Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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

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

Routing Suggestions:

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

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

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

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

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About the *Medicare A Bulletin*

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

The Medicare Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Monthly publications allow our team to better serve our customers by making valuable information available in a more timely manner. The previous quarterly publications have become too large in scope and size making it difficult to navigate through the large volume of information.

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

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

Who Receives the *Bulletin*?

Anyone may view, print or dowload the *Bulletin* from our provider education website. Providers who cannot obtain the *Bulletin* from the Internet (because of a technical barrier) are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form published in the Third Quarter 2006 *Medicare A Bulletin* page 9). Registration forms must be submitted annually or when the provider's business practices have experienced a change in circumstances that impact electronic access.

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

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

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

What Is in the *Bulletin*?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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Jacksonville, FL 32232-5270

Sign up to our *eNews* electronic mailing list

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

GENERAL INFORMATION

Uniform Billing (UB-04) Implementation—UB-92 Replacement

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

Note: CMS has revised this MLN Matters article on November 6, 2006, to reflect changes due to CMS' revision of change request (CR) 5072 on November 3, 2006. The CR transmittal number, release date, and Web address for accessing CR 5072 were revised. All other information remains the same. This article was originally published in the September 2006 *Medicare A Bulletin* (pages 4-5).

Provider Types Affected

All providers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), using the UB-92 (universal billing-92)

Provider Action Needed

STOP – Impact to You

The UB-04 is replacing the UB-92. You may begin using it **on March 1, 2007,** during an initial transitional period. **Starting May 23, 2007, all of your paper claims must use the UB-04** since the UB-92 will no longer be acceptable.

CAUTION – What You Need to Know

CR 5072 announces the replacement of the UB-92 by the UB-04, effective March 1, 2007. The UB-04, which is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements, incorporates the national provider identifier (NPI), taxonomy, and additional codes.

GO – What You Need to Do

Make sure that your billing staffs are aware of this new uniform institutional provider bill form for paper claims.

Background

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. **Effective March 1, 2007,** institutional claim filers such as hospitals, skilled nursing facilities, hospices, and others can begin using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007, during which time either the UB-92 or the UB-04 may be used.

Starting May 23, 2007, all institutional paper claims must be submitted on the UB-04. The UB-92 will no longer be acceptable, even as an adjustment claim, after May 22, 2007.

UB-04

The UB-04 is the basic form that CMS prescribes for the Medicare program. It is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

It incorporates the national provider identifier (NPI), taxonomy, and additional codes. (Please refer to the crosswalk file attached to CR 5072 to show how data elements crosswalk from the UB-92 to the UB-04.)

Note: While most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change.

There are a few details that you should be aware of:

- The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.
- When filing, you should retain the copy designated "Institution Copy" and submit the remaining copies to your FI, managed care plan, or other insurer.
- Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.
- If you omit any required data, your FI will either ask you for them or obtain them from other sources and will maintain them on its history record. It will not obtain data that are not needed to process the claim.
- Data elements in the CMS uniform electronic billing specifications are consistent with the Form CMS-1450 (another name for the UB-04) data set to the extent that one processing system can handle both. The definitions are identical, although in some situations, the electronic record contains characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.
- Also note that CMS is accepting valid NPIs on the UB-04 between March 1, 2007, and May 22, 2007, and the NPI is required as of May 23, 2007.

Additional Information

You may find more information about the UB-04 (Form CMS-1450) by going to CR 5072, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1104CP.pdf*.

Included with this CR are the following:

- A copy of the UB-04 form (front and back) in PDF format (Attachment E)
- The UB-92-to-UB-04 crosswalk (Attachment B)
- UB-04 mapping to the HIPAA institutional 837 (Attachment C)

Uniform Billing (UB-04) Implementation—UB-92 Replacement (continued)

- The revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill – Form CMS-1450 [UB-04]) and 71 (General Instructions for Completion of Form CMS-1450 [UB-04]) (Attachment A). These sections contain very detailed instructions for completing the form.

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

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

MLN Matters Number: MM5072 – Revised
Related Change Request (CR) Number: 5072
Related CR Release Date: November 3, 2006
Related CR Transmittal Number: R1104CP
Effective Date: March 1, 2007
Implementation Date: March 1, 2007

Source: CMS Pub. 100-04, Transmittal 1104, CR 5072

Reopenings and Revisions of Claim Determinations and Decisions

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 submit Part A or Part B fee-for-service claims to Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs) and carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs) for payment.

Provider Action Needed
STOP – Impact to You

This article, based on change request (CR) 4147, notifies you about changes to the *Medicare Claims Processing Manual*, which ensure that claims with **clerical errors (which include minor errors and omissions)** should be processed as "**reopenings**" and not as "**appeals.**"

CAUTION – What You Need to Know

All reopenings are conducted at the discretion of your Medicare contractor and are therefore not appealable. Your Part A Medicare contractor may continue to handle some errors through the claim adjustment process. The Centers for Medicare & Medicaid Services (CMS) has added "Missing data items, such as provider number or missing date of service" to the definition of clerical errors. Note that clerical errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. Please note that third party payer errors **do not** constitute clerical errors.

GO – What You Need to Do

Please refer to the *Additional Information* section of this article and to the information in the manual attachment to CR 4147 (Pub. 100-04, *The Medicare Claims Processing Manual*, Chapter 34, Section 10) for detailed and updated information regarding reopenings. Please note also that this information replaces what was previously found in Chapter 29, Section 90 of *The Medicare Claims Processing Manual*.

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 937 of MMA requires the establishment of a process for the correction of minor errors and omissions that do not necessitate the use of the formal appeals process.

Additional Information

"A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record." (Pub. 100-04, *The Medicare Claims Processing Manual*, Chapter 34, Section 10.) If your reopening request is denied, you may not appeal the contractor's refusal to reopen but you can appeal the original claim denial as long as the timeframe to request an appeal has not expired. **Requesting a reopening does not toll the timeframe to request an appeal.** If a reopening results in a revised determination, new appeal rights will be afforded on that revised determination. Not all reopenings result in a revised determination. Some important points to note about reopenings as a result of these changes are as follows:

- Medicare contractors will not use reopenings as an appeal when a formal appeal is not available.
- Medicare contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) beneficiary or provider/supplier recovery claims are not reopening actions except where the recovery claim is a MSP provider/supplier recovery claim. All other MSP beneficiary or provider /supplier recovery claims are initial determinations.

Reopenings and Revisions of Claim Determinations and Decisions (continued)

- If a claim is suspended for medical review, a request for additional documentation (ADR) may be required to make a determination. If no response is received within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on lack of documentation. In such cases, if appealed with the requested documentation, the Medicare contractor will perform a reopening instead of an appeal. The reopenings will be performed by the medical review department.
- For Part A Medicare, there are a limited number of clerical errors that can be corrected through the reopening process. Many FIs are handling the correction of errors through the submission of an adjustment or corrected claim. FIs who are handling errors through adjustments will continue to do so.
- Medicare contractors will accept reopening requests only if they are made in writing or over the telephone. Please note that the telephone reopenings process is not required for fiscal intermediaries.
- Medicare contractors will ask the providers or suppliers to fax in the proof to support changes and error correction, when necessary.
- In cases where the issue is: (1) too complex to be handled over the phone or (2) there is a need for additional medical documents, the Medicare contractor will inform the party that their request cannot be processed over the phone. In such instances, the contractor will advise the requestor to file their request in writing.
- Medicare contractors will require the following three items from the caller, prior to conducting a telephone reopening: (1) provider/ physician/supplier name & ID # or NSC #; (2) Beneficiary last name & first initial; and (3) Medicare HICN. **Note: Items must match exactly.**

CR 4147 is the official instruction issued to your FI/ RHHI, carrier, DMERC, or DME MAC regarding changes mentioned in this article. CR 4147 may be found by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1069CP.pdf*.

For additional information relating to the Medicare appeals process, you may wish to refer to Chapter 29 of the *Medicare Claims Processing Manual*, which is available at *http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf*.

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

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

MLN Matters Number: MM4147
Related Change Request (CR) Number: 4147
Related CR Release Date: September 29, 2006
Related CR Transmittal Number: R1069CP
Effective Date: November 29, 2006
Related CR Transmittal Number: R1069CP
Implementation Date: November 29, 2006

Source: CMS Pub. 100-04, Transmittal 1069, CR 4147

New 2007 Current Procedural Terminology Codes for Mammography Services

The American Medical Association has assigned new 2007 *Current Procedural Terminology (CPT)* codes for reporting screening and diagnostic mammography services effective for claims with dates of service **on or after January 1, 2007.**

The new *CPT* codes for 2007 will replace the current *CPT* codes; however the *CPT* code descriptors for the services are unchanged. The following new *CPT* codes have been assigned to report mammography services provided **on or after January 1, 2007:**

New *CPT* code *77051* replaces code *76082*

New *CPT* code *77052* replaces code *76083*

New *CPT* code *77055* replaces code *76090*

New *CPT* code *77056* replaces code *76091*

New *CPT* code *77057* replaces code *76092*

Claims submitted for mammography services with dates of service on or after January 1, 2007, containing *CPT* codes *76082, 76083, 76090, 76091,* or *76092* will be returned to the provider. ❖

Source: CMS Pub. 100-04, Transmittal 1070, CR 5327

Revision to the Electronic Funds Transfer Authorization Agreement (Form CMS-588)

The Centers for Medicare & Medicaid Services (CMS) issued revisions to the CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement. EFT deposits your Medicare payments directly into your bank account. *CMS requires that all providers that are enrolling in the Medicare program or making any changes to their Medicare enrollment file, must sign up for EFT.* Effective December 1, 2006, First Coast Service Options, Inc. can only accept Form CMS 588 (08/06) version of the Electronic Funds Transfer (EFT) Authorization Agreement.

To sign up, you must complete Form CMS-588 (08/06) version available at *http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf*. The completed form must be signed and dated by the provider or authorized/delegated official (for groups or organizations). For existing Medicare providers, the authorized delegated official must be the same authorized delegated the contractor has on file. **The signature must be original and cannot be a copy or stamped signature.**

Under the Physician/Provider/Supplier Information section, the form asks for "Medicare Identification Number." In this field, please indicate your Medicare provider identification number (PIN) (also known as Medicare legacy number). This field can be left blank if you are submitting the EFT authorization agreement with an initial enrollment application. The national provider identifier (NPI) must be included in the "National Provider Identifier (NPI)" field.

Include a copy of a voided check or deposit ticket containing your preprinted name with the Form CMS-588 (08/06).

Medical groups under the Medicare Part B do not need to submit an EFT authorization agreement for each of its members. Only the group submits the form and indicates the group PIN in the Medicare identification number field.

Action Required by Providers

Providers must submit Form CMS-588 (08/06) version of the Electronic Funds Transfer (EFT) Authorization Agreement beginning December 1, 2006, when enrolling in the Medicare program or making any changes to their existing provider file.

Source: CMS Joint Signature Memorandum 06684, September 21, 2006

Update to Medicare Deductible, Coinsurance and Premium Rates for 2007

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and Part A/B MACs for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5345, which announces the 2007 Medicare rates and instructs your Medicare contractors to make necessary updates to their claims processing systems.

Background

There are beneficiary-related costs for using certain services under Parts A and B of Medicare, typically in the form of deductibles, co-payments, and/or premium payments. Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for **more than 60 days** during a spell of illness, he or she is responsible for **a coinsurance amount equal to one-fourth** of the inpatient hospital deductible **per-day for the 61st-90th day** spent in the hospital.

An individual has 60 lifetime reserve days (LRDs) of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these LRDs is equal to one-half of the inpatient hospital deductible.

For skilled nursing facility (SNF) services furnished during a spell of illness, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day.

Most individuals **age 65 and older**, and many **disabled individuals under age 65**, are **insured for health insurance (HI) benefits without a premium payment**. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium.

Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment occurs more than 12 months after the date a person is initial eligibility to enroll, a 10 percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

Under **supplementary medical insurance (SMI) or Part B**, all enrollees are **subject to a monthly premium**. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When SMI enrollment takes place more than **12 months after a person's initial enrollment** period, there is a permanent **10 percent increase in the premium** for each year the beneficiary could have enrolled and failed to enroll.

Medicare Part A for 2007

For calendar year (CY) 2007, the following rates are applicable for Medicare Part A deductible, coinsurance, and premium amounts:

Deductible: $992.00 per benefit period

Update to Medicare Deductible, Coinsurance and Premium Rates for 2007 (continued)

Coinsurance: $248.00 a day for days 61-90 in each period
$496.00 a day for days 91-150 for each LRD used
$124.00 a day in a SNF for days 21-100 in each benefit period

Premium: $410.00 per month for those who must pay a premium
$451.00 per month for those who must pay both a premium and a 10 percent increase
$226.00 per month for those who have 30-39 quarters of coverage
$248.60 per month for those who have 30-39 quarters of coverage and must pay a 10 percent increase

Medicare Part B for 2007

For CY 2007, the following rates are applicable for Medicare Part B deductible and coinsurance:

Deductible: $131.00 per year
Coinsurance: 20 percent

CMS updates the Part B premium each year. These adjustments are made according to formulas set by statute. By law, the monthly Part B premium must be sufficient to cover 25 percent of the program's costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent.

Below are the annual Part B premium amounts from Calendar Year (CY) 1996 to 2006. For these years, and years prior to 1996, the Part B premium is a single established rate for all beneficiaries.

Year	Part B Premium
1996	$42.50
1997	$43.80
1998	$43.80
1999	$45.50
2000	$45.50
2001	$50.00
2002	$54.00
2003	$58.70
2004	$66.60
2005	$78.20
2006	$88.50

Beginning on January 1, 2007, the Part B premium will be based on the income of the beneficiary. Below are the CY 2007 **Part B premium amounts based on beneficiary income parameters**.

Income Parameters for Determining Part B Premium		
Premium/ Monthly	**Individual Income**	**Combined Income (Married)**
$ 93.50	$ 80,000.00 or less	$160,000.00 or less
$105.80	$ 80,000.01 – $100,000.00	$160,000.01 – $200,000.00
$124.40	$100,000.01 – $150,000.00	$200,000.01 – $300,000.00
$142.90	$150,000.01 – $200,000.00	$300,000.01 – $400,000.00
$161.40	$200,000.01 or more	$400,000.01 or more

Implementation

The implementation date for CR 5345 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC, intermediary, RHHI, or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R41GI.pdf*.

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

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

MLN Matters Number: MM5345
Related Change Request (CR) Number: 5345
Related CR Release Date: October 27, 2006
Related CR Transmittal Number: R41GI
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-01, Transmittal 41, CR 5345

Laboratory Competitive Bidding Demonstration

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

Note: This article was previously published as MM5205, based on change request (CR) 5205, which discussed the initial phase of implementing this demonstration. The *MLN Matters* article MM5205 was published in the October 2006 *Medicare A Bulletin* (pages 8-9).

Provider Types Affected

Physicians and all providers who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites.

Background

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

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

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

Key Points

This article and CR 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this article and CR5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

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

Required Bidders

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

These laboratory firms will be referred to as "required bidders."

Passive Laboratories

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

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

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

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- **Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considers "passive-ESRD" laboratories.** Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007 through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

Winners

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

Nonwinners

Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of

Laboratory Competitive Bidding Demonstration (continued)

where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled "nonwinners." Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. Nonwinner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, nonwinner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration. Although non-winner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory. For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses metropolitan statistical areas (MSAs) to define the CBAs. The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's ZIP code of residence.

CMS will provide the contractors with a list of zip codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs. The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of Pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs. Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR 5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1). During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national ZIP code pricing file identifying the ZIP codes included in the first CBA. Also, in that same timeframe, CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1. For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule. Claims submitted by nonwinner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

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

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

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

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

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

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

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

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

Implementation

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

Laboratory Competitive Bidding Demonstration (continued)

Additional Information

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R50DEMO.pdf*.

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

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

MLN Matters Number: MM5359
Related Change Request (CR) Number: 5359
Related CR Release Date: November 1, 2006
Effective Date: April 1, 2007
Related CR Transmittal Number: R50DEMO
Implementation Date: April 2, 2007

Source: CMS Pub. 100-19, Transmittal 50, CR 5359

Disclaimer 1. – Please note that the demonstration design described in transmittal # R49DEMO, which provides instructions to Medicare contractors for the implementation of a CMS laboratory competitive bidding demonstration, is a proposed design and has not yet received final approval from the Office of Management and Budget.

Laboratory Competitive Bidding Demonstration

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

Note: This article has been superseded by *MLN Matters* article MM5359. The *MLN Matters* article MM5359 is being published in this publication. Please review MM5359 for more current information regarding this demonstration effort. *MLN Matters* article MM5359 is also available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5359.pdf*.

The *MLN Matters* article MM5205 was published in the October 2006 *Medicare A Bulletin* (pages 8-9).

MLN Matters Number: MM5205 – Revised
Related Change Request (CR) Number: 5205
Related CR Release Date: August 1, 2006
Related CR Transmittal Number: R49DEMO
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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

Flu Shot Reminder

Flu season is here! Medicare patients give many reasons for not getting their flu shot, including:

"It causes the flu"

"I don't need it"

"It has side effects"

"It's not effective"

"I didn't think about it"

"I don't like needles!"

The fact is that out of the average 36,000 people in the U.S. who die each year from influenza and complications of the virus, greater than 90 percent of deaths occur in persons 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk to your Medicare patients about the importance of getting their annual flu shot—and don't forget to immunize yourself and your staff.

Protect yourself, your patients, and your family and friends. – Get Your Flu Shot!

Remember: Influenza vaccination is a covered Medicare Part B benefit.

Note: Influenza vaccine is not a Medicare Part D covered drug.

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

Source: CMS Provider Education Resource 200611-01

Sunset of the Provider Nomination Provision and the Policy to Assign Providers to the Local Fiscal Intermediary

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

Note: CMS has revised this *MLN Matters* article on November 2, 2006, to show that the Centers for Medicare & Medicaid Services no longer allows freestanding or independent providers that enter the Medicare program to express a preference for a particular fiscal intermediaries (FI). CMS regional offices (ROs) must assign the new provider to the designated local FI. All other information remains the same. This article was originally published in the January 2006 *Medicare A Bulletin* Special Issue (pages 43-44).

Provider Types Affected

Providers billing Medicare FIs.

Provider Action Needed

STOP – Impact to You

This special edition article is based on the Centers for Medicare & Medicaid Services recent instructions to Medicare FIs regarding the sunset of the provider nomination provision contained under Title XVIII of the Social Security Act, Section 1816, which expired on September 30, 2005.

CAUTION – What You Need to Know

CMS will no longer allows freestanding or independent provider that enters the Medicare program to express a preference for a particular FI. CMS ROs must assign the new provider to the designated local FI.

GO – What You Need to Do

See the *Background* section of this article for further details.

Background

CMS has announced that the provider nomination provision contained under Title XVIII of the Social Security Act, Section 1816 (*http://www.ssa.gov/OP_Home/ssact/title18/1816.htm*) expired on September 30, 2005.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 911(d) (2) (B) *http://www.cms.hhs.gov/MMAUpdate*) allows CMS to take appropriate steps to transition from agreements under Section 1816 of the Social Security Act to contracts with Medicare administrative contractors (MACs) under section 1874A.

Therefore, **CMS will no longer allows freestanding or independent provider that enters the Medicare program to express a preference for a particular FI. CMS regional offices (ROs) must assign the new provider to the designated local FI.**

Note: For Puerto Rico and the U.S. Virgin Islands, providers must be assigned to Cooperativa de Seguros de Vida de Puerto Rico.

In situations where there is a change of ownership (CHOW), and the new owner **does not accept** assignment of the existing provider agreement, the new owner will be considered as a new applicant to the program. They will have to go through the application process, have the state survey agency (SA) perform a survey, and receive approval from the RO. Then the provider:

- Is given a new provider number; and
- Will be assigned to the local Blue Cross plan.

This is because the provider will be treated as a new enrollee if they do not accept assignment of the provider agreement. For state jurisdiction designations, please refer to the Intermediary-Carrier Directory, which is posted on the CMS website at *http://www.cms.hhs.gov/contacts/incardir.asp*.

Exceptions to this policy will be made for new and existing freestanding specialty providers, provider-based facilities, and providers that belong to CMS-certified chain organizations as follows:

- Freestanding specialty providers such as (but not limited to) home health agencies (HHAs) and hospices will continue to be assigned to their designated specialty FIs.
- Provider-based facilities will continue to be assigned to the audit FI that serves the parent provider.
- New providers that belong to CMS-recognized chains have the option to be assigned to the local Blue Cross plan or to the FI that serves the chain home office.
- Providers involved in CHOWs where the new owner accepts assignment of the existing provider agreement will remain with their current FI.

These measures are effective immediately and are consistent with the effective and efficient administration of the Medicare program.

Additional Information

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

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

Medlearn Matters Number: SE0582 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: Effective immediately
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0582

HMO Information Available on the Interactive Voice Response Unit

Effective November 1, 2006, the interactive voice response unit (IVR) began voicing HMO information under option 5, and option 7. When health maintenance organization (HMO) information is offered, you will hear the following script, depending on the selected HMO option:

Option 3 – Eligibility, HMO and Deductible Information

- HMO Option A B C
- For this patient, Medicare is responsible only for dialysis services. For all other services, this patient is currently on an HMO.

Afterward, the system will allow you to hear specific information by pressing *1* on the keypad. The following HMO information is voiced on the requested beneficiary:

- HMO number
- Name and address of the HMO
- Effective date of the HMO

Option 7 – HMO Name and Address

Under option 7, you may enter an HMO number, and the system will voice the name and address of the HMO, which has been recorded from the HMO list on the CMS website. For example: If you enter HMO number *H1036* (Humana Medical Plan), the IVR will voice "Humana Medical Plan" as the name of the HMO, and will also voice Humana's address.

For your convenience, the IVR hours of operation for patient eligibility and claims status information are Monday through Friday 6:00 a.m. – 6:00 p.m. Eastern and Central Time. ❖

Notification Regarding Fix to Correct National Provider Identifier Information within the 837 Institutional Crossover Claim Files

The Centers for Medicare & Medicaid Services (CMS) has learned that its October 2, 2006, fiscal intermediary shared system (FISS) release introduced error conditions (zeroes being populated in the 2010AA and 2010AB segments for the national provider identifier [NPI]) that negatively impacted the volume of Part A 837 COB claims that should have crossed to the supplemental (next) payer(s) after Medicare. The error condition created noncompliant HIPAA transactions that, as of October 27, prevented up to 97 percent of the Part A 837 COB claims from crossing to the next payer.

CMS has aggressively pursued a fix to the problem within the FISS and has been informed that the fix to correct the issue has been successfully tested. The installation of the fix into production has occurred or will occur and will produce two outcomes: 1) upon installation date of the fix into production at the fiscal intermediary (FI) locations, all claims transmitted to CMS' coordination of benefits contractor (COBC) to be crossed over to the next payer will no longer contain the error condition and the Part A Medicare claims crossover process will return to normal; 2) all claims that errored out due to this problem will be repaired and retransmitted to the COBC to be crossed over. As a result of the fix being installed at most FIs, the error rate for Part A 837 COB claims that were transmitted to the COBC for crossover to the next payer has dropped to 47 percent as of November 2 2006.

CMS anticipates that the Medicare paid claims affected by the error condition from October 2, 2006, until the individual production date of the fix at each fiscal intermediary will be repaired and retransmitted to the COBC for crossover to the next payer by the week of November 6th at the latest.

All FIs have reported that they have installed the fix into production with the exception of the following list. It is anticipated that these FIs will move the fix into production no later than November 5, 2006, enabling the Part A Medicare claims crossover process to return to its regular schedule and to recover the claims that did not cross from October 2, 2006, through November 4, 2006.

Noridian (Oregon, Idaho, North Dakota, Arizona, Utah, Wyoming, North Dakota)

Montana Blue Cross

Nebraska Blue Cross

Cahaba (Iowa, South Dakota)

AdminaStar Federal

Cooperativa de Seguros de Vida de Puerto Rico

Kansas Blue Cross

United Government Services. ❖

Source: CMS Provider Education Resource 200611-04

AMBULANCE SERVICES

Ambulance Inflation Factor for Calendar Year 2007

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

Provider Types Affected

Providers and suppliers of ambulance services billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

Provider Action Needed

This article is for your information only. It provides the ambulance inflation factor (AIF) for calendar year (CY) 2007. The AIF for CY 2007 is 4.3 percent.

Background

Section 1834(l)(3)(B) of the Social Security Act (SSA) provides the basis for updating the payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services. The national fee schedule for ambulance services has been phased in over a five-year transition period beginning April 1, 2002. The AIF updates payments annually and is equal to the percentage increase in the ending with June of the previous year.

The AIF for CY 2007 will be 4.3 percent. The following displays the AIF for 2007 and for the previous four years.

Ambulance Inflation Factor

2007	4.3 percent
2006	2.5 percent
2005	3.3 percent
2004	2.1 percent
2003	1.1 percent

Additionally, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) will have a baseline "floor" amount.

Payment will not be less than this "floor," which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule to calculate a regional conversion factor and a regional mileage payment.

Some key issues related to the AIF include:

National or Regional Fee Schedules

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate.

Payments Based on Blended Methodology

During the five-year transition period, your payments are based on a blended methodology. For CY 2007, this blend will be 20 percent regional ground base rate and 80 percent national ground base rate.

Before January 1, 2007, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional) and to the reasonable cost/charge portion. Then, these two amounts were added together to determine each provider or supplier's total payment amount. As of January 1, 2007, the total payment amount for air ambulance providers and suppliers continues to be based on 100 percent of the national ambulance fee schedule, while the total payment amount for ground ambulance providers and suppliers will be based on either 100 percent of the national ambulance fee schedule or 80 percent of the national ambulance fee schedule and 20 percent of the regional ambulance fee schedule.

Part B Coinsurance and Deductible Requirements

Part B coinsurance and deductible requirements apply.

Additional Information

You can find more information about the ambulance inflation factor by going to CR 5358, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1102CP.pdf*.

There you will find updated Medicare *Claims Processing Manual* (100-04), Chapter 15, Ambulance, Section 20.6.1, Ambulance Inflation Factor (AIF) as an attachment to that CR.

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

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

MLN Matters Number: MM5358
Related Change Request (CR) Number: 5358
Related CR Release Date: November 3, 2006
Related CR Transmittal Number: R1102CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1102, CR 5358

NATIONAL PROVIDER IDENTIFICATION

Electronic Claims Submitted Without the Medicare Legacy Number During the Stage 2 Transition Period

In previous provider educational notifications addressing the national provider identifier (NPI) initiative, Medicare has strongly recommended that providers, clearinghouses, and billing services continue to submit the Medicare fee-for-service legacy number during the stage 2 implementation of the NPI transition period that started on October 1, 2006.

During the stage 2 NPI transition period of October 1, 2006, through May 22, 2007, Medicare is recommending that providers submitting Medicare fee-for-service claims send in **both** NPIs and legacy provider numbers. Electronic claims must be submitted either by using:

- **Only** the provider's Medicare legacy number, such as a provider identification number (PIN), NSC number, OSCAR number or UPIN; or
- **Both** the provider's NPI and legacy number.

If providers submit Medicare claims with only an NPI, the following may occur:

- Claims may be processed and paid, or
- Claims for which Medicare systems are unable to properly match the incoming NPI with the Medicare legacy number (e.g., PIN, OSCAR number) may be returned to the provider, and then the provider will need to resubmit the claim with the appropriate Medicare legacy number.

Based on the above guidelines, **effective for claims processed on or after October 1, 2006,** and until further notice, claims submitted with only an NPI will be returned to the provider if a properly matching Medicare legacy number cannot be found.

Action Required by Providers

Providers must resubmit claims with the appropriate Medicare legacy number when a claim is returned to them because of a missing legacy number. The same means of submission **must** be used to refile the claim (e.g.; providers that submitted electronically shall resubmit electronically). ❖

Source: CMS Pub. 100-20, Transmittal 249, CR 5378

Just Six Months Remaining—National Provider Identifier Reminder

NPI: Get It. Share It. Use It.

Over 1.4M national provider identifiers (NPIs) have been issued. Do you have yours?

Think you don't need an NPI? Think again, and be sure. If you are a health care provider who bills for services, you probably do need an NPI. If you bill Medicare for services, you definitely do!

The bad news is that as of November 23. 2006, only six months remain until the NPI compliance date. The implementation of the NPI is a complex process that will impact all business functions of your practice, office or institution including billing, reporting and payment. This is why providers are urged to get, share, and use their NPI NOW to avoid a disruption in cash flow.

If you don't have an NPI, get one. If you have one, start the testing process with your health plan and use it on your claims and other transactions.

The Center for Medicare & Medicaid Services (CMS) continues to urge providers to include legacy identifiers on their NPI applications. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

Key NPI Facts

The CMS along with the Workgroup for Electronic Data Interchange (WEDI) and other industry health plans would like to remind providers of the following key NPI facts:

- Every covered health care provider must get and use the NPI; and even if a health care provider is an individual and is not conducting electronic transactions and is, therefore, not a covered provider, he or she may be required by health plans or employers to obtain an NPI.
- The NPI is not just a number. It does affect internal and external business and systems operations and can affect the appropriate payment of claims in a timely manner.
- It is estimated that use of the NPI can require a transition period of no less than 120 days.
- Providers should begin to test and use their NPIs in electronic health care transactions no later than January 31, 2007.
- May 23, 2007 is not when the process starts, but when the process must be completed.
- Providers may be requested to communicate their NPIs to health plans, clearinghouses, and other providers well before the compliance date.

Just Six Months Remaining—National Provider Identifier Reminder (continued)

- A health care provider who is a **sole proprietor** is considered an individual and can only have ONE NPI.

Sharing NPIs

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that request it. In fact, as outlined in current regulation, all providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes – including designation of ordering or referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their numbers for them.

NPIs are FREE!

Health care providers should know that getting an NPI is free. You do not need to pay an outside source to btain your NPI for you. All CMS education on the NPI is also free. CMS does not charge for its education or materials.

NPI Questions

CMS continues to update our Frequently Asked Questions (FAQs) to answer many of the NPI questions we receive on a daily basis. Visit the following link to view all NPI FAQs:

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=Qjr3YRYh&p_lva=&p_li=&p_page=1&p_cv=&p_pv=&p_prods=0&p_cats=&p_hidden_prods=&prod_lvl1=0&p_sea

Providers should remember that the NPI Enumerator can **only** answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203.

Upcoming WEDI Events

WEDI has several NPI events scheduled in the upcoming month. Visit *http://www.wedi.org/npioi/index.shtml* to learn more about these events. Please note that there is a charge to participate in WEDI events.

Important Information for Medicare Providers

Communicating NPIs to Medicare

Medicare providers should know that there is no "special process" or need to call to communicate NPIs to the Medicare program. NPIs can be shared with the Medicare program in three different ways, as part of the following standard procedures:

- Medicare providers should use their NPI, along with appropriate legacy identifiers, on their Medicare claims.
- For new Medicare providers, an NPI must be included on the CMS-855 enrollment application.
- Existing Medicare providers must provide their NPIs when making any changes to their Medicare enrollment information.

Still Confused?

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

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

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

Source: CMS Provider Education Resource 200611-15

GENERAL COVERAGE

Changes to the Laboratory National Coverage Determination Edit Software for January 2007

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5384, which announces the changes that will be included in the January 2007 release of the edit module for clinical diagnostic laboratory national coverage determinations (NCDs).

Background

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

The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 16, Section120.2, available on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf*.)

These updating changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and biannual updates of the ICD-9-CM codes. In addition, many of the listed changes may correct *Current Procedural Terminology (CPT)* codes to reflect the current CPT update.

CR 5384 informs your Medicare carrier, FI, or A/B MAC about changes to the laboratory edit module and changes in laboratory NCD code lists effective for services furnished on or after January 1, 2007.

CR 5384 specifically announces the addition of the following ICD-9-CM code(s):

- **V58.83** (Encounter for therapeutic drug monitoring) to the list of 1) ICD-9-CM codes covered by Medicare for the prothrombin time (190.17) NCD and 2) ICD-9-CM codes covered by Medicare for the partial thromboplastin time (190.16) NCD;
- **783.0** (Anorexia) and **793.99** (Other nonspecific abnormal findings on radiological and other examinations of body structure) to the list of ICD-9-CM codes covered by Medicare for the thyroid testing (190.22) NCD; and
- **995.20** (Unspecified adverse effect of unspecified drug, medicinal and biological substance) to the list of ICD-9-CM codes covered by Medicare for the fecal occult blood test (190.34) NCD.

CR 5384 also modifies the descriptor for *CPT* code *87088* in urine culture, bacterial NCD (190.12) to read "Culture, bacterial; with isolation and presumptive identification of each isolates, urine."

Additional Information

For complete details, please see the official instruction issued to your carrier, FI, or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1093CP.pdf*.

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

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

MLN Matters Number: MM5384
Related Change Request (CR) Number: 5384
Related CR Release Date: October 27, 2006
Related CR Transmittal Number: R1093CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1093, CR 5384

Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms

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

Provider Types Affected

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (MACs) for subject services.

Background

This article and related CR 5235 highlight the fact that section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for abdominal aortic aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007, subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test.

Key Points

This article and CR 5235 define the parameters for AAA to Medicare beneficiaries as follows:

- The term "ultrasound screening for abdominal aortic aneurysm" means:
  - A procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, as specified by the Secretary of Health & Human Services through the national coverage determination process) provided for the early detection of abdominal aortic aneurysms; and
  - Includes a physician's interpretation of the results of the procedure.
- Effective for dates of service on and after January 1, 2007 Medicare will pay for a one-time ultrasound screening for AAA, for beneficiaries who meet the following criteria:
  - Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (IPPE). For more details on the IPPE, see *MLN Matters* article MM3638 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf*.
  - Receives such ultrasound screening from a provider or supplier who is authorized to provide covered diagnostic services.
  - Has not been previously furnished such an ultrasound screening under the Medicare program
  - Is included in at least one of the following risk categories:
    1. Has a family history of abdominal aortic aneurysm.
    2. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime
    3. Is a beneficiary, who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health & Human Services, through the national coverage determinations process.

Payment

The Part B deductible for screening AAA is waived effective January 1, 2007, but coinsurance is applicable.

If the screening is provided in a physician office, the service is billed to the carrier using the HCPCS code G0389: Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening.

- Short Descriptor: Ultrasound exam AAA screen
- Modifiers: TC, 26 (modifiers are optional)
- Payment is under the Medicare physician fee schedule (MPFS).

FIs will pay for the AAA screening only when the services are performed in a hospital, including a **CAH, IHS facility, an SNF, RHC, or FQHC** and submitted on one of the following types of bills (TOBs): **12x, 13x, 22x, 23x, 71x, 73x, 85x.**

The following table describes the payment methodology Medicare will use for AAA screening:

Facility	Type of Bill	Payment
Hospitals subject to OPPS	12x, 13x	OPPS
Method I and method II critical access hospitals (CAHs)	12x and 85x	101 percent of reasonable cost
IHS providers	13x, revenue code 051x	OMB-approved outpatient per visit all inclusive rate (AIR)
IHS providers	12x, revenue code 024x	All-inclusive inpatient ancillary per diem rate
IHS CAHs	85x, revenue code 051x	101 percent of the all-inclusive facility specific per visit rate
IHS CAHs	12x, revenue code 024x	101 percent of the all-inclusive facility specific per diem rate
SNFs **	22x, 23x	onfacility rate on the MPFS
RHCs*	71x, revenue code 052x	All-inclusive encounter rate
FQHCs*	73x, revenue code 052x	All-inclusive encounter rate
Maryland hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12x, 13x	94 percent of provider submitted charges or according to the terms of the Maryland waiver

Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms (continued)

*****If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI using TOBs 71x and 73x, respectively, and the appropriate site of service revenue code in the 052x revenue code series. If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier under the practitioner's ID following instructions for submitting practitioner claims to the Medicare carrier. If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI under the base provider's ID, following instructions for submitting claims to the FI from the base provider.

****** The SNF consolidated billing provision allows separate Part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a TOB 22x. Screening services provided by other provider types must be reimbursed by the SNF.

Implementation

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

Information Regarding Advanced Beneficiary Notices

Medicare contractors will deny an AAA screening service billed more than one in a beneficiary's lifetime.

If a second G0389 is billed for AAA for the same beneficiary or if any of the other statutory criteria for coverage listed in Section 1861(s)(2)(AA) of the Social Security Act are not met, the service would be denied as a statutory (technical) denial under Section 1861(s)(2)(AA), not a medical necessity denial.

If a provider cannot determine whether or not the beneficiary has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN-G. Likewise, if all of the statutory requirements for coverage have been met, but a question of medical necessity still exists, the provider should issue the ABN-G.

Additional Information

The official instructions for CR 5235, issued to your Medicare carrier, FI, MAC, FQHC, RHC, SNF, or CAH regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1113CP.pdf*.

The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 18, has been updated to include the requirements to implement section 5112 of the DRA of 2005. The new sections of this chapter address the payment and allowable settings for AAA and the sections are attached to CR 5235.

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

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

MLN Matters Number: MM5235
Related Change Request (CR) Number: 5235
Related CR Release Date: November 17, 2006
Effective Date: January 2, 2007
Related CR Transmittal Number: R1113CP
Implementation Date: January 1, 2007

Source: CMS Pub. 100-04, Transmittal 1113, CR 5235

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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 Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "***eNews***" link on the navigational menu and follow the prompts.

HOSPITAL SERVICES

New Edits Established to Enforce Proper Transfer Coding and Payment in Inpatient Rehabilitation Facility Prospective Payment System Claims

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

Provider Types Affected

Inpatient rehabilitation facilities (IRFs) submitting claims to Medicare fiscal intermediaries (FIs) 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) 5354 which informs your FI that edits will be implemented within Medicare's common working file (CWF) that will be used when reviewing claims and will match 1) beneficiary discharge dates with 2) admission dates to others providers to identify possible miscoded claims. Claims coded incorrectly will be cancelled and returned to the IRF for correction.

Background

In response to a recommendation by the Office of the Inspector General (OIG) the Centers for Medicare & Medicaid Services (CMS) will implement edits, effective April 1, 2007, to match **beneficiary discharge dates** with **admission dates to other providers** in order to identify potentially miscoded claims. Claims identified as transfers will be canceled back to the provider for correction and thus ensure proper payment.

For the inpatient rehabilitation facility-prospective payment system (IRF-PPS), transfer cases are defined as those in which:

- A Medicare beneficiary is transferred to either:
  - Another rehabilitation facility (patient status code 62),
  - A long term care hospital (patient status code 63),
  - An inpatient hospital (patient status code 02), **or**
  - A nursing home that accepts payment under either the Medicare program and/or the Medicaid program (patient status codes 03, 61, or 64); **AND**
- The length of stay (LOS) of the case is less than the average length of stay (ALS) for a given case-mix group (CMG).

The transfer policy consists of a per diem payment amount which is calculated **by dividing 1)** the per discharge CMG payment rate **by 2)** the average LOS for the CMG. Medicare will pay transfer cases a per diem amount, and an additional half-day payment for the first day. Transfer payments will be calculated by:

- First adding the LOS of the case to 0.5 (to account for the addition of the half day payment for the first day), and
- Then multiplying the result by the CMG per diem amount.

IRFs should note that timely filing rules will apply to resubmitted claims.

Additional Information

For complete details, please see the official instruction (CR 5354) issued to your FI or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1099CP.pdf*.

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

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

MLN Matters Number: MM5354
Related Change Request (CR) Number: 5354
Related CR Release Date: November 2, 2006
Related CR Transmittal Number: R1099CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1099, CR 5354

Clarification on Billing for Cryosurgery of the Prostate Gland

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

Provider Types Affected

Hospitals submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for services related to cryosurgery of the prostate gland.

Provider Action Needed

This article is based on change request (CR) 5376, which revises sections of the *Medicare Claims Processing Manual* related to cryosurgery of the prostate, expands revenue codes permissible for billing for this service, and corrects the payment method for Indian health service (IHS) facilities. Be sure your billing staff are aware of the revenue code information.

Background

Cryosurgery of the prostate, also known as cryoablation of the prostate (CAP), destroys prostate gland tissue by applying extremely cold temperatures; this reduces the size of the prostate gland.

This article is based on CR 5376 which:

- Relocates the section on cryosurgery of the prostate **from** Chapter 18, Screening and Preventive Services, in the *Medicare Claims Processing Manual* (Publication 100-04) **to** Chapter 32, Billing Requirements for Special Services, in the same manual, and
- Expands the revenue codes permissible for billing this service to include 0360 and 0369, as well as 0361.

CR 5376 also changes the manual to clarify the payment method for cryosurgery in IHS facilities. These revised sections of the manual are included as attachments to CR 5376.

Additional Information

CAHs That Elect Method II Must Do So Annually

In addition, CR 5376 revises the *Medicare Claims Processing Manual* by clarifying that critical access hospitals (CAHs) wishing to be paid using the optional method (method II) for professional outpatient services must make the election to do so annually.

Note: There are no policy changes related to these clarifications.

For complete details, please see the official instruction, CR 5376, issued to your FI or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1111CP.pdf*.

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

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

MLN Matters Number: MM5376
Related Change Request (CR) Number: 5376
Related CR Release Date: November 9, 2006
Related CR Transmittal Number: R1111CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1111, CR 5376

Common Working File Duplicate Claim Edit for the Technical Component of Radiology and Pathology Laboratory Services Provided to Hospital Patients

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

Provider Types Affected

Radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the technical component (TC) of **radiology** laboratory services provided to Medicare fee-for-service hospital inpatients. Also affected are independent laboratories billing Medicare carriers for the TC of **pathology** laboratory services provided to Medicare fee-for-service hospital patients.

Provider Action Needed

Effective April 1, 2007, CMS will install systems edits to prevent improper payments to radiology suppliers, physicians and nonphysician practitioners for the TC of radiology laboratory services during an inpatient stay. The system edits will also apply to independent laboratories for the TC of pathology laboratory services provided to beneficiaries during a covered inpatient hospital stay or provided on the same date of service as an outpatient service. This change applies to claims with dates of service **on or after January 1, 2007,** where the claim is received on or after April 1, 2007. Please be sure billing staff are aware of these changes.

Background

Current Medicare billing practices allow either the hospital or the supplier performing the TC of physician pathology laboratory services to bill the carrier for these services. This policy has contributed to the Medicare program paying twice for the TC service, first through the prospective payment system (PPS) to the hospital and again to the supplier that bills the carrier, instead of the hospital, for the TC service.

CWF Duplicate Claim Edit for the TC of Radiology and Pathology Laboratory Services Provided ... (continued)

Effective for claims received on or after April 1, 2007 for services on or after January 1, 2007, CMS will install systems edits to prevent additional improper payments to radiology suppliers, physicians and nonphysician practitioners billing Medicare carriers for the TC of **radiology** laboratory services during an inpatient stay. The edits will also apply to independent laboratories for the TC of pathology services provided to beneficiaries during an inpatient stay or for the same date of service as an outpatient service.

Key Points

- Effective for claims received **on or after April 1, 2007,** Medicare will reject/deny a Part B TC or globally billed radiology service with a service date **on or after January 1, 2007,** that falls within the admission and discharge dates of a covered hospital inpatient stay. Such services will also be rejected/denied when they match with a date of service of a hospital inpatient previously processed by Medicare.
- Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed pathology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay when billed by a physician/supplier. Such services will also be rejected/denied when they match with a date of service of a hospital outpatient bill (bill types 13x and 85x) previously processed by Medicare.
- If providers submit a TC of a radiology or pathology service with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay the carrier will use remittance advice reason code 109 "Claim not covered by this payer/contractor." when denying a service line item.
- Where Medicare systems detect that a Part B TC or globally billed radiology or physician pathology service has been paid and Medicare subsequently receives a hospital inpatient bill for the same date of service, the Medicare carrier will adjust a TC of a radiology or physician pathology service line item and recoup the payment made for that service from the physician/supplier. The Medicare carrier will also adjust a TC of a pathology service for an outpatient claim. The same remittance advice reason code of 109 will be used in such cases.
- Effective for claims received on or after April 1, 2007, the carrier will deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a posted hospital inpatient bill. Again, the carrier will use remittance advice reason code 109. In addition, the Medicare carrier will recoup payment made to the physician/supplier if a subsequent hospital inpatient bill is received for those same services.
- Carriers will not search their files to either retract payment or retroactively pay claims prior to the implementation of CR 5347. However, they will adjust claims if they are brought to their attention.

Implementation

This change will be implemented on April 2, 2007.

Additional Information

For complete details regarding this CR, please see the official instruction issued to your Medicare fiscal intermediary (FI), carrier or A/B MAC. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1098CP.pdf*.

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

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

MLN Matters Number: MM5347
Related Change Request (CR) Number: 5347
Related CR Release Date: November 2, 2006
Related CR Transmittal Number: R1098CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1098, CR 5347

Holding Claims for Diagnostic and/or Screening Mammography Services on Type of Bill 13x

Previously, diagnostic and screening mammography services furnished by hospitals were required to be billed under type of bill (TOB) 14x. In change request (CR) 3469, issued on October 29, 2004, the Centers for Medicare & Medicaid Services (CMS) instructed fiscal intermediaries (FIs) to no longer allow these services to be billed under TOB 14x effective for claims with dates of service on or after April 1, 2005. Subsequently, CR 3835, issued on October 28, 2005, redefined the TOB 14x to apply only to nonpatient laboratory specimens effective for claims with dates of service on or after October 1, 2004.

As a result, TOB 14x claims containing diagnostic and/or screening mammography services with dates of service October 1, 2004, through March 31, 2005, will not process to payment in the FI shared system (FISS). FIs will hold all TOB 13x claims with dates of service October 1, 2004, through March 31, 2005, containing diagnostic and/or screening mammography services (revenue codes 0401 or 0403) until the FISS is modified on June 4, 2007. At that time these claims may be released for payment and the appropriate interest payment will be applied.

Action Required by Providers

Hospitals need to resubmit the claims by changing the TOB from 14x to 13x for diagnostic and/or screening mammography services with dates of service October 1, 2004, through March 31, 2005, to receive payment for these services on the scheduled release date of June 4, 2007.

Note: **C**laims resubmitted on a TOB 13x with revenue codes 0401 or 0403 will be held under reason code 75098 in status location S/MSPRM. ❖

Source: CMS Joint Signature Memorandum 07067, November 15, 2006

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LOCAL COVERAGE DETERMINATIONS

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

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

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

Local Coverage Determination Table of Contents

Additions/Revisions to Existing LCDs

Additional Medical Information

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

ADDITIONS/REVISIONS TO LCDS

A84484: Troponin—Addition to the LCD

The local coverage determination (LCD) for troponin was last revised on November 3, 2005. Since that time, ICD-9–CM codes 729.5, 780.2, and 789.06 have been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD and language has been added to the "Documentation Requirements" section of the LCD.

Effective Dates

The additions to the LCD are effective for services provided **on or after December 7, 2006.**

The full text for this LCD (L1577) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AEPO: Epoetin alfa—Revision to the LCD

The local coverage determination (LCD) for epoetin alfa was last updated on October 1, 2006. Since that time, a correction has been made to the list of ICD-9-CM codes that support medical necessity. With the 2007 annual ICD-9-CM update, several new ICD-9-CM codes were included in the diagnosis range 235.0-238.9, that were not appropriate for the myelodysplastic syndrome (MDS) indication found in the LCD. Therefore, the range of ICD-9-CM codes that support medical necessity has been broken down to individual diagnosis ranges and codes in order to correctly identify the appropriate ICD-9-CM codes for MDS. The new diagnosis ranges and codes will appear as follows in the LCD:

235.0-235.9	Neoplasm of uncertain behavior of digestive and respiratory systems
236.0-236.99	Neoplasm of uncertain behavior of genitourinary organs
237.0-237.9	Neoplasm of uncertain behavior of endocrine glands and nervous system
238.0	Neoplasm of uncertain behavior of bone and articular cartilage
238.1	Neoplasm of uncertain behavior of connective and other soft tissue
238.2	Neoplasm of uncertain behavior of skin
238.3	Neoplasm of uncertain behavior of breast
238.4	Neoplasm of uncertain behavior of polycythemia vera
238.5	Neoplasm of uncertain behavior of hystiocytic and mast cells
238.6	Neoplasm of uncertain behavior of plasma cells
238.72	Low grade myelodysplastic syndrome lesions
238.73	High grade myelodysplastic syndrome lesions
238.74	Myelodysplastic syndrome with 5q deletion
238.75	Myelodysplastic syndrome, unspecified
238.8	Neoplasm of uncertain behavior of other specified sites
238.9	Neoplasm of uncertain behavior of site unspecified

This revision to the LCD is effective for claims processed on or after November 30, 2006, for services provided on or after October 1, 2006.

In addition to this revision, a request was received to allow for several off-label dosing schedules for indication #2, anemia in chronic kidney disease (CKD), #4, anemia in cancer patients receiving chemotherapy for non-myeloid malignancy, # 5, anemia related to MDS and #7, anemia associated with malignancy.

The following off-label dosing schedule was added as medically reasonable for indication #2: Extended (maintenance dosing) for patients not requiring dialysis, who already receive EPO and have a stable Hgb level greater than or equal to 11:

- 20,000 units subcutaneously once every two weeks to maintain target Hgb level
- 30,000 units subcutaneously once every three weeks to maintain target Hgb level
- 40,000 units subcutaneously once every four weeks to maintain target Hgb level

The following off-label dosing schedule was added as medically reasonable for indications # 4, #5 and #7:

Maintenance dosing – 120,000 units subcutaneously once every three weeks to maintain target Hgb. This dosing schedule should not be used as initial dosing. The patient should already be receiving EPO and responding to the drug as evidenced by the patients Hgb increasing at least 2g/dl.

This revision to the LCD is effective for services provided on or after October 19, 2006.

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

AJ1745: Infliximab (Remicade®)—Revision to the LCD

The local coverage determination (LCD) for infliximab (Remicade®) was last updated on March 23, 2006. Since that time, the LCD has been revised. A request was received to add the new Food and Drug Administration (FDA) indication for plaque psoriasis. The indications and limitations section of the LCD was revised to allow for the new indication, plaque psoriasis, and the language for indication number 1 and number 3 was revised to align with the FDA approved drug label. In addition to these revisions, the list of ICD-9-CM codes that support medical necessity was revised to include ICD-9-CM code 696.1 (Other psoriasis), as medically necessary.

Effective Date

This revision to the LCD is effective for claims processed **on or after November 16, 2006,** for services provided **on or after September 26, 2006.**

The full text for this LCD (L1387) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ9000: Antineoplastic Drugs—Revision to the LCD

The local coverage determination (LCD) for antineoplastic drugs was last updated on October 30, 2006. Since that time, the following revisions were made based on new approved FDA indications for rituximab (J9310).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for rituximab, HCPCS code J9310, the following indications were added:

- For the first-line treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in combination with CVP chemotherapy.
- For the treatment of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy.

Effective Dates

The revisions to the LCD are effective for services provided **on or after September 29, 2006.**

The full text for this LCD (L1447) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

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

The local coverage determination (LCD) for darbepoetin alfa (Aranesp) (novel erythropoiesis stimulating protein [NESP]) was last updated on October 1, 2006. Since that time, a correction has been made to the list of ICD-9-CM codes that support medical necessity. With the 2007 annual ICD-9-CM update, several new ICD-9-CM codes were included in the diagnosis range 235.0-238.9, that were not appropriate for the myelodysplastic syndrome (MDS) indication found in the LCD. Therefore, the range of ICD-9-CM codes that support medical necessity has been broken down to individual diagnosis ranges and codes in order to correctly identify the appropriate ICD-9-CM codes for MDS. The new diagnosis ranges and codes will appear as follows in the LCD:

235.0-235.9	Neoplasm of uncertain behavior of digestive and respiratory systems
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237.0-237.9	Neoplasm of uncertain behavior of endocrine glands and nervous system
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238.1	Neoplasm of uncertain behavior of connective and other soft tissue
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238.3	Neoplasm of uncertain behavior of breast
238.4	Neoplasm of uncertain behavior of polycythemia vera
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238.72	Low grade myelodysplastic syndrome lesions
238.73	High grade myelodysplastic syndrome lesions
238.74	Myelodysplastic syndrome with 5q deletion
238.75	Myelodysplastic syndrome, unspecified
238.8	Neoplasm of uncertain behavior of other specified sites
238.9	Neoplasm of uncertain behavior of site unspecified

Effective Date

This revision to the LCD is effective for claims processed on or after November 30, 2006, for services provided **on or after October 1, 2006.**

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

APULMDIAGSVCS: Pulmonary Diagnostic Services—Revision to the LCD

The local coverage determination (LCD) for pulmonary diagnostic services was last revised on October 1, 2006. Since that time, this LCD has been revised to add ICD-9-CM code 277.02 (Cystic fibrosis with pulmonary manifestations) and the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised accordingly.

Effective Dates

The revisions to the LCD are effective for services provided **on or after December 14, 2006.**

The full text for this LCD (L16651) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ADDITIONAL MEDICAL INFORMATION

A77520: Draft LCD for Proton Beam Radiotherapy Not Finalized

The draft local coverage determination (LCD) for proton beam radiotherapy (A77520) was posted for comment on May 19, 2006. Since that time, it was determined that proton beam radiotherapy will only be used in Florida as a Part B service. Therefore First Coast Service Options, Inc. (FCSO) will not be finalizing this LCD. ❖

CRITICAL ACCESS HOSPITAL SERVICES

Critical Access Hospital Annual Election of Method II for Outpatient Services

The Centers for Medicare & Medicaid Services (CMS) reminds critical access hospitals (CAHs) under method II (optional method) payment that wish to continue to be paid at 101 percent of reasonable cost for facility services plus fee schedule for professional services **to renew their method II elections on an annual basis.**

This joint signature memorandum/technical direction letter (JSM/TDL) clarifies the annual election instructions in Chapter 4, sections 250 and 250.2 of CMS Pub.100-04, Medicare Claims Processing Manual. The instructions in sections 250 and 250.2 are clarified in change request (CR) 5376, which was issued on November 9, 2006.

The election of method II must be made in writing, made on an annual basis, and delivered to the fiscal intermediary or A/B MAC servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made.

An election of the method II payment, once made for a cost reporting period, remains in effect for all of that cost reporting period and, effective for cost reporting periods beginning on or after July 1, 2004, applies to all services furnished to outpatients during that period by a physician or other practitioner who has reassigned his or her billing rights to the CAH.

Unless the CAH elects to be paid for services to its outpatients under method II on an annual basis, payment will be made under method I, cost based facility services with billing to the carrier for professional services. ❖

Source: CMS Joint Signature Memorandum 07071, November 16, 2006

Claims for Trauma Response/Trauma Team Activation

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries (FIs) that charges billed by method I and II critical access hospitals (CAHs) under revenue code 068x (trauma response, charges for a trauma team activation) are being rejected as nonbillable when submitted on type of bill 85x (CAH).

Trauma response/trauma team activation services are billable by CAHs, as well as hospitals.

Revenue code 068x may be used by trauma centers/hospitals licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons.

FIs and A/B Medicare administrative contractors (MACs) have updated their revenue code table to allow type of bill 85x for revenue code 068x **with an effective date of October 1, 2002.**

Billing guidelines for these services are:

- Units are required on the claim and should normally be billed as **one** unit.
- Healthcare Common Procedure Coding System (HCPCS) codes are not required. CAHs may choose to bill an appropriate HCPCS code.

For more information on revenue code 068x, see Chapter 25, section 60.4 of Pub.100-04, *Medicare Claims Processing Manual*.

Action Required by Affected Providers

CAH providers affected by this correction may resubmit or adjust previous rejected claims meeting the above criteria since the FIs will not search their files for claims to adjust. ❖

Source: CMS Joint Signature Memorandum 07036, November 1, 2006

ESRD SERVICES

Line Item Billing Requirement for End-Stage Renal Disease Claims

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

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for end-stage renal disease (ESRD) services

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5039, which provides updates to line-item billing requirements for ESRD claims (type of bill 72x).

CAUTION – What You Need to Know

CR 5039 instructs that line-item billing is required for all ESRD claims with dates of service on or after April 1, 2007. Renal dialysis facilities are then required to bill all services with line item date of service detail, except supplies and epoetin alfa (EPO).

GO – What You Need to Do

See the *Background* section of this article for further details regarding this change.

Background

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) Implementation Guide, the Centers for Medicare & Medicaid Services (CMS) **requires that all outpatient claims contain a line item date of service for each revenue code billed on the claim**. CMS has completed implementation of line-item billing for most institutional Part B claims and has encouraged renal dialysis facilities (RDFs) to begin line-item billing. CMS has permitted RDFs to continue to roll-up the services provided throughout the month; and choose one date of service within the billing period on the claim to report all instances of each revenue code on a single line.

As a result, ESRD claims are currently being received and processed using both methods: line-item billing; and services rolled-up for all instances of each revenue code.

The method of rolling up all instances of each revenue code on a single line does not provide the most accurate claims data since the claim is reporting that all of a given service is provided on the same date. **Inherent with this method of billing is an increase in the number of claims that cannot be processed to payment due to claims with overlapping dates of service**.

In these overlapping claim cases, RDFs must report service dates of other providers within the month they are billing using an occurrence span code 74 on the claim to prevent the overlap of the claims and allow both claims to be paid. RDFs have expressed to CMS that this is a difficult task because they are not always informed of the beneficiary receiving services performed by other providers.

The Medicare claims processing system has the ability to compare services on multiple claims to the line date that could prevent both the unnecessary suspension of claims for overlapping billing periods and the reporting of the occurrence span code 74 for the RDFs.

To apply this system functionality to the ESRD claims, the claim must provide the line item date of service detail for each service being billed on the claim. This is a substantial benefit that line item billing can provide for RDFs in submitting ESRD claims.

Benefits of Line Item Billing Include:

- More accurate and timely claim payments to providers.
- Less staff time needed to research dates of services performed by other providers.
- Clinical data will no longer need to be rolled up to accommodate the claims processing systems and therefore, will more closely match the claim record.
- More detailed claim data could be used to assist the CMS in future refinements to improve the accuracy and equity of ESRD payments.
- HIPAA compliance for submitting the appropriate line item date of service for both the CMS and its providers is ensured.

Line Item Details

CR 5039 instructs RDFs to:

- Bill a separate line item for each dialysis session performed.
- Report the appropriate line item date of service to conform with the date the service was provided to the beneficiary. The units reported on the line for each date dialysis was performed should not exceed one.
- The use of occurrence span code 74 will not be necessary for ESRD claims with dates of service on or after April 1, 2007.
- Reporting value code 67 will not be required for ESRD claims with dates of service on or after April 1, 2007.

Medicare FIs will return to the provider any claims with dates of service on or after April 1, 2007, when:

- The claim contains units exceeding 1 reported on lines containing revenue codes 0821, 0831, 0841, or 0851.

Coding Adequacy for Hemodialysis

All claims billing for hemodialysis sessions must continue to report *CPT* code *90999* (unlisted dialysis procedure, inpatient or outpatient), and modifiers G1 through G6 used for reporting the urea reduction ratio (URR) for determining the adequacy of hemodialysis.

Line Item Billing Requirement for End-Stage Renal Disease Claims (continued)

However, it is not required that *CPT* code *90999* and a G1-G6 modifier be reported on every line item that contains a hemodialysis session.

Home Dialysis Under Method One

For intermittent home dialysis under method one, providers should submit a separate line item for each dialysis session using the dates in the predetermined plan of care schedule provided to the beneficiary unless informed by the beneficiary that the schedule was changed.

In the event that the schedule was changed, the provider should note the changes in the medical record and bill according to the revised schedule.

For continuous ambulatory peritoneal dialysis (CAPD) and continuous cycling peritoneal dialysis (CCPD) under method one, providers should submit a separate line item for the dialysis for each day of the month.

If the provider is aware of an inpatient stay for the beneficiary within the month, the RDF may include the date of admission and date of discharge as a billable day for the dialysis but should omit the dates within the inpatient stay.

In the event that the RDF is unaware of an inpatient stay during the month, the Medicare system will detect the overlapping dates and reject only the line item dates within the inpatient stay but pay the remainder of the claim for any dates that are not within the inpatient stay.

Implementation

The implementation date for the instruction is April 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1084CP.pdf*.

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

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

MLN Matters Number: MM5039
Related Change Request (CR) Number: 5039
Related CR Release Date: October 27, 2006
Related CR Transmittal Number: R1084CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1084, CR 5039

SKILLED NURSING FACILITY SERVICES

Skilled Nursing Facility Prospective Payment System Fact Sheet now Available

The *Skilled Nursing Facility Prospective Payment System Fact Sheet*, which is the first in an upcoming series of payment fact sheets, 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: CMS CMS Provider Education Resource 200610-17

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CORF SERVICES

Outpatient Therapy Cap Exceptions Clarifications

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

Provider Types Affected

Providers, physicians, and nonphysician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries [RHHIs], Part A/B Medicare administrative contractors [A/B MACs], and carriers) under the Part B benefit for therapy services.

Provider Action Needed

CR 4364, released February 15, 2006, described the exception process to the caps set on outpatient therapy services (physical therapy and occupational therapy). CR 5271, upon which this article is based, clarifies questions (below) that have arisen about this exception process. Thus, the article is meant primarily for informational purposes.

Background

A brief history may be beneficial at this point. The Balanced Budget Act of 1997 placed financial limitations on Medicare covered therapy services (therapy caps), which were implemented in 1999 and again for a short time in 2003. Congress placed moratoria on these caps for 2004 and 2005, but the moratoria are no longer in place, and the caps were re-implemented on January 1, 2006. However, Congress, through the Deficit Reduction Act has provided that (only for calendar year 2006) exceptions to caps may be made when provision of additional therapy services is determined to be medically necessary.

Review of This Exception Process

Section 1833(g)(5) of the Social Security Act provides that, **for services provided during calendar year 2006**, FIs, RHHIs, and carriers can, in certain circumstances, grant an exception to the therapy cap when requested by the individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).

Exception Processes fall into two categories: 1) **Automatic** process exceptions, or 2) **Manual** process exceptions. Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if the beneficiary:

- meets specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 5, (as revised by CR 4364) for exception from the therapy cap for 2006; or
- meets specific criteria for exception, in addition to those listed in the *above referenced manual*, when the Medicare contractor believes (based on the strongest evidence available) that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.

Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

Clarifications to Questions Generated from CR 4364

Your FI, RHHI, or carrier:

1. Will grant exceptions for any number of medically necessary services for 2006 that meet the automatic process exception criteria, if the beneficiary meets the conditions described in *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 4364).
2. Will grant an exception to the therapy cap, by approving any number of additional therapy treatment days, when these additional treatment days are deemed medically necessary based on documentation that you have submitted in 2006.
3. Will utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance in which you do not submit all required documentation with the exception request in 2006.
4. Must reply as soon as practicable to a request for exception. They will grant an exception to the therapy cap, approving the number of treatment days that you or the beneficiary request (not to exceed 15 future treatment days), if they do not make a decision within 10 business days of receipt of any request and appropriate documentation in 2006.
5. Will allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.
6. Will follow the manual description for allowing exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process in 2006.
7. Will allow automatic process exceptions when complexities occur in combination with other conditions that **may or may not be on the list** in the *Medicare Claims Processing Manual* in 2006.
8. Will, when a patient is being treated under the care of two physicians for separate conditions, accept as appropriate documentation either 1) A combined plan of care certified by one of the physicians/NPPs, or 2) Two separate plans of care certified by separate physicians/NPPs.

Outpatient Therapy Cap Exceptions Clarifications (continued)

9. Will update the list of exceptions in 2006 according to the changes provided in this transmittal. You should be aware that they may expand (but not contract) this list if their manual process exception decisions lead them to believe further exceptions should be allowed.

10. Will not require the additional documentation that is encouraged but not required in the manuals.

11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.

12. Will not deny payment for re-evaluation **only** because an evaluation or re-evaluation was recently done, as long as documentation supports the need for re-evaluation. A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.

13. Will, on pre or postpay medical review, require clinicians to write progress reports at least during each progress report period. Note that required elements of the progress report that are written into the treatment notes or in a plan of care, acceptably fulfill the requirement for a progress report. In these instances, a separate progress report is not required.

14. Will require, on pre or postpay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each progress report period and sign the progress report.

15. Will continue to use Medicare summary notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: "ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are $1,740 for PT and SLP combined and $1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE."

16. Will continue to enforce local coverage determinations (LCDs).

Final Note: *You should keep in mind that claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable.*

Additional Information

You can find more information about outpatient therapy cap exceptions by going to CR 5271, issued in three transmittals. As attachments to those transmittals, you will find updated manual sections for:

- The *Medicare Claims Processing Manual*, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services, section 10.2, The Financial Limitation. This is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1106Cp.pdf*.
- The *Medicare Program Integrity Manual*, Chapter 3, Verifying Potential Errors and Taking Corrective Actions, Section 3.4.1.1.1, Exception from the Uniform Dollar Limitation ("Therapy Cap"). This is available at *http://www.cms.hhs.gov/Transmittals/downloads/R171PI.pdf*.
- The *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3, Documentation Requirements for Therapy Services. This is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R60BP.pdf*.

These manual revisions include numerous additional changes clarifications.

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

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

MLN Matters Number: MM5271
Related Change Request (CR) Number: 5271
Related CR Release Date: November 9, 2006
Related CR Transmittal Number: R60BP, R171PI, R1106CP

Effective Date:	**December 9, 2006, for nonsystem changes, January 2, 2007 for system changes**
Implementation Date:	**December 9, 2006, for nonsystem changes, January 2, 2007 for system changes**

Source: CMS Pub. 100-04, Transmittal 1106, CR 5271

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Reporting and Payment of No-Cost and Reduced-Cost Devices Furnished by Outpatient Prospective Payment System Hospitals

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 fiscal intermediaries (FIs) for devices used in the process of providing services to Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5263, which expands the definition of **modifier FB** and further specifies how no-cost devices and reduced cost devices are to be reported and paid for by hospitals paid under the outpatient prospective payment system (OPPS).

Background

In general, Medicare packages payment for devices into the payment for the service in which the device is used. In some cases, the cost of the device is a very large proportion of the cost for the procedure on which the APC (ambulatory payment classification) for the procedure is based. Section 1862(a)(2) of the Social Security Act excludes payment for items or services for which neither the beneficiary nor any party on the beneficiary's behalf are liable. Therefore is it necessary to adjust the payment for the APC so that it no longer includes payment for a device that is being furnished without cost to the beneficiary.

Medicare requires that hospitals paid under OPPS must report the Healthcare Common Procedure Coding System (HCPCS) code for devices they use in performing a service, including those implanted in a patient (temporarily or permanently), and the outpatient code editor (OCE) returns claims to the provider for selected HCPCS procedures if an approved HCPCS code for the device is not included on the claim.

In addition, the Medicare claim processing system used by FIs requires that there be a charge for each HCPCS code reported on the claim, and an OPPS hospital may not refrain from billing for a device furnished under warranty, without cost to the provider or beneficiary. Therefore, CMS authorized hospitals (in CR 3915) to report a token charge of less than $1.01 for the device in these cases, so that the claim could be processed. See the MLN Matters article associated with CR 3915 (Transmittal 599, June 30, 2005) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3915.pdf*.

CMS subsequently announced in CR 4250 the creation of **modifier FB,** with the following definition:

FB Item provided without cost to provider, supplier or practitioner (examples, but not limited to: covered under warranty, replaced due to defect, free samples).

See the MLN Matters article associated with CR 4250 (Transmittal 804, January 3, 2006) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4250.pdf*.

CR 5263 expands the definition of **modifier FB to include credits received for a replacement device** by a hospital from a manufacturer or other entity **effective January 1, 2007.**

CR 5263 further revises the *Medicare Claims Processing Manual* (Chapter 4), which instructs OPPS hospitals to:

- Report **modifier FB** on the same line as the procedure code (not the device code) for a service that requires a device:
  - For which neither the hospital, nor the beneficiary, is liable to the manufacturer; or
  - When the manufacturer gives credit for a device being replaced with a more costly device.
- Append **modifier FB** to the procedure code (not the device code) that reports the services provided to replace the device when the hospital:
  - Replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS website at *http:www.cms.hhs.gov/HospitalOutpatientPPS/*; and
  - Receives the device without cost from a manufacturer. The hospital must report a token charge for the device (less than $1.01) in the covered charges field; or
  - Receives a credit in the amount that the device being replaced would otherwise cost. The hospital must charge the difference between its usual charge for the device being implanted and its usual charge for the device for which it received credit. This charge should be billed in the covered charges field.

Payment for the replacement procedure is reduced by the offset amount applicable to the APC for which the service was furnished. These offset amounts are displayed on the OPPS CMS website at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

The following table includes hypothetical claim examples and aim to reflect the pricing concepts, **effective January 1, 2007.** The rates in the following examples do not represent actual payment rates because they are rounded to simplify the example claims scenarios.

Reporting and Payment of No-Cost and Reduced-Cost Devices Furnished by OPPS Hospitals (continued)

Example	HCPCS	Description	SI	Units	Charge	APC	Unadjust. Payment	Offset Amount	New Unadj. Payment
Claim 1: Free ICD device	G0297 **FB**	Implant ICD	T	1	$6,000	107	$16,000	$14,000	$2,000
	C1772	ICD	N	1	$1	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
Claim 2: Credit for upgrade device	G0297 FB	Implant ICD	T	1	$6,000	107	$16,000	$14,000	$2,000
	C1772	ICD	N	1	$5,000	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
Claim 3: Multiple procedure discount	G0297 FB	Implant ICD	T	1	$6,000	107	$16,000	$14,000	$1,000 ($2,000 x .5)
	C1772	ICD	N	1	$1	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
	33241	Removal Puls Generator	T	1	$5,000	105	$2,500	---	$2,500
Claim 4: Terminated procedure along with free device	G0297 FB and 73	Implant ICD	T	1	$6,000	107	$16,000	$14,000	$1,000 ($2,000 x .5)
	C1772	ICD	N	1	$1	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
Claim 5: Modifier FB on free device line	G0297	Implant ICD	T	1	$6,000	107	OCE Edit #75: Incorrect billing of FB modifier		
	C1772 FB	ICD	N	1	$1	---			
	93005	EKG	S	2	$100	99			

Implementation

The implementation date for CR 5263 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1103CP.pdf*.

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

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

MLN Matters Number: MM 5263
Related Change Request (CR) Number: CR 5263
Related CR Release Date: November 3, 2006
Related CR Transmittal Number: R1103CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1103, CR 5263

Notification and Testing of an Integrated Outpatient Code Editor for the July 2007 Release

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

Provider Types Affected

Non-outpatient prospective payment system (OPPS) hospitals submitting outpatient claims to Medicare fiscal intermediaries (FIs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5344 which informs FIs of the integration and testing of the non-OPPS outpatient code editor (OCE) into the OPPS OCE **effective July 1, 2007.**

Background

This article is based on change request (CR) 5344 that informs your FI of the integration and testing of the non-OPPS OCE into the OPPS OCE effective July 1, 2007. The integration of the non-OPPS OCE into the OPPS OCE:

- Will result in the routing of all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.
- Does not change the current logic that is applied to outpatient bill types that already pass through the OPPS OCE software. It merely expands the software usage to include non-OPPS hospitals. Note: This new software product will be referred to as the integrated OCE.

Note: Claims with dates of service prior to July 1, 2007 will be routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim.

The principal reason for the integration of the non-OPPS OCE into the OPPS OCE is the long-standing systems issues related to the non-OPPS OCE software that require corrective action.

Editing that only applied to OPPS hospitals (e.g., blood, drug, partial hospitalization logic) in the past will not be applied to non-OPPS hospitals at this time. However, with the integrated OCE non-OPPS hospitals will be assigned specific edit numbers and dispositions, where in the past, this type of detail was not provided.

OPPS OCE

The current OPPS OCE:

- Processes claims for all outpatient institutional providers with the exception of hospitals not subject to OPPS.
- Performs detailed editing and evaluates patient data to help identify possible coding errors, returning a series of edit flags with claim/line item actions.
- Assigns ambulatory payment classification (APC) numbers based on Healthcare Common Procedure Coding System (HCPCS) codes for payment under the OPPS.
- Sets a series of indicators/flags based on various coding criteria and sends those indicators/flags to the OPPS PRICER to determine pricing.

Non-OPPS OCE

The current non-OPPS OCE:

- Processes claims for the following non-OPPS hospitals: Indian health service hospitals, critical access hospitals (CAHs), Indian health service hospitals (IHS)/ tribal hospitals including IHS/ tribal CAHs, Maryland hospitals, as well as hospitals located in American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands.
- Processes claims from Virgin Island hospitals with dates of service 1/1/02 and later, and from hospitals that furnish only inpatient Part B services with dates of service January 1, 2002 and later.
- Does not perform detailed editing and grouping (**unlike the OPPS OCE**) since it is not required for these hospitals.

CR 5344 provides instructions and specifications for the integrated OCE, which will be used to process outpatient claims for the following institutional providers:

- **OPPS providers** (hospital outpatient departments, community mental health centers (CMHC's) and for limited services provided in a home health agency (HHA) not under the home health prospective payment system, or to a hospice patient for the treatment of a non-terminal illness).
- **Non-OPPS hospitals** (Indian health service hospitals, critical access hospitals (CAHs)), Maryland hospitals, as well as hospitals located in American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands. In addition, claims from Virgin Island hospitals with dates of service January 1, 2002, and later, and hospitals that furnish only inpatient Part B services with dates of service January 1, 2002, and later are edited in the non-OPPS OCE.
- **All non-hospital outpatient institutional providers** (HHAs, skilled nursing facilities, rural health clinics, federally qualified health centers, hospices, renal dialysis facilities, religious non-medical healthcare institutions, comprehensive outpatient rehabilitation facilities, and outpatient physical therapy providers).

The changes specific to the July release for the new integrated OCE will be issued in a separate recurring CR, which will replace the non-OPPS, and the OPPS recurring CRs for July. As a result, there will only be one recurring CR for each quarterly release of the OCE beginning with the July release.

Implementation

The implementation date for CR 5344 is July 2, 2007.

Notification and Testing of an Integrated Outpatient Code Editor for the July 2007 Release (continued)

Additional Information

Integrated Edit/Disposition Table for Hospitals

Edit	Disposition	Application to Hospitals
01 – Invalid diagnosis code	RTP	Apply to all hospital claims
02 – Dx/age conflict	RTP	Apply to all hospital claims
03 – Dx/sex conflict	RTP	Apply to all hospital claims
04 – MSP alert (v1.0,v1.1 only)	–	Inactive (Do not apply)
05 – E-code as reason for visit	RTP	Apply to all hospital claims
06 – Invalid procedure code	RTP	Apply to all hospital claims
07 – Procedure/age conflict	–	Inactive (Do not apply)
08 – Procedure/sex conflict	RTP	Apply to all hospital claims
09 – Noncovered service (other than statute)	LID	Apply to all hospital claims
10 – Svc submitted for verification of denial (condition code 21)	CD	Apply to all hospital claims
11 – Svc submitted for FI review (condition code 20)	CS	Apply to all hospital claims
12 – Questionable covered svc	CS	Apply to all hospital claims
13 – Service not paid	–	Inactive – 1/1/06
14 – Non-OPPS site of svc	–	Inactive – 1/1/06
15 – Svc units out of range	RTP	Apply to all hospital claims
16 – Multiple bilateral procedures (edit deleted)	–	Inactive (Do not apply)
17 – Inappropriate specification of bilateral proc	RTP	Apply to all hospital claims
18 – Inpatient procedure	LID	Apply to all hospital claims
19 – Mutually exclusive procedure – modifier irrelevant	LIR	Apply to OPPS hospitals only
20 – Comprehensive/ Component proc – modifier irrelevant	LIR	Apply to OPPS hospitals only
21 – Med visit same day as type T or S w.o modifier 25	LIR	Apply to OPPS hospitals only
22 – Invalid modifier	RTP	Apply to all hospital claims
23 – Invalid date	RTP	Apply to all hospital claims
24 – Date out of OCE range	CS	Use OPPS Date 8/1/2000. For non OPPS, use integration date (planned 7/07)
25 – Invalid age	RTP	Apply to all hospital claims
26 – Invalid sex	RTP	Apply to all hospital claims
27 – Only incidental services reported	CR	Apply to OPPS hospitals only
28 – Code not recognized by Medicare	LIR	Apply to all hospital claims
29 – Partial hospitalization service for nonmental health diagnosis	RTP	Apply to OPPS hospitals only
30 – Insufficient services on day of partial hospitalization	CS	Apply to OPPS hospitals only
31 – Partial hospitalization on same day as ECT or type T procedure (edit deleted)	CS	Inactive (Do not apply)
32 – Partial hospitalization claim spans 3 or less days with insufficient services, or ECT or significant procedure on at least one of the days	CS	Apply to OPPS hospitals only
33 – Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	CS	Apply to OPPS hospitals only
34 – Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	CS	Apply to OPPS hospitals only
35 – Only activity therapy and/or occupational therapy services provided	RTP	Apply to OPPS hospitals only
36 – Extensive mental health services provided on day of ECT or significant procedure (edit deleted)	–	Inactive (do not apply)
37 – Terminated bilateral, or terminated proc w units greater than 1	RTP	Apply to OPPS hospitals only
38 – Inconsistency between implanted device and implantation procedure	RTP	Apply to OPPS hospitals only
39 – Mutually exclusive procedure; allowed if CCI modifier coded	LIR	Apply to OPPS hospitals only
40 – Comp/Comp procedure; allowed if CCI modifier coded	LIR	Apply to OPPS hospitals only
41 – Invalid revenue code	RTP	Apply to all hospital claims
42 – Multiple med visits same day w same rev code, w.o CC G0	RTP	Apply to OPPS hospitals only

Notification and Testing of an Integrated Outpatient Code Editor for the July 2007 Release (continued)

Edit	Disposition	Application to Hospitals
43 – Transfusion or blood product exchange w.o specification of blood product	RTP	Apply to OPPS hospitals only
44 – Observation revenue code w non-observation HCPCS	RTP	Apply to OPPS hospitals only
45 – Inpatient separate procedure not paid	LIR	Apply to OPPS hospitals only
46 – PH cond code 41 not allowed for TOB	RTP	Apply to all hospital claims
47 – Svc not separately payable	LIR	Apply to OPPS hospitals only
48 – Rev center requires HCPCS	RTP	Apply to OPPS hospitals only
49 – Svc on same day as inpatient procedure	LID	Apply to OPPS hospitals only
50 – Noncovered based on statutory exclusions	LIR	Apply to all hospital claims
51 – Multiple observations overlap in time (not activated)	–	Inactive (Do not apply)
52 – Observation does not meet minim hours, qualifying diagnosis, and/or 'T' procedure conditions (edit deleted)	–	Inactive (Do not apply)
53 – Observation G codes only allowed with bill type 13x **or 85x**	LIR	Apply to all hospital claims
54 – Multiple codes for the same service	RTP	Apply to all hospital claims
55 – Non-reportable for site of service	RTP	NA to hospitals
56 – E/M or ancillary procedure conditions are not met and line item date for obs code G0244 is not 12/31 or 1/1 (edit deleted)	–	Inactive (Do not apply)
57 – E/M or ancillary procedure conditions are not met and line item date for obs code G0378 1/1	CS	Apply to OPPS hospitals only
58 – G0379 only allowed with G0378	RTP	Apply to OPPS hospitals only
59 – Clinical trials requires diagnosis code V707 as other than primary diagnosis	RTP	Apply to OPPS hospitals only
60 – Use of modifier CA with more than one procedure not allowed	RTP	Apply to OPPS hospitals only
61 – Service can only be billed to the DMERC	RTP	Apply to all hospital claims
62 – Code not recognized by OPPS; alternate code for same service may be available	RTP	Apply to OPPS hospitals only
63 – This OT code only billed on partial hospitalization claims	RTP	Apply to OPPS hospitals only
64 – AT service not payable outside the partial hospitalization program	LIR	Apply to OPPS hospitals only
65 – Revenue code not recognized by Medicare	LIR	Apply to all hospital claims
66 – Code requires manual pricing	CS	Apply to OPPS hospitals only
67 – Service provided prior to FDA approval	LIR	Apply to all hospital claims
68 – Service provided prior to NCD approval	LIR	Apply to all hospital claims
69 – Service provided outside approval period	LIR	Apply to all hospital claims
70 – CA modifier requires patient status code 20	RTP	Apply to OPPS hospitals only
71 – Claim lacks required device code	RTP	Apply to OPPS hospitals only
72 – Service not billable to the fiscal intermediary	RTP	Apply to all hospital claims with the exception of CAH Method II billing revenue codes 096X, 097X, and 098X.
73 – Incorrect billing of blood and blood products	RTP	Apply to OPPS hospitals only
74 – Units greater than one for bilateral procedure billed with modifier 50	RTP	Apply to OPPS hospitals only

Note: All edits that currently apply to providers other than hospitals remain unchanged with this integrated product.

CR = claim rejection, CD = claim denial, RTP = return to provider, CS = claim suspension, LIR = line item rejection, LID = line item denials

Notification and Testing of an Integrated Outpatient Code Editor for the July 2007 Release (continued)

For more complete details, especially regarding the edits of the integrated OCE, please see the official instruction (CR 5344) issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1107CP.pdf*.

Current OCE Web-based training may be found under Medicare Payment Policy training at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1*.

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

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

MLN Matters Number: MM5344
Related Change Request (CR) Number: 5344
Related CR Release Date: November 9, 2006
Related CR Transmittal Number: R1107CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100- 04, Transmittal 1107, CR 5344

The Hospital Outpatient Prospective Payment System Fact Sheet Is now Available

The *Hospital Outpatient Prospective Payment System Fact Sheet* is now available in downloadable format on the Centers for Medicare & Medicaid Services Medicare Learning Network (MLN) at *http://www.cms.hhs.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf*.

This fact sheet provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment rates are set. Print versions of the fact sheet will be available from the MLN in approximately six weeks. ❖

Source: CMS Provider Education Resource 200611-14

ELECTRONIC DATA INTERCHANGE

Returning Paper Claims Received From Clearinghouses

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

Provider Types Affected

All Medicare providers who submit paper claims to clearinghouses for filing with Medicare.

Provider Impact

If a clearinghouse submits claims for you on paper (rather than electronically) your payments may be affected. The Administrative Simplification Compliance Act (ASCA) requires that claims a clearinghouse submits to Medicare on your behalf must be submitted electronically. When your carrier or fiscal intermediary (FI) identifies that a clearinghouse has submitted a claim for you on paper, they will return the claim unprocessed to the clearinghouse.

Background

Section 3 of the Administrative Simplification Compliance Act (ASCA), PL 107-105; the implementing regulation at 42 CFR 424; and the *Medicare Claims Processing Manual* Chapter 24, Section 90-90.6 and its exhibits all require (except in limited situations) that you submit claims to Medicare electronically. And, while ASCA regulations do allow you (as a provider) to submit some, or all, claims on paper in very specific and limited instances; HIPAA covered entities (other than providers) are not eligible for an exemption from these electronic Medicare claim submission requirements.

CR 5341, from which this article is taken, addresses claims that your clearinghouse submits to Medicare on your behalf. To be specific, if you contract with a clearinghouse to send claims to Medicare for you, they are required to submit these claims electronically.

But this being said, there is evidence that some clearinghouses are routinely submitting paper claims without the providers' knowledge. You should be aware that your carriers and FIs, having identified that a provider's clearinghouse has submitted your claims in paper form, will return them back to the clearinghouse without action.

Additional Information

The official instruction (CR 5341) issued to your Medicare contractor (carriers, durable medical equipment regional carrier [DMERC], DME Medicare Administrative Contractor [DME MAC], fiscal intermediary (FI), or Part A/B Medicare administrative contractor [A/B MAC]) regarding paper claims that they receive from clearinghouses is located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R247OTN.pdf*.

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

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

MLN Matters Number: MM5341
Related Change Request (CR) Number: 5341
Related CR Release Date: November 3, 2006
Related CR Transmittal Number: R247OTN
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-20, Transmittal 247, CR 5341

Reporting of Taxonomy Codes To Identify Provider Subparts on Institutional Claims

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

Note: CMS has revised for the second time this *MLN Matters* article on November 9, 2006, to reflect changes made to CR 5243 to include a more complete definition for the 2000A loop in the second bullet under the reporting of taxonomy codes for institutional providers. The article was also revised to reflect the new CR transmittal number, CR release date, and the Web address for accessing CR 5243. All other information remains the same. The revision to this article was published in the October 2006 *Medicare A Bulletin* (pages 13-15).

Provider Types Affected

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

Provider Action Needed
STOP – Impact to You

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

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

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

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

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

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

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

- Report the service facility locator loop (2310E) in an 837-I claim whenever the service was furnished at an address other than the address reported on the claim for the billing or pay to provider.
- Input the taxonomy code in the 837-I provider loop 2000A (billing or pay-to-provider taxonomy code, but do not report taxonomy in this loop if there is no data reported in the service facility locator loop of the claim).
- Submit separate batches of claims for each subpart identified by a different taxonomy code.
- Providers submitting claims for their primary facility and its subparts must submit a nine-digit ZIP code on their claims.
- CMS recommends submitting both the OSCAR number and the NPI on claims submitted through May 22, 2007. (Note that failure to report an OSCAR number that corresponds to your NPI could result in a payment delay.)

Implementation Date

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

Additional Information

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

CR 5243 is the official instruction issued to your Medicare FI regarding changes mentioned in this article. CR 5243 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1108CP.pdf*.

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

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

MLN Matters Number: MM5243 – Revised
Related Change Request (CR) Number: 5243
Related CR Release Date: November 9, 2006
Related CR Transmittal Number: R1108CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1108, CR 5243

Electronic Data Interchange Media Changes

Some contractors allowed providers to submit EDI claims via fax imaging, diskette, tape, or other similar storage media. It is no longer cost effective for the Medicare program to accept claims submitted in this manner.

An EDI transaction is defined by its initial manner of receipt. Depending upon the capability of a carrier, DMERC, or FI and the details as negotiated between carrier/DMERC/FI and electronic claim submitters, an electronic claim could be submitted via central processing unit (CPU) to CPU transmission, dial up frame relay, direct wire (T-1 line or similar), or personal computer modem upload or download (also see section 30.3).

When counting electronic claims for workload reporting, the contractor includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through another FI, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. See § 90 of this chapter for information about application of the claims payment floor when a claim is submitted electronically in a non-HIPAA compliant format.

Carriers, DMERCs, and FIs are not permitted to classify the following as electronic claims for CROWD reporting, for payment floor or Administrative Simplification Compliance Act (ASCA, see section 90) mandatory electronic claim submission purposes:

- Bills received from providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for these bills.
- Adjustment bills (FIs only)
- Misdirected bills transferred to another carrier, DMERC, or FI
- HHA bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.)
- Bills paid by an HMO and processed by the contractor
- Transactions submitted on diskettes, CDs, DVDs or similar storage media that should only be accepted as part of a disaster recovery process

Carriers, DMERCs, DME MACs, A/B MACs, and FIs are no longer permitted to accept claims via fax imaging, tape/diskette/similar storage media. Carriers, DMERCs, DME MACs, A/B MACs, and FIs are to assist billers using such media to transition to more efficient electronic media, such as the free Medicare claim submission or commercially available software that are considered to be more cost effective. ❖

Source: CMS Pub. 100-04, Transmittal 1081, CR 5225

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

December 2006 – February 2007

NPI CMS Module-3, Sub-Parts

When: **Wednesday, December 13, 2006**

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

Type of Event: **Webcast**

Hot Topics (Topics To Be Determined)

When: **Tuesday, January 9, 2007**

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

Type of Event: **Teleconference**

NPI CMS Modules 4 & 5

When: **Thursday, January 18, 2007**

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

Type of Event: **Webcast**

Ask the Contractor (Topics To Be Determined)

When: **Tuesday, February 13, 2007**

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

Type of Event: **Teleconference**

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

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

What Is a Webcast?

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

Online Registration

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Provider Address: _____

City, State, ZIP Code: _____

Source: Julie Stiles, Medicare Provider Outreach &Education

PREVENTIVE SERVICES

November is American Diabetes Awareness Month

The prevalence of diabetes is a growing health concern in the United States.

Approximately 20.8 million people, or 7.0 percent of the population, have diabetes. It is estimated that 20.9 percent of people age 60 years or older have diabetes. Left undiagnosed, diabetes may lead to severe complications such as heart disease, stroke, blindness, kidney disease, and lower limb amputation as well as premature death.

Millions of people have diabetes and don't know it. However, with early detection and treatment people with diabetes can take steps to control the disease and lower the risk of complications.

The good news is that scientific evidence now shows that treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

The Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to remind health care professionals that Medicare provides coverage of diabetes screening tests, for beneficiaries at risk for diabetes or those diagnosed with prediabetes.

The diabetes screening benefit covered by Medicare can help improve the quality of life for Medicare beneficiaries by preventing more severe health conditions that can occur without proper treatment from undiagnosed or untreated diabetes.

Coverage includes the following diabetes screening tests:

- A fasting blood glucose test, **and**
- A post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for nonpregnant adults), **or**
- A two-hour post-glucose challenge test alone.

In addition to the diabetes screening service, Medicare also provides coverage for diabetes self-management training, medical nutrition therapy, certain diabetes supplies, and glaucoma screenings for eligible beneficiaries.

We Need Your Help

CMS needs your help in ensuring that people with Medicare are assessed for and informed about their risk factors for diabetes or pre-diabetes, and that those who are eligible take full advantage of the diabetes screening benefit and all preventive services covered by Medicare for which they may be eligible.

For More Information

For more information about Medicare's coverage of diabetes screening services, diabetes self management training, medical nutrition therapy, diabetes supplies, and glaucoma screening:

- See Special Edition *MLN Matters* article SE0660 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0660.pdf*
- Visit the CMS website: *http://www.cms.hhs.gov/home/medicare.asp*

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

- The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

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

For more information about American Diabetes Month, please visit *http://www.diabetes.org/home.jsp*.

Thank you for joining with CMS during American Diabetes Month to ensure that people with Medicare learn more about diabetes and their risk factors for the disease and that they take full advantage of the diabetes screening services and all other Medicare-covered preventive services and screenings for which they may be eligible. ❖

Source: CMS Provider Education Resource 200611-02

The Great American Smokeout—November 16, 2006

In conjunction with the 30th Anniversary of the Great American Smokeout, the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join us in helping people with Medicare break the smoking habit. This one-day event is designed to encourage 45.1 million adult smokers in the United States to quit. Although smoking rates have significantly declined, 9.3 percent of the population age 65 and older smokes cigarettes. Approximately 440,000 people die annually from smoking related diseases, with the majority of deaths – 68 percent (300,000) – being among people ages 65 and older.

Interest in smoking cessation is increasing. The Centers for Disease Control and Prevention estimated in 2002 that 57 percent of smokers age 65 and over reported a desire to quit. Currently, about 10 percent of elderly smokers quit each year, with 1 percent relapsing. CMS would like to take this opportunity to remind health care professionals that Medicare provides coverage of smoking and tobacco-use cessation counseling for people with Medicare who:

- Use tobacco and have a disease or an adverse health effect that has been found by the U.S. surgeon General to be linked to tobacco use; or
- Are taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on Food and Drug Administration approved information.

Eligible beneficiaries are covered under Medicare Part B when certain conditions of coverage are met, subject to certain frequency and other limitations.

How Can You Help

Seniors who quit smoking experience rapid improvements in breathing and circulation. They decrease their risk for heart disease and stroke within one year of quitting. Talk with your patients about the health benefits of smoking cessation. Older smokers have been shown to be more successful in their quit attempts than younger smokers and respond favorably to their health care providers' advice to quit smoking. Your quit smoking recommendation can make a difference in the quality of life for your patients.

For More Information

- For more information about Medicare's coverage of Smoking and Tobacco-Use Cessation Counseling Services:
  - See *MLN Matters* articles MM3834 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3834.pdf* and MM4104 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4104.pdf*.
  - See Smoking and Tobacco-Use Cessation Counseling Services brochure *http://www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf*.
  - Visit the CMS website: *http://www.cms.hhs.gov/home/medicare.asp*.
- CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.
  - The *MLN* Preventive Services Educational Products Web Page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- For products to share with your Medicare patients, visit *http://www.medicare.gov* on the Web.
- For more information on the Great American Smokeout, please visit *http://www.cancer.org/docroot/PED/ped_10_4.asp** or by telephone: 800-227-2345. Information on how to quit smoking is also available at *http://www.smokefree.gov* and all 50 states, the District of Columbia, and several U.S. territories now have quit lines, which can be reached by telephone: 800–QUIT–NOW (800–784–8669).

Thank you for joining with CMS in encouraging people with Medicare to break the smoking habit. ❖

Source: CMS Provider Education Resource 200611-09

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

National Influenza Vaccination Week: November 27 – December 3, 2006

November 27 to December 3 is National Influenza Vaccination Week. The Centers for Disease Control and Prevention has designated the week after Thanksgiving as national influenza vaccination week.

This week long event is designed to raise awareness of the importance of continuing influenza (flu) vaccination, as well as foster greater use of flu vaccine through the months of November, December and beyond. Since flu activity typically does not peak until February or later, November and December still provide good opportunities to get vaccinated. The Centers for Medicare & Medicaid Services (CMS) invites you to join in this event as an opportunity to ensure that people with Medicare get their flu shot.

The flu vaccine is the best way to protect your patients from the flu. Though Medicare provides coverage for the flu vaccine and its administration, there are still many beneficiaries who don't take advantage of this benefit. If you have Medicare patients who have not yet received their flu shot, we ask that you encourage these patients to protect themselves from the risk and severity of the flu virus. – And don't forget to immunize yourself and your staff.

Protect yourself, your patients, and your family and friends. Get Your Flu Shot.

Remember: Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf*. ❖

Source: CMS Provider Education Resource 200611-16

EDUCATIONAL RESOURCES

Understanding the Remittance Advice for Institutional Providers Web-based Training Course now Available

Understanding the Remittance Advice for Institutional Providers Web-based training (WBT) course is now available through the Medicare Learning Network. This WBT course is designed to provide institutional providers and their billing staff with general remittance advice (RA) information. This course provides instructions to help institutional providers interpret the RA received from Medicare and reconcile it against submitted claims. Course participants will receive guidance on how to read electronic remittance advices (ERAs) and standard paper remittance (SPR) advices, as well as information regarding balancing an RA.

The course also provides an overview of software that Medicare provides free to providers for viewing ERAs. The course takes approximately 90 minutes to complete and participants may receive 0.2 of CEUs (continued education units) to participants who successfully complete this program. To register for taking this WBT course, participants can go to the Medicare Learning Network's Product Ordering Page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

Click on the Web-based training courses section on the left navigational menu and select the course title. ❖

Source: CMS Provider Education Resource 200610-16

Teaching Physicians, Interns and Residents Fact Sheet Available For Order

The updated *Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet* 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: CMS Provider Education Resource 200610-14

Revised Hospice Payment System Fact Sheet now Available

The recently released downloadable version of the hospice payment system fact sheet has been revised and can be accessed on the Centers for Medicare & Medicaid Services Medicare Learning Network (MLN) at *http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf*.

Print versions of the fact sheet will be available from the MLN in approximately six weeks. ❖

Source: CMS Provider Education Resource 200611-13

ORDER FORM - PART A MATERIALS

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

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Sign up to our *eNews* electronic mailing list

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

IMPORTANT ADDRESSES , TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

PROVIDER EDUCATION

Medicare Communication and Education
P. O. Box 45157
Jacksonville, FL 32232-5157

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION

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

OVERPAYMENT COLLECTIONS

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

MEDICARE REGISTRATION

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

Telephone Numbers

PROVIDERS

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

BENEFICIARY

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

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Websites

PROVIDERS

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

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

RAILROAD MEDICARE

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

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

MEDICARE A BULLETIN

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

*** ATTENTION BILLING MANAGER ***