MEDICARE B Update!

A NEWSLETTER FOR CONNECTICUT AND FLORIDA MEDICARE PART B PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education Web sites which may be accessed at: *http://www.fcso.com.*

Routing Suggestions:

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Vol. 6, No. 2
February 2008

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The *Medicare B Update!* is published monthly by First Coast Service Options, Inc. (FCSO) Provider Outreach and Education Division, to provide timely and useful information to Medicare Part B providers in Connecticut and Florida.

Questions concerning this publication or its contents may be faxed to (904) 361-0723.

FROM THE CONTRACTOR

2008 Medifest Symposium—Mark Your Calendars

May 6 – 7, 2008 in Orlando

Have you heard the news? Our popular 2008 Medifest Symposium is coming to Florida providers on May 6 – 7 in Orlando, FL. This popular educational seminar brings together Medicare experts, providers, billing staff, coders, and suppliers throughout Florida to learn the latest on the Medicare program and to network with their peers.

Our Provider Outreach and Education team is working hard to make this the most rewarding and convenient Medifest ever.

What's New This Year

We are excited to announce new enhancements to this year's Medifest:

Two 1-Day Events

To better accommodate your busy schedule, we will offer Medifest as two 1-day sessions, conducting general classes in the morning and specialty courses in the afternoon. Come for one day or stay for two, there will still be a diversity of classes for you to choose.

Panel Discussions

This new event is the direct result of your feedback. During this 3-hour session, you will have the opportunity to discuss the latest issues with a panel of representatives from FCSO leadership, as well as to network with your peers.

More Advanced Classes

Based on your recommendations, we will conduct all courses at a more advanced level this year. To ensure everyone benefits from this new curriculum, participants must complete one Web-based Training (WBT) course prior to registering for each class. These pre-requisite WBTs will be made available in February 2008 through our Learning Management System.

Medifest Classes

Our classes are based on the latest hot topics and data analysis trends. In the morning session, we will offer a menu of general Medicare courses on:

- Reimbursement Efficiency – Part A/B
- Provider Self-Service Techniques – Part A/B
- Evaluation and Management Coding – Part B
- Florida Hospital Association (FHA) – Part A
- Fraud and Abuse – Part A /B
- Medical Review/Data Analysis – Part A/B

The afternoon session focuses on specialty classes and panel discussions:

- Evaluation and Management Documentation – Part A/B
- Rehabilitation – Part A/B
- Skilled Nursing Facility (SNF) – Part A
- Independent Diagnostic Testing Facility – Part B
- Panel Discussion – Part A/B

Don't Forget to Mark Your Calendars

More information on registration and how to complete pre-requisite WBT courses will be coming soon in future communications. Stay tuned to our Web site at *www.fcso.com*, or through our event registration hotline at 904-791-8103.

This will be the only Medifest event for Florida providers in 2008, so don't forget to mark your calendars:

What: 2008 Medifest Symposium
When: May 6 & 7, 2008
Where: Marriott Orlando Downtown
400 West Livingston Street, Orlando, FL 32801
(407) 843-6664 or (800) 574-3160
http://www.marriott.com/default.mi

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

The *Medicare B Update!* is a comprehensive publication developed by First Coast Service Options, Inc. (FCSO) for Part B providers in Connecticut and Florida.

The Provider Outreach & Education Publications team distributes the *Medicare B Update!* on a monthly basis.

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education Web site, *http://www.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who Receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education Web site(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM.

Distribution of the *Update!* in hardcopy or CD-ROM format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to either Connecticut or Florida Medicare for processing 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 registration form to us*. Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

We use the same mailing address for *all* correspondence, and cannot designate that the *Update!* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Clear Identification of State-Specific Content

Articles common to both states appear at the beginning of the publication. Within common articles, references to phone numbers, addresses, reimbursement amounts, past publications, etc., are state-specific as appropriate. Content specific to Connecticut is next, followed by content specific to Florida. Connecticut and Florida local coverage determination (LCD) summaries are combined into one section. Articles in this section applies to both Connecticut and Florida unless otherwise noted.

Publication Format

The *Update!* is arranged into distinct sections.

Following the table of contents, a letter from the carrier medical director (as needed), and an administrative information section, the *Update!* provides content applicable to both states, as noted previously. Within this section, information is categorized as follows.

- The **claims** section provides claim submission requirements and tips, plus correspondence (appeals and hearings) information.
- The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **electronic data interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **general information** section includes fraud and abuse, and Medicare Secondary Payer topics, plus additional topics not included elsewhere.

Educational resources. Important **addresses, phone numbers**, and **Web sites** will *always* be in state-specific sections.

Quarterly Provider Update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the Quarterly Provider Update by going to the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU listserv to ensure timely notification of all additions to the QPU.

Advance Beneficiary Notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient Liability Notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131form as part of the Beneficiary Notices Initiative (BNI) The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users. Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI Web site at *http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage.*

ABN Modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier **GA** (waiver of liability statement on file) or **GZ** (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier **GZ** may be used in cases where a signed ABN is *not* obtained from the patient; however, when modifier **GZ** is billed, the provider assumes financial responsibility if the service or item is denied.

"GA" Modifier and Appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier **GA** (wavier of liability statement on file).

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable **must** have the patient's ***written consent*** for an appeal. Written appeals requests should be sent to:

Connecticut
Medicare Part B Redeterminations Appeals
PO Box 45010
Jacksonville, FL 32232-5010

OR

Florida
Medicare Part B Redeterminations Appeals
PO Box 2360
Jacksonville, FL 32231-0018

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 Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

CLAIMS

2008 Annual Update for the Health Professional Shortage Area Bonus Payment

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the November 2007 Medicare B Update! page 8.

Note: This article was revised on December 31, 2007, to reflect that change request (CR) 5698 was revised. The CR release date, transmittal number and Web address for accessing CR 5698 were changed. All other information remains the same.

Provider Types Affected

Physicians and providers submitting claims to Medicare administrative contractors (A/B MACs), carriers, and fiscal intermediaries (FIs) for services provided in health professional shortage area (HPSAs).

Impact on Providers

This article is based on CR 5698, which alerts affected physicians, carriers, A/B MACs and FIs that the new HPSA bonus payment information for 2008 will be available soon. This article is informational only for a physician that the 2008 automated bonus payments applies to claims with dates of service on or after January 1, 2008, through December 31, 2008.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (section 413[b]) mandated an annual update to the automated HPSA bonus payment files, and the Centers for Medicare & Medicaid Services (CMS) creates these new automated HPSA bonus payment files annually. The 2008 HPSA bonus payment file will be used for the automated bonus payment for claims with dates of service on or after January 1, 2008, through December 31, 2008. Physicians and providers should review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in their ZIP code area or whether a modifier must be submitted.

In addition, physicians will find annual HPSA bonus payment files, as they become available, and other important HPSA information at *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/* on the CMS Web site.

Additional Information

The official instruction (CR 5698) issued to your Medicare A/B MAC, carrier, or FI is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1404CP.pdf* on the CMS Web site.

For the CMS information about HPSA/PSA (Physician Bonuses), you may visit: *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5698 *Revised*
Related Change Request (CR) #: 5698
Related CR Release Date: December 28, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1404CP
Implementation Date: January 7, 2008

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 Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

Revised Guidance for Completing Form CMS-1500

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

Provider Types Affected

All physicians, providers, and suppliers who submit claims using CMS-1500 to Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], and durable medical equipment Medicare administrative contractors [DME/MACs]).

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5749 that notifies physicians and suppliers who use the CMS-1500 (those providers who qualify for a waiver from the Administrative Simplification Compliance Act [ASCA]) that changes are being made to submission instructions for completing boxes 32a and 32b of the CMS-1500.

CAUTION – What You Need to Know

The *Key Points* section of this CR outlines the changes required in the CMS-1500.

GO – What You Need to Do

Make certain your office staffs are aware of these changes in the content requirements of the CMS-1500.

Background

The CMS-1500 claim completion instructions are being revised in order to provide guidance **related to the submission of service facility identifiers**.

The CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program and is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act (ASCA) and the implementing regulation at 42 CFR 424.32.

Key Points

Providers note the changes in chapter 26 of the *Medicare Claims Processing Manual* that impact the CMS-1500, boxes 32a and 32b.

- **Box 32a**: If required by Medicare claims processing policy, enter the national provider identifier (NPI) of the service facility.
- **Box 32b:** If required by Medicare claims processing policy, **enter the legacy provider identification number (PIN)** of the service facility preceded by the **ID qualifier 1C**. There should be one blank space between the qualifier and the PIN.

Additional Information

To see the official instruction (CR 5749) issued to your carrier, DME/MAC, or A/B MAC, refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1393CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5749
Related Change Request (CR) #: 5749
Related CR Release Date: December 14, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1393CP
Implementation Date: January 7, 2008

AMBULANCE

2008 Ambulance Fee Schedule

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, fiscal intermediaries, and Part A/B Medicare administrative contractors use to determine how much to pay you for the claims that you submit for ambulance services.

Specifically, this section of the Act provides for a 2008 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF). CR 5801 furnished the calendar year 2008 AIF, which is 2.7 percent. The revised fees are effective for dates of service January 1, 2008 and after.

Connecticut Fees

Code	Fee
A0425	6.42
A0426	285.36
A0427	451.82
A0428	237.80
A0429	380.48
A0430	2952.17
A0430	4428.26*
A0431	3432.33
A0431	5148.49*
A0432	416.15
A0433	653.95
A0434	772.84

*=Rural Rate

Florida Fees

Code	Loc 99	Loc 03	Loc 04
A0425	6.42	6.42	6.42
A0426	229.04	240.27	249.50
A0427	362.64	380.44	395.04
A0428	190.86	200.23	207.92
A0429	305.38	320.37	332.67
A0430	2,624.31	2,715.08	2,789.59
A0430	3,936.46	4,072.62	4,184.39*
A0431	3,051.13	3,156.67	3,243.31
A0431	4,576.70	4,735.01	4,864.96*
A0432	334.01	350.40	363.85
A0433	524.88	550.63	571.77
A0434	620.31	650.74	675.73

* = Rural Rate

Source: Publication 100-20, Change Request 5944

Revision to Certification for Hospital Services Covered by the Supplementary Medical Insurance Program as it Pertains to Ambulance Services

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 contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for ambulance services provided to Medicare beneficiaries.

Provider Action Needed

Change request (CR) 5833 rescinds and fully replaces CR 5684. This article is based on CR 5833, which updates the section 20 of chapter 4 of the *Medicare General Information, Eligibility, and Entitlement Manual* as it pertains to physician certification statement (PCS) requirements for all ambulance providers. CR 5833 deletes from that manual section the paragraph that requires a physician certification of ambulance services provided by a hospital to transport a patient during an emergency situation, such as transport from the scene of an accident.

Background

The Centers for Medicare & Medicaid Services (CMS) discovered there was a problem with a paragraph in the *Medicare General Information, Eligibility, and Entitlement Manual*, chapter 4, section 20 regarding language not allowing the current exception under PCS, i.e., that the PCS is **not** required during an emergency situation (such as the scene of an accident).

Therefore, CR 5833 deleted the following paragraph in chapter 4 (section 20) of the *Medicare General Information, Eligibility, and Entitlement Manual* (Pub 100-01) that pertained to Physician Certification and Recertification of Services and Ambulance Services because it conflicted with title 42 of the Code of Federal Regulations (CFR), sections 410.40(d) (2) and (3):

Certification by a physician in connection with ambulance services furnished by a participating hospital is required. In cases in which the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify as to the medical need for the ambulance service.

Deletion of this paragraph brings the manual into alignment with current regulations, which eliminate the PCS requirement in these emergency situations.

Revision to Certification for Hospital Services Covered by the SMI Program as it Pertains to Ambulance Services, continued

Additional Information

The official instruction, CR 5833, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R50GI.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5833
Related CR Release Date: December 21, 2007
Related CR Transmittal #: R50GI9

Related Change Request (CR) #: 5833
Effective Date: September 17, 2007
Implementation Date: January 7, 2008

AMBULATORY SURGICAL CENTER

Core-Based Statistical Area Crosswalk

Prior to 2008, geographic payment differences for ambulatory surgical centers (ASC) were based on metropolitan statistical areas (MSA). Beginning January 1, 2008, MSAs are replaced by core-based statistical area (CBSA). ASC providers need to know their CBSA before they can determine the correct fees utilizing the 2008 ASC Fee Schedule Lookup located at:

Connecticut: *http://www.connecticutmedicare.com/Part_B/Fee_Schedules/118499.asp*.

Florida: *http://www.floridamedicare.com/Part_B/Fee_Schedules/118499.asp*.

You can determine the CBSA in which your facility is located by using the applicable county/CBSA crosswalk:

Connecticut

County Name	MSA	MSA Name	CBSA	CBSA Name
Fairfield	5483	New Haven-Bridgeport-Stamford-Waterbury-Danb	14860	Bridgeport-Stamford-Norwalk, Ct
Hartford	3283	Hartford, Ct	25540	Hartford-West Hartford-East Hartford, Ct
Litchfield	3283	Hartford, Ct	07	Rural Ct
Middlesex	3283	Hartford, Ct	25540	Hartford-West Hartford-East Hartford, Ct
New Haven	5483	New Haven-Bridgeport-Stamford-Waterbury-Danb	35300	New Haven-Milford, Ct
New London	5523	New London-Norwich, Ct	35980	Norwich-New London, Ct
Tolland	3283	Hartford, Ct	25540	Hartford-West Hartford-East Hartford, Ct
Windham	07	Connecticut - Rest Of State	07	Rural Ct
	07	Connecticut - Rest Of State	07	Rural Ct

Florida

County Name	MSA	MSA Name	CBSA	CBSA Name
Alachua	2900	Gainesville, Fl	23540	Gainesville, Fl
Baker	10	Florida	27260	Jacksonville, Fl
Bay	6015	Panama City, Fl	37460	Panama City-Lynn Haven, Fl
Bradford	10	Florida - Rest Of State	10	Rural Fl
Brevard	4900	Melbourne-Titusville-Palm Bay, Fl	37340	Palm Bay-Melbourne-Titusville, Fl
Broward	2680	Fort Lauderdale, Fl	22744	Ft Lauderdale-Pompano Beach-Deerfield

Core-Based Statistical Area Crosswalk, continued

County Name	MSA	MSA Name	CBSA	CBSA Name
Calhoun	10	Florida - Rest Of State	10	Rural Fl
Charlotte	6580	Punta Gorda, Fl	39460	Punta Gorda, Fl
Citrus	10	Florida - Rest Of State	10	Rural Fl
Clay	3600	Jacksonville, Fl	27260	Jacksonville, Fl
Collier	5345	Naples, Fl	34940	Naples-Marco Island, Fl
Columbia	10	Florida - Rest Of State	10	Rural Fl
De Soto	10	Florida - Rest Of State	10	Rural Fl
Dixie	10	Florida - Rest Of State	10	Rural Fl
Duval	3600	Jacksonville, Fl	27260	Jacksonville, Fl
Escambia	6080	Pensacola, Fl	37860	Pensacola-Ferry Pass-Brent, Fl
Flagler	2020	Daytona Beach, Fl	37380	Palm Coast, Fl
Franklin	10	Florida - Rest Of State	10	Rural Fl
Gadsden	8240	Tallahassee, Fl	45220	Tallahassee, Fl
Gilchrist	10	Florida	23540	Gainesville, Fl
Glades	10	Florida - Rest Of State	10	Rural Fl
Gulf	10	Florida - Rest Of State	10	Rural Fl
Hamilton	10	Florida - Rest Of State	10	Rural Fl
Hardee	10	Florida - Rest Of State	10	Rural Fl
Hendry	10	Florida - Rest Of State	10	Rural Fl
Hernando	8280	Tampa-St. Petersburg-Clearwater, Fl	45300	Tampa-St. Petersburg-Clearwater, Fl
Highlands	10	Florida - Rest Of State	10	Rural Fl
Hillsborough	8280	Tampa-St. Petersburg-Clearwater, Fl	45300	Tampa-St. Petersburg-Clearwater, Fl
Holmes	10	Florida - Rest Of State	10	Rural Fl
Indian River	10	Florida - Rest Of State	42680	Sebastian-Vero Beach, Fl
Jackson	10	Florida - Rest Of State	10	Rural Fl
Jefferson	10	Florida	45220	Tallahassee, Fl
Lafayette	10	Florida - Rest Of State	10	Rural Fl
Lake	5960	Orlando, Fl	36740	Orlando-Kissimmee, Fl
Lee	2700	Fort Myers-Cape Coral, Fl	15980	Cape Coral-Fort Myers, Fl
Leon	8240	Tallahassee, Fl	45220	Tallahassee, Fl
Levy	10	Florida - Rest Of State	10	Rural Fl
Liberty	10	Florida - Rest Of State	10	Rural Fl
Madison	10	Florida - Rest Of State	10	Rural Fl
Manatee	7510	Sarasota-Bradenton, Fl	42260	Sarasota-Bradenton-Venice, Fl
Marion	5790	Ocala, Fl	36100	Ocala, Fl
Martin	2710	Fort Pierce-Port St. Lucie, Fl	38940	Port St. Lucie, Fl
Miami-Dade	5000	Miami, Fl	33124	Miami-Miami Beach-Kendall, Fl
Monroe	10	Florida - Rest Of State	10	Rural Fl
Nassau	3600	Jacksonville, Fl	27260	Jacksonville, Fl
Okaloosa	2750	Fort Walton Beach, Fl	23020	Fort Walton Beach-Crestview-Destin, Fl
Okeechobee	10	Florida - Rest Of State	10	Rural Fl
Orange	5960	Orlando, Fl	36740	Orlando-Kissimmee, Fl
Osceola	5960	Orlando, Fl	36740	Orlando-Kissimmee, Fl
Palm Beach	8960	West Palm Beach-Boca Raton, Fl	48424	West Palm Beach-Boca Raton-Boynton Fl
Pasco	8280	Tampa-St. Petersburg-Clearwater, Fl	45300	Tampa-St. Petersburg-Clearwater, Fl

Core-Based Statistical Area Crosswalk, continued

County Name	MSA	MSA Name	CBSA	CBSA Name
Pinellas	8280	Tampa-St. Petersburg-Clearwater, Fl	45300	Tampa-St. Petersburg-Clearwater, Fl
Polk	3980	Lakeland-Winter Haven, Fl	29460	Lakeland, Fl
Putnam	10	Florida - Rest Of State	10	Rural Fl
Santa Rosa	6080	Pensacola, Fl	37860	Pensacola-Ferry Pass-Brent, Fl
Sarasota	7510	Sarasota-Bradenton, Fl	42260	Sarasota-Bradenton-Venice, Fl
Seminole	5960	Orlando, Fl	36740	Orlando-Kissimmee, Fl
St. Johns	3600	Jacksonville, Fl	27260	Jacksonville, Fl
St. Lucie	2710	Fort Pierce-Port St. Lucie, Fl	38940	Port St. Lucie, Fl
Statewide	10	Florida - Rest Of State	10	Rural Fl
Sumter	10	Florida - Rest Of State	10	Rural Fl
Suwannee	10	Florida - Rest Of State	10	Rural Fl
Taylor	10	Florida - Rest Of State	10	Rural Fl
Union	10	Florida - Rest Of State	10	Rural Fl
Volusia	2020	Daytona Beach, Fl	19660	Deltona-Daytona Beach-Ormond Beach, Fl
Wakulla	10	Florida - Rest Of State	45220	Tallahassee, Fl
Walton	10	Florida - Rest Of State	10	Rural Fl
Washington	10	Florida - Rest Of State	10	Rural Fl

DRUGS AND BIOLOGICALS

January 2008 Quarterly Average Sales Price Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

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 contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

What You Need to Know

CR 5852, from which this article is taken, instructs Medicare contractors to download and implement the January 2008 average sales price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2007, April 2007, July 2007, October 2007, April 2006, July 2006, and October 2006 files.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS), are paid based on the ASP methodology.

The ASP methodol*ogy* is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, *DME* MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” have been operationalized in the context of payment under section 1847A.

For the purpose of identifying “single source drugs” and “biological products” subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

January 2008 Quarterly ASP Drug Pricing Files and Revisions to Prior Quarterly Pricing Files, continued

1. The Food and Drug Administration (FDA) approval
2. Therapeutic equivalents as determined by the FDA
3. The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of "not otherwise classified, (NOC)" HCPCS codes.

ASP Methodology

In general, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on the ASP methodology for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities)
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

Summary of Exceptions to this General Rule

1. Except for blood clotting factors, the payment allowance limits for blood and blood products (that are not paid on a prospective payment basis) are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia; and will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

Note: For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 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. For 2008, a separate fee of $0.158 per I.U. of blood-clotting factor furnished is payable when separate payment for the blood-clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

2. Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) 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 or incident to a professional service. The payment allowance limits will not be updated in 2008. Similarly, payment allowance limits for infusion drugs furnished through a covered item of DME 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 unless the drug is compounded or furnished incident to a professional service.

3. The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except, when administered in a hospital outpatient department, the vaccines are paid at reasonable cost.

4. Except for new drugs and biologicals that are produced, or distributed, under a new drug application (or other application) approved by the FDA, the payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug pricing file or not otherwise classified (NOC) pricing file, are based on the published wholesale acquisition cost (WAC) or invoice pricing (except under OPPS in which the payment allowance limit is 95 percent of the published AWP).

   In determining the payment limit based on WAC, contractors will follow the methodology specified in the *Medicare Claims Processing Manual*, chapter 17, Drugs and Biologicals, for calculating the AWP but will substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC.

5. The payment allowance limits for new drugs and biologicals that were first sold on or after January 1, 2005; and are: 1) Produced or distributed under a new drug application (or other new application) approved by the FDA, and 2) Not included in the ASP Medicare Part B Drug pricing file or NOC pricing file; are based on 106 percent of the WAC (or invoice pricing if the WAC is not published) except under OPPS in which the payment allowance limit is 95 percent of the published AWP.

6. The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Contractors should determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

7. The payment methodology for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology (as described above) unless the drug furnished incident to the filling or refilling of an implantable pump or reservoir is a compounded drug, then pricing is performed by the local contractor.

   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 that they perform the service. Contractors must find the use of the implantable pump or reservoir

January 2008 Quarterly ASP Drug Pricing Files and Revisions to Prior Quarterly Pricing Files, continued

medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment 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 the medication administered is:

- Accepted as a safe and effective treatment of the patient's illness or injury;
- There is a medical reason that the medication cannot be taken orally; and
- The skills of the nurse are needed to infuse the medication safely and effectively.

On or after December 18, 2007, the January 2008 ASP file and ASP NOC files will be available for retrieval from the CMS ASP Web page. If CMS determines that revisions to the January 2007, April 2007, July 2007, October 2007, April 2006, July 2006 and October 2006 ASP payment files are necessary, the revised files will also be available for retrieval from the CMS Web page on or after December 18, 2007. The revised payment files will be applied to claims processed or reprocessed on or after this CR's (5852) effective date.

Table 1 below displays the payment allowance limit revision dates, and the applicable dates of service.

Table 1

Payment Allowance Limit Revision Date	Applicable Dates of Service
January 2008	January 1, 2008 through March 31, 2008
Revised January 2007*	January 1, 2007 through March 31, 2007
Revised April 2007*	April 1, 2007 through June 30, 2007;
Revised July 2007*	July 1, 2007 through September 30, 2007
Revised October 2007*	October 1, 2007 through December 31, 2007
Revised April 2006*	April 1, 2006 through June 30, 2006;
Revised July 2006*	July 1, 2006 through September 30, 2006
Revised October 2006*	October 1, 2006 through December 31, 2006

*If made available by CMS

Note: The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

Final Notes

The absence or presence 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.

Contractors (at their discretion) may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files, or that CMS has not otherwise made available on its Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

Contractors will not search for, and adjust, a claim that has already been processed unless you bring it to their attention.

Implementation

The implementation date is January 7, 2008.

Additional Information

For complete details, please see the official instruction (CR 5852) issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change, by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1406CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5852
Related CR Release Date: January 8, 2008
Related CR Transmittal #: R1406CP
Related Change Request (CR) #: 5852
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Medicare Payment for Pre-Administration-Related Services Associated with Intravenous Immune Globulin Administration—Payment Extended through CY 2008

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

Provider Types Affected

Physicians or hospital outpatient facilities billing Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services related to the preadministration of intravenous immune globulin (IVIG) for Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

In 2006 and 2007, Medicare made a separate payment to physicians and hospital outpatient departments for pre-administration-related services associated with administration of IVIG, Healthcare Common Procedure Coding System (HCPCS) code G0332.

CAUTION – What You Need to Know

CR 5713, from which this article was taken, states that the Centers for Medicare & Medicaid Services (CMS) is extending the temporary IVIG pre-administration-related services payment to hospital outpatient departments and physicians that administer IVIG through calendar year (CY) 2008. This IVIG pre-administration service may only be billed by the physician or outpatient hospital providing the IVIG infusion once per patient per day of IVIG administration. For services on or after January 1, 2008, the service must be billed on the same claim form as the IVIG product (J1566, J1568, J1569, J1561 and/or J1572) and have the same date of service as the IVIG product and a drug administration service.

GO – What You Need to Do

Make certain that your billing staff is aware of these billing requirements.

Background

Under section 1861(s)(1) and 1861(s)(2), Medicare Part B covers IVIG administered by physicians in physician offices and by hospital outpatient departments. More specifically, when you administer IVIG to a Medicare beneficiary in the physician office or hospital outpatient department, Medicare makes separate payments to the physician or hospital for both the IVIG product itself and for its administration via intravenous infusion.

This payment is for the additional pre-administration-related services required to locate and acquire adequate IVIG product during this current period where there may be potential market issues.

As a reminder, here are some important details that you should know:

- The policy and billing requirements concerning the IVIG pre-administration-related services payment are the same in 2008 as they were in 2007 and 2006.
- This IVIG pre-administration service payment is in addition to Medicare's payments to the physician or hospital for the IVIG product itself and for its administration by intravenous infusion.
- Medicare carriers, FIs, or A/B MACs will pay for these services, that are provided in a physician office, under the physician fee schedule; and FIs or A/B MACs will pay for them under the outpatient prospective payment system (OPPS), for hospitals subject to OPPS (bill types: 12x, 13x) or under current payment methodologies for all non-OPPS hospitals (bill types: 12x, 13x, 85x).
- You need to use HCPCS code G0332, Pre-administration-Related Services for IVIG, to bill for this service.
- You can bill for only one IVIG pre-administration per patient per day of IVIG administration.
- For services on or after January 1, 2008, the service must be billed on the same claim form as the IVIG product (HCPCS codes J1566, J1568, J1569, J1561, and/or J1572) and have the same date of service as the IVIG product and a drug administration service. Physicians' claims will be rejected as unprocessable and hospital claims will be returned by your FI, carrier, or A/B MAC if one of the IVIG product HCPCS codes is not included with G0332 for that date of service. In doing so, the contractor will use one or both of the following codes:

  M67–"Missing other procedure codes"
  16–"Claim/service lacks information which is needed for adjudication."
- Physicians' claims will be rejected as unprocessable and hospital claims will be returned for pre-administration-related services by your FI, carrier, or A/B MAC if more than 1 unit of service of G0332 is indicated on the same claim for the same date of service. They will use the appropriate reason/remark code such as:

  M80–"Not covered when performed during the same session/date as a previously processed service for the patient"
  B5–"Payment adjusted because coverage/program guidelines were not met or were exceeded."

Note: The definition for J1566 is changed effective January 1, 2008. The new definition is "Injection, immune globulin, intravenous, lyophilized (e.g., powder), NOS, 500MG"

Additional Information

For complete details regarding this issue, please see the official instruction (CR 5713) issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1338CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

You may also want to view CR 5635, which implemented HCPCS Coding Changes for Immune Globulin, effective for services on or after July 1, 2007. For the article related to this CR, please visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5635.pdf* on the CMS Web site.

Payment for Pre-Administration-Related Services Associated with IVIG Administration—Payment Extended through CY 2008, continued

MLN Matters Number: MM5713
Related Change Request (CR) #: 5713
Related CR Release Date: September 21, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1338CP
Implementation Date: January 7, 2008

EVALUATION AND MANAGEMENT SERVICES

Incorrect Denial of Procedure Codes 99143–99145

First Coast Service Options, Inc. (FCSO) identified a processing issue with procedure codes 99143–99145 that were processed from January 1, 2006 through January 6, 2008. During this time, these procedures were denied incorrectly with the following message: "Denied-Medicare does not pay separately. Do not bill patient."

No Action is Required by Providers at This Time

The issue was corrected and services processed on or after January 7, 2008, processed correctly. FCSO will adjust impacted claims systematically; therefore no action is required by the provider at this time. We respectfully request that providers not submit appeal or reopenings, and to refrain from calling the customer service line in regard to this error. Requesting appeals, reopenings and or telephone inquiries will not expedite payments.

We apologize for any inconvenience this may have caused.

Incorrect Payment for Downcoded New Patient Office Visits

First Coast Service Options, Inc. (FCSO) identified a processing issue with claims processed from October 1, 2005 through August 31, 2007. This issue impacts claims for multiple new patient office visits billed by the same provider, same group practice or providers of the same specialty within three years. When this situation occurs, FCSO downcodes the second new patient office visit to the corresponding subsequent office visit. Services processed on or after September 1, 2007, processed correctly. The correct corresponding subsequent office visits are:

If the new patient code is....	Then the correct subsequent code is....
99201	99212
99202	99213
99203	99214
99204	99215
99205	99215

No Action is Required by Providers at This Time

FCSO will adjust impacted claims systematically; therefore no action is required by the provider at this time. We respectfully request that providers not submit appeals or reopenings and to refrain from calling the customer service line in regard to this coding issue. Requesting appeals, reopenings and/or telephone inquiries will not expedite payments.

We apologize for any inconvenience this may have caused.

INDEPENDENT DIAGNOSTIC TESTING FACILITY

New 2008 IDTF Approved Procedure Codes

With the annual 2008 HCPCS update, effective January 1, 2008, the following new codes have been approved as allowable by an independent diagnostic testing facility (IDTF):

75557 75561
75559 75563

The CMS-855B with Attachment 2 will need to be submitted and the IDTF will need to be approved by First Coast Service Options, Inc. to bill for the new procedure codes prior to reimbursement.

CMS-855B Reminder

Medicare may reimburse IDTFs only for procedure codes for which they are approved, based on equipment and personnel requirements. IDTFs are required to submit to Medicare Provider Enrollment a list of all procedure codes performed by the facility. The codes and equipment should be listed on Attachment 2, Section A and B of Enrollment Application Form CMS-855B. It is the responsibility of the IDTF to provide any changes to its list of procedures on an updated CMS-855B (with Attachment 2) to each Medicare contractor with which it does business.

Source: CMS Pub 100-04, Transmittal 1358, CR 5774

LABORATORY/PATHOLOGY

Reporting of Hematocrit or Hemoglobin Levels for the Administration of Erythropoiesis Stimulating Agents

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Competitive Acquisition Plan [CAP] designated carriers, and A/B Medicare administrative contractors [A/B MACs]) for providing Erythropoiesis Stimulating Agents (ESAs) and related anti-anemia administration services to Medicare beneficiaries.

Impact on Providers

Effective for services on or after January 1, 2008, you must report the most recent hemoglobin or hematocrit levels on any claim for a Medicare patient receiving: (1) ESA administrations, or (2) Part B anti-anemia drugs other than ESAs used in the treatment of cancer that are not self-administered. In addition, non-end stage renal disease (ESRD) claims for the administration of ESAs must also contain one of three new Healthcare Common Procedure Coding System (HCPCS) modifiers effective January 1, 2008.

Failure to report this information will result in your claim being returned as unprocessed. (Note that renal dialysis facilities are already reporting this information on claim types 72x, so change request (CR) 5699 applies to providers billing with other types of bills.) See the rest of this article for reporting details.

Background

Medicare Part B provides payment for certain drugs used to treat anemia caused by the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation, and surgical therapy. The treatment of anemia in cancer patients commonly includes the use of drugs, specifically ESAs such as recombinant erythropoietin and darbepoetin. Emerging data and recent research has raised the possibility that ESAs administered for a number of clinical indications may be associated with significant adverse effects, including a higher risk of mortality in some populations.

Most recently, section 110 of Division B of the Tax Relief and Health Care Act (TRHCA) of 2006 directs the Secretary to amend Section 1842 of the Social Security Act by adding at the end the following new subsection: *"Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual."*

In light of the health and safety factors and the TRHCA legislation, effective January 1, 2008, the Centers for Medicare & Medicaid Services (CMS) is implementing an expanded reporting requirement for all claims billing for administrations of an ESA. Hematocrit and /or hemoglobin readings are already required for ESRD claims for administrations of an ESA. Effective with the implementation of change request (CR) 5699, all other claims for ESA administrations will also require the reporting of the most recent hematocrit or hemoglobin reading, along with one of three new HCPCS modifiers effective January 1, 2008.

In addition, CR 5699 requires the reporting of the most recent hematocrit or hemoglobin readings on all claims for the administration of Part B anti-anemia drugs OTHER THAN ESAs used in the treatment of cancer that are not self-administered.

Reporting of Hematocrit or Hemoglobin Levels for the Administration of ESA, continued

What you Need to Know

CR 5699, from which this article is taken, instructs all providers and suppliers that:

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading.
    - For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Such claims for ESAs not reporting a value code 48 or 49 will be returned to the provider.
    - Effective for services on or after January 1, 2008, for professional paper claims, test results are reported in item 19 of the CMS-1500. For professional electronic claims (837P) billed to carriers or A/B MACs, providers report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1=hemoglobin or R2=hematocrit (a 2-position alpha-numeric element), and the most recent numeric test result (a 3-position numeric element, decimal implied [xx.x]). Results exceeding 3-position numeric elements (10.50) are reported as 10.5.

      Examples: If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.
    - Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.
    - When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include claim adjustment reason code 16 (Claim/service lacks information which is needed for adjudication.) and remittance advice code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)
2. Effective January 1, 2008, all non-ESRD ESA claims billing HCPCS J0881 and J0885 must begin reporting one **(and only one)** of the following three modifiers on the same line as the ESA HCPCS:
    - EA: ESA, anemia, chemo-induced
    - EB: ESA, anemia, radio-induced
    - EC: ESA, anemia, non-chemo/radio
    - Non-ESRD ESA institutional claims that do not report one of the above three modifiers along with HCPCS J0881 or J0885 will be returned to the provider.
    - Non-ESRD ESA professional claims that are billed without one of the three required modifiers as line items along with HCPCS J0881 or J0885 will be returned as unprocessable with reason code 4 and remark code MA130. If more than one modifier is reported, the claim will be returned with reason code 125 and remark code N63.
3. Effective January 1, 2008, all non-ESRD, non-ESA claims billing for the administration of Part B anti-anemia drugs used in the treatment of cancer that are not self-administered must report the most recent hematocrit or hemoglobin reading.

- Institutional claims that do not report the most recent hematocrit or hemoglobin reading will be returned to the provider.
    - Professional claims that do not report the most recent hematocrit or hemoglobin reading will be returned as unprocessable using reason code 16, and remarks codes MA130 and N395
    - Your Medicare contractor will not search for claims with dates of service on or after January 1, 2008, processed prior to implementation of this CR, but will adjust such claims when you bring them to the attention of your contractor.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5699) issued to your Medicare carrier, FI, DME MAC, CAP designated carrier, and A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1412CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5699
Related Change Request (CR) #: 5699
Related CR Release Date: January 11, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1412CP
Implementation Date: April 7, 2008

MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

New 2008 Payment Rates for Services Paid Under Medicare Physician Fee Schedule

The Medicare, Medicaid, and SCHIP Extension Act of 2007 made several changes affecting payments to physicians. One such change provides for a 0.5 percent increase to the physician fee schedule conversion factor for January 1 through June 30, 2008, instead of the -10.1 percent that was scheduled to take place. As of July 1, 2008, the -10.1 percent update to the physician fee schedule will go into effect.

Since there is a change to the 2008 Medicare physician fee schedule rates, CMS is extending the participation enrollment period an additional 45 days. The participation decision period now runs through February 15, 2008, instead of ending on December 31, 2007. All participating status changes will be effective January 1, 2008.

To become a participating physician, complete the CMS-460, which may be found on the CD that was mailed to physicians in November. The form is also available on the CMS Web site at *http://www.cms.hhs.gov/cmsforms/downloads/cms460.pdf*.

The CMS-460 must be post-marked by February 15, 2008, and sent to the following address:

Connecticut
Medicare Part B CT Correspondence
Attention Provider Enrollment
PO Box 45010
Jacksonville, FL 32232-5010

Florida
Provider Enrollment
P O Box 44021
Jacksonville, FL 32231-4021

Also, if changing your participation status to nonparticipating, please send your request in a letter to the above address, post-marked by February 15, 2008.

Source: Publication 100-20, Transmittal 312, Change Request 5944

Information Regarding the New 2008 Medicare Physician Fee Schedule Amounts

In previous messages, the Centers for Medicare & Medicaid Services (CMS) indicated that the Medicare, Medicaid and SCHIP Extension Act of 2007 replaced the scheduled 10.1 percent reduction in the Medicare physician fee schedule (MPFS) conversion factor with a 0.5 percent increase for dates of service beginning January 1, 2008, through June 30, 2008. CMS has received a number of inquiries asking whether physicians need to take any special action to get paid at the rates required by the statute.

Physicians do not need to take any additional action in order for their MPFS claims to be paid at the new rate that reflects the 0.5 percent increase in the conversion factor. Medicare contractors are able to process claims for services paid under the MPFS that contain dates of service January 1, 2008, and after with the new 2008 rates. No adjustments should be necessary. Your Medicare contractor has been instructed to process, beginning January 7, 2008, all claims with dates of service January 1, 2008, and after, that contain MPFS services.

We are also taking this opportunity to reiterate two points made in earlier messages:

1. The new fees were posted on your local contractor's Web site by January 11, 2008. The "Medicare Physician Fee Schedule Look-Up" link on the CMS Web site, which allows you to customize your search, was updated with the new 2008 fees during the week of January 21, 2008. However, the carrier specific public use files are available now on the CMS Web site for the new 2008 MPFS rates at the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp#TopOfPage*.
2. CMS extended the participation decision period an additional 45 days. The participation decision period now runs through February 15, 2008, instead of ending on December 31, 2007. All participating status changes will be effective January 1, 2008. Contractors will accept and process any participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before February 15, 2008.

Contractors will not automatically make adjustments for providers who change their participation status after January 1, 2008 (you should begin billing claims according to the participation decision that you have made). However, they will adjust claims based on participation status changes that you bring to their attention.

An official CMS change request and an *MLN Matters* article will be forthcoming.

Source: Provider Education Resources Listserv, Message 200801-11

2008 Carrier-Priced Fee Schedule Services

Reimbursement for most procedures paid on the basis of the Medicare physician fee schedule database (MPFSDB) is calculated by CMS and provided to carriers annually. These are listed on the MPFSDB with a code status of "A" (Active code). Each carrier calculates reimbursement for other procedures, known as status "C" status or carrier-priced codes. Per CMS, status "C" indicates carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis, following review of documentation, such as an operative report.
In many instances, however, enough historical data has been collected to allow the carrier to develop a consistent allowance for some C status codes. These codes and allowances below are effective for services rendered on or after January 1, 2008.

Connecticut Fees

Proc	Mod	Par	Nonpar	Lmt Chg	Note
G0186		642.43	610.31	701.86	
G0186		622.18	591.07	679.73	#
R0070		168.25	159.84	183.82	
R0075		168.25	159.84	183.82	
0145T		643.90	611.71	703.47	
0145T	TC	347.07	329.72	379.18	C
0145T	26	98.66	93.73	107.79	
0146T		643.90	611.71	703.47	
0146T	TC	347.07	329.72	379.18	C
0146T	26	98.66	93.73	107.79	
0147T		643.90	611.71	703.47	
0147T	TC	347.07	329.72	379.18	C
0147T	26	98.66	93.73	107.79	
0148T		643.90	611.71	703.47	
0148T	TC	347.07	329.72	379.18	C
0148T	26	98.66	93.73	107.79	
0149T		643.90	611.71	703.47	
0149T	TC	347.07	329.72	379.18	C
0149T	26	98.66	93.73	107.79	
0150T		643.90	611.71	703.47	
0150T	TC	347.07	329.72	379.18	C
0150T	26	98.66	93.73	107.79	
0151T		150.75	143.21	164.69	
0151T	TC	100.50	95.48	109.80	
0151T	26	50.25	47.74	54.90	
70170		59.91	56.91	65.45	
70170	TC	44.43	42.21	48.54	
70557		404.91	384.66	442.36	
70557	TC	242.95	230.80	265.42	
70558		447.69	425.31	489.11	
70558	TC	268.62	255.19	293.47	
70559		449.48	427.01	491.06	
70559	TC	269.69	256.21	294.64	
71090		107.97	102.57	117.96	
71090	TC	78.70	74.77	85.99	
72291		208.27	197.86	227.54	
72291	TC	124.96	118.71	136.52	
72292		241.55	229.47	263.89	
72292	TC	144.93	137.68	158.33	
73530		39.00	37.05	42.61	
73530	TC	23.89	22.70	26.11	
74190		85.74	81.45	93.67	
74190	TC	60.84	57.80	66.47	
74300		51.04	48.49	55.76	
74300	TC	30.62	29.09	33.45	
74301		29.62	28.14	32.36	
74301	TC	17.77	16.88	19.41	
74305		58.37	55.45	63.77	
74305	TC	36.50	34.68	39.88	
74328		182.98	173.83	199.90	
74328	TC	146.79	139.45	160.37	
74330		193.11	183.45	210.97	
74330	TC	146.79	139.45	160.37	
74340		150.05	142.55	163.93	
74340	TC	122.12	116.01	133.41	
74355		161.33	153.26	176.25	
74355	TC	122.12	116.01	133.41	
74360		175.16	166.40	191.36	
74360	TC	146.79	139.45	160.37	
74420		140.96	133.91	154.00	
74420	TC	122.12	116.01	133.41	
74425		79.68	75.70	87.06	
74425	TC	60.84	57.80	66.47	
74445		111.91	106.31	122.26	
74445	TC	52.46	49.84	57.32	
74450		85.19	80.93	93.07	
74450	TC	67.87	64.48	74.15	
74470		86.08	81.78	94.05	
74470	TC	58.16	55.25	63.54	
74775		100.32	95.30	109.60	
74775	TC	67.87	64.48	74.15	
75801		295.74	280.95	323.09	
75801	TC	252.17	239.56	275.49	
75803		312.44	296.82	341.34	
75803	TC	252.17	239.56	275.49	
75805		326.88	310.54	357.12	
75805	TC	284.32	270.10	310.62	
75810		644.92	612.67	704.57	
75810	TC	586.16	556.85	640.38	
75894		1191.60	1132.02	1301.82	
75894	TC	1123.10	1066.95	1226.99	
75896		1045.13	992.87	1141.80	
75896	TC	976.75	927.91	1067.10	
75898		134.52	127.79	146.96	

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2008 Carrier-Priced Fee Schedule Services, continued

Proc	Mod	Par	Nonpar	Lmt Chg	Note
75898	TC	48.89	46.45	53.42	
75940		614.76	584.02	671.62	
75940	TC	586.16	556.85	640.38	
75945		198.31	188.39	216.65	C
75945	TC	176.76	167.92	193.11	C
75952		705.07	669.82	770.29	
75952	TC	423.04	401.89	462.17	
75953		256.86	244.02	280.62	
75953	TC	154.12	146.41	168.37	
75954		628.42	597.00	686.55	
75954	TC	377.05	358.20	411.93	
75970		580.09	551.09	633.75	
75970	TC	536.71	509.87	586.35	
75980		326.41	310.09	356.60	
75980	TC	252.17	239.56	275.49	
75992		761.55	723.47	831.99	
75992	TC	732.85	696.21	800.64	
76001		157.47	149.60	172.04	
76001	TC	122.12	116.01	133.41	
76125		50.47	47.95	55.14	
76125	TC	36.50	34.68	39.88	
76350		18.76	17.82	20.49	
76932		106.90	101.56	116.79	
76932	TC	71.22	67.66	77.81	
76940		188.28	178.87	205.70	
76940	TC	77.64	73.76	84.82	
76941		142.02	134.92	155.16	
76941	TC	70.99	67.44	77.56	
76945		105.67	100.39	115.45	
76945	TC	70.99	67.44	77.56	
76975		113.90	108.21	124.44	
76975	TC	71.22	67.66	77.81	
78282		55.23	52.47	60.34	
78282	TC	33.14	31.48	36.20	
78414		64.45	61.23	70.41	
78414	TC	38.67	36.74	42.25	
78459		1704.61	1619.38	1862.29	C
78459	TC	1624.16	1542.95	1774.39	C
78491		1019.77	968.78	1114.10	
78491	TC	931.94	885.34	1018.14	
78492		1663.93	1580.73	1817.84	
78492	TC	1554.39	1476.67	1698.17	
78608		1302.61	1237.48	1423.10	C
78608	TC	1225.84	1164.55	1339.23	C
78811		1307.31	1241.94	1428.23	C
78811	TC	1225.84	1164.55	1339.23	C
78812		1326.59	1260.26	1449.30	C
78812	TC	1225.84	1164.55	1339.23	C
78813		1330.31	1263.79	1453.36	C
78813	TC	1225.84	1164.55	1339.23	C
78814		1340.12	1273.11	1464.08	C
78814	TC	1225.84	1164.55	1339.23	C
78815		1352.47	1284.85	1477.58	C
78815	TC	1225.84	1164.55	1339.23	C
78816		1355.34	1287.57	1480.71	C
78816	TC	1225.84	1164.55	1339.23	C
79300		231.35	219.78	252.75	
79300	TC	138.81	131.87	151.65	
86485		21.11	20.05	23.06	
91132		75.67	71.89	82.67	
91132	TC	45.41	43.14	49.61	
91133		95.15	90.39	103.95	
91133	TC	57.09	54.24	62.38	
92978		309.86	294.37	338.53	
92978	TC	212.10	201.50	231.73	
92979		185.31	176.04	202.45	
92979	TC	107.05	101.70	116.96	
93235		145.95	138.65	159.45	
93236		122.12	116.01	133.41	
93315		400.51	380.48	437.55	
93315	TC	240.31	228.29	262.53	
93317		264.44	251.22	288.90	
93317	TC	158.66	150.73	173.34	
93318		279.40	265.43	305.24	
93318	TC	167.64	159.26	183.15	
93511		1985.83	1886.54	2169.52	
93511	TC	1684.13	1599.92	1839.91	
93524		2613.30	2482.64	2855.04	
93524	TC	2201.76	2091.67	2405.42	
93527		2633.31	2501.64	2876.89	
93527	TC	2201.76	2091.67	2405.42	
93528		2729.55	2593.07	2982.03	
93528	TC	2201.76	2091.67	2405.42	
93529		2488.64	2364.21	2718.84	
93529	TC	2201.76	2091.67	2405.42	
93530		1037.04	985.19	1132.97	
93530	TC	791.32	751.75	864.51	
93531		2740.45	2603.43	2993.94	
93531	TC	2262.34	2149.22	2471.60	
93561		50.83	48.29	55.53	
93561	TC	25.23	23.97	27.57	
93562		23.73	22.54	25.92	
93562	TC	15.63	14.85	17.08	
93571		311.87	296.28	340.72	
93571	TC	211.87	201.28	231.47	
93602		169.68	161.20	185.38	
93602	TC	51.91	49.31	56.71	
93603		196.37	186.55	214.53	
93603	TC	78.70	74.77	85.99	
93609		404.45	384.23	441.86	

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2008 Carrier-Priced Fee Schedule Services, continued

Proc	Mod	Par	Nonpar	Lmt Chg	Note
93609	TC	127.59	121.21	139.39	
93610		230.97	219.42	252.33	
93610	TC	63.64	60.46	69.53	
93612		243.25	231.09	265.75	
93612	TC	75.58	71.80	82.57	
93615		63.24	60.08	69.09	
93615	TC	14.95	14.20	16.33	
93618		421.20	400.14	460.16	
93618	TC	185.31	176.04	202.45	
93619		780.16	741.15	852.32	
93619	TC	360.46	342.44	393.81	
93620		1722.45	1636.33	1881.78	
93620	TC	1033.47	981.80	1129.07	
93621		316.20	300.39	345.45	
93621	TC	189.72	180.23	207.26	
93622		506.94	481.59	553.83	
93622	TC	304.17	288.96	332.30	
93623		423.11	401.95	462.24	
93623	TC	253.86	241.17	277.35	
93624		373.35	354.68	407.88	
93624	TC	93.21	88.55	101.83	
93640		528.81	502.37	577.73	
93640	TC	335.12	318.36	366.11	
93641		663.15	629.99	724.49	
93641	TC	335.12	318.36	366.11	
93662		436.54	414.71	476.92	
93662	TC	261.92	248.82	286.14	
94642		31.56	29.98	34.48	
95824		113.82	108.13	124.35	
95824	TC	68.29	64.88	74.61	
95951		906.66	861.33	990.53	
95951	TC	544.00	516.80	594.32	
95965		1170.64	1112.11	1278.93	
95965	TC	702.39	667.27	767.36	
95966		584.32	555.10	638.37	
95966	TC	350.59	333.06	383.02	
95967		511.58	486.00	558.90	
95967	TC	306.95	291.60	335.34	
99143		59.49	56.52	65.00	
99144		59.49	56.52	65.00	
99145		26.95	25.60	29.44	
99148		59.49	56.52	65.00	
99149		59.49	56.52	65.00	
99150		26.95	25.60	29.44	

Florida Fees

		Localities 1 & 2			Locality 3			Locality 4			
Proc	Mod	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Note
G0186		581.01	551.96	634.75	606.51	576.18	662.61	629.37	597.90	687.59	
G0186		564.45	536.23	616.66	588.68	559.25	643.14	610.94	580.39	667.45	#
R0070		108.06	102.66	118.06	108.06	102.66	118.06	108.06	102.66	118.06	
R0075		108.06	102.66	118.06	108.06	102.66	118.06	108.06	102.66	118.06	
0145T		535.44	508.67	584.97	568.97	540.52	621.60	606.85	576.51	662.99	
0145T	TC	293.75	279.06	320.92	323.62	307.44	353.56	356.47	338.65	389.45	C
0145T	26	91.93	87.33	100.43	94.63	89.90	103.39	97.90	93.01	106.96	
0146T		535.44	508.67	584.97	568.97	540.52	621.60	606.85	576.51	662.99	
0146T	TC	293.75	279.06	320.92	323.62	307.44	353.56	356.47	338.65	389.45	C
0146T	26	91.93	87.33	100.43	94.63	89.90	103.39	97.90	93.01	106.96	
0147T		535.44	508.67	584.97	568.97	540.52	621.60	606.85	576.51	662.99	
0147T	TC	293.75	279.06	320.92	323.62	307.44	353.56	356.47	338.65	389.45	C
0147T	26	91.93	87.33	100.43	94.63	89.90	103.39	97.90	93.01	106.96	
0148T		535.44	508.67	584.97	568.97	540.52	621.60	606.85	576.51	662.99	
0148T	TC	293.75	279.06	320.92	323.62	307.44	353.56	356.47	338.65	389.45	C
0148T	26	91.93	87.33	100.43	94.63	89.90	103.39	97.90	93.01	106.96	
0149T		535.44	508.67	584.97	568.97	540.52	621.60	606.85	576.51	662.99	
0149T	TC	293.75	279.06	320.92	323.62	307.44	353.56	356.47	338.65	389.45	C
0149T	26	91.93	87.33	100.43	94.63	89.90	103.39	97.90	93.01	106.96	
0150T		535.44	508.67	584.97	568.97	540.52	621.60	606.85	576.51	662.99	
0150T	TC	293.75	279.06	320.92	323.62	307.44	353.56	356.47	338.65	389.45	C
0150T	26	91.93	87.33	100.43	94.63	89.90	103.39	97.90	93.01	106.96	
0151T		150.75	143.21	164.69	150.75	143.21	164.69	150.75	143.21	164.69	
0151T	TC	98.99	94.04	108.15	100.50	95.48	109.80	100.50	95.48	109.80	

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2008 Carrier-Priced Fee Schedule Services, continued

		Localities 1 & 2			Locality 3			Locality 4			
Proc	Mod	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Note
0151T	26	50.25	47.74	54.90	50.25	47.74	54.90	50.25	47.74	54.90	
21088		6,391.87	6,072.28	6,983.12	6,391.87	6,072.28	6,983.12	6,391.87	6,072.28	6,983.12	
21088		4,090.80	3,886.26	4,469.20	4,090.80	3,886.26	4,469.20	4,090.80	3,886.26	4,469.20	#
70170		51.05	48.50	55.78	54.34	51.62	59.36	58.15	55.24	63.53	
70170	TC	36.72	34.88	40.11	39.65	37.67	43.32	43.02	40.87	47.00	
70557		374.06	355.36	408.66	384.75	365.51	420.34	396.70	376.87	433.40	
70557	TC	224.44	213.22	245.20	230.85	219.31	252.21	238.02	226.12	260.04	
70558		414.05	393.35	452.35	426.42	405.10	465.87	440.29	418.28	481.02	
70558	TC	248.43	236.01	271.41	255.85	243.06	279.52	264.17	250.96	288.60	
70559		416.47	395.65	455.00	429.84	408.35	469.60	444.85	422.61	486.00	
70559	TC	249.88	237.39	273.00	257.90	245.01	281.76	266.91	253.56	291.59	
71090		92.08	87.48	100.60	98.07	93.17	107.15	105.00	99.75	114.71	
71090	TC	65.13	61.87	71.15	70.36	66.84	76.87	76.41	72.59	83.48	
72291		196.15	186.34	214.29	215.74	204.95	235.69	234.04	222.34	255.69	
72291	TC	117.70	111.82	128.59	129.44	122.97	141.42	140.42	133.40	153.41	
72292		235.47	223.70	257.26	269.98	256.48	294.95	303.99	288.79	332.11	
72292	TC	141.29	134.23	154.36	161.99	153.89	176.97	182.40	173.28	199.27	
73530		33.48	31.81	36.58	35.24	33.48	38.50	37.24	35.38	40.69	
73530	TC	19.51	18.53	21.31	20.88	19.84	22.82	22.45	21.33	24.53	
74190		73.14	69.48	79.90	77.63	73.75	84.81	82.78	78.64	90.44	
74190	TC	50.04	47.54	54.67	53.86	51.17	58.85	58.24	55.33	63.63	
74300		47.54	45.16	51.93	50.32	47.80	54.97	52.63	50.00	57.50	
74300	TC	28.52	27.09	31.15	30.19	28.68	32.98	31.59	30.01	34.51	
74301		27.02	25.67	29.52	28.49	27.07	31.13	29.73	28.24	32.48	
74301	TC	16.21	15.40	17.71	17.10	16.25	18.69	17.83	16.94	19.48	
74305		50.53	48.00	55.20	53.56	50.88	58.51	57.07	54.22	62.35	
74305	TC	30.19	28.68	32.98	32.60	30.97	35.62	35.39	33.62	38.66	
74328		154.38	146.66	168.66	164.58	156.35	179.80	176.32	167.50	192.63	
74328	TC	120.75	114.71	131.92	130.00	123.50	142.03	140.59	133.56	153.59	
74330		163.85	155.66	179.01	174.34	165.62	190.46	186.42	177.10	203.67	
74330	TC	120.75	114.71	131.92	130.00	123.50	142.03	140.59	133.56	153.59	
74340		126.31	119.99	137.99	134.67	127.94	147.13	144.28	137.07	157.63	
74340	TC	100.43	95.41	109.72	108.10	102.70	118.11	116.88	111.04	127.70	
74355		136.82	129.98	149.48	145.49	138.22	158.95	155.46	147.69	169.84	
74355	TC	100.43	95.41	109.72	108.10	102.70	118.11	116.88	111.04	127.70	
74360		146.99	139.64	160.59	156.95	149.10	171.47	168.39	159.97	183.97	
74360	TC	120.75	114.71	131.92	130.00	123.50	142.03	140.59	133.56	153.59	
74420		118.00	112.10	128.92	126.24	119.93	137.92	135.72	128.93	148.27	
74420	TC	100.43	95.41	109.72	108.10	102.70	118.11	116.88	111.04	127.70	
74425		67.61	64.23	73.86	72.00	68.40	78.66	77.07	73.22	84.20	
74425	TC	50.04	47.54	54.67	53.86	51.17	58.85	58.24	55.33	63.63	
74445		98.74	93.80	107.87	103.93	98.73	113.54	110.01	104.51	120.19	
74445	TC	43.14	40.98	47.13	46.43	44.11	50.73	50.21	47.70	54.86	
74450		72.05	68.45	78.72	76.89	73.05	84.01	82.48	78.36	90.11	
74450	TC	55.86	53.07	61.03	60.16	57.15	65.72	65.08	61.83	71.10	
74470		73.78	70.09	80.60	78.17	74.26	85.40	83.24	79.08	90.94	
74470	TC	47.90	45.51	52.34	51.60	49.02	56.37	55.85	53.06	61.02	
74775		86.03	81.73	93.99	91.24	86.68	99.68	97.26	92.40	106.26	
74775	TC	55.86	53.07	61.03	60.16	57.15	65.72	65.08	61.83	71.10	

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2008 Carrier-Priced Fee Schedule Services, continued

		Localities 1 & 2			Locality 3			Locality 4			
Proc	Mod	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Note
75801		248.60	236.17	271.60	266.29	252.98	290.93	286.75	272.41	313.27	
75801	TC	207.39	197.02	226.57	223.24	212.08	243.89	241.40	229.33	263.73	
75803		263.43	250.26	287.80	280.87	266.83	306.85	300.93	285.88	328.76	
75803	TC	207.39	197.02	226.57	223.24	212.08	243.89	241.40	229.33	263.73	
75805		273.67	259.99	298.99	292.95	278.30	320.05	315.14	299.38	344.29	
75805	TC	233.89	222.20	255.53	251.81	239.22	275.10	272.34	258.72	297.53	
75810		536.23	509.42	585.83	574.29	545.58	627.42	617.90	587.01	675.06	
75810	TC	481.58	457.50	526.13	518.08	492.18	566.01	559.81	531.82	611.59	
75894		987.27	937.91	1,078.60	1,059.73	1,006.74	1,157.75	1,142.83	1,085.69	1,248.54	
75894	TC	923.22	877.06	1,008.62	993.51	943.83	1,085.40	1,073.96	1,020.26	1,173.30	
75896		866.16	822.85	946.28	928.95	882.50	1,014.88	1,000.89	950.85	1,093.48	
75896	TC	802.83	762.69	877.09	863.89	820.70	943.81	933.77	887.08	1,020.14	
75898		119.80	113.81	130.88	125.18	118.92	136.76	131.48	124.91	143.65	
75898	TC	40.29	38.28	44.02	43.42	41.25	47.44	47.01	44.66	51.36	
75940		508.41	482.99	555.44	545.93	518.63	596.42	588.91	559.46	643.38	
75940	TC	481.58	457.50	526.13	518.08	492.18	566.01	559.81	531.82	611.59	
75945		167.05	158.70	182.51	181.56	172.48	198.35	196.77	186.93	214.97	C
75945	TC	146.45	139.13	160.00	159.88	151.89	174.67	173.68	165.00	189.75	C
75952		661.80	628.71	723.02	722.78	686.64	789.64	778.88	739.94	850.93	
75952	TC	397.08	377.23	433.81	433.67	411.99	473.79	467.34	443.97	510.57	
75953		256.81	243.97	280.57	302.86	287.72	330.88	349.22	331.76	381.52	
75953	TC	154.09	146.39	168.35	181.71	172.62	198.51	209.53	199.05	228.91	
75954		628.48	597.06	686.62	742.57	705.44	811.26	858.02	815.12	937.39	
75954	TC	377.08	358.23	411.96	445.54	423.26	486.75	514.81	489.07	562.43	
75970		481.40	457.33	525.93	516.10	490.30	563.85	555.88	528.09	607.30	
75970	TC	441.05	419.00	481.85	474.54	450.81	518.43	512.85	487.21	560.29	
75980		276.36	262.54	301.92	294.15	279.44	321.36	314.63	298.90	343.74	
75980	TC	207.39	197.02	226.57	223.24	212.08	243.89	241.40	229.33	263.73	
75992		629.16	597.70	687.36	675.92	642.12	738.44	729.50	693.03	796.98	
75992	TC	602.45	572.33	658.18	648.33	615.91	708.30	700.85	665.81	765.68	
76001		133.62	126.94	145.98	142.55	135.42	155.73	152.88	145.24	167.03	
76001	TC	100.43	95.41	109.72	108.10	102.70	118.11	116.88	111.04	127.70	
76125		43.12	40.96	47.10	45.89	43.60	50.14	49.08	46.63	53.62	
76125	TC	30.19	28.68	32.98	32.60	30.97	35.62	35.39	33.62	38.66	
76350		15.01	14.26	16.40	16.54	15.71	18.07	17.55	16.67	19.17	
76932		91.79	87.20	100.28	97.36	92.49	106.36	103.83	98.64	113.44	
76932	TC	58.95	56.00	64.40	63.70	60.52	69.60	69.17	65.71	75.57	
76940		174.51	165.78	190.65	188.66	179.23	206.11	206.21	195.90	225.29	
76940	TC	68.01	64.61	74.30	75.82	72.03	82.83	85.33	81.06	93.22	
76941		124.38	118.16	135.88	130.91	124.36	143.01	138.52	131.59	151.33	
76941	TC	58.36	55.44	63.76	62.79	59.65	68.60	67.88	64.49	74.16	
76945		90.59	86.06	98.97	95.97	91.17	104.85	102.17	97.06	111.62	
76945	TC	58.36	55.44	63.76	62.79	59.65	68.60	67.88	64.49	74.16	
76975		98.60	93.67	107.72	104.57	99.34	114.24	111.51	105.93	121.82	
76975	TC	58.95	56.00	64.40	63.70	60.52	69.60	69.17	65.71	75.57	
77520		905.25	859.99	988.99	905.25	859.99	988.99	905.25	859.99	988.99	
77522		936.93	890.08	1,023.59	936.93	890.08	1,023.59	936.93	890.08	1,023.59	
77523		973.14	924.48	1,063.15	973.14	924.48	1,063.15	973.14	924.48	1,063.15	

- These amounts apply when service is performed in a facility setting.
C - The payment for the technical component is capped at the OPPS amount.

2008 Carrier-Priced Fee Schedule Services, continued

		Localities 1 & 2			Locality 3			Locality 4			
Proc	Mod	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Note
77525		1,086.30	1,031.99	1,186.79	1,086.30	1,031.99	1,186.79	1,086.30	1,031.99	1,186.79	
78282		49.41	46.94	53.98	52.22	49.61	57.05	54.55	51.82	59.59	
78282	TC	29.65	28.17	32.40	31.33	29.76	34.22	32.72	31.08	35.74	
78414		58.60	55.67	64.02	61.76	58.67	67.47	64.34	61.12	70.29	
78414	TC	35.16	33.40	38.41	37.05	35.20	40.48	38.60	36.67	42.17	
78459		1,448.56	1,376.13	1,582.55	1,590.63	1,511.10	1,737.77	1,746.80	1,659.46	1,908.38	C
78459	TC	1,374.40	1,305.68	1,501.53	1,514.05	1,438.35	1,654.10	1,667.58	1,584.20	1,821.83	C
78491		856.36	813.54	935.57	924.64	878.41	1,010.17	985.66	936.38	1,076.84	
78491	TC	775.20	736.44	846.91	841.07	799.02	918.87	899.31	854.34	982.49	
78492		1,394.23	1,324.52	1,523.20	1,507.18	1,431.82	1,646.59	1,607.85	1,527.46	1,756.58	
78492	TC	1,293.12	1,228.46	1,412.73	1,403.15	1,332.99	1,532.94	1,500.44	1,425.42	1,639.23	
78608		1,108.88	1,053.44	1,211.46	1,216.66	1,155.83	1,329.20	1,335.30	1,268.54	1,458.82	C
78608	TC	1,037.36	985.49	1,133.31	1,142.78	1,085.64	1,248.49	1,258.68	1,195.75	1,375.11	C
78811		1,114.31	1,058.59	1,217.38	1,223.08	1,161.93	1,336.22	1,343.18	1,276.02	1,467.42	C
78811	TC	1,037.36	985.49	1,133.31	1,142.78	1,085.64	1,248.49	1,258.68	1,195.75	1,375.11	C
78812		1,131.90	1,075.31	1,236.61	1,241.00	1,178.95	1,355.79	1,361.37	1,293.30	1,487.30	C
78812	TC	1,037.36	985.49	1,133.31	1,142.78	1,085.64	1,248.49	1,258.68	1,195.75	1,375.11	C
78813		1,135.25	1,078.49	1,240.26	1,244.43	1,182.21	1,359.54	1,364.87	1,296.63	1,491.12	C
78813	TC	1,037.36	985.49	1,133.31	1,142.78	1,085.64	1,248.49	1,258.68	1,195.75	1,375.11	C
78814		1,144.25	1,087.04	1,250.10	1,253.58	1,190.90	1,369.54	1,374.14	1,305.43	1,501.24	C
78814	TC	1,037.36	985.49	1,133.31	1,142.78	1,085.64	1,248.49	1,258.68	1,195.75	1,375.11	C
78815		1,155.46	1,097.69	1,262.34	1,265.02	1,201.77	1,382.04	1,385.77	1,316.48	1,513.95	C
78815	TC	1,037.36	985.49	1,133.31	1,142.78	1,085.64	1,248.49	1,258.68	1,195.75	1,375.11	C
78816		1,158.08	1,100.18	1,265.21	1,267.69	1,204.31	1,384.96	1,388.48	1,319.06	1,516.92	C
78816	TC	1,037.36	985.49	1,133.31	1,142.78	1,085.64	1,248.49	1,258.68	1,195.75	1,375.11	C
79300		218.22	207.31	238.41	230.15	218.64	251.44	239.60	227.62	261.76	
79300	TC	130.94	124.39	143.05	138.10	131.20	150.88	143.76	136.57	157.06	
86485		16.34	15.52	17.85	18.01	17.11	19.68	19.04	18.09	20.80	
91132		67.57	64.19	73.82	71.61	68.03	78.23	74.92	71.17	81.85	
91132	TC	40.54	38.51	44.29	42.96	40.81	46.93	45.02	42.77	49.19	
91133		84.27	80.06	92.07	88.90	84.46	97.13	92.61	87.98	101.18	
91133	TC	50.55	48.02	55.22	53.34	50.67	58.27	55.58	52.80	60.72	
92978		264.22	251.01	288.66	279.93	265.93	305.82	297.97	283.07	325.53	
92978	TC	174.36	165.64	190.49	187.62	178.24	204.98	202.82	192.68	221.58	
92979		160.37	152.35	175.20	169.32	160.85	184.98	179.67	170.69	196.29	
92979	TC	88.19	83.78	96.35	95.01	90.26	103.80	102.86	97.72	112.38	
93235		122.51	116.38	133.84	130.83	124.29	142.93	140.40	133.38	153.39	
93236		100.43	95.41	109.72	108.10	102.70	118.11	116.88	111.04	127.70	
93315		362.91	344.76	396.47	381.36	362.29	416.63	395.93	376.13	432.55	
93315	TC	217.73	206.84	237.87	228.82	217.38	249.99	237.55	225.67	259.52	
93317		239.28	227.32	261.42	251.16	238.60	274.39	260.43	247.41	284.52	
93317	TC	143.56	136.38	156.84	150.70	143.17	164.65	156.26	148.45	170.72	
93318		290.75	276.21	317.64	304.68	289.45	332.87	315.23	299.47	344.39	
93318	TC	174.46	165.74	190.60	182.81	173.67	199.72	189.13	179.67	206.62	
93511		1,669.21	1,585.75	1,823.61	1,790.97	1,701.42	1,956.63	1,931.90	1,835.31	2,110.61	
93511	TC	1,391.64	1,322.06	1,520.37	1,502.61	1,427.48	1,641.60	1,630.57	1,549.04	1,781.40	
93524		2,199.09	2,089.14	2,402.51	2,359.07	2,241.12	2,577.29	2,544.36	2,417.14	2,779.71	
93524	TC	1,819.84	1,728.85	1,988.18	1,965.22	1,866.96	2,147.00	2,132.95	2,026.30	2,330.25	

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C - The payment for the technical component is capped at the OPPS amount.

2008 Carrier-Priced Fee Schedule Services, continued

		Localities 1 & 2			Locality 3			Locality 4			
Proc	Mod	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Note
93527		2,217.65	2,106.77	2,422.79	2,378.43	2,259.51	2,598.44	2,564.72	2,436.48	2,801.95	
93527	TC	1,819.84	1,728.85	1,988.18	1,965.22	1,866.96	2,147.00	2,132.95	2,026.30	2,330.25	
93528		2,306.88	2,191.54	2,520.27	2,470.88	2,347.34	2,699.44	2,661.05	2,528.00	2,907.20	
93528	TC	1,819.84	1,728.85	1,988.18	1,965.22	1,866.96	2,147.00	2,132.95	2,026.30	2,330.25	
93529		2,083.86	1,979.67	2,276.62	2,239.41	2,127.44	2,446.56	2,419.38	2,298.41	2,643.17	
93529	TC	1,819.84	1,728.85	1,988.18	1,965.22	1,866.96	2,147.00	2,132.95	2,026.30	2,330.25	
93530		880.83	836.79	962.31	941.55	894.47	1,028.64	1,012.05	961.45	1,105.67	
93530	TC	653.83	621.14	714.31	705.93	670.63	771.22	766.01	727.71	836.87	
93531		2,312.79	2,197.15	2,526.72	2,479.12	2,355.16	2,708.43	2,671.99	2,538.39	2,919.15	
93531	TC	1,870.09	1,776.59	2,043.08	2,019.60	1,918.62	2,206.41	2,192.12	2,082.51	2,394.89	
93561		45.20	42.94	49.38	47.91	45.51	52.34	51.12	48.56	55.84	
93561	TC	21.41	20.34	23.39	23.46	22.29	25.63	25.90	24.61	28.30	
93562		20.91	19.86	22.84	22.49	21.37	24.58	24.38	23.16	26.63	
93562	TC	13.33	12.66	14.56	14.63	13.90	15.99	16.20	15.39	17.70	
93571		265.85	252.56	290.44	281.72	267.63	307.77	299.95	284.95	327.69	
93571	TC	174.20	165.49	190.31	187.53	178.15	204.87	202.81	192.67	221.57	
93602		152.91	145.26	167.05	160.75	152.71	175.62	170.12	161.61	185.85	
93602	TC	42.90	40.76	46.87	46.32	44.00	50.60	50.26	47.75	54.91	
93603		175.25	166.49	191.46	185.06	175.81	202.18	196.72	186.88	214.91	
93603	TC	65.13	61.87	71.15	70.36	66.84	76.87	76.41	72.59	83.48	
93609		363.02	344.87	396.60	381.07	362.02	416.32	402.47	382.35	439.70	
93609	TC	105.42	100.15	115.17	113.79	108.10	124.32	123.42	117.25	134.84	
93610		209.20	198.74	228.55	219.85	208.86	240.19	232.63	221.00	254.15	
93610	TC	52.89	50.25	57.79	57.29	54.43	62.59	62.39	59.27	68.16	
93612		219.42	208.45	239.72	230.93	219.38	252.29	244.71	232.47	267.34	
93612	TC	62.64	59.51	68.44	67.73	64.34	73.99	73.62	69.94	80.43	
93615		57.36	54.49	62.66	59.38	56.41	64.87	61.74	58.65	67.45	
93615	TC	12.36	11.74	13.50	13.35	12.68	14.58	14.47	13.75	15.81	
93618		372.47	353.85	406.93	392.79	373.15	429.12	416.73	395.89	455.27	
93618	TC	152.96	145.31	167.11	165.00	156.75	180.26	178.87	169.93	195.42	
93619		686.20	651.89	749.67	724.46	688.24	791.48	769.40	730.93	840.57	
93619	TC	297.61	282.73	325.14	321.08	305.03	350.78	348.12	330.71	380.32	
93620		1,564.39	1,486.17	1,709.10	1,654.23	1,571.52	1,807.25	1,727.31	1,640.94	1,887.08	
93620	TC	938.64	891.71	1,025.47	992.54	942.91	1,084.35	1,036.39	984.57	1,132.26	
93621		292.28	277.67	319.32	311.26	295.70	340.06	327.22	310.86	357.49	
93621	TC	175.37	166.60	191.59	186.77	177.43	204.04	196.33	186.51	214.49	
93622		485.61	461.33	530.53	539.76	512.77	589.69	591.09	561.54	645.77	
93622	TC	291.36	276.79	318.31	323.85	307.66	353.81	354.66	336.93	387.47	
93623		389.85	370.36	425.91	412.44	391.82	450.59	430.74	409.20	470.58	
93623	TC	233.91	222.21	255.54	247.47	235.10	270.37	258.45	245.53	282.36	
93624		335.82	319.03	366.88	351.87	334.28	384.42	370.91	352.36	405.21	
93624	TC	77.13	73.27	84.26	83.32	79.15	91.02	90.49	85.97	98.87	
93640		456.56	433.73	498.79	484.81	460.57	529.66	517.73	491.84	565.62	
93640	TC	276.33	262.51	301.89	297.90	283.01	325.46	322.71	306.57	352.56	
93641		581.50	552.43	635.29	614.47	583.75	671.31	653.11	620.45	713.52	
93641	TC	276.33	262.51	301.89	297.90	283.01	325.46	322.71	306.57	352.56	
93662		410.21	389.70	448.16	447.38	425.01	488.76	481.50	457.43	526.04	
93662	TC	246.13	233.82	268.89	268.43	255.01	293.26	288.91	274.46	315.63	

- These amounts apply when service is performed in a facility setting.
C - The payment for the technical component is capped at the OPPS amount.

2008 Carrier-Priced Fee Schedule Services, continued

		Localities 1 & 2			Locality 3			Locality 4			
Proc	Mod	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Par	Nonpar	Lmt Chg	Note
94642		27.64	26.26	30.20	30.12	28.61	32.90	31.58	30.00	34.50	
95824		92.06	87.46	100.58	103.24	98.08	112.79	108.40	102.98	118.43	
95824	TC	55.23	52.47	60.34	61.94	58.84	67.67	65.04	61.79	71.06	
95951		817.13	776.27	892.71	858.72	815.78	938.15	890.45	845.93	972.82	
95951	TC	490.27	465.76	535.62	515.23	489.47	562.89	534.28	507.57	583.71	
95965		1,054.12	1,001.41	1,151.62	1,103.65	1,048.47	1,205.74	1,140.86	1,083.82	1,246.39	
95965	TC	632.48	600.86	690.99	662.19	629.08	723.44	684.52	650.29	747.83	
95966		537.15	510.29	586.83	566.61	538.28	619.02	590.19	560.68	644.78	
95966	TC	322.29	306.18	352.11	339.97	322.97	371.42	354.10	336.40	386.86	
95967		471.52	447.94	515.13	498.02	473.12	544.09	519.43	493.46	567.48	
95967	TC	282.92	268.77	309.09	298.81	283.87	326.45	311.66	296.08	340.49	
99082		2.00	1.90	2.19	2.00	1.90	2.19	2.00	1.90	2.19	
99143		49.10	46.65	53.65	52.82	50.18	57.71	56.31	53.49	61.51	
99144		49.10	46.65	53.65	52.82	50.18	57.71	56.31	53.49	61.51	
99145		21.92	20.82	23.94	23.74	22.55	25.93	25.45	24.18	27.81	
99148		49.10	46.65	53.65	52.82	50.18	57.71	56.31	53.49	61.51	
99149		49.10	46.65	53.65	52.82	50.18	57.71	56.31	53.49	61.51	
99150		21.92	20.82	23.94	23.74	22.55	25.93	25.45	24.18	27.81	

- These amounts apply when service is performed in a facility setting.
C - The payment for the technical component is capped at the OPPS amount.

Source: Publication 100-04, Transmittal 312, Change Request 5944

Medicare Physician Fee Schedule Database Indicators

The following information provides definitions of the national policy indicators for each procedure code (and modifier, where applicable) on the Medicare physician fee schedule database (MPFSDB). Use this in conjunction with the Medicare Physician Fee Schedule - National Searchable Database located at *http://www.cms.hhs.gov/PFSlookup/* on the CMS Web site.

Procedure Code (PROC)

The *CPT* or HCPCS procedure code.

Modifier (MOD)

For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:

26 = Professional component
TC = Technical component

For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of *CPT* modifier *53*, which indicates that separate Relative Value Units (RVUs) and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy code *45378* and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier *53* are subject to carrier medical review and priced by individual consideration.

53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Code Status (STATUS)

Provides the fee schedule status of each code.

A= Active code. These codes are separately paid under the physician fee schedule if covered. There will be relative value units (RVUs) and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B= Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C= Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

D*= Deleted/discontinued codes.

*Codes with these indicators had a 90-day grace period before January 1, 2005.

Medicare Physician Fee Schedule Database Indicators, continued

E =Excluded from physician fee schedule by regulation. These codes are for items and/or services that the Centers for Medicare & Medicaid Services (CMS) chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F =Deleted/discontinued codes. (Code not subject to a 90 day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

G =Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

H* =Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the data base with the H status.

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

J =Anesthesia services (no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia services.)

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

M =Measurement codes, used for reporting purposes only.

N =Noncovered service. These codes are carried on HCPCS as noncovered services.

P =Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule.
If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service).
If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.

R =Restricted coverage. Special coverage instructions apply.

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

*Codes with these indicators had a 90-day grace period before January 1, 2005.

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

Facility Pricing

Codes that have reduced fees when performed in a facility setting. Facility fees are calculated at a national level with a reduced practice expense, because of reduced physician overhead associated with services provided in a facility.

Place of service codes to be used to identify facilities:

21 inpatient hospital
22 outpatient hospital
23 emergency room
24 ambulatory surgical center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC
26 military treatment facility
31 skilled nursing facility
34 hospice
41 ambulance - land
42 ambulance air or water
51 inpatient psychiatric facility
52 psychiatric facility partial hospitalization
53 community mental health center
56 psychiatric residential treatment facility
61 comprehensive inpatient rehabilitation facility

Professional Component/Technical Component Indicator (PC/TC)

0 =Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers *26* and *TC* cannot be used with these codes. The total RVUs include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

1 =Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests (e.g., pulmonary function tests), or therapeutic radiology procedures (e.g., radiation therapy). These codes generally have both a professional and technical component. Modifiers *26* and *TC* can be used with these codes.
The total RVUs for codes reported with modifier *26* include values for physician work, practice expense, and malpractice expense.
The total RVUs for codes reported with modifier *TC* include values for practice expense and malpractice expense only.
The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.

2 =Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component

Medicare Physician Fee Schedule Database Indicators, continued

of the diagnostic test only and another associated code that describes the global test.

An example of a professional component only code is *93010, Electrocardiogram; interpretation and report*. Modifiers *26* and *TC* cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 =Technical component only codes: This indicator identifies stand-alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.

An example of a technical component code is *93005, Electrocardiogram, tracing only, without interpretation and report*. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers *26* and *TC* cannot be used with these codes.

The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

4 =Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers *26* and *TC* cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

5 =Incident to codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision.

Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers *26* and *TC* cannot be used with these codes.

6 =Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier *TC* cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.

7 =Physical therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist.

8 =Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code *85060*. No *TC* billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.

No payment is recognized for code *85060* furnished to hospital outpatients or non- hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 =Concept of a professional/technical component does not apply.

Global Surgery (GLOBAL)

Provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

000 =Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.
010 =Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.
090 =Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.
MMM =Maternity codes; usual global period does not apply.
XXX =Global concept does not apply
YYY =Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.
ZZZ =Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

Preoperative, Intraoperative, and Postoperative Percentages

- Preoperative percentage (**PRE OP**) - modifier *56*
- Provides the percentage for the preoperative portion of the global package.
- Intraoperative percentage (**INTRA OP**) - modifier *54*
- Provides the percentage for the intraoperative portion of the global package including postoperative work in the hospital.
- Postoperative percentage (**POST OP**) - modifier *55*
  Provides the percentage for the postoperative portion of the global package that is provided in the office after discharge from the hospital.
  The total of preoperative, intraoperative, and postoperative percentages will usually equal one. Any variance is slight and results from rounding.

Multiple Procedure (M/S) - Modifier *51*

Indicates which payment adjustment rule for multiple procedures applies to the service.

0 =No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.
1 =Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996

Medicare Physician Fee Schedule Database Indicators, continued

MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

2 =Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

3 =Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure).

Multiple endoscopy rules are applied to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).

If an endoscopic procedure is reported with only its base procedure, carriers do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.
(See Endoscopic Base Codes, below)

4 =Subject to 25 percent reduction of the *TC* diagnostic imaging (**effective for services January 1, 2006, and after**)

9 =Concept does not apply.

Bilateral Surgery (B/S) - Modifier *50*

Provides an indicator for services subject to a payment adjustment.

0 =150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier *50* or with modifiers *RT* and *LT*, base payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-*LT* with an actual charge of $100 and XXXXX-*RT* with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).
The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 =150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with modifiers *RT* and *LT* or with a 2 in the units field), base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.

2 =150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with modifiers *RT* and *LT* with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-*LT* with an actual charge of $100 and YYYYY-*RT* with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).
The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

3 =The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (e.g., with modifiers *RT* and *LT* or with a 2 in the units field), base payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules.
Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

9 =Concept does not apply.

Assistant at Surgery (A/S)

Provides an indicator for services where an assistant at surgery is never paid for per IOM (CMS Internet-Only Manual).

0 =Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 =Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.

2 =Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.

9 =Concept does not apply.

Medicare Physician Fee Schedule Database Indicators, continued

Co-Surgeons (CO) - Modifier *62*

Provides an indicator for services for which two surgeons, each in a different specialty, may be paid.
0 =Co-surgeons not permitted for this procedure.

1 =Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.

2 =Co-surgeons permitted; no documentation required if two specialty requirements are met.

9 =Concept does not apply.

Team Surgeons (TEAM) - Modifier *66*

Provides an indicator for services for which team surgeons may be paid.

0 =Team surgeons not permitted for this procedure.

1 =Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report.

2 =Team surgeons permitted; pay by report.

9 =Concept does not apply.

Physician Supervision of Diagnostic Procedures (SUPV DX)

Provides levels of physician supervision required for diagnostic tests payable under the physician fee schedule.

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

01 =Procedure must be performed under the general supervision of a physician.

02 =Procedure must be performed under the direct supervision of a physician.

03 =Procedure must be performed under the personal supervision of a physician.

04 =Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.

05 =Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.

06 =Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under state law.

21 =Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.

22 =May be performed by a technician with on-line real-time contact with physician.

66 =May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.

6A =Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.

77 =Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.

7A =Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.

09 =Concept does not apply.

Endoscopic Base Codes

Identifies an endoscopic base code for each code with a multiple surgery indicator of **3**.

Diagnostic Imaging Family Indicator

01 =Family 1 Ultrasound (Chest/Abdomen/Pelvis – Non Obstetrical

02 =Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)

03 =Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)

04 =Family 4 MRI and MRA (Chest/Abd/Pelvis)

05 =Family 5 MRI and MRA (Head/Brain/Neck)

06 =Family 6 MRI and MRA (spine)

07 =Family 7 CT (spine)

08 =Family 8 MRI and MRA (lower extremeties)

09 =Family 9 CT and CTA (lower extremeties)

10 =Family 10 Mr and MRI (upper extremeties and joints)

11 =Family 11 CT and CTA (upper extremeties)

Imaging Cap Indicator

1 =subject to OPPS payment cap

9 =not subject OPPS payment cap

Source: CMS Pub 100-04, CR 5774, Transmittal 1358

PULMONARY SERVICES

Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases

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

Provider Types Affected

Providers and suppliers who bill Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], carriers, Medicare administrative contractors [A/B MAC], and durable medical equipment administrative contractors [DME MAC] for nebulized beta adrenergic agonist therapy services for lung diseases.

What You Need to Know

Change request (CR) 5820, from which this article is taken, provides that (effective September 10, 2007) no national coverage determination (NCD) for nebulized beta adrenergic agonist therapy for lung diseases is appropriate. Therefore, you should make sure that your billing staffs are aware that local contractors will continue to make section 1862(a)(1)(A) reasonable and necessary decisions through a local coverage determination process or case-by-case adjudication.

Note: No changes to process or policy are being made with CR 5820.

Background

Lung diseases such as chronic obstructive pulmonary disease (COPD) and asthma are characterized by airflow limitation that may be partially or completely reversible. Pharmacologic treatment with bronchodilators (intended to improve the movement of air into and from the lungs by relaxing and dilating the bronchial passageways) is used to prevent and/or control daily symptoms that may cause disability for persons with these diseases.

Beta adrenergic agonists (which can be administered via nebulizer, metered dose inhaler, orally, or dry powdered inhaler) are a commonly prescribed class of bronchodilator drug. For example, nebulized beta adrenergic agonist with racemic albuterol has been used for many years, and more recently, levalbuterol, the (R) enantiomer of racemic albuterol, has been used in some patient populations.

Because of concerns regarding the appropriate use of nebulized beta adrenergic agonist therapy for lung disease, the Centers for Medicare & Medicaid Services (CMS) internally generated a formal request for a national coverage determination (NCD) to determine when treatment with a nebulized beta adrenergic agonist is reasonable and necessary for Medicare beneficiaries with COPD.

The examination of the published medical evidence did not provide sufficient information that would enable CMS to define, at this time, specific populations of patients who would benefit from a particular treatment with particular medications. Moreover, because an NCD is defined, in part, as including "whether or not a particular item or service is covered nationally" under title XVIII, sections 1862(l), 1869(f)(1)(B); CMS does not believe a national policy is possible or prudent at this time.

Therefore, effective with dates of service on and after September 10, 2007, Medicare contractors will continue to make 1862(a)(1)(A) reasonable and necessary decisions and process claims for nebulized beta adrenergic agonist therapy for lung disease through their local coverage determination process or case-by-case adjudication.

Note: No changes to process or policy are being made with CR 5820.

Additional Information

You may find the official instruction, CR 5820, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R79NCD.pdf* on the CMS Web site. You will find the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations, Section 200.2 - Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases – (Effective September 10, 2007) as an attachment to that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5820
Related Change Request (CR) #: 5820
Related CR Release Date: December 21, 2007
Effective Date: September 10, 2007
Related CR Transmittal #: R79NCD
Implementation Date: January 22, 2008

RADIOLOGY

Mammography: Change Certification-Based Action from Return to Provider/Return as Unprocessable to Denial

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the January 2008 Medicare B Update! pages 39-41.

Note: This article was revised on January 15, 2008, to correct the RA reason code for carriers/B MACs for claims that contain a film mammography HCPCS code and the facility is certified for digital mammography only. The correct RA code is 171 and not B6 as previously stated. All other information remains unchanged.

Provider Types Affected

Providers who bill Medicare fiscal intermediaries, carriers, and Part A/B Medicare administrative contractors (MACs) for mammography services

What You Need to Know

Change request (CR) 5577, from which this article is taken, instructs FIs, carriers and A/B MACs to deny claims for mammography services (rather than returning them as unprocessable[RUC]) if the appropriate Food and Drug Administration (FDA) certification status is not listed on the FDA-created, CMS-supplied, Mammography Quality Standard Act (MQSA) data file.

You should make sure that your billing staffs list the FDA certification status as required.

Background

Depending on which contractor you bill, FIs and A/B MACs return to provider (RTP), and carriers or A/B MACs RUC, claims for mammography services when:

- A film mammography Healthcare Common Procedure Coding System (HCPCS) code is submitted on a claim, and the facility is Food and Drug Administration (FDA)-certified for only digital mammography
- A digital mammography HCPCS code is submitted on a claim, and the facility is FDA certified for only film mammography
- Either a film or digital mammography HCPCS code is submitted (*carriers/B MACs only*) on a claim and there is no FDA certification number on the claim's Mammography Quality Standard Act (MQSA) data file.

In order to ensure that the facility has a right to appeal an inappropriate denial based on the status of its FDA certification, CR 5577, from which this article is taken, instructs Medicare FIs, carriers and A/B MACs to deny all claims for screening or diagnostic mammography services (rather than return them to the provider, or RUC to the supplier), if the appropriate FDA certification status is not listed on the claim. Please note, however, that carriers/B MACs will continue to RUC the claim if the facility's FDA-assigned certification number is missing from the claim.

The MQSA requires that all facilities providing mammography services meet national quality standards, and provides the specific standards for those qualified to perform screening and diagnostic mammograms and how they should be certified.

The FDA Center for Devices and Radiological Health is responsible for collecting certificate fees and surveying mammography facilities; and effective October 1, 1994, all facilities that provide screening and mammography services (except those in the Veterans Administration) must have an FDA-issued certificate to continue to operate.

In addition, Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000 provided new payment methodologies for both diagnostic and screening mammograms that use digital technology. Medicare pays for film mammography and digital mammography at different rates, and moreover, pays for a service only if the provider or supplier is certified by the Food and Drug Administration (FDA) to perform those types of mammograms for which payment is sought.

Medicare determines whether the mammography facility is certified to perform the mammography services billed by using data that the FDA sends to CMS on a weekly basis. This information indicates whether a mammography facility is certified to perform digital mammography.

To verify that the facility is certified by the FDA to perform mammography services, carriers/B MACs match the supplier's (i.e., independent facility) mammography certification number submitted on the claim to the 6-digit FDA-assigned certification number appearing on the file for the billing facility (in item 32 of the Form CMS-1500 for paper claims, or in the 2400 loop (REF02 segment, where 01=EW segment) of the ASC X12 837 professional claim format, version 4010A1, for electronic claims). If the facility's FDA-assigned 6-digit number is not on the claim, the carrier/B MAC will RUC the claim using remittance reason code 16 (Claim/service lacks information which is needed for adjudication.) and remark code MA128 (Missing/incomplete/invalid FDA approval number.).

Intermediaries/A MACs identify the facility using the provider number submitted on the claim and use the certification data contained on the MQSA file. In addition, both intermediaries/A MACs and carriers/B MACs look for the film indicator (designated by "1") or the digital indicator (designated by "2") on the MQSA file to verify the type of mammography (film and/or digital) that the facility is certified to perform.

Therefore, effective April 1, 2008:

- FIs/A MACs will verify that the provider number on the claim corresponds with a certified mammography facility on the MQSA file, and if it does not, they will deny the claim. In denying these claims submitted by providers not listed as certified facilities on the MQSA file, the Medicare contractor will use:

Mammography: Change Certification-Based Action from RTP/RUC to Denial, continued

  - Medicare summary notice (MSN) message 16.2 (This service cannot be paid when provided in this location/facility)
  - Remittance advice (RA) reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service) and
  - RA remark code N110 (This facility is not certified for film mammography).
- Carriers/B MACs will verify that the FDA-assigned, 6-digit mammography certification number on the claim corresponds to the FDA mammography certification number appearing on the billing facility's file. They will deny the claim if:
  - The facility's certification number submitted on the claim does not match the certification number on the MQSA file
  - The facility certification number on the claim matches the facility certification number on the MQSA file, but the facility name reported on the claim does not match the facility name on the MQSA file
  - The facility certification number reported on the claim matches the facility certification number on the MQSA file, but the facility address reported on the claim does not match the facility address on the MQSA file.
- In denying the claim because of an invalid facility certification number, they will use MSN message 9.4 (This item or service was denied because information required to make payment is missing); and RA reason code 125 (Payment adjusted due to a submission/billing error(s).) and remark code MA128 (Missing/incomplete/invalid FDA-approval number).

Further, Medicare contractors will use the FDA certification data to verify that the billing facility is eligible to bill for the type of mammography service submitted on the claim.

They will deny the claim if the facility is not certified by the FDA to perform such service (if the HCPCS code on the claim, for either film or digital mammogram, does not match the type of certification indicated on the MQSA file).

In denying these claims because the facility is not certified by the FDA to perform either a screening or diagnostic mammography service, Medicare contractors will use:

- MSN 16.2 (This service cannot be paid when provided in this location/facility)
- RA reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service)
- Remark code N110 (This facility is not certified for film mammography).

They will deny the claim if it contains a film mammography HCPCS code and the facility is certified for digital mammography only. In denying these claims because the facility is not certified to perform film mammography, they will use MSN message MSN 16.2. In this instance, carriers/B MACs will use RA reason code 171 (Payment is denied when performed/billed by this type of provider in this type of facility) and remark code N110 and FIs/A MACs will use reason code B7.

Similarly, Medicare contractors will deny the claim if it contains a digital mammography HCPCS code and the facility is certified for film mammography only. In denying these claims because the facility is not certified to perform digital mammography, they will again use MSN message 16.2. In this instance:

- Carriers/B MACs will use:
  - RA reason code 171 (Payment is denied when performed/billed by this type of provider in this type of facility)
  - Remark code N92 (This facility is not certified for digital mammography).
- FIs/A MACs will use reason code B7
- Carriers/B MACs will continue to use the MQSA file to verify the facility's FDA-assigned 6-digit certification number submitted on the claim, and will RUC the claim to the supplier if it does not contain the facility's certification number.

Additional Information

You may find the official instruction, CR 5577, issued to your carrier, FI, or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1387CP.pdf* on the CMS Web site. Additionally, you can find the revised sections of the *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 20.2 (HCPCS and Diagnosis Codes for Mammography Services) as an attachment to CR 5577.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5577 *Revised*
Related Change Request (CR) #: 5577
Related CR Release Date: December 7, 2007
Effective Date: April 1, 2008
Related CR Transmittal #: R1387CP
Implementation Date: April 7, 2008

2008 Portable X-ray Transportation Allowances

Carriers are required to update the rates for portable X-ray transportation allowances on an annual basis using independently determined measures of the cost of providing this service. A number of readily measured indicators (e.g., ambulance inflation factor, the Medicare economic index) that are used by the Medicare program to adjust payment rates for other types of services may be appropriate to use to update the rate for years that the carrier does not re-evaluate the payment. Each carrier has the flexibility to identify the index it will use to update this rate. In addition, the carrier can consider locally identified factors that are measured independently of the Centers for Medicare & Medicaid Services (CMS) as an adjunct to the annual adjustment. First Coast Service Options, Inc. utilized the ambulance inflation factor of 2.7 percent as outlined in the CMS change request 5801, transmittal 1375 dated November 9, 2007, in determining the payment limit on claims for portable X-ray transportation services with dates of service on or after January 1, 2008.

HCPCS Code	Allowance
R0070	$168.25
R0075	$168.25

Source: Pub 100-04, Transmittal 1375, Change Request 5801

2008 Radiopharmaceutical Pricing

The Medicare Modernization Act (MMA), Section 303(h), states that for dates of service on or after January 1, 2005, radiopharmaceutical payment allowance limits are not subject to average sale price (ASP). The prices First Coast Service Options, Inc. (FCSO) will use, effective for claims with dates of service on or after January 1, 2008, are listed below. Whenever possible FCSO uses 92 percent of the lowest average wholesale price (AWP) for the most current year's Redbook.

A valid invoice will be required for radiopharmaceuticals that have no established pricing and/or no specific HCPCS code. A valid invoice must be patient specific, containing the patient's name in printed fashion. Patient's names written on the invoice are not acceptable. In instances where this is not possible, the invoice will be considered valid if accompanied by a patients specific medical note or written order for the radiopharmaceutical. (Note: Electronic claim submissions will be developed to request this information.) The invoice date should be within 30 days of, but no more than 45 days after the date of service. The invoice must be maintained in the patients' medical record and the invoice and/or medical record must contain all of the, following information:

- Name of the radiopharmaceutical
- Dosage being administered
- Unit price per dose
- Total cost of radiopharmaceutical
- Date radiopharmaceutical was administered

HCPCS Code	Description	2008 Allowance
A4642	Indium In-111 satumomab pendetide, diagnostic, per study dose up to 6 millicuries	Invoice
A9500*	Technetium TC-99m sestamibi, diagnostic, per study dose up to 40 millicuries	$117.85
A9501	Technetium TC-99m Teboroxime, diagnostic, per study dose	Invoice
A9502*	Technetium TC-99m Tetrofosmin, diagnostic, per study dose up to 40 millicuries	$117.23
A9503*	Technetium TC-99m medronate, diagnostic, per study dose up to 30 millicuries	$36.59
A9504*	Technetium TC-99m apcitide, diagnostic, per study dose up to 20 millicuries	Invoice
A9505*	Thallium Ti-201 thallous chloride, diagnostic per millicuries	$32.18
A9507*	Indium In-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries	$3,456.08
A9508*	Iodine I-31 iobenguane sulfate, diagnostic per 0.5 millicuries	$1,283.40
A9509	Iodine I-123 Sodium Iodide, diagnostic, per millicurie	Invoice
A9510*	Technetium TC-99m disofenin, diagnostic, per study dose up to 15 millicuries	$42.32
A9512	Technetium TC-99m pertechnetate, diagnostic, per millicuries	Invoice
A9516	Iodine I-123 sodium iodide capsule(s), diagnostic per 100 microcuries up to 999 microcuries	$100.20
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic per millicuries	$195.50

2008 Radiopharmaceutical Pricing, continued

HCPCS Code	Description	2008 Allowance
A9521	Technetium TC-99m exametazine, diagnostic, per study dose, up to 25 millicuries	$549.68
A9524	Iodine I-131 iodinated serum albumin, diagnostic, per 5 microcuries	$57.22
A9526	Nitrogen N-13 ammonia, diagnostic, per study dose, up to 40 millicuries	Invoice
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicuries	Invoice
A9528	Iodine I-131 sodium iodide capsules(s), diagnostic, per millicuries	Invoice
A9529	Iodine I-131 sodium iodide solution, diagnostic, per millicuries	Invoice
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicuries	Invoice
A9531	Iodine I-131 sodium iodide diagnostic per microcuries, up to 100 microcuries	Invoice
A9532	Iodine I-125 serum albumin, diagnostic per 5 microcuries	Invoice
A9535	Injection, methylene blue, 1ml	$4.36
A9536	Technetium TC-99m depreotide, diagnostic, per study dose up to 35 millicuries	$736.00
A9537	Technetium TC-99m mebrofenin, diagnostic, per study dose up to 15 millicuries	$61.05
A9538	Technetium TC-99m pyrophosphate, diagnostic, per study dose up to 25 millicuries	$39.52
A9539	Technetium TC-99m pentetate, diagnostic, per study dose up to 25 millicuries	$15.73
A9540	Technetium TC-99m macroaggregated albumin, diagnostic, per study dose up to 10 millicuries	$21.16
A9541	Technetium TC-99m sulfur colloid, diagnostic, per study dose up to 20 millicuries	$42.32
A9542	Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries	$2,682.17
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	$23,219.74
A9544	Iodine I –131 tositumomab, diagnostic, per study dose	$2,558.52
A9545	Iodine I –131 tositumomab, therapeutic, per treatment dose	$22,173.84
A9546	Cobalt Co-57/58 cyanocobalamin, diagnostic, per study dose, up to 1 microcuries	Invoice
A9547	Indium In- 111 oxyquinoline, diagnostic, per 0.5 millicuries	$564.80
A9548	Indium In- 111 pentetate, diagnostic, per 0.5 millicuries	$790.85
A9550	Technetium TC-99m sodium gluceptate, diagnostic, per study dose up to 25 millicuries	Invoice
A9551	Technetium TC-99m succimer diagnostic, per study dose up to 10 millicuries	$122.63
A9552	Fluorodeoxyglucose F-18 FDG, diagnostic per study dose, up to 45 millicuries	$220.80
A9553	Chromium Cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries	$50.84
A9554	Iodine I-125 sodium iothalamate, diagnostic, per study dose, up to 10 microcuries	Invoice
A9555	Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries	$400.00
A9556	Gallium Ga-67 citrate, diagnostic, per millicuries	Invoice
A9557	Technetium TC-99m bicisate, diagnostic, per study dose up to 25 millicuries	$410.79
A9558	Xenon Xe- 133 gas, diagnostic per 10 millicuries	Invoice
A9559	Cobalt Co-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcuries	$80.88
A9560	Technetium TC-99m labeled red blood cells, diagnostic, per study dose	$103.11

*Nonpar reduction will apply

THERAPY SERVICES

Outpatient Therapy Caps with Exceptions Start January 1, 2008

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

Provider Types Affected

Therapists and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], or Medicare administrative contractors [A/B MAC]) for therapy services for Medicare beneficiaries.

Provider Action Needed

Change request (CR) 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008, and clarifies the *Medicare Claims Processing Manual* regarding exceptions to outpatient therapy services.

On January 1, 2008, the financial limits on outpatient therapy services will be $1,810 for combined physical therapy and speech-language pathology services; and $1,810 for occupational therapy services.

You should make sure that your billing staffs are aware of these new outpatient therapy caps. You might also want to refer to the updated *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation), for the complete documentation of the outpatient therapy services exceptions clarifications (which are summarized below). The complete revised manual sections are attached to CR 5871, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1414CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Background

The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital services. The 2006 Deficit Reduction Act enacted exceptions to the limits, and the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the cap exceptions process through June 30, 2008. The dollar amount of the cap is updated annually in accordance with the Medicare Economic Index.

CR 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008. Effective January 1, 2008, the financial limits on outpatient therapy services will be $1,810 for combined physical therapy and speech-language pathology services; and $1,810 for occupational therapy services. Exceptions are allowed for medically necessary outpatient therapy services.

The financial limits on outpatient therapy services over the last three years are displayed in Table 1.

Table 1
Financial Limits on Outpatient Therapy Services*

Year	Physical Therapy and Speech Language Pathology Combined	Occupational Therapy
2008	$1,810	$1,810
2007	$1,780	$1,780
2006	$1,740	$1,740

Note: Medicare pays up to 80 percent of the limits after the deductible has been met.

The Medicare summary notice (MSN) message 38.18 has been updated to read: ALERT: Coverage by Medicare is limited to $1,780 in 2007 and $1,810 in 2008 for outpatient physical therapy and speech-language pathology combined. Occupational therapy services have the same limits. Medicare pays up to 80 percent of the limits after the deductible has been met. Exceptions to these limits apply to therapy billed by hospital outpatient departments and may also apply to medically necessary services.

CR 5871 also clarifies the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation), regarding exceptions to outpatient therapy services (except when billed by outpatient hospitals). A summary of the major manual clarifications follows:

1. Section 10.2, Subsection B. Moratoria and Exceptions for Therapy Claims

Future exceptions language added as follows:

The cap exception for therapy services billed by outpatient hospitals was part of the original legislation (Balanced Budget Act of 1997), and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions, as they did for 2007 and as they again extended through June 30, 2008, as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Outpatient Therapy Caps With Exceptions Start January 1, 2008, continued

2. Section 10.2, Subsection C-1 Exceptions to Therapy Caps – General

When the exceptions process (as directed by legislation) is in effect the policies in this section apply. Further, with the exception of the use of the KX modifier, the guidance in this section applies to all therapy services addressed by this section.

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps.

3. Section 10.2, Subsection C-2 Automatic Process Exceptions

Beginning January 1, 2007, all exceptions are processed automatically. You should be aware that the term "automatic process exceptions" indicates that the claims processing for the exception is automatic, and not that the exception, itself, is automatic.

In making a decision about whether to utilize the automatic process for exception, clinicians should consider, (among other considerations) whether services are appropriate to the patient's condition including the diagnosis, complexities and severity You should be aware that the list of the ICD-9 codes (for conditions and complexities that might qualify a beneficiary for exception to caps) that is found in the table in subsection 10.2 C-3 is only a guideline; and neither assures that services on the list will be excepted, nor limits the provision of covered and medically necessary services for conditions that are not on the list.

Not all patients who have a condition or complexity on the ICD-9 code list are "automatically" excepted from therapy caps. You should see the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), section 230.3 (Practice of Speech-Language Pathology) for documenting the patient's condition and complexities. Note that Medicare contractors may scrutinize claims from providers whose services exceed caps more frequently than is typical. Further guidance on billing therapy services are found in the local coverage determinations (LCDs) of some contractors.

4. Subsection C-3. ICD-9 Codes That are Likely to Qualify for the Automatic Process Therapy Cap Exception Based Upon Clinical Condition or Complexity

Some Medicare contractors' LCDs do not allow the use of some of the codes on the list in this Subsection to be in the primary diagnosis position on a claim. If your contractor has determined that these codes do not characterize patients who require medically necessary services, you may not use these codes. Rather, to describe the patient's condition, you must use a billable diagnosis code that your contractor allows.

Medicare will apply therapy caps to services based on the medical necessity of the service for the patient's condition, not on the condition itself. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.

You may use the automatic process for exception for medically necessary services when the patient has a billable condition that is not on the list in this subsection. The diagnosis on this list may be put in a secondary position on the claim and/or in the medical records, as your contractor directs.

Additional Information

You may find more information about the outpatient therapy caps for 2008, and the *Medicare Claims Processing Manual* clarifications regarding exceptions to outpatient therapy services by going to CR 5871, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1414CP.pdf* on the CMS Web site. The updated *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation) is an attachment to that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5871
Related Change Request (CR) #: 5871
Related CR Release Date: January 10, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1414CP
Implementation Date: January 25, 2008

Outpatient Therapy Cap Financial Limitation Revision

Effective January 1, 2008, the financial limits on outpatient therapy services has been revised. The new amounts are:

Combine physical therapy and speech-language pathology - $1,810
Occupational therapy - $1,810

Notice of Exclusion from Medicare Benefits Form

It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and that, where necessary, appropriate care above the limits may be obtained at a hospital outpatient therapy department. Although use of the Notice of Exclusion from Medicare Benefits (NEMB) form is not a Medicare requirement, it is encouraged. Providers may use the NEMB (No. CMS 20007 & Formulario No. CMS 20007) form, or a similar form of their own design to inform beneficiaries of the therapy financial limitation and the cap exclusion process. The NEMB form may be found at: *http://www.cms.hhs.gov/BNI/11_FFSNEMBGeneral.asp#TopOfPage* on the CMS Web site.

Additional Information

Additional information is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5871.pdf*

Source: Publication 100-04, Chapter 5, Section 10.2

GENERAL COVERAGE

The Importance of Billing the Correct Place of Service

Physicians are required to report the place of service (POS) on the health insurance claim forms that they submit to Medicare Part B carriers. The place of service code is used to identify where the procedure is furnished. Physicians are paid for services according to the Medicare physician fee schedule. This schedule is based on a payment system that includes three major categories that drive the reimbursement for physician services:

- practice expense*
- physician work
- malpractice insurance

*** It's important for you to know that the practice expense reflects the overhead costs involved when providing a service.**

In order to account for the increased practice expense that physicians incur by performing services in their offices, Medicare reimburses physicians a higher amount for services performed in their offices (POS code 11) rather than in an outpatient hospital (POS 22-23) or an ASC (POS code 24).

Therefore, it's important for you to know, that the POS also plays a factor in the reimbursement.

The place of service code is entered in Item 24B on the CMS-1500 form or the electronic equivalent. This is a required field. Always ensure you are using the correct place of service code, which identifies the service location, for each item used or service performed and billed on the claim.

Medicare claim form instructions specifically state that each provider or practitioner is responsible for becoming familiar with Medicare coverage and billing requirements. Some physician offices submit their own claims to Medicare carriers; other offices hire billing services to submit their claims. Physicians are responsible for all Medicare payments generated regardless of your claim submission choice (electronic or paper).

First Coast Service Options, Inc. is stressing to physicians and their billing agents the importance of reporting the correct place of service code. For example, billing physician's office (POS 11) for a minor surgical procedure that is actually performed in a hospital outpatient department (POS 22) and collecting a higher payment is inappropriate billing and could be viewed as program abuse.

Therefore, it is imperative that you have internal control systems to prevent Medicare billings with incorrect place of service codes.

Place of Service Codes for Professional Claims

Listed below are place of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. Check the CMS Web site for revisions to this listing frequently and validate you are referring to the most current version. Refer to "Helpful Links" below.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.

The Importance of Billing the Correct Place of Service, continued

Place of Service Code(s)	Place of Service Name	Place of Service Description
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison- Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders (effective 7/1/06).
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code (Effective 04/01/08.).
17-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.

The Importance of Billing the Correct Place of Service, continued

Place of Service Code(s)	Place of Service Name	Place of Service Description
26	Military Treatment Facility	A medical facility operated by one or more of the uniformed services. military treatment facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only (effective 10/1/03).
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility- Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

The Importance of Billing the Correct Place of Service, continued

Place of Service Code(s)	Place of Service Name	Place of Service Description
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location, which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03) .
58/59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63/64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician (effective 10/1/03).
72	Rural Health Clinic	A certified facility, which is located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

Helpful Links

A complete set of the national POS code set and instructions is provided via the links below: *http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf* on the CMS Web site. Additional information is also available at *http://www.cms.hhs.gov/PlaceofServiceCodes/03_POSDatabase.asp#TopOfPage* on the CMS Web site.

Source: Publication 100-04, Chapter 26, Section 10.5

New Healthcare Common Procedure Coding System Modifiers when Billing for Patient Care in Clinical Research Studies

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], Medicare administrative contractors [A/B MACs] and durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries in clinical research studies.

What Providers Need to Know

This article is based on change request (CR) 5805. The Centers for Medicare & Medicaid Services (CMS) is discontinuing the Healthcare Common Procedure Coding System (HCPCS) modifiers QA (FDA Investigational Device Exemption), QR (Item or Service Provided in a Medicare Specified Study), and QV (Item or Service Provided as Routine Care in a Medicare Qualifying Clinical Trial) as of December 31, 2007, and creating two new modifiers that will be used solely to differentiate between routine and investigational clinical services.

These new modifiers will be included in the 2008 Annual HCPCS Update and are effective for dates of service on and after January 1, 2008:

Q0 Investigational clinical service provided in a clinical research study that is in an approved clinical research study. Q0 replaces QA and QR.

Q1 Routine clinical service provided in a clinical research study that is in an approved clinical research study. Q1 replaces QV.

Use these two new modifiers as follows:

Investigational clinical services are defined as those items and services that are being investigated as an objective within the study. Investigational clinical services may include items or services that are approved, unapproved, or otherwise covered (or not covered) under Medicare.

Routine clinical services are defined as those items and services that are covered for Medicare beneficiaries outside of the clinical research study; are used for the direct patient management within the study; and, do not meet the definition of investigational clinical services. Routine clinical services may include items or services required solely for the provision of the investigational clinical services (e.g., administration of a chemotherapeutic agent), clinically appropriate monitoring, whether or not required by the investigational clinical service (e.g., blood tests to measure tumor markers), and items or services required for the prevention, diagnosis, or treatment of research related adverse events (e.g., blood levels of various parameters to measure kidney function).

Medicare contractors will not search their files to adjust affected claims processed prior to implementation of this change, but they will adjust such claims that you bring to their attention.

Note: If a Category A or B investigational device is used on the clinical trial, providers should continue to include the investigational device exemption (IDE) in item 23 of the CMS-1500 claim form or the electronic equivalent. Also, your Medicare contractor will validate the IDE# number when it appears on the claim with the modifier Q0 and the IDE# does not meet validation criteria, the claim will be returned as unprocessable.

Additional Information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

You may see the official instruction (CR 5805) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1418CP.pdf* on the CMS Web site.

MLN Matters Number: MM5805
Related Change Request (CR) #: 5805
Related CR Release Date: January 18, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1418CP
Implementation Date: April 7, 2008

ELECTRONIC DATA INTERCHANGE

Medicare Part B January Release Prepass Edit Notification—Update

Due to the high volume of new informational edits being received a decision was made to turn off the new informational edits previously posted. Those edits ranged from M393–M406 and M417–M429. Medicare strongly encourages all providers that are successfully submitting national provider identifier (NPIs) to start removing their "legacy" Medicare provider numbers and begin sending the national NPI only.

The following prepass edits are still active.

When a claim is received and the Entity Type Qualifier (NM102) contains a value of 2 indicating the entity type is a non-person entity (organization) and there are values in the First Name (NM104), Middle Name or Initial (NM105), and/or Suffix (NM107) elements, the claim will be **rejected**.

Provider	Loop	Prepass Edits	Level Edit
Receiver Loop	1000A	M407	file
Billing Provider Loop	2010AA	M408	batch
Pay-to Provider Loop	2010AB	M409	batch
Subscriber Loop	2010BA	M410	claim
Responsible Party Loop	2010BC	M411	claim
Claim Referring Provider	2310A	M412	claim
Claim Rendering Provider	2310B	M413	claim
Purchase Service Provider	2310C	M414	claim
Other Payer Subscriber Name	2330A	M415	claim
Detail Rendering Provider	2420A	M416	claim

Additional Information

For additional information related to these prepass edits, please contact Medicare EDI Transaction Support at:

Connecticut: 1-203-639-3160, option 6

Florida: 1-904-354-5977, option 4.

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 Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

GENERAL INFORMATION

Reminder—Mandatory Reporting of the National Provider Identifier on All Part B Claims

Effective March 1, 2008, your Medicare fee-for-service claims must include a national provider identifier (NPI) in the primary provider fields on the claim (i.e., the billing, pay-to provider, and rendering provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., referring, ordering and supervising) may continue to include only your legacy number, if you choose.

Failure to submit an NPI in the primary provider fields will result in your claim being rejected, beginning March 1, 2008.

In addition, if you already bill using the NPI/legacy pair in the primary provider fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI in the primary provider fields. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

Contact Information for Electronic Claims

For additional information regarding electronic claims, please contact Medicare EDI at:

Connecticut - 1-203-639-3160, option 6.

Florida - 1-904-354-5977, option 4.

Source: CMS Joint Signature Memorandum 08048, November 14, 2007

Compliance Date Enforcement and Clarification of Key NPI Implementation Dates

NPI Is Here. NPI Is Now. Are You Using It?

Industry-Wide Enforcement of the NPI Compliance Date

The compliance date for the national provider identifier (NPI) for all HIPAA covered entities except small health plans was May 23, 2007. (Small health plans have until May 23, 2008 to comply.) In guidance provided on April 2, 2007, the Centers for Medicare & Medicaid Centers (CMS) announced that, through May 23, 2008, it would not impose penalties on covered entities that deploy contingency plans to facilitate the compliance of their trading partners. **On May 24, 2008, CMS will lift its enforcement-leniency policy.** Complaints will be investigated as they are today, but penalties will be a legitimate resolution if the entity does not demonstrate compliance or corrective action. CMS will continue to employ a complaint-driven approach to enforcement. For example, if a complaint is received alleging a failure to comply with the NPI requirements, CMS will contact the entity to secure evidence of compliance and the contingency plan that had been in place. If violations are identified, enforcement actions will take place.

This notice does not prohibit covered entities from lifting contingency plans prior to May 24, 2008.

In sum, no later than May 24, 2008, all covered entities are expected to be using the NPI in a compliant manner, and all contingency plans should be lifted.

NPPES and the NPI Enumerator – Misconceptions and Facts

In conversations and correspondence with health care providers, health plans, and others within the health care industry, it is very clear that there are misconceptions concerning the National Plan and Provider Enumeration System (NPPES) and the NPI Enumerator. Below we have listed some common misconceptions and the facts that correct those misconceptions.

Misconception

NPPES sends data directly to the Medicare provider enrollment system.

Fact

NPPES **does not send** data to the Medicare provider enrollment system or to the provider enrollment system of any health plan. As explained in the NPI final rule, applying for enrollment in a health plan is a completely separate process from the process of applying for an NPI.

Misconception

NPPES sends data directly to the Medicare claim system.

Fact

NPPES does not send data to the Medicare claims system or to the claim system of any health plan. Medicare extracts certain NPPES data and uses those data in its Medicare NPI crosswalk. That crosswalk is used in processing Medicare Part A and Part B claims. Other health plans are also free to use NPPES data to help process their claims.

Compliance Date Enforcement and Clarification of Key NPI Implementation Dates, continued

Misconception

NPPES is part of the Medicare provider enrollment system.

Fact

Obtaining an NPI is required in order for a health care provider to enroll in Medicare; however, the NPPES does not function as a part of the Medicare provider enrollment system. Medicare requires a health care provider to have an NPI and to furnish that NPI on the Medicare provider enrollment application form (CMS-855). In addition, once a health care provider submits a CMS-855 to Medicare, Medicare compares the NPI and certain other information on the CMS-855 to certain information in that health care provider's record in NPPES. If the information being compared does not match, the health care provider must correct whichever information (NPPES or CMS-855) is incorrect in order for the enrollment process to continue.

Misconception

Obtaining an NPI guarantees payment to the health care provider by a health plan.

Fact

As explained in the NPI Final Rule, obtaining an NPI does not guarantee payment to the health care provider by Medicare or by any other health plan. NPI assignment simply establishes the uniqueness of an enumerated health care provider amongst all other enumerated health care providers. Most health plans will not pay a health care provider that is not enrolled in that health plan.

Misconception

NPPES verifies licenses and credentials that are reported by health care providers when applying for NPIs.

Fact

NPPES does not verify licenses or credentials. NPPES verifies only two things:
(1) It verifies a health care provider's social security number if the health care provider is an individual who furnished his/her SSN when applying for the NPI; and
(2) Using special software, it verifies that the health care provider's business mailing and practice location addresses are legitimate postal service addresses, but not that the health care provider is actually associated with or located at either of those addresses. Licensure and credentials must be verified by health plans as part of their enrollment processes. It is possible, under certain circumstances that the NPI Enumerator may contact health care providers who have submitted applications, updates, or deactivations to verify information that was furnished in order to properly process those actions. Health care providers are reminded that the information they send to NPPES must be true, correct, and complete, in accordance with the certification statement of the NPI Application/Update Form (paper form and Web-based form).

Misconception

NPPES is a Medicare system.

Fact

NPPES is not a Medicare system; it belongs to no health plan. It is maintained by CMS for the health care industry in general, in accordance with the NPI final rule and as part of CMS' delegated HIPAA authority. Health care providers who apply for NPIs are not required to furnish any information about their enrollment in any health plan. In an optional field, health care providers may report legacy identifiers that health plans have assigned to them in the past. This field, "Other Provider Identification Numbers," can capture the legacy identifiers and the issuers of those identifiers (i.e., the names of the health plans that assigned them). The information in this field is used by health plans to help them locate their enrolled providers in NPPES in order to know of their NPI assignments. For this reason, Medicare providers are urged to report their Medicare legacy identifiers in this field.

Misconception

The NPI Enumerator can update the Medicare claims and enrollment systems.

Fact

The NPI Enumerator cannot view, update, or interact with the Medicare claims or the Medicare enrollment systems, nor can it do so with any health plan's claims or enrollment systems.

Misconception

The NPI Enumerator can view and update/change the Medicare NPI crosswalk.

Fact

The NPI Enumerator cannot view or update/change the Medicare NPI crosswalk. The NPI Enumerator can assist providers with certain aspects of updating their NPPES records, and some of that information in those NPPES records could be used by Medicare in the Medicare NPI crosswalk.

Misconception

The NPI Enumerator serves Medicare providers and supports Medicare operations, not other providers or health plans.

Fact

The NPI Enumerator operates under contract to CMS in accordance with the NPI final rule and as part of CMS' delegated HIPAA authority. The NPI Enumerator serves the entire health care provider community for NPI purposes, not just Medicare providers. The functions of the NPI Enumerator are not specific to any health plan.

CMS has posted information that lists the specific duties and responsibilities of the NPI Enumerator in a recent MLN Matters article located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0751.pdf*.

An article that further clarifies the functions of NPPES and the NPI Enumerator is in development; this article will be announced once available.

Important Information for Medicare Providers

Medicare's Key Dates

There are two key dates remaining for 2008 in Medicare's NPI implementation plan. There is also some confusion as to the difference between the implementation steps for March 1st and May 23rd.

Compliance Date Enforcement and Clarification of Key NPI Implementation Dates, continued

The chart below indicates the implementation steps for each date; as well a new column to help further clarify the difference between these two dates.

Date	Implementation Steps	Key Point
March 1, 2008	• Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to, and rendering provider fields). • You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary provider fields. • Failure to submit an NPI in the primary provider fields will result in your claim being rejected or returned as unprocessable. • Until further notice, you may continue to include legacy identifiers only for the secondary provider fields.	**Claims with only legacy identifiers in the primary provider fields will be rejected.**
May 23, 2008	• In keeping with the Contingency Guidance issued on April 2, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims and SPR remittance advice. (Note that this date is one day earlier than that mandated by the National Enforcement Policy) • This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction. • CMS will also stop sending legacy identifiers on COB crossover claims at this time.	**If the claim contains a legacy identifier in any field, it will be rejected.**

Only Four Months Until May 23, 2008 – Test NPI-only Claims NOW

While Medicare is receiving well over 90 percent of claims containing an NPI in primary provider fields, there is a very small percent of claims submitted with NPI only. **Until you submit claims with an NPI-only, you will not have a preview of what your experience will be on May 23.** The time for correcting problems, should there be any, is getting short. CMS urges that **all** Medicare providers test **now** so that problems can be resolved prior to May 23rd. For example, if there is a problem that requires a change in your Medicare enrollment information, you will need to act immediately.

How to Test

After Medicare providers have submitted claims containing both NPIs and legacy identifiers and those claims have been paid, Medicare urges these providers to send a small batch of claims now with **only the NPI** in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch.

Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.

Remember, if you test and your claims are processed successfully, you can approach the May 23rd date with confidence. If you do not, you may face unanticipated cash flow problems.

Medicare DMEPOS Suppliers: If Your Claims Are Rejecting!

Medicare DMEPOS suppliers may be experiencing claims rejections if they did not obtain their NPIs properly, if they are not properly enrolled in Medicare, or both. For example, if a DMEPOS supplier who is a sole proprietorship enrolled with the national supplier clearinghouse (NSC) as an organization and furnished an employer identification number (EIN) instead of a social security number (SSN), but obtained a national provider identifier (NPI) as an entity type 1 - Individual, the Medicare NPI crosswalk will be unable to link that DMEPOS supplier's Medicare legacy identifier (the NSC number) to its NPI. This is because the NSC number and the NPI identify different entity types—one identifies an organization and the other an individual. When a linkage between a Medicare legacy identifier and an NPI used in a claim does not exist in the Medicare NPI crosswalk, the claim will reject. DMEPOS suppliers should contact the DME MAC if they do not understand the error message they received.

Compliance Date Enforcement and Clarification of Key NPI Implementation Dates, continued

If the rejection was due to the inability of the Medicare NPI crosswalk to link the NPI to the NSC number, the DMEPOS supplier should check the NPPES record to ensure the appropriate entity type (1 = Individual; or 2 = Organization) is reflected in that record. Individuals (including sole proprietorships) obtain NPIs as entity type 1. Organizations obtain NPIs as entity type 2. If the NPPES record shows the appropriate entity type, the DMEPOS supplier should contact the NSC to ensure the enrollment record is correct. If the NPPES record does not show the appropriate Entity type, the DMEPOS supplier needs to take action to ensure the appropriate entity type is selected. If assistance is necessary, the NPI Enumerator (1-800-465-3203) can explain to the DMEPOS supplier how this is done.

Once the NPPES record is correct, the DMEPOS supplier needs to ensure that it is properly enrolled in Medicare. The NSC, once contacted, will ask appropriate questions to determine if the DMEPOS supplier is, in fact, a sole proprietorship, and if so, properly reflected as such in the enrollment record.

The NSC will assist the DMEPOS suppliers in correcting their enrollment records.

DMEPOS suppliers who are sole proprietorships should be aware of the following:

- A DMEPOS supplier who is a sole proprietorship obtains an entity type 1 (Individual) NPI.
- When enrolling in Medicare (form CMS-855S) with the NSC, a DMEPOS supplier who is a sole proprietorship furnishes his/her SSN as the taxpayer identification number (TIN).
- The legal name of the sole proprietorship business is the sole proprietor's name.
- It is possible for the sole proprietorship to have a "doing business as" (dba) name. The dba name can be reported on the CMS-855S and in the NPI application (in the "Other Name" field). A dba name, however, is not a legal name.
- It is possible that the sole proprietorship requested and received an EIN from the Internal Revenue Service (IRS) if the sole proprietorship has employees. This EIN will protect the sole proprietor's SSN from appearing in claims and on W-2s.
- Medicare will treat the EIN as the TIN for purposes of claims processing, but the SSN must still be reported on the CMS-855S.
- When Medicare reports tax information to the IRS for that EIN, the IRS will link that EIN to the sole proprietor's SSN.

Additional Information on Reporting a National Provider Identifier (NPI) for Ordering/ Referring and Attending/Operating/Other/ Service Facility for Medicare Claims

Visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5890.pdf* for a recently released *MLN Matters* article on the topic of reporting NPIs for order/referring and attending/operating/other/service facility for Medicare claims.

CMS to Host National NPI Roundtable on February 6, 2008

CMS will host a national NPI Roundtable on Wednesday, February 6, from 2:30 – 4:00 p.m. ET. This call will focus on the status of the Medicare implementation and a related question and answer session.

Registration details are available on the CMS Web site at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/listservwording2-6-08npicall.pdf*.

WEDI To Host NPI Audio Cast

The Workgroup for Electronic Data Interchange (WEDI) will host an audio cast to discuss NPI implementation from an industry-wide standpoint. The audio cast will be held on February 21, 2008.

Visit *http://www.wedi.org/npioi/index.shtml* for registration details. Please note there is a charge to participate in WEDI events.

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI may be found at the CMS NPI Web page *http://www.cms.hhs.gov/NationalProvIdentStand*.

Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203

Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the CMS Web page *http://www.cms.hhs.gov/NationalProvIdentStand*.

Getting an NPI Is Free – Not Having One May Be Costly

Source: CMS Provider Education Resource 200801-20

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.

Attention: FFS Medicare Physicians, Nonphysician Practitioners & Other Suppliers

The NPI is here. The NPI is now. Are you using it?

March 1st is a Critical Date!

Last week, CMS issued the January national provider identifier (NPI) message to all providers. (You may view the January NPI message online at *http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp* on the CMS Web site.) This week begins a weekly messaging campaign for Medicare Fee-For-Service providers in order to raise the level of urgency as the March 1 implementation date approaches.

Prior to March 1, 2008

- Claims with both an NPI and a Medicare legacy number are rejected if the pair is not found on the Medicare NPI crosswalk.
- Claims submitted with just a Medicare legacy number are being paid (unless of course, they have other errors that cause them to be rejected).

As of March 1, 2008

- Claims with both an NPI and a Medicare legacy number will continue to be rejected if the pair is not found on the Medicare NPI crosswalk.
- Claims without an NPI in the primary provider field will be rejected!
- Claims with only a Medicare legacy number in the primary provider field will be rejected!

This means that you will not be able to get paid for any Medicare services you provide until you begin using your NPI. Also, if needed, you must correct any data, which may be preventing an NPI/legacy match on the NPI crosswalk. The correction might require that you file a CMS-855 Medicare Provider Enrollment form with your Medicare carrier, A/B MAC, or DME MAC a process which can take a number of months to accomplish.

Test NPI-Only Now

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number).

If the Medicare NPI crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims reject, call your Medicare carrier or A/B MAC enrollment staff for advice right away. The enrollment number is likely to be quite busy after the March 1 deadline, so don't wait.

Need More Information?

Not sure what an NPI is and how you can get it, share it, and use it? More information and education on the NPI can be found through the CMS NPI page *www.cms.hhs.gov/NationalProvIdentStand* on the CMS Web site. Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the *www.cms.hhs.gov/NationalProvIdentStand* CMS Web page.

Source: Provider Education Resources Listserv, Message 200801-23

Additional Information on Reporting a National Provider Identifier for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims

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

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], Medicare administrative contractors [A/B MAC], or durable medical equipment Medicare administrative contractors [DME MAC]) for services or items furnished to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Effective with claims received on or after May 23, 2008, Medicare will not pay for referred or ordered services or items; unless the fields for the name and national provider identifier (NPI) of the ordering, referring and attending, operating, other, or service facility providers are completed on the claims.

CAUTION – What You Need to Know

Change request 5890, from which this article is taken, provides that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers NPIs for claims. Further, it requires that the provider or supplier who is furnishing the services or items, after unsuccessfully attempting to obtain the NPI from these providers; report their own name and NPI in the ordering/referring/attending/operating/other/service facility provider/purchased service provider fields of the claims.

Additional Information on Reporting a NPI for Medicare Claims, continued

GO – What You Need to Do

Make sure that your billing staffs are aware of this requirement to place the "furnishing" provider or supplier's name and NPI in the appropriate fields and to use your name and NPI if those of the ordering/referring and attending/operating/other/service facility provider/purchased service providers are not obtainable.

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The NPI final rule (45 CFR Part 162, CMS-045-F), published on January 23, 2004, established the NPI as this standard; and mandates that all entities covered under HIPAA (including health care providers) comply with the requirements of this NPI final rule.

Medicare previously required a unique physician identification number (UPIN) be reported on claims for any ordering, referring/attending, operating, other, and service facility providers (i.e., or for any provider that is not a billing, pay-to, or rendering provider). Further, in accordance with the NPI final rule; effective May 23, 2008, when reported on a claim, the identifier for such a provider must be an NPI, regardless of whether the provider is a covered entity, or participates in the Medicare program. **Therefore, Medicare will not pay for referred or ordered services, or items, unless the name and NPI number of the ordering, referring and attending, operating, other, or service facility provider are on the claim.**

Note: Physicians (MD and DO) and the following nonphysician practitioners: 1) nurse practitioners (NP); 2) clinical nurse specialist (CNS); 3) physician assistants (PA); 4) and certified nurse midwives (CNM) are the only types of providers eligible to refer/order services or items for beneficiaries.

You should be aware that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers' NPIs on the claim. If these providers do not directly furnish their NPIs to the billing provider at the time of the order, the billing provider must contact them to obtain their NPIs prior to delivery of the services or items.

If, after several unsuccessful attempts to obtain the NPI from the ordering, referring, attending, operating, other, service facility provider, or purchased service provider; CR 5890, from which this article is taken, requires that (effective May 23, 2008) the provider or supplier who is furnishing the services or items report their own name and NPI in the claim's ordering/referring/attending/operating/other/service facility provider/purchased service provider fields.

Additional Information

You may find more information about reporting an NPI for ordering, referring and attending, operating, other, service facility providers for Medicare claims by going to CR 5890, located at *http://www.cms.hhs.gov/Transmittals/downloads/R235PI.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5890
Related Change Request (CR) #: 5890
Related CR Release Date: January 18, 2008
Effective Date: May 23, 2008
Related CR Transmittal #: R235PI
Implementation Date: April 7, 2008

April 2008 Update to the Medicare Code Editor and GROUPER

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

Provider Types Affected

Hospitals that bill Medicare fiscal intermediaries (FI) or Medicare administrative contractors (A/B MAC) for services they provide to Medicare beneficiaries.

What You Need to Know

CR 5876, from which this article is taken, announces an April 2008 update to the Medicare code editor (MCE) and GROUPER to accommodate the addition of the new patient status discharge code 70: "Discharges or Transfers to Other Types of Health Care Institutions not defined elsewhere in the UB-04 (CMS-1450) Manual Code List."

Hospitals should make sure their billing staffs are aware of these MCE and GROUPER changes so that they can update their systems to incorporate them, as needed.

Background

Section 503(a) of Public Law 108-173, as part of the amendments related to recognizing new technology under the inpatient prospective payment system (IPPS), included a requirement to update ICD-9-CM codes twice a year instead of the single yearly (October 1) update. This section amended section 1886(d) (5) (K) of the Act by adding a clause (vii) which states that the "Secretary shall provide for the addition of new diagnosis and procedure codes on April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) until the fiscal year that begins after such date."

April 2008 Update to the Medicare Code Editor and GROUPER, continued

However, while coding updates for April releases of MCE/GROUPER will not adjust payment; for this April 2008 release, the Centers for Medicare & Medicaid Services (CMS) needs to update the diagnosis-related group (DRG) software and other systems in order to recognize and accept the new patient status code of 70.

Additional Information

You may find more information about the April 2008 update to the MCE and GROUPER by going to CR 5876, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1411CP.pdf* on the CMS Web site. You might also want to read the implementing instructions for patient discharge status code 70, which are discussed in *MLN Matters* Article MM5764 (New Patient Status Discharge code 70 to Define Discharges or Transfers to Other Types of Health Care Institutions not Defined Elsewhere in the UB-04 (CMS-1450) Manual Code List) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5764.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5876
Related Change Request (CR) #: 5876
Related CR Release Date: January 11, 2008
Effective Date: Discharges on or after April 1, 2008
Related CR Transmittal #: R1411CP
Implementation Date: April 7, 2008

Clarification Regarding the Coordination of Benefits Agreement Medigap Claim-based Crossover Process

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 contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for Medicare Part B services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5837 which clarifies instructions regarding the Coordination of Benefits Agreement (COBA) Medigap claim-based crossover process.

CAUTION – What You Need to Know

CR 5837 provides formal confirmation of a recent Centers for Medicare & Medicaid Services (CMS) decision to **not require** Medicare Part B contractors (including DME MACs) to update their internal insurer tables or files with each Medigap insurer's newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based ID, as was previously prescribed in CR 5662. In addition, CR 5837 conveys clarifying provider billing requirements in relation to Medigap claim-based crossovers.

GO – What You Need to Do

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

Background

Effective October 1, 2007, the CMS transferred responsibility for the mandatory Medigap crossover process (also known as the "Medicare claim-based crossover process") to its Coordination of Benefits contractor. With this change, Part B contractors, including A/B MACs and DME MACs:

- No longer maintain crossover relationships with Medigap insurers
- No longer bill such entities for crossover claims effective with the last claims file that they transmit to these entities no later than October 31, 2007.

In a directive issued on September 18, 2007, CMS communicated to Medicare Part B contractors (carriers, DME MACs, and A/B MACs) its decision that they are not required to update their internal insurer files or tables with the Coordination of Benefits contractor (COBC)-assigned COBA Medigap claim-based identifiers (IDs). This is because, as discussed in CR 5601, the contractors' front-end system now simply verifies that a Medigap claim-based crossover identifier on an incoming claim is syntactically correct (5 digits, beginning with a "5"). CMS' Common Working File (CWF) system is now tasked with validation of the actual ID submitted on incoming claims.

The September 18, 2007, directive represented a departure from previous guidance communicated in CR 5662 (see *MLN Matters* article, MM5662, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf* on the CMS Web site), in which CMS provided for transitional updating of the contractors' internal insurer files/tables prior to October 1, 2007, once the COBC had:

- Assigned COBA Medigap claim-based IDs to the various Medigap insurers
- Deemed Medigap insurers "production-ready."

CMS also required Medicare contractors to post language on their provider Web sites stipulating that:

- Providers are not to begin including the new COBA Medigap claim-based IDs on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) before October 1, 2007.

Clarification Regarding the COBA Medigap Claim-based Crossover Process, continued

CR 5837 instructs Part B contractors (including A/B MACs and DME MACs) that they are not required to update their internal insurer files/tables following a Medigap insurer's readiness to move into production with the COBC. This requirement formerly applied to situations where CMS expected that contractors update their internal insurer files/tables prior to October 1, 2007, in accordance with CR 5662 (transmittal 283). These Part B contractors may retain their older Other Carrier Name and Address (OCNA) or N-key identifiers within their internal insurer files/tables for purposes of avoiding system issues or for the printing of post-hoc beneficiary-requested Medicare summary notices (MSNs). However, in accordance with CR 5601, at *http://www.cms.hhs.gov/transmittals/downloads/R1242CP.pdf* on the CMS Web site**,** contractors will have disabled the logic that they formerly used to tag claims for crossover to Medigap insurers effective prior to claims they received for processing on October 1, 2007.

Effective with CR 5837, all Part B contractors (including A/B MACs and DME MACs) will discontinue publication of their routine Medigap newsletters. These contractors may, however, at their discretion, publish one last edition of this newsletter if desired to include the provider education language that follows:

> ***In accordance with the language modification to MSN message 35.3***
> ***—"A copy of this notice will not be forwarded to your Medigap insurer because the information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."—which contractors made as part of Transmittal 1242, CR 5601, all Part B contractors, including A/B MACs, and DME MACs shall make available a Spanish translation of the modified MSN message, which shall read as follows: "No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap."***

All Part B contractors (including A/B MACs, and DME MACs) are to inform their associated billing providers that are exempted from billing their claims electronically under the Administrative Simplification Compliance Act (ASCA) that they should only be entering the newly assigned 5-byte COBA Medigap claim-based ID (range 55000 to 59999) with item 9d of the CMS-1500 for purposes of triggering a crossing over of the claim to a Medigap insurer.

All Part B contractors (including A/B MACs, and DME MACs) are also to provide a link on their provider Web sites (preferably under "Hot Topics") to the recently published special edition *MLN* article (SE0743 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0743.pdf* on the CMS Web site) that clarifies for providers the differences between:

- Medigap crossover that is accomplished via the automatic, eligibility file-based crossover process
- The Medigap claim-based crossover process, which is triggered by information that they include on incoming claim.

Providers should note that the listing at *http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf* on the CMS COB Web site is:

- Complete and up-to-date
- The only source for the identifiers to be included on incoming claims for purposes of triggering crossovers to those Medigap insurers that **do not** participate fully in the automatic crossover process.

Additional Information

The official instruction, CR 5837, was issued in two transmittals issued to your Medicare carrier, DME MAC, or A/B MAC. Those transmittals may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1420CP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R135FM.pdf* on the CMS Web site. These transmittals make revisions to the *Medicare Claims Processing* and *Medicare Financial Management Manuals*, respectively.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5837
Related Change Request (CR) #: 5837
Related CR Release Date: January 25, 2008
Effective Date: October 1, 2007
Related CR Transmittal #: R1420CP and R135FM
Implementation Date: February 1, 2008

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 Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

Modification to the Model Medicare Redetermination Notice

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

Provider Types Affected

All physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare administrative contractors [A/B MAC], or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided or supplied to Medicare beneficiaries.

What You Need to Know

Change request (CR) 5836, from which this article is taken, modifies the Reconsideration Request Form that is included with the model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations), to clarify the minimum set of elements on the form that you must complete in order for the request to be considered valid for reconsideration.

You should make sure that your billing staffs are aware that they must complete items 1, 2a, 6, 7, 11 & 12 on this Reconsideration Request form.

Background

The Reconsideration Request form modification that CR 5836 requires is necessary because the current Medicare manual instructions do not clearly identify all of the elements required for a reconsideration request to be considered valid in accordance with Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), section 405.964(b).

The modification to the form is as follows:

> **"**Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11 & 12 but to help us serve you better, please include a copy of the redetermination notice with your request."

Those elements that, as a minimum, you must complete on the form are:

1. Name of Beneficiary
2a. Medicare Number
6. Item or service you wish to appeal
7. Date of the service (From and To dates)
11. Name of Person Appealing
12. Signature of Person Appealing/Date

Additional Information

You may find more information about the modification to the model Medicare redetermination notice (for partly or fully unfavorable redeterminations) by going to CR 5836, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1408CP.pdf* on the CMS Web site. The updated *Medicare Claims Processing Manual*, chapter 29, section 320.7 (Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)) is an attachment to that CR. The Reconsideration Request form is also attached to CR 5836.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5836
Related Change Request (CR) #: 5836
Related CR Release Date: January 11, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1408CP
Implementation Date: February 11, 2008

Use of an 8-Digit Registry Number on Clinical Trial Claims

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], Medicare administrative contractors [A/B MACs] and durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries in clinical research studies.

Provider Action Needed

This article is based on change request (CR) 5790 that notifies providers and suppliers that Medicare claims forms will be modified to accommodate the 8-digit clinical trial number for claims that Medicare receives on or after April 1, 2008. Reporting this number is voluntary and claims submitted without the clinical trial number will be paid the same as claims containing a number. While reporting is voluntary, the number will assist the Centers for Medicare & Medicaid Services (CMS) in informing beneficiaries about the availability of clinical trials and to use claims information to inform coverage decisions. Be sure your billing staff is aware of this rule.

Background

The purpose of CR 5790 is to instruct providers and suppliers on new, voluntary reporting for placing a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination Manual*, Publication 100-03, section 310.1. That publication is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS Web site. The clinical trial number that the CMS is requesting to be voluntarily reported is the number assigned by the National Library of Medicine (NLM) Clinical Trials Data Bank when a new study is registered by a sponsor or investigator. Information regarding NLM clinical trials is available at *http://clinicaltrials.gov/* on the Internet.

CMS will use this number to identify all items and services provided to beneficiaries during their participation

Use of an 8-Digit Registry Number on Clinical Trial Claims, continued

in a clinical trial. Furthermore, this identifier will permit CMS to meet the recommendations of the 2000 Institute of Medicine report that led to the Executive Memorandum to increase participation of Medicare beneficiaries in clinical trials and the development and implementation of the CMS clinical trials policy.

Recommendations from The White House Executive Memorandum included:

- Tracking Medicare payments
- Ensuring that the information gained from the research is used to inform coverage decisions
- Making certain that the research focuses on issues of importance to the Medicare population
- Enabling CMS to better inform Medicare beneficiaries about the clinical studies available for their participation.

Key Points

- Claims submitted without the clinical trial number will be paid the same as claims containing a number.
- Institutional clinical trial claims are identified through the presence of all of the following elements:
  - Value Code D4 and corresponding 8-digit clinical trial number (when present on the claim)
  - ICD-9 diagnosis code V70.7
  - Condition Code 30
  - HCPCS modifier Q1: outpatient claims only. (See MM5805 related to CR 5805 for more information regarding modifier Q1).
- Practitioner/DME clinical trial claims are identified through the presence of all of the following elements:
  - ICD-9 diagnosis code V70.7
  - HCPCS modifier Q1
  - 8-digit clinical trial number (when present on the claim).
- On institutional claims, the 8-digit numeric clinical trial number should be placed in the value amount of value code D4 on the paper claim UB-40 (Form Locators 39-41) or in Loop 2300, HI – Value Information segment, qualifier BE on the 837I.
- On professional claims, the clinical trial registry number should be preceded by the two alpha characters of "CT" and placed in Field 19 of the paper Form CMS-1500 or it should be entered WITHOUT the "CT" prefix in the electronic 837P in Loop 2300 REF02(REF01=P4).

Additional Information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

You may see the official instruction (CR 5790) issued to your Medicare A/B MAC, FI, DME/MAC, or carrier by going to *http://www.cms.hhs.gov/Transmittals/downloads/R310OTN.pdf* on the CMS Web site. You may see the article related to the Q1 modifier, MM5805, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5805.pdf* on the CMS Web site.

MLN Matters Number: MM5790
Related Change Request (CR) #: 5790
Related CR Release Date: January 18, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R310OTN
Implementation Date: April 7, 2008

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.*

Individuals Authorized Access to CMS Computer Services—Provider Community

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the January 2008 Medicare B Update! pages 49-51.

Note: This article was revised on January 15, 2008, to add another question and answer to emphasize that potential user should only register once in IACS.

The Second in a Series of Articles

This article contains:

- Four questions and answers about the registration process for provider organizations. (See NOTE below.)
- Links to the Quick Reference Guides for completing the registration process for provider organizations. (See Note below.)

Note: For purposes of the IACS-PC, "Provider Organizations" include individual practitioners who will delegate IACS-PC work to staff as well as their staff using IACS-PC.

Provider Types Affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Individuals Authorized Access to CMS Computer Services—Provider Community, continued

Special Note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in this new series on IACS-PC, which may be found on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Provider Action Needed

Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider and/or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC).

What Providers Need to Know

In the near future, the CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

Registering in IACS-PC

The provider community is the first in a series of IACS communities, which are the front-door to protecting and allowing access to CMS enterprise applications. Communities are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (ex. Providers need access to provider-related CMS applications). The next community, which will become available in early 2008, is the FI/carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FI's, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider Community".

The first *MLN Matters* article in this series provided an overview of the IACS-PC registration process as well as registration instructions for security officials (SOs) and individual practitioners using IACS-PC personally. This article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

Four Questions and Answers about the Provider Organization Registration Process

1. How can I get registered in IACS-PC? Can I just figure it out by myself?

We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and interpretations of error messages. To directly access IACS-PC, go to *https://applications.cms.hhs.gov* and then click on **Enter CMS Applications Portal.**

2. I want to register as an SO. I do not have my organization's IRS CP-575. What else can I send?

In addition to the CP-575, SOs may also submit copies of other official IRS documentation. An official IRS document should have the following information:

Required:
- IRS letterhead
- Legal business name (not handwritten)
- TIN/EIN (not handwritten).

Optional:
- Form number in upper right; and
- Reference to a letter or form number in body of text.

Examples of acceptable IRS documents include, but are not limited to:
- Copy of IRS CP-575
- Copy of IRS 147C letter; or
- Copy of Federal Tax Deposit Coupon.

All documents received must be legible.

3. I will work for more than one provider, or serve in multiple roles in the same organization. Do I need to register in IACS separately for each organization or role?

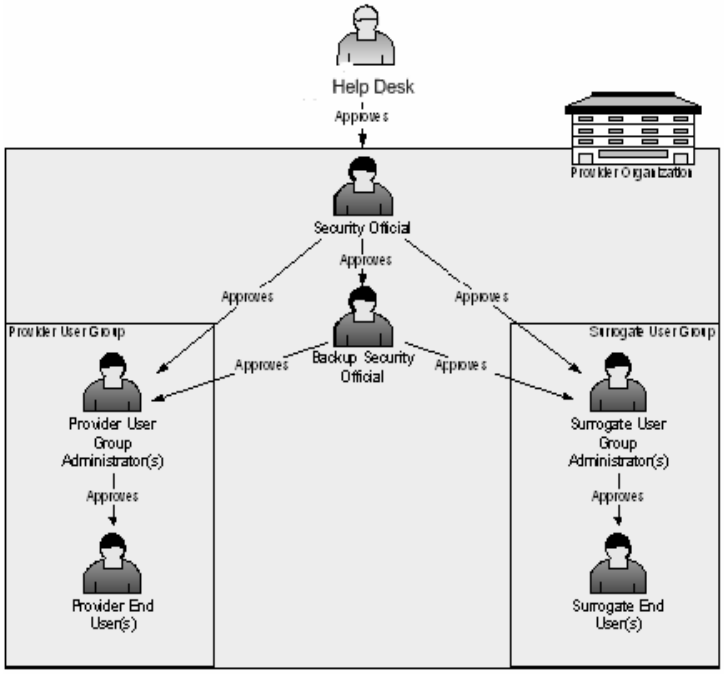
No. Each user will receive only one IACS-PC User ID and password. If you will work for more than one provider, or have multiple roles in the same provider, register in IACS for one role. Once you receive approval and your user ID and password, you can add additional roles to your account.
Instructions for modifying your IACS profile will be released shortly. In the meantime, questions may be directed to the help desk as shown in the *Additional Help* section at the end of this article.

4. My organization is too small to fill all these roles. What should I do?

As few as 2 staff can be registered in IACS-PC for a provider organization to access CMS enterprise applications. The first person must register as a SO, the second registers as a User Group Administrator (UGA). The UGA may access CMS applications as approved by the SO.
The Backup Security Official is an optional role. End users are only required for provider organizations with 10 or more IACS-PC users.
If you are an individual practitioner who will be using IACS-PC personally, please refer to the first *MLN* article which may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

Individuals Authorized Access to CMS Computer Services—Provider Community, continued

Quick Reference Guides for Completing the Provider Organization Registration Process



IACS-PC Registration Approval Process

1. **Backup Security Official (BSO) Guide**

   BSOs will request access to an organization using the BSO Registration Quick Reference Guide at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_backup_security_official_registration_qrg_12_06_07.pdf* on the CMS Web site.

2. **User Group Administrator (UGA) Guide**

   UGAs are the first user type able to request access to CMS Web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.
   Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS-PC and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which s/he is responsible, so they should know everyone in their user group.
   The UGA Registration Quick Reference Guide may be found at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_user_group_administrator_registration_qrg_12_06_07.pdf* on the CMS Web site.

Special note for UGAs of Surrogate User Groups

A surrogate user group is established by individuals or a company outside of the provider organization which performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: *Surrogate Billing Company ABC will work on behalf of Provider Organization XYZ. Once the Provider Organization XYZ is approved in IACS-PC, the Surrogate Billing Company ABC can register in IACS-PC and request to create a surrogate user group under the Provider Organization XYZ.* Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.
At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of three different provider organizations, the UGA for the surrogate user group will need to make three different requests to create three different surrogate user groups, one for each provider with which the UGA needs to associate. If a provider organization does not appear in IACS-PC, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider appears in IACS-PC.
If the provider organization does appear in IACS-PC, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS-PC.

Individuals Authorized Access to CMS Computer Services—Provider Community, continued

In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to individual practitioners within IACS-PC.

3. **An End User Registration Quick Reference Guide may be found on the CMS Web site at** *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_end_user_registration_qrg_12_06_07.pdf*.

4. **Approver Quick Reference Guide**

   The Approver Quick Reference Guide provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS-PC. The Approver Quick Reference Guide may be found at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_approver_qrg_12_07_07.pdf* on the CMS Web site.

Next Steps in Accessing a CMS Enterprise Application

A third *MLN* article discussing the final steps in accessing CMS enterprise applications has been released on this issue, and may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf* on the CMS Web site.

Additional Help

The CMS has established an External User Services (EUS) Help Desk to assist with your access to IACS-PC. The EUS Help Desk may be reached by E-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you can find an informative reference chart outlining the steps for accessing CMS enterprise applications at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf* on the CMS Web site.

MLN Matters Number: SE0753 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Individuals Authorized Access to CMS Computer Services—Provider Community

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

Note: This article contains three steps to accessing a CMS Enterprise Provider Application including how to request a provider application role in IACS-PC (See step 2).

The Third in a Series of Articles
Provider Types Affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers: Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in a new series on IACS-PC which may be found at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site

Provider Action Needed

CMS enterprise applications to be made available via the web soon include the Provider Enrollment, Chain and Ownership System (PECOS) and the Provider Statistical and Reimbursement Report (PS&R) System. Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC).

What Providers Need to Know

In the near future, the CMS will be formally announcing new online enterprise applications that will allow Medicare Fee-For-Service (FFS) providers to access, update, and submit information over the Internet.

CMS enterprise applications are those hosted and managed by CMS and for the most part do not include Internet applications offered by FI/carrier/MAC. Details of these provider applications will be announced as they become available.

The first article in this series provided an overview of the IACS-PC registration process as well as registration instructions for Security Officials (SOs) and individual practitioners. This article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

The second article addressed questions and gave remaining instructions for registering provider organizations including registering as a Backup Security Official (BSO), User Group Administrator (UGA), and End User (EU). It also discussed approving user requests. This article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf* on the CMS Web site.

Individuals Authorized Access to CMS Computer Services—Provider Community, continued

Note: IACS Provider Community (IACS-PC) includes individual practitioners who will be working on their own accord and will not have any other company staff (they may have surrogates or "contractors" who are not their employees which they may contract with to work on their behalf), and also includes "Provider Organizations" defined in IACS as practices, groups, single and multi-specialty offices etc. where the provider may have additional staff in IACS and delegate IACS-PC work to staff as well as their staff using IACS-PC.

The 3 Steps to Access a CMS Enterprise Application

Provider IACS-PC users must take 3 steps to access a CMS enterprise application:

Step 1: Be Approved for an IACS-PC Role.

The first two *MLN Matters* articles in this series discussed how to register in IACS-PC.

The purpose of the IACS-PC registration process is to:

- Confirm the identity of the person requesting registration;
- Assure registrants have a legitimate business need to access CMS provider systems;
- Provide the registrant an IACS-PC role (e.g., SO, BSO, UGA, or end User) that defines their responsibilities (if any) for approving the registration requests of others in their organization; and
- Provide the registrant a User ID and Password for IACS-PC.

Step 2: Be Approved for an Application Role

After receiving approval for an IACS-PC role, a registered user in a Provider Organization may then request to be an "application approver" or an "end user." (Note: Because individual practitioners do work in the application themselves, they do not designate "application approver" roles).

This role determines:

- Their responsibilities (if any) to approve application access requests from others in their organization;
- What CMS enterprise applications (if any) they have a legitimate need to access, and
- The appropriate level of access to each application for their job function (which application "role" they require).

Users who received approval in IACS-PC in Step 1, may now request access to specific CMS enterprise applications using their IACS-PC account.

This can be done by requesting either an "application approver" or an application "user" role for each application needed to perform Medicare-related job functions. For provider applications, there are specific roles within the application that define what the user can do. For example, some application users may be limited to viewing information and printing reports, while others can enter, edit and submit information to CMS. These roles will be specific to each application.

Each user must request a specific application role in IACS-PC for each CMS enterprise provider application they wish to use.

The "Request Access to CMS Application Quick Reference Guide" provides instructions for requesting an application role. It may be found at *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Request_Access_to_CMS_Application_QRG_111607.pdf* on the CMS Web site.

Application Approvers

Organizations must have designated persons that approve each end user's request for an application role. The person who performs this task is an "application approver" and as such cannot personally access applications for which they serve in this role.

Though the UGA may frequently be the appropriate persons to have this role, organizations have discretion in how they designate the application approvers so that it is appropriate for their particular organization. For example, the UGA may be designated by the SO or BSO to serve in this role for their user group, or an end User may be approved for this role by the SO or BSO for the user group with which they are associated.

Note: If a user group does not have an application approver for an application, the requests will, by default, be routed to the SO and BSO for a decision.

Application Approver Key Points

- An application approver must be a member of the user group(s) for which they serve as an application approver (this does not apply if the SOs/BSOs is the application approver).
- Providers have flexibility in assigning the application approver role:
- The UGA does not have to be the application approver within the user group.
- An end user within a user group may serve in the role of the application approver.
- A different person may serve as an application approver in a user group for each application.
- The same person can be the application approver for multiple applications in a user group.
- The same person can be the application approver for multiple user groups (though they must be a member of each group.)
- There can be multiple application approvers for the same application within the same user group. In this situation, the first approver who approves or denies the request will serve as the decision authority. All of the application approvers within the user group do not need to act on each request.
- A person can be an application approver for one application, and an application user for a different application, just not for the same one.
- If an application approver does not exist for an application in a user group, the user group requests for that application will go to the SO and BSO for a decision.
- Organizations with a large number of IACS-PC users are encouraged to have application approvers in each user group for each application (can be the same person) so that all of the application requests are not routed to the SO and BSO as the default application approvers.

Note: System security requires a "separation of duties" – which means that those who approve user requests

Individuals Authorized Access to CMS Computer Services—Provider Community, continued

for CMS enterprise application roles will not have access to the applications for which they have an approver role. Therefore those in Application Approver roles will not have access to the application for which they are an approver. Security Officials and Backup Security Officials, by definition, can never access any applications as they serve as the default Application Approvers as noted above.

Instructions for approving application approver and application user role requests are the same as for approving IACS-PC registration requests. The Approver Quick Reference Guide may be found at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_approver_qrg_12_07_07.pdf* on the CMS Web site.

Step 3: Enter the application when it becomes available.

You will be notified as CMS enterprise applications become available. After you have been approved in steps 1 and 2, you will be able to access available CMS enterprise applications using your approved application specific roles via the CMS Web site.

Additional CMS Partner and Customer Communities will use IACS

The provider community is the first in a series of IACS communities that are the front door to protecting and allowing access to CMS enterprise applications. Communities are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (ex. Providers need access to provider-related CMS applications). The next community, which will become available in early 2008, is the FI/carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FIs, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider Community".

Additional Help

CMS has established the End User Services (EUS) Help Desk to support access to IACS-PC. The EUS Help Desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

Coming Soon

- CMS enterprise applications to be made available via the web include the Provider Enrollment, Chain and Ownership System (PECOS) and the Provider Statistical and Reimbursement Report (PS&R)
- IACS Web site
- Instructions for modifying your user profile
- What to do if you forget your user ID or password
- Tools for SOs, BSOs and UGAs to manage user accounts

MLN Matters Number: SE0754
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Medicare Health and Part D Plan Enrollees Expected Smooth Transition to 2008

Medicare beneficiaries who have chosen to change their health and drug coverage for 2008 should experience very few difficulties when getting their covered prescription drugs through Medicare Part D, the Centers for Medicare & Medicaid Services (CMS) announced today.

"A top priority throughout the fall open enrollment season has been to help beneficiaries prepare and compare their plan choices so that they could make informed decisions about switching plans. In addition, we've been working hard to ensure a smooth enrollment process," said CMS Acting Administrator Kerry Weems.

The CMS has taken multiple steps to ensure that pharmacies can obtain accurate enrollment information in 2008, particularly for low-income beneficiaries. CMS has improved procedures for getting accurate plan information into the E1 eligibility system, which is the computer system that pharmacists use to identify current plan enrollment, often for beneficiaries who were reassigned to new plans, or who may not have received their new drug card. The CMS has also implemented better processing requirements for all enrollees, and CMS continues support a point-of-sale facilitated enrollment process that provides immediate coverage for people with Medicare who have Medicaid or have qualified for extra help, but aren't enrolled in a Medicare drug plan.

The CMS also has worked aggressively to ensure a smooth transition for low-income subsidy (LIS) eligible beneficiaries who would be responsible for paying a portion of their plan premium in 2008.

Earlier this fall, these beneficiaries received letters explaining steps they could take to remain in their plan by paying a small premium and a list of all the zero premium plans available in their community.

Blue reassignment letters were mailed to people who qualify for the full extra help and who will be reassigned to a new plan in 2008. Tan letters were sent to beneficiaries receiving the LIS who selected a plan, but who will be responsible for paying a portion of their plan premium beginning in January 2008 unless they join a new plan. Beneficiaries who received one of these letters can receive personalized assistance at their local State Health Insurance Assistance Program (SHIP) office or their local Social Security office.

While CMS does not expect beneficiaries to encounter difficulties at the pharmacy counter due to the collaborative work among beneficiaries, partners and advocates, pharmacies, and plans, nevertheless, those beneficiaries who have newly

Medicare Health and Part D Plan Enrollees Expected Smooth Transition to 2008, continued

enrolled or changed plans should keep these four tips in mind when visiting the pharmacy:

1. Bring your red, white, and blue Medicare card, a photo ID, and your new drug plan membership card – these items will help the pharmacist in verifying your coverage;
2. Bring an enrollment acknowledgement, confirmation letter, or the name of your new drug plan if you have not received a plan membership card – your enrollment search might take longer, but these items will assist the pharmacist in verifying your coverage;
3. Keep copies of your receipts – in the rare instance where the pharmacist cannot confirm enrollment, you can work with your new plan prospectively to obtain reimbursement; and
4. Don't leave the pharmacy counter without your medicine – if you cannot pay out of pocket, call 1-800 MEDICARE for assistance or ask the pharmacist to dial the special hotline for these cases.

In addition, CMS and others have taken the following measures to smooth beneficiaries' transition into 2008:

Online Enrollment and Toll-Free Assistance

Since November 15, 2007, Medicare's online enrollment center has processed more than 347,000 enrollments. In the same period, its Web site has recorded over 36 million page views on www.medicare.gov and over 19 million page views of the Medicare Prescription Drug Plan Finder.

Since November 15, 2007, 1-800-MEDICARE has received more than three million calls and more than 3,000 customer service representatives are ready to answer questions about enrollment status. The Medicare ombudsman's office has senior casework analysts available to resolve problems for beneficiaries who need individualized assistance because of a critical health need or financial circumstance.

At the Pharmacy

National and local chains and independent pharmacies have worked closely with beneficiaries to provide information and assistance during the open enrollment period.

Thousands of pharmacies have helped beneficiaries through in-store informational days, medication reviews, and community presentations. For example, Rotz Pharmacy, an independent pharmacy in Winchester, Va., provides a navigation guide to the www.medicare.gov Medicare Drug Plan Finder, other comparison tools as well as personalized consultation to beneficiaries who need help in finding a plan that best suits their needs. In-person counseling and other enrollment assistance has been provided nationwide and regionally by many chains, including: CVS; Kroger; Longs Pharmacy; Medicine Shoppe International; Rite-Aid; Target; Stop & Shop, Giant Foods and Giant Food Stores; Walgreens; and Wal-Mart.

In-Person

At more than 10,000 events held nationwide, Medicare has worked closely with its partner organizations, including the National Aging Services network of state, local and community service providers, to provide enrollment counseling and sign-up opportunities where people with Medicare live, work, play and pray.

The 2007 CMS Mobile Office Tour visited 128 communities across the nation sharing information about Part D with beneficiaries. That tour highlights the personalized assistance provided by the many thousands of partners across the country who are helping beneficiaries compare their drug plan options and change enrollment if necessary.

Through the Secret Shopper initiative, CMS officials have attended over 220 events to ensure that health plans are adhering to marketing and enrollment guidelines.

Recent surveys show that a large majority of seniors enrolled in the Medicare drug benefit are satisfied with their plan and few intend to change their plan in 2008. A Wall St. Journal /Harris Interactive survey of U.S. adults age 65 or older shows that 87 percent of Medicare drug benefit enrollees are satisfied with their plan. "Our educational efforts are paying off and we will continue to provide information and assistance throughout 2008," said Weems.

The annual open enrollment period for prescription drug coverage began on November 15, 2008, and runs through December 31, 2007. For Medicare Advantage plans only, beneficiaries can make one change in enrollment — enrolling in a new plan, changing plans or canceling a plan – between January 1, 2008, and March 31, 2008. However, beneficiaries cannot join or drop Medicare drug coverage during this time.

Beneficiaries eligible for the LIS have the ability to change plans at any time. They can continue to visit *www.medicare.gov* and view all the health and prescription plans available in their area. Users can compare plans based on costs, coverage, customer service and quality of each plan. They may also receive the same online information by calling 1-800-MEDICARE.

For more information on where to find a SHIP counselor available to provide free one-on-one help with your Medicare questions or problems, visit *www.medicare.gov/contacts/static/allStateContacts.asp*.

Source: Provider Education Resources Listserv, Message 200801-07

2008 Physician Quality Reporting Initiative Question of the Week

Q: What is the bonus available for eligible professionals who successfully participate in 2008 Physician Quality Reporting Initiative (PQRI)?

A: As in 2007, incentive payments for successful participation in 2008 PQRI will be paid from the Medicare Part B Trust Fund. Eligible professionals may earn a bonus payment of 1.5 percent of total allowed charges for covered services payable under the Medicare Physician Fee Schedule.

Source: Provider Education Resources Listserv, Message 200801-07

2008 Physician Quality Reporting Web Site Reorganization

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the Physician Quality Reporting Initiative (PQRI) Web site has been reorganized to facilitate access and navigation to 2008 PQRI information and educational resources, including:
2008 PQRI Tool Kit.

- Key documents related to 2008 measure specifications have been retained and placed as downloadable documents within their corresponding sections.
- New documents that further inform eligible providers about 2008 PQRI have been added.

Information about the 2007 PQRI program, which ended on December 31, 2007, has also been reorganized with relevant documents pertaining to 2007 measures retained for reference.

We encourage all eligible providers to visit the Web site and become familiar with the 2008 materials at: *http://www.cms.hhs.gov/PQRI*, on the CMS Web site.

Source: Provider Education Resources Listserv, Message 200801-14

2008 Physician Quality Reporting Initiative PowerPoint Presentation—Module VI

Eligible professionals should begin submitting appropriate 2008 Quality Data Codes on qualifying Part B claims with a date of service of January 1, 2008. Information on the 119 2008 Physician Quality Reporting Initiative (PQRI) measures, release notes, and detailed specifications are available on *http://www.cms.hhs.gov/pqri* on the Centers for Medicare & Medicaid Services (CMS) Web site. Eligible professionals are encouraged to contact their professional associations for additional information and tools that will facilitate participation.

The American Medical Association (AMA) has posted PQRI worksheets for the 2008 PQRI program on the AMA Web site at *http://www.ama-assn.org* . These worksheets will also be available in the CMS 2008 PQRI Toolkit, which will be announced and posted soon on *http://www.cms.hhs.gov/pqri* on the CMS Web site. Cut and paste the URL into your Internet browser should you have a problem accessing the URL embedded in this message.

CMS is pleased to announce that the PowerPoint presentation that will be used during the December 19, 2008, PQRI National Provider call is now available on the CMS Web site. This presentation will provide a basic overview of the 2008 Physician Quality Reporting Initiative and the 119 quality reporting measures. To access the presentation, go to *http://www.cms.hhs.gov/PQRI*, and select the Educational Resources tab on the left side of the page. Next, scroll down to the Downloads section and under the heading PowerPoint Presentations, select "2008 PQRI -Module VI."

Source: Provider Education Resources Listserv, Message 200801-05

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Medicare Competitive Acquisition Program for Physicians Updates

An additional election period for the 2008 Medicare Part B Drug Competitive Acquisition Program (CAP) will begin on January 15, 2008, and will conclude on February 15, 2008. The CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an approved CAP vendor, thus reducing the time they spend buying and billing for drugs.

This additional election period is for physicians who have not already elected to participate in the CAP for 2008. Effective dates of participation for physicians who elect to join the CAP during this additional election period will be April 1, 2008, to December 31, 2008.

Once a physician has elected to participate in CAP, they must obtain all drugs on the CAP drug list from the CAP drug vendor. Physicians can still continue to purchase and bill Medicare under the average sale price system for those drugs that are not provided by the physician's CAP vendor.

Additional information about the CAP is available at the following Web site: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp*.

The physician election form may be found at the following Web page in the Downloads section. Additional information for physicians may also be found at this site: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp*.

The list of drugs supplied by the CAP vendor, including national drug codes, is in the Downloads section at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp*.

Please note that completed and signed physician election forms should be returned by mail to your local carrier. Forms must be postmarked on or before February 15, 2008. **Do not** return forms to the Centers for Medicare & Medicaid offices.

Source: Provider Education Resources Listserv, Message 200801-07

CAP Additional Election Period

The 2008 Additional Physician Election Period for the CAP will begin on January 15, 2008, and will conclude on February 15, 2008. For questions on the CAP election process or general program inquiries, please call NAS' CAP Vendor Contact Center at 1-888-671-0536.

An additional election period for the 2008 Medicare Part B Drug CAP began on January 15, 2008, and will conclude on February 15, 2008. The CAP is a voluntary program that offers physicians the option to acquire many drugs they use in their practice from an approved CAP vendor, thus reducing the time they spend buying and billing for drugs. For physicians who join during this additional election period, effective dates of participation will be April 1, 2008, to December 31, 2008.

Physicians are instructed to submit their CAP election forms to their local carrier or A/B MAC. As per change request (CR) 4064, local carriers are required to forward a list to the CAP designated carrier of all physicians and practitioners who have elected to participate in the CAP. This list is due on February 22, 2008. A joint signature memo (JSM) with instructions pertaining to posting information on the ATC and processing additional election applications was sent out.

Participating CAP physicians are required to use CAP-specific modifier codes and the dose specific prescription order number on their claims. The following CRs pertain to the Part B Drug CAP and may be found on the "Transmittals" page at *http://www.cms.hhs.gov/transmittals*:

2007: R1239CP, R1207CP, 1390CP
2006: R841CP, R839CP, R1034CP, R57MSP, R1088CP, R1076CP, R1055CP, R1313CP
2005: R777CP, R761CP, R715CP, R699CP

Additional information about the CAP is available at the following Web site:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp.

The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp.

To view and download the billing instructions for Participating CAP Physicians, see "CAP Physician Billing Tips" in the Downloads section of the "Information for Physicians" page:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp.

For questions on the CAP election process or general program inquiries, please call the CAP Designated Carrier, Noridian Administrative Services, at their CAP Vendor Contact Center at 1-888-671-0536.

Source: Provider Education Resources Listserv, Message 200801-16

Ambulatory Surgical Center Fee Schedule Fact Sheet

The Ambulatory Surgical Center Fee Schedule Fact Sheet, which provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508.pdf*.

Source: Provider Education Resources Listserv, Message 200801-08

January Flu Shot Reminder

It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year.

Please encourage your Medicare patients who haven't already done so to get their annual flu shot. And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu!

Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing special edition *MLN Matters* article SE0748 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS Web site.

Source: Provider Education Resources Listserv, Message 200801-03

Medicare Provides Coverage for Many Preventive Services and Screenings

The Centers for Medicare & Medicaid Services (CMS) has released the following special edition *MLN Matters* article, SE0752 Medicare Provides Coverage for Many Preventive Services and Screenings, located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0752.pdf* on the CMS Web site.

This article serves as a reminder of the many preventive services and screenings now covered by Medicare and provides a list of related provider educational resources developed by CMS to inform fee-for-service health care professionals and their staff about the preventive services and screenings now covered by Medicare.

Visit the Medicare Learning Network - it's free!

Source: Provider Education Resources Listserv, Message 200801-02

January is National Glaucoma Awareness Month

Approximately three million Americans have glaucoma. Because the disease often progresses silently in the initial stages, with no symptoms, it is estimated that up to half of the approximately three million Americans with the disease don't know they have it. Vision loss from glaucoma is permanent and irreversible. While anyone can get glaucoma, certain groups of people are at higher risk for the disease. Glaucoma is more likely to occur in African Americans than in Caucasians and is a leading cause of blindness among African American and Hispanic populations in the United States. People with diabetes are nearly twice as likely to develop glaucoma as adults without diabetes. And people with a family history of glaucoma are more likely to get glaucoma too. Although glaucoma cannot be cured, early detection and treatment usually can stop further damage and prevent blindness. The benefit provided by Medicare offers a comprehensive glaucoma screening for seniors and others with Medicare at high risk for the disease.

Medicare Coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic Americans age 65 and older.

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

What Can You Do?

CMS needs your help to ensure that all eligible people with Medicare take full advantage of the annual glaucoma screening benefit. Your high-risk Medicare patients may not remember to schedule their annual glaucoma-screening exam. You can help remind them by talking with them about glaucoma and their risk for the disease, what can happen when glaucoma goes undetected/untreated, and how they can help protect themselves from severe consequences with early detection by getting an annual glaucoma screening exam. Your reminder and referral for a glaucoma-screening exam can help provide high-risk Medicare beneficiaries with peace of mind and safeguard their vision.

For More Information

CMS has developed a variety of educational products and resources to help health care professionals and their staff learn more about coverage, coding, billing, and reimbursement for preventive services and screenings 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 at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* on the CMS Web site.

Glaucoma Screening Brochure - This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of glaucoma screening services. To view online go to *http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf* on the CMS Web site. To order copies of the brochure, go to the *Medicare Learning Network* Product Ordering System located at: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

The CMS Web site provides information for preventive service covered by Medicare. Go to *http://www.cms.hhs.gov*, select "Medicare", scroll down to the "Prevention" section.

For information to share with your Medicare patients, visit *http://www.medicare.gov*.

For more information about glaucoma, visit The National Eye Institute *http://www.nei.nih.gov/index.asp*.

For more information about National Glaucoma Awareness Month, please visit *http://www.preventblindness.org/*.

Source: Provider Education Resources Listserv, Message 200801-04

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Notice of Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the current value of funds rate (five percent for calendar year 2008) or the private consumer rate (PCR) as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health and Human Services that the PCR has been changed to 12.125 percent, effective January 18, 2008. The PCR will remain in effect until a new rate change is published.

Source: Publication 100-06, Transmittal 134, Change Request 5753

LOCAL COVERAGE DETERMINATIONS

Unless otherwise indicated, articles apply to both Connecticut and Florida.

This section of the *Medicare B Update!* features summaries of new and revised local coverage determinations (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 that the carrier's LCDs and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text LCDs on our provider education Web sites, *http://www.fcso.com*. Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each LCD, and are based on the date of service (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 Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new LCDs are posted to the Web site, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to our Web site *http://www.fcso.com* , select Medicare Providers, Connecticut or Florida,, click on the "eNews" link located on the upper-righ-hand corner of the page and follow the prompts.

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Local Coverage Determinations - Table of Contents

Advance Beneficiary Notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

NEW LCD

J9305: Pemetrexed—New LCD

Pemetrexed is an antifolate containing the pyrrolopyrimidine-based nucleus that exerts its antineoplastic activity by disrupting folate-dependent metabolic processes essential for cell replication.

Pemetrexed is approved by the Food and Drug Administration (FDA) for use in combination with cisplatin for the treatment of patients with malignant pleural mesothelioma (MPM). It is also used alone for treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) after prior chemotherapy.

This local coverage determination (LCD) was developed to include indications and limitations of coverage, documentation requirements, utilization guidelines, and ICD-9-CM codes that support medical necessity.

Effective Date

This new LCD will be effective for services rendered on or after February 29, 2008. The full text of this LCD is available through our provider education Web site at *http://www.fcso.com*.

REVISION TO THE LCD

THERSVCS: Therapy and Rehabilitation Services—Revision to the LCD

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on June 30, 2007. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to incorporate new, revised language surrounding the therapy cap limitations and the exception process for therapy caps. Change request (CR) 5871, dated January 10, 2008, outlines the new therapy cap limits and revises language for the therapy cap exception process. The limit for therapy caps for calendar year 2008 is $1,810 for physical therapy and speech-language pathology services combined and $1,810 for occupational therapy services. The exception process for therapy caps has been extended through June 30, 2008. For a complete discussion on the therapy caps and the exception process, please refer to the LCD and the Centers for Medicare & Medicaid Services (CMS) Manual Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 5, Section 10.2.

This revision to the LCD is effective **January 14, 2008** for services rendered **on or after January 1, 2008.**

In addition, the coding guideline has been revised to add *CPT* code *96125 (Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report)* to the table of "always therapy services", in accordance with CR 5810. Please see the coding guideline for a complete discussion of the "always therapy table".

Effective Date

This revision to the LCD is effective **January 7, 2008,** for services rendered **on or after January 1, 2008**. The full text of this LCD is available through our provider education Web site at *http://www.fcso.com* on or after this effective date.

ADDITIONAL INFORMATION

J1440: G-CSF (Filgrastim, Neupogen®)—Clarification

First Coast Service Options, Inc. (FCSO) has discovered, through medical review and subsequent data analysis that providers are inappropriately administering Neupogen® (J1440 and J1441) to patients who are receiving a chemotherapeutic agent.

Neupogen® is not a cancer chemotherapy agent. It is a class II hematopoietic growth factor that acts on progenitor cells. Because Neupogen® acts only on progenitor cells that are already committed to one pathway, it increases only the neutrophil count. The local coverage determination (LCD) for Neupogen® outlines the Food and Drug Administration (FDA) approved indications and the off-label indications FCSO will cover when the medical necessity criteria are met.

Under the "Limitations" section of the LCD, it is outlined that Neupogen® should not be given within 24 hours before or after a dose of a chemotherapeutic agent, as rapidly dividing myeloid cells are potentially sensitive to these agents. This instruction is also outlined in the FDA-approved label. This rule applies to any indication in the LCD that requires the administration of a chemotherapeutic agent.

An example of inappropriate administration found during medical review of claims shows that providers are administering Neupogen® the day before, the day of and the day after chemotherapy administration. In the cases reviewed, patients received one injection of Neupogen® less than 12 hours before chemotherapy, then received an injection immediately following chemotherapy infusion and received a Neupogen® injection, the next day, less than 12 hours after the chemotherapy infusion. The documentation reviewed, also did not show a documented fever. For this example, the indication as outlined in the LCD for the chemotherapy patient, is to decrease the incidence of infection, as manifested by febrile neutropenia, for patients on myelosuppressive chemotherapy.

FSCO would like to reiterate to providers that the continued practice of inappropriate administration of Neupogen® might lead to medical review of documentation. FCSO does not expect to see Neupogen® billed the day before, the day of or the day after chemotherapy administration. If providers do bill Neupogen® the day before or the day after chemotherapy administration, the medical record must show that Neupogen® was not given less than 24 hours before and/or less than 24 hours after chemotherapy and that this requirement is documented in the medical record. Claims that cannot support this requirement may be denied as not medically necessary.

FCSO strongly encourages providers to review the current LCD for Neupogen® to ensure their patients meet the coverage criteria outlined for each indication, and that all other documentation and utilization requirements are met. The LCD may be located on our Web site at *http://www.fcso.com*. Questions regarding coverage or the appropriate administration of Neupogen® should be forwarded to *medical.policy@fcso.com*. Providers who feel the language in the LCD is not appropriate can refer to FCSOs reconsideration process located on our Web site.

FLORIDA ONLY - REVISION TO LCD

64470: Paravertebral Facet Joint Blocks—Revision to the LCD

The local coverage determination (LCD) for paravertebral facet joint blocks was last revised on September 30, 2007. Since that time, a revision was made to add language under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to extend coverage for only one type of procedure during one day/session of treatment unless the patient has recently discontinued anticoagulant therapy for the purpose of interventional pain management (Diagnosis V58.61 in addition to the primary diagnosis should be billed when anticoagulant therapy has been discontinued to facilitate therapeutic injections for pain management).

Effective Date

This revision to the LCD is effective for services rendered on or after February 29, 2008. The full text of this LCD is available through our provider education Web site at *http://www.fcso.com* on or after this effective date.

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 Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

February 2008 – March 2008

Evaluation & Management Education Series Webcast

Topic: Emergency Department Services
Discussion will include guidelines for proper use of Emergency Department codes.

When: February 19, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

National Provider Identifier (NPI) Webcast

When: February 20, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Hot Topics Webcast

Learn about recent Medicare changes, new/revised Local Coverage Determinations (LCDs) and how to avoid top claim denials and Comprehensive Error Rate Testing (CERT) errors.

When: March 12, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Provider Outreach & Education Advisory Group (POE AG) Meeting

For membership information, visit the POE AG page in the Provider Outreach & Education section of *www.connecticutmedicare.com*.

When: March 19, 2008
Time: 8:30 a.m. – 10:00 a.m.
Type of Event: Teleconference

Note: *Dates and times are subject to change prior to opening of event registration advertisement.*

Two Easy Ways To Register!

Online - Simply log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the course you wish to register for. Class materials will be available under "My Courses" no later than one day before the event. If you need assistance with the provider training Web site, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an email to *fcsohelp@geolearning.com*.

- To locate any of these courses on the provider training Web site, click on the following links/buttons in this order:
  - "Course Catalog" from the top navigation bar, then "Catalog" in the middle of the page;
  - Type a keyword in the search box for the course you are interested in (such as “Hot Topics”) and hit the “Search” button.
  - In the short list of courses that will appear, click the link for the course you’ve chosen and then click the “Preview Schedule” button at the bottom of the class description page;
  - On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are registering for and click the "Register" link in the Options column.
- **First-time user?** Please set up an account using the instructions located at *www.connecticutmedicare.com/Education/108651.asp*.

Fax - If you would like to participate in any of these events and do not have access to the Internet, please complete the registration section below, circle your selection(s) above and fax to (904) 361-0407.

Registrant’s Name: _____

Registrant’s Title: _____

Provider’s Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

FLORIDA EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

February 2008 – March 2008

Ask the Contractor Teleconference/Webcast – More about Modifiers

When: February 14, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Evaluation & Management – Emergency Department Services Webcast

When: February 19, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

National Provider Identifier (NPI) Webcast

When: February 20, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Hot Topics: Medicare Updates Teleconference/Webcast

When: March 13, 2008
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Webcast

Two Easy Ways To Register

Online – To register for this seminar, please visit our new training Web site at *http://www.fcsomedicaretraining.com*.

- If you are already a registered user of FCSO's Learning Management System (LMS), simply log on, select the specific session you are interested in, and click the "Register" button.
- If you are a **first-time user** of the LMS, you will need to set up an account. To do so, follow these steps:
  - From the welcome page, click on "I need to request an account" just above the log on button.
  - Complete the Request User Account form. (**Note:** Providers who do not yet have an NPI may use 9999.) You will receive your log on information within 72 hours of requesting an account.
  - Once your registration is complete, log on and select "Course Catalog," then select "Catalog." Select the specific session you are interested in, and then click the "Register" button.

Fax – If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to (904) 361-0407. Keep listening to information on the FCSO Provider Education 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.
- Dates and times are subject to change prior to event advertisement.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

More educational events (teleconferences, webcasts, etc.) will be planned to help providers with hot issues. Keep checking our Web site, *http://www.floridamedicare.com* or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events!

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

Connecticut Medicare Part B welcomes any questions that you may have regarding the Medicare Part B program. Always be sure to clearly explain your question or concern. This will help our staff to know exactly what issues to address when developing a response to your inquiry.

Please submit your questions to the appropriate department. This will ensure that your concerns are handled in a proper and timely manner. This can be achieved by including an Attention Line below the address on the envelope. Listed below is a directory of departments that includes the issues that you would address to their attention.

With the exception of Redeterminations and Medicare EDI, please submit all correspondence with the appropriate attention line to:

***Attention:* (*insert dept name*)**
Medicare Part B CT
P.O. Box 45010
Jacksonville, FL 32232-5010

Attention: Correspondence

The Correspondence attention line is used for inquiries pertaining to general issues regarding Medicare Part B. Some examples of these issues are deductibles, assignment, and beneficiary address changes. Do not use words such as *REVIEW* or *RECHECK* when sending general correspondence.

Attention: Financial Services

Use this attention line to return duplicate payments or overpayment refunds.

Attention: Fraud and Abuse

If you encounter what you believe is suspected, potential, or possible fraud or abuse of the Medicare program, we encourage you to contact this department.

Attention: Freedom of Information (FOIA)

This department handles requests for information available under the Freedom of Information Act.

Attention: Medical Review

Questions regarding LMRPs/LCDs and correct documentation for evaluation and management services are handled by this department. Documentation for off-label chemotherapy use should also be submitted to the Medical Review Department.

Attention: MSP

Write to the Medicare Secondary Payer (MSP) department when submitting an Explanation of Benefits from a primary insurance, Exhaust letters from Auto Liability claims, and MSP calculation review requests.

Attention: Pricing/ Provider Maintenance

Address your envelope to this department to apply for a new provider number, change a business or billing address of a provider, or to make any changes in the status of a provider. This department also handles fee schedule requests and inquiries, participation requests, and UPIN requests.

Attention: Resolutions

Use the Resolutions attention line when inquiring or submitting information regarding dates of death, incorrect Medicare (HIC) numbers, incorrect beneficiary information, etc.

MAILING ADDRESS EXCEPTIONS

We have established special P.O. boxes to use when mailing your redeterminations and hearings requests, paper claims, or to contact Medicare EDI:

Redeterminations/Appeals

Please mail only your requests for redeterminations to this P.O. Box. *DO NOT* send new claims, general correspondence, or other documents to this location; doing so will cause a delay in the processing of that item.

If you believe the payment or determination is incorrect and want a claim to be reconsidered, then send it to the attention of the review department. Requests for redeterminations must be made within 120 days of the date of the Medicare Summary Notice. These requests should not include redetermination requests on Medicare Secondary Pay calculations. Claims that are denied for return/reject need to be resubmitted and should **not** be sent as a redetermination. These resubmitted claims should be sent in as new claims.

Post Office Box for Appeals:

Medicare Part B CT Appeals
First Coast Service Options, Inc.
P.O. Box 45041
Jacksonville, FL 32232-5041

Post Office Box for EDI:

Electronic Media Claims/EDI

The Electronic Data Interchange department handles questions and provides information on electronic claims submission (EMC).

Medicare Part B CT Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Claims

The Heath Insurance Portability and Accountability Act (HIPAA) requires electronic submission of mpst types of Medicare claims. We realize, however, that on occasion it is necessary to submit a paper claim. When this happens, submit your claims on the approved red-and-white Form CMS-1500 to:

Medicare Part B CT Claims
P.O. Box 44234
Jacksonville, FL 32231-4234

CONNECTICUT MEDICARE PHONE NUMBERS

Beneficiary Services
1-800-MEDICARE ***(toll-free)***
1-866-359-3614 *(hearing impaired)*
First Coast Service Options, Inc.
Provider Services
Medicare Part B
1-888-760-6950

Appeals
1-866-535-6790, option 1

Medicare Secondary Payer
1-866-535-6790, option 2

Provider Enrollment
1-866-535-6790, option 4

Interactive Voice Response
1-866-419-9455

Electronic Data Interchange (EDI)
Enrollment
1-203-639-3160, option 1

PC-ACE® PRO-32
1-203-639-3160, option 2

Marketing and Reject Report Issues
1-203-639-3160, option 4

Format, Testing, and Remittance Issues
1-203-639-3160, option 5

Electronic Funds Transfer Information
1-203-639-3219

Hospital Services
National Government Services
Medicare Part A
1-888-855-4356

Durable Medical Equipment
NHIC
DME MAC Medicare Part B
1-866-419-9458

Railroad Retirees
Palmetto GBA
Medicare Part B
1-877-288-7600

Quality of Care
Qualidign (Peer Review Organization)
1-800-553-7590

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

To Report Lost or Stolen Medicare Cards
1-800-772-1213

Health Insurance Counseling Program (CHOICES)/Area Agency on Aging
1-800-994-9422

Department of Social Services/ConnMap
1-800-842-1508

ConnPACE/ Assistance with Prescription Drugs
1-800-423-5026 or 1-860-832-9265 (Hartford area or from out of state)

MEDICARE WEB SITES

PROVIDER
Connecticut
http://www.connecticutmedicare.com
Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov

BENEFICIARIES
Centers for Medicare & Medicaid Services
http://www.medicare.gov

Florida Medicare Part B Mail Directory

CLAIMS SUBMISSIONS

Routine Paper Claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating Providers
Medicare Part B Participating Providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic Claims
Medicare Part B Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance Claims
Medicare Part B Ambulance Dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare Secondary Payer
Medicare Part B Secondary Payer Dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD Claims
Medicare Part B ESRD Claims
P. O. Box 45236
Jacksonville, FL 32232-5236

COMMUNICATIONS

Redetermination Requests
Medicare Part B Claims Review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair Hearing Requests
Medicare Hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Administrative Law Judge Hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration Manager

Status/General Inquiries
Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B Financial Services
P. O. Box 44141
Jacksonville, FL 32231-4141

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For Education Event Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare Claims for Railroad Retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and Abuse
First Coast Service Options, Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Florida Medicare Phone Numbers

PROVIDERS

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992

BENEFICIARY

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

For Education Event Registration (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

DME, ORTHOTIC OR PROSTHETIC CLAIMS

Cigna Government Services
1-866-270-4909

MEDICARE PART A

Toll-Free:
1-866-270-4909

Medicare Web sites

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

ORDER FORM — 2008 PART B MATERIALS

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO with the designated account number indicated below.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Medicare B Update! Subscription – The Medicare B Update! is available free of charge online at http://www.fcso.com (click on Medicare Providers). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2007 through September 2008.	40300260	Hardcopy $60.00		
		CD-ROM $20.00		
2008 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2008 through December 31, 2008, is available free of charge online at http://www.fcso.com (click on Medicare Providers). Additional copies or a CD-ROM is available for purchase. The Fee Schedule contains calendar year 2008 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the Medicare B Update! Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	40300270	Hardcopy: FL $12.00		
		Hardcopy: CT $12.00		
		CD-ROM: FL $6.00		
		CD-ROM CT $6.00		
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

First Coast Service Options, Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Please make check/money order payable to: FCSO Account # (fill in from above)
(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

MEDICARE B UPDATE!

FIRST COAST SERVICE OPTIONS, INC.
P.O. BOX 2078 JACKSONVILLE, FL 32231-0048 (FLORIDA)
P.O. BOX 44234 JACKSONVILLE, FL 32231-4234 (CONNECTICUT)

* ATTENTION BILLING MANAGER *