MEDICARE B Update!

A NEWSLETTER FOR FLORIDA MEDICARE PART B PROVIDERS

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

In This Issue...

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:

- ☐ Physician/Provider
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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 1-904-361-0723.

FROM THE CONTRACTOR

FAREWELL TO CONNECTICUT PROVIDERS

HELLO EVERYONE!

This is the last issue of the *Medicare B Update!* to be published by First Coast Service Options Inc. (FCSO) for Connecticut providers. As you know, as of August 1, 2008, FCSO will no longer be the Medicare Part B carrier in Connecticut; National Government Services (NGS) will be the Medicare administrative contractor (MAC) for both Medicare Part A & B for the states of Connecticut and New York.

The Connecticut Provider Outreach & Education department would like to take this opportunity to thank each and every one of our providers for your attendance in educational events, participation in the Provider Outreach & Education Advisory Group (POE AG) meetings, and for all your suggestions and recommendations over the years that helped us to help you. NGS, as the incoming contractor, will now be providing outreach and education, and it is our sincere hope that you will be able to forge as positive a relationship with them as you have with us.

Warmest Regards,

Andrea Freibauer & Donna Pisani
FCSO Connecticut Provider Outreach & Education

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.

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.

AMBULANCE

INCREASED PAYMENT FOR GROUND AMBULANCE SERVICES UNDER MIPPA

The Centers for Medicare & Medicaid Services will soon be issuing formal contractor instructions that will incorporate the information contained in this announcement.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. In accordance with Section 146(a) of MIPPA, ambulance fee schedule amounts for ground ambulance services will increase.

The increase will be effective for claims with dates of service on or after July 1, 2008, and before January 1, 2010. Specifically,

- For covered ground ambulance transports which originate in a rural area, the fee schedule amounts are increased by 3 percent; and
- For covered ground ambulance transports which originate in a non-rural area, the fee schedule amounts are increased by 2 percent.

Contractors have been instructed to hold all ambulance claims affected by these changes, and release them for processing upon implementation of the revised fee schedule files. Contractors have also been instructed to identify and, to the extent possible, automatically reprocess any claims that were paid under the pre-MIPPA fee schedule rates and to complete that reprocessing no later than September 30, 2008. There will, however, be some claims that cannot be automatically adjusted (e.g., the initial claim's submitted charge was below the new fee schedule amount). Ambulance providers should contact their claims processing contractor for guidance on obtaining an adjustment of these claims.

In addition MIPAA Section 146(b)(1) makes changes for certain air ambulance services provided July 1, 2008 – December 31, 2009. CMS will be issuing guidance to contractors on how to implement these changes and will send out another listserv message when additional information is available on this provision.

Source: Provider Education Resource Message 200807-28

AMBULATORY SURGICAL CENTER

JULY 2008 UPDATE TO THE AMBULATORY SURGICAL CENTER PAYMENT SYSTEM; SUMMARY OF PAYMENT POLICY CHANGES

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

PROVIDER TYPES AFFECTED

Providers (ASCs) who submit claims to Medicare administrative contractors (A/B MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

PROVIDER ACTION NEEDED

This article is based on change request (CR) 6095 which describes changes to, and billing instructions for, payment policies implemented in the July 2008 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals, descriptors for newly created Level II Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biologicals, and payment rates and descriptors for three newly created Category III *Common Procedural Terminology* (*CPT*) codes that are added to the list of payable procedures. Code deletions are also identified in this notification. Be sure billing staff is aware of these changes.

Key Points of CR 6905
Billing for Drugs and Biologicals

The Centers for Medicare & Medicaid Services (CMS) strongly encourages ASCs to report charges for all separately payable drugs and biologicals, using the correct HCPCS codes for the items used. ASCs billing for these products should make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of the drug or biological that was used in the care of the patient. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.

Remember that under the outpatient prospective payment system (OPPS), if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product report an appropriate unlisted code such as J9999 or J3490.

July 2008 Update to the ASC Payment System; Summary of Payment Policy Changes (continued)

Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective July 1, 2008

- Payments for separately payable drugs and biologicals based on the ASP will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates for previous quarter(s) are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2008 release of the ASC DRUG FILE.
- Your Medicare contractors will make available to the ASCs the list of any newly added codes and previous quarter payment rate changes as identified in CR 6095.
- Providers take note that, if your claims were processed prior to the installation of the revised January or April 2008 ASC Drug file, your Medicare AB/MAC or carrier will adjust, as appropriate, claims you bring to their attention that have dates of service on or after January 1, 2008 but prior to July 1, 2008.

New HCPCS Drugs and Biologicals Separately Payable under the ASC Payment System Effective July 1, 2008

The four HCPCS codes that are newly payable in ASCs and their descriptors are listed in Table 1 below.

Table 1
New Drugs and Biologicals Separately Payable under the ASC Payment System as of July 1, 2008

HCPCS Code	Short Descriptor
C9242	Injection, fosaprepitant
C9356	TendoGlide Tendon Prot, cm2
C9357	Flowable Wound Matrix, 1 cc
C9358	SurgiMend, per 0.5cm2

The payment rates for these drugs in Table 1 are included in the July 2008 update of the ASC Addendum BB which will be posted at the end of June at *http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp* on the CMS Web site.
No HCPCS codes are being deleted from the ASC DRUG file for July 2008.

Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008

The payment rates for several HCPCS codes were incorrect in the January 2008 ASC DRUG file. The corrected payment rates are listed below in Table 2 and have been included in the revised January 2008 ASC DRUG file, effective for services furnished on January 1, 2008 through March 31, 2008. Your Medicare contractor will adjust Claims affected by these corrections if you bring such claims to their attention.

Table 2
Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008

HCPCS	Short Descriptor	ASC Payment Indicator	Corrected Payment Rate
90675	Rabies vaccine, im	K2	150.27
J2820	Sargramostim injection	K2	25.02
J9010	Alemtuzumab injection	K2	549.29
J9015	Aldesleukin/single use vial	K2	764.56
J9226	Supprelin LA implant	K2	14694.12

Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

The payment rates for several HCPCS codes were incorrect in the April 2008 ASC DRUG file. The corrected payment rates are listed below in Table 3 and have been corrected in the revised April 2008 ASC DRUG file effective for services furnished on April 1, 2008 through June 30, 2008. Your Medicare contractor will adjust Claims affected by these corrections if you bring such claims to their attention.

Table 3
Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

HCPCS	Short Descriptor	ASC Payment Indicator	Corrected Payment Rate
J2323	Natalizumab injection	K2	7.51
J2778	Ranibizumab inj	K2	406.18
J3350	Urea Injection	K2	23.23
J3488	Reclast injection	K2	216.61

Correct Reporting of Units for Drugs

ASCs are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

- For example, if the drug's HCPCS code descriptor specifies six mg, and six mg of the drug were administered to the patient, the units billed should be one.
- As another example, if the drug's HCPCS descriptor specifies 50 mg and 200 mg of the drug were administered to the patient, the units billed should be four.
- ASCs should not bill the units based on how the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies one mg and a 10 mg vial of the drug was administered to the patient, 10 units should be reported on the bill, even though only one vial was administered.

July 2008 Update to the ASC Payment System; Summary of Payment Policy Changes (continued)

- HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

Payment for Brachytherapy Sources as of July 1, 2008

The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires CMS to pay for brachytherapy sources for the period of January 1 through June 30, 2008 at hospitals' charges adjusted to costs. Consistent with CMS policy to pay ASCs at contractor-priced rates if prospective OPPS rates are not available for brachytherapy sources, for the period January 1 through June 30, 2008, ASCs are paid at contractor-priced rates for these sources. The prospective payment rates for each source, which are listed in Addendum BB to CMS CY 2008 final rule dated November 27, 2007, will be used for payment from July 1 through December 31, 2008. These payment rates are also included in the revised ASCFS effective for dates of service beginning July 1, 2008. The "H7" payment indicators assigned to brachytherapy source HCPCS codes in the April 2008 Addendum BB on the CMS Web site will change to "H2" to reflect the policy to pay for brachytherapy sources at prospectively determined rates, as in Addendum BB published with the CY 2008 OPPS/ASC final rule with comment period.

The HCPCS codes for separately payable brachytherapy sources, long descriptors, and payment indicators for CY 2008 are listed in Table 4 below.

Note that when billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and not bill as one unit per strand. The payment rates for these brachytherapy sources will be available in Addendum BB posted on the CMS Web site at the end of June.

Table 4
Comprehensive List of Brachytherapy Sources Payable as of July 1, 2008

HCPCS	Short Descriptor	Payment Indicator
A9527	Iodine I-125 sodium iodide	H2
C1716	Brachytx, non-str, Gold-198	H2
C1717	Brachytx, non-str, HDR Ir-192	H2
C1719	Brachytx, NS, Non-HDRIr-192	H2
C2616	Brachytx, non-str, Yttrium-90	H2
C2634	Brachytx, non-str, HA, I-125	H2
C2635	Brachytx, non-str, HA, P-103	H2
C2636	Brachy linear, non-str,P-103	H2
C2638	Brachytx, stranded, I-125	H2
C2639	Brachytx, non-stranded, I-125	H2
C2640	Brachytx, stranded, P-103	H2
C2641	Brachytx, non-stranded, P-103	H2
C2642	Brachytx, stranded, C-131	H2
C2643	Brachytx, non-stranded,C-131	H2
C2698	Brachytx, stranded, NOS	H2
C2699	Brachytx, NOS	H2

Category III *CPT* Codes

CMS is implementing three new Category III *CPT* codes that are appropriate for payment in ASCs, effective July 1, 2008. The new Category III codes and their ASC payment indicators are shown in Table 5 below. Payment rates for these services can be found in Addendum AA of the July 2008 ASC update that will be posted on the CMS Web site at the end of June. These new Category III *CPT* codes and their payment rates are included in the July release of the ASC fee schedule.

Table 5
Category III *CPT* Codes Implemented as ASC Covered Surgical Procedures as of July 1, 2008

CPT	Short Descriptor	SI
0190T	Place intraoc radiation src	G2
0191T	Insert ant segment drain int	G2
0192T	Insert ant segment drain ext	G2

ASC Payment for Office-Based Procedures and Radiology Services

ASC payment for office-based procedures and radiology services are made at the lesser of the non-facility practice expense (PE) relative value units (RVU) amount under the Medicare physician fee schedule or the ASC rate for the service calculated according to the standard ASC methodology. The provisions of Section 109(b) of the Medicare, Medicaid and SCHIP Extension Act of 2007 expire after June 30, 2008 and, therefore, the MPFS payment rates for July 1 through December 31, 2008 will be those issued by CMS in the MPFS final rule (72 FR 66410). The changes to those rates result in changes to rates for some covered office-based surgical procedures and covered ancillary radiology services paid under the ASC payment system.

Beginning July 1, 2008, ASC payment amounts for office-based procedures and radiology services will be equal to the rates displayed in Addenda AA and BB to the OPPS/ASC final rule with comment period (72 FR 66945 and 67165) and will be included in Addenda AA and BB that will be posted on the CMS Web site at the end of June. These revised rates are included in the July release of the ASCFS.

July 2008 Update to the ASC Payment System; Summary of Payment Policy Changes (continued)

ADDITIONAL INFORMATION

To see the official instruction (CR 6095) issued to your Medicare carrier or A/B MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R1540CP.pdf* on the CMS Web site. Your Medicare contractor will make the July 2008 ASC fee schedule data for their localities available on their Web site.

If you have questions, please contact your Medicare 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: MM6095
Related CR Release Date: June 20, 2008
Related CR Transmittal #: R1540CP
Related Change Request (CR) #: 6095
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

CONSOLIDATED BILLING

OCTOBER QUARTERLY UPDATE TO 2008 ANNUAL UPDATE OF HCPCS CODES USED FOR SKILLED NURSING FACILITY CONSOLIDATED BILLING ENFORCEMENT

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 and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is based on change request (CR) 6111 which provides the October quarterly update to the 2008 Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing facility (SNF) consolidated billing (CB) enforcement.

BACKGROUND

The Social Security Act (Section 1888; see *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm* on the Internet) codifies SNF prospective payment system (PPS) CB, and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law.

Services appearing on this list of updated HCPCS codes that are submitted on claims to Medicare fiscal intermediaries, carriers, or A/B MACs will not be paid by Medicare to any providers other than an SNF when included in SNF CB.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

For October 1, 2008, the only change is that Medicare systems will add HCPCS code L5670 (Addition to lower extremity, below knee, molded supracondylar suspension [PTS or similar]) to the file 1 coding list. Your Medicare contractor will reopen and reprocess claims with dates of service on or after January 1, 2008 that are affected by this change if you bring such claims to their attention.

ADDITIONAL INFORMATION

The official instruction, CR 6111, issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1537CP.pdf* on the CMS Web site.

If you have any questions, please contact your 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: MM6111
Related Change Request (CR) #: 6111
Related CR Release Date: June 20, 2008
Effective Date: October 1, 2008
Related CR Transmittal #: R1537CP
Implementation Date: October 6, 2008

EVALUATION AND MANAGEMENT

PAYMENT FOR INPATIENT HOSPITAL VISITS—GENERAL

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the April 2008 Medicare B Update! pages 20-21.

Note: This article was revised on June 30, 2008, to reflect changes made to change request (CR) 5792. The CR was revised to clarify that hospital emergency services are not paid for the same date as critical care services when provided by the same physician to the same patient. The CR transmittal number, release date, and Web address for accessing the CR were also changed. All other information remains the same.

PROVIDER TYPES AFFECTED

Physicians and nonphysician practitioners (NPPs), submitting claims to Medicare administrative contractors (A/B MACs) and/or carriers for services provided to Medicare beneficiaries during a hospital visit.

PROVIDER ACTION NEEDED

Providers should note the payment policy for billing inpatient hospital visits provided on the same day as critical care services. See the *Key Points* section of this article for a complete list of the updates.

BACKGROUND

CR 5792 updates chapter 12, section 30.6.9 of the *Medicare Claims Processing Manual*. The updated section of this manual is attached to CR 5792 and the address/link to that CR is listed in the *Additional Information* section of this article.

Key Points

Physicians and qualified NPPs should note the payment policy requirements according to CR 5792 are as follows:

- When a hospital inpatient or office/outpatient evaluation and management (E/M) service is furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care, both the critical care services (*Current Procedural Terminology* (*CPT*) codes *99291* and *99292*) and the previous E/M service may be paid for the same date of service. (Note that hospital emergency department services are not paid for the same date as critical care services when provided by the same physician to the same patient.)
- During critical care management of a patient those services that do not meet the level of critical care should be reported using an inpatient hospital care service with *CPT* subsequent hospital care using a *CPT* code in the *99231-99233* range.
- Physicians and qualified NPPs may report both critical care services and an inpatient hospital care service for the same patient on the same calendar date when during critical care management of a patient the services do not meet the level of critical care services.
- Physicians and qualified NPPs are reminded that both initial hospital care codes (*CPT* codes *99221-99223*) and subsequent hospital care codes are "per diem" services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.
- Physicians and qualified NPPs are advised to retain documentation for discretionary Medicare carrier or A/B MAC review in case claims are questioned. The retained documentation must support why the same physician or physicians of the same specialty in a group practice submitted claims for both critical care services and other E/M services for the patient on the same date of service.

ADDITIONAL INFORMATION

You may see the official instruction (CR 5792) issued to your Medicare A/B MAC or carrier by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1545CP.pdf* on the CMS Web site.

If you have questions, please contact your Medicare A/B 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).

MLN Matters Number: MM5792 *Revised*
Related Change Request (CR) #: 5792
Related CR Release Date: June 27, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1545CP
Implementation Date: April 7, 2008

CRITICAL CARE VISITS AND NEONATAL INTENSIVE CARE

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2008 Medicare B Update! pages 16-21.

Note: This article was revised on July 10, 2008, to reflect changes made to change request (CR) 5993 on July 9. CR 5993 was revised to reflect longstanding policy regarding critical care services and other evaluation and management services on the same day, to correct information regarding calculation of critical care time to be consistent with the *American Medical Association's Current Procedural Terminology (CPT)*, and to make minor clarifications in language related to time spent reviewing or discussing patient information and off the unit/floor and split/shared service discussions.

PROVIDER TYPES AFFECTED

Physicians and qualified nonphysician practitioners (NPPs) who bill Medicare carriers and Medicare administrative contractors (A/B MAC) for critical care services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

CR 5993, from which this article is taken, revises the *Medicare Claims Processing Manual*, chapter 12 (Physicians/Nonphysician Practitioners), section 30.6.12. (Critical Care Visits and Neonatal Intensive Care [Codes 99291 - 99292]), replacing all previous critical care payment policy language in the section and adding general Medicare evaluation and management (E/M) payment policies that impact payment for critical care services.

Specifically, CR 5993:

- Explains the definition of, and how to bill for, critical care services, and includes the *CPT* definitions of critical care and critical care services.
- Adds a new *CPT* code for 2008 (*36591*) which replaces code *36540*. Code *36591* identifies a bundled vascular access procedure when performed with a critical care service.

Make sure that your billing staffs are aware of these revisions.

BACKGROUND

CR 5993, from which this article is taken, explains the definition of critical care services and how to correctly bill for these services. It discusses medically necessary services, full physician attention, counting the hours of critical care billing, performance of other evaluation and management (E/M) services on the same day as critical care services, group practice issues, services by a qualified nonphysician practitioner (NPP), bundled procedures, global surgery issues, ventilation management, teaching physician issues, physician services off the unit/floor, split/shared services, unbundled procedures, and inappropriate use of time and family counseling and discussions.

The following summarizes the information contained in CR 5993 and in *Medicare Claims Processing Manual*, chapter 12, section 30.6.12, which is an attachment to CR 5993.

Use of Critical Care Codes (CPT codes *99291-99292*)

Critical care is defined as a physician's (or physicians') direct delivery of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system functions to treat single, or multiple, vital organ system failure; and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include (but are not limited to):

- Central nervous system failure
- Circulatory failure
- Shock
- Renal, hepatic, metabolic, and/or respiratory failure.

Although it typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.

You should remember that providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. While critical care is usually given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department, payment may also be made for critical care services that you provide in any location as long as this care meets the critical care definition.

When all these criteria are met, Medicare contractors (carriers and A/B MACs) will pay for critical care and critical care services that you report with *CPT* codes *99291* and *99292* (described below).

Critical Care Services and Medical Necessity

Critical care services must be reasonable and medically necessary. As explained above, critical care services encompass both the treatment of "vital organ failure" and "prevention of further life threatening deterioration in the patient's condition." Therefore, delivering critical care in a moment of crisis, or upon being called to the patient's bedside emergently, is not the only requirement for providing critical care service. Treatment and management of a patient's condition, in the threat of imminent deterioration; while not necessarily emergent, is required.

In this context, examples of patients whose medical conditions may warrant critical care services would include:

1. An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and vasopressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
2. A 67 year old female patient is three days status post mitral valve repair. She develops petechiae, hypotension, and hypoxia requiring respiratory and circulatory support.
3. A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive two days after admission.
4. A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

You should not consider that the provision of care to a critically ill patient is automatically a critical care service just because the patient is critically ill or injured. To this point, each physician providing critical care services to a patient during the critical care episode of an illness or injury must be managing one or more of the critical illness(es) or injury(ies) in whole, or in part.

In this context, examples of scenarios in which a patient's medical condition may not warrant critical care services would include:

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1. A dermatologist evaluating and treating a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist.
2. Daily management of a patient on chronic ventilator therapy unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence.
3. Management of dialysis or care related to dialysis for a patient receiving end-stage renal disease (ESRD) hemodialysis, unless the critical care is separately identifiable from the chronic long term management of the dialysis dependence (Refer to *Medicare Claims Processing Manual*, chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), section 160.4 (Requirements for Payment).

Note: When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed it may be billed as critical care, if critical care requirements are met. Modifier 25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) should be appended to the critical care code when applicable in this situation.

Similarly, examples of patients who may not satisfy Medicare medical necessity criteria for critical care payment would include:

- Patients admitted to a critical care unit because no other hospital beds were available.
- Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose).
- Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

You may also want to consult the *CPT* for the applicable codes and guidance for critical care services provided to neonates, infants and children. Critical care services provided in the outpatient setting (e.g., emergency department or office) for neonates and pediatric patients up through 24 months of age, use the hourly critical care codes *99291* and *99292*.

For all other inpatient neonatal and pediatric critical care, refer to *CPT* for guidance on the correct use of codes.

Critical Care Services and Full Attention of the Physician

The duration of critical care services that physicians should report is the time you actually spend evaluating, managing, and providing the critically ill, or injured, patient's care. Be aware that during this time, you cannot provide services to any other patient, but rather must devote your full attention to this particular critically ill patient.

This time must be spent at the patient's immediate bedside or elsewhere on the floor, or unit, so long as you are immediately available to the patient. For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be reported as critical care, even when it does not occur at the bedside; if this time represents your full attention to the management of the critically ill/injured patient.

Note: Time spent off the unit or floor where the critically ill/injured patient is located (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) floor may not be reported as critical care time because the physician is not immediately available to the patient. This time is regarded as pre- and post-service work bundled in evaluation and management services.

Critical Care Services and Qualified NPPs

Qualified NPPs may provide critical care services (and report for payment under their national provider identifier [NPI]), when these services meet the above critical care services definition and requirements.

Notes

1) The critical care services that NPPs provide must be within the scope of practice and licensure requirements for the state in which they practice and provide the services.

2) NPPs must meet the collaboration, physician supervision requirements, and billing requirements; and physician assistants (PA) must meet the general physician supervision requirements.

Critical Care Services and Physician Time

Critical care is a time- based service. Payment for critical care services is not restricted to a fixed number of hours, days, or physicians (on a per-patient basis) when such services meet medical necessity; and time counted toward critical care services may be continuous clock time or intermittent in aggregated time increments (e.g. 50 minutes of continuous clock time or five ten minute blocks of time spread over a given calendar date). Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient. For each medical encounter, the physician's progress notes must document the total time that critical care services are provided.

For Medicare Part B physician services, paid under the physician fee schedule, critical care is not a service that is paid on a "shift" basis or a "per day" basis. Documentation may be requested for any claim to determine medical necessity. Examples of critical care billing that may require further review could include:

- Claims from several physicians submitting multiple units of critical care for a single patient.
- Submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date.

Physicians assigned to a critical care unit (e.g., hospitalist, intensivist etc.) may not report critical care for patients based on a "per shift" basis. You should use *CPT* code *99291* (evaluation and management of the critically ill or critically injured patient, first 30-74 minutes) to report the first 30-74 minutes of critical care on a given calendar date of service. You can only use this code once per calendar date to bill for care provided for a particular patient by the same physician or physician group of the same specialty.

CPT code *99292* (critical care, each additional 30 minutes) is used to report each additional 30 minutes beyond the first 74 minutes of critical care. It may also be used to report the final 15 - 30 minutes of critical care on a given date. Critical care of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes is not separately payable. Critical care of less than 30 minutes total duration on a given calendar date is not reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

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Table 1 (below) illustrates the correct reporting of critical care services, followed by a clinical example.

Table 1
Reporting of Critical Care Services

Total Duration of Critical Care	Appropriate CPT Codes
Less than 30 minutes	99232 or 99233 or other appropriate E/M code
30 - 74 minutes	99291 x 1
75 - 104 minutes	99291 x 1 and 99292 x 1
105 - 134 minutes	99291 x1 and 99292 x 2
135 - 164 minutes	99291 x 1 and 99292 x 3
165 - 194 minutes	99291 x 1 and 99292 x 4
194 minutes or longer	99291 – 99292 as appropriate (per the above illustrations)

Clinical Example of Correct Billing of Time

A patient arrives in the emergency department (ED) in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the ED and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the CCU. In this instance, the ED physician provided 40 minutes of critical care services and reports only the critical care code (*CPT* code *99291*) and not also codes for emergency department services. Using *CPT* code *99291*, the cardiologist may also report the 35 minutes of critical care services provided in the ED. Additional critical care services by the cardiologist in the CCU (on the same calendar date) using *99292* or another appropriate E/M code depending on the clock time involved.

Other Critical Care Issues

There are some specific rules about physician services and time that you should know:

1. Only one physician can bill for critical care during any one single period of time. Unlike other E/M services, critical care services reflect one physician's (or qualified nonphysician practitioner's [NPP) care and management of a critically ill or critically injured patient for the specified reportable period of time. You cannot report a split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) as a critical care service. The critical care service reported should reflect the evaluation, treatment and management of the patient by the individual physician or qualified nonphysician practitioner and not representative of a combined service between a physician and a qualified NPP.
   When *CPT* code requirements for time and critical care requirements are met for a medically necessary visit by an individual clinician the service shall be reported using the appropriate individual NPI number. Medically necessary visit(s) that do not meet these requirements shall be reported as subsequent hospital care services. Please note that medically necessary service(s) that do not meet critical care criteria may be reported as subsequent hospital care services.
   In denying a claim for a critical care service that is a split/shared service, carriers and A/B MACs will use the following messages:

   Claims Adjustment Reason Code
   150 – Payment adjusted because the payer deems the information submitted does not support this level of service.

   Remittance Advice Reason Code
   N180 – This item or service does not meet the criteria for the category under which it was billed.

   Medicare Summary Notice
   17.11 – This item or service cannot be paid as billed.

   For unassigned claims, Medicare contractors will use add-on message 16.34 – You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the "you may be billed" column.

   For assigned claims, Medicare contractors will use add-on message 16.35 – You do not have to pay this amount.

2. When performed on the day a physician bills for critical care, the following services are included in the critical care service, and should not be reported separately:
   - the interpretation of cardiac output measurements (*CPT 93561*, *93562*)
   - chest x-rays, professional component (*CPT 71010*, *71015*, *71020*)
   - blood draw for specimen (*CPT 36415*)
   - blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data [*CPT 99090*])
   - gastric intubation (*CPT 43752*, *91105*)
   - pulse oximetry (*CPT 94760*, *94761*, *94762*)
   - temporary transcutaneous pacing (*CPT 92953*)
   - ventilator management (*CPT 94002 – 94004*, *94660*, *94662*)
   - vascular access procedures (*CPT 36000*, *36410*, *36415*, *36591*, *36600*)

   No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately.

3. Concurrent care by more than one physician (generally representing different physician specialties) is payable if the services all meet critical care requirements, are medically necessary, and are not duplicative. Refer to *Medicare Benefit Policy Manual*, chapter 15 (Covered Medical and Other Health Services), section 30 (Physician Services) for concurrent care policy discussion).
   Critically ill or injured patients may require the care of more than one physician medical specialty, but keep in mind that the critical care services provided by each physician must be medically necessary. Medicare will pay for non-duplicative, medically necessary critical care services provided by 1) physicians from the same group practice; or 2) from different group practices to the same patient.

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Note: Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the carrier who adjudicates the claims. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative the critical care services may be reported by each regardless of their group practice relationship.

Your medical record documentation must support that the critical care services each physician provided were necessary for treating and managing the patient's critical illness(es) or critical injury(ies). Each physician must accurately report the service(s) he/she provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Refer to *Medicare Claims Processing Manual*, chapter 12 [Physicians/Nonphysician Practitioners], and section 40 [Surgeons and Global Surgery]; and *Medicare Benefit Policy Manual*, chapter 15 [Covered Medical and Other Health Services], and section 30 [Physician Services]).
You will need to follow these specific coding requirements.

- The initial critical care time (billed as *CPT 99291*) must be met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date. A history or physical examination performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.
- Subsequent critical care visits performed on the same calendar date are reported using *CPT 99292*. The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for *CPT 99292*. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care in order to combine the times.
- Physicians in the same group practice who have the same specialty may not each report *CPT* initial critical care code *99291* for critical care services to the same patient on the same calendar date. Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician. (Refer to *Medicare Claims Processing Manual*, chapter 12 (Physicians/Nonphysician Practitioners.)
- Physicians in the same group practice, with different specialties, who provide critical care to a critically ill or critically injured patient may not always each report the initial critical care code (*CPT 99291*) on the same date. When these physicians are providing care that is unique to his/her individual medical specialty, and are managing at least one of the patient's critical illness(es) or critical injury(ies); then the initial critical care service may be payable to each. However, if a physician (or qualified NPP) within a group provides "staff coverage" or "follow-up" for another group physician who provided critical care services on that same calendar date but has left the case; the second group physician (or qualified NPP) should report the *CPT* critical care add-on code *99292*, or another appropriate E/M code.

Clinical Examples of Critical Care Services

a) Two pulmonary specialists, who share a group practice, each provide critical care services (at different times during the same day) to a patient who has multiple organ dysfunction (including cerebral hematoma, flail chest and pulmonary contusion), is comatose, and has been in the intensive care unit for 4 days following a motor vehicle accident. Both physicians may report medically necessary critical care services provided at the different time periods. One physician would report *CPT* code *99291* for the initial visit and the second, as part of the same group practice, would report *CPT* code *99292* on the same calendar date if the appropriate time requirements are met.

b) A 79 year old male comes to the emergency room with vague joint pains and lethargy. The ED physician evaluates him and phones his primary care physician to discuss his medical evaluation. His primary care physician visits the ER and admits him to the observation unit for monitoring, and diagnostic and laboratory tests; during which time he has a cardiac arrest. His primary care physician provides 50 minutes of critical care services, and admits him to the intensive care unit. On the same calendar day his condition deteriorates and he requires intermittent critical care services. In this scenario, the ED physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.

4. When a patient requires critical care services upon presentation to a hospital emergency department, you may only report critical care codes *99291 - 99292*. You may not also report an emergency department visit code.

   However, when critical care services are provided on a day during which a hospital, emergency department, or office/outpatient evaluation and management service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous evaluation and management service may be paid. Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient. Physicians are advised to submit documentation to support a claim when critical care is additionally reported on the same calendar date as when other evaluation and management services are provided to a patient by the same physician or physicians of the same specialty in a group practice.

5. Critical care services will not be paid on the same calendar date that the physician also reports a procedure code with a global surgical period, unless the critical care is billed with *CPT* modifier 25 to indicate that the critical care is a significant, separately identifiable, evaluation and management service that is above and beyond the usual pre and post operative care associated with the procedure that is performed. Services such as endotracheal intubation (*CPT 31500*)

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and the insertion and placement of a flow directed catheter e.g., Swan-Ganz (*CPT 93503*) are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier *25*. The time spent performing the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, should be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0, 10, or 90 day global period including cardiopulmonary resuscitation (CPR — *CPT 92950*). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care maybe billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier *25*. The time spent performing CPR should be excluded from the determination of the time spent providing critical care. In this instance the physician who performs the resuscitation must bill for this service. Members of a code team cannot each bill Medicare Part B for this service.

When a physician, other than the surgeon, provides postoperative critical care services (for procedures with a global surgical period); no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, both the surgeon and intensivist, who are submitting claim, must use *CPT* modifiers *54* (surgical care only) and *55* (postoperative management only).

Critical care services must meet all the conditions previously described, and the medical record documentation of the surgeon and physician who assumes a transfer (e.g., intensivist's), must both support claims for services when *CPT* modifiers *54* and *55* are used indicating the transfer of care from the surgeon to the intensivist.

6. In addition to a global fee, critical care services provided during the preoperative portion and postoperative portions of the global period of procedures with 90-day global period in trauma and burn cases may be paid if the patient is critically ill and requires the full attention of the physician; and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed.

   Such patients may meet the definition of being critically ill and criteria for conditions where there is a high probability of imminent or life threatening deterioration in the patient's condition. Preoperatively, in order for these services to be paid, two reporting requirements must be met. Codes *99291 - 99292* and modifier *25* (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used, and documentation identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

   Postoperatively, in order for these services to be paid, two reporting requirements must also be met. Codes *99291 - 99292* and modifier *24* (unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted.

   An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

   Note: Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

7. Critical care *CPT* codes *99291* and *99292* include pre and post service work. Routine daily updates or reports to family members and or surrogates are considered part of this service.

   However, time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options (as described in *CPT*), may be counted toward critical care time when these specific criteria are met:

   - The patient is unable or incompetent to participate in giving a history and/or making treatment decisions.
   - The discussion is necessary for determining treatment decisions.

   For such family discussions, the physician should document:

   - The medically necessary treatment decisions for which the discussion was needed.
   - That the patient is unable or incompetent to participate in giving history and/or making treatment decisions.
   - The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family."
   - A summary in the medical record that supports this medical necessity.

   Telephone calls to family members and or surrogate decision-makers may be counted towards critical care time, only if they meet the same criteria as described in the aforementioned paragraph. Further, no other family discussions (no matter how lengthy) may be additionally counted towards critical care.

8. A teaching physician, to bill for critical care services, must meet the requirements for critical care described above. For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes. (See *Medicare Claims Processing Manual*, chapter 12 (Physicians/Nonphysician Practitioners), section 100.1.4 (Time-Based Codes).

   Time spent teaching may not be counted towards critical care time. Nor, can the teaching physician bill, as critical care or other time-based services, for time spent by the resident (in the teaching physician's absence). Only time that the teaching physician

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spends alone with the patient (and that he/she and the resident spend together with the patient), can be counted toward critical care time.

A combination of the teaching physician's documentation and the resident's documentation may support critical care services. Provided that all requirements for critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment.

However, the teaching physician medical record documentation must provide substantive information including:

- Time the teaching physician spent providing critical care.
- That the patient was critically ill during the time the teaching physician saw the patient.
- What made the patient critically ill.
- The nature of the treatment and management provided by the teaching physician.

The medical review criteria are the same for the teaching physician as for all physicians. (See *Medicare Claims Processing Manual,* chapter 12 (Physicians/Nonphysician Practitioners), section 100.1.1 (Evaluation and Management (E/M) Services) for teaching physician documentation guidance).

The following is an example of acceptable teaching physician documentation: "Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care." Conversely, the following is an example of unacceptable documentation from a teaching physician: "I came and saw (the patient) and agree with (the resident)."

9. Medicare recognizes ventilator codes (*CPT* codes *94002 - 94004*, *94660* and *94662*) as physician services payable under the physician fee schedule. Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to an E/M service (e.g., critical care services, *CPT* codes *99291 - 99292*) on the same day for the patient even when the E/M service is billed with *CPT* modifier *25*.

Physicians should consult the *CPT* manual for the applicable codes and guidance for critical care services provided to neonates, infants and children. Critical care services provided in the outpatient setting (e.g., emergency department or office) for neonates and pediatric patients up through 24 months of age, use the hourly critical care codes *99291* and *99292*.

For all other inpatient neonatal and pediatric critical care, refer to *CPT* for guidance on the correct use of codes.

ADDITIONAL INFORMATION

You may find more information about critical care visits and neonatal intensive care (codes *99291 - 99292*) by going to CR 5993, located at *http://www.cms.hhs.gov/Transmittals/downloads/*R1548CP*.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. Updated *Medicare Claims Processing Manual*, chapter 12 (Physicians/Nonphysician Practitioners), section 30.6.12. (Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292) is an attachment to that CR.

If you have any questions, please contact your 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.

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LABORATORY/PATHOLOGY

PAYMENT OF PHYSICIAN PATHOLOGY SERVICES FOR INDEPENDENT LABORATORIES

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

Note: This article was rescinded on July 17, 2008, since change request 6088 was rescinded on the same date.

MLN Matters Number: MM6088 *Rescinded*
Related Change Request (CR) #: 6088
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REINSTATEMENT OF MORATORIUM FOR ILS BILLING PATHOLOGY TC FOR HOSPITAL PATIENTS

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated that it would implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory (IL) could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule. As such, during this time, the carriers and, more recently, Medicare administrative contractors (MAC) have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

The most recent extension of the moratorium, established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), Section 104, expired on June 30, 2008. A new extension of the moratorium has been established by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Section 136, retroactive to July 1, 2008.

A previous communication indicated that the moratorium had ended and that independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This prohibition is rescinded and the moratorium will continue effective for claims with dates of service on and after July 1, 2008, but prior to January 1, 2010.

Source: Provider Education Resources Listserv, Message 200807-23
CMS Joint Signature Memorandum 08413, dated July 16, 2008

NEW WAIVED TESTS

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

PROVIDER TYPES AFFECTED

Providers and suppliers submitting claims to Medicare contractors (carriers and/or Part A/B Medicare administrative contractors [A/B MACs]) for clinical laboratory services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

STOP – Impact to You

This article is based on change request (CR) 6060 which informs Medicare contractors of new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA).

CAUTION – What You Need to Know

These 24 newly added CLIA waived tests are marketed immediately after approval and, through CR 6060, the Centers for Medicare & Medicaid Services (CMS) notifies its Medicare contractors of the new tests so that the contractors can accurately process claims.

GO – What You Need to Do

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

BACKGROUND

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that the CMS only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

The following table includes the latest new tests approved by the Food and Drug Administration as waived tests under CLIA. The *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test.

CPT Code	Effective Date	Description
86318QW	February 1, 2005	Alfa Scientific Designs Instant View H. Pylori Whole Blood Rapid Test
82977QW, 84460QW	January 22, 2007	Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 6 Panel){Whole Blood}
82977QW, 84460QW	January 22, 2007	Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 6 Panel){Whole Blood}
82150QW, 82977QW, 84075QW, 84460QW	January 22, 2007	Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}
82150QW, 82977QW, 84075QW, 84460QW	January 22, 2007	Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}

Reinstatement of Moratorium for ILs Billing Pathology TC for Hospital Patients (continued)

CPT Code	Effective Date	Description
82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84450QW, 84520QW	March 14, 2007	Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 6 Panel){Whole Blood}
82565QW, 82947QW, 82950QW, 82951QW,82952QW, 84450QW, 84520QW	March 14, 2007	Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 6 Panel){Whole Blood}
82042QW, 82247QW, 82310QW, 82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84157QW, 84450QW, 84520QW, 84550QW	March 14, 2007	Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}
82042QW, 82247QW, 82310QW, 82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84157QW, 84450QW, 84520QW, 84550QW	March 14, 2007	Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}
80101QW	June 28, 2007	Alfa Scientific Designs, Inc. Instant View Multi-Drug of Abuse Urine Test
80101QW	June 28, 2007	Alfa Scientific Designs, Inc. Instant-View Multi-Drug of Abuse Urine Cup Test
82330QW, 82374QW, 82435QW, 82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84132QW, 84295QW, 84520QW	September 21, 2007	Abbott i-STAT Chem8+ Cartridge {Whole Blood}
82274QW, G0328QW	October 5, 2007	BTNX Inc. Rapid Response Fecal Occult Blood (FOB) Self Test
82274QW, G0328QW	October 5, 2007	BTNX Inc. Know Fecal Occult Blood (FOB) Self Test
80101QW	January 8, 2008	Abbott Diagnostics Signify ER Drug Screen Test
86308QW	January 8, 2008	Jant Pharmacal Accutest Value + Mononucleosis Rapid Test {Whole Blood}
86308QW	January 8, 2008	Stanbio Rely Mono Rapid Test{Whole Blood}
87880QW	January 22, 2008	Becton Dickinson BD Chek Group A Strep A Test
86318QW	January 22, 2008	Diagnostic Test Group Clarity H. pylori Rapid Test Device {Whole Blood}
80101QW	January 30, 2008	BTNX Inc. Rapid Response Multi-Drug One Step Screen Test Panel (Urine)
80101QW	January 30, 2008	BTNX Inc. Know Multi-Drug One Step Screen Test Panel (Urine)
87807QW	February 25, 2008	Quidel Quick Vue RSV Test
84443QW	February 29, 2008	Qualigen, Inc. FastChek TSH {Whole Blood}]
83036QW	March 31, 2008	Bayer A1CNow+ {For professional use}

The new waived *CPT*/Healthcare Common Procedure Coding System (HCPCS) code(s):

- *84550QW* has been assigned for the uric acid test performed using the Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}
- *82330QW, 82374QW, 82435QW, 84132QW* and *84295QW* have been assigned for the ionized calcium, carbon dioxide, chloride, potassium, and sodium tests performed using the Abbott i-STAT Chem8+ Cartridge {Whole Blood}.

Previously, CR 5913 (see *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5913.pdf* on the CMS Web site) assigned the following *CPT*/HCPCS codes:

- *80048QW* for the tests performed using the Abaxis Piccolo Blood Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}
- *80053QW* for the tests performed using the Abaxis Piccolo Blood Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood}.

Reinstatement of Moratorium for ILs Billing Pathology TC for Hospital Patients (continued)

The effective date for the above *CPT*/HCPCS codes mentioned in CR 5913 is revised from January 16, 2008 to October 30, 2007.

CR 6060 also includes an attachment listing tests granted waived status under CLIA. The tests mentioned on the first page of the attachment (i.e., *CPT* codes: *81002, 81025, 82270, 82272*, G0394, *82962, 83026, 84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

ADDITIONAL INFORMATION

The official instruction, CR 6060, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1538CP.pdf* on the CMS Web site.

If you have any questions, please contact your 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: MM6060	Related Change Request (CR) #: 6060
Related CR Release Date: June 20, 2008	Effective Date: July 1, 2008
Related CR Transmittal #: R1538CP	Implementation Date: July 7, 2008

MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

2008 MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT RATES

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted on July 15, 2008. As a result, the mid-year 2008 Medicare Physician Fee Schedule (MPFS) rate of -10.6 percent has been replaced with a 0.5 percent update, retroactive to July 1, 2008.

Physicians, nonphysician practitioners, and other providers of services paid under the MPFS should begin to receive payment at the 0.5 percent update rates in approximately 10 business days, or less. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, nonphysician practitioners and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims that have been on hold on a rolling basis (first in/first out) for payment at the -10.6 percent update level. After your local contractor begins to pay claims at the new 0.5 percent rate, to the extent possible, the contractor will begin to automatically reprocess any claims paid at the lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later, billed with a submitted charge at least at the level of the January 1 – June 30, 2008, fee schedule amount, will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Nonparticipating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Contractor Web sites are being updated with the new rates and these should be available shortly. Be aware that any published *MLN Matters* articles affected by the new law will be revised or rescinded as appropriate.

Finally, be on the alert for more information about other legislative provisions which may affect you.

Further instructions regarding other provisions of MIPPA will be forthcoming.

Source: CMS Joint Signature Memorandum 08410, dated July 16, 2008
Provider Education Resource Message 200807-17
Provider Education Resource Message 200807-18

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REVISED FEES FOR SELECTED MENTAL HEALTH SERVICES

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted on July 15, 2008. As a result, the mid-year 2008 Medicare Physician Fee Schedule rate of -10.6 percent has been replaced with a 0.5 percent update, retroactive to July 1, 2008.

As a result, fees have been revised for selected mental health codes, effective for dates of service on and after July 1, 2008, through December 31, 2008.

CONNECTICUT FEES

Code/Mod	Par	Non-Par	Ltg Chg	Code/Mod	Par	Non-Par	Ltg Chg
90804	70.06	66.56	76.54	*90813*	117.63	111.75	128.51
*90804**	59.68	56.70	65.20	*90813**	104.42	99.20	114.08
90805	77.28	73.42	84.43	*90814*	152.89	145.25	167.03
*90805**	66.91	63.56	73.10	*90814**	143.46	136.29	156.73
90806	98.33	93.41	107.43	*90815*	162.37	154.25	177.39
*90806**	91.27	86.71	99.71	*90815**	149.17	141.71	162.97
90807	108.76	103.32	118.82	*90816*	65.17	61.91	71.20
*90807**	98.86	93.92	108.00	*90817*	71.45	67.88	78.06
90808	144.91	137.66	158.31	*90818*	96.81	91.97	105.76
*90808**	137.36	130.49	150.07	*90819*	103.40	98.23	112.96
90809	154.39	146.67	168.67	*90821*	143.33	136.16	156.59
*90809**	144.49	137.27	157.86	*90822*	149.42	141.95	163.24
90810	74.16	70.45	81.02	*90823*	70.27	66.76	76.77
*90810**	65.21	61.95	71.24	*90824*	77.40	73.53	84.56
90811	85.64	81.36	93.56	*90826*	103.16	98.00	112.70
*90811**	72.43	68.81	79.13	*90827*	108.09	102.69	118.09
90812	107.26	101.90	117.18	*90828*	149.36	141.89	163.18
*90812**	96.41	91.59	105.33	*90829*	154.13	146.42	168.39

*These amounts apply when service is performed in a facility setting.

FLORIDA FEES

	Participating			Non-Participating			Limiting Charge		
Code/Mod	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
90804	64.06	66.02	68.06	60.86	62.72	64.66	69.99	72.13	74.36
*90804**	55.82	57.19	58.74	53.03	54.33	55.80	60.98	62.48	64.17
90805	70.78	72.83	74.93	67.24	69.19	71.18	77.33	79.57	81.86
*90805**	62.54	64.00	65.60	59.41	60.80	62.32	68.32	69.92	71.67
90806	90.83	93.22	95.74	86.29	88.56	90.95	99.23	101.84	104.60
*90806**	85.21	87.20	89.39	80.95	82.84	84.92	93.09	95.27	97.66
90807	100.39	103.22	106.24	95.37	98.06	100.93	109.68	112.77	116.07
*90807**	92.53	94.78	97.35	87.90	90.04	92.48	101.09	103.55	106.35
90808	134.18	137.62	141.29	127.47	130.74	134.23	146.59	150.35	154.36
*90808**	128.18	131.20	134.51	121.77	124.64	127.78	140.04	143.34	146.95
90809	143.00	146.82	150.93	135.85	139.48	143.38	156.23	160.40	164.89
*90809**	135.12	138.39	142.03	128.36	131.47	134.93	147.62	151.19	155.17
90810	68.26	70.41	72.73	64.85	66.89	69.09	74.57	76.92	79.46
*90810**	61.14	62.78	64.69	58.08	59.64	61.46	66.80	68.59	70.67
90811	78.35	80.83	83.41	74.43	76.79	79.24	85.60	88.31	91.13
*90811**	67.86	69.58	71.56	64.47	66.10	67.98	74.14	76.02	78.18
90812	98.54	101.24	104.00	93.61	96.18	98.80	107.65	110.60	113.62
*90812**	89.93	92.00	94.26	85.43	87.40	89.55	98.25	100.51	102.98
90813	108.14	111.24	114.47	102.73	105.68	108.75	118.14	121.53	125.06
*90813**	97.65	99.99	102.61	92.77	94.99	97.48	106.68	109.24	112.10
90814	141.15	144.84	148.70	134.09	137.60	141.26	154.21	158.24	162.45
*90814**	133.65	136.80	140.23	126.97	129.96	133.22	146.01	149.45	153.20
90815	149.97	154.04	158.34	142.47	146.34	150.42	163.84	168.29	172.99
*90815**	139.47	142.79	146.49	132.50	135.65	139.17	152.37	156.00	160.04

Revised Fees for Selected Mental Health Services (continued)

	Participating			Non-Participating			Limiting Charge		
Code/Mod	**Loc 01/02**	**Loc 03**	**Loc 04**	**Loc 01/02**	**Loc 03**	**Loc 04**	**Loc 01/02**	**Loc 03**	**Loc 04**
90816	60.40	62.00	63.75	57.38	58.90	60.56	65.99	67.73	69.65
90817	66.36	68.01	69.77	63.04	64.61	66.28	72.50	74.30	76.22
90818	89.75	92.01	94.43	85.26	87.41	89.71	98.05	100.52	103.16
90819	96.35	98.79	101.50	91.53	93.85	96.42	105.26	107.93	110.89
90821	133.13	136.42	139.94	126.47	129.60	132.94	145.44	149.04	152.88
90822	139.55	143.19	147.28	132.57	136.03	139.92	152.46	156.44	160.90
90823	65.14	66.81	68.60	61.88	63.47	65.17	71.17	72.99	74.95
90824	72.08	73.99	76.13	68.48	70.29	72.32	78.75	80.83	83.17
90826	95.88	98.41	101.18	91.09	93.49	96.12	104.75	107.51	110.54
90827	100.70	103.20	105.96	95.66	98.04	100.66	110.01	112.75	115.76
90828	138.63	142.02	145.64	131.70	134.92	138.36	151.45	155.16	159.11
90829	143.69	147.20	151.04	136.51	139.84	143.49	156.98	160.82	165.01

Source: CMS Joint Signature Memorandum 08410, dated July 16, 2008
Provider Education Resource Message 200807-17
Provider Education Resource Message 200807-18

HOLDING OF CLAIMS PAID UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE

The questions and answers below apply to the recent decision by the Centers for Medicare & Medicare Services to hold claims paid under the Medicare physician fee schedule (MPFS) up to 10 business days that contain July 2008 dates of service.

Q1. Will claims containing services paid under the MPFS be held that contain both June and July dates of service?
A1. Yes, your local contractor will hold the entire claim for 10 business days.

Q2. Will claims be held that contain both services paid under the MPFS and services paid under a separate fee schedule?
A2. Yes, claims that contain both services paid and not paid under the MPFS will be held. For example, a claim with a July date containing an evaluation and management code and a drug code would be held.

Q3. Does the holding of claims paid under the MPFS also include anesthesia and purchased diagnostic services?
A3. Yes, contractors will hold all claims with dates of service July 1, 2008, and after that contain services paid under the MPFS, including anesthesia and purchased diagnostic services.

Source: Joint Signature Memorandum 08389, dated July 2, 2008
Provider Education Resource Listserv, Message 200807-04

PREVENTIVE SERVICES

REMINDER—MEDICARE PROVIDES COVERAGE OF DIABETES SCREENING TESTS

The Centers for Medicare & Medicaid Services (CMS) has released special edition *MLN Matters* article SE0821 titled "Reminder - Medicare Provides Coverage of Diabetes Screening Tests" located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0821.pdf*.

This article reminds health care professionals that Medicare pays for diabetes screening tests for eligible beneficiaries and provides the correct procedure and diagnosis codes and modifier to use when filing claims for this screening service.

Source: Provider Education Resource Message 200807-02

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RADIOLOGY

CARDIAC COMPUTED TOMOGRAPHIC ANGIOGRAPHY

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 cardiac computed tomographic angiography (CTA) services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is informational only and based on change request (CR) 6098 which announces that the Centers for Medicare & Medicaid Services (CMS), upon review of the available evidence, has determined that the coverage of cardiac CTA to diagnosis coronary artery disease (CAD) will remain at local Medicare contractor discretion, and no national coverage determination (NCD) is appropriate at this time.

BACKGROUND

CTA is a noninvasive method (using intravenous contrast) to visualize the coronary arteries (or other vessels) using high resolution, high speed computed tomography (CT).

After examining the medical evidence, CMS has determined that no NCD is appropriate at this time, effective March 12, 2008. Pursuant to the Social Security Act (Section 1862[a][1][A]), decisions should be made by local contractors through:

- the local coverage determination process
- case-by-case adjudication

Therefore, all claims for CTA used to diagnose CAD will continue to be determined by local Medicare contractor discretion and section 220.1 of Publication 100-03 of the *NCD Manual* remains unchanged.

ADDITIONAL INFORMATION

The official instruction, CR 6098, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R85NCD.pdf* on the CMS Web site.

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: MM6098
Related Change Request (CR) #: 6098
Related CR Release Date: June 27, 2008
Effective Date: March 12, 2008
Related CR Transmittal #: R85NCD
Implementation Date: July 28, 2008

SURGERY

INTRACRANIAL PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY WITH STENTING

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

PROVIDER TYPES AFFECTED

Physicians and providers who may wish to submit claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for percutaneous transluminal angioplasty (PTA) with stenting.

WHAT PROVIDERS NEED TO KNOW

Be aware that the Centers for Medicare & Medicaid Services (CMS) has reviewed the evidence and on May 12, 2008 posted a final decision memorandum following reconsideration of its national coverage determination (NCD) on PTA with intracranial stent placement at section 20.7.B.5 of the *Medicare NCD Manual*. With change request (CR) 6137, CMS reaffirms its existing NCD with no changes, and will continue to cover PTA and stenting of intracranial arteries for the treatment of cerebral artery stenosis > 50 percent in patients with intracranial atherosclerotic disease when furnished in accordance with the Food and Drug Administration (FDA) approved protocols governing Category B investigational device exemption (IDE) clinical trials. CMS will continue its national noncoverage for all other indications for PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries.

BACKGROUND

This article is based on CR 6137, which responds to a request on August 24, 2007 by the manufacturer to reconsider and expand coverage to include coverage with evidence development (CED) for intracranial stenting and angioplasty for patients in the IDE clinical trails.

ADDITIONAL INFORMATION

You may see the official instruction (CR 6137) issued to your Medicare carrier, FI, or A/B MAC, by going to *http://www.cms.hhs.gov/Transmittals/downloads/R87NCD.pdf* on the CMS Web site. Section 20.7 of the *Medicare NCD Manual* is attached to CR 6137.

Intracranial PTA with Stenting (continued)

You may also review MM5432 which preceded this article and provides the previous CMS response to PTA with stenting at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5432.pdf* on the CMS Web site.

If you have 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.

MLN Matters Number: MM6137
Related Change Request (CR) #: 6137
Related CR Release Date: July 11, 2008
Effective Date: May 12, 2008
Related CR Transmittal #: R87NCD
Implementation Date: August 11, 2008

THERAPEUTIC SERVICES

CONTINUOUS POSITIVE AIRWAY PRESSURE THERAPY FOR OBSTRUCTIVE SLEEP APNEA

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

IMPACT ON PROVIDERS

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of continuous positive airway pressure (CPAP) therapy based upon a positive diagnosis of obstructive sleep apnea (OSA) by home sleep testing (HST), subject to the requirements of change request (CR) 6048.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 national coverage determination (NCD) for CPAP therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with section 240.4 of the Medicare NCD Manual (see the Additional Information section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR 6048. (Note that billing guidelines for capped rental equipment are contained in the *Medicare Claims Processing Manual*, chapter 20, section 30.5, which is available at *http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf* on the CMS Web site.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent oxygen desaturation. The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Key Points of CR 6048

1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

Note: DME prosthetics, orthotics, and supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively. 42 CFR 424.57(c)(12). Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges. 42 CFR 424.57(d).

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
   - Polysomnography (PSG) performed in a sleep laboratory
   - Unattended home sleep monitoring device of Type II
   - Unattended home sleep monitoring device of Type III
   - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels

Note: In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Distress Index (RDI) is met:
   - AHI or RDI greater than or equal to 15 events per hour, or

CPAP Therapy for Obstructive Sleep Apnea (continued)

- AHI or RDI greater than or equal to five and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

Note: The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The RDI is equal to the average number of respiratory disturbances per hour.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the *NCD Manual* revision attached to CR 6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at section 310.1 of the *NCD Manual* and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual*. These manuals are available at *http://www.cms.hhs.gov/manuals/IOM/list.asp* on the CMS Web site.

Note: The following HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at section 240.4 of the *NCD Manual*, and do not necessarily convey coverage, which is determined at local contractor discretion.

G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.
G0398	Short Descriptor: Home sleep test/type 2 Porta
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
G0399	Short Descriptor: Home sleep test/type 3 Porta
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels
G0400	Short Descriptor: Home sleep test/type 4 Porta

ADDITIONAL INFORMATION

To see the official instruction (CR 6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R91NCD.pdf* on the CMS Web site.

If you have questions, please contact your Medicare A/B MAC, FI, carrier, 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: MM6048 Related Change Request (CR) #: 6048
Related CR Release Date: July 25, 2008 Effective Date: March 13, 2008
Related CR Transmittal #: R91NCD Implementation Date: August 4, 2008

THERAPY SERVICES

REMINDER THAT EXCEPTIONS TO THERAPY CAPS ARE RESTRICTED AS OF JULY 1, 2008

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2007 Medicare B Update! page 35.

Note: This article was rescinded on July 17, 2008, since legislation extended the exceptions to the therapy caps. See MLN Matters article SE0826 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0826.pdf* for more details.

MLN Matters Number: SE0815 *Rescinded* Related Change Request (CR) #: 5871
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

EXTENSION OF THERAPY CAP EXCEPTIONS

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. One provision of this legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with the modifier KX for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810 for calendar year 2008. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the modifier KX will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit the modifier KX on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the modifier KX that would qualify for an exception.

Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit these claims appending the modifier KX so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim.

In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary.

Source: CMS Joint Signature Memorandum 08411, dated July 16, 2008
Provider Education Resource Message 200807-20

GENERAL COVERAGE

IMPORTANT INFORMATION ON THE NEW MEDICARE LAW – THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. ***This article contains a compilation of messages that were issued on July 16, 2008.***

PROVIDER TYPES AFFECTED

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or durable medical equipment MACs [DME MACs]) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. This legislation alters a number of Medicare policies, which have been the subject of a number of change requests (CRs) and *MLN Matters* articles published in recent months. The Centers for Medicare & Medicaid Services (CMS) is in the process of revising these previously issued CRs and *MLN Matters* articles as a result of this legislation. However, CMS feels it is important that physicians, providers and suppliers be aware of five critical issues immediately.

These five issues are:

- New 2008 Medicare physician fee schedule (MPFS) payment rates effective for dates of service July 1, 2008 through December 31, 2008
- Extension of the exceptions process for the therapy caps
- A delay in the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program
- Reinstatement of the moratorium that allows independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients
- Extension of the payment rule for Brachytherapy and Therapeutic Radiopharmaceuticals.

Be sure your billing staff is aware of these changes.

BACKGROUND

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. While MIPPA calls for numerous changes to the Medicare program, this special edition article covers five key provisions as noted above.

1. New 2008 MPFS Payment Rates
Effective for Dates of Service July 1, 2008 through December 31, 2008

As a result of this legislation, the mid-year 2008 MPFS rate of -10.6 percent has been replaced with the January-June 2008 0.5 percent update, retroactive to July 1, 2008.

Physicians, nonphysician practitioners (NPP) and other providers of services paid under the MPFS should begin to receive payment at the 0.5 percent update rates in approximately 10 business days, or less, for claims with dates of service on or after July 1, 2008. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, NPPs and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims with dates of service on or after July 1, 2008, that have been on hold. These claims will be processed on a rolling basis (first in/first out) for payment at the -10.6 percent update level. After your Medicare contractor begins to pay claims at the new 0.5

Important Information on the New Medicare Law – The MIPPA of 2008 (continued)

percent rate, to the extent possible, the contractor will begin to automatically reprocess any claims paid at the lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1, 2008, and later billed with a submitted charge at least at the level of the January 1, 2008 – June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Nonparticipating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Medicare contractor Web sites are being updated with the new rates and these should be available shortly. Be aware that any published *MLN Matters* articles affected by the new law will be revised or rescinded as appropriate.

2. Extension of Therapy Cap Exceptions

Another key provision of the MIPPA legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with the modifier KX for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810 for calendar year 2008. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the modifier KX will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit the modifier KX on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the modifier KX that would qualify for an exception.

Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit these claims appending the modifier KX so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim.

In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary.

3. Delay in the DMEPOS Competitive Bidding Program

This new law also has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding the new law's impact on this program will be forthcoming.

4. Reinstatement of the Moratorium That Allows Independent Laboratories to Bill for the TC of Physician Pathology Services Furnished to Hospital Patients

In the final physician fee schedule regulation published in the Federal Register on November 2, 1999, CMS stated that it would implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the MPFS for the TC of physician pathology services for hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule. As such, during this time, Medicare contractors have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

The most recent extension of the moratorium, established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), Section 104, expired on June 30, 2008. A new extension of the moratorium has been established by Section 136 of MIPPA, retroactive to July 1, 2008.

A previous communication (MLN Matters article MM6088) indicated that the moratorium had ended and that independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This prohibition is rescinded and the moratorium will continue effective for claims with dates of service on and after July 1, 2008, but prior to January 1, 2010.

5. Extension of Payment Rule for Brachytherapy and Therapeutic Radiopharmaceuticals

MIPPA extends the use of the cost to charge payment methodology for Brachytherapy and Therapeutic Radiopharmaceuticals through January 1, 2010. This change is retroactive to July 1, 2008. Some claims have already been processed, however, using the outpatient prospective payment system (OPPS) rates that were in effect until MIPAA enactment. To avoid a disruption in payment while the cost to charge payment methodology is re-implemented, impacted claims will continue to be paid based on the OPPS rates. Contractors will mass adjust all impacted OPPS claims with dates of service beginning July 1, 2008, as soon as the cost to charge payment methodology has been implemented. Reprocessing of affected claims will be complete by September 30, 2008.

ADDITIONAL INFORMATION

Be on the alert for more information about other legislative provisions which may affect you.

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: SE0826
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

ELECTRONIC DATA INTERCHANGE

CLAIM STATUS CATEGORY CODE AND CLAIM STATUS CODE UPDATE

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], regional home health intermediaries [RHHI], Part A/B Medicare administrative contractors [A/B MAC], and durable medical equipment Medicare administrative contractors [DME MAC] for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change request (CR) 6090, from which this article is taken, reminds providers of the periodic updates to the claim status codes and claim status category codes that Medicare contractors use with the Health Care Claim Status request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

BACKGROUND

The claim category and claim status codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1).

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6090, from which this article is taken, updates the changes in the Claim Status Codes and Claim Status Category Codes from the February 2008 committee meeting, which were posted at *http://www.wpc-edi.com/content/view/180/223/* on February 29, 2008 (previously referenced by *http://www.wpc-edi.com/codes*). CR 6090 reminds Medicare contractors that they must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by its implementation date (October 6, 2008). On and after this date, these code changes are to be used in editing of all X12 276 transactions processed, and to be reflected in the X12 277 transactions issued.

ADDITIONAL INFORMATION

You may find the official instruction, CR 6090, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1533CP.pdf* on the CMS Web site

If you have any questions, please contact your carrier, FI, RHHI, 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: MM6090
Related Change Request (CR) #: 6090
Related CR Release Date: June 13, 2008
Effective Date: October 1, 2008
Related CR Transmittal #: R1533CP
Implementation Date: October 6, 2008

DMEPOS COMPETITIVE BIDDING PROGRAM

CANCELLED—ACCREDITATION DEADLINES FOR DMEPOS COMPETITIVE BIDDING

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

As a result of this delay, the special accreditation deadlines previously established for the second round of the program have been cancelled. Specifically, prior to enactment of this new law, suppliers must have been accredited or have applied for accreditation by July 21, 2008, to be eligible to submit a bid for the second round of competitive bidding and must have obtained accreditation by January 14, 2009, to be eligible for a second round contract. Both of these deadlines have been cancelled and no longer apply.

The deadline of September 30, 2009, that was previously established by which all DMEPOS suppliers must be accredited is still in effect.

Source: Provider Education Resource Message 200807-25

DELAY OF THE MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding this new law will be forthcoming.

Source: Provider Education Resource 200807-21

PHASE 2 MANUAL REVISIONS FOR THE DMEPOS COMPETITIVE BIDDING PROGRAM

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2008 Medicare B Update! pages 40-44.

Note: This article is impacted by the Medicare Improvements for Patients and Providers Act of 2008, which was enacted on July 15, 2008. That legislation delays the implementation of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program until 2009 and makes other changes to the program. This article will be further revised and/or replaced as more details of the modified program are available.

PROVIDER TYPES AFFECTED

All Medicare DMEPOS suppliers who bill durable medical equipment Medicare administrative contractors (DME MACs) as well as any providers who refer or order DMEPOS for Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change request (CR) 6119, from which this article is developed, is the second installment of, and adds information to, chapter 36 DMEPOS Competitive Bidding Program in the *Medicare Claims Processing Manual*. CR 5978 provided the first installment of chapter 36 and details the initial requirements of this program. The companion *MLN Matters* article to CR 5978 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5978.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Chapter 36 manualizes policies and instructions for Medicare contractors on the DMEPOS Competitive Bidding Program. Subsequent installments may follow providing additional sections to the chapter.

This article complements MM5978, SE0805, SE0806, and SE0807, which already cover many of the sections of the new chapter being added to the *Medicare Claims Processing Manual*. These articles in combination with this one cover the key sections of chapter 36.

BACKGROUND

The Medicare payment for most DMEPOS is currently based on fee schedules. However, in amending section 1847 of the Social Security Act (the Act), section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates a competitive bidding program to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

In compliance with the statute's mandate that this competitive bidding program be phased in beginning in 2007, CMS issued the regulation for the competitive bidding program (published on April 10, 2007 (72 *Federal Register* 68 [10 April 2007 pp. 17991-18090]). This regulation is available at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid* on the CMS Web site.

Key Points of Change Request 6119

Key Points of CR 6119 that address a number of areas detailed in chapter 36 of the *Medicare Claims Processing Manual* are as follows:

Home Health Agencies

Home health agencies must submit a bid and be awarded a contract for the DMEPOS Competitive Bidding Program in order to furnish competitively bid items directly to Medicare beneficiaries who maintain a permanent residence in a CBA. If a home health agency is not awarded a contract to furnish competitively bid items, then they must use a contract supplier for these items.

Prescription for Particular Brand, Item, or Mode of Delivery

Contract suppliers are required to furnish a specific brand name item or mode of delivery to a beneficiary if prescribed

Phase 2 Manual Revisions for the DMEPOS Competitive Bidding Program (continued)

by a physician or treating practitioner (that is a physician assistant, clinical nurse specialist, or nurse practitioner) to avoid an adverse medical outcome for the beneficiary. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome. This documentation should include the following:

- The product's brand name or mode of delivery
- The features that this product or mode of delivery has versus other brand name products or modes of delivery
- An explanation of how these features are necessary to avoid an adverse medical outcome.

If a physician or treating practitioner prescribes a particular brand or mode of delivery to avoid an adverse medical outcome, the contract supplier must either:

- Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner
- Consult with the physician or treating practitioner to find another appropriate brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner
- Assist the beneficiary in locating a contract supplier that can furnish the particular brand of item or mode of delivery prescribed by the physician or treating practitioner.

Any change in the prescription requires a revised written prescription for Medicare payment. A contract supplier is prohibited from submitting a claim to Medicare if it furnishes an item different from that specified in the written prescription received from the beneficiary's physician or treating practitioner.

Payment for Rental of Inexpensive or Routinely Purchased DME

The monthly rental payment amounts for inexpensive or routinely purchased DME (identified using Healthcare Common Procedure Coding System (HCPCS) modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item.

Payment for Oxygen and Oxygen Equipment

The monthly payment amounts for oxygen and oxygen equipment are equal to the single payment amounts established for the following classes of items:

- Stationary oxygen equipment (including stationary oxygen concentrators) and oxygen contents (stationary and portable)
- Portable equipment only (gaseous or liquid tanks)
- Oxygen generating portable equipment (OGPE) only (used in lieu of traditional portable oxygen equipment/ tanks)
- Stationary oxygen contents (for beneficiary-owned stationary liquid or gaseous equipment)
- Portable oxygen contents (for beneficiary-owned portable liquid or gaseous equipment).

In cases where a supplier is furnishing both stationary oxygen contents and portable oxygen contents, the supplier is paid both the single payment amount for stationary oxygen contents and the single payment amount for portable oxygen contents. The payment amounts for purchase of supplies and accessories used with beneficiary-owned oxygen equipment are equal to the single payment amounts established for the supply or accessory.

Change in Suppliers for Oxygen and Oxygen Equipment

The following rules apply when the beneficiary switches from one supplier of oxygen and oxygen equipment to another supplier after the beginning of each round of competitive bidding:

- Noncontract supplier to contract supplier

In general, monthly payment amounts may not exceed a period of continuous use of longer than 36 months. However, if the beneficiary switches from a noncontract supplier to a contract supplier before the end of the 36-month period, at least 10 monthly payment amounts would be made to a contract supplier that begins furnishing oxygen and oxygen equipment in these situations provided that medical necessity for oxygen continues.

For example, if a contract supplier begins furnishing oxygen equipment to a beneficiary in months 2 through 26, payment would be made for the remaining number of months in the 36-month period, because the number of payments to the contract supplier would be at least 10 payments. To provide a more specific example, a contract supplier that begins furnishing oxygen equipment beginning with the 20th month of continuous use would receive 17 payments (17 for the remaining number of months in the 36-month period). However, if a contract supplier begins furnishing oxygen equipment to a beneficiary in month 27 or later, no more than 10 monthly payments would be made assuming the oxygen equipment remains medically necessary.

- **Contract supplier to another contract supplier**

This rule does not apply when a beneficiary switches from a contract supplier to another contract supplier to receive his/her oxygen and oxygen equipment. In this scenario, the new contract supplier is paid based on the single payment amount for the remaining number of months in the 36-month period assuming the oxygen equipment remains medically necessary.

Payment for Capped Rental DME Items

The monthly rental payment amounts for capped rental DME (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first 3 months and 7.5 percent of the single payment amount established for purchase of the item for months 4 through 13.

Change in Suppliers for Capped Rental DME Items

The following rules apply when the beneficiary switches from one supplier of capped rental DME to another supplier after the beginning of each round of competitive bidding:

- **Noncontract supplier to contract supplier**

In general, rental payments may not exceed a period of continuous use of longer than 13 months. However, if the beneficiary switches from a noncontract supplier to a contract supplier before the end of the 13-month rental period, a new 13-month period begins and payment is made on the basis of the single payment amounts described above under "Payment for Capped Rental DME Items". The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the new 13-month rental period, the contract supplier is required to transfer title of the capped rental item to the beneficiary. Once the beneficiary switches from a

Phase 2 Manual Revisions for the DMEPOS Competitive Bidding Program (continued)

noncontract supplier to a contract supplier, he/she may not switch back to a noncontract supplier if he/she continues to maintain a permanent residence in a competitive bidding area (CBA). If, however, the beneficiary relocates out of the CBA to a non-CBA, then he/she may switch to a noncontract supplier and a new 13-month rental period does not begin.

- Contract supplier to another contract supplier

If the beneficiary switches from one contract supplier to another contract supplier before the end of the 13-month rental period, a new 13-month period does not begin. This rule applies in situations where the beneficiary changes suppliers within a CBA and in situations where the beneficiary relocates and switches from a contract supplier in one CBA to a contract supplier in another CBA. The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the 13-month rental period, the contract supplier is required to transfer title of the capped rental item to the beneficiary.

Payment for Purchased Equipment

Payment for purchase of new equipment (identified using HCPCS modifier NU), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 100 percent of the single payment amounts established for these items. Payment for purchase of used equipment (identified using HCPCS modifier UE), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 75 percent of the single payment amounts established for new purchase equipment items.

Payment for Repair and Replacement of Beneficiary-Owned Equipment

Beneficiaries who maintain a permanent residence in a CBA may go to any Medicare-enrolled supplier (contract or noncontract supplier) for the maintenance or repair of beneficiary-owned equipment, including parts that need to be replaced in order to make the equipment serviceable. Labor to repair equipment is not subject to competitive bidding and, therefore, will be paid in accordance with Medicare's general payment rules. Payment for replacement parts that are part of the competitive bidding program for the CBA in which the beneficiary resides is based on the single payment amount in that CBA for that replacement part. Payment is not made for parts and labor covered under a manufacturer's or supplier's warranty.

Beneficiaries must obtain replacements of all items that are part of the competitive bidding program for the areas in which the beneficiary resides from a contract supplier unless the item is a replacement part or accessory that is replaced as part of the service of repairing beneficiary-owned base equipment (e.g. wheelchair, walker, hospital bed, continuous positive pressure airway device, oxygen concentrator, etc.). All base equipment that is replaced in its entirety because of a change in the beneficiary's medical condition or because the base equipment the beneficiary was using was either lost, stolen, irreparably damaged, or used beyond the equipment's reasonable useful lifetime (see section 110.2.C of chapter 15 of the *Medicare Benefit Policy Manual* at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site) must be obtained from a contract supplier in order for Medicare to pay for the replacement. Payment for replacement of items that are part of the competitive bidding program for the CBA in which the beneficiary resides is based on the single payment amount for that item. The contract supplier is not required to replace an entire competitively bid item with the same make and model as the previous item unless a physician or treating practitioner prescribes that make and model.

If beneficiary-owned oxygen equipment or capped rental DME that is a competitively bid item for the CBA in which the beneficiary maintains a permanent residence has to be replaced prior to the end of its reasonable useful lifetime, then the replacement item must be furnished by the supplier (contract or noncontract supplier) that transferred ownership of the item to the beneficiary.

Payment for Enteral Nutrition Equipment

The monthly rental payment amounts for enteral nutrition equipment (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first three months and 7.5 percent of the single payment amount established for purchase of the item for months 4 through 15.

Maintenance and Servicing of Enteral Nutrition Equipment

The contract supplier that furnishes the equipment to the beneficiary in the 15th month of the rental period must continue to furnish, maintain, and service the equipment after the 15 month rental period is completed until a determination is made by the beneficiary's physician or treating practitioner that the equipment is no longer medically necessary. The payment for maintenance and servicing enteral nutrition equipment is 5 percent of the single payment amount established for purchase of the item.

Traveling Beneficiaries

Beneficiaries, who travel outside their CBA, for example, to visit family members or reside in a State with warmer climates during winter months, need to consider the following three factors when traveling:

- Where to go to obtain a DMEPOS item
- Identify whether the item is a competitively bid item or not
- Determine the Medicare payment amount for that item.

Depending on where the beneficiary travels (whether to a CBA or a non-CBA), the beneficiary may need to obtain DMEPOS from a contract supplier in order for Medicare to cover the item. For example, a beneficiary who travels to a non-CBA may obtain DMEPOS, if medically necessary, from any Medicare-enrolled supplier. On the other hand, a beneficiary who travels to a CBA should obtain competitively bid items in that CBA from a contract supplier in that CBA in order for Medicare to cover the item. The chart below shows whether a beneficiary should go to a contract supplier or any Medicare-enrolled supplier when the beneficiary travels.

Phase 2 Manual Revisions for the DMEPOS Competitive Bidding Program (continued)

Beneficiary Permanently Resides in	Travels to	Type of Supplier
a CBA	a CBA	The beneficiary should obtain competitively bid items in that CBA from a contract supplier located in that CBA if the beneficiary wants Medicare to cover the item.
	a non-CBA	Medicare will cover DMEPOS, if medically necessary, from any Medicare-enrolled DMEPOS supplier.
non-CBA	a CBA	The beneficiary should obtain the competitively bid item from a contract supplier in the CBA if the beneficiary wants Medicare to cover the item.
	non-CBA	Medicare-enrolled DMEPOS supplier

Suppliers that furnish DMEPOS items to Medicare beneficiaries who maintain a permanent residence in a CBA and who travel to a non-CBA need to be aware of the public use files at *http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home* on the Competitive Bidding Implementation Contractor (CBIC) Web site. These files contain the ZIP codes for the CBAs, the HCPCS codes for competitively bid items, and related single payment amounts for competitively bid items. The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. For example:

1. If a beneficiary maintains a permanent residence in a CBA and travels outside of the CBA, payment for a competitively bid item for the CBA in which the beneficiary maintains a permanent residence is the single payment amount for that item in the beneficiary's CBA.
2. When a beneficiary maintains a permanent residence in an area that is not in a CBA and travels to CBA or non-CBA, the supplier that furnishes the item will be paid the fee schedule amount for the area where the beneficiary maintains a permanent residence.

Traveling Beneficiaries and Transfer of Title of Oxygen Equipment or Capped Rental Items

If a beneficiary who has two residences in different areas and uses a local supplier in each area or if a beneficiary changes suppliers during or after the rental period, this does not result in a new rental episode. The supplier that provides the item in the 36th month of rental for oxygen equipment or the 13th month of rental for capped rental DME is responsible for transferring title to the equipment to the beneficiary. This applies to "snow bird" or extended travel patients and coordinated services for patients who travel after they have purchased the item.

Advance Beneficiary Notice (ABN)
Billing Procedures Related to ABN Upgrades under the Competitive Bidding Program

In general, an item included in a competitive bidding program must be furnished by a contract supplier for Medicare to make payment. This requirement applies to situations where the item is furnished directly or indirectly as an upgrade. An upgrade is an item with features that go beyond what is medically necessary. An upgrade may include an excess component. An excess component may be an item feature or service, which is in addition to, or is more extensive than, the item that is reasonable and necessary under Medicare coverage requirements. An item is indirectly furnished if Medicare makes payment for it because it is medically necessary and is furnished as part of an upgraded item. The billing instructions for upgraded equipment found in section 120 of chapter 20 of the *Medicare Claims Processing Manual* (available at *http://www.cms.hhs.gov/manuals/Downloads/clm104c20.pdf* on the CMS Web site) continue to apply under the DMEPOS Competitive Bidding Program. Consider the following:

1. Where a beneficiary, residing in a competitive bidding area, elects to upgrade to an item with features or upgrades that are not medically necessary:

- **Upgrades from a bid item to a non-bid item**

In this situation, Medicare payment will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.

- **Upgrades from a non-bid item to a bid item**

When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

- **Upgrades from a bid item in one product category (category "S") to a bid item in another product category (category "U")**

In this case, Medicare payment is only made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category "S."

2. Where a beneficiary, who does not reside in a competitive bidding area, but travels to a competitive bidding area, elects to upgrade to an item with features that are not medically necessary:

- **Upgrades from a bid item to a non-bid item**

In this situation, Medicare payment is only made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item.

- **Upgrades from a non-bid item to a bid item**

When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

- **Upgrades from a bid item in one product category (category "S") to a bid item in another product category (category "U")**

In this case, Medicare payment is only made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category "S."

Phase 2 Manual Revisions for the DMEPOS Competitive Bidding Program (continued)

Note: In the *Medicare Claims Processing Manual* chapter 36 section 40.11 attached to CR 6119 at *http://www.cms.hhs.gov/Transmittals/downloads/R1532CP.pdf* on the CMS Web site, a detailed chart describe situations where a beneficiary, residing in a CBA, elects to upgrade to an item with features or upgrades that are not medically necessary.

Beneficiary Liability

Under the competitive bidding program, a beneficiary has no financial liability to a noncontract supplier that furnishes an item included in the competitive bidding program for a competitive bidding area, unless the beneficiary has signed an advance beneficiary notice (ABN). Similarly, beneficiaries who receive an upgraded item from a noncontract supplier in a competitive bidding area are not financially liable for the item unless the supplier has obtained a signed ABN from the beneficiary.

In the case of upgrades, for a beneficiary to be liable for the extra cost of an item that exceeds their medical needs, an appropriate ABN must be signed by the beneficiary. See chapter 20, section 120 of the *Medicare Claims Processing Manual* at *http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf* on the CMS Web site for additional information on ABN upgrades.

Billing Procedures Related to Downcoding under the Competitive Bidding Program

The following downcoding guidelines describe situations where Medicare reduces the level of payment for the prescribed item based on a medical necessity partial denial of coverage for the additional, not medically necessary, expenses associated with the prescribed item.

1. For beneficiaries who reside in a CBA and for whom Medicare determines that the prescribed item should be downcoded to an item that is reasonable and necessary under Medicare's coverage requirements.

- Downcodes from a non-bid item to a bid item

In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.

- Downcodes from a bid item to a non-bid item

Medicare payment in this downcoding scenario will be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

- **Downcodes from a bid item in one product category (category "U") to a bid item in another product category (category "S")**

In this case, Medicare payment will be made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category "S."

2. For a beneficiary who does not reside in a CBA, but travels to a CBA and for whom Medicare determines that the prescribed item is downcoded to an item that is reasonable and necessary under Medicare's coverage requirements.

- **Downcodes from a non-bid item to a bid item**

In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item.

- **Downcodes from a bid item to a non-bid item**

Medicare payment in this downcoding scenario will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

- **Downcodes from a bid item in one product category (category "U") to a bid item in another product category (category "S")**

In this case, Medicare payment will only be made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category "S".

A detailed chart of downcoding scenarios is in the new chapter 36, section 40.12 (attached to CR 6119) for beneficiaries who reside in a CBA and for whom Medicare determines that the prescribed item should be downcoded to an item that is reasonable and necessary under Medicare's coverage requirements.

ADDITIONAL INFORMATION

You may find more information about the payment changes for DMEPOS items as a result of the DMEPOS competitive bidding program and the Deficit Reduction Act of 2005 by going to CR 6119, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1532CP.pdf* on the CMS Web site. You will find the updated *Medicare Claims Processing Manual* Chapter 36 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program) as an attachment to that CR.

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, may be found at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/* on the CMS dedicated Web site. Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.

If you have any questions, please contact your carrier, FI, RHHI, 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: MM6119 *Revised*
Related Change Request (CR) #: 6119
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Related CR Transmittal #: R1592CP
Implementation Date: July 7, 2008

MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM NEWS

OMBUDSMAN PROGRAM

The Ombudsmen for the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program are now available to assist providers, suppliers, and beneficiaries by providing information and education and by facilitating the resolution of complaints and concerns. The ombudsmens' role is to investigate and address complaints by providers, suppliers, and beneficiaries specifically related to the Competitive Bidding Program. There are eight ombudsmen who are located within the initial Competitive Bidding Areas (CBAs).

You may contact an ombudsman:

- For general information about the DMEPOS Competitive Bidding Program
- To obtain assistance in locating a contract supplier
- For educational programs and activities
- To report concerns about the program, a supplier, or a referral agent
- The quality of services or items, and/or suspected fraud or abuse
- For assistance with questions, issues, and complaints specifically pertaining to the competitive bidding program and policies.

You may find a list of the ombudsmen with contact information on the DMEPOS Competitive Bidding Implementation Contractor (CBIC) Web site at *www.dmecompetitivebid.com*.

DMEPOS Competitive Bidding Program Competitive Bidding Areas Are Defined by ZIP Codes

Two CBA ZIP code files have been posted on the Competitive Bidding Implementation Contractor (CBIC) Web site:

- one file containing mail order ZIP codes per CBA
- one file containing non-mail order ZIP codes per CBA.

These files will be updated on a quarterly basis, as needed, to reflect changes in ZIP codes included in the various CBAs. Although the boundaries of a CBA will not change during a competitive bidding contract period, ZIP codes in general do change from time to time (e.g., when one ZIP code/area is subdivided into two or more new ZIP codes/areas, etc.).

ZIP codes contained in each CBA may be accessed through the CMS DMEPOS Competitive Bidding Web site at located at *www.cms.hhs.gov/DMEPOSCompetitivebid/*. Just click on the "Metropolitan Statistical Areas, Competitive Bidding Areas, and ZIP Codes" tab and scroll down to "Related Links Outside CMS."

Important Requirements of the "Grandfathered" Supplier Provision

Noncontract suppliers located in the 10 DMEPOS CBAs should have taken the appropriate steps to notify beneficiaries whose permanent residence is in a CBA of their decision to become, or not to become grandfathered suppliers for each competitively bid item. These decisions should be conveyed through a written notification to the beneficiary before the start date of the new program.

Important Note: This notification should only be sent to beneficiaries who maintain a permanent residence in a CBA.

Suppliers can determine if a beneficiary resides in a CBA by comparing the beneficiary's ZIP code to the ZIP code files on the CBIC's Web site.

Suppliers that choose to become "grandfathered" should maintain a record as to whether the beneficiary chose to continue to receive the item from the grandfathered supplier, chose to go to a contract supplier, or did not respond.

For suppliers that choose not to become grandfathered, the beneficiary will have to switch to a contract supplier.

CMS expects suppliers to work together to ensure there is no break in service or in the furnishing of medically necessary items (e.g., oxygen, enteral nutrition, CPAP). In order for this transition to occur, a coordinated effort including delivery and pick-up of supplies must take place.

For more detailed information on this topic, please refer to the *MLN Matters* article MM5978 and the *Medicare Learning Network's* Tip Sheet for "Grandfathered" Suppliers on the CMS DMEPOS Competitive Bidding Web site located at *www.cms.hhs.gov/DMEPOSCompetitivebid/*. Go to the "Provider Educational Products and Resources" tab and scroll to the "Downloads" section.

Source: Provider Education Resource Message 200806-19

DMEPOS COMPETITIVE BIDDING NEWS

CLARIFICATION OF MAIL ORDER

The Centers for Medicare & Medicaid Services (CMS) has posted information on the Competitive Bidding Implementation Contractor (CBIC) Web site to clarify its policy with regard to mail order suppliers. This posting provides further guidance on common carriers and local storefront suppliers. Please visit the Supplier's Frequently Asked Questions (FAQs) section at *http://www.dmecompetitivebid.com* for more information.

Source: Provider Education Resource Message 200806-25

MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM BEGAN JULY 1, 2008

IF YOU REFER OR ORDER DMEPOS FOR MEDICARE BENEFICIARIES

Under the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Bidding Program, beneficiaries who permanently reside in or travel to a designated competitive bidding area (CBA) are required to obtain competitive bid items from a contract supplier, unless an exception applies (e.g., grandfathered suppliers). You (e.g. physicians, practitioners, discharge planners, social workers, pharmacists, and home health agencies) will play a critical role in helping your DMEPOS contract suppliers. The *Medicare Learning Network's* "Tip Sheet for Referral Agents" may help! Downloadable copies are available at *www.cms.hhs.egov/DMEPOSCompetitivBid*. Click on the "Provider Educational Products and Resources" tab on the left then scroll down to the "Downloads" section.

ENTERAL NUTRITION IS NOT A "GRANDFATHERED" COMPETITIVELY BID ITEM

Under the DMEPOS Competitive Bidding Program, enteral nutrition must be furnished by a contract supplier and cannot be provided by a noncontract grandfathered supplier. To ensure that there is no gap in service, this is important information for providers who order enteral nutrition for Medicare beneficiaries who permanently reside in, or are visiting a CBA.

THERE IS NO APPLICATION OR REGISTRATION REQUIRED TO BECOME A GRANDFATHERED SUPPLIER

Suppliers servicing Medicare patients in a CBA need only notify their Medicare clients that they have elected to become a grandfathered supplier and receive a response that the Medicare beneficiary elects to continue services. For more details, see the "DMEPOS Grandfathered Suppliers" tip sheet on the Centers for Medicare & Medicaid Services (CMS) dedicated Web site at *www.cms.hhs.gov/DMEPOSCompetitiveBid*. Click on the "Provider Educational Products and Resources" tab on the left then scroll down to the "Downloads" section.

NEW FREQUENTLY ASKED QUESTIONS (FAQ) NOW POSTED ON THE CMS WEB SITE

Twenty-six (26) new FAQs have recently been posted on the CMS DMEPOS Competitive Bidding provider Web site. See what's new by going to *www.cms.hhs.gov/DMEPOSCompetitiveBid*. Click on the "Provider Educational Products and Resources" tab on the left then scroll down to "Related Links Inside CMS."

NEW *MLN MATTERS* ARTICLE ON CMS CLAIMS PROCESSING MANUAL REVISIONS

The CMS has issued change request (CR) 6007, Manual Revisions to Reflect Special Billing Instructions for DMEPOS Items as a Result of the DMEPOS Competitive Bidding Program and the corresponding *MLN Matters* article. The article is available at *www.cms.hhs.gov/MLNMattersArticles/downloads/MM6007.pdf* and will also be available on the "Provider Educational Products and Resources" page of the CMS DMEPOS Competitive Bidding provider Web site soon.

WEB SITE ADDITION – SINGLE PAYMENT AMOUNTS

A new link to DMEPOS Competitive Bidding single payment amounts has been added to the dedicated Web site to allow easy access to the files that list the single payment amount for competitively bid items. Go to *www.cms.hhs.gov/DMEPOSCompetitiveBid* and click on the "Single Payment Amounts" tab on the left.

All the information that you need to know as a DMEPOS supplier, or an enrolled Medicare provider who refers beneficiaries for DMEPOS is available on the CMS DMEPOS Competitive Bidding dedicated Web site located at *www.cms.hhs.gov/DMEPOScompetitivebid*.

Visit the *Medicare Learning Network* ~ it's free!

Source: Provider Education Resource Message 200806-23

FRAUD AND ABUSE

CMS PILOT PROGRAM SAVING NEARLY $700 MILLION IN IMPROPER MEDICARE PAYMENTS

The Centers for Medicare & Medicaid Services (CMS) today released a new report offering fresh evidence that the recovery audit contractors (RACs) pilot program is successfully identifying improper payments. The findings will also help the agency improve the program as it is expanded nationwide within two years, officials say.

The evaluation report shows that $693.6 million in improper Medicare payments was returned to the Medicare Trust Funds between 2005 and March 2008. The funds returned to the Medicare Trust Funds occurred after taking into account the dollars repaid to health care providers, the money overturned on appeal and the costs of operating the RAC demonstration program.

To view the entire press release, please click: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.
To view the RAC Evaluation Report: *http://www.cms.hhs.gov/RAC*.

Source: Provider Education Resource Message 200807-14

NATIONAL PROVIDER IDENTIFIER

PART B CLAIM DENIAL DUE TO REPORTING SERVICE FACILITY PROVIDER INFORMATION

Effective for claims processed on or after August 25, 2008, Medicare Part B claims containing the billing provider's national provider identifier (NPI) as the service facility location provider (Item 32a of the CMS-1500 or loop 2310D of the electronic equivalent) will be returned as unprocessable. If unable to obtain the service facility location provider's NPI, no identifier should be reported. Do not report the billing provider's NPI as the service facility location provider.

Note: This article addresses only the reporting of the service facility location provider's NPI. This instruction does not revise the existing requirements for reporting the name and address of service facility location provider.

Source: Publication 100-08, Change Request 6093

PROVIDER QUALITY REPORTING INITIATIVE

MEDICARE PAYS OVER $36 MILLION TO 2007 PQRI PARTICIPATING PHYSICIANS

The Centers for Medicare & Medicaid (CMS) today announced payment of more than $36 million in bonus payments to many of the more than 56,700 health professionals who satisfactorily reported quality information to Medicare under the 2007 Physician Quality Reporting Initiative (PQRI).

"Creating a value-based purchasing system is a critical way to improve our health care systems. By collecting quality data, health care providers can use the information to improve the quality care of beneficiaries," said Health and Human Services Secretary Michael Leavitt.

Physicians, physician group practices, and other PQRI eligible professionals should receive their payments by August 2008. The average incentive amount for individual professionals is over $600 and average incentive payment for a physician group practice is over $4,700, with the largest payment to a physician group practice totaling over $205,700.

The PQRI is part of the President's Value-driven Health Care Agenda that seeks to address current problems in the health care sector regarding preventable errors, uneven quality of care and rising health care costs.

More information about the PQRI program, including how eligible professionals can participate and the criteria to qualify for an incentive payment, is available at *www.cms.hhs.gov/PQRI*.

To read the entire CMS press release issued today click here: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: Provider Education Resource Message 200807-16

2008 PHYSICIAN QUALITY REPORTING INITIATIVE: NEW EDUCATIONAL PRODUCT

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a new educational resource has been posted to the Physician Quality Reporting Initiative (PQRI) Web page on the CMS Web site and is available for ordering through the *Medicare Learning Network* product ordering system.

The following item is available for download on the PQRI Educational Resources Web page:

2008 PQRI Reporting Options Quick Reference Chart – This two-sided laminated reference chart gives eligible professionals and practice staff a quick reference to the new reporting options available for 2008 PQRI with their corresponding alternative reporting periods.

To access this new and available educational resource, visit *http://www.cms.hhs.gov/PQRI* on the CMS Web site and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the "Downloads" section and click on the "2008 PQRI Quick Reference Chart" link.

To order this product, visit *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS Web site and click on the "2008 Physician Quality Reporting Initiative (PQRI) Reporting Quick Option Reference Chart (ICN# 900843) (May 2008)" link.

Source: Provider Education Resource Message 200807-11

2008 PHYSICIAN QUALITY REPORTING INITIATIVE ESTABLISHMENT OF ALTERNATIVE REPORTING PERIODS AND REPORTING CRITERIA

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2008 Medicare B Update! pages 58-61.

Note: This article was revised on July 2, 2008, to remove the phrase "on 15 consecutive patients" from the first two G code descriptions located under *HCPCS Codes*. All other information remains the same.

PROVIDER TYPES AFFECTED

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI).

WHAT YOU NEED TO KNOW

CMS is taking steps to encourage physicians and other eligible professionals to participate in the Physician Quality Reporting Initiative (PQRI), a program designed to improve the quality of care provided to Medicare beneficiaries. Change request (CR) 6104, from which this article is taken, announces the establishment of alternative reporting periods and alternative criteria for satisfactorily reporting quality measures for the 2008 PQRI.
Make sure that your billing staffs are aware of the PQRI reporting changes.

BACKGROUND

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the CMS to establish the PQRI, that included an incentive payment for eligible professionals who satisfactorily reported data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period).

Under this program, CMS paid eligible professionals, who satisfactorily reported such data, an incentive payment equivalent to 1.5 percent of their total allowed charges for Medicare Physician Fee Schedule (MPFS)-covered professional services (referred to as total allowed charges) furnished during the 2007 reporting period (July 1, 2007 – December 31, 2007). The statute defines satisfactory reporting to be reporting of up to 3 applicable measures in at least 80 percent of the cases in which such measures are reportable. A total of 74 clinical quality measures were available for reporting for 2007, which occurred only via claims.
TRHCA also required that CMS establish a PQRI measure set for 2008. The 2008 set:

- Includes 119 measures that eligible professionals can select from (117 clinical quality measures, and two structural measures [use of electronic health records and electronic prescribing]); and
- Addresses the submission of PQRI measures data through registries. In the 2008 MPFS final rule, CMS described plans to test two methods for submission of quality measures data through registries during 2008, and the testing process for these registries is currently underway; with test data submission slated to begin in July, 2008, and to end by September 1, 2008.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA – Public Law 110-173), enacted on December 29, 2007, authorizes CMS to make PQRI incentive payments for satisfactory reporting quality measures data for services furnished in 2008. For 2008, eligible professionals who meet the criteria for satisfactory submission of quality measures data on services furnished during the reporting period (January 1, 2008 – December 31, 2008) will earn an incentive payment of 1.5 percent of their total allowed charges for PFS covered professional services furnished during that same period (the 2008 calendar year).

MMSEA also requires that, for 2008 and 2009, the Secretary of Health and Human Services (HHS) establish alternative reporting periods and criteria for the satisfactory reporting of measure groups; and for satisfactorily reporting quality measures data through registries. Thus, in 2008, eligible professionals may earn the incentive payment based on data submitted through these alternative mechanisms. Also, please note that while TRHCA established a cap on incentive payments for 2007 (based on an average per measure payment amount) there is no cap on incentive payments under MMSEA for 2008 and 2009.

CR 6104, from which this article is taken announces the establishment of the MMSEA-mandated alternative reporting periods and alternative criteria for satisfactorily reporting 2008 PQRI quality measures.

Measures Groups

There are four measures "groups" for the 2008 PQRI: 1) Diabetes Mellitus; 2) End-Stage Renal Disease; 3) Chronic Kidney Disease (CKD); and 4) Preventive Care. Each of the measure groups contains at least four PQRI measures.

The individual Diabetes Mellitus Measures are:

- Measure 1 – Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus
- Measure 2 – Low Density Lipoprotein Control in type 1 or 2 Diabetes Mellitus
- Measure 3 – High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus
- Measure 117 – Dilated Eye Exam in Diabetic Patients
- Measure 119 – Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

The individual End-Stage Renal Disease (ESRD) measures are:

- Measure 78 – Vascular Access for Patients Undergoing Hemodialysis
- Measure 79 – Influenza Vaccination in Patients with ESRD
- Measure 80 – Plan of Care for ESRD Patients with Anemia
- Measure 81 – Plan of Care for Inadequate Hemodialysis in ESRD Patients

The individual measures for CKD are:

- Measure Number 120 – ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD
- Measure Number 121 – CKD: Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)
- Measure Number 122 – CKD: Blood Pressure Management
- Measure Number 123 – CKD: Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)

2008 PQRI Establishment of Alternative Reporting Periods and Reporting Criteria (continued)

The individual measures in the Preventive Care group are:

- Measure Number 39 – Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- Measure Number 48 – Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- Measure Number 110 – Influenza Vaccination for Patients > 50 Years Old
- Measure Number 111 – Pneumonia Vaccination for Patients 65 Years and Older
- Measure Number 112 – Screening Mammography
- Measure Number 113 – Colorectal Cancer Screening
- Measure Number 114 – Inquiry Regarding Tobacco Use
- Measure Number 115 – Advising Smokers to Quit
- Measure Number 128 – Universal Weight Screening and Follow-Up

Note: If you elect to report a group of measures, you must report all of the measures in the group that are applicable to the patient.

General Reporting Guidance for Professionals

CR 6104 also contains some general guidance about reporting PQRI measures that you may find to be helpful before the alternative reporting periods and criteria are described:

- "Patients" or "Medicare patients" means Part B Medicare Fee-For-Service (FFS) patients. Non-FFS Medicare (e.g. Medicare Part C patients including those enrolled in Private FFS plans) and/or Non-Medicare patients may only be included in registry based reporting under the consecutive patient criteria. "Non-Medicare patients" means persons not enrolled in Part B or Part C of Medicare.
- "Consecutive" means next in order by date of service. Patients are considered consecutive without regard to gender even though some measures in a group (e.g., preventive care measures) may apply only to males or only to females.
- "Patients for whom the measures of one measures group apply" means patients to whom services are furnished during the reporting period and for whom the measures of a particular group apply as defined by the denominator of the measures.
- Measures groups reporting requires that eligible professionals must report on each of the measures in the measures group that is applicable to the patient.
- The alternative reporting criteria for the data required for measures groups reported for the January 1, 2008 – December 31, 2008, reporting period through registry-based submission only are 30 consecutive patients for whom the measures of one measures group apply; or 80 percent of Medicare patients for whom the measures of the measures group apply, without regard to whether the patients are consecutive.
- The alternative reporting criteria for the data required for measures groups reported for the July 1, 2008 – December 31, 2008 reporting period are: 15 consecutive patients for whom the measures of one measure group apply for measures groups reported through registry-based reporting; 15 consecutive Medicare patients for whom the measures of one measures group apply for measures groups reported through the claims mechanism; or 80 percent of Medicare patients for whom the measures of the measures group apply, without regard to the submission mechanism used or whether the patients are consecutive.
- Eligible professionals who submit measures both through registries and through claims-based submission will be eligible to receive an incentive payment provided they meet the requirements for satisfactory reporting under either reporting mechanism. Qualification under both submission mechanisms will result in only one incentive bonus payment based on the longest reporting period for which the eligible professional satisfactorily reports.

Guidance for Registries

- In order to qualify to submit data under the registry-based reporting alternatives for 2008, a registry must have been in existence on January 1, 2008, and the registry also must meet certain technical and other requirements that CMS specifies. Those registry requirements will be available at *http://www.cms.hhs.gov/pqri* on the CMS Web site.
- The requirements for qualified registries include, but are not limited to, 1) submission of a self-nomination by a certain date. Registries that participated and/or self-nominated for the 2008 registry testing process will need to submit a new self-nomination specific to this new process in order to be considered for potential qualification; and 2) the registry having entered (or entering) into appropriate legal arrangements that provide for the registry's receipt of patient-specific data from eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program.
- Each registry seeking to submit data for the PQRI program will be required to meet all technical and other requirements CMS identifies for registries to submit such information.
- CMS will post on the CMS Web site by August 31, 2008, the names of those registries that qualify to the CMS PQRI Web site at *http://www.cms.hhs.gov/pqri*.
- Registry-based submissions under the 2008 registry-based reporting alternatives will begin after the completion of the 2008 registry testing process.
- Eligible professionals must comply with all applicable laws in establishing a relationship with a registry whereby the registry will report quality measures data to CMS on their behalf based on the data the eligible professional submits to the registry. The eligible professional will need to document and be able to demonstrate that this relationship has been established, and must attest to the validity of the data submitted by the eligible professional to the registry.
- The registry-based submission must meet the criteria for satisfactory reporting for PQRI measure results and/or measures group results.
- Registries must submit to CMS all required data that will include reporting and performance rates on PQRI measures or PQRI measures groups and numerator and denominators for the performance rates.

2008 PQRI Establishment of Alternative Reporting Periods and Reporting Criteria (continued)

- Registries must attest that the eligible professional has satisfactorily reported data for clinical quality measures or measures groups under the PQRI program. Registries must specify the reporting criteria and reporting periods for which the eligible professional satisfactorily reported.
- Registries must also attest that all applicable statutory, regulatory, and contractual requirements for reporting of information to CMS have been met.
- Registry reporting for each eligible professional must be on 2008 PQRI measures for patient services furnished during the applicable reporting period.

Alternative Reporting Periods and Reporting Options

A description of the MMSEA-mandated alternative reporting periods and alternative criteria for satisfactorily reporting 2008 PQRI quality measures follows. There are two alternative reporting periods and nine options for the 2008 PQRI.

- Alternative Reporting Periods

The two alternative reporting periods are January 1, 2008 – December 31, 2008; and July 1, 2008 – December 31, 2008.

- Reporting Options

Three of the nine reporting options from which you may select, are claims-based and six are registry-based.

Notes:

1) The claims-based reporting mechanism for measures groups will be first available July 1, 2008, therefore the July 1, 2008 – December 31, 2008 reporting period applies only when using the claims-based option to report measure groups.

2) Both reporting periods apply when using the registry-based option to report both measure groups and individual measures.

A description of each option follows:

Option 1 – Reporting individual measures using the claims-based option (reporting period January 1, 2008 – December 31, 2008)
If you elect the claims-based option to report individual measures, you must report 3 measures (or 1 -2 measures if less than 3 measures apply to you) on 80 percent of applicable patient claims for 1 – 3 measures).

Option 2 – Reporting measure groups using the claims-based option (reporting period July 1, 2008 – December 31, 2008)
If you elect the claims-based option to report measure groups, you must report all of the measures in one measure group that apply to each of 15 consecutive patients. To start the count of the 15 consecutive patients, you should report the measure group specific "G code" on the claim for the first of these patients.

Option 3 – Reporting measure groups using the claims-based option (reporting period July 1, 2008 – December 31, 2008)
If you elect the claims-based option to report measures groups, you must report all measures in one measures group on 80 percent of patients for the applicable measures group during the reporting period. You should report the measures group specific "G code" or the claim to indicate the intent to report the measures group.

Option 4 – Reporting individual measures using the registry-based option (reporting period January 1, 2008 – December 31, 2008)
If you elect the registry-based option to report individual measures, you must report at least 3 measures on 80 percent of applicable Medicare FFS patients.

Option 5 – Reporting individual measures using the registry-based reporting option (reporting period July 1, 2008 – December 31, 2008)
If you elect the registry-based option to report individual measures, you must report at least 3 PQRI measures on 80 percent of applicable Medicare FFS patients.

Option 6 – Reporting measure groups using the registry-based reporting option (reporting period July 1, 2008 – December 31, 2008)
If you elect to use the registry-based option to report measure groups, you must report all of the measures in one measure group that apply to each of 15 consecutive patients. The consecutive patients may include (but not be exclusively) non-Medicare patients. The reporting of a measures group specific "G-code" is not required for registry-based reporting.

Option 7 – Reporting measure groups using the registry-based reporting option (reporting period January 1, 2008 – December 31, 2008)
If you elect to use the registry-based option to report measure groups, you must report all of the measures in one measure group that apply to each of 30 consecutive patients. The consecutive patients may include (but not be exclusively) non-Medicare patients. The reporting of a measures group specific "G-code" is not required for registry-based reporting.

Option 8 – Reporting measure groups using the registry-based reporting option (reporting period July 1, 2008 – December 31, 2008)
If you elect to use the registry-based option to report measure groups, you must report all of the measures in one measure group on 80 percent of Medicare FFS patients for the applicable measures group on services provided during the reporting period. The reporting of a measures group specific "G-code" is not required for registry-based reporting.

Option 9 – Reporting measure groups using the registry-based option (reporting period January 1, 2008 – December 31, 2008)

If you elect to use the registry-based option to report measure groups, you must report all of the measures in one measure group on 80 percent of Medicare FFS patients for the applicable measures group for services provided during the reporting period. The reporting of a measures group specific "G-code" is not required for registry-based reporting.

HCPCS Codes

Effective for dates of service on or after July 1, 2008, Medicare carriers and A/B MACs will recognize the following Healthcare Common Procedure Coding System (HCPCS) codes, which will be included in the July Update to the 2008 MPFS Database. These codes are required for claims-submission of measures groups:

2008 PQRI Establishment of Alternative Reporting Periods and Reporting Criteria (continued)

- **G8485** (Clinician intends to report the Diabetes measure) for intent to report the Diabetes measure group
- **G8486** (Clinician intends to report the Preventive Care measure group) for intent to report the Preventive Care measure group
- **G8487** (Clinician intends to report the Chronic Kidney Disease (CKD) measure group) for intent to report the Chronic Kidney Disease measure group
- **G8488** (Clinician intends to report the ESRD measure group) for intent to report the End-Stage Renal Disease measure group.

Note: The alternative reporting criteria for measure groups apply regardless of whether the measures are reported through claims-based submission or through registry-based reporting; however, these G-codes that are required for claims-submission of measures groups will not be implemented until July 1, 2008.

Therefore, the July 1, 2008 – December 31, 2008 reporting period is the only available reporting period for measure group data that you submit on claims.

ADDITIONAL INFORMATION

You may find more information about the establishment of alternative reporting periods and criteria for the 2008 PQRI by going to CR 6104, located at *http://www.cms.hhs.gov/Transmittals/downloads/R355OTN.pdf* on the CMS Web site.

If you have any questions, please contact your 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: MM6104 *Revised*
Related Change Request (CR) #: 6104
Related CR Release Date: June 13, 2008
Effective Date: July 1, 2008
Related CR Transmittal #: R355OTN
Implementation Date: July 7, 2008

GENERAL INFORMATION

WAIVING RETROACTIVE BENEFICIARY COST SHARING DUE TO INCREASED PAYMENT RATES

The United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG) has issued a policy statement that assures Medicare providers, practitioners, and suppliers affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) that they will not be subject to OIG administrative sanctions if they waive retroactive beneficiary cost-sharing amounts attributable to those increased payment rates, subject to the conditions noted in the policy statement. To view the document, go to *http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA_Policy_Statement.PDF*.

Source: Provider Education Resource Message 200807-28

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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.

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 & Human Services that the PCR has been changed to **11.125 percent, effective July 24, 2008**. The PCR will remain in effect until a new rate change is published. The following table lists previous interest rates.

Period	Interest Rate
April 18, 2008 – July 23, 2008	11.375%
January 18, 2008 – April 17, 2008	12.125%
October 19, 2007 – January 17, 2007	12.5%
July 20, 2007 – October 18, 2007	12.625%
April 20, 2007 – July 19, 2007	12.375%
January 19, 2007 – April 19, 2007	12.5%
October 18, 2006 – January 18, 2007	12.375%

Source: CMS Pub. 100-06, Transmittal 140, CR 5751

CLARIFICATIONS TO AUDIOLOGY UPDATE TRANSMITTAL 1470

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

PROVIDER TYPES AFFECTED

Audiologists submitting claims to Medicare administrative contractors (A/B MACs) and carriers for services provided to Medicare beneficiaries.

IMPACT ON PROVIDERS

This article is based on change request (CR) 6061, which alerts Audiologists who are not currently enrolled to the fact that they are required to obtain their NPI and use it on claims for services they render on or after October 1, 2008. An audiologist not previously enrolled with Medicare should initiate Medicare enrollment as soon as they obtain an NPI.

BACKGROUND

Transmittal 1470, (CR 5717) titled, "Update to Audiology Policies", was issued February 29, 2008, with clarifications to the *Medicare Claims Processing Manual*. (An *MLN Matters* article related to CR 5717 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5717.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.) In chapter 12, section 30.3, the manual instructions state, ". . . the audiologist's NPI is required on all claims for services furnished by audiologists." CR 6061 responds to questions concerning CR 5717.

Key Points

- Audiologists who are enrolled and bill Medicare independently must have obtained their NPI on Medicare claims as of May 23, 2008, and must currently use it on claims for services they render.
- Those audiologists not currently enrolled with Medicare should obtain their NPI and enroll with Medicare as soon as possible prior to October 1, 2008. Audiologists who are not currently enrolled may continue to have their services billed as diagnostic test services by a physician or group until October 1, 2008.
- The audiologist's NPI is required on all claims for services rendered by audiologists as of October 1, 2008.

ADDITIONAL INFORMATION

To see the official instruction (CR 6061) issued to your Medicare A/B MACs and carriers visit *http://www.cms.hhs.gov/Transmittals/downloads/R1550CP.pdf* on the CMS Web site.

To learn more about the NPI and how to obtain your NPI, visit *http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp* on the CMS Web site. Information on enrolling as a Medicare provider is available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* on the CMS site.

If you have questions, please contact your Medicare A/B 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.

MLN Matters Number: MM6061
Related Change Request (CR) #: 6061
Related CR Release Date: July 18, 2008
Effective Date: October 1, 2008
Related CR Transmittal #: R1550CP
Implementation Date: August 18, 2008

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PRIVATE CONTRACTING/OPTING OUT OF MEDICARE

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

PROVIDER TYPES AFFECTED

Physicians and practitioners who opted out of Medicare and continue to bill Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for services to Medicare beneficiaries.

IMPACT ON PROVIDERS

This article is based on change request (CR) 6081 and notifies providers of the update by the Centers for Medicare & Medicaid Services (CMS) to *Medicare Benefit Policy Manual*, chapter 15, sections 40.5, 40.6, 40.9, 40.11, 40.13, 40.20, 40.26, and 40.35.

- The added sections clarify that the consequences for the failure on the part of a physician or practitioner to maintain opt-out apply regardless of whether or when a carrier/MAC notifies a physician or practitioner of the failure to maintain opt-out.
- A new paragraph was also added to clarify that in situations where a violation is not discovered by the carrier/MAC during the 2 year opt-out period when the violation actually occurred, then the requirements are applicable from the date that the first violation for failure to maintain opt-out occurred until the end of the opt-out period during which the violation occurred (unless the physician or practitioner takes good faith efforts to restore opt-out conditions, for example, by refunding the amounts in excess of the charge limits to beneficiaries with whom he or she did not sign a private contract).

Key Points of CR 6081

Failure on the part of a physician or practitioner to maintain opt-out will result in the following (unless the physician or practitioner takes good faith efforts, within 45 days of any notice from the carrier/MAC that the physician or practitioner failed to maintain opt-out, or within 45 days of the physician's or practitioner's discovery of the failure to maintain opt-out, whichever is earlier, to correct his or her violations).

A. Failure to maintain opt-out occurs if during the opt-out period

- The physician/practitioner has filed an affidavit in accordance with section 40.9 and has signed private contracts in accordance with section 40.8 but, the physician/practitioner knowingly and willfully submits a claim for Medicare payment (except as provided in section 40.28) or the physician/practitioner receives Medicare payment directly or indirectly for Medicare-covered services furnished to a Medicare beneficiary (except as provided in section 40.28); (For specific information about chapter 15, sections 8 and 28, refer to *http://www.cms.hhs.gov/Manuals/downloads/bp102c15.pdf* on the CMS Web site. The sections of chapter 15 that are revised by CR 6081 are attached to CR 6081.)
- The physician/practitioner fails to enter into private contracts with Medicare beneficiaries for the purpose of furnishing items and services that would otherwise be covered by Medicare, or enters into private contracts that fail to meet the specifications of section 40.8
- The physician/practitioner fails to comply with the provisions of section 40.28 regarding billing for emergency care services or urgent care services
- The physician/practitioner fails to retain a copy of each private contract that the physician/practitioner has entered into for the duration of the opt-out period for which the contracts are applicable or fails to permit CMS to inspect them upon request.

B. Violation discovered by the carrier during the 2-year opt-out period

- If a physician/practitioner fails to maintain opt-out in accordance with the provisions outlined in section A. of this article, and fails to demonstrate within 45 days of a notice from the carrier that the physician/practitioner has taken good faith efforts to maintain opt-out (including by refunding amounts in excess of the charge limits to the beneficiaries with whom the physician/practitioner did not sign a private contract), the following will result effective 46 days after the date of the notice, but only for the remainder of the opt-out period:

  1. All of the private contracts between the physician/practitioner and Medicare beneficiaries are deemed null and void.
  2. The physician's or practitioner's opt-out of Medicare is nullified.
  3. The physician or practitioner must submit claims to Medicare for all Medicare covered items and services furnished to Medicare beneficiaries.
  4. The physician or practitioner or beneficiary will not receive Medicare payment on Medicare claims for the remainder of the opt-out period, except as stated above.
  5. The physician or practitioner is subject to the limiting charge provisions as stated in section 40.10.
  6. The practitioner may not reassign any claim except as provided in the *Medicare Claims Processing Manual*, chapter 1, "General Billing Requirements," section 30.2.13. (For more information about the General Billing Requirements refer to *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the CMS Web site).
  7. The practitioner may neither bill nor collect any amount from the beneficiary except for applicable deductible and coinsurance amounts.
  8. The physician or practitioner may not attempt to once more meet the criteria for properly opting out until the 2-year opt-out period expires.

C. Violation not discovered by the carrier during the 2-year opt-out period

- In situations where a violation of section A is not discovered by the carrier during the 2-year opt-out period when the violation actually occurred, the requirements of section B (1) through B (8) of this article are applicable from the date that the first violation of section A occurred until the end of the opt-out period during which the violation occurred.

Note: For a physician/practitioner who has never enrolled in the Medicare program and wishes to opt-out of Medicare, the physician/practitioner must provide the carrier or A/B MAC with a national provider identifier (NPI). For information on the NPI, see the NPI Resource sheet visit *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Resource_Sheet.pdf* on the CMS Web site.

Private Contracting/Opting out of Medicare (continued)

ADDITIONAL INFORMATION

To see the official instruction (CR 6081) issued to your carrier or A/B MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R92BP.pdf* on the CMS Web site.

If you have questions, please contact your 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: MM6081
Related CR Release Date: June 27, 2008
Related CR Transmittal #: R92BP
Related Change Request (CR) #: 6081
Effective Date: September 29, 2008
Implementation Date: September 29, 2008

SIGNATURE ON REQUEST FOR REDETERMINATION

BACKGROUND

When submitting a written request for a redetermination, the request must indicate what you are appealing and why. The following outlines two acceptable written ways to request a redetermination:

- Complete and submit Form CMS-20027 to the address listed on the form (if applicable); or
- Submit a written request (not on Form CMS-20027)

All requests for redeterminations must contain all of the following information:

- Beneficiary name
- Complete Medicare health insurance claim (HIC) number
- The specific service(s) and/or item(s) for which the redetermination is being requested
- The specific date(s) of the service (mm/dd/yy), and
- The name and signature of the party or the representative of the party

Source: Publication 100-04, Chapter 29, Section 310.1

SIGNATURE REQUIREMENTS

In regard to the signature, please remember:

- Typed signatures are NOT acceptable
- The signature must contain at minimum the first initial and full last name
- A stamped signature is acceptable, but must be first/last name

REQUESTING MEDICARE SECONDARY PAYER CONDITIONAL PAYMENTS

WHAT IS A CONDITIONAL PAYMENT?

A conditional payment is a Medicare payment for Medicare covered services for which another insurer is primary payer. Conditional payments are made under the condition that they are subject to repayment if and when the primary payer makes payment.

WHEN WILL MEDICARE MAKE A CONDITIONAL PAYMENT?

Medicare will make a conditional payment for Medicare covered services in the situations listed below. For more specific circumstances under which a Medicare conditional payment may not be made, refer to the CMS Internet-Only Manuals, Publication 100-05, Medicare Secondary Payer Manual.

- If the Workers' Compensation (WC), No-Fault (NF), or liability insurance will not pay or will not pay promptly (i.e., within 120 days), Medicare makes conditional payments to prevent the patient from using his or her own money to pay the claim. However, Medicare has the right to recover any conditional payments. Refer to the MSP Manual, Chapter 1, Section 20, for the definition of "Promptly."

  Note: If the injury resulted from an automobile accident and/or there is an indication of primary coverage under a Group Health Plan (GHP), the provider bills the liability insurer or no-fault insurer and/or GHP as appropriate before requesting conditional Medicare payments.

In Third Party Liability (TPL) cases, the provider may, after 120 days:

- Bill Medicare for conditional payments while withdrawing all claims/liens against the liability insurance/patient's liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance), or
- Maintain all claims/liens against the liability insurance/patient's liability insurance settlement. If this option is chosen, Medicare may not be billed until the settlement is reached and only then if no monies were paid to the patient. All usual claims processing rules would still apply. The provider may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs but may not collect payment from the patient until after the proceeds of the liability insurance are available to the patient.

- If because of physical or mental incapacity of the patient, the provider or patient failed to file a proper* claim with the primary payer.
- When benefits have been exhausted under the non-group health plan (WC, NF, Liability).
- When the provider files a proper* claim with the GHP and the GHP denies the claim in whole or in part for reasons that include:

Requesting MSP Conditional Payments (continued)

- The patient is not entitled to benefits
- The plan benefits are exhausted
- The services rendered are not covered services under the plan
- The patient is appealing the GHP's denial (refer to *MSP Manual*, chapter 5, section 40.6 for exception)
- The primary payer is bankrupt or insolvent and proceedings have concluded (refer to *MSP Manual*, chapter 5, section 40.5 for additional information).

***Proper Claim** – A claim that is filed timely and meets all other claims filing requirements specified by the plan, program, or insurer (e.g., mandatory second opinion, prior notification before seeking treatment).

How to Request a Conditional Payment

When submitting paper claims:

For providers who have been approved to submit paper claims, attach a copy of the primary payer's Explanation of Benefits (EOB) statement or other supporting documentation that clearly shows the reason for non-payment or payment delay.

When submitting electronic claims:

The following fields must be completed, as indicated, for a conditional Medicare payment request. For all other data segments that must normally be completed for an MSP claim, please refer to the HIPAA EDI Implementation Guide.

For **Claim Level** coding:

- Enter six zeroes in the syntax of the 2320 loop AMT segment for the Coordination of Benefits (COB) Allowed Amount:
  AMT01 = "B6" indicating Allowed Amount
  AMT02 = '0000.00'
- Enter six zeroes in the syntax of the 2320 loop AMT segment for the COB Payer Paid Amount:
  AMT01 = "D" indicating Payer Amount Paid
  AMT02 = '0000.00'
- Enter the date the claim was adjudicated by the primary payer in the syntax of the 2330B loop DTP segment for Adjudication Date:
  DTP01 = '573' indicating Date Claim Paid
  DTP02 = 'D8' indicating Date Format
  DTP03 = Actual primary payer adjudication date
- Enter the reason code and adjustment amount for the services not paid by the primary payer in the syntax of the 2430 loop CAS segment for Line Adjustment Information:
  CAS01 = Claim Adjustment Group Code
  CAS02 = Claim Adjustment Reason Code

For **Line Level** coding:

- Enter six zeroes in the syntax of the 2400 loop AMT segment for the Approved Amount:
  AMT01 = "AAE" indicating Approved Amount
  AMT02 = '0000.00'
- Enter six zeroes in the syntax of the 2430 loop SVD segment for Line Adjudication Information:
  SVD02 = '0000.00'
- Enter the date the claim was adjudicated by the primary payer in the syntax of the 2430 loop DTP segment for Line Adjudication Date:
  DTP01 = '573' indicating Date Claim Paid
  DTP02 = 'D8' indicating Date Format
  DTP03 = Actual primary payer adjudication date
- Enter the reason code and adjustment amount for the services not paid by the primary payer in the syntax of the 2430 loop CAS segment for Line Adjustment Information:
  CAS01 = Claim Adjustment Group Code
  CAS02 = Claim Adjustment Reason Code
  CAS03 = Actual Monetary Adjustment Amount
  CAS04 = Actual Service Line Adjusted Units

When a Medicare MSP Denial is Received

Submit a written request to the address indicated below along with a copy of the primary payer's Explanation of Benefits (EOB) statement or other supporting documentation that clearly shows the reason for non-payment or payment delay. Please ensure that the correspondence clearly states, "Conditional Payment Request."

First Coast Service Options Inc.
Attn: MSP Overpayments/Inquiry Unit
P. O. Box 44078
Jacksonville, Florida 32231

Connecticut Top Inquiries for May 2008

Below are the inquiries received most frequently by the Connecticut Part B Provider Contact Center during the month of May 2008, as well as tips and resources to help you avoid many of these issues. We will update this list each month.

Unprocessable Claim Denials

The most frequent unprocessable denial is for patients who are covered under a managed care plan. Look up Medicare Advantage plan names and addresses using our IVR. Contact the IVR by calling (866) 419-9455. For instructions, refer to the IVR Operating Guide at *http://www.connecticutmedicare.com/Reference/IVR/108307.asp.*

Release of Eligibility Information to Providers

Check current eligibility for beneficiaries as well as eligibility for a previous date of service using the IVR. Contact the IVR by calling (866) 419-9455. For instructions, refer to the IVR Operating Guide at *http://www.connecticutmedicare.com/Reference/IVR/108307.asp.*

Address/Phone/Fax/Web Address

FCSO contact information may be found at *http://www.connecticutmedicare.com/header/Contact/110268.asp* on our Web site.

Claims Denial Explanation

Access *http://www.connecticutmedicare.com/EDI/Remittance_Advice/index.asp* for links to Understanding the RA, Reason Codes, and Remark Codes.

Claim Not On File

Check claims status though the IVR. Contact the IVR by calling (866) 419-9455. For instructions, refer to the IVR Operating Guide at *http://www.connecticutmedicare.com/Reference/IVR/108307.asp.*

For electronic claim submitters, please refer to your Batch Detail Control Listing (error reports/prepass edits) for information. This report can be retrieved electronically from your mailbox normally within 24 hours. Contact the Medicare EDI Department at (203) 639-3160, option 4, for

Connecticut Top Inquiries for May 2008 (continued)

additional information. Check with your vendor to be certain electronic claims were submitted successfully.

- If submitting paper claims, allow time for FCSO to receive, scan, and enter claims into the system.
- Patient not eligible for Medicare (Services after DOD, services prior to effective date)
- In order to ensure that claims are not submitted for services prior to the patient's Medicare effective date, make sure to have on file a copy of the patient's Medicare card and reference it before submitting claims.
- Simple typing errors cost time and money. Always double-check the date of service before submitting a claim.

CLAIM STATUS – APPLIED TO DEDUCTIBLE

Contact the IVR by calling (866) 419-9455 to check the amount remaining due on a patient's yearly Medicare deductible. For instructions, refer to the IVR Operating Guide at *http://www.connecticutmedicare.com/Reference/IVR/108307.asp*.

CLAIM STATUS SUSPENDING/PENDING CLAIMS

Providers must check claim status for most Medicare numbers by using the IVR at (866) 419-9455. For instructions, refer to the IVR Operating Guide at *http://www.connecticutmedicare.com/Reference/IVR/108307.asp*.

LOCAL COVERAGE DETERMINATION (LCD) DENIAL (DENIED/REDUCED BASED ON LCD)

This denial indicates that the procedure code billed is not compatible with the diagnosis. You may access the procedure to diagnosis look up tool to determine if the procedure code to be billed is payable under the specific diagnosis. The tool is located at: *http://www.cms.hhs.gov/mcd/serviceindication_criteria.asp?from2=serviceindication_criteria.asp&* on the Connecticut Medicare provider Web site. On the same page, you may also refer to the Final Local Coverage Determinations (LCDs) in order to determine if specific Healthcare Common Procedure Coding System (HCPCS) codes are applicable to each LCD, as well as which diagnoses are and are not considered reasonable and necessary under that LCD.

GENERAL QUESTION REGARDING AN ADS LETTER

Remember, both prepayment and post payment reviews may require providers to submit medical records. When medical records are requested, the provider must submit them within the specified timeframe or the claim will be denied.

For requirements, tips and information about additional development request (ADR/ADS) letters, check out the "Medical Documentation Requests" Web-based training on FCSO Medicare Training Web site and read the Medical Review Fact Sheet on the CMS Web site (*www.cms.hhs.gov/MedicalReviewProcess/Downloads/mrfactsheet.pdf*).

Remember to use the IVR for claim status, eligibility (Medicare, MSP and Medicare Advantage [formerly Medicare HMO]), deductible information, and financial information (last three checks, month/year to date dollar amounts). In addition, you may obtain duplicate copies of Medicare Remittance Notices through the IVR. Contact the IVR by calling (866) 419-9455. For instructions, refer to the IVR Operating Guide.

CONNECTICUT PART B TOP CLAIM DENIAL REASONS – MAY 2008

Below are the most frequent denial reasons for claims processed by Connecticut Medicare during May 2008, as well as tips and resources to help you avoid many of these issues. Please share this information with all who need to know, such as your IT staff, billing service, vendor, or clearinghouse. Billing Medicare correctly the first time saves everyone time and money.

ANSI Reason Code/Description	Tips/Resources
CO 18 Duplicate claim/service (DUPLICATE CHARGE PAID ?002XX ON CLAIM ?001XXXXXXXX.) (DUPLICATE CHARGE OF CLAIM ?001XXXXXXXX NOW BEING PROCESSED.)	This denial indicates a claim has been submitted to Medicare Part B for the same service and the same date of service for the same patient (duplicate) as a claim that has already been adjudicated (processed). When partial payment has been made on a claim and the situation is one where you can correct and resubmit the charge, do not resubmit the entire claim. In order to avoid this denial, resubmit denied line(s) only. OR This denial indicates that two lines on the same claim are for the same service and there is no modifier present to indicate why the same service was done twice on the same day. Append the appropriate modifier to the second service in order to avoid this denial. OR This denial indicates a claim has been submitted to Medicare Part B for the same service and the same date of service for the same patient (duplicate) as a claim that is currently processing. Before sending in another claim, check the status of the previously submitted claim by calling the interactive voice response unit (IVR) at 866-419-9455. For instructions, refer to the IVR Operating Guide at *http://www.connecticutmedicare.com/Reference/IVR/108307.asp*. Please wait 10 business days before checking on your claims through the automated IVR.

Connecticut Part B Top Claim Denial Reasons – May 2008 (continued)

ANSI Reason Code/Description	Tips/Resources
CO 96 Non-covered charge(s) (MEDICARE DOES NOT PAY FOR THESE SERVICES OR SUPPLIES.) THE PROCEDURE CODE SUBMITTED IS A NON-COVERED MEDICARE SERVICE.	Providers use this denial in order to show that Medicare does not cover a service when billing a supplemental insurer or the beneficiary. When billing for denial for supplemental insurer, remember to use GA/GY/GZ modifiers as appropriate.
CO 11 The diagnosis is inconsistent with the procedure. (THIS PROCEDURE/ITEM NOT PAYABLE FOR THE DX AS REPORTED [LMRP])	This denial indicates that the procedure code billed is not compatible with the diagnosis. You may access the procedure to diagnosis look up tool to determine if the procedure code to be billed is payable under the specific diagnosis. The tool is located at *http://www.cms.hhs.gov/mcd/serviceindication_criteria.asp?from2=serviceindication_criteria.asp&*. On the same page, you may also refer to the Final Local Coverage Determinations (LCDs) in order to determine if specific Healthcare Common Procedure Coding System (HCPCS) codes are applicable to each LCD, as well as which diagnoses are and are not considered reasonable and necessary under that LCD.
CO 96 Non-covered charge(s) THE PROCEDURE CODE SUBMITTED IS A NON-COVERED MEDICARE SERVICE	Use GA, GY & GZ modifiers as appropriate when billing for denial for supplemental insurer.
CO 97 Payment adjusted because this procedure/service is not paid separately. (DENIED/REDUCED SERVICE/PROCEDURE NOT PAID SEPARATELY.) (SEPARATE PAYMENT NOT MADE FOR THIS SERVICE. DO NOT BILL PATIENT.)	This denial indicates that the service billed has already been paid as part of another service billed on the same date of service. Please take note to the quarterly updates to the National Correct Coding Initiative (NCCI) edits which are available at *http://www.cms.hhs.gov/NationalCorrectCodInitEd*. The purpose of the NCCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. To learn more about NCCI, check out our Web-based training course on *www.fcsomedicaretraining.com*. All services should be submitted on the same claim to avoid fragmented billing practices. To learn more about MSP, check out our Web-based training course on *www.fcsomedicaretraining.com*. All services should be submitted on the same claim to avoid fragmented billing practices.
CO 170 Expenses incurred after coverage terminated. (CHARGES INCURRED DURING NONENTITLED PERIOD.)	This denial occurs when the patient is no longer covered under Medicare. This occurs most often when services are billed after the patient's date of death or after the patient has disenrolled in Medicare Part B. Providers should ensure that they keep current with changes in the patient's insurance coverage as well as double-checking dates of service prior to submitting claims in order to avoid these denials.
CO 22 Payment adjusted because this care may be covered by another payer per coordination of benefits. (CLAIM MUST BE SENT TO EGHP FIRST.)	When this denial is received, it indicates Medicare has information that the patient has another insurance primary to Medicare (called Medicare Secondary Payer, or MSP). Submit the claim to the primary payer; once it is processed, a claim can be submitted to Medicare for possible secondary payment. If the provider has information the MSP file is incorrect, the beneficiary and/or the provider will need to contact the Coordination of Benefits Contractor (COBC) at 1-800-999-1118 (Monday - Friday from 8:00 a.m. to 8:00 p.m. Eastern Time) to have the file updated. Once the file is updated, the claim can be submitted to Medicare as primary. To learn more about MSP, check out our Web-based training course on *www.fcsomedicaretraining.com*.

CONNECTICUT PART B TOP RETURN UNPROCESSABLE CLAIMS REASONS – MAY 2008

Below are the most frequent return unprocessable (RUC) reasons for claims processed by Connecticut Medicare Part B during May 2008, as well as tips and resources to help you avoid many of these issues. Please share this information with all who need to know, such as your IT staff, billing service, vendor, or clearinghouse. Billing Medicare correctly the first time saves everyone time and money.

ANSI Reason Code/Description	**Tips/Resources**
CO 24 Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan (THIS CLAIM MUST BE SUBMITTED TO THE PATIENT'S HMO.)	This denial occurs when the Medicare files show that the patient is enrolled in a Health Maintenance Organization (HMO). Providers need to verify the patient's HMO enrollment information using the IVR and if the patient is enrolled in an HMO, the claims must be submitted to the HMO, not Medicare. Medicare is not the secondary payer for patients enrolled in an HMO. If the patient has disenrolled from the HMO, the claim can be sent to Medicare once the system has been updated to show the disenrollment.
CO 31 Claim denied as patient cannot be identified as our insured (PATIENT'S HIC# NONENTITLED. SUBMIT A NEW CLAIM WITH VALID HIC#.)	This denial indicates that the Medicare number submitted is not valid. Providers need to ensure that a copy of the patient's most recently issued Medicare card is in the patient's file in order to compare that number with the one submitted. Once the correct number is determined, resubmit the claim with the correct Medicare number.
CO 140 Patient/Insured health identification number and name do not match. (PATIENT'S HIC# NONENTITLED. SUBMIT A NEW CLAIM WITH VALID HIC#.)	Ensure that you have a copy of the patient's most recent Medicare card in order to determine whether the patient was entitled to Medicare on the date of service Check the patient's entitlement dates using the IVR at (866) 419-9455. Instructions located at *http://www.connecticutmedicare.com/Reference/IVR/108307.asp*.
CO 16 Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice FACILITY ZIP CODE OR STATE CODE INVALID OR MISSING (REFERRING NAME AND UPIN REQUIRED. RESUBMIT AS A NEW CLAIM.) DENIED-INVALID/INCORRECT ICD-9 CODE. RESUBMIT AS A NEW CLAIM (DENIED-RENDERING PHYSICIAN # INVALID/MISSING. SUBMIT A NEW CLAIM) (DENIED-FIELD 11 OF HCFA [CMS[1500 MUST BE COMPLETED) DENIED 2-DIGIT PLACE OF SERVICE REQUIRED. SUBMIT NEW CLAIM. DENIED-EXACT DATES AND CHARGES NEEDED. REKEY ELECTRONIC CLAIM.	CO 16 denials can occur for a variety of reasons. In all the situations below, providers should resubmit the claim as a new claim with the proper information. For more information on proper completion of items/fields on the CMS-1500 claim form, please reference the CMS Internet Only Manual (IOM) 100-04, chapter 26 at *www.cms.hhs.gov/manuals/downloads/clm104c26.pdf* • In Item 32, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home (POS 12) has been required on claims received on or after April 1, 2004. • When the claim has been denied due to lack of or invalid UPIN and name, review Section 10.4 of the IOM 100-04 Chapter 26 for the services and situations which require the submission of referring physician information (Item 17, 17a and/or 17b or their electronic equivalents). • When a claim is denied for incorrect/invalid ICD-9-CM codes, providers should ensure that they are referencing the book for the current year. Remember, ICD-9-CM codes are updated (added, changed, deleted) as of October 1 each year and are usually valid from then to September 30 of the following year. The grace period for ICD-9-CM codes was eliminated as of October 1, 2004. If an ICD-9-CM code is considered invalid, it is usually due to either not enough digits or too many digits in the code billed. Ensure that you code to the highest and most appropriate level of diagnosis specificity.

Connecticut Part B Top RUC Reasons – May 2008 (continued)

ANSI Reason Code/Description	Tips/Resources
CO 16 (continued)	• When a group NPI is entered in Item 33a, remember that an individual NPI must be entered in Item 24J (bottom, unshaded portion). Until May 23, 2008, providers can also enter a group PIN in Item 33b with a corresponding individual PIN in Item 24J (top, shaded portion). • Item 11 is required - enter "None" in Item 11 if Medicare is the primary payer
CO 4 Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice (DENIED-MODIFIER INVALID/MISSING. RESUBMIT AS A NEW CLAIM.)	Providers who need help with modifiers should check out our modifier Web-based trainings on *www.fcsomedicaretraining.com*. Currently, we have separate courses on modifiers 24, 25, 78, 79, and 58.
CO B18 This procedure code and modifier were invalid on the date of service. THIS CODE IS NO LONGER VALID. RESUBMIT WITH THE CORRECT CODE.	When a claim is denied for incorrect/invalid procedure codes, which includes *Current Procedural Terminology* (*CPT*) codes and Healthcare Common Procedure Coding System (HCPCS) codes, providers should ensure that they are referencing the book for the current year. Remember, CPT and HCPCS codes are updated (added, changed, deleted) as of January 1 each year and are usually valid from then through December 31 of the same year. The grace period for procedure codes was eliminated as of January 1, 2005.

FLORIDA TOP PART B INQUIRIES FOR MAY 2008

Below are the inquiries received most frequently by the Florida Medicare Part B Provider Contact Center during the month of May 2008, as well as tips and resources to help you avoid many of these issues. We will update this list each month.

PROVIDER ENROLLMENT

- First Coast Service Options, Inc. (FCSO) has established a new process whereby certain calls (such as those relating to provider enrollment or debt collection) may be given more comprehensive service.
- Call FCSO's customer service toll-free line (1-866-454-9007) for assistance on all inquiries.
- When the FCSO representative determines your provider enrollment (or debt collection issue) requires more in-depth research and assistance, he or she will provide a new toll free number for the extended service line and assign a referral number.
- Call the toll-free number and supply the assigned referral number.
- You work directly with a representative from the appropriate operational area within FCSO to resolve your issue.
- Several articles and helpful tip sheets are available on the Provider Enrollment Web page at *http://www.floridamedicare.com/Reference/Provider_Enrollment/index.asp*.

RELEASE OF ELIGIBILITY INFORMATION TO PROVIDERS

You may now check current eligibility for beneficiaries as well as eligibility for a previous date of service using the interactive voice response (IVR). Contact the IVR by calling 1-877-847-4992. Instructions located at *http://www.floridamedicare.com/Reference/IVR/108326.asp*.

UNPROCESSABLE CLAIM DENIALS (CMS-1500 ITEM)

Access the Internet Only Manual (IOM) at *http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf* - Publication 100-04, chapter 26 gives detailed instruction regarding completion of Form CMS-1500

Complete the WBT titled "CMS Form 1500 (08/05) (May 2007)" available via the CMS Web site (at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1*)

CLAIMS DENIAL EXPLANATION (EXCLUDING UNPROCESSABLE CLAIMS DENIALS)

Access "Understanding the Remittance Advice" guide and links to reason and remark codes at *http://www.floridamedicare.com/EDI/Remittance_Advice/index.asp*

WEB SITE ASSISTANCE

Access the Web site Tutorial at *http://www.floridamedicare.com/header/Help/105840.asp*.

Florida Top Part B Inquiries for May 2008 (continued)

FINANCIAL

FCSO has established a new process whereby certain calls (such as those relating to provider enrollment or debt collection) may be given more comprehensive service. For details, refer to the information listed above under "Provider Enrollment."

Overpayment forms can be located easily on our Web site - just click "Forms (Part B)" link in the Quick Find section of the home page and then scroll down to the link for "Part B: Overpayment Refund Form" or for direct link at *http://www.floridamedicare.com/Part_B/Forms/105650.pdf*.

CLAIM NOT ON FILE

Check claims status though the IVR. Contact the IVR by calling 1-877-847-4992. For instructions, refer to the Part B IVR Operating Guide located at *http://www.floridamedicare.com/Reference/IVR/108326.asp*.

For electronic claim submitters, please refer to your Batch Detail Control Listing (error reports/prepass edits) for information. This report can be retrieved electronically from your mailbox normally within 24 hours. Contact the Medicare EDI Department at 904-354-5977 option 2 for additional information. Check with your vendor to be certain electronic claims were submitted successfully.

If submitting paper claims, allow time for FCSO to receive, scan, and enter claims into the system.

PRICING/ALLOWED AMOUNT

Information pertaining to Medicare pricing and allowances may be found in the Fee Schedule section of this Web site at *http://www.floridamedicare.com/Part_B/Fee_Schedules/index.asp*. The FCSO Medicare Fee Schedule look up tool is available on this page, or may be accessed at *http://www.floridamedicare.com/Part_B/Fee_Schedules/Look-ups/116556.asp*.

MSP (NON-TRANSFER/REFERRAL ISSUE)

Use the Medicare Secondary (MSP) Questionaire to determine Medicare primary or secondary status located at *http://www.floridamedicare.com/Reference/MSP/105751.asp*.

You may contact the Coordination of Benefits Contractor (COBC) and update the patient's files by conducting a conference call with the patient. You may reach the COBC at (800) 999-1118.

APPEALS INFORMATION (GENERAL)

Minor errors or omissions can be corrected outside of the appeals process. A clerical error reopening can be initiated via the telephone or in writing; or, in many cases, the denied service (s) may simply be resubmitted. For more information, refer to the Appeals Process FAQ located at *http://www.floridamedicare.com/Part_B/FAQs/119119.asp*.

Please remember to use the IVR for claim status, eligibility (Medicare, MSP and Medicare Advantage [formerly Medicare HMO]), deductible information, and financial information (last three checks, month/year to date dollar amounts). In addition, you may obtain duplicate copies of Medicare Remittance Notices through the IVR. Contact the IVR by calling 1-877-847-4992. For instructions, refer to the Part B IVR Operating Guide located at *http://www.floridamedicare.com/Reference/IVR/108326.asp*.

FLORIDA PART B TOP CLAIM DENIAL REASONS – MAY 2008

Below are the most frequent denial and RUC reasons for claims processed by Florida Medicare Part B during May 2008, as well as tips and resources to help you avoid many of these issues. Please share this information with all who need to know, such as your IT staff, billing service, vendor, or clearinghouse. Billing Medicare correctly the first time saves everyone time and money.

ANSI Reason Code/Description	Tips/Resources
CO18 Duplicate claim/service (DUPLICATE CHARGE PAID ?002XX ON CLAIM ?001XXXXXXXX) (DUPLICATE CHARGE OF CLAIM ?001XXXXXXXX NOW BEING PROCESSED) THIS IS A DUPLICATE OF A CHARGE WE HAVE PROCESSED.	• Do not resubmit entire claim when partial payment made, resubmit denied lines only (when appropriate) • Ensure that appropriate modifier(s) are on claim lines
CO 11 The diagnosis is inconsistent with the procedure. (THIS PROCEDURE/ITEM NOT PAYABLE FOR THE DX AS REPORTED [LMRP])	This denial indicates that the procedure code billed is incompatible with the diagnosis. You may access the Procedure to Diagnosis Look-Up/Service Indication Tool located at *http://www.cms.hhs.gov/mcd/serviceindication_criteria.asp?from2=serviceindication_criteria.asp&* to determine if the procedure code to be billed is payable under the specific diagnosis. You may also refer to *http://www.floridamedicare.com/Part_B/Local_Medical_Coverage/Final_LCDs/index.asp* for a list of HCPCS

Florida Part B Top Claim Denial Reasons – May 2008 (continued)

ANSI Reason Code/Description	Tips/Resources
CO 11 (continued)	codes that spell out which services the LCD applies to, the diagnosis for which a service is covered, and the diagnosis for which the service is not considered reasonable and necessary.
CO 97 Payment adjusted because this procedure/service is not paid separately (DENIED/REDUCED SERVICE/PROCEDURE NOT PAID SEPARATELY)	This denial indicates that the services billed have already been paid as part of another service billed on the same date of service. Please make note of the quarterly updates to the Correct Coding Initiative (CCI) edits available at *http://www.cms.hhs.gov/NationalCorrectcodInitED/*. The purpose of the CCI edits is to ensure that the most comprehensive groups of codes are billed, rather than the component parts.
CO 170 This payment is adjusted when performed/billed by this type of provider. (THIS SERVICE BY A CHIROPRACTOR IS NOT COVERED BY MEDICARE)	Access the CMS Internet-Only Manual (IOM), Publication 100-02, chapter 15, section 30.5 that gives guidelines pertaining to chiropractor services at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf*.
CO 22 Payment adjusted because this care may be covered by another payer per coordination of benefits. (CLAIM MUST BE SENT TO EGHP FIRST)	When this denial is received, it indicates Medicare has information that the patient has another insurance primary to Medicare (called Medicare Secondary Payer, or MSP). Submit the claim to the primary payer; once it is processed, a claim can be submitted to Medicare for possible secondary payment. If the provider has information the MSP file is incorrect, the beneficiary and/or the provider will need to contact the Coordination of Benefits Contractor (COBC) at 1-800-999-1118 (Monday - Friday from 8:00 a.m. to 8:00 p.m. Eastern Time) to have the file updated. Once the file is updated, the claim can be submitted to Medicare as primary. To learn more about MSP, check out our Web-based training course on *www.fcsomedicaretraining.com*.
CO B9 Services are not covered because the patient is enrolled in a hospice. (THESE SERVICES ARE DENIED BECAUSE THE PATIENT IS IN A HOSPICE)	There are specific guidelines pertaining to Medicare hospice benefits. Certain Medicare coverage does not apply to a beneficiary that is enrolled in a hospice program. This link will produce a document titled “Medicare Hospice Benefits”, which details the guidelines applying to hospice cases: *http://www.hospiceelpaso.org/files/cms_medicare.pdf* To determine if a patient is enrolled in a hospice program, contact the interactive voice response (IVR) unit, from which the following data pertaining to the beneficiary can be obtained: • Hospice effective date • Hospice termination date (if applicable) • Servicing contractor number • Web site link Certain modifiers apply when the services/providers are not related to hospice: **GV** Attending physician not employed or paid under agreement by the patient’s hospice provider **GW** Services not related to the hospice patient’s terminal condition
CO 96 Non-covered charge(s) (THE PROCEDURE CODE SUBMITTED	To verify if services are covered/noncovered by Medicare, there are multiple resources that providers can consult:

FLORIDA PART B TOP RETURN UNPROCESSABLE CLAIMS REASONS – MAY 2008

Below are the most frequent return unprocessable (RUC) reasons for claims processed by Florida Medicare Part B during May 2008, as well as tips and resources to help you avoid many of these issues. Please share this information with all who need to know, such as your IT staff, billing service, vendor, or clearinghouse. Billing Medicare correctly the first time saves everyone time and money.

ANSI Reason Code/Description	Tips/Resources
CO 24 Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan (THIS CLAIM MUST BE SUBMITTED TO THE PATIENT'S HMO.)	This usually means that a member has a Medicare Advantage Plan or has a Plan that is primary to Medicare. Below are points relating to this: • HMO enrollment information may be obtained via the IVR (at 1-877-847-4992). • Claims must be submitted to HMO before Medicare.
CO 31 Claim denied as patient cannot be identified as our insured (PATIENT'S HIC# NONENTITLED. SUBMIT A NEW CLAIM WITH VALID HIC#.)	• Ensure that you have a copy of the patient's most recently issued Medicare card in order to compare that number with the one you are submitting. • Resubmit claim with correct Medicare number. • Verify how the beneficiary's name is listed on their Medicare card and place it that way on the claim (i.e. no nicknames). • Verify the beneficiary's DOB. • Ensure that numbers are not being transposed (possibly via software). • Via the Medicare card, verify for which part(s) of Medicare the patient is eligible.
CO 16 Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice. (DENIED-RENDERING PHYSICIAN #INVALID/MISSING. SUBMIT A NEW CLAIM) (REFERRING NAME AND UPIN REQUIRED. RESUBMIT AS A NEW CLAIM.) (DENIED-CLIA NUMBER INVALID OR MISSING.)	• When group information is entered in Item 33a (NPI) and/or Item 33b (PIN) then individual NPIs and/or PINs are entered in Item 24J. • Rendering PIN is entered in the top/shaded section and rendering NPI is entered in bottom/unshaded portion. • Referring provider information must be included. • Regarding CLIA, see Internet Only Manual (IOM) Publication 100-04, Chapter 26 pertaining to Item 23.
CO 140 Patient/insured health identification number and name do not match. PATIEINT'S HIC NONENTITLED. SUBMIT A NEW CLAIM WITH VALID HIC#.	• Ensure you have a copy of the patient's most recently issued Medicare card in order to compare that number with the one you are submitting. • Via the Medicare card, verify for which part(s) of Medicare the patient is eligible. • Check current eligibility for beneficiaries using the IVR. Call (877) 847-4992; from the main menu, press "3," then "1" (current eligibility).
CO B18 Payment adjusted because this procedure code and modifier were invalid on the date of service. DOCTOR'S SPECIALTY NOT APPROVED TO PRESCRIBE THIS EQUIPMENT.	This occurs when providers are using outdated procedure codes or using the wrong modifiers with a particular procedure code. • Ensure that you are using the most recent CPT codes and modifiers. • Verify that the procedure codes being billed are payable/allowed under the Medicare program.

Florida Part B Top RUC Reasons – May 2008 (continued)

ANSI Reason Code/Description	Tips/Resources
CO B18 (continued)	• The Florida Medicare Web site has links that address local medical coverage. Specific codes and data can be found within the local medical coverage "Final LCDs" for indications and limitations of coverage or medical necessity.
CO B16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.). 269H BILLING PROVIDER NPI FORMAT	On ASC X12N ANSI 837 4010A1 transactions. • The billing provider information must be submitted in the 2010AA loop. It is imperative that when submitting your NPI numbers they are associated correctly. Examples: • If the billing provider is a group, Limited Liability Corporation (LLC), Professional Association (PA), or other corporate entity, identify the billing and rendering providers. It is imperative that you submit the group type 2 organization NPI in the 2010AA Billing Provider Loop, which relates to box 33 on the paper claim when printed. Then you must also submit the individual NPI in the 2310B Rendering Provider Loop, which relates to box 24J when the claim is printed. Not placing the correct NPI number in the correct loop will result in your file being rejected at pre-pass. • If the billing provider is an independent laboratory, Ambulatory Surgical Center (ASC), Independent Diagnostic Testing Facility (IDTF), ambulance supplier, or solo practitioner, the NPI should only be sent in the 2010AA Billing Provider Loop, which relates to box 33 on the paper claim when printed. You should not send a 2310B rendering provider loop. Your claim will not be rejected, however you will received development letters or denials that will prolong your payments.

MEDICARE GUIDE TO RURAL HEALTH SERVICES

The print version of the revised Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians (April 2008) is now available from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network. This guide contains rural health information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005.

To place your order, visit *http://www.cms.hhs.gov/mlngeninfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: Provider Education Resource Message 200807-08

REVISED RURAL REFERRAL CENTER FACT SHEET

The Revised Rural Referral Center Fact Sheet (April 2008), which provides information about the Rural Referral Center program requirements, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network.

To place your order, visit *http://www.cms.hhs.gov/mlngeninfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: Provider Education Resource Message 200807-07

RURAL HEALTH CLINIC FACT SHEET

The April 2008 version of the Rural Health Clinic Fact Sheet provides the following information about rural health clinic services:

- Medicare certification
- Visits
- Payments
- Cost reports
- Annual reconciliation

This fact sheet is now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network* in downloadable format at *http://www.cms.hhs.gov/MLNProducts/downloads/RuralHlthClinfctsht08.pdf*. If this hyperlink does not take you directly to the fact sheet, please copy and paste the URL into your Internet browser.

Source: Provider Education Resource Message 200807-13

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-right-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.

REVISION TO THE LCDS

IDTF: INDEPENDENT DIAGNOSTIC TESTING FACILITY—CODING GUIDELINES REVISION

LCD ID NUMBER: L26330 (CONNECTICUT) L26304 (FLORIDA)

The local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was effective for services rendered on or after February 29, 2008. The "Credentialing Matrix" in the "Coding Guidelines" attachment was last revised April 22, 2008. Since that time, the "Coding Guidelines" attachment has been revised for the "Technician Qualification Requirements" for procedures codes *78000-78816* listed in the "Credentialing Matrix" to delete the requirement of "State License: General Radiographer."

EFFECTIVE DATE

This revision to the "Coding Guidelines" attachment is effective for services **rendered on or after July 8, 2008**. The full text of this LCD (L26330 [CT] L26304 [FL]) is available (on or after this effective date) through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

NCSVCS: THE LIST OF MEDICARE NONCOVERED SERVICES—REVISION TO THE LCD

LCD ID NUMBER: L15232 (CONNECTICUT) L5780 (FLORIDA)

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on June 30, 2008. Since that time, the LCD has been revised to add *CPT* codes *0190T* and *0191T* under the "*CPT*/HCPCS Codes," "Local Noncoverage Decisions, Procedures" section of the LCD, as these procedures are considered investigational.

EFFECTIVE DATE

This LCD revision is effective for services **rendered on or after July 1, 2008**. The full text of this LCD (L15232 [CT] L5780 [FL]) is available (on or after this effective date) through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

ADDITIONAL INFORMATION

J9025: VIDAZA® AND ADMINISTRATION CODE *96401*—CLARIFICATION OF CORRECT BILLING

There has been recent discussion between First Coast Service Options Inc. (FCSO) and providers regarding VIDAZA® and chemotherapy administration code *96401* (Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic).

VIDAZA® is indicated for treatment of patients with the following myelodysplastic syndrome subtypes:

- Refractory anemia or refractory anemia with ringed sideroblasts (if accompanied by neutropenia or thrombocytopenia or requiring transfusion)
- Refractory anemia with excess blasts
- Refractory anemia with excess blasts in transformation
- Chronic myelomonocytic leukemia (CMML)

VIDAZA® can be administered intravenously or subcutaneously. Discussion between FCSO and the provider community regarding VIDAZA® administration has focused on the subcutaneous route. For subcutaneous administrations of VIDAZA® where the dose is greater than 4 mL, the dose should be divided equally into two syringes and administered into two different sites. Oncology offices are paid extra for chemotherapy administration (as opposed to other drug administration) given the risk and side effects associated with these drugs and the associated overhead to monitor. There is not a doubling of risk given the dose is split between two injections that are given one after the other. The additional cost for the syringe and nurse work is not a major factor since the code is weighted three times a therapeutic injection. Therefore, FCSO would not expect to see more than one unit of *96401* billed for the administration of VIDAZA®.

QUANTITATIVE SENSORY TESTING (QST)—0107T

CPT Level III code *0107T* (Quantitative sensory testing [QST]), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation) was established effective January 1, 2006. At that time, First Coast Service Options Inc. determined QST was experimental and investigational, and included this on our List of Medicare Noncovered Services Local Coverage Determination (LCD).

The American Association of Electrodiagnostic Medicine (AAEM) supports that available data does not allow conclusions regarding the relative merits of individual QST instruments. The Xilas vibration perception threshold (VPT) meter, which is similar to the Vibrometer, was designed to identify patients with sensory neuropathy. This instrument provides a quantitative measurement of VPT and should be billed with *CPT* code *0107T*. It is not appropriate to bill QST with *CPT* code *95926* (Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs). Therefore, QST (*0107T*) remains on our List of Medicare Noncovered Services LCD.

FLORIDA ONLY - NEW LCDS

J2916: FERRLECIT® AND VENOFER®—NEW LCD

LCD ID NUMBER: L28094

This new local coverage determination (LCD) has been written to outline the appropriate indications and limitations for Ferrlecit® and Venofer®. Ferrlecit® is approved by the Food and Drug Administration (FDA) as a first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy. Venofer® is FDA approved as a first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy. On June 17, 2005, Venofer® is also FDA approved for iron deficiency anemia in non-dialysis dependent chronic kidney disease patients who are or are not receiving supplemental erythropoietin therapy.

This new LCD outlines the FDA approved indications and limitations, documentation requirements and utilization guidelines. The LCD also outlines the appropriate ICD-9-CM codes for Ferrlecit® (J2916) and Venofer® (J1756). These drugs require a dual diagnosis to be billed. An appropriate anemia ICD-9-CM code must be billed with one of the listed chronic kidney disease (CKD) ICD-9-CM codes.

EFFECTIVE DATE

This new LCD will be effective for services **rendered on or after September 30, 2008**. The full text of this LCD (L28094) will be available (on or after this effective date) through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

84999: GENE EXPRESSION PROFILING PANEL FOR USE IN THE MANAGEMENT OF BREAST CANCER TREATMENT—NEW LCD

LCD ID NUMBER: L28092

Genomics focuses on how the complex set of genes in the genome are expressed and interact to regulate cell behavior in health and disease. An important genomic parameter is the pattern of gene expression, which can be ascertained by measuring the levels of expressed ribonucleic acid (RNA). To date, therapeutic decisions for locally advanced breast cancer are mainly guided by clinicopathological parameters, such as patient age and functional status, comorbidities, estrogen receptor status, tumor grade, tumor size and lymph node status. Clinical studies have shown that incorporation of gene expression signatures into clinical risk stratification may be useful for prognostic and therapeutic strategies in breast carcinoma.

The application of gene expression profiling using Oncotype DXTM is employed to identify patients who are predicted to obtain the most therapeutic benefit from adjuvant tamoxifen and may not require adjuvant chemotherapy. The Oncotype DXTM (Genomic Health, Redwood City, California), uses reverse transcription polymerase chain reaction (RT-PCR) to determine the expression of a panel of 21 genes isolated from formalin-fixed, paraffin-embedded tissue (FPET).

A Recurrence Score™ (RS) is calculated from the gene expression results using a proprietary Oncotype DXTM algorithm, which is then used to assign a patient to one of three groups by estimated risk of distant recurrence: low, intermediate and high. Patients with high recurrence scores (RS) appear to achieve relatively more benefit from adjuvant chemotherapy.

This test is provided throughout the United States by the Clinical Laboratory Improvement Amendments (CLIA)-regulated laboratory of Genomic Health Inc., in Northern California. Therefore, when this test is a Part B service, most or all coverage decisions for Medicare beneficiaries are made by the Part B contractor serving Genomic Health, Inc., which is National Heritage Insurance Company (NHIC).

84999: Gene Expression Profiling Panel for use in the Management of Breast Cancer Treatment—New LCD, continued

INDICATIONS

First Coast Service Options Inc., (FCSO) will consider the application of gene expression profiling using Oncotype DXTM as medically reasonable and necessary, with case by case review as needed, when used to assess the need for adjuvant chemotherapy in patients with recently diagnosed breast cancer (six months or less have elapsed) when all of the following criteria are met:

- Breast cancer is nonmetastatic (node-negative) (lymph nodes with micrometastases are not considered positive)
- Breast cancer is unilateral and non-fixed (i.e., tumor not adhered to chest wall)
- Breast tumor is hormone receptor-positive (estrogen receptor (ER)-positive or progesterone receptor (PR)-positive)
- Breast tumor is HER2-receptor negative
- Breast tumor size is 0.6-1 cm with moderate/poor differentiation or unfavorable features, OR tumor size is >1 cm
- Breast tumor is stage 1 or stage II
- Breast cancer will be treated with hormonal therapy
- Adjuvant chemotherapy is not precluded due to any other factor (e.g., advanced age and/or significant co-morbidities)
- Testing is being done specifically to guide the decision as to whether or not adjuvant chemotherapy will be used and, prior to testing the patient and oncologist have discussed the potential results of the test and agree to use the results to guide therapy (i.e., the patient will forgo adjuvant chemotherapy if Oncotype DXTM score is low).

Medical tests are covered only when ordered by the treating oncologist, when necessary for diagnosis or treatment decisions, and when used in patient care (42 CFR 410.32).

EFFECTIVE DATE

This new local coverage determination (LCD) is effective for services **rendered on or after September 30, 2008**. The full text of this LCD (L28092) will be available (on or after this effective date) through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

FLORIDA ONLY - REVISION TO THE LCDS

J9355: TRASTUZUMAB (HERCEPTIN®)—REVISION TO THE LCD

LCD ID NUMBER: L25079

The local coverage determination (LCD) for trastuzumab (Herceptin®) was last updated on January 18, 2008. Since that time, a revision was made to update language for additional approved indications based on the Food and Drug Administration (FDA) drug label, for trastuzumab – J9355.

Revisions for FDA approved indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for adjuvant and metastatic breast cancer. The LCD now has the following verbiage for these indications:

ADJUVANT BREAST CANCER

Herceptin is indicated for adjuvant treatment of HER2-overexpressing node positive or node negative (ER/PR negative or with one high risk feature) breast cancer:

- As part of a treatment regimen consisting of doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel
- As a single agent following multi-modality anthracycline based therapy

METASTATIC BREAST CANCER

Herceptin is indicated:

- In combination with paclitaxel for first-line treatment of HER2-overexpressing metastatic breast cancer
- As a single agent for treatment of HER2-overexpressing breast cancer in patients who have received one or more chemotherapy regimens for metastic disease

In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

EFFECTIVE DATE

This revision to the LCD is effective for services **rendered on or after May 22, 2008**. The full text of this LCD (L25079) is available (on or after this effective date) through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

NCSVCS: THE LIST OF MEDICARE NONCOVERED SERVICES—REVISION TO THE LCD

LCD ID NUMBER: L5780

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised July 1, 2008. Since that time, the LCD has been revised to add *CPT* code *42299* (Palatal implants [Pillar™]) to the list of procedures under the "local noncoverage decisions" section of the LCD. Palatal implants (Pillar™) are considered experimental and investigational.

EFFECTIVE DATE

This revision to the LCD is effective for services **rendered on or after September 30, 2008**. The full text of this LCD (L5780) is available (on or after this effective date) through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

VISCO: VISCOSUPPLEMENTATION THERAPY FOR KNEE – REVISION TO THE LCD

LCD ID NUMBER: L6729

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised April 1, 2008. Since that time, a revision was made to the LCD to clarify coverage guidelines regarding the frequency of courses of treatment allowed, documentation guidelines to support frequency of courses of treatment, conservative treatment, and the use of imaging when administering viscosupplementation of the knee.

EFFECTIVE DATE

This revision to the LCD is effective for services **rendered on or after September 30, 2008**. The full text of this LCD (L6729) is available (on or after this effective date) through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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.

FLORIDA EDUCATIONAL RESOURCES

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS

AUGUST - SEPTEMBER 2008

HOT TOPICS: ASK THE CONTRACTOR TELECONFERENCE

Topic: Psychiatric Services - Billing Requirements and Medical Review Documentation
When: August 14, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

HOT TOPICS: HOT TOPICS TELECONFERENCE/UPDATES TELECONFERENCE

When: September 11, 2008
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

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.

Fax – Providers without Internet access can leave a message on our Registration Hotline at 904-791-8103 requesting a fax registration form. Class materials will be faxed to you the day of the event.

TIPS FOR USING THE FCSO PROVIDER TRAINING WEB SITE

The best way to search and register for Florida events on *www.fcsomedicaretraining.com* is by clicking on the following links in this order:

- "Course Catalog" from top navigation bar
- "Catalog" in the middle of the page
- "Browse Catalog" on the right of the search box
- "FL – Part B or FL – Part A" from list in the middle of the page.

Select the specific session you're interested in, click the "Preview Schedule" button at the bottom of the page. On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are interested in and click the "Register" link in the Options column.

If you need assistance, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an e-mail to *fcsohelp@geolearning.com*.

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.) are being planned to help providers with hot issues. Keep checking our Web site, *www.fcso.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: 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.

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

Electronic Media Claims (EMC)/ The Electronic Data Interchange (EDI)
The EDI 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

Freedom of Information (FOIA)
Freedom of Information Act Requests
Post Office Box 2078
Jacksonville, Florida 32231

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
FAX : 1-904-361-0695
E-mail Address:
AskCTMedicare@fcso.com

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

BENEFICIARY

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

COMMUNICATION

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

Freedom of Information Act
Freedom of Information Act Requests
Post Office Box 2078
Jacksonville, Florida 32231

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
E-mail Address:
AskFloridaB@fcso.com
FAX: 1-904-361-0696

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

PROVIDER

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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 ♦