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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Publication Staff

Millie C. Pérez
Kimberly McCaw
Terri Drury
Betty Alix

The *Medicare A Bulletin* is published monthly by Medicare Communication and Education, 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:

Medicare Part A
Publications – 10T
P.O. Box 45270
Jacksonville, FL
32232-5270

About *The Medicare A Bulletin*

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

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

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

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

Who Receives the *Bulletin*?

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

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

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

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

What Is in the *Bulletin*?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

Editor, *Medicare A Bulletin* – 10T
Medicare Communication & Education
P.O. Box 45270
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

Billing Clarification for J2505 Pegfilgrastim

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

Provider Types Affected

Providers who bill Medicare fiscal intermediaries (FIs) for Pegfilgrastim

Important Points to Remember

- Change request 4380 announces to providers that Medicare FIs will make payment for one unit for every 6 mg (or .06 mL) of Pegfilgrastim administered to the beneficiary.
- Make certain when billing for Pegfilgrastim that you show the correct number of multiples of 6 mg, **not** the number of mgs.
- Be aware that FIs will return to provider (RTP) any claim received for 6 units of Healthcare Common Procedure Coding System (HCPCS) code J2505.

Background

The Centers for Medicare & Medicaid Services (CMS) learned that providers are billing incorrectly for Pegfilgrastim. An analysis of claims revealed a number of providers billing multiple units of J2505 per date of service. CMS also noted that many providers billing multiple units of J2505 were consistently billing 6 units per date of service, indicating that 36mg of Pefilgrastim were given.

HCPCS code J2505 is usually administered via a pre-filled syringe of 0.6 mL, which is equivalent to 6 MG of Pefilgrastim.

Providers should ensure they are billing for the number of **multiples of 6 mg** administered rather that the **number of mgs** administered.

Incorrect billing may result in overpayments with subsequent recoupment and/or investigation.

Implementation

The implementation date for this instruction is August 14, 2006.

Additional Information

The official instructions issued to your Medicare FI regarding this change can be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R949CP.pdf*.

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

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

MLN Matters Number: MM4380
Related Change Request (CR) Number: 4380
Related CR Release Date: May 12, 2006
Related CR Transmittal Number: R949CP
Effective Date: August 14, 2006
Implementation Date: August 14, 2006

Source: CMS Pub. 100-04, Transmittal 949, CR 4380

Billing Clarification for Pegfilgrastim—HCPCS Code J2505

The Centers for Medicare & Medicaid (CMS) has performed an analysis of paid claims that revealed a number of hospital outpatient providers billing multiple units of J2505 per date of service. It was noted that many of the providers billing multiple units of HCPCS code J2505, were consistently billing 6 units per date of service, indicating that 36 mg of Pegfilgrastim were given.

The descriptor for HCPCS code J2505 is: injection, pegfilgrastim, 6 mg. **Therefore, when billing for pegfilgrastim, providers must ensure that the number of units reported indicates the multiples of 6 mg administered rather that the number of mgs administered.**

Incorrect billing of this nature results in overpayments with subsequent recoupment and/or investigation. ❖

Source: CMS Pub. 100-4, Transmittal 949, CR 4380

Hold on Medicare Payments—Full Replacement of Rescinded CR 4349

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

Note: CMS has rescinded change request (CR) 4349 and reissued the applicable information under CR 5047 – Hold on Medicare Payments. The article related to CR 4349 was published in the Third Quarter 2006 *Medicare A Bulletin* (page 33).

Provider Types Affected

Providers and physicians who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) for their services

Key Points

- A brief hold will be placed on Medicare payments for **ALL** claims (e.g., initial claims, adjustment claims, and Medicare secondary payer claims) for the last **nine** days of the federal fiscal year, i.e., September 22, 2006-September 30, 2006.
- In essence, no payments on claims will be made from September 22-30, 2006. Providers need to be aware of these payment delays, which **are mandated by section 5203 of the Deficit Reduction Act (DRA) of 2006.**
- Accelerated payments using normal procedures will be considered.
- No interest will be accrued or paid, and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.
- **All** claims held as a result of this one-time policy that would have otherwise been paid on one of these **nine** days will be paid on **October 2, 2006**.

Additional Information

This policy applies only to claims subject to payment. It does not apply to full denials and no-pay claims. It also does not apply to periodic interim payments, home health request for anticipated payments, cost reports settlements, and other non-claim payments.

Additionally, Medicare contractors will continue to apply the fourteen day electronic claim payment floor and the 29-day paper claim payment floor. On a case-by-case basis, Medicare FIs, RHHIs or carriers may make adjustments, after October 1, 2006, for extenuating circumstances raised by a provider. For example, adjustments may be made to not charge a provider interest on an overpayment for those days for which offsets could not be made due to the hold of payments required by this DRA provision.

Please note that:

- Payments will not be staggered
- No advance payments during the nine-day hold will be allowed.

CR 5047 is the official instruction issued to your FI, RHHI, or carrier regarding changes mentioned in this article. CR 5047 may be found by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R944CP.pdf*.

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

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

MLN Matters Number: MM5047
Related Change Request (CR) Number: 5047
Related CR Release Date: May 10, 2006
Related CR Transmittal Number: R944CP
Effective Date: September 22, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 944, CR 5047

Coverage of Prescription Niacin Products Under Part D for 2006

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

Provider Types Affected

Physicians and other providers who prescribe medications for Medicare patients under Medicare Part D

Key Points

- On April 11, 2006, the Centers for Medicare & Medicaid Services (CMS) informed Medicare Part D prescription drug coverage plans, via a memorandum titled **"CMS Clarification of Coverage of Prescription Niacin Under Part D,"** that was issued over the Health Plan Management System (HPMS), that prescription niacin products (Niaspan®, Niacor®) can be a covered Part D drug for treatment of dyslipidemic therapy and may be included on Medicare prescription drug plan formularies. Medicare prescription drug plans have the option of covering those drugs immediately.
- For the remainder of contract year 2006, Medicare Part D plans may put prescription niacin products (Niaspan®, Niacor®) on their formularies, but they are not required to do so. As a result, enrollees may obtain coverage of prescription niacin products either as a formulary drug or as a non-formulary drug through the exceptions process.
- For contract year 2007, prescription niacin products (e.g., Niaspan® and Niacor®) used at dosages much higher than appropriate for nutritional supplementation should be considered for formulary inclusion similar to all other Medicare Part D drugs.
- Please refer to the *Additional Information* section of this Special Edition article for specific information regarding two methods for Part D Medicare beneficiary enrollees to obtain prescription niacin products for the remainder of 2006.

Background

The prescription niacin products are used therapeutically for the treatment of dyslipidemia at much higher dosages than are appropriate for nutritional supplementation. They do not serve as a nutritional supplement or to address a vitamin deficiency. For these reasons, CMS has decided that prescription niacin products should not be considered a prescription vitamin for purposes of Medicare Part D coverage.

Prescription niacin products are not universally excluded from coverage under the Medicare prescription drug program. This reverses an earlier February 3, 2006 decision by CMS that prescription niacin products (Niaspan®, Niacor®) are prescription vitamins and therefore are excluded from the definition of a Medicare Part D drug under the statute.

Additional Information

Prescribing Prescription Niacin products (Niaspan®, Niacor®) for the Remainder of 2006

For Medicare beneficiaries in plans that INCLUDE prescription niacin products on their formulary:

- If prescription niacin products **are not subject** to prior authorization – a Medicare prescriber writes a prescription for the prescription niacin product and the Part D enrollee has the prescription filled at a local retail pharmacy or a mail order pharmacy. If the enrollee is a resident of a long-term care facility, the prescription will be filled by the long-term care pharmacy serving that facility.
- If prescription niacin products **are subject** to prior authorization–the Medicare prescriber must file a prior authorization request on behalf of the enrollee.
- Each Medicare Part D plan has its own form, available on the plans' websites (some plans have specific forms for particular drugs; others use a standard prior authorization form).
- Plans must approve or inform the enrollee why they have disapproved a prior authorization request within 72 hours. An enrollee or an enrollee's physician can request an "expedited coverage determination" for a decision within 24 hours if the enrollee's health, life, or ability to regain maximum function may be seriously jeopardized by waiting 72 hours for a decision.
- If a Medicare Part D plan disapproves a prior authorization request (i.e., makes an "adverse coverage determination"), the enrollee has the right to request a redetermination from the plan sponsor (see below).

For plans that **do not** have prescription niacin products (Niaspan®, Niacor®) on their formularies:

- If a Medicare beneficiary is currently taking a prescription niacin product and is enrolled in a Medicare Part D plan that does not include prescription niacin products on its formulary, the beneficiary can now ask for an exception to get coverage for a prescription niacin product (see below).
- If a Medicare beneficiary who is currently taking a prescription niacin product enrolls in a Medicare Part D plan that does not include prescription niacin products on its formulary, the plan is required to have a process to ensure the enrollee's smooth transition into the plan and to allow the enrollee time to obtain medically necessary exceptions to the plan's formulary.
- Many Medicare Part D plans have adopted a "first fill" policy that will allow enrollees to have their first prescription for the prescription niacin product filled even if prescription niacin product are not on the plan's formulary. This will allow Medicare beneficiaries who have been stabilized on a prescription niacin product to continue taking it while they request exceptions.
- The transition process is a very temporary solution, however, and enrollees and providers should not delay pursuing exceptions. Prescribers may advise enrollees to contact their plans for more information about their plan's transition process.

Exceptions and Appeals

If a physician prescribes a non-formulary drug for an enrollee, the enrollee or physician must request an exception, which is a type of coverage determination, to obtain

Coverage of Prescription Niacin Products Under Part D for 2006 (continued)

the non-formulary drug for the enrollee. If the plan sponsor's coverage determination is unfavorable, the enrollee may appeal the plan sponsor's decision.

Exceptions

An enrollee or an enrollee's physician has the right to request an **exception** for coverage of non-formulary prescription niacin products. The enrollee's prescribing physician should submit a statement supporting the exception request. The Part D plan must notify the enrollee of its decision within 72 hours after receiving the physician's supporting statement. If the enrollee or physician requests an expedited decision, the plan sponsor must notify the enrollee of its decision within 24 hours after receiving the physician's supporting statement if the plan determines, or the enrollee's physician indicates, that applying the 72-hour timeframe may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

The plan must grant the exception if it determines that the requested drug is medically necessary, consistent with the physician's statement. The Medicare provider physician's statement must state that the exception is medically because all of the covered Medicare Part D drugs on any tier of the plan's formulary for treatment of the same condition would not be as effective as prescription niacin products, would have adverse effects, or both.

Appeals

If a plan sponsor issues an adverse coverage determination, the decision may be appealed. There are five successive levels of appeal.

- If a plan sponsor issues an unfavorable coverage determination, the enrollee has the right to request a standard or expedited **redetermination** with the plan sponsor within 60 calendar days from the date of the notice of the plan sponsor's adverse coverage determination. Enrollees or their prescribing physician can submit written evidence and legal arguments for coverage of prescription niacin products during the redetermination process. The plan sponsor must notify the enrollee of its decision within seven calendar days after receiving a standard request, or 72 hours after receiving an expedited request.
- If the plan sponsor's redetermination decision is unfavorable, the enrollee has the right to request **reconsideration** by the independent review entity (IRE) that contracts with CMS. This request must be submitted in writing within 60 calendar days from the date of the notice of the plan sponsor's adverse redetermination decision. The IRE must solicit the views of the prescribing physician orally or in writing and must notify the enrollee of its decision within seven calendar days after receiving a standard request, or 72 hours after receiving an expedited request.
- If the IRE denies the request for coverage and the amount remaining in controversy is at least $110, the Medicare beneficiary enrollee has the right to request a **hearing before an administrative law judge** (ALJ). The request must be filed in writing within 60 calendar days from the date of the notice of the IRE's adverse reconsideration determination.
- If the ALJ's decision is unfavorable, the enrollee has the right to request a review by the **Medicare Appeals Council.** The request must be filed in writing within 60 calendar days from the date of the notice of the ALJ's adverse decision.
- If the MAC issues an adverse decision, the enrollee has the right to request judicial review of the ALJ's decision by **filing a civil action in U.S. District Court** if the amount remaining in controversy is at least $1,090. The request must be filed in writing within 60 calendar days from the date of the notice of the MAC's adverse decision.

For additional information, CMS has a number of MLN Matters special edition articles on the new drug program, especially the fourth and fifth articles in the MLN Matters series about Medicare's new prescription drug coverage. SE0537, *New Educational Products Available*, is the fourth article in the series and may be found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0537.pdf*.

SE0541, *More Web-based Educational Products Available on Medicare Prescription Drug Coverage*, is the fifth article in the series. It is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0541.pdf*.

MLN Matters Number: SE0626
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0626

Issue with Code Pair Edit 92526/G0283 Under the Correct Coding Initiative

The Centers for Medicare & Medicaid Services has notified fiscal intermediaries that an erroneous modifier indicator in the outpatient prospective payment system (OPPS) outpatient code editor (OCE) for a code pair edit, subject to the Correct Coding Initiative (CCI), resulted in a line item rejection of HCPCS code G0283 when billed with *CPT 92626*.

The edit for code pair 92526/G0283, with incorrect modifier indicator of "0," was implemented **on January 1, 2005,** for hospitals subject to OPPS (type of bills (TOB) 12x and 13x). In addition to the OPPS hospitals, this edit was effective **on January 1, 2006,** for the following providers:

- Skilled nursing facilities – TOBs 22x and 23x)
- Comprehensive outpatient rehabilitation facilities – TOB 75x)
- Outpatient physical therapy and speech language pathology service providers – 74x
- Home health agencies – TOB 34x.

With the OPPS OCE July 2006 release, the modifier indicator for CCI code pair 92526/G0283 will be changed to "1"to allow the use of modifier 59 when reporting services for HCPCS code G0283 with *CPT 92526* when performed by different therapy disciplines in outpatient providers of Part B therapy services.

After the implementation of the OPPS OCE July 2006 release, scheduled for July 3, 2006, First Coast Service Option, Inc. will reprocess and adjust claims where the line item for HCPCS G0283 was rejected based on the "0"modifier indicator.

No Action Required by Providers

Providers who have claims with a line item incorrectly rejected because of this issue do **not** need to take any action. An updated remittance advise will be sent after the automatic adjustments on the affected claims are performed. ❖

Source: CMS Joint Signature Memorandum 06433, May 8, 2006

Inconsistency in Liability Assignment for Screening Services

Effective for claims submitted on or after April 1, 2004, change request (CR) 2634 (transmittal 25) was implemented regarding the billing of noncovered services to fiscal intermediaries.

However, due to an issue within the Fiscal Intermediary Shared System (FISS), the Medicare summary notice (MSN) message for noncovered screening services may be displaying incorrectly for services going back to April 1, 2004. Instead of the MSN reflecting the provider as liable, the message printed on the MSN indicated that the beneficiary was liable. Unless the GA modifier/32 occurrence code is present on the claim for the service, and the advance beneficiary notice (ABN) was provided to the beneficiary, the provider is liable.

Once FISS has been corrected, First Coast Service Options, Inc. (FCSO) expects to have the message display problem corrected with all MSNs processed July 3, 2006. At that point, we will reprocess all claims that displayed the incorrect liability message to reflect the correct message on the claim history.

Reminder: Providers are liable for screening services denied due to frequency limits if appropriate advanced beneficiary notice (ABN) is not provided to the patient prior to the services being provided. If an ABN is provided to the beneficiary prior to the services being provided, the provider should indicate the date the ABN was provided with submission of the 32 occurrence code. Modifier GA should also be indicated on the line item for the screening service. If occurrence code 32 and modifier GA are not submitted on the claim, then Medicare will hold the provider liable.

Complete information is available on CR 2634 at *http://www.cms.hhs.gov/Transmittals/Downloads/R25CP.pdf*. ❖

Source: CMS Pub. 100-04, Transmittal 25, CR 2634

Quarterly Medicare Summary Notice Printing Cycle

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), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries

Impact on Providers

This article is based on change request (CR) 5062, which instructs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) to print and mail no-pay medicare summary notices (MSNs) on a quarterly schedule (rather than the current monthly schedule).

Quarterly Medicare Summary Notice Printing Cycle (continued)

Background

Current instructions from the Centers for Medicare & Medicaid Services (CMS) require all Medicare contractors to issue a MSN to each beneficiary for whom a claim was processed during the last 30 days (possibly for services received more than 30 days ago) to inform the beneficiary of the disposition of all claims (i.e., a record of services received, the status of any deductibles, and appeal rights).

In an effort to reduce overall operating costs, CR 5062 instructs your intermediary/carrier to change from their current monthly (30 day) no-pay MSN mailing schedule to a quarterly (90 day) no-pay MSN mailing schedule. All MSN information should continue to print; however, summations will occur on a quarterly basis as opposed to a monthly basis.

No-pay MSNs are the standard, system-generated MSNs produced for beneficiaries in which Medicare did not issue payment to the beneficiary for the respective claim. Beneficiaries often need these MSNs in order to obtain payment from another payer/insurer,

In those situations where a no-pay MSN is needed or lost by a beneficiary, they can request a no-pay MSN by calling 1-800 Medicare. On-demand requests will be generated and mailed once the request is made.

In summary, CR 5062 provides the following instructions:

- Beginning no later than October 1, 2006, Medicare contractors will issue no-pay MSNs on a quarterly/90-day mailing cycle as opposed to the previous monthly/30-day mailing cycle.
- MSNs with checks will continue to be mailed out as processed.
- If a beneficiary requests a monthly no-pay MSN (as opposed to the quarterly MSN), then Medicare contractors must generate and mail out the MSN at the time of the request.

Implementation

The implementation date for the instruction is June 12, 2006, for carriers, July 3, 2006, for DMERCs, and September 1, 2006 for FIs.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R955CP.pdf*.

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

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

MLN Matters Number: MM5062
Related Change Request (CR) Number: 5062
Related CR Release Date: May 12, 2006
Related CR Transmittal Number: R955CP
Effective Date: Carriers-June 12, DMERCs July 1, FIs-September 1
Implementation Date: Carriers, June 12, DMERCs, July 3, FIs-Sept. 1

Source: CMS Pub. 100-04, Transmittal 955, CR 5062

July Update to the 2006 Medicare Physician Fee Schedule Database

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

Provider Types Affected

Physicians, providers, suppliers submitting claims to carriers or fiscal intermediaries (FIs) for services paid under the Medicare physician fee schedule (MPFS) provided to Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5102, which amends payment files issued to your carrier/intermediary that were based on the November 21, 2005, Medicare physician fee schedule (MPFS) final rule. Attachment 1 of CR 5102 also includes new category II and category III codes.

Background

The Social Security Act (Section 1848(c)(4); *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Change request 5102:

- Amends payment files issued to your carrier/intermediary based upon the November 21, 2005, MPFS final rule.
- Includes new category II and category III codes.

CR 5102 also instructs that your carrier/intermediary should:

- Give providers 30 days notice before implementing the revised payment amounts identified in CR 5102 (Attachment 1) in accordance with the Medicare Claims Processing Manual (Pub 100-4, Chapter 23, Section 30.1; *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*).

  Note that unless otherwise stated in CR 5102, changes will be retroactive to January 1, 2006.
- Not search their files to either retract payment for claims already paid or to retroactively pay claims.
- Adjust claims brought to their attention.

July Update to the 2006 Medicare Physician Fee Schedule Database (continued)

Changes included in the July update to the 2006 MPFS database (CR5102 (Attachment 1)) are as follows:

CPT/HCPCS Code	ACTION
95991	Non-Facility RVU = 1.50
G0978	Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 *or* *t3a†* gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases
G9125	Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or bcr-abl positive; *blast phase not†* in hematologic, cytogenetic, or molecular remission
G9127	Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or bcr-abl positive; extent of disease unknown, under evaluation, not listed (for use in a Medicare-approved demonstration project)

In addition, effective July 1, 2006, a number of **category II codes** will be added to the MPFSDB with a status indicator of "M". Rather than repeat all those category II codes in this article, we refer you to attachment 1 of CR 5102, which contains the codes and their descriptors. CR 5102 is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R963CP.pdf*.

The long descriptor for **category II code 1000F** has been revised. **The new descriptor is effective for services performed on or after January 1, 2005** (date code was implemented).

Category II Code *1000F*
Long Descriptor: *Tobacco use assessed (CAD1, CAP1, COPD1, DM4, PV1)*

The descriptors for **category II code *4015F*** have been revised. The new descriptors are **effective for services performed on or after January 1, 2006** (date code was implemented).

Category II Code *4015F*
Long Descriptor (Revised): *Persistent asthma, preferred long term control medication or acceptable alternative treatment, prescribed (Asthma[1])*
Short Descriptor: Persist asthma medicine ctrl

Also, note that G code (G8085) was inadvertently not included in the April update.

G8085 is added with a status indicator of "M" and is effective for services on or after January 1, 2006. The long descriptor for G8085 is "End-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula."

Effective July 1, 2006, the category III codes of *0155T-0161T* will be added to the MPFSDB. The descriptors and other indicators for these codes may also be found in attachment 1 of CR 5102.

Implementation

The implementation date for CR 5102 is July 3, 2006

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R963CP.pdf*.

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

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

MLN Matters Number: MM5102
Related Change Request (CR) Number: 5102
Related CR Release Date: May 26, 2006
Related CR Transmittal Number: R963CP
Effective Date: January 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 963, CR 5102

Competitive Acquisition Program for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and Other Issues Proposed Rule (CMS 1270-P)

Overview

Providers and suppliers that furnish certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to Medicare beneficiaries under Medicare Part B will have an opportunity to participate in a competitive acquisition program (the "Medicare DMEPOS Competitive Bidding Program"). This program will improve the effectiveness of Medicare's payments for certain DMEPOS, reduce beneficiary out-of-pocket expenses, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services. Today the Centers for Medicare & Medicaid Services (CMS) issued a rule describing the proposed methodologies for selecting the areas in which the program will be first implemented and the items to be included in the program and for determining payments under the program, among other provisions. This fact sheet identifies some key elements but please refer to the proposed rule for a full discussion of the issues involved.

Legislative Background

Section 302(b) (1) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) requires the Secretary to establish and implement the Medicare DMEPOS Competitive Bidding Program. This program will change the way that Medicare pays for DMEPOS under Part B of the Medicare program by utilizing bids submitted by DMEPOS suppliers to establish Medicare payment amounts.

The MMA requires that competitive bidding programs be established and implemented in areas throughout the United States but provides the Secretary with the authority to phase in competitive bidding programs. Competition under the program would be phased in beginning in 2007 in 10 of the largest metropolitan statistical areas (MSAs), in 80 of the largest MSAs in 2009, and in other areas after 2009. Areas that may be exempt from competitive acquisition of DMEPOS include rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service.

The Secretary may also determine which items will be part of the competitive acquisition program, focusing first on the highest cost and volume items and services or those items and services that have the largest savings potential.

The MMA requires suppliers to achieve and maintain compliance with CMS DMEPOS quality standards in order to submit a bid and be awarded a contract to become a contract supplier for certain DMEPOS in competitive bidding areas. CMS will establish the new DMEPOS quality standards through program instructions and post them on the CMS website.

The MMA also requires the Secretary to establish a Program Advisory and Oversight Committee (PAOC) to provide advice and assistance to the Secretary in implementing the Medicare DMEPOS Competitive Bidding Program. The PAOC members were appointed by the Secretary and represent a broad mix of relevant industry, consumer, and government entities. CMS has presented numerous issues to the PAOC on the development and implementation of this program and utilized their expertise, knowledge and experience to formulate the proposed methodologies.

Proposed Program

Under the proposed rule, suppliers in a competitive bidding area would submit bids for selected items using a request for bid form provided by CMS. The CMS would use this information to select winning suppliers.

Selection of Competitive Bidding Areas

CMS proposed to select the first 10 competitive bidding areas by looking at a combination of factors including the total population in an area, total Medicare spending in the area on DMEPOS items, per beneficiary spending, and the number of suppliers per beneficiary. However, we proposed to exclude the three MSAs with a population of more than nine million (New York, NY; Los Angeles, CA; and Chicago, IL) from the 2007 implementation to allow us to obtain additional experience with competitive acquisition before implementing the program in the areas with the largest population. The proposed rule provides illustrative data on the top 50 metropolitan statistical areas (MSA) but we propose to use the most recent data available to actually select the sites under the proposed methodology.

Selection of Competitive Acquisition Items and Services

The MMA gives CMS discretion to phase in items for bidding based on high cost and volume or largest savings potential. CMS proposes to group similar items used for treatment into product categories, such as hospital beds and accessories, so that beneficiaries will be able to receive all related items in the product category from one supplier to minimize disruption of services. CMS proposes to identify the 20 top product categories in terms of total Medicare spending, from which the items or groups of items for inclusion in the bidding process would be selected for the first phase of the program. The bid items may vary by competitive bidding areas.

Bidding

Under the proposed rule, suppliers in a competitive bidding area would submit bids for product categories and CMS would determine the winning suppliers based on these bids. The rule proposes a specific methodology for determining winning bid amounts based on the total capacity needed to meet Medicare demand for DMEPOS items in the area. The Medicare payment amounts would be the median of the winning suppliers' bids for selected items. Suppliers whose bids are lower than the Medicare payment amount set under the competitive bidding program could offer a rebate to beneficiaries.

Competitive Acquisition Program for Certain DMEPOS and Other Issues Proposed Rule (continued)

Suppliers

Suppliers must have a Medicare supplier billing number to submit claims for Medicare payment. In addition, all suppliers must be accredited by a CMS-approved accreditation organization to ensure they meet applicable quality standards. Failure to meet the standards can result in the revocation or suspension of billing privileges and the inability to participate in the Medicare Competitive Bidding Program.

The proposed rule provides an opportunity for suppliers to develop a network to collectively bid to furnish items included in a product category under the Medicare Competitive Bidding Program.

This provision would provide important assistance to small suppliers. We also proposed a grandfather provision to allow suppliers who are not selected to participate in the Medicare Competitive Acquisition Program to continue to serve their existing customers.

Impact on Medicare Beneficiaries

The DMEPOS competitive bidding program would have a significant positive impact on Medicare beneficiaries by reducing their out-of-pocket costs. Beneficiary co-payments would be reduced due to lower Medicare DMEPOS prices set through competition. Additionally, beneficiaries may receive rebate offers from the selected contracted suppliers. Because contracted suppliers would be accredited as meeting quality standards, beneficiaries would be assured access to quality medical equipment and DMEPOS supplier services.

Tips for the Public

The proposed rule seeks public comment on a number of key elements of the DMEPOS Competitive Bidding Program. Key elements include:

- The proposed methodology for selecting the ten MSAs for 2007.
- Alternatives to defining competitive bidding areas.
- The proposed methodologies for determining whether an area within an urban area that has a low population density is not competitive.
- Standards for exempting particular rural areas from competitive bidding.
- Methodologies for setting the single payment amount.
- The proposed approach for calculating market demand and estimating supplier capacity.
- Best method of weighting individual items within a product category to determine the composite bid.
- Financial standards evaluation criteria and required documentation.
- Additional options to ensure that small suppliers have opportunities to be considered for participation in the program.
- A process to determine items and/or HCPCS codes for identifying off-the-shelf (OTS) orthotics subject to competitive bidding.
- The proposed rebate process outlined and how to handle those cases in which the rebates would exceed the co-payment amount.

The proposed rule outlines additional requirements that include: 1) application processes to become a CMS approved accreditation organization for the purpose of applying CMS new quality standards for all DMEPOS suppliers; 2) a new fee schedule for home dialysis supplies and equipment that are still paid on a reasonable charge basis; 3) clarification of Medicare policy on the scope of the statutory eyeglass coverage exclusion; and 4) implementation of a revised methodology for calculating fee schedule amounts for new DMEPOS items.

The proposed rule is on display today at the Office of the Federal Register and will be published in the May 1, 2006, *Federal Register.* Public comments were accepted until June 30, 2006, and a final rule will be published later this year. ❖

Source: CMS Provider Education Resource 200605-23

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

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

Provider Types Affected

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

Background

Once a Centers for Medicare & Medicaid Services (CMS) data system recognizes a beneficiary has enrolled in an MA organization, the MA organization receives capitation payments for the beneficiary. In some cases, enrollments with retroactive dates are processed. The result is that Medicare may pay for the services rendered during a specific period twice; once for the specific service which was paid by the fee-for-service Medicare contractor and secondly by the MA payment systems in the monthly capitation rate to the plan. Change request 5105 and *MLN Matters* 5105 (see *http://www.cms.hhs.gov/MLNArticles/downloads/MM5105.pdf*) describe how CMS ensures that any fee-for-service claims that are approved for payment erroneously are adjusted and overpayments recovered by Medicare carriers and/or FIs.

A variety of CMS systems issues over the past 18 months prompted CMS to recently synchronize Medicare Advantage enrollment and disenrollment information. As a result, providers may have claims that were affected by this synchronization in one of two ways, both of which are addressed below.

Medicare Policy Regarding Collection of Fee-for-Service Payments Made During Periods of Managed Care (continued)

Scenario 1. Claims Paid in Error

About 386,000 claims for about 100,000 beneficiaries enrolled in MA organizations have been identified as having been paid on a fee-for-service basis by FIs or carriers during this time. FIs and carriers will, over the next six months, adjust these claims and seek overpayments.

Where such an overpayment is recovered from a provider, the related remittance advice for the claim adjustment will indicate reason code 24, which states:

> "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan". Upon receipt, providers are to contact the MA plan for payment.

Providers Who Bill Carriers

The carrier will alert you via letter or alternate method of the following:

- The beneficiary was in a MA plan on the date of service.
- You should bill the managed care plan.
- The plan identification number.
- Where to find the plan name and address associated with the plan number on the CMS Internet site.

Providers Who Bill Fiscal Intermediaries

The adjustment will occur automatically, and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly. To associate plan identification numbers with the plan name, go to the CMS website *http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage*.

The number that will appear on the contractor notices will begin with 'H'. For the following 11 plans, the alpha prefix is actually an 'R'. A technical correction will be made in the CMS systems in October 2006. Prior to October, when using the Web page look up tool, make sure to replace the 'H' with an 'R'. The 11 plans are:

R3175 R5287 R5342 R5553 R5566 R5595
R5674 R5826 R5863 R5941 R9943

Medicare Advantage Plans Have Been Notified

MA plans know that the resynchronization may result in an increase in payment requests from providers who had claims previously paid, but subsequently overturned by Medicare fee-for-service FIs and carriers. Whenever CMS reverses fee-for service payments as a result of confirmed retroactive enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary. The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations.

Scenario 2. Claims Denied in Error

Because CMS has synchronized Medicare advantage enrollment and disenrollment information, it is possible that fee-for-service claims were previously denied because the beneficiary was incorrectly identified as being a member of an MA plan. If a provider believes past claims have been denied in error due to problems in enrollment and disenrollment information, those claims may now be resubmitted. For any Part B services, the 10 percent reduction for timely filing will be waived.

Additional Information

For more information regarding the manualization of this policy, see the MLN Matters article on the CMS website at *http://www.cms.hhs.gov/MLNArticles/downloads/MM5105.pdf*.

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

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

MLN Matters Number: SE0638
Related Change Request (CR) Number: 5105
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source:CMS Special Edition MLN Matters Article SE0638

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

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

Provider Types Affected

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

Impact on Providers

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

Background

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

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

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

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

Overview of the Medicare Advantage Plan Enrollment Process

When an MA plan enrollment is processed retroactively:

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

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

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

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

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

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

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

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

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

In summary, CMS issued CR 5105 to:

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

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

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R97FM.pdf*.

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

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

MLN Matters Number: MM5105
Related Change Request (CR) Number: 5105
Related CR Release Date: May 26, 2006
Related CR Transmittal Number: R97FM
Effective Date: October 1, 2003
Implementation Date: June 26, 2006

Source: CMS Pub. 100-06, Transmittal 97, CR 5105

Announcing New Interactive Voice Response Unit Features

First Coast Service Options, Inc. (FCSO) strives to provide you, our customers, quick access to information and service to help you better manage your work. In keeping with our continuous service improvements, we are proud to announce the addition of new features to our provider interactive voice response unit (IVR). You will now be able to use new **speech recognition** technology; as well as, the familiar **touch-tone** format, while navigating through the IVR to retrieve needed information. You can continue to access the IVR by dialing the same toll free number 1-877-602-8816.

Authentication

Please have the following information available for authentication, to protect the privacy of all individuals (HIPAA requirement), to access patient eligibility, deductible and claims information via the IVR.

- Provider number
- Provider name
- Beneficiary Medicare number
- Beneficiary name as printed on the red, white, and blue Medicare card
- Beneficiary date of birth
- Date of service (if applicable)

Speech Recognition

This new feature has been added under all the menu options where authentication is required, and can be used when responding in the IVR. In order to optimize results when speaking, we offer the following tips:

- Use a telephone with a handset or headset
- Avoid using a speakerphone or cell phone
- Avoid calling from areas with loud background noise
- Speak the requested information clearly

Note: After two unsuccessful attempts of voicing the requested information, you will be required to key the information on the third attempt.

Touch Tone Tips

In the event the system does not accept the spoken information, touch-tone is still available and can be used under all menu options. In order to receive the desired results, when using touch-tone, we offer the following tips:

- Enter dates in the following format (MMDDYYYY).
- Press * to signal you are entering an alpha suffix or letter.
- Press the key that includes the letter, then the corresponding number that denotes where the letter is located on the number key.
- Press the pound (#) sign after all desired letters have been keyed to end your entry.

Additional assistance is available throughout the IVR and/or on the provider IVR operating guide, which is available at: *http://www.floridamedicare.com*.

"WE WILL KEEP YOU UPDATED"

Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

On **May 1, 2006**, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately**.

Initially, these applications will be available only from the CMS provider enrollment website. The link for that CMS website is listed in the *Additional Information* section of this article.

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

Key Points

This special edition outlines the significant revisions to the Medicare enrollment applications and they are as follows:

Enhancements

- Improved the application's aesthetics via a more visually appealing format, larger font, clarified headings, and the use of plain language.
- Revised cover page to include instructions that help applicants submit the correct enrollment application, inform applicants where to mail the application, and provide information on the documents that must be furnished with the enrollment application.
- Added tips on how to avoid delays in the enrollment process.
- Redesigned Section 17 (Supporting Documentation) to make it easier for providers and suppliers to know which documents must be submitted with an enrollment application.

Significant Changes

- Require the submission of the National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application.
- Require that providers and suppliers complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT – making a change to their enrollment information.
- Removed Sections 9 (Electronic Claims Submission Information), 10 (Staffing Companies), and 11 (Surety Bonds) from the application. In addition, information regarding overpayments no longer must be submitted.

Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)

- A sole proprietor who incorporates (and who is the sole owner of that business) only needs to complete the CMS 855I form. In the past, such suppliers had to complete the CMS 855B, CMS 855I and CMS 855R. However, the person will still need to report information about the practice, such as the legal business name and adverse legal history.

Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)

- Removed the requirement to collect crew member and certain vehicle information from ambulance companies in **Attachment 1** of the application.
- Revised the independent diagnostic testing facility information contained in **Attachment 2** of the application.

Application-Specific Changes for Institutional Providers (CMS-855A)

- Eliminated questions dealing with fiscal intermediary preferences. This change implements section 911(d) (2) (B) of the Medicare Modernization Act.

  See MLN Matters article SE0582 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0582.pdf* for further information.

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit on the CMS website *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Special Edition article SE0612 contains helpful information about the Medicare enrollment process. You may review the article on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf*.

MLN Matters Number: SE0632
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0632

Facilitating Your Medicare Enrollment

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately**.

Initially, these applications will be available only from the CMS provider enrollment website. The link for that CMS website is listed in the *Additional Information* section of this article.

Key Points

This special edition article provides additional information regarding the submission of a Medicare enrollment application.

All Provider Enrollment Applications

To ensure timely processing of your application, make certain to completely fill out the application and provide all required supporting documentation at the time of filing.

Section 17 of the Medicare enrollment application lists the types of supporting documentation that you will need to submit with your enrollment application. In addition to providing the documentation previously required, all applicants are required to:

- Submit their national provider identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application; and complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT - making a change to their enrollment information.

To obtain a list of specific supporting documentation that you must submit with your enrollment application, contact the designated Medicare fee-for-service contractor serving your area before submitting your application.

Contractor Request for Additional Information

At any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application. Applicants are responsible for providing this documentation in a timely manner. Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

Applications Received Through June 2, 2006

Medicare contractors will continue to accept the 11/2001 version of the Medicare enrollment applications through June 2, 2006, as long as the application is complete and contains the NPI notification from NPPES. In addition, providers and suppliers who choose to use the 11/2001 version of the 855 will be required to complete and submit Section 1 or Section 4 (completed by the provider) of the 04/06 version of the CMS-855. Providing this information will ensure that Medicare is able to link existing Medicare identification number(s) to the NPI that the provider or suppliers plan to use for billing purposes.

Specifically, Section 1 must be completed by physician assistants and providers reassigning all of their benefits, as this is where NPI data is reported. All other providers must furnish the NPI and Medicare identification number in Section 4 of the CMS-855; this is the only data that must be reported in Section 4.

Applications Received On or After June 5, 2006

All applications received on or after June 5, 2006, must be filed using the 04/06 version of the CMS-855 and contain all supporting documentation, including the NPI notification and the CMS-588.

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit the CMS website at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Special edition article SE0612 and SE0632 contain helpful information about the Medicare enrollment process. You may review the article on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf*, and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0632.pdf*, respectively, on the CMS site.

MLN Matters Number: SE0634
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0634

Revised CMS-855 Medicare Provider Enrollment Applications

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised CMS-855 Medicare provider enrollment applications. As part of the revised enrollment process, initial enrollees and existing enrollees making changes to their enrollment information must include their National Provider Identifier (NPI) number and a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with the enrollment application. No initial application can be approved and no updates to existing enrollment information can be made without this NPI information.

All health care providers and suppliers who bill Medicare are required to obtain their NPI in advance of enrolling in or changing their Medicare enrollment data.

If you are an individual or sole proprietor, who furnishes health care, you are eligible for one and only one NPI. If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself and an NPI for your corporation or LLC. If you are an organization that furnishes health care, you may determine that you have components, called "subparts," that need their own NPI. For additional information about the NPI, please go to *http://www.cms.hhs.gov/NationalProvIdentStand/*.

Source: CMS Provider Education Resource 200605-16

If you have not yet obtained your NPI number, CMS encourages you to do so soon. This applies even if you are not enrolling or making a change to your Medicare enrollment information. An information sheet designed to provide basic information about the NPI, including the three different ways to apply for your NPI is available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/EnrollmentSheet_WWWWH.pdf*.

Whatever method you use to obtain your NPI, be sure to keep this information, share it with your health care partners, and update your information with NPPES whenever any of the information used to get your NPI changes.

Starting May 23, 2007, the NPI will replace all of your existing provider numbers that you use to bill Medicare, Medicaid, and other health care payers. Although this date is still a year away, you should begin sharing this information with Medicare, other payers, and your other health care partners in order to make the transition to NPI as smooth as possible.

For more information about the revised provider enrollment process, please contact your Medicare contractor or go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll*. ❖

MEDICARE SECONDARY PAYER

Modifications to Online Medicare Secondary Payer Questionnaire: This CR Rescinds and Replaces CR 4098

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

Note: CMS has rescinded change request (CR) 4098 and reissued the applicable information under CR 5087. The article related to CR 4098 was published in the First Quarter 2006 *Medicare A Bulletin* (pages 42-46).

Provider Types Affected

Medicare physicians/providers/suppliers that, upon providing services to a Medicare patient, use a questionnaire to determine other insurance coverage that may be primary to Medicare

Provider Action Needed
STOP – Impact to You

Questions have arisen over Part V of the model Medicare Secondary Payer questionnaire.

CAUTION – What You Need to Know

CR 5087 provides clarification regarding Part V, provides major revisions to other parts of the model Medicare Secondary Payer questionnaire, and rescinds and replaces CR 4098.

GO – What You Need to Do

You should replace any previous versions of the model questionnaire with the new version, available as an attachment to CR 5087.

Background

In 1980, Congress enacted provisions that made Medicare the secondary payer to certain additional primary plans (group health plans, workers' compensation plans, liability insurance, or no-fault insurance). To help you identify such Medicare secondary payer (MSP) situations, CMS has developed a model Medicare Secondary Payer questionnaire (found in IOM 100.05 (Medicare Secondary Payer Manual) Chapter 3, Section 20.2.1). You may use this model questionnaire as a guide, at each inpatient and outpatient admission, to help identify other payers that may be primary to Medicare.

CR 4098 (released October 21, 2005) made changes to this model questionnaire that have generated several questions, specifically regarding PART V (Disability). In response, CR 5087 (from which this article is taken) incorporates the changes that were made in CR 4098, modifies the changes previously made to PART V to address the questions that have arisen, and makes additional changes to other parts of the model questionnaire to

Modifications to Online Medicare Secondary Payer Questionnaire: This CR Rescinds and Replaces CR 4098 (continued)

improve the wording and sequencing of questions in these parts.

The changes to the model questionnaire are too numerous to list here. As such, please refer directly to the revised section in the *Medicare Secondary Payer (MSP) Manual*, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries), which contains the complete, updated model questionnaire. The changes are identified in redline and italics.

Please keep in mind the following:

1. This questionnaire is a model. Other questions may be added to help identify other payers that may be primary to Medicare.
2. If you choose to use this model questionnaire, please be aware that it was developed to be used in sequence. The instructions listed after the questions are to direct the patient to the next appropriate question to facilitate transition between questions.

Additional Information

You can find more information about the Medicare Secondary Payer Questionnaire by viewing CR 5087 at *http://www.cms.hhs.gov/Transmittals/downloads/R53MSP.pdf*.

Attached to the CR is the revised section of the *Medicare Secondary Payer (MSP) Manual*, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries), which contains the complete, updated model questionnaire.

If you have any questions, please contact your carrier (including durable medical equipment regional carrier), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf*.

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

MLN Matters Number: MM5087
Related Change Request (CR) Number: 5087
Related CR Release Date: June 9, 2006
Related CR Transmittal Number: R53MSP
Effective Date: September 11, 2006
Implementation Date: September 11, 2006

Source: CMS Pub. 100-05, Transmittal 53, CR 5087

NATIONAL PROVIDER IDENTIFICATION

National Provider Identifier Enumeration System—Countdown Reminder

Countdown has begun; do you have your national provider identifier (NPI)? Don't risk disruption to your cash flow – Get your NPI now! National provider identifiers (NPIs) will be required on claims sent on or after May 23, 2007. **Every** healthcare provider needs to get an NPI! Learn more about NPI and how to apply by visiting the CMS website at *http://www.cms.hhs.gov/NationalProvIdentStand/*.

This page also contains a section for Medicare fee-for-service (FFS) providers with helpful information on the Medicare NPI implementation. A countdown clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at *http://www.wedi.org/npioi/index.shtml*. ❖

Source: CMS Joint Signature Memorandum 06468, May 30, 2006

The National Provider Identifier Information

Background: The National Provider Identifier (NPI) will replace the provider identification numbers that providers use today in the HIPAA standard transactions that they conduct with health plans. Those transactions include the electronic claim, eligibility inquiry and response, claim status inquiry and response, payment and remittance advice, prior authorization/referral, and coordination of benefits transactions.

Providers who conduct any of those electronic transactions must have their NPIs and be ready to use them to identify themselves, and possibly other providers, in those transactions before May 23, 2007. That is only a year from now. Some health plans might be ready to accept NPIs much earlier than next May. The health plans with whom you do business will inform you as to when you may begin using your NPIs in these electronic transactions.

- CMS reminds health care providers that they need to obtain their NPIs.
- Today, approximately 530,000 providers who are individuals and organizations have obtained their NPIs.
- Providers can obtain NPIs by:
  - Going to the web at https://nppes.cms.hhs.gov and filling out their application on line.
  - Obtaining a paper application form, filling it out, and mailing it to the NPI enumerator. They can obtain the paper application form (CMS-10114) by downloading it from *http://www.cms.hhs.gov/forms* or by calling the NPI enumerator at 1-800-465-3203 and requesting a copy.
  - Submitting an application through Electronic File Interchange (EFI). EFI allows an approved organization, after obtaining the permission of a provider, to send the provider's NPI application data to us in an electronic file.
- Medicare organization providers are required by the NPI final rule to determine if they have subparts and if those subparts should have their own NPIs. Many enrolled Medicare providers are actually subparts of other enrolled Medicare providers who are their "parents." In January 2006, Medicare posted a paper about the subpart concept and its effect on Medicare organization providers (downloadable from *http://www.cms.hhs.gov/NationalProvIdentStand*, click on "Medicare NPI Implementation" on the left). Medicare encourages its enrolled organization providers to become familiar with the contents of that paper if they have not already done so, and to use that paper in making decisions concerning subparts and their assignment of NPIs.
- Providers and suppliers are required to include their NPI on the 04/2006 version of the CMS-855 Medicare enrollment application when they apply to enroll in Medicare.
- Medicare will accept either the Medicare provider number (the legacy provider number) or the NPI and the Medicare provider number (both numbers) on the claims it receives from providers through October 2, 2006.
- Beginning October 2, 2006, and continuing through May 22, 2007, Medicare will accept the NPI or the Medicare provider number (legacy provider number) on the claims it receives from providers. If there is any issue with the provider's NPI and no Medicare provider number is included on the claim, the provider might not be paid. Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare provider number (the legacy provider number) as a secondary identifier until May 22, 2007.
- CMS has posted many documents related to the NPI, including Medicare's timetable for implementation of the NPI, on its NPI web page: *http://www.cms.hhs.gov/NationalProvIdentStand*.

  We urge you to visit that website and become familiar with the NPI and how it will be used, if you have not already done so.
- We encourage all organizations and associations to inform their members about the need to obtain, test, and use the NPI. ❖

Source: CMS Provider Education Resource 200605-22

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.

Do You Have Your National Provider Identifier Number Yet?

If so, that's great! If not, remember there are three ways that you can obtain your National Provider Identifier number (NPI):

- Complete the **online application** at the NPPES website at *https://NPPES.cms.hhs.gov*.
- Download the **paper application** form CMS-10114 available at *http://www.cms.hhs.gov/forms*.
- Call the NPI Enumerator at 1-800-465-3203 and request a paper application.

In addition, you may also authorize an employer or other approved organization that has obtained the permission of the provider, to obtain the NPI for you through bulk enumeration, known as **Electronic File Interchange** (EFI).

Regardless of how you obtain your NPI, it is important that you **retain the notification documentation that NPPES sends to you containing your NPI**. You will need to share this notification with other health care partners, when enrolling in Medicare for the first time, or making changes to your current Medicare provider file.

National Provider Identifier Timeline

Electronic claim submitters only

January 3, 2006 – October 1, 2006	NPI optional and Medicare numbers required
October 2, 2006 – May 22, 2007	NPI and Medicare number
May 23, 2007 – Forward	NPI only

Small health plans have until May 23, 2008

Important Note

Paper claim submitters

Submission of the NPI on paper claims will not be applicable until the new CMS-1500 form (08/05) and the CMS-1450 (UB-04) is implemented.

EDI Information

For specific electronic claim guidelines for NPI submission, visit the EDI section of the website at: *www.floridamedicare.com*.

Beginning January 3, 2006, through October 1, 2006, electronic Medicare claims may be submitted with the NPI number along with the existing Medicare number. If the NPI is submitted alone, the claims will reject as unprocessable.

Beginning October 2, 2006, through May 22, 2007, CMS systems (including those used by the fiscal intermediaries and carriers) will accept the NPI with or without an existing Medicare number on claims. If there is an issue with the provider's NPI, the claim may not be paid. Therefore, **Medicare strongly recommends** that providers, clearinghouses, and billing services continue to submit the Medicare number in addition to the NPI.

Beginning May 23, 2007, CMS systems will only accept the NPI. Small health plans have until May 23, 2008 to begin using the National Provider Identifier.

For more information, go to *http://www.cms.hhs.gov/NationalProvIdentStand/*. ❖

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

GENERAL COVERAGE

Bariatric Surgery for Morbid Obesity

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services related to bariatric surgery

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5013, which modifies the *Medicare National Coverage Determination Manual* (NCDM, Sections 40.5 and 100.1) and adds section 150 to Chapter 32 of the *Medicare Claims Processing Manual* to be consistent with the new Centers for Medicare & Medicaid Services (CMS) policy for bariatric surgery.

CAUTION – What You Need to Know

Effective for services on or after February 21, 2006, Medicare will cover open and laparoscopic Roux-en Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB) and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS) if certain criteria are met and the procedure is performed in an approved facility.

In addition, effective for services performed on or after February 21, 2006, Medicare has decided that open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding are nationally noncovered for Medicare.

GO – What You Need to Do

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

Background

Bariatrics is the branch of medicine dealing with obesity, and bariatric surgery can be an effective treatment for patients who have been unsuccessful with diet and exercise and have comorbid conditions such as:

- Coronary artery disease
- Diabetes
- Sleep apnea.

Bariatric surgery procedures are performed to treat many comorbid conditions associated with obesity, and two types of surgical procedures are employed:

- Malabsorptive surgical procedures divert food from the stomach to a lower part of the digestive tract where the normal mixing of digestive fluids and adsorption of nutrients cannot occur.
- Restrictive surgical procedures restrict the size of the stomach and decrease intake.

Some surgeries combine both of these types of procedures, and brief descriptions of bariatric surgery procedures are included in the *Additional Information* section of this article. Also, see the *Medicare National Coverage Determinations Manual* (Pub. 100-03, Chapter 1, Part 2, Section 100.1 (Bariatric Surgery for Morbid Obesity (effective February 21, 2006), Subsection A (General)), attached to CR 5013.

Note: Bariatric surgery is recommended only for individuals with health concerns related to their obesity.

CMS has determined the evidence is adequate to conclude that:

- **If** a Medicare beneficiary has documented in their medical record that they:
  - Have a body-mass index (BMI) > 35, with at least one co-morbidity related to obesity; **and**
  - Have been previously unsuccessful with medical treatment for obesity;
- **Then** the following procedures (performed on or after February 21, 2006) are considered reasonable and necessary:
  - Open and laparoscopic Roux-en-Y gastric bypass (RYGBP)
  - Laparoscopic adjustable gastric banding (LAGB)
  - Open and laparoscopic biliopancreatic diversion (BPD) with duodenal switch (DS).

Approved Facilities

In addition, CMS has determined that covered bariatric surgery procedures are reasonable and necessary **only** when performed at facilities certified by:

- The American College of Surgeons ((ACS) *http://www.facs.org/cqi/bscn/*)) as a level 1 bariatric surgery center (BSC; program standards and requirements in effect on February 15, 2006); or
- The American Society for Bariatric Surgery ((ASBS) *http://www.asbs.org/*)) as a bariatric surgery center of excellence (BSCOE; program standards and requirements in effect on February 15, 2006).

A list of approved facilities and their approval dates will be listed and maintained on the CMS coverage website at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage*. This information will also be published in the *Federal Register*.

When services are performed in an unapproved facility, Medicare will deny the claim with a claim reason adjustment code of 58. (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.)

For providers to avoid liability for charges when services are performed in an unapproved facility, physicians must have the beneficiary sign an advanced beneficiary

Bariatric Surgery for Morbid Obesity (continued)

notice (ABN), and hospitals, including critical access hospitals, must have the beneficiary sign a hospital issued notice of noncoverage (HINN).

Noncovered Procedures

The evidence is not adequate to conclude that the following bariatric surgery procedures are reasonable and necessary; therefore, the following procedures are noncovered for all Medicare beneficiaries:

- Open vertical banded gastroplasty
- Laparoscopic vertical banded gastroplasty
- Open sleeve gastrectomy
- Laparoscopic sleeve gastrectomy
- Open adjustable gastric banding.

Changes in Manuals

The *Medicare Claims Processing Manual* (Pub.100-04, Chapter 32 (Billing Requirements for Special Services), Section 150 (Billing Requirements for Bariatric Surgery for Morbid Obesity)) is being added to reflect the new coverage for bariatric surgery.

In addition, the Medicare *National Coverage Determination Manual* (NCDM, Pub. 100-03, Chapter I, Sections 40.5 and 100.1) are being modified to be consistent with the new CMS policy for bariatric surgery. These revisions are attached to CR5013.

The revision of the NCDM will include a reference to the covered surgical procedures, and revise the obesity policy with the final bariatric surgery policy.

The modified obesity policy will read as follows (changes bolded and italicized):

> "Obesity may be caused by medical conditions such as hypothyroidism, Cushing's disease, and hypothalamic lesions or can aggravate a number of cardiac and respiratory diseases as well as diabetes and hypertension. Non-surgical services in connection with the treatment of obesity are covered when such services are an integral and necessary part of a course of treatment for one of these medical conditions. ***Certain designated surgical services for the treatment of obesity are covered for Medicare beneficiaries who have a BMI = 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity."***

Treatments **for obesity alone** remain noncovered, and the following noncoverage determinations in the *National Coverage Determination Manual* (NCDM, Chapter 1, Part 2; *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf*) remain unchanged:

- Section 100.8 (Intestinal Bypass Surgery)
- Section 100.11 (Gastric Balloon for Treatment of Obesity).

Additional Instructions

CR 5013 further instructs your carrier and/or fiscal intermediary to:

- Accept the following Healthcare Common Procedure Coding System (HCPCS) as of February 21, 2006:

  43770 *Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)*

  43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)*

  43645 *Laparoscopy with gastric bypass and small intestine reconstruction to limit absorption. (Do not report 43645 in conjunction with 49320, 43847.)*

  43845 *Gastric restrictive procedure with partial gastrectomy, pyloruspreserving duodenoileostomy and ileoieostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)*

  43846 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less Roux-en-Y gastroenterostomy. (For greater than 150 cm, use 43847) (For laparoscopic procedure, use 43644)*

  43847 *with small intestine reconstruction to limit absorption*

- Accept *CPT* codes *43770, 43644, 43645, 43845, 43846 and 43847* submitted with at least one of the following diagnosis codes: V85.35; V85.36; V85.37; V85.38; V85.39; V85.4; or 278.01. (Claims will be denied without an appropriate diagnosis code.)
- Accept International Classification of Diseases, Ninth Revision (ICD-9) procedure codes 44.38, 44.39, 44.95, 43.89, 45.51, and 45.91, when the following diagnosis codes are reported: V85.35; V85.36; V85.37; V85.38; V85.39; V85.4; and 278.01. (Claims will be denied without an appropriate diagnosis code and none of the V diagnosis codes for BMI = 35 or 278.01 for morbid obesity can be the principal diagnosis on an inpatient Medicare claim).
- Accept the following ICD-9-CM procedure codes as of February 21, 2006:
  - 44.38 – Laparoscopic gastroenterostomy (laparoscopic Roux-en-Y)
  - 44.39 – Other Gastroenterostomy (open Roux-en-Y)
  - 44.95 – Laparoscopic gastric restrictive procedure (laparoscipic adjustable gastric band and port insertion)

Important Note:

There is not a distinction between laparoscopic and open biliopancreatic diversion (BPD) with duodenal switch (DS) for the inpatient setting. The codes would apply to the open approach as follows:

43.89 Other partial gastrectomy

45.51 Isolation of segment of small intestine

45.91 Small to small intestinal anastomosis.

Bariatric Surgery for Morbid Obesity (continued)

Should claims be denied for failure to have the appropriate diagnosis code, the carrier/FI will use claim adjustment reason code 167 to denote "This/these diagnosis(es) is (are) not covered."

Note that 44.68 (Laparoscopic gastroplasty (vertical banded gastroplasty)) is noncovered for Medicare effective February 21, 2006.

Additional Fiscal Intermediary Billing Requirements

The FI will pay for Bariatric Surgery only when the services are submitted on type of bill (TOB) 11x.
The type of facility and setting determines the basis of payment:

- For services performed in inpatient hospitals, TOB 11x, IPPS payment is based on the DRG.
- For services performed in CAH inpatient hospitals, TOB 11x, on 101 percent of facility specific per visit rate.
- For services performed in IHS inpatient hospitals TOB 11x under IPPS based DRG.
- For services performed in IHS critical access hospitals, TOB 11x, under 101 percent facility specific per diem rate.

Implementation

The implementation date for CR 5013 is May 30, 2006 for physician claims billed to Medicare carriers and October 2, 2006, for hospital claims billed to FIs.

Additional Information

For complete details, please see the official instruction, CR 5013, issued to your carrier/intermediary regarding this change. There will be two parts to this CR, one for the NCD and one for the claims processing instruction. The NCD, which includes descriptions of the bariatric surgery procedures, is on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R54NCD.pdf* and the claims processing instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R931CP.pdf*.

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

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

MLN Matters Number: MM5013
Related Change Request (CR) Number: 5013
Related CR Release Date: April 28, 2006
Related CR Transmittal Number: R931CP and R54NCD
Effective Date: February 21, 2006
Implementation Date: May 30, 2006 for physician claims billed to carriers, and October 2, 2006, for hospital claims billed to FIs

Source: CMS Pub. 100-04, Transmittal 931, CR 5013

Correct Reporting of Diagnosis Codes on Screening Mammography Claims

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

Provider Types Affected

All providers billing Medicare carriers and fiscal intermediaries (FIs) for screening mammography claims

Providers Action Needed

This article and change request (CR) 5050 provide specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSIX12 837) on claims that contain **only screening** mammography services.
- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837, and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain **other** services in addition to a screening mammography.

In addition, CR 5050 updates Chapter 18, Section 20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:

- It **removes type of bill (TOB) 12x** from the list of applicable TOBs for diagnostic mammography.
- It **adds HCPCS code G0202** to the list of valid codes for the billing of screening mammography.
- It **adds HCPCS codes G0204 and G0206** to the list of valid codes for the billing of diagnostic mammographies.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This CR adjusts that requirement.

Correct Reporting of Diagnosis Codes on Screening Mammography Claims (continued)

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf*.

The revised Section 20.4 of Chapter 18 of the *Medicare Claims Processing Manual* is attached to CR 5050.

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

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

MLN Matters Number: MM5050
Related Change Request (CR) Number: 5050
Related CR Release Date: April 28, 2006
Related CR Transmittal Number: R916CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 916, CR 5050

Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus Vaccine Claims and Use of *CPT* Code *90660*

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

Provider Types Affected

Physicians and providers billing Medicare carriers and fiscal intermediaries (FIs) for influenza and/or pneumococcal pneumonia virus (PPV) vaccines and vaccine administration

Providers Action Needed

This article and change request (CR) 5037 provide specific information regarding payment for Influenza and/or PPV vaccines and their administration. Effective for dates of service on or after October 1, 2006, the following are the new instructions:

- **Report diagnosis code V06.6** on claims that contain influenza virus and/or PPV **vaccines and their administration** when the purpose of the visit was to **receive both** vaccines.
- Continue reporting **diagnosis code V03.82** on **claims that contain only PPV vaccine** and its administration.
- Continue reporting **diagnosis code V04.81** on **claims that contain only influenza viru**s vaccine and its administration.
- Use ***CPT* code *90660*** on claims when billing for influenza virus vaccine, live, for intranasal use.
- Neither a deductible nor a coinsurance will be applied to influenza virus vaccine, *CPT* code *90660*, and its administration.
- Use **HCPCS code G0008** when billing for the **administration of *CPT* code *90660***.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding payment for influenza and/or PPV vaccines and its administration.

Currently, providers are required to report diagnosis codes V03.82 for PPV and its administration and diagnosis code V04.81 for influenza virus vaccine and its administration. This instruction allows the reporting of diagnosis code V06.6 in place of V03.82 and V04.81 when reporting influenza virus and/or PPV vaccines when the purpose of the visit was to receive both vaccines. In addition, this instruction requires Medicare carriers/FIs to accept claims containing *CPT* code *90660* for the influenza virus vaccine.

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R921CP.pdf*.

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

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

MLN Matters Number: MM5037
Related Change Request (CR) Number: 5037
Related CR Release Date: April 28, 2006
Related CR Transmittal Number: R921CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 921, CR 5037

Payment for Carotid Artery Stenting Post-Approval Extension Studies

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

Provider Types Affected

Physicians or providers submitting claims to carriers or fiscal intermediaries (FIs) for carotid artery Stenting (CAS) post approval extension studies.

Impact on Providers

This article is based on change request (CR) 5088, which informs providers that the Centers for Medicare & Medicaid Services (CMS) has determined that all extension studies must be reviewed by the Food and Drug Administration (FDA).

The FDA will issue an acknowledgement letter stating that the extension study is scientifically valid and will generate clinically relevant post-market data. Upon receipt of this letter and review of the extension study protocol, CMS will issue a letter to the study sponsor indicating that the study under review will be covered by Medicare.

Background

CMS issued CR 3489 (Transmittal 314, dated October 15, 2000, *http://www.cms.hhs.gov/transmittals/Downloads/R314CP.pdf*) to provide Medicare contractors (carriers and/or FIs) with instructions for processing claims for CAS procedures performed in FDA-approved post-approval studies. As the post-approval studies began to end, CMS received requests to extend their coverage.

CMS reviewed the extension requests and has determined that patients participating in post-approval extension studies are also included in the currently covered population of patients participating in FDA-approved post-approval studies (*Medicare National Coverage Determinations Manual*, Pub. 100-3, Chapter 1, Part 1, Section 20.7; available on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf*).

To grant approval for post-approval studies, the FDA reviews each study protocol, and once approval is granted, the FDA issues a formal approval letter to the study sponsor.

Extensions of post-approval studies are not subject to approval by the FDA because they surpass the post-approval study requirements identified in the conditions of approval for post-approval studies. Therefore, since the FDA cannot approve these extension studies, individual post-market approval (PMA) numbers cannot be issued to separately identify each study.

Currently, in order to receive reimbursement for procedures performed as part of a carotid artery stenting post-approval study, providers must include the FDA-issued PMA number on each claim to indicate participation in a specific study.

CMS has determined that the FDA must review all extension study protocols. If the FDA determines the extension study protocol is scientifically valid, the FDA will:

- Issue an acknowledgement letter stating that the extension study protocol is scientifically valid; and
- Generate clinically relevant post-market data.

CMS will issue a letter to the study sponsor indicating that the study under review will be covered by Medicare upon receipt of the FDA's:

- Acknowledgement letter; and
- Review of the extension study protocol indicating the study protocol is scientifically valid.

Because an individual PMA number cannot be assigned by the FDA to each extension study, these studies will use the PMA number assigned to the original FDA-approved post-approval study (i.e., CAPTURE 2 shall use the PMA number assigned to CAPTURE 1).

To receive Medicare coverage for patients participating in post-approval extension studies, providers should follow the process for informing Medicare contractors of their participation as established in CR 3489 (Transmittal 314, dated October 15, 2004, *http://www.cms.hhs.gov/transmittals/Downloads/R314CP.pdf*).

There is also an MLN Matters article related to CR 3489 on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf*.

Providers should submit to their Medicare contractor:

- The FDA acknowledgement letter
- The CMS letter providing coverage for the extension study to their contractor
- Any other materials their Medicare contractor would require for FDA-approved post-approval studies.

In response, the provider's Medicare contractor will issue a letter assigning an effective date for each facility's participation in the extension study.

Providers:

- **Should follow** the billing instructions from CR 3489 (Transmittal 314, dated October 15, 2004).
- **May bill** for procedures performed in the extension study for dates of service on and after the assigned effective date.
- **Must bill** using the most current ICD-9 CM procedure codes **when billing FIs**. For example, when billing a CAS extension study with dates of service July 1, 2006 through July 15, 2006, the provider should bill the most current ICD-9 CM procedure codes 00.61 and 00.63 (instead of the 39.50 and 39.90 procedure codes published in CR [3]489).

Please note that:

- Providers participating in the Capture 2 post-approval extension study must submit copies of two letters to their local contractor, i.e., an FDA acknowledgement letter and a CMS coverage letter.
- After receiving the above letters, the Medicare contractor will issue a letter to the provider assigning an effective date for participation in the extension study.
- Providers may bill for procedures performed in the extension study for dates of service on and after the assigned effective date

Payment for Carotid Artery Stenting Post-Approval Extension Studies (continued)

- Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.
- Providers should continue to follow the guidelines for processing post approval study claims as directed in CR 3489, Transmittal 314, issued October 15, 2004.

Implementation

The implementation date for the instruction is June 12, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R951CP.pdf*.

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

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

MLN Matters Number: MM5088
Related Change Request (CR) Number: 5088
Related CR Release Date: May 12, 2006
Related CR Transmittal Number: R951CP
Effective Date: February 28, 2006
Implementation Date: June 12, 2006

Source: CMS Pub. 100-04, Transmittal 951, CR 5088

Documentation Submission for Carotid Artery Stenting Post-Approval Extension Studies

In order to establish Medicare coverage for beneficiaries participating in the carotid artery stenting (CAS) post-approval extension studies, providers billing for these services are required to submit the following documentation to their fiscal intermediaries:

- The Food and Drug Administration acknowledge letter
- The CMS letter providing coverage for the extension study to their contractors
- Any other materials their Medicare contractor would require for FDA-approved post-approval studies.

Providers may send this documentation to:

First Coast Service Options, Inc.
Medical Policy – 19T
532 Riverside Avenue
Jacksonville, Florida 32202

In response, the provider's Medicare contractor will issue a letter assigning an effective date for each facility's participation in the extension study.

The complete coverage and billing guidelines for CAS post-approval extension studies may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5088.pdf*. ❖

Source: CMS Pub. 100-04, Transmittal 951, CR 5088

Payment for Positron Emission Tomography Scans—Use of Modifiers QR and QV

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

Provider Types Affected

Physicians and other providers who bill Medicare carriers and fiscal intermediaries (FI) for the use of fluoro-D-glucose (FDG) positron emission tomography (PET) scans for oncology and dementia/neurodegenerative diseases.

Provider Action Needed

STOP – Impact to You

Effective January 28, 2005, for certain FDG PET indications (listed in the *Background* section below), rather than the **QV** modifier previously required, you must use the **QR** modifier on all carrier claims to identify that this service is provided in a Medicare-specified study.

CAUTION – What You Need to Know

CR 5124 revises transmittal 527 (CR 3741) to require that you use the appropriate *CPT* code and the **QR** modifier (item or service provided in a Medicare-specified study), rather than the **QV** modifier (other than inpatient), on carrier claims for services for dementia and neurodegenerative diseases, and a broad range of cancer indications listed as "coverage with evidence development."

Claims submitted to FIs must contain the principal diagnosis code, the appropriate *CPT* code, and V70.7 diagnosis code. In addition, CMS has entered into an agreement with the Academy of Molecular Imaging (AMI) in which AMI collects data for a broad range of cancers through the National Oncologic PET Registry (NOPR). NOPR, which began accepting patients on May 8, 2006, satisfies Medicare's requirement that the FDG PET provider and Medicare beneficiary participate in a prospective clinical study in order for the services to be considered

Payment for Positron Emission Tomography Scans—Use of Modifiers QR and QV (continued)

reasonable and necessary. NOPR information and registration materials are available at its website, provided in the *Additional Information* section below.

GO – What You Need to Do

Make sure that your billing staffs are aware of these coding changes for FDG PET services in your Medicare claims.

Background

Positron Emission Tomography

PET is a noninvasive imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images obtained by detecting radioactivity from a radioactive tracer substance (radionuclide), 2-[F-18] fluoro-D-glucose (FDG).

Note: Refer to Publication 100-03, the *National Coverage Determinations (NCD)* Manual, section 220.6, for coverage instructions that indicate conditions under which a PET scan is performed. The manual is available on the CMS website at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

Covered FDG PET Scans

For cancers listed as "coverage with evidence development" in section 220.6 of the NCD Manual, CMS has determined that (effective for services performed on or after January 28, 2005) FDG PET scans are reasonable and necessary only when the provider is participating in, and patients are enrolled in:

- A clinical trial that meets the requirements of Food and Drug Administration (FDA) category B investigational device exemption (42 CFR 405.201); or
- An FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management.

CR 3741, released April 15, 2005, indicated that there is adequate evidence to conclude that an FDG PET scan for the detection of pre-treatment metastases (i.e., staging) in newly-diagnosed cervical cancer (after conventional imaging that is negative for extra-pelvic metastasis), is reasonable and necessary as an adjunct test, and it expanded coverage to include FDG PET for certain indications of cervical cancer.

CR 3741 also designated **QV** as the correct modifier to be used in carrier claims for beneficiaries participating in CMS-approved clinical trials utilizing FDG PET scans for dementia and neurodegenerative diseases.

CR 5124, upon which this article is based, revises CR 3741 to provide that (effective for services on or after January 28, 2005) you will be reimbursed for the use of FDG PET services for:

- Dementia and neurodegenerative disease (see NCD Manual (100.03) section 220.6.13)
- Certain indications for cancers of the cervix, lung (including small cell), esophagus, colon and rectum, head and neck, breast, thyroid, brain, ovary, pancreas, and testes; and lymphoma, melanoma, and soft tissue sarcoma (as listed in sections 220.6.2-220.6.7 and 220.6.10-220.6.14); and
- All other cancer indications not previously specified (as listed in section 220.6.15).
- **Only** if these scans were performed as part of a Centers for Medicare & Medicaid Services (CMS) approved-clinical trial.

In fact, be aware that FDG PET scans for all cancer indications listed in section 220.6 as "coverage with evidence development" remain nationally noncovered unless they are performed in conjunction with a CMS-approved clinical trial.

Using Appropriate CPT Code and QR Modifier

In line with the requirement for including these patients in clinical trials, you must submit all (other than inpatient) FDG PET claims to your carriers using the appropriate *CPT* code and the **QR** modifier, which was created for use on Part B claims (and other outpatient claims) to identify items/services that are covered when provided in a Medicare-specified study.

You may no longer use the **QV** modifier when a beneficiary undergoes an FDG PET scan in a facility participating in a Medicare-approved study specified by the above-referenced NCDs.

National Oncologic PET Registry (NOPR)

You should also be aware that CMS contracted with the Academy of Molecular Imaging to establish the NOPR, a national, Internet-based data registry that reports on oncologic FDG PET scans received by Medicare beneficiaries as outlined in the NCD.

Reporting data to the NOPR for the oncologic FDG PET scan indications listed in section 220.6 as "coverage with evidence development" is a requirement of Medicare coverage. Without appropriately reported data, Medicare may be unable to approve claims and/or may be required to take action to recoup payments already made if data reporting discrepancies are discovered through post-payment claims analysis.

Remember that you are responsible for ensuring that data is accurately reported to the NOPR and that claims are accurately submitted. CMS recommends that you contact NOPR so that your facility may provide expanded oncologic FDG PET benefits under the NCD.

When submitting such claims to your FIs, you should use the appropriate principal diagnosis code, the appropriate *CPT* code, and ICD-9 code V70.7 in the second diagnosis position on the CMS-1450 (UB-92), or the electronic equivalent.

Finally, note that effective for PET scan claims with dates of service on or after January 28, 2005 until implementation of CR 5124 on June 19, 2006, your carriers and FIs do not need to search their files to either retract erroneous payment for claims already paid or to retroactively pay claims incorrectly processed, unless you bring those claims to their attention.

Additional Information

You can find more information about FDG PET scans in patients undergoing Medicare-approved clinical trials by

Payment for Positron Emission Tomography Scans—Use of Modifiers QR and QV (continued)

going to CR 5124, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R956CP.pdf*.

Additionally, you might want to look at the *National Coverage Determinations (NCD) Manual*, sections 220.6, 220.6.2 - 220.6.7, 220.6.10 - 220.6.12, 220.6.14, and 220.6.15 for important information regarding FDG PET for oncology.

The transmittal that conveyed the above NCD is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R31NCD.pdf*.

A related Medicare Claims Processing Manual transmittal is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R527CP.pdf*.

A related MLN Matters article appears on the same site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3741.pdf*.

Information and registration materials are available at NOPR's website *http://www.cancerPETregistry.org*.

A regularly updated list of NOPR's Medicare approved facilities is located on the CMS website at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/NOPR/list.asp#TopOfPage*.

NOPR may also be reached at 800-227-5463, extension 4859, or 215-717-0859. If you have any questions, please contact your carrier or FI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf*.

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

MLN Matters Number: MM5124
Related Change Request (CR) Number: 5124
Related CR Release Date: May 19, 2006
Related CR Transmittal Number: R956CP
Effective Date: January 28, 2005
Implementation Date: June 19, 2006

Source: CMS Pub. 100-04, Transmittal 956, CR 5124,

Nesiritide for Treatment of Heart Failure Patients

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 May 19, 2006, to clarify some of the language regarding the use of nesiritide under the "Key Points" section. All other information remains the same. This article was originally published in the Third Quarter 2006 *Medicare A Bulletin* (pages 54-55).

Provider Types Affected

Providers and physicians that submit claims to Medicare fiscal intermediaries (FIs) and carriers for nesiritide when provided as a treatment for chronic heart failure.

Key Points

- Effective for dates of service **on or after March 2, 2006,** the Centers for Medicare & Medicaid Services (CMS) will deny coverage of nesiritide for the treatment of chronic heart failure in Medicare beneficiaries. For billing guidelines about the noncovered use of nesiritide, please refer to the *Additional Information* section of this article.
- CMS has determined that there is insufficient evidence to conclude that the use of nesiritide for the treatment of chronic heart failure is reasonable and necessary for Medicare beneficiaries in any setting.
  This determination does not change local contractor discretion for treatment of acute(ly) decompensated heart failure consistent with the Food and Drug Administration (FDA) labeled indication in Medicare beneficiaries who may have underlying chronic heart failure. Nor does it affect local contractor discretion for other off-label uses of nesiritide in Medicare beneficiaries who may have underlying chronic heart failure.
- For claims submitted to FIs, the requirement to deny nesiritide for chronic heart failure will only affect type of bill (TOBs) 13x and 85x.
- TOBs 11x and 12x will be rejected.
- CMS recommends that FIs create medical policy parameters to deny outpatient claims for nesiritide for chronic heart failure in the absence of acutely decompensated heart failure.
- CMS recommends that FIs reject inpatient claims where the primary diagnosis is chronic heart failure in the absence of acutely decompensated heart failure (TOBs 11x and 12x) when billed with nesiritide for chronic heart failure.
- For inpatient claims where the beneficiary is admitted with a primary diagnosis other than heart failure and nesiritide is administered under a DRG (diagnosis

Nesiritide for Treatment of Heart Failure Patients (continued)

related group) payment, the administration of nesiritide should not be the sole basis for denial of the entire inpatient claim.

- The provider will be held liable unless occurrence code 32 is present on the claim or modifier GA is present on the line on an outpatient bill when nesiritide is used to treat chronic heart failure without documented evidence of acute decompensation.
- All other indications for the use of nesiritide not otherwise indicated as noncovered (other off-label uses or uses consistent with the current FDA indication for intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea at rest or with minimal activity) are left to local contractor (carrier or FI) discretion.
- This addition to Chapter 1, Section 200.1, of the *Medicare National Coverage Determinations Manual* (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act (the Act).
- NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1064, effective May 1, 2005).
- An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Act.)

Background

Nesiritide is FDA-approved for the short-term intravenous treatment of patients with acutely decompensated CHF who have dyspnea (shortness of breath) at rest or with minimal activity.

Recent published studies of nesiritide have highlighted safety concerns, specifically increased mortality and decreased renal function in patients treated with nesiritide.

In addition, an independent advisory panel of cardiac experts sponsored by Scios, manufacturer of Natrecor® (nesiritide), recommends that *"The use of nesiritide should be strictly limited to patients presenting to the hospital with acutely decompensated congestive heart failure who have dyspnea at rest…."*

Additional Information

Claims submitted with Healthcare Common Procedure Coding System (HCPCS) code J2325 (Injection, nesiritide, 0.1 mg) with International Classification of Diseases (ICD-9) codes of:

428.0, 428.1, 428.20, 428.22, 428.30, 428.32, 428.40, 428.42, or 428.9; **and not accompanied by:** 428.21, 428.23, 428.31, 428.33, 428.41, or 428.43, **will be denied**.

Denied claims will be returned with the following claims adjustment codes:

- **Reason code 50:** These are noncovered services because the payer does not deem this a 'medical necessity'.
- **Remark code M76:** Missing/incomplete/invalid diagnosis or condition.

Contractors shall apply the following Medicare summary notice messages:

- **15.20** – The following policy [NCD 200.1] was used when we made this decision.
- **15.4**: – The information provided does not support the need for this service or item.

Contractors shall not search for, but may adjust, claims brought to their attention with dates of service March 2, 2006, through implementation.

Relevant Links

CR 4312 is the official instruction issued to your FI or carrier, regarding changes mentioned in this article. There are two transmittals related to CR 4312. One is transmittal number R51NCD, which relates to the NCD. It may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R51NCD.pdf*.

The second transmittal, R218OTN, relates to Medicare claims processing instructions, and it may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R218OTN.pdf*.

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

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

MLN Matters Number: MM4312
Related Change Request (CR) Number: 4312
Related CR Release Date: April 7, 2006
Related CR Transmittal Number: R218OTN and R51NCD
Effective Date: March 2, 2006
Implementation Date: May 22, 2006

Source: CMS Pub. 100-20, Transmittal 218, CR 4312

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

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

Provider Types Affected

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

Key Points

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

Background

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

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

Category B IDE Study Claims and Post-approval Study Claims

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

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

CAS with Embolic Protection Claims

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

Related Links

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

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

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

CR 5022 is the official instruction issued to your FI or carrier regarding changes mentioned in this article, MM5022.

CR 5022 may be found by going to Transmittal 911CP on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R911CP.pdf* for the claims processing instructions and to Transmittal 53NCD for the NCD Manual section, which is at *http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf*.

Clarification on Billing Requirements for PT Concurrent with the Placement of FDA-approved Carotid Stent (continued)

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

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

MLN Matters Number: MM5022
Related Change Request (CR) Number: 5022
Related CR Release Date: April 21, 2006
Related CR Transmittal Number: R911CP and R53NCD
Effective Date: March 17, 2005
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 911, CR 5022

Changes to the Laboratory National Coverage Determination Edit Software for July 2006

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

Provider Types Affected

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

Impact on Providers

This article is based on change request (CR) 5108, which communicates requirements to Medicare contractors (carriers and FIs) notifying them of changes to the laboratory edit module and to update the laboratory edit module for changes in laboratory national coverage determination (NCD) code lists for July 2006.

Background

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

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

These changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and several of the listed changes correct *Current Procedural Terminology (CPT)* codes to reflect the current *CPT* update.

CR 5108 informs your Medicare carrier and FI about changes in the laboratory NCD code lists for July 2006 that require updating of the laboratory edit module.

The key change being made to the NCD code lists for July 2006 is that *CPT* code *83704 (Quantitation of lipoprotein particle numbers and lipoprotein particles subclasses*) is being added to the list of HCPCS/*CPT* codes covered by Medicare for the lipids testing NCD.

Implementation

The implementation date for the instruction is July 3, 2006.

Additional Information

For complete details, please see the official instruction (CR 5108) issued to your carrier/intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R959CP.pdf*.

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

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

MLN Matters Number: MM5108
Related Change Request (CR) Number: 5108
Related CR Release Date: May 26, 2006
Related CR Transmittal Number: R959CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 959, CR 5108

Low Vision Rehabilitation Demonstration—Additional Clarification of CR 3816 Business Requirements

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

Provider Types Affected

Physicians and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for treatment provided to beneficiaries under the Low Vision Rehabilitation Demonstration project

Providers Action Needed

This article is based on change request (CR) 5023 and this article actually revises the article for CR 3816 by providing specific information clarifying billing instructions as directed in the Administrative Simplification Compliance Act (ASCA). Be aware that:

- National provider identification (NPI) numbers replace UPIN numbers by May 23, 2007.
- CR 3816 for the Low Vision Rehabilitation Demonstration states that **providers** are to document the plan of care by indicating the date the plan was developed or reviewed in Block 19 (Reserved for Local Use) of the CMS-1500 or its electronic equivalent. This is no longer necessary for claims submission for the Low Vision Rehabilitation Demonstration.
- **Facilities** must document the date the plan of care was established or reviewed using occurrence code 17 on CMS-1450 or its electronic equivalent. **This is no longer necessary for claims submission for the Low Vision Rehabilitation Demonstration.**

Background

According to CR 3816, the date the plan of care was established was to be placed in Block 19 of the CMS 1500 form. However, there is no place for this information in the electronic claims form. Therefore, this requirement has been removed whether submitting a paper claim or an electronic claim by providers or facilities.

In addition, although the business requirements in CR 3816 mention use of remittance advice messages, and the background makes reference to using the most appropriate Medicare summary notice (MSN) messages unless specified otherwise in the business requirements, there is no corresponding reference to the remittance advice message in the background.

Please note that your carrier/FI will use the most appropriate remittance advice and remark codes when denying a claim unless otherwise specified in CR 3816.

Implementation

The implementation date for the instruction is July 28, 2006.

Additional Information

For details of enforcement of the ASCA, please see related MLN Matters article MM3440, "Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims," on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3440.pdf*.

To view the MLN Matters article related to CR 3816, go to the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3816.pdf*.

The official instructions issued to your intermediary or carrier regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R46DEMO.pdf*.

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

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

MLN Matters Number: MM5023
Related Change Request (CR) Number: 5023
Related CR Release Date: April 28, 2006
Related CR Transmittal Number: R46DEMO
Effective Date: July 28, 2006
Implementation Date: July 28, 2006

Source: CMS Pub. 100-19, Transmittal 46, CR 5023

New Requirements for Low Vision Rehabilitation Demonstration Billing

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

Note: CMS has issued change request (CR) 5023 providing additional clarifications to CR 3816. Please note that MLN Matters article MM5023 contains updated information regarding remittance advice and remark codes and regarding the use of provider identifiers, especially UPINs and the national provider identifier. MM5023 is based on CR 5023, released on April 28, 2006. To see MM5023, go to the CMS website *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5023.pdf*. MLN Matters article MM5023 is being published in this issue of the Medicare A Bulletin. The MLN Matters article MM3816 was originally published in the Second Quarter 2006 *Medicare A Bulletin* (pages 38-41).

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

Physicians, providers and suppliers should note that the Centers for Medicare & Medicaid Services (CMS) is:

- Implementing an outpatient vision rehabilitation demonstration project in selected areas across the country to examine the impact of standardized Medicare coverage for vision rehabilitation services.
- Extending coverage under Part B for the same services to provide vision rehabilitation that would otherwise be payable when provided by an occupational or physical therapist if they are now provided by a vision rehabilitation professional under the general supervision of a qualified physician.

Background

The Secretary of the Department of Health & Human Services is directed to carry out an outpatient vision rehabilitation demonstration project as part of the FY 2004 appropriations conference report to accompany Public Law HR 2673. This demonstration project will examine the impact of standardized Medicare coverage for vision rehabilitation services provided in the home, office, or clinic, under the general supervision of a physician. The services may be supplied by the following:

- Physicians
- Occupational therapists
- Certified low vision therapists
- Certified orientation and mobility specialists
- Certified vision rehabilitation therapists.

Under this low vision rehabilitation demonstration, Medicare is extending coverage under Part B for the same rehabilitation services to treat vision impairment that would otherwise be payable when provided by an occupational or physical therapist if they are now provided by a certified vision rehabilitation professional under the general supervision of a qualified physician.

This demonstration will last for five years through March 31, 2011, and is limited to services provided specifically in New Hampshire, New York City (all five boroughs), North Carolina, Atlanta, Kansas, and Washington State.

Payment for vision rehabilitation services under this demonstration may be made to:

- Either the qualified physician who is supervising the occupational therapist or certified vision rehabilitation professional; or an occupational therapist in private practice; or
- A qualified facility, such as a rehabilitation agency or clinic that has a contractual relationship with the certified vision rehabilitation professional; and
- Where the services are furnished under the individualized written plan of care.

Payment for these services will be made under the physician fee schedule even when such services are billed by a facility. They are not subject to bundling under the outpatient prospective payment system (OPPS).

Under this Low Vision Rehabilitation Demonstration, Medicare will cover low vision rehabilitation services to people with a medical diagnosis of moderate or severe vision impairment that is not correctable by conventional methods or surgery (i.e. cataracts).

Services will be provided under an individualized, written plan of care developed by a qualified physician or qualified occupational therapist in private practice (OTPP) that is reviewed at least every 30-days by a qualified physician.

The plan of care must attest that vision rehabilitation services are medically necessary and the beneficiary receiving vision rehabilitation is capable of receiving rehabilitation and deriving benefit from such services, and should include:

- An initial assessment that documents the level of visual impairment.
- Specific measurable goals to be fulfilled during rehabilitation and the criteria by which the goals will be measured.
- The location of where the rehabilitation services will be conducted.
- Description of specific rehabilitative services to be directed toward each goal provided during the course of rehabilitation.
- A reasonable estimate of the amount of treatment necessary to reach the goals.

Rehabilitative services will be conducted within a three-month period of time, in intervals appropriate to the patient's rehabilitative needs, and will not exceed 36 units of 15 minutes each, or nine hours total.

Rehabilitation will be judged completed when the treatment goals have been attained and any subsequent services would be for maintenance of a level of functional ability, or when the patient has demonstrated no progress on two consecutive visits.

All services covered under this demonstration are one-on-one, face-to-face services. Group services will not be covered.

New Requirements for Low Vision Rehabilitation Demonstration Billing (continued)

Vision rehabilitation services will be furnished in an appropriate setting, including the home of the individual receiving the services, as specified in the plan of care and can be provided by the following:

- A qualified physician as defined in the Social Security Act (Section 1861r (1) and (4)) and who is an ophthalmologist or a doctor of optometry;
- A qualified occupational therapist in private practice;
- A qualified occupational therapist who is an employee of the physician; or
- A certified vision rehabilitation professional including low vision therapists, orientation and mobility specialists, and vision rehabilitation therapists who have received certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

Occupational therapists employed by the physician and certified vision rehabilitation professionals may furnish services while under the general supervision of a qualified physician.

General supervision means that the physician does not need to be "on premises" nor in the immediate vicinity of the rehabilitation services as would be the case with "incident to" requirements stated in Section 2050 of the *Medicare Carriers Manual.*

Payment for vision rehabilitation services will be made to the qualified physician under the Medicare physician fee schedule (MPFS) or to a facility, including the following:

- Hospitals
- Comprehensive outpatient rehabilitation facilities (CORF)
- Other rehabilitation agencies or clinics
- Facilities that bill Medicare for providing occupational therapy, through which services are furnished under an individualized, written plan of care.

Occupational therapists in private practice may also submit claims under their own provider number for providing low vision rehabilitation services. However, for occupational therapists in private practice who are participating in the low vision rehabilitation demonstration, claims submitted must contain the same information as on a physician's claim form and must use the demonstration "G" code for occupational therapists (G9041) for the claim to be considered.

Occupational therapists in private practice may not supervise therapy assistants or certified low vision rehabilitation professions, nor may they submit claims for the services of these individuals under the demonstration.

Certified vision rehabilitation professionals provide services pursuant to a plan of care and under the general supervision of the qualified physician who develops the plan of care. However, if the certified vision rehabilitation professional has a contractual arrangement with the facility where services are furnished, the facility may submit the bill for services.

Payment to practitioners and facilities will be made using the Medicare physician fee schedule (MPFS) with jurisdictional pricing; vision services covered under the demonstration provided in a hospital outpatient setting will **not** be paid under the OPPS system.

Payment for services under this demonstration is limited to low vision rehabilitation. Evaluation and management (E&M) services are not billable under the demonstration.

Vision impairment refers to significant vision loss from disease, injury or degenerative condition that cannot be corrected by conventional means, such as medication or surgery.

The impairment must be manifest by one or more of the conditions listed in the following table:

Levels of Vision Impairment	Description
Moderate Visual impairment	Best-corrected visual acuity is less than 20/60 in the better eye (including a range of 20/70 to 20/160)
Severe visual impairment (legal blindness)	Best-corrected visual acuity is less than 20/160 including 20/200 to 20/400; or visual field diameter is 20 degrees or less (largest field diameter for Goldman isopter III4e, 1/100 white test object or equivalent) in the better eye.
Profound visual impairment (moderate blindness)	Best-corrected visual acuity is less than 20/400, or visual field is 10 degrees or less.
Near-total visual impairment (severe blindness)	Best-corrected visual acuity is less than 20/1000, or visual field is five degrees or less.
Total visual impairment (total blindness)	No light perception

New Requirements for Low Vision Rehabilitation Demonstration Billing (continued)

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes indicated below will be used to support medical necessity for coverage under the demonstration.

ICD-9-CM Code	Description
368.41	Scotoma involving central area
368.45	Generalized contraction or constriction
368.46	Homonymous bilateral field defect
368.47	Heteronymous bilateral field defect
369.01	Better eye: total vision impairment lesser eye: total vision impairment
369.03	Better eye: near-total vision impairment lesser eye: total vision impairment
369.04	Better eye: near-total vision impairment lesser eye: near-total vision impairment
369.06	Better eye: profound vision impairment lesser eye: total vision impairment
369.07	Better eye: profound vision impairment lesser eye: near-total vision impairment
369.08	Better eye: profound vision impairment lesser eye: profound vision impairment
369.12	Better eye: severe vision impairment lesser eye: total vision impairment
369.13	Better eye: severe vision impairment lesser eye: near-total vision impairment
369.14	Better eye: severe vision impairment lesser eye: profound vision impairment
369.16	Better eye: moderate vision impairment lesser eye: total vision impairment
369.17	Better eye: moderate vision impairment lesser eye: near-total vision impairment
369.18	Better eye: moderate vision impairment lesser eye: profound vision impairment
369.22	Better eye: severe vision impairment lesser eye: severe vision impairment
369.24	Better eye: moderate vision impairment lesser eye: severe vision impairment
369.25	Better eye: moderate vision impairment lesser eye: moderate vision impairment

Most rehabilitation is short-term and intensive, and sessions are generally conducted over a consecutive 90-day period of time with intervals appropriate to the patient's rehabilitative needs.

Patients usually receive therapy one or two times per week, and not less frequently than once every two weeks. The sessions are generally 30-60 minutes in duration.

For the purposes of this demonstration, vision rehabilitation services will not be subject to physical or occupational therapy caps.

CMS established four different series of temporary demonstration, or "G", codes to accommodate rehabilitation services for low vision. Each code series will correspond to the low vision rehabilitation professional that provided the service and will be included in the official instruction issued to your carrier/intermediary.

That instruction, CR 3816, may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/2005Trans/List.asp#TopOfPage*.

From that Web page, search for CR 3816 and CR 4294, and click on the files for those CRs.

Example "G" codes include:

- Code G9041 for services provided by a qualified occupational therapist.
- Code G9042 for services provided by a certified orientation and mobility specialist.
- Code G9043 for services provided by a certified low vision rehabilitation therapist.
- Code G9044 for services provided by a certified vision rehabilitation therapists.

Payable places of service (POS) for Part B claims include:

- Office (11)
- Home (12)
- Assisted living facility (13)
- Group home (14)
- Custodial care facility (33)
- Independent clinic (49).

In addition, facilities that are qualified to submit claims include the following:

- Outpatient hospital clinics (TOB 13x)
- Outpatient CAH clinics (TOB 85x)
- Comprehensive outpatient rehabilitation facilities (CORFs) (TOB 75x)
- Freestanding rehabilitation clinics (TOB 74x).

Fiscal intermediaries (FIs) will use the claim related condition code 79 to indicate when services are provided outside the facility. When no condition code appears it will indicate that rehabilitation services were provided in the facility. Providers will be required to indicate either no code or code 79 on claims.

Facility claims will also use the revenue code 0949 (other rehabilitation services) in addition to the demonstration G-code, which indicates the type of professional who provided the rehabilitation service.

This will apply to all institutional settings and CAH outpatient departments. CAHs that elect to use method II billing will use revenue code 0969 or revenue code 0962, whichever is most appropriate.

Carriers will accept and process claims from qualified physicians when those claims include:

- An appropriate ICD-9-CM code that supports medical necessity.
- An appropriate rehabilitation ("G") code for the demonstration.
- Evidence of a written plan of care that specifies the type and duration of the rehabilitative services being furnished.

New Requirements for Low Vision Rehabilitation Demonstration Billing (continued)

The plan of care and date can be indicated in block 19 (Reserved for Local Use) of the [CMS]-1500. Facilities will use occurrence code 17 for date the plan of care was established or reviewed.

Qualified physicians, occupational therapists and low vision professionals practicing in designated demonstration areas may provide low vision rehabilitation services to eligible residents of the demonstration areas.

Approved demonstration locales are limited to the following; New Hampshire, New York City (all five boroughs), North Carolina, Atlanta, Kansas, and Washington State.

Providers should note that the residence of the beneficiary receiving services and the physician or facility providing the services must be in the same approved demonstration locale (state or metropolitan area) as determined by matching primary residence and primary practice ZIP codes.

Implementation

The implementation date for the instruction is April 3, 2006.

Additional Information

As mentioned above, CMS will establish four different series of temporary demonstration, or "G", codes to accommodate rehabilitation services for low vision. Each code series will correspond to the low vision rehabilitation professional that provided the service and will be included in the official instruction issued to your carrier/intermediary.

You can view the official instruction issued to your carrier/intermediary for complete details regarding this change. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/2005Trans/List.asp#TopOfPage*.

Search for 3816 and 4294 in and click on the file for those CRs.

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

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

MLN Matters Number: MM3816 – Revised
Related Change Request (CR) Number: 3816
Related CR Release Date: June 7, 2005
Related CR Transmittal Number: R25DEMO
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Source: CMS Pub. 100-19, Transmittal 25, CR 3816

HOSPITAL SERVICES

Pancreas Transplants Alone

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

Provider Types Affected

Physicians and providers billing Medicare fiscal intermediaries (FIs) and carriers for pancreas transplantation alone (PA)

Background

Medicare covers whole organ pancreas transplantation when it is performed in conjunction with or after kidney transplantation (*National Coverage Determination (NCD) Manual*, Section 260.3). However, Medicare does not cover PA in diabetes patients without end-stage renal failure because of a lack of sufficient evidence, based in large part on a 1994 Office of Health Technology Assessment report.

Key Points

This article is based on information contained in change request (CR) 5093, which informs physicians and providers that, effective for services performed on or after April 26, 2006, Medicare will cover PA for beneficiaries in the following limited circumstances:

- Facilities must be Medicare-approved for kidney transplantation (Approved centers are found on the CMS website at *http://www.cms.hhs.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage*).
- Patients must have a diagnosis of type I diabetes:
  - The patient with diabetes must be beta cell autoantibody positive; or
  - The patient must demonstrate insulinopenia, defined as a fasting C-peptide level that is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will be considered valid only with a concurrently obtained fasting glucose <225 mg/dL.
- Patients must have a history of medically-uncontrollable labile (brittle) insulin dependent diabetes mellitus with documented recurrent, severe, acutely life threatening metabolic complications that require hospitalization.
- These complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks.
- Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically recognized advanced insulin formulations and delivery systems.
- Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression.
- Patients must otherwise be suitable candidates for transplantation.

Billing and Claims Processing

The following ICD-9 CM codes will be recognized by FIs and carriers for pancreas transplantation alone for beneficiaries with type I diabetes when billed with *CPT 48554*:

250.01	250.03	250.11	250.13	250.21
250.23	250.31	250.33	250.41	250.43
250.51	250.53	250.61	250.63	250.71
250.73	250.81	250.83	250.91	250.93

Carriers and FIs who receive claims for PA services that were performed in an **unapproved facility** should use the following messages upon the reject or denial:

Medicare Summary Notice (MSN) Message – MSN code 16.2 (This service cannot be paid when provided in this location/facility)

Remittance Advice Message – Claim adjustment reason code 58 (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service)

Carriers and FIs who receive claims for PA services that are **not billed using the covered diagnosis/procedure codes listed** above should use the following messages upon the reject or denial:

Medicare Summary Notice (MSN) Message – MSN code 15.4 (The information provided does not support the need for this service or item)

Remittance Advice Message – Claim adjustment reason code 11 (The diagnosis is inconsistent with the procedure)

Modification of the current coverage policy on pancreas transplants may be found in Publication 100-03, Section 260.3 and claims processing information is located in Publication 100-04, Chapter 3, Section 90.5.1. The location of this information is listed in the *Additional Information* section of this article.

Note: Carriers and FIs will hold any PA claims with dates of service on or after April 26, 2006, until the claims can be processed in their systems. For FIs this date is October 2, 2006, and for carriers the date is July 3, 2006.

Implementation

The implementation date for this instruction is no later than:

- July 3, 2006, for carriers
- October 2, 2006, for FIs.

Pancreas Transplants Alone (continued)

Additional Information

The official instructions issued to your Medicare FI or carrier regarding this change may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R56NCD.pdf* for the NCD manual revision and *http://www.cms.hhs.gov/Transmittals/downloads/R957CP.pdf* for changes to the *Medicare Claims Processing Manual*.

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

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

MLN Matters Number: MM5093
Related Change Request (CR) Number: 5093
Related CR Release Date: May 19, 2006
Related CR Transmittal Number: R56NCD and R957CP
Effective Date: April 26, 2006
Implementation Date: July 3, 2006 for carriers; October 2, 2006 for FIs

Source: CMS Pub. 100-04, Transmittal 957, CR 5093

Temporary Hold of Pancreas Transplantation Alone Claim Submission

Effective April 26, 2006, Medicare covers pancreas transplantation alone for patients who meet certain criteria identified with type I diabetes when the service is performed in an approved facility and all the coverage requirements are met.

The Centers for Medicare & Medicaid Services (CMS) has established the implementation date for processing Medicare Part A claims for October 2, 2006, to coincide with the installation of the fiscal year 2007 GROUPER software, version 24.0. This version of the GROUPER software, among other things, updates diagnosis related group (DRG) 513 (pancreas transplant) to not require kidney transplant ICD-9-CM diagnosis codes along with the pancreas transplant.

CMS has instructed fiscal intermediaries to hold in the system any pancreas transplantation alone claims with discharge dates on or after April 26, 2006 through October 1, 2006.

In addition, CMS is encouraging Part A providers **not** to submit to their fiscal intermediaries claims for pancreas transplantation alone until the GROUPER software has been installed. ❖

Source: CMS Pub. 100-04, Transmittal 957, CR 5093

Hospital Payment Information for Certain Elective Procedures and Admissions

Important Step Toward Transparency in Health Care Costs and Quality

To help consumers, providers, and payers make more informed health care decisions, the Department of Health & Human Services through its Centers for Medicare & Medicaid Services (CMS) has issued information on what Medicare pays for 30 common elective procedures and other hospital admissions. President Bush directed the data be made publicly available to all Americans as part of the Administration's commitment to make health care more affordable and accessible.

The new information posted by CMS at *http://www.cms.hhs.gov/HealthCareConInit/01_Overview.asp#TopOfPage* shows the range of payments by county and the number of cases treated at each hospital for a variety of treatments provided to seniors and people with disabilities in fiscal year 2005. These include 30 common elective procedures including heart operations and implanting cardiac defibrillators, hip and knee replacements, kidney and urinary tract operations, gallbladder operations and back and neck operations, and for common non-surgical admissions.

Please click the following link to read more from the HHS Press Release *http://www.hhs.gov/news/press/2006pres/20060601a.html*.

Click on the CMS fact sheet at *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1872*.

Also, you mayan read more helpful information on the CMS Web page for health care consumer initiatives located at *http://www.cms.hhs.gov/HealthCareConInit/01_Overview.asp#TopOfPage*. ❖

Source: CMS Provider Education Resource 200606-03

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens—Update to Section 1011

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

Provider Types Affected

Physicians, hospitals, and ambulance services that provide emergency health services to undocumented aliens.

Impact on Providers

STOP – Impact to You

You may not be receiving funds that are available to you for services you furnish to undocumented aliens, and the Centers for Medicare & Medicaid Services (CMS) is providing this special edition article to inform and/or remind you about these available funds.

CAUTION – What You Need to Know

The Medicare Prescription Drug Improvement and Modernization Act (MMA) (Section 1011) provides $250 million each year for fiscal years (FY) 2005-2008 for payments to eligible providers for emergency health services given to undocumented and other specified aliens. You may be eligible to receive some of these funds.

GO – What You Need to Do

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

Background

CMS previously issued *MLN Matters* Special Edition article SE0535 (MMA – CMS' Implementation of Section 1011 of the Medicare Modernization Act – Federal Funding of Emergency Health Services Furnished to Undocumented Aliens) to inform physicians, hospitals, and ambulance services about the federal funding available to help pay for services furnished to undocumented aliens. (See SE0535 on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0535.pdf*.)

Because some providers may not be utilizing these available funds, CMS is issuing this additional special edition article to inform (and remind) providers about the funds that are available for emergency health services furnished to undocumented aliens.

The MMA (Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens) provides $250 million each year for FY 2005-2008 for payments to eligible providers for emergency health services given to undocumented and other specified aliens:

- Two-thirds of the funds are divided among all 50 states and the District of Columbia, based on their relative percentages of undocumented aliens; and
- One-third of the funds are divided among the six states with the largest number of undocumented alien apprehensions.

Note: Current state allocations of these funds may be viewed on the CMS website at *http://www.cms.hhs.gov/UndocAliens/04_state_alloc.asp#TopOfPage*.

From the respective state allotments, payments are made directly to enrolled hospitals, physicians, and ambulance providers for some or all of the costs of providing emergency health care (required under Section 1867) and related hospital inpatient services, outpatient services, and ambulance services provided to eligible individuals.

As of May 1, 2006, nationally, over 9,000 provider enrollment applications have been approved. The first Section 1011 payment to providers was issued on February 27, 2006, totaling nearly $25.5 million, and the next quarterly payment to providers was scheduled for May 29, 2006.

TrailBlazer Health Enterprises, LLC, is the national contractor for the Section 1011 program and is the only contractor for processing all requests for Section 1011 provider payments. So, if you want to request 1011 payments, you must do so by enrolling with TrailBlazer and then submit your requests to TrailBlazer. **Do NOT submit requests for 1011 payment to your regular fiscal intermediary or carrier.** To learn more about the Section 1011 program, or to enroll as a provider, see the TrailBlazer website at *https://www.trailblazerhealth.com/section1011/*.

TrailBlazer may also be contacted directly by telephone at (866) 860-1011.

Additional Information

Additional information regarding Section 1011 of the MMA and CMS' policy for the implementation and administration of this program may be found on the CMS website at *http://www.cms.hhs.gov/UndocAliens/*.

MLN Matters Number: SE0633
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0633

Inpatient Rehabilitation Facility Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment rates for services by inpatient rehabilitation facilities (IRFs) and modify payment policies for fiscal year (FY) 2007. The proposed policies, if finalized, are estimated to increase Medicare payments to approximately 1,240 IRFs in FY 2007 by $40 million.

The new payments and policies would apply to discharges on or after October 1, 2006, through September 30, 2007.

A display copy is available on the CMS IRF PPS website at *http://www.cms.hhs.gov/InpatientRehabFacPPS/downloads/cms1540pdisplay050806.pdf*.

For publication details, please visit the Office of the Federal Register's website at *http://archives.gov/federal-register/public-inspection/*. ❖

Source: CMS Provider Education Resource 200605-10

Revisions to the Inpatient Rehabilitation Facility Prospective Payment System

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

Provider Types Affected

Facilities billing Medicare fiscal intermediaries (FIs) for inpatient rehabilitation services

Provider Action Needed

STOP – Impact to You

You are excluded from the acute care hospital prospective payment system (PPS) if you provide intensive rehabilitative services for an inpatient population that meets, or exceeds, a compliance percentage defined by Congress in the Deficit Reduction Act of 2005 (outlined below).

CAUTION – What You Need to Know

CR 5016 (from which this article is taken) revises the inpatient rehabilitation facility (IRF) PPS instructions to adopt the IRF compliance percentage as set forth by Congress in the Deficit Reduction Act of 2005; clarifies the use of medical record review in determining the IRF compliance percentage; and effect new policy on the IRF compliance percentage when patients are admitted under the Secretary of Health and Human Services' declaration of a public health emergency under section 319 of the Public Health Service Act.

GO – What You Need to Do

Make sure that your billing staffs are aware of these changes in billing for inpatient rehabilitation services.

Background

A rehabilitation hospital is excluded from the acute care hospital PPS if it has an agreement in effect to participate as a hospital, and if it meets what is commonly referred to as a compliance percentage. This means that during a most recent, consecutive, and appropriate 12-month time period (as defined by the Centers for Medicare & Medicaid Services or your FI, the hospital provided intensive rehabilitative services (to treat one or more specified medical conditions) for a portion of its inpatient population that met or exceeded specific percentage thresholds.

CR 5016 revises the IRF PPS instructions to adopt the IRF compliance percentage as set forth by Congress in the Deficit Reduction Act of 2005:

- The compliance percentage threshold for cost reporting periods:
  - During the 12-month period beginning on or after July 1, 2006 and before July 1, 2007, this percentage is 60 percent.
  - During the 12-month period beginning on or after July 1, 2007 and before July 1, 2008, it is 65 percent.
  - Beginning on or after July 1, 2008, it is 75 percent.

Note that a patient's comorbidity will not be included in the inpatient population used to determine the compliance percentage for cost reporting periods beginning on or after July 1, 2008.

- In certain cases, in addition to using the presumptive method to determine whether you have met the compliance percentage, your FI (according to written policies that describe the reasons for so choosing) may also review a random sample of medical records to make this determination for the applicable cost reporting period. And you should be aware that the compliance percentage that your FI determines through this medical record review will supersede the percentage that was determined for the same compliance review period by using the presumptive method.
- Lastly, in a public health emergency or major disaster situation, there is an exception to the general guideline regarding the submission of a listing of an IRF's patients. Here is the explanation for this exception:
  - Should the Secretary of Health & Human Services (HHS) declare a public health emergency under section 319 of the Public Health Service Act (or another appropriate statute), or the President declares either a national emergency under the National Emergencies Act or a major disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (or other appropriate law), the requirements stipulated in certain regulations or operational policies may, on occasion, be waived in specific geographic areas for a specific time period. In such instances, in accordance with the waiver provisions, the IRF may be permitted to admit patients who otherwise would be admitted to another inpatient setting.

Revisions to the Inpatient Rehabilitation Facility Prospective Payment System (continued)

To ensure that these (national emergency or disaster) inpatients are not included as part of your total inpatient population when your compliance percentage is being determined, do not submit their assigned hospital numbers to your FI when submitting the list of hospital numbers for the percentage calculations mentioned above. You should, however, appropriately document in the medical record sufficient information that identifies them as national emergency or disaster inpatients.

Note: For the period from August 24, 2005, through the implementation date of CR 5016, FIs will not search their files to determine whether national emergency or disaster inpatients were excluded as part of the IRF's total patient population in determining the IRF compliance percentage, but they may review cases that are called to their attention.

Additional Information

You can find more information about this instruction (CR 5016) on inpatient rehabilitation facility prospective payment system by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R938CP.pdf*.

Additionally, you might want to read the revised *Medicare Claims Processing Manual* (IOM [Pub] 100.04), Chapter 3 (Inpatient Hospital Billing), Section 140 (Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)), which you can find as an attachment to this CR.

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/MedlearnProducts/downloads/CallCenterTollNumDirectory.pdf*.

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

MLN Matters Number: MM5016
Related Change Request (CR) Number: 5016
Related CR Release Date: May 5, 2006
Related CR Transmittal Number: R938CP
Effective Date: August 7, 2006
Implementation Date: August 7, 2006

Source: CMS Pub. 100-04, Transmittal 938, CR 5016

Billing and Payment of Certain Colorectal Cancer Screenings for Non-Patients on Type of Bill 14x

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 services related to colorectal cancer screening for nonpatients on type of bill (TOB 14x).

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4272, which clarifies the use of TOB 14x for a nonpatient laboratory specimen when billing for colorectal cancer screenings Healthcare Common Procedure Coding System (HCPCS) code G0107 or G0328 when performed in a hospital setting.

CAUTION – What You Need to Know

Payment will be based on the clinical diagnostic laboratory fee schedule for all hospitals, including critical access hospitals (CAHs) and hospitals located in Maryland under the jurisdiction of the Health Services Cost Review Commission (HSCRC) when billed on TOB 14x. All colorectal cancer screenings billed on TOB 13x for all hospitals will continue to be paid under current payment methodologies. In addition, this instruction clarifies payment to Maryland waiver hospitals for TOB 13x for colorectal cancer screenings.

GO – What You Need to Do

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

Background

CR 3835 (Transmittal 734**,** dated October 28, 2005, *http://new.cms.hhs.gov/transmittals/downloads/R734CP.pdf*) implements the redefined type of bill (TOB) 14x to be used by hospitals for billing of nonpatient laboratory specimens effective for dates of service **on and after April 1, 2006.**

The National Uniform Billing Committee (NUBC) has redefined the TOB 14x to be limited in use for *nonpatient* laboratory specimens.

A *nonpatient* is defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital that has a specimen that is submitted for analysis and the beneficiary is not physically present.

A *MLN Matters* article is available on CR 3835 on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3835.pdf*.

Payment

Payment for HCPCS codes G0107 and G0328, when submitted on TOB 14x, will be based on the clinical diagnostic laboratory fee schedule for all hospitals, including critical access hospitals (CAHs) and Maryland hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC).

Special Payment Instructions for Non-Patient Laboratory Specimen (TOB 14x) for All Hospitals

Payment for colorectal cancer screenings (HCPCS codes G0107 and G0328) to a hospital for a nonpatient

Billing and Payment of Certain Colorectal Cancer Screenings for Non-Patients on Type of Bill 14x (continued)

laboratory specimen (TOB 14x), is the lesser of the actual charge, the fee schedule amount, or the national limitation amount (NLA), (including CAHs and Maryland waiver hospitals).

Part B deductible and coinsurance do not apply.

Billing Requirements for Claims Submitted to FIs

Hospitals use the ANSI X12N 837I to bill the FI or the hardcopy Form CMS-1450.

Hospitals bill revenue codes and HCPCS codes as follows:

Screening Test/Procedure	Revenue Code	HCPCS Code	TOB
Fecal Occult blood test	030x	G0107, G0328	13x, 14x, 83x, 85x**
Barium enema	032x	G0106, G0120, G0122	13x, 85x
Flexible Sigmoidoscopy	*	G0104	13x, 83x, 85x
Colonoscopy-high risk	*	G0105, G0121	13x, 83x, 85x

***** The appropriate revenue code when reporting any other surgical procedure.
****** TOB 14x is only applicable for nonpatient laboratory specimens

Note: All colorectal cancer screenings billed on TOB 13x or 85x will continue to be paid under current payment methodologies.

Implementation

The implementation date for the instruction is July 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R821CP.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.pdf*.

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

MLN Matters Number: MM4272
Related Change Request (CR) Number: 4272
Related CR Release Date: February 1, 2006
Related CR Transmittal Number: R821CP
Effective Date: April 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 821, CR 4272

Processing of Outpatient Prospective Payment System Claims with Certain Drug Administration Code Pairs

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) for drug administration services

Provider Action Needed
STOP – Impact to You

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to address concerns about Correct Coding Initiative (CCI) edits on coding for drug administration services under the outpatient prospective payment system (OPPS).

CAUTION – What You Need to Know

Change Request (CR) 5011 (Transmittal 896) instructed FIs to implement CCI edits (Version 12.0) for drug administration services paid under the OPPS and furnished on or after April 1, 2006. When an OPPS claim triggers a CCI edit, the entire claim is not rejected or returned. Instead, only one line item is rejected (i.e., the CCI edits identify pairs of codes that are not appropriately reported together unless an edit permits use of a modifier to signal that the codes represent separate and distinct services/procedures). Hospitals have subsequently expressed concerns about the impact of these CCI edits on coding for drug administration services under the OPPS, and this special edition instructs your FI regarding resolution to these concerns.

GO – What You Need to Do

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

Background

CMS updated payment policies for drug administration services furnished under the hospital OPPS in the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 4, Section 230) with CR 4258 (Transmittal 785CP, dated December 16, 2005; *http://www.cms.hhs.gov/transmittals/downloads/R785CP.pdf*) effective January 1, 2006. Subsequently, the updated payment policies contained in the manual revision generated requests to clarify the new manual language.

Therefore, in order to support continued hospital implementation efforts of correct coding concepts for drug administration services, CMS added clarifying language to

Processing of Outpatient PPS Claims with Certain Drug Administration Code Pairs (continued)

the existing policies in the *Medicare Claims Processing Manual* (Pub.100-04, Chapter 4, Section 230) with the release of CR 4388 (Transmittal 902, dated April 7, 2006; *http://www.cms.hhs.gov/transmittals/downloads/R902CP.pdf*) effective January 1, 2006.

Issue

CMS instructed FIs to implement version 12.0 of the CCI edits for drug administration services paid under the OPPS and furnished on or after April 1, 2006, in CR5011 (Transmittal 896, dated March 24, 2006; *http://www.cms.hhs.gov/transmittals/downloads/R896CP.pdf*) effective April 1, 2006.

When an OPPS claim triggers a CCI edit, the entire claim is not rejected or returned. Instead, only one line item is rejected. That is, the CCI edits identify pairs of codes that are not appropriately reported together unless an edit permits use of a modifier to signal that the codes represent separate and distinct services/procedures.

Hospitals have subsequently expressed concerns about the impact of these CCI edits on coding for drug administration services under the OPPS.

Solution

To address these concerns, CMS is providing this special edition article to instruct FIs to:

- Institute a process (via the claims processing system used by the FIs) that will add Healthcare Common Procedure Coding System (HCPCS) modifier 59 (Distinct Procedural Service; *http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf*), where appropriate, to the line item containing the HCPCS code in column 2 of the following code pairs (reported with dates of service on or after April 1, 2006, through June 30, 2006) to enable claims to process to payment without triggering a line item rejection and CCI edit.

HCPCS Codes	
Column 1	**Column 2**
C8950	C8952
C8953	C8950
C8953	C8952
C8954	C8950
C8954	C8952
C8954	C8953

- After the previous step has been taken, FIs should notify providers that they may submit adjustment bills to receive payment if one of the codes in any of the above code pairs has been rejected for payment.

Note: Version 12.1 of the CCI edits, which will be incorporated in the July 2006 OPPS outpatient code editor (OCE) update, will not include CCI edits for the six code pairs listed above.

Additional Information

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

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

MLN Matters Number: SE0635
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0635

Adjustment Claim Submission for Certain Drug Administration Code Pairs

The Centers for Medicare & Medicaid Services (CMS) has instructed fiscal intermediaries to establish a system process to address the concerns raised by hospitals about the impact of the Correct Coding Initiative (CCI) edits when certain drug administration code pairs are reported on the same claim for the same date of service without modifier 59.

Modifier 59 has been added to the appropriate HCPCS codes to allow the line item containing the HCPCS code in column 2 of the following code pairs, reported with dates of service **on or after April 1, 2006, through June 30, 2006**, to process for payment without triggering a line item rejection and a CCI edit.

Note: Version 12.1 of the CCI edits, which will be incorporated in the July 2006 OPPS outpatient code editor (OCE) update, will not include CCI edits for the six code pairs listed here.

HCPCS Codes	
Column 1	**Column 2**
C8950	C8952
C8953	C8950
C8953	C8952
C8954	C8950
C8954	C8952
C8954	C8953

Action Required by Providers

Hospitals may adjust claims to receive payment if one of the HCPCS codes in any of the above code pairs have been rejected for payment for services provided on or after April 1, 2006. ❖

Source: CMS Joint Signature Memorandum 06435, May 8, 2006

Coding Drug Administration Services for Payment Under the Calendar Year 2006 OPPS

The Centers for Medicare & Medicaid Services (CMS) issued transmittal 785, change request (CR) 4258, on December 16, 2005 to revise Chapter 4, section 230 of the *Medicare Claims Processing* Manual (Pub. 100-04). The manual revision updated payment policies for drug administration services furnished under the hospital outpatient prospective payment system (OPPS) effective January 1, 2006.

In response to requests for further clarification of correct coding for drug administration services paid under the OPPS, CMS further revised Chapter 4, Section 230 of the Medicare Claims Processing Manual in transmittal 902, CR 4388), issued on April 7, 2006. The link to these transmittals is: *http://www.cms.hhs.gov/Transmittals/2006Trans/list.asp*.

Transmittal 896, CR 5011, issued on March 24, 2006, instructed fiscal intermediaries (FIs) to implement version 12.0 of Correct Coding Initiative (CCI) edits for drug administration services paid under the OPPS that are furnished on or after April 1, 2006. When an OPPS claim triggers a CCI edit, the entire claim is not rejected or returned. Rather, only one line item is rejected. That is, the CCI edits identify pairs of codes that are not appropriately reported together unless an edit permits use of a modifier to signal that the codes represent separate and distinct services/procedures.

Hospitals have raised particular concerns about the impact of CCI edits when the following code pairs are reported on the same claim for the same date of service without modifier 59. Because these codes represent services, which may be frequently furnished together during a single outpatient encounter, hospitals report that they would have to review virtually every outpatient claim to manually add modifier 59 so that claims with these code pairs would process to payment without triggering a CCI edit.

HCPCS Codes	
Column 1	**Column 2**
C8950	C8952
C8953	C8950
C8953	C8952
C8954	C8950
C8954	C8952
C8954	C8953

CMS is currently working to resolve as swiftly as possible concerns that have been raised by numerous hospitals about the impact of CCI edits on reporting these particular code pairs. CMS will announce on the CMS website, through the hospital listserv, through contractors, and through other communication channels the steps it is taking to address the issues raised by hospitals in connection with these particular CCI edits. Hospitals are encouraged to await instructions from their FI before modifying internal billing processes. ❖

Source: CMS Provider Education Resource 200605-07

CRITICAL ACCESS HOSPITAL SERVICES

July 2006 Non-Outpatient Prospective Patient System Outpatient Code Editor Specifications (Version 21.3)

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

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services not subject to the outpatient prospective payment system (OPPS)

Provider Action Needed

This article is based on change request (CR) 5066, which announces that the July 2006 non-OPPS OCE has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System (HCPCS) codes and procedure codes.

Background

CR 5066 informs your FIs and RHHIs that the non-OPPS outpatient code editor (OCE) used to process claims from hospitals not paid under the OPPS has been updated with new additions, changes, and deletions to Healthcare Common procedure Coding System/*Current Procedural Terminology* (HCPCS/*CPT*) codes and descriptions.

To view the specific code updates, please see CR 5066 on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R960CP.pdf*.

Implementation

The implementation date for the instructions is July 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.hhs.gov/Transmittals/downloads/R960CP.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.pdf*.

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

MLN Matters Number: MM5066
Related Change Request (CR) Number: 5066
Related CR Release Date: May 26, 2006
Related CR Transmittal Number: R960CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 9602, CR 5066

Ambulance Claims Submitted by Critical Access Hospitals

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries of a processing issue affecting claims submitted by critical access hospitals (type of bill 85x) for ambulance services (revenue code 054x).

A system release to correct this issue is scheduled for implementation on June 5, 2006.

Currently, claims meeting the above criteria are suspending in location S/MFINH. Once the system release is implemented on June 5, 2006, the claims will be released for processing.

Providers **do not need** to take any action on this issue. ❖

Source: CMS Joint Signature Memorandum 06410, April 27, 2006

Anesthesia and Ambulance Services in Critical Access Hospitals

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) for critical access hospital (CAH) anesthesia and ambulance services provided to Medicare beneficiaries

Impact on Providers

This Special Edition article is based on recent instructions from the Centers for Medicare & Medicaid Services (CMS) to your FI to hold the following until errors with Medicare's Fiscal Intermediary Shared System (FISS) are corrected on June 5, 2006:

- All CAH method II claims that have revenue code 0964 (CRNA professional services) and anesthesia HCPCS code (00100-01999).
- All CAH claims with revenue codes 054x (ambulance services).

The FISS is used by FIs to process your claims.

Background

Recently, CMS became aware of these two CAH claims processing issues:

1. CAH Method II claims **are reimbursing at an incorrect rate** when the claims have both:
   - **Revenue code 0964** (certified registered nurse anesthetist [CRNA] professional services)
   - Anesthesia Healthcare Common Procedure Coding System (HCPCS) codes 00100-01999
2. All CAH claims with ambulance services (revenue codes 054x) are suspending because the **line level coinsurance total does not match the claim level coinsurance.**

This Special Edition article advises that your FI has been instructed to hold claims that fall into the above two categories until a FISS correction is released and installed by your FI no later than June 5, 2006.

Additional Information

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

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

Source: CMS Special Edition MLN Matters Article SE0631

SKILLED NURSING FACILITY SERVICES

Benefits Exhaust and No-Payment Billing Instructions

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

Provider Types Affected

Skilled nursing facilities (SNFs) that bill Medicare fiscal intermediaries (FIs) for skilled nursing care benefits

Important Points to Remember

- CR 4292 implements a standard process for billing claims in ***benefits exhaust*** and ***no payment*** situations.

  Note: Currently, requirements for billing such claims for SNF providers vary; this instruction implements a standard process.

- This standard process applies **only** to SNF residents who are newly admitted to, or are in, Medicare Part A stays on or after October 1, 2006.

Background

An SNF is required to submit a bill even though no benefits may be payable by Medicare. The Centers for Medicare & Medicaid Services (CMS) maintains a record of all inpatient services for each beneficiary, whether those services are covered by Medicare or not.

The related information is used for national health care planning and also enables CMS to keep track of the beneficiary's benefit period. These bills are required in two situations:

- When the beneficiary has exhausted their 100 covered days under the Medicare SNF benefit (referred to below as benefits exhaust bills); and
- When the beneficiary no longer needs a Medicare covered level of care (referred to below as no-payment bills).

Benefits Exhaust Situations

An SNF must submit a benefits exhaust bill monthly for those patients that continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

- **Full benefits exhaust claims:** no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim and
- **Partial benefits exhaust claims:** only one or some benefit days in the beneficiary's applicable benefit period remain for the submitted statement covers from/through date of the claim.

These bills are required in order to extend the beneficiary's applicable benefit period posted in the Medicare system's common working file (CWF).

Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

No-Payment Situations

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered care and subsequently dropped to a noncovered level of care but continue to reside in a Medicare-certified area of the facility.

Consolidated billing (CB) legislation indicates that physical therapy, occupational therapy, and speech language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a noncovered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a type of bill (TOB) 22x (inpatient Part B).

Billing Guidance

Under the new standard process, effective on October 1, 2006, the billing guidance for submitting either benefits exhaust or no-payment claims is as follows:

1. **Benefits Exhaust Claims**
   SNF providers must submit **benefits exhaust claims** for those beneficiaries that continue to receive skilled services as follows:

Full or partial benefits exhaust claim:

- **Type of Bill –** Use appropriate covered TOB (i.e., 211, 212, 213 or 214 for SNF and 181, 182, 183, or 184 for swing bed [SB]).

  Note: TOB 210 or 180 should not be used for benefits exhaust claims.

- **Covered Days and Charges –** Submit all covered days and charges as if beneficiary had days available.
- **Value Code 09** (first year coinsurance amount) **or Value Code 11** (second year coinsurance amount) = 1.00. (If applicable, the Medicare system will assign the correct coinsurance amount.)
- **Patient Status Code** – Use appropriate code.

Benefits exhaust claim with a drop in level of care within the month patient remains in the Medicare-certified area of the facility after the drop in level of care:

- **Type of Bill –** Use appropriate TOB (i.e., 212 or 213 for SNF and 182 or 183 for SB).

  Note: TOB 210 or 180 should not be used for benefits exhaust claims.

Benefits Exhaust and No-Payment Billing Instructions (continued)

- **Occurrence Code 22 (date active care ended) –** Include the date active care ended; this should match the statement covers through date on the claim.
- **Covered Days and Charges –** Submit all covered days and charges as if the beneficiary had days available up until the date active care ended.
- **Value Code 09 (**first year coinsurance amount**) or Value Code 11 (**second year coinsurance amount**)** = 1.00. (If applicable, the Medicare system will assign the correct coinsurance amount.)
- **Patient Status Code –** 30 (still patient).

Benefits exhaust claim with a patient discharge:

- **Bill Type** – 211 or 214 for SNF and 181 or 184 for SB.

  Note: Bill type 210 or 180 should not be used for benefits exhaust claims.
- **Covered Days and Charges –** Submit all covered days and charges as if beneficiary had days available up until the date of discharge.
- **Value Code 09** (first year coinsurance amount) **or Value Code 11** (second year coinsurance amount) = 1.00 (If applicable, the Medicare system will assign the correct coinsurance amount.)
- **Patient Status Code –** Use appropriate code other than patient status code 30 (still patient).

Note: Billing all covered days and charges allows the Medicare CWF system to assign the correct benefits exhaust denial to the claim and appropriately post the claim to the patient's benefit period. Benefits exhaust bills must be submitted monthly.

2. No-Payment Claims

SNF providers will submit **no-payment claims** for beneficiaries that previously dropped to non-skilled care and continue to reside in the Medicare-certified area of the facility using either of the following options.

Patient previously dropped to non-skilled care within the month. Provider needs Medicare denial notice for other insurers:

- **Type of Bill –** TOB 210 (no-payment bill type)
- **Statement Covers From and Through Dates** – days provider is billing, which may be submitted as frequently as monthly, in order to receive a denial for other insurer purposes. No-payment billing shall start the day following the date active care ended.
- **Days and Charges –** Noncovered days and charges beginning with the day after active care ended.
- **Condition Code 21** (billing for denial)
- **Patient Status Code –** Use appropriate code.

Patient previously dropped to non-skilled care. In these cases, the provider must only submit the final discharge bill that may span multiple months:

- **Type of Bill –** TOB 210 (no-payment bill type)
- **Statement Covers From and Through Dates** – days billed by the provider, which may span multiple months, in order to show final discharge of the patient. No-payment billing shall start the day following the date active care ended.
- **Days and Charges –** Non-covered days and charges beginning with the day after active care ended.
- **Condition Code 21** (billing for denial)
- **Patient Status Code –** Use appropriate code other than patient status code 30 (still patient).

Implementation

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

Additional Information

The official instructions issued to your Intermediary regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R930CP.pdf*.

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

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

MLN Matters Number: MM4292
Related Change Request (CR) Number: 4292
Related CR Release Date: April 28, 2006
Related CR Transmittal Number: R930CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 930, CR 4292

CORF SERVICES

Changes Conforming to Change Request 3648 for Therapy Services

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for therapy services

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4014, which updates language in the *Medicare National Coverage Determinations Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) by changing the term "speech therapy" to "speech-language pathology."

CAUTION – What You Need to Know

To conform to changes in CR 3648, CR 4014 removes from the *Medicare Claims Processing Manual* (Publication 100-04) the requirement to include the date last seen by a physician for outpatient services provided by a physical or occupational therapist or speech-language pathologist.

Requirements for therapy services incident to a physician have not been changed.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) is updating language in the *Medicare National Coverage Determinations (NCD) Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) as follows: The term "speech therapy" is being changed to "speech-language pathology." In addition, CMS is changing requirements in Chapter 1 of the *Medicare Claims Processing Manual* where therapists are to provide information on CMS-1500 seen by the physician to conform with instructions in CR 3648, Transmittal 36, dated June 24, 2005; subject: Publication 100-02, Chapter 15, Sections 220 and 230 Therapy Services. CR 3648 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf*.

The Health Insurance Portability and Accountability Act (HIPAA) guidelines require the following information only when it impacts the payer's adjudication process:

- Date last seen; and
- The unique provider identification number (UPIN) of the physician.

Medicare payment is not impacted by this information except when the service is provided "incident to" the services of a physician or nonphysician practitioner (NPP), in which case it is required. CR 4014 updates instructions in CR 3648 (related to claims for services "incident to" a physician's/NPP's service) by acknowledging that:

- The "incident to" service can be identified only on prepay or postpay review;
- Manual review of all therapy claims is not required; and
- "Incident to" policies have not changed and still apply to therapy services.

CR 4014 also clarifies selected business requirements in CR 3648 to indicate that some contractor actions:

- Will occur on prepay or postpay review.
  For example, compare the following:

  Business Rule (BR) 3648.8 – Contractors shall pay for therapy services only when the service qualifies as a therapy service and the service is furnished by qualified professionals, or qualified personnel as defined in the manuals;

  with

  BR 4014.8 – On prepay or post pay review of outpatient therapy claims for services provided on or after July 25, 2005, contractors shall pay for physical therapy and occupational therapy services only when the service is furnished by qualified professionals, or qualified personnel as defined in the appropriate Medicare manuals.
- Should not be applied to services "incident to." (e.g., BR 3648.3 – Medicare contractors shall not deny therapy claims based on missing documentation of a visit to the physician on prepay or post pay review).

CR 3648 omitted the requirement for a physician visit when therapy services are billed. This change omits the requirement that the physician visit be documented on the claim.

This change does not affect the requirements for services billed "incident to" a physician.

Therefore, when a therapy service is billed "incident to," the following requirements remain in effect because they are required by "incident to" policies:

- An initial physician visit (date last seen); and
- Identification of the ordering (and supervising) physicians/NPPs.

Implementation

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

Additional Information

CR 3648 (Transmittal 36 dated June 24, 2005, subject Pub. 100-02, Chapter 15, Sections 220 and 230 Therapy

Changes Conforming to Change Request 3648 for Therapy Services (continued)

Services) may be reviewed on the CMS website at *http://www.cms.hhs.gov/manuals/pm_trans/R36BP.pdf*.

The MLN Matters article, MM3648 may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3648.pdf*.

For complete details, please see the official instructions (CR 4014) issued to your carrier/intermediary regarding this change. There are two transmittals for CR 4014, the NCD, transmittal 55 is available at *http://www.cms.hhs.gov/Transmittals/downloads/R55NCD.pdf*.

Transmittal 941 is the *Medicare Claims Processing Manual* update, which is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R941CP.pdf*.

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

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

MLN Matters Number: MM4014
Related Change Request (CR) Number: 4014
Related CR Release Date: May 5, 2006
Related CR Transmittal Number: R941CP and R55NCD
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 941, CR 4014

Use of the KX Modifier on Claims Submitted to the Fiscal Intermediary When Some Services Exceed the Therapy Caps

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

Provider Types Affected

All providers billing Medicare fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs) for physical therapy, speech-language pathology, and occupational therapy services

Background

The Centers for Medicare & Medicaid Services (CMS) is aware that some claims processed by fiscal intermediaries are being improperly denied. These improper denials occur when some services on the claim are below the therapy cap and not billed with the KX modifier, and other services on the same claim are above the therapy cap, and billed with the KX modifier.

This special edition (SE) article outlines the proper use of the KX modifier only for claims submitted to and processed by fiscal intermediaries. This is a temporary instruction to be implemented until systems changes are completed.

Key Points

- The KX modifier is added to each claim line for an outpatient therapy service procedure when the beneficiary is qualified for exception to the therapy caps through either the automatic process or the manual process of exception.
- When the KX modifier is appropriate for at least one of the outpatient therapy service line items on an intermediary claim, providers should bill the KX modifier on all outpatient therapy service line items on the same claim for those services representing the same therapy cap (that is, either the combined physical therapy, and speech-language pathology cap, or the separate occupational therapy cap).
- Do not add the KX modifier to line items that would not be eligible for exception if the service was provided after the cap is reached. That is, if the services would require a manual exception if the cap is exceeded and that exception has not yet been approved, do not bill for that service using the KX modifier.
- Services for billing periods after the cap has been exceeded which are not eligible for exceptions may be billed for denial using condition code 21.
- Do not submit claims that have the KX modifier on some, but not all, lines that apply to the same cap for outpatient therapy services.
- The Medicare system will recognize the services that fall below the therapy cap and those that fall above the therapy cap and process for payment accurately.
- Providers will not be penalized for using the KX modifier on medically necessary services that would be eligible for an exception above the cap when those services are below the therapy cap and billed on the same claim as services that appropriately use the KX modifier to signify services from the same therapy cap that appropriately exceeds that therapy cap.
- Continue to avoid using the KX modifier on claims where none of the therapy services on that claim that count toward the same therapy cap is appropriate for the use of the KX modifier.

Examples

The following examples are applicable only when the provider has researched Medicare policies and identified that the beneficiary is reaching the therapy cap threshold and the billed services are medically necessary:

- When providers submit claims with multiple line items for physical therapy and/or speech-language pathology services; **and**

Use of the KX Modifier on Claims Submitted to FIs When Some Services Exceed the Therapy Caps (continued)

- Some of the lines represent services that are appropriate for use of the KX modifier; **but**
- None of the lines represent services that would not be eligible for use of a KX modifier if the cap was exceeded; **then**
- Apply the KX modifier to all of the physical therapy and speech-language pathology line items on that same claim.
- Services may be eligible for use of the KX modifier either by qualifying for use of the automatic exception process, or with approval of the contractor for manual exceptions.
- When providers submit claims with multiple line items for occupational therapy services, the presence or absence of the KX modifier on the physical therapy speech-language pathology line items does not affect the use of the KX modifier for occupational therapy services.
- Apply the KX modifier to all of the occupational therapy line items if:
  - All of the line items would represent services that are appropriate for use of the KX modifier if the services exceeded the cap; and
  - Some of the lines represent services that are currently eligible for use of the KX modifier on this claim.
- Or, apply the KX modifier to none of the occupational therapy line items, if appropriate.

Note: These rules do not apply to suppliers billing to carriers. For carrier claims, continue to use the KX modifier only on the lines that exceed the therapy cap. Where the therapy cap is being approached, use the KX modifier for the services that might exceed the therapy cap.

Additional Information

The CMS fact sheet, "Outpatient Therapy Caps: Exceptions Process Required by the Deficit Reduction Act (DRA)," may be found on the CMS website at *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1782*.

MLN article MM4364 describes the Therapy Caps Exception Process and may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4364.pdf*.

See also Publication 100-04, Chapter 5, Section 10.2, for a description of therapy caps and exceptions on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf*.

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

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

MLN Matters Number: SE0637
Related Change Request (CR) Number: NA
Related CR Release Date: NA
Related CR Transmittal Number: NA
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Source: CMS Special Edition MLN Matters Article SE0637

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Hospital Outpatient Prospective Payment System Manual Revision: Clarification of Coding and Payment for Drug Administration

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 drug administration services under the hospital outpatient prospective payment system (OPPS)

Provider Action Needed

This article is based on change request (CR) 4388, which clarifies the revision to the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 4, Section 230.2) regarding the coding and payment for drug administration under the hospital OPPS.

Background

The Centers for Medicare & Medicaid Services (CMS) previously revised the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 4, Section 230) in CR 4258 (Transmittal R785CP, on the CMS website at *http://cms.hhs.gov/transmittals/downloads/R785CP.pdf*).

That manual revision updated payment policies for drug administration services furnished under the OPPS effective January 1, 2006. CMS wants to clarify the new manual language.

To assist hospitals in ensuring continued correct drug administration services coding concepts, CR 4388 adds clarifying language to the existing policies in the *Medicare Claims Processing Manual* (Chapter 4, Section 230.2).

Following is a key excerpt from the revised portion of Section 230.2 that highlights (bolded and italicized) these clarifications:

***Medicare Claims Processing* Manual**
Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS) Section 230.2 (Coding and Payment for Drug Administration) (Rev.785, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)
B. Billing for Infusions and Injections
Intravenous or Intra-Arterial Push – Hospitals are to bill push codes (e.g. C8952, C8953, 96420) for services that meet either of the following criteria:

- A healthcare professional administering an injection is continuously present to administer and observe the patient; or
- An infusion lasting 15 minutes or less.

Hospitals are to bill for additional IV pushes of different substances or drugs using multiple units of the appropriate push code. ***Additional IV pushes of the same substance or drug are not separately reported with multiple units of a push code because the number of units reported with the IV push code is to indicate the number of separate substances or drugs administered by IV push.***

Included Services – Hospitals are instructed that the following ***items and*** services, when performed to facilitate an infusion or injection, are not separately billable.

However, hospitals have one of two choices: (1) continue to report separate charges so long as the charges are reported ***without*** *a CPT/HCPCS code but, rather are reported with an appropriate packaged revenue code or (2) do not report any separate charges but include the charges for the items/services as part of the charge for the procedure in which the items/services are supplied.*

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes and supplies
- Preparation of chemotherapy agent(s)

Fluid used to administer drug(s) is considered incidental hydration and a separate nonchemotherapy infusion service should not be reported.

EXAMPLE 1

A nonchemotherapy infusion lasts three hours and seven minutes. The hospital bills one unit of C8950 (for the first hour) and two units of C8951 (for the second and third hour). Hospitals cannot bill push codes for carryover infusion services not otherwise eligible for billing of a subsequent infusion hour. Payment will be one unit of APC 0120. (**Note:** See section 230.1 for drug billing instructions.)

C. Use of Modifier 59
(Rev.)

With respect to chemotherapy administration and nonchemotherapy drug infusion, the use of modifier 59 indicates a distinct encounter on the same date of service. In the case of chemotherapy administration or nonchemotherapy infusion, modifier 59 is appended to drug administration HCPCS codes that meet the following criteria:

1. **a.** The drug administration occurs during a distinct encounter on the same date of service of previous drug administration services; and

   b. The same HCPCS code has already been billed for services provided during a separate and distinct encounter earlier on that same day.

   OR

Hospital OPPS Manual Revision: Clarification of Coding and Payment for Drug Administration (continued)

2. A distinct and separate drug administration service is provided on the same day as a procedure when there is an OPPS National Correct Coding Initiative edit for the drug administration service and procedure code pair that may be bypassed with a modifier, and the use of the modifier is clinically appropriate.

The *CPT* modifier 59 is NOT to be used when a beneficiary receives infusion therapy at more than one vascular access site of the same type (intravenous or intra-arterial) in the same encounter or when an infusion is stopped and then started again in the same encounter.

In the instance where infusions of the same type (e.g. chemotherapy, nonchemotherapy, intra-arterial) are provided through two vascular access sites of the same type in one encounter, hospitals may report two units of the appropriate first hour infusion code for the initial infusion hours without modifier 59.

The outpatient code editor (OCE) will pay one unit of the corresponding APC for each separate encounter ***of an appropriately billed drug administration service***, up to the daily maximum listed in Table 1. Units of service exceeding daily maximum allowances will be packaged and no additional payment will be made.

Implementation

The implementation date for CR4388 is May 8, 2006.

Additional Information

Transmittal 896, CR 5011, issued on March 24, 2006, instructed FIs to implement version 12.0 of the Correct Coding Initiative (CCI) edits for drug administration services paid under the OPPS and furnished on or after April 1, 2006.

When an OPPS claim triggers a CCI edit, the entire claim is not rejected or returned. Rather, only one line item is rejected. That is, the CCI edits identify pairs of codes that are not appropriately reported together unless an edit permits use of a modifier to signal that the codes represent separate and distinct services/procedures.

Hospitals have expressed concerns about the impact of CCI edits on coding for drug administration services under the OPPS.

Therefore, CMS instructed fiscal intermediaries on May 8, 2006, to enable claims with dates of service on or after April 1, 2006, through June 30, 2006, to process to payment without triggering a line item rejection and CCI edit when the following code pairs are reported on the same claim with the same date of service, but without modifier 59:

HCPCS Codes	
Column 1	**Column 2**
C8950	C8952
C8953	C8950
C8953	C8952
C8954	C8950
C8954	C8952
C8954	C8953

Providers may submit adjustment bills to receive payment if one of the codes in any of the above code pairs has been rejected for payment.

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/R902CP.pdf*.

For complete details of CR 5011, 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/R896CP.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.pdf*.

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

MLN Matters Number: MM4388
Related Change Request (CR) Number: 4388
Related CR Release Date: April 7, 2006
Effective Date: January 1, 2006
Related CR Transmittal Number: R902CP
Implementation Date: May 8, 2006

Source: CMS Pub. 100-04, Transmittal 902, CR 4388

July 2006 Outpatient Prospective Payment System Code Editor Specifications (Version 7.2)

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

Provider Types Affected

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

Impact on Providers

This article is based on change request (CR) 5065, which informs your FI that the July 2006 outpatient prospective payment system outpatient code editor (OPPS OCE) specifications have been updated with new additions, deletions, and changes.

July 2006 Outpatient Prospective Payment System Code Editor Specifications (Version 7.2) (continued)

Background

CR 5065 reflects specifications that were issued for the April 2006 revision of the OPPS OCE (Version 7.1). All shaded material in attachment A of CR 5065 reflects changes that were incorporated into the July version of the revised OPPS OCE (Version 7.2).

CR 5065 provides the revised OPPS OCE instructions and specifications that will be utilized under the OPPS for hospital outpatient departments, community mental health centers (CMHCs) and for limited services provided in a home health agency (HHA) not under the home health prospective payment system (HH PPS) or to a hospice patient for the treatment of a non-terminal illness.

Attachment A of CR 5065 contains specifications issued for the July 2006 OCE (Version 7.2), and all shaded material reflects changes from the prior release of which have been incorporated into the April 2006 version of the OPPS OCE (Version 7.1).

The modifications of the OPPS OCE for the July 2006 release (V7.2) are detailed in the tables within CR 5065, and that CR is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R962CP.pdf*.

You should also read the specifications attached to CR 5065 and note the highlighted sections, which indicate changes from the prior release of the OPPS OCE software.

Note also that some of these modifications have an effective date earlier than July 1, 2006, and such dates are reflected at the beginning of each table in CR 5065.

The following is an excerpt of the table in CR 5065 (Attachment A, Appendix L). It summarizes the key modifications of the OCE/APC for the July 2006 release (V7.2).

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

	Mod. Type	Effective Date	Description
	Logic	8/1/00	Modify the OCE program such that for codes with SI of V that are also on the Inherent Bilateral list, condition code 'G0' will take precedence over the bilateral edit to allow multiple medical visits on the same day (Appendix A, B).
	Logic	1/1/06	Modify appendices E & F to remove CORFs (bill type 75x) from OPPS vaccine payment.
	Logic	7/1/06	Modify appendix F to bypass edit 48 for rev codes 0524, 0525, 0527, 0528
	Logic	8/1/00	Modify appendix F to bypass edit 48 for rev codes 0521, 0522
4	Logic	1/1/06	Modify the OCE program to change the SI from 'C' to 'E' for *CPT* code *43842* when submitted from 2/21/06 – 3/31/06 … The SI will be changed in the OCE tables, effective 4/1/06.
5	Logic	1/1/06	Update appendix D to use the 'terminated procedure' discount formula (#3) for terminated non-type T procedures. (Note: The discount fraction (50 percent) is the same as formula #5, reimbursement calculation will yield the same outcome as terminated procedures always have units = 1.)
6	Content		Make HCPCS/APC/SI changes, as specified by CMS.
7	Content	7/1/06	Implement version 12.1 of the NCCI file, removing all code pairs which include Anesthesia (00100-01999), E&M (*92002-92014*, *99201-99499*), or MH (*90804-90911*) and the following drug administration code pairs: HCPCS codes C8950-C8952, C8953-C8950, C8953-C8952, C8954-C8950, C8954-C8952, C8954-C8953.
8	Content	8/1/00	Reinstate Inherent Bilateral indicator in the OCE for CPT codes *92002*, *92004*, *92012* and *92014*.
9	Content	7/1/06	Add revenue codes 0524, 0525, 0527, 0528 to the list of valid revenue codes (recognized by Medicare)

Implementation

The implementation date for this instruction is July 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R962CP.pdf*.

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.pdf*.

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

MLN Matters Number: MM5065
Related Change Request (CR) Number: 5065
Related CR Release Date: May 26, 2006
Related CR Transmittal Number: R962CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 962, CR 5065

PROVIDER AUDIT ISSUES

Hospital Inpatient PPS Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to Wage Index

On April 3, 2006, in Bellevue Hospital Center versus Leavitt, the Court of Appeals for the Second Circuit ("the Court") ordered the Centers for Medicare & Medicaid Services (CMS) to apply the occupational mix adjustment to 100 percent of the wage index effective for federal fiscal year (FY) 2007. The Court required CMS to "immediately … collect data that are sufficiently robust to permit full application of the occupational mix adjustment." The Court also required that all "data collection and measurement and any other preparations necessary for full application should be complete by September 30, 2006, at which time we instruct the agency to immediately apply the adjustment in full."

To comply with the court's order, we are issuing a proposed rule to modify the methodology and data used to calculate the occupational mix adjustment for the FY 2007 hospital inpatient prospective payment system (IPPS) proposed wage index (71 FR 24075, April 25, 2006). This proposed rule would revise the methodology for calculating the occupational mix adjustment by applying the occupational mix adjustment to 100 percent of the wage index using the new data collected on the 2006 Medicare Wage Index Occupational Mix Survey (Form CMS-10079 (2006)). This proposed rule also proposes to modify hospitals' procedures for withdrawing requests to reclassify for the FY 2007 wage index and for supplementing the FY 2008 reclassification application with official data used to develop the FY 2007 wage index. In addition, we are proposing to replace in full the descriptions of the data and methodology that would be used in calculating the occupational mix adjustment discussed in the FY 2007 IPPS proposed rule.

There will be a 30-day public comment period on this new proposed rule that coincides with the close of the IPPS comment period on June 12, 2006.

The display version of CMS-1488-P2 may be found on the CMS website at *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488p2.pdf*.

For additional IPPS information, access CMS website at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*. ❖

EDUCATIONAL RESOURCES

Understanding the Remittance Advice Guide now Available in CD-ROM

The Medicare Learning Network is pleased to announce that Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers is now available on CD-ROM.

Copies of this CD-ROM may be ordered, free of charge, through the Medicare Learning Network (MLN) Product Ordering page located on the CMS website at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

This publication may also be downloaded and viewed online on the MLN publications page at the following url *http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=keyword&filterValue=remit&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=*.

The Web version of the "*RA Guide*" may be reprinted or redistributed as needed. Hard copies of the "*RA Guide*" will be available later this spring. ❖

Source: CMS Provider Education Resource 200605-06

Announcing the Revised Medicare Physician Guide

The revised ***Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*** (previously titled Medicare Resident & New Physician Guide: Helping Health Care Professionals Navigate Medicare) is now available in downloadable format on the MLN Publication page located on the Centers for Medicare & Medicaid Services website at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*.

The guide will be available in print format in approximately six weeks. ❖

Source: CMS Provider Education Resource 200605-20

New Fact Sheets Available

The rural referral center, Medicare disproportionate share hospital, rural health clinic, critical access hospital program, federally qualified health center, and sole community hospital fact sheets are now available in print format free of charge from the Centers for Medicare & Medicare Services' (CMS) Medicare Learning Network Product Ordering page located on the CMS website at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*. ❖

Source: CMS Provider Education Resource 200605-11

PREVENTIVE SERVICES

New Preventive Services Web-Based Training Course Now Available

Medicare Preventive Services: Part 3 Expanded Benefits Web-based Training (WBT) Course Is now Available.

This WBT provides information about Medicare coverage for the three new services added to the Medicare program in 2005, as a result of the Medicare Modernization Act of 2003; initial preventive physical exam (a.k.a. "Welcome to Medicare" physical exam), diabetes and cardiovascular disease screenings. The course also includes information on diabetes self-management training, medical nutrition therapy and other diabetes supplies, colorectal, prostate, and glaucoma screenings and bone mass measurements. The information presented in this course will be helpful for physicians, nurses, medical administrators and other health care professionals who provide these preventive services and screenings to Medicare patients. This course is the third in a series of three Web-based training courses developed by CMS as part of a comprehensive program designed to promote awareness and increase utilization of preventive benefits and to help those who bill Medicare for these services to file claims effectively.

The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington DC 20006. CMS has awarded .2 of CEU's (continuing education units) to participants who successfully complete this program.

The authors of this program have nothing to disclose.

You can access the Medicare Preventive Services Series: Part 3 Expanded Benefits WBT at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1*. ❖

Source: CMS Provider Education Resource 200605-12

May Is National Osteoporosis Awareness and Prevention Month

The Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to remind health care professionals that Medicare provides coverage of bone mass measurements once every 24 months (more often if medically necessary) for people with Medicare at risk for osteoporosis.

Osteoporosis (often called the "silent disease" because bone loss occurs without symptoms) is responsible for an estimated 1.5 million fractures annually – an event that often leads to a downward spiral in physical health and quality of life, including losing the ability to walk, stand up, or dress, and can lead to premature death. Twenty percent of senior citizens who suffer a hip fracture die within one year.

According to the US Surgeon General's 2004 report *Bone Health and Osteoporosis: A Report of the Surgeon General*, due to the aging of the population and the previous lack of focus on bone health, the number of hip fractures in the United States could double or triple by the year 2020. The report found that many patients were not being given appropriate information about prevention; and many patients were not having appropriate testing to diagnose osteoporosis or establish osteoporosis risk.

What Can You Do?

National Osteoporosis Awareness and Prevention Month presents an excellent opportunity for you to promote prevention, detection, and treatment of osteoporosis.

1) Become familiar with Medicare's coverage for bone mass measurements.
2) Talk with your patients about their risks for osteoporosis and prevention.
3) Encourage utilization of bone mass measurements for eligible Medicare patients.

Osteoporosis can be prevented. As a health care professional, you play a critical role in helping your patients maintain strong, healthy bones throughout their life. Please join with CMS in spreading the word about prevention and early detection of osteoporosis and encouraging the utilization of bone mass measurements for eligible Medicare patients.

For More Information

Special Edition MLN Matters Article SE0630 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0630.pdf* – provides information about the array of preventive services and screenings for which Medicare provides payment and lists the many resources developed by CMS to educate health care professionals about these services.

U.S. Department of Health and Human Services. *Bone Health and Osteoporosis: A Report of the Surgeon General.* U.S. Department of Health and Human Services, Office of the Surgeon General, 2004. This document can be downloaded from the Department of Health and Human Services website at *http://www.hhs.gov/surgeongeneral/library/bonehealth/*.

The National Osteoporosis Foundation *http://www.nof.org* – to learn more about National Osteoporosis Awareness and Prevention Month. ❖

Source: CMS Provider Education Resource 200605-14

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 Men's Health Week

In conjunction with National Men's Health Week and in commemoration of Father's Day (June 18), the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join with us as we strive to heighten the awareness of prevention and encourage early detection and treatment of disease. Medicare now provides coverage for preventive screenings for heart disease, stroke, diabetes and cancer – four of the leading diseases that significantly impact the health of men. Medicare provides payment for a full range of preventive services specific for men's health that aim to prevent disease from developing or prevent serious complications of disease.

Although Medicare is now providing better benefits, many men with Medicare are not yet taking full advantage of them, leaving significant gaps in prevention. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. With your help we can begin to close the prevention gap.

How Can You Help? As a trusted source, your recommendation is the most important factor in increasing the use of preventive and screening services. We need your help to ensure that men with Medicare are aware of these covered benefits and that they are encouraged to take advantage of the preventive services for which they may be eligible.

For Patients New to Medicare – When appropriate, provide the *Welcome to Medicare Visit.* This one time exam, which must be received within the first six months of the beneficiary's Medicare Part B effective date, is an excellent opportunity to orient new beneficiaries to Medicare, assess risk factors for disease, discuss lifestyle modifications that support a healthy lifestyle and may reduce the complication of disease, and encourage utilization of preventive screenings through referral for appropriate services. Remember to follow-up with patients on all screening results, even negative ones—every one likes to hear good news.

Established Patients – Remember to talk with your patients about their risk for disease and the importance and value of prevention, detection, early treatment, and lifestyle modifications. Encourage appropriate utilization of preventive services for which they may be eligible and provide follow-up on all screening results and continue to promote a prevention-oriented lifestyle.

National Men's Health Week (continued)

Working together we can begin to:

- increase awareness of prevention, and early detection and treatment of disease affecting men's health,
- prevent and reduce serious complications of disease,
- reduce mortality for many diseases effecting men,
- improve the health and quality of life of men,
- ensure that men with Medicare take advantage of preventive benefits they may be eligible for, and
- ultimately, save health care dollars.

Educational Products and Resources for Health Care Professionals

CMS has developed a variety of educational products and resources to help health care professionals and their staff becomes familiar with the coverage of and payment for the array of preventive and screening services covered by Medicare.

- The *MLN Matters* Preventive Services Educational Products Web page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.
- The CMS website also has a prevention website which contains a section on each of the preventive services. Click on *http://www.cms.hhs.gov*, select "Medicare", and scroll down to "Prevention".
- For products to share with your Medicare patients go to the Web to *http://www.medicare.gov*.

Men's health conditions do not simply affect men. Wives, mothers, daughters, and sisters are all impacted, making men's health a family matter. Encourage your patients to take advantage of Medicare-covered preventive services—it could save their life.

Thank you for joining with CMS to spread the message about prevention, early detection and treatment. For more information about National Men's Health Week visit on the Web *http://www.menshealthweek.org/*. ❖

Source: CMS Provider Education Resource 200606-06

Men's Health Prevention Awareness Continues

National Men's Health Week and Father's Day are over, but that doesn't mean that your prevention awareness messages to your patients should stop! CMS invites you to join with us as we strive to close the prevention gap by spreading the word to your patients that Medicare provides coverage for many preventive services and screenings that are meant to prevent disease from developing, detect disease early, identify risks for disease, reduce serious complications and provide early treatment when outcomes are more favorable.

What Can You Do To Help?

We still need your help to ensure that men with Medicare are aware of the many preventive and screening services covered by Medicare and that they are encouraged to take advantage of the preventive services for which they may be eligible. We ask that you:

- Become familiar with the preventive services for which Medicare provides payment.
- Ensure that your staff is educated about coverage, eligibility, frequency, coding, claim filing, and reimbursement requirements for these services.
- Remember to talk with your patients about their risk for disease and the importance and value of prevention, detection, early treatment, and lifestyle modifications.
- Encourage appropriate patient utilization of preventive services for which they may be eligible.
- Provide follow-up on all screening results and continue to promote a prevention-oriented lifestyle.

As men increase their knowledge of their risk for disease and the benefits of prevention, they will be able to make more informed decisions about the use of preventive services, treatment options, and appropriate lifestyle modifications.

For More Information...

CMS has developed a variety of educational products and resources to help health care professionals and their staff become more familiar with the coverage of and payment for the array of preventive and screening 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 page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.
- The CMS website also has a prevention website which contains a section on each of the preventive services. Click on *http://www.cms.hhs.gov*, select "Medicare", and scroll down to "Prevention".
- For products to share with your Medicare patients go the Web page *http://www.medicare.gov*. And effective immediately, beneficiaries can find out which regular checkups they may have missed by calling (800) MEDICARE – (800) 633-4227 – or by visiting *http://www.medicare.gov/health/overview.asp*.

We hope you will use these resources to assist you in communicating with your patients about Medicare preventive benefits.

Remember – Men's health conditions do not simply affect men. Wives, mothers, daughters, and sisters are all impacted, making men's health a family matter. Encourage your patients to take advantage of Medicare-covered preventive services – it could save their life.

Thank you for joining with CMS to spread the message about prevention, early detection and treatment. ❖

Source: CMS Provider Education Resource 200606-10

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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

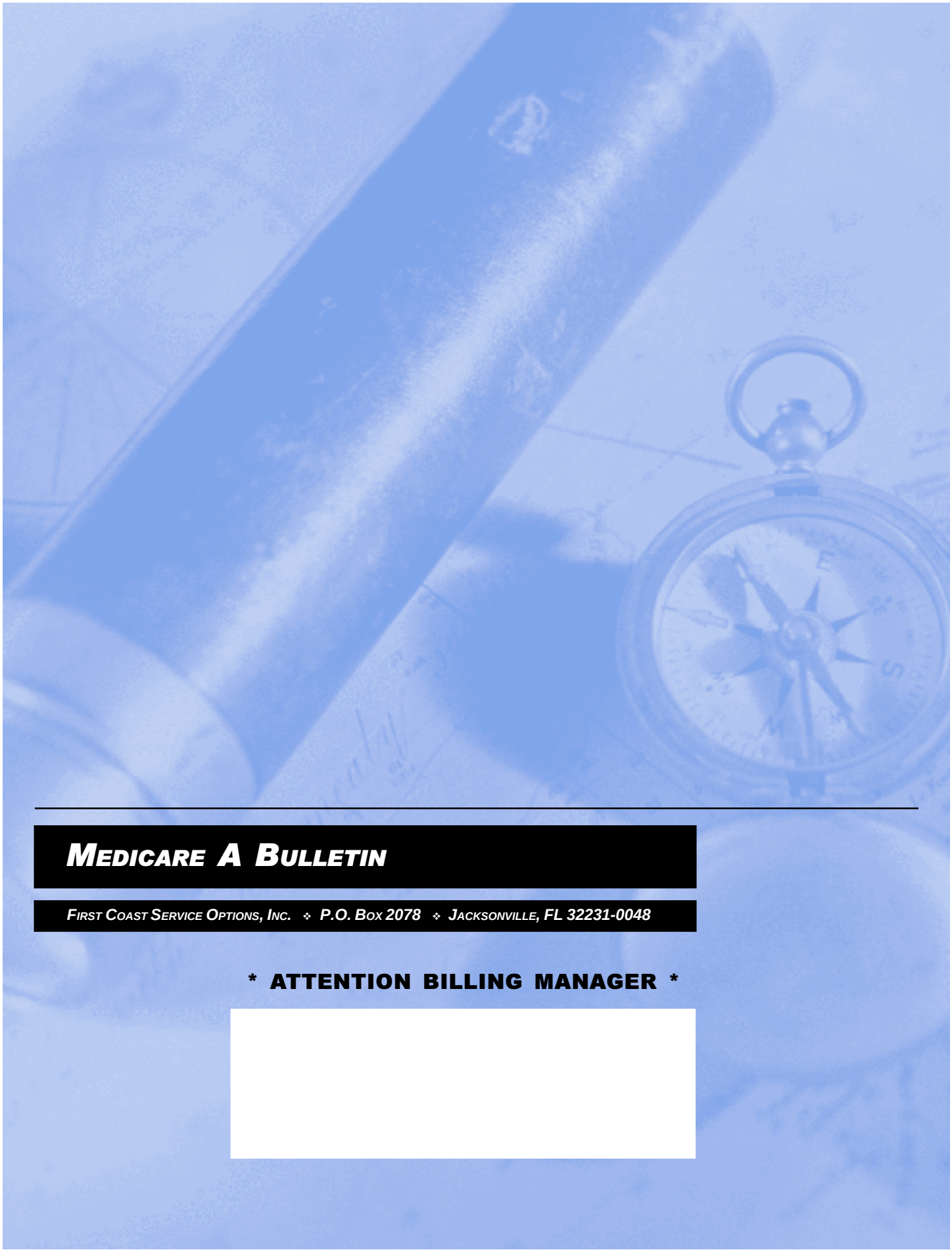
Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators – Gulf Coast
34650 US Highway 19 North, Suite 202
Palm Harbour, FL 34684-2156

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 ***