Force (USPSTF) found good evidence that PSA screening can detect early-stage prostate cancer, it has mixed and inconclusive evidence that early detection improves health outcomes. The USPSTF notes that screening is associated with potential harms and concludes that evidence is insufficient to determine whether the benefits outweigh the possible harms for a screened population. Consequently, the USPSTF recommends that clinicians discuss the potential benefits and possible harms of prostate cancer screening with their patients before performing screening procedures. (For more information on potential benefits and possible harms associated with prostate cancer screening, please refer to "USPSTF Screening for Prostate Cancer" on the Internet *http://www.ahcpr.gov/clinic/uspstf/uspsprca.htm*.)

September is Prostate Cancer Awareness Month (continued)

You Can Help Your Patients Make an Informed Decision

You can help your Medicare patients make an informed decision about prostate cancer screening by:

- Providing your patients with current information to help them understand the nature of prostate cancer and their risks factors for developing the disease.
- Talking with your patients about the types of prostate cancer screenings covered by Medicare and the potential benefits and possible risks of the screenings.

Prostate Cancer Awareness Month is the perfect time to promote discussion about prostate cancer and the screening benefit covered by Medicare. As a trusted source of health care information, your recommendation can help your patients make an informed decision about prostate cancer screening. It could potentially save their lives.

Additional Information

For more information about Medicare's prostate cancer screening benefit, visit the CMS website at *http://www.cms.hhs.gov/ProstateCancerScreening/*.

CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.
- The CMS Website provides information for each preventive service covered by Medicare. Click on *http://www.cms.hhs.gov*, select "Medicare", and scroll down to "Prevention".

For products to share with your Medicare patients, visit *www.medicare.gov* on the Web.

For more information about prostate cancer and Prostate Cancer Awareness Month, visit the following websites:

- Centers for Disease Control and Prevention *http://www.cdc.gov/cancer/prostate*
- National Cancer Institute *http://www.cancer.gov/*
- National Prostate Cancer Coalition *http://www.fightprostatecancer.org*

Thank you for joining with CMS to promote awareness of prostate cancer and the screening benefit covered by Medicare. ❖

Source: CMS Provider Education Resource 200609-03

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Immunization: Promoting Prevention for a Healthier Life

September 24 – 30 is National Adult Immunization Awareness Week

This annual heath observance provides an excellent reminder for you to talk with your Medicare patients about vaccine-preventable diseases and ensure that they are protected against influenza and pneumonia, which together are the fifth leading cause of death among adults 65 and older in the U.S. These vaccines are safe and effective, and there are no out-of-pocket costs for your Medicare patients.

CMS needs your help to ensure that Medicare beneficiaries take full advantage of these preventive benefits. For information about National Adult Immunization Awareness Week, go to *http://www.cdc.gov/nip/events/naiaw/default.htm*.

For information about Medicare's coverage of adult immunizations and educational resources, go to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf*. ❖

Source: CMS Provider Education Resource 200609-10

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

October – December 2006

Provider Outreach & Education Advisory Group (POE AG) Meeting

When: Tuesday, October 24, 2006

Time: 11:30 a.m. – 1:00 p.m. Eastern Standard Time

Type of Event: Teleconference

For membership information, visit the POE AG Web page at *http://www.floridamedicare.com*.

UB-04 Claim Form and Taxonomy Codes for Subparts

When: Wednesday, November 1, 2006

Time: 12:00 p.m. – 1:00 p.m. Eastern Standard Time

Type of Event: Webcast

Hot Topics Based on Various Data Analysis and Therapy Cap

When: Thursday, November 9, 2006

Time: 11:30 p.m. – 12:30 p.m. Eastern Standard Time

Type of Event: Teleconference

Ask the Contractor

When: Tuesday, November 14, 2006

Time: 11:30 a.m. – 1:00 p.m. Eastern Standard Time

Type of Event: Teleconference

Online Registration

To participate in the above educational events, please access *http://www.floridamedicare.com*. Select "Calendar" or "Event List" on the left navigation menu.

More events will be planned soon for this quarter. Keep checking our website at *http://www.floridamedicare.com*, or listening to information on the FCSO Provider Education and Outreach Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

Please Note: Pre-registration is required for all teleconferences, webcasts and in-person educational seminars. D*ates and times are subject to change prior to event advertisement and/or registration.*

What Is a Webcast?

Webcasting is our newest training approach, combining the best of in-person events and teleconferences into one venue. Webcasts may include online presentations, website demonstrations, handouts and interactive quizzes. Experience the interactivity of training online with the convenience of listening to the speaker via teleconference! ❖

ORDER FORM - PART A MATERIALS

The following materials are available for purchase. To order, please complete and submit this form along with your check/money order (PAYABLE TO: FCSO – account number 700284).

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	***Medicare A Bulletin* Subscriptions –** The *Medicare A Bulletin* is available free of charge online at *http://www.floridamedicare.com.* Hardcopy or CD-ROM distribution is limited to one copy per medical facility who has billed at least one Part A claim to the fiscal intermediary in Florida for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet these criteria must register to receive the *Bulletin* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be used. Non-providers (e.g., billing agencies, consultants, software vendors, etc.) or providers who need additional copies at other office facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published during calendar year 2006 (back issues sent upon receipt of the order). Please check here if this will be a: [ ] Subscription Renewal or [ ] New Subscription	700284	$250.00 (Hardcopy) $20.00 (CD-ROM)

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Mail this form with payment to:

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Medicare Publications – ROC 10T

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Jacksonville, FL 32232-5280

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(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID –

DO NOT FAX - PLEASE PRINT

NOTE: *The Medicare A Bulletin is available* ***free of charge*** *online at* ***www.floridamedicare.com****.*

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "***eNews***" link on the navigational menu and follow the prompts.

IMPORTANT ADDRESSES , TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

PART A REDETERMINATION

Medicare Part A Redetermination and Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

MEDICARE SECONDARY PAYER (MSP)

Information on Hospital Protocols
Admission Questionnaires
Audits
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

General MSP Information
Completion of UB-92 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

PROVIDER EDUCATION

Provider Outreach and Education
P. O. Box 45157
Jacksonville, FL 32232-5157

Provider Event Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

"DDE Startup"
Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE

Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

PART A RECONSIDERATION

Claims Denied at the Redetermination Level
MAXIMUS
QIC Part A East Project
Eastgate Square
50 Square Drive
Victor, NY 14564-1099

OVERPAYMENT COLLECTIONS

Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

MEDICARE REGISTRATION

American Diabetes Association Certificates
Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

Telephone Numbers

PROVIDERS

Customer Service Center Toll-Free
1-877-602-8816
Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY

Customer Service Center Toll-Free
1-800-MEDICARE
1-800-633-4227
Speech and Hearing Impaired
1-800-754-7820

ELECTRONIC MEDIA CLAIMS

EMC Start-Up
1-904-791-8767, option 4

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

Direct Data Entry (DDE) Support
1-904-791-8131

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

Help Desk (Confirmation/Transmission)
1-904-905-8880

Medicare Websites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators – Gulf Coast
34650 US Highway 19 North, Suite 202
Palm Harbour, FL 34684-2156

RAILROAD MEDICARE

Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
Palmetto Goverment Benefit Administrators
P. O. Box 100141
Columbia, SC 29202-3141

MEDICARE A BULLETIN

FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. BOX 2078 ❖ JACKSONVILLE, FL 32231-0048

*** ATTENTION BILLING MANAGER ***