

Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers



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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
- _____
- _____
- _____



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2006 HCPCS ANNUAL UPDATE

Annual Procedure Code Update

Effective for Services Furnished on or after January 1, 2006

The Centers for Medicare & Medicaid Services (CMS) uses the Healthcare Common Procedure Coding System (HCPCS) to administer the Medicare program. The HCPCS is a collection of codes and descriptors for reporting medical procedures, supplies, products and services that may be provided to Medicare beneficiaries. The HCPCS annual update is designed to promote uniform reporting and statistical data collection of medical procedures, supplies and services.

The HCPCS is updated annually to reflect changes in the practice of medicine and provisions of the health care industry. The HCPCS annual update also contains modifiers, which are two-position codes and descriptors used to indicate a furnished or performed service that has been altered by some specific circumstance but not changed in its definition or code.

Description of HCPCS Coding Levels

Code additions, deletions and revisions may be made annually to the three levels of the HCPCS coding structure and to Category III temporary codes established for reporting new emerging technologies. These coding levels structures are:

Level I – Numeric Codes (CPT)

Level I codes include five-digit numeric codes. These codes describe various physician and laboratory procedures and are contained in the American Medical Association

(AMA) *Current Procedural Terminology* Fourth Edition (CPT®). It also includes two-digit alpha and or numeric modifiers.

Level II – Alpha Numeric (HCFA-Assigned)

Level II codes and modifiers include alphanumeric codes assigned by CMS. These codes describe various nonphysician and a relatively few number of physician services. These procedure codes begin with an alpha character in the A-V range and are used for durable medical equipment (DME), ambulance services, prosthetics, orthotics, ostomy supplies, etc.

Category III Codes – New Emerging Technology Codes

During 2001, the AMA CPT Editorial Panel established a new category of CPT codes called Category III codes. These codes are a set of temporary codes intended for tracking emerging technologies. Review of emerging technology codes is made by the CPT Editorial Panel as part of its procedures to annually update CPT codes. The CPT Editorial Panel will determine if a temporary emerging technology code should be converted to a permanent existing technology Category I CPT code or if a new emerging technology code should be established. The syntax of emerging technology codes is four digits followed by the letter "T". ❖

The 2006 Healthcare Common Procedure Coding System Update

The 2006 Healthcare Common Procedure Coding System (HCPCS) update is divided into the following major sections:

Additions

The procedure/modifier codes listed under "Modifiers and Procedure Codes Added for 2006" section are newly identified CPT/HCPCS codes and modifiers that must be used only for services furnished **on or after January 1, 2006**.

Revisions

The procedure/modifier codes listed under "Modifiers and Procedure Codes Revised for 2006" section include CPT/HCPCS codes in which the descriptor or administrative instructions have changed from 2005. When using these codes, refer to the 2006 CPT or HCPCS coding books to ensure the correct code is billed for the service furnished.

Reinstated Codes

The procedure/modifier codes listed under "Modifiers and Procedure Codes Reinstated for 2006" section include CPT/HCPCS codes that were discontinued during 2005 or for 2006; however after some reconsideration CMS has reinstated these codes for 2006.

Discontinued Procedures

The procedure codes listed under "Modifiers and Procedure Codes Discontinued for 2006" section may not be reported for service dates **after December 31, 2005**.

Effective January 1, 2005, **fiscal intermediaries return to the provider any claim containing services reported under discontinued HCPCS codes for the current year.**

When billing for services listed in the discontinued code section, the code(s) indicated in the "Codes to Report" column must be used. If more than one replacement code or no replacement code exists, refer to the appropriate coding book for additional guidelines.

A Word About Coverage

CPT/HCPCS codes that are noncovered by Medicare due to statute are not represented on these lists. However, inclusion of a code on the lists does not necessarily constitute Medicare coverage. For example, a code may be noncovered on the basis of local coverage determinations (LCDs). Diagnostic tests that are noncovered due to a LCD are noncovered whether purchased or personally furnished.

The 2006 Healthcare Common Procedure Coding System Update (continued)

Jurisdiction

The lists of added, revised, or discontinued *CPT/HCPCS* codes for 2006 are complete with no regard to contractor jurisdiction. The majority of procedure codes in the HCPCS are processed in Florida by the local Medicare Part A fiscal intermediary, First Coast Service Options, Inc. (FCSO). However, some HCPCS codes listed represent services processed by the durable medical equipment regional carrier (DMERC). The DMERC that serves Florida is Palmetto Government Benefits Administrators (<http://www.palmettogba.com>). It is the responsibility of the billing provider to submit claims to the appropriate Medicare contractor.

Use of Unlisted *CPT/HCPCS* Codes

If a *CPT/HCPCS* code cannot be found that closely relates to the actual service furnished, an “unlisted or not otherwise classified” *CPT/HCPCS* code may be submitted with a complete narrative description of the service provided in the “Remarks” field of Form UB-92 CMS-1450 or its electronic equivalent.

Every effort should be made to locate a specific replacement code, since the use of unlisted procedure codes may result in delays in claim processing.

Reminder for EMC Billers

Unlisted or not otherwise classified *CPT/HCPCS* codes may be submitted with a brief descriptor, the required information may be indicated in the appropriate narrative record. Providers may need to contact their EMC (electronic media claims) vendors to determine if their system has this capability.

Questions or Concerns?

Providers are encouraged to refer to all available resource materials for specific *CPT/HCPCS* coding instructions and claims filing information. Medicare Part A reference materials include the *Medicare A Bulletin* and special bulletins.

However, if the information cannot be found in any of the reference materials, contact the Medicare Part A Customer Service department at (877) 602-8816. ❖

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Modifiers and Procedure Codes Added for 2006

Modifiers	<i>CPT-4</i> Codes	<i>CPT-4</i> Codes	<i>CPT-4</i> Codes	<i>CPT-4</i> Codes
27	0102T	0152T	15321	33881
63	0103T	0153T	15330	33883
AQ	0104T	0154T	15331	33884
BL	0105T	01965	15335	33886
CR	0106T	01966	15336	33889
FB	0107T	1003F	15340	33891
GR	0108T	1004F	15341	33925
GS	0109T	1005F	15360	33926
J1	0110T	1006F	15361	36598
J2	0111T	1007F	15365	37184
J3	0115T	1008F	15366	37185
P1	0116T	15040	15420	37186
P2	0117T	15110	15421	37187
P3	0120T	15111	15430	37188
P4	0123T	15115	15431	37718
P5	0124T	15116	2001F	37722
P6	0126T	15130	2002F	4003F
QR	0130T	15131	2003F	4012F
	0133T	15135	2004F	4014F
	0135T	15136	22010	4015F
<i>CPT-4</i> Codes	0137T	15150	22015	4016F
0089T	0140T	15151	22523	4017F
0090T	0141T	15152	22524	4018F
0091T	0142T	15155	22525	43770
0092T	0143T	15156	28890	43771
0093T	0144T	15157	3000F	43772
0094T	0145T	15170	3002F	43773
0095T	0146T	15171	32503	43774
0096T	0147T	15175	32504	43886
0097T	0148T	15176	33507	43887
0098T	0149T	15300	33548	43888
0099T	0150T	15301	33768	44180
0100T	0151T	15320	33880	44186
0101T				

Modifiers and Procedure Codes Added for 2006 (continued)

| HCPCS Codes |
|--------------------|--------------------|--------------------|--------------------|--------------------|
| J3471 | L0634 | L6621 | Q0490 | Q9956 |
| J3472 | L0635 | L6677 | Q0491 | Q9957 |
| J7188 | L0636 | L6883 | Q0492 | Q9958 |
| J7189 | L0637 | L6884 | Q0493 | Q9959 |
| J7306 | L0638 | L6885 | Q0494 | Q9960 |
| J7318 | L0639 | L7400 | Q0495 | Q9961 |
| J7341 | L0640 | L7401 | Q0496 | Q9962 |
| J7620 | L0859 | L7402 | Q0497 | Q9963 |
| J7627 | L2034 | L7403 | Q0498 | Q9964 |
| J7640 | L2387 | L7404 | Q0499 | S0133 |
| J8498 | L3671 | L7405 | Q0500 | S0142 |
| J8515 | L3672 | L7600 | Q0501 | S0143 |
| J8540 | L3673 | L8609 | Q0502 | S0145 |
| J8597 | L3702 | L8623 | Q0503 | S0146 |
| J9025 | L3763 | L8624 | Q0504 | S0197 |
| J9027 | L3764 | L8680 | Q0505 | S0198 |
| J9175 | L3765 | L8681 | Q0510 | S0265 |
| J9225 | L3766 | L8682 | Q0511 | S0595 |
| J9264 | L3905 | L8683 | Q0512 | S0613 |
| K0730 | L3913 | L8684 | Q0513 | S0625 |
| L0491 | L3919 | L8685 | Q0514 | S2068 |
| L0492 | L3921 | L8686 | Q0515 | S2075 |
| L0621 | L3933 | L8687 | Q4079 | S2076 |
| L0622 | L3935 | L8688 | Q4080 | S2077 |
| L0623 | L3961 | L8689 | Q9945 | S2078 |
| L0624 | L3967 | Q0480 | Q9946 | S2079 |
| L0625 | L3971 | Q0481 | Q9947 | S2114 |
| L0626 | L3973 | Q0482 | Q9948 | S2117 |
| L0627 | L3975 | Q0483 | Q9949 | S2900 |
| L0628 | L3976 | Q0484 | Q9950 | S3005 |
| L0629 | L3977 | Q0485 | Q9951 | S3626 |
| L0630 | L3978 | Q0486 | Q9952 | S3854 |
| L0631 | L5703 | Q0487 | Q9953 | S8270 |
| L0632 | L5858 | Q0488 | Q9954 | S8940 |
| L0633 | L5971 | Q0489 | Q9955 | V2788 |

Modifiers and Procedure Codes Revised for 2006

Modifiers	CPT-4 Codes	CPT-4 Codes	CPT-4 Codes	CPT-4 Codes
TS	2000F	34834	67902	86022
	30130	36415	75900	86023
CPT-4 Codes	30140	37209	76012	86920
0078T	30801	4006F	77412	86921
15000	30930	4009F	78491	86922
15100	31520	4011F	78492	87534
15001	31525	43848	78608	87535
15101	31526	44202	78609	87536
15120	31530	44310	78811	87537
15121	31531	44320	78812	87538
15200	31535	45119	78813	87539
15201	31536	45540	78814	87901
15220	31540	45550	78815	87902
15240	31541	50688	78816	87903
15260	31561	52647	82270	87904
15400	31560	52648	83036	88175
15401	31570	57421	83630	90680
16020	31571	61864	83898	90713
16025	33502	64613	83901	90715
16030	34833	67901	84238	90870

Modifiers and Procedure Codes Revised for 2006 (continued)

CPT-4 Codes	HCPCS Codes	HCPCS Codes	HCPCS Codes	HCPCS Codes
90940	A4554	B4153	E0625	J0152
91020	A4630	B4154	E0935	J0880
92506	A4632	B4155	E0637	J1564
92507	A4641	C1716	E0638	J2324
92520	A4642	C1717	E0638	J7340
92568	A4932	C1718	E0761	J7342
92569	A5119	C1719	E0935	J7343
95250	A5500	C1720	E0951	J7344
90657	A5501	C2616	E0952	J7350
90658	A5503	C2633	E0955	J7626
96405	A5504	C2634	E0956	K0669
96406	A5505	C2635	E0957	L1820
96423	A5506	C8918	E0967	L1832
96420	A5507	C8919	E0971	L1843
96422	A5508	C8920	E0978	L1844
97024	A5509	C9211	E0986	L1845
97542	A5510	D0350	E1010	L1846
97811	A5511	D0415	E1038	L2035
97813	A6025	D0480	E1039	L2036
97814	A6412	D2710	E1011	L2037
99050	A6550	D2910	E1014	L2038
99056	A7032	D3332	E1025	L2039
99058	A7033	D4210	E1026	L2320
99298	A9500	D4211	E1027	L2330
99299	A9502	D4240	E1038	L2405
	A9503	D4241	E1225	L2755
	A9504	D4260	E1226	L2800
	A9505	D4261	G0173	L3031
	A9507	D4273	G0237	L3170
	A9508	D4276	G0238	L3215
	A9510	D4341	G0239	L3216
	A9512	D4381	G0244	L3217
	A9516	D6056	G0260	L3219
	A9517	D6057	G0295	L3221
	A9521	D7111	G0308	L3222
	A9524	D7286	G0309	L3230
	A9525	D7287	G0310	L3906
	A9526	D7490	G0311	L3923
	A9528	D7955	G0312	L4040
	A9529	E0116	G0313	L4045
	A9530	E0118	G0314	L4050
	A9531	E0203	G0315	L4055
	A9532	E0221	G0316	L6890
	A9534	E0240	G0317	L6895
	A9600	E0450	G0318	L7180
	A9605	E0461	G0319	L8010
	A9699	E0463	G0320	Q3001
	B4100	E0464	G0321	Q3031
	B4149	E0550	G0322	S2150
	B4150	E0560	G0323	T2005
	B4152	E0616	J0150	V2745

Procedure Codes Reinstated for 2006

CPT-4 Codes

0019T

Modifiers and Procedure Codes Discontinued for 2006

Modifiers

QB
 QQ
 QU

CPT-4 Codes

0010T To report, use 86480
 0020T To report, use 28890
 0023T To report, use 87900
 0033T To report, use 33880
 0034T To report, use 33881
 0035T To report, use 33883
 0036T To report, use 33884
 0037T To report, use 33889
 0038T To report, use 75956
 0039T To report, use 75957
 0040T To report, use 75958, 75959
 01964 To report, use 01965, 01966
 15342 To report, see 15170, 15175, 15340, 15360, 15365
 15343 To report, see 15171, 15176, 15341, 15361, 15366
 15350 To report, see 15300, 15320, 15330, 15335
 15351 To report, see 15301, 15321, 15331, 15336
 15810
 15811
 16010 To report, see 16020-16030
 16015 To report, see 16020-16030
 21493
 21494
 31585
 31586
 32520
 32522
 32525
 33918 To report, see 33925, 33926
 33919 To report, see 33925, 33926
 37720
 37730 To report, use 37722, 37718
 42325
 42326
 43638
 43639
 44200 To report, use 44180
 44201 To report, use 44186
 44239 To report, use 45499
 69410
 76375
 78160
 78162
 78170
 78172
 78455
 82273 To report, use 82271
 83715 To report, use 83700, 83701
 83716 To report, use 83700, 83701
 86064 To report, use 86355
 86379 To report, use 86357

CPT-4 Codes

86585 To report, use 86580
 86587 To report, use 86367
 90780 To report, see 90760, 90761, 90765-90768
 90781 To report, see 90760, 90761, 90765-90768
 90782 To report, use 90772
 90783 To report, use 90773
 90784 To report, use 90774
 90788 To report, use 90772
 90799 To report, use 90779
 90871
 90939 To report, use 90940
 92330
 92335
 92390
 92391
 92392
 92393
 92395
 92396
 92510
 95858
 96100 To report, see 96101, 96102,
 96103
 96115 To report, use 96116
 96117 To report, see 96118, 96119,
 96120
 96400 To report, see 96401, 96402
 96408 To report, use 96409
 96410 To report, use 96413
 96412 To report, use 96415
 96414 To report, use 96416
 96520 To report, use 96520
 96530 To report, use 96522
 96545
 97020 To report, use 97024
 97504 To report, use 97760
 97520 To report, use 97761
 97703 To report, use 97762
 99052
 99054
 99141 To report, see 99143-99145
 99142 To report, see 99143-99145
 99261
 99262
 99263
 99271
 99272
 99273
 99274
 99275
 99301
 99302
 99303
 99311
 99312
 99313
 99321

CPT-4 Codes

99322
 99323
 99331
 99332
 99333

CMS Assigned Codes

A4254
 A4260 See code J7306
 A4643
 A4644
 A4645
 A4646
 A4647
 A4656
 A5119
 A5509
 A5511
 A6551
 A9511
 A9513
 A9514
 A9515
 A9519
 A9520
 A9522
 A9523
 A9525
 A9533
 A9534
 B4184
 B4186
 C1079 See code A9546
 C1080 See code A9544
 C1081 See code A9545
 C1082 See code A9542
 C1083 See code A9543
 C1091 See code A9547
 C1092 See code A9548
 C1093 See code A9566
 C1122 See code A9549
 C1200
 C1201 See code A9551
 C1305 See code J7340
 C1775 See code A9552
 C9000 See code A9553
 C9007 See code J0476
 C9008 See code J0475
 C9009 See code J0475
 C9013
 C9102 See code A9553
 C9103 See code A9554
 C9105 See code 90371
 C9112 See code Q9957
 C9123
 C9126 See code Q4079
 C9127 See code J9264
 C9128 See code J2503
 C9129 See code J9027

*Modifiers and Procedure Codes Discontinued for 2006 (continued)***HCPCS Codes**

C9200 See code J7340
 C9201 See code J7342
 C9202 See code Q9956
 C9203 See code Q9955
 C9205 See code J9263
 C9206 See code J7343
 C9211 See code J0215
 C9212 See code J0215
 C9218 See code J9025
 C9223 See code J0150, J0152
 C9226 See code J2278
 C9400 See code A9505
 C9401 See code A9600
 C9402 See code A9517
 C9403 See code A9528
 C9404 See code A9529
 C9405 See code A9530
 C9410 See code J1190
 C9411 See code J2430
 C9413 See code J7317
 C9414 See code J8560
 C9415 See code J9000
 C9417 See code J9040
 C9418 See code J9060
 C9419 See code J9065
 C9420 See code J9070
 C9421 See code J9093
 C9422 See code J9100
 C9423 See code J9130
 C9424 See code J9150
 C9425 See code J9181
 C9426 See code J9200
 C9427 See code J9208
 C9428 See code J9209
 C9429 See code J9211
 C9430 See code J9218
 C9431 See code J9265
 C9432 See code J9280
 C9433 See code J9340
 C9435 See code J1620
 C9436 See code J7501
 C9437 See code J9050
 C9438 See code J7502
 C9439 See code J9165
 C9440 See code J9390
 C9704 See code 0133T
 C9713 See code 52648
 C9718 See code 22523
 C9719 See code 22525
 C9720 See code 0102T
 C9721 See code 28890
 C9722 See code 77421
 E0169
 E0752 See code L8680
 E0754 See code L8681
 E0756
 E0757 See code L8682
 E0758 See code L8683
 E0759 See code L8684
 E0953 See code E2211

HCPCS Codes

E0954 See code E2219
 E0972
 E0996 See code E2220
 E1000 See code E2214
 E1001 See code E2224
 E1019
 E1021
 E1025
 E1026
 E1027
 E1210
 E1211
 E1212 See code K0010
 E1213 See code K0010
 E1239
 G0030
 G0031
 G0032
 G0033
 G0034
 G0035
 G0036
 G0037
 G0038
 G0039
 G0040
 G0041
 G0042
 G0043
 G0044
 G0045
 G0046
 G0047
 G0110
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 G0112
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 G0115
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 G0125
 G0210
 G0211
 G0212
 G0213
 G0214
 G0215
 G0216
 G0217
 G0218
 G0220
 G0221
 G0222
 G0223
 G0224
 G0225
 G0226
 G0227
 G0228
 G0229

HCPCS Codes

G0230
 G0231
 G0232
 G0233
 G0234
 G0242
 G0244
 G0252
 G0253
 G0254
 G0258
 G0263
 G0264
 G0279
 G0280
 G0296
 G0336
 G0338
 G0345
 G0346
 G0347
 G0348
 G0349
 G0350
 G0351
 G0353
 G0354
 G0355
 G0356
 G0357
 G0358
 G0359
 G0360
 G0361
 G0362
 G0363
 G0369 See code Q0510
 G0370 See code Q0511, Q0512
 G0371 See code Q0513
 G0374 See code Q0514
 J0880
 J1563
 J1564
 J1750
 J2324
 J7051
 J7317
 J7320
 J7616
 J7617
 K0064 See code E2213
 K0066 See code E2220
 K0067 See code E2211
 K0068 See code E2212
 K0074 See code E2214
 K0075 See code E2219
 K0076 See code E2221
 K0078 See code E2215
 K0102 See code E2207
 K0104 See code E2208

Modifiers and Procedure Codes Discontinued for 2006 (continued)

HCPCS Codes

K0106 See code E2209
 K0415
 K0416
 K0452 See code E2210
 K0600 See code E0762
 K0618 See code L0491
 K0619 See code L0492
 K0620 See code A6457
 K0628 See code A5512
 K0629 See code A5513
 K0630 See code L0621
 K0631 See code L0622
 K0632 See code L0623
 K0633 See code L0624
 K0634 See code L0625
 K0635 See code L0626
 K0636 See code L0627
 K0637 See code L0628
 K0638 See code L0629
 K0639 See code L0630
 K0640 See code L0631
 K0641 See code L0632
 K0642 See code L0633
 K0643 See code L0634
 K0644 See code L0635
 K0645 See code L0636
 K0646 See code L0637
 K0647 See code L0638
 K0648 See code L0639
 K0649 See code L0640
 K0670 See code E1392
 K0671 See code E1392
 K0731 See code L8623
 K0732 See code L8624
 L0860 See code L0859
 L1750 See code A4565
 L2039
 L3963
 L8100 See code A6530

HCPCS Codes

L8110 See code A6531
 L8120 See code A6532
 L8130 See code A6533
 L8140 See code A6534
 L8150 See code A6535
 L8160 See code A6536
 L8170 See code A6537
 L8180 See code A6538
 L8190 See code A6539
 L8195 See code A6540
 L8200 See code A6541
 L8210 See code A6542
 L8220 See code A6543
 L8230 See code A6544
 L8239 See code A6549
 L8620
 Q0136 See code J0885
 Q0137 See code J0881
 Q0187 See code J7189
 Q1001
 Q1002
 Q2001
 Q2002 See code J9175
 Q2003 See code J0365
 Q2005
 Q2006 See code J1162
 Q2007 See code J1430
 Q2008 See code J1451
 Q2011 See code J1640
 Q2012 See code J2504
 Q2013 See code J2513
 Q2014
 Q2018 See code J3355
 Q2019 See code J0480
 Q2020 See code J1675
 Q2021 See code J1945
 Q2022 See code J7188
 Q3000
 Q3002

HCPCS Codes

Q3003
 Q3004
 Q3005
 Q3006
 Q3007
 Q3008
 Q3009
 Q3010
 Q3011
 Q3012
 Q4054 See code J0882
 Q4055 See code J0886
 Q4075 See code J0133
 Q4076 See code J1265
 Q4077 See code J3285
 Q9941
 Q9942
 Q9943
 Q9944
 S0016 See code S0072
 S0071
 S0072
 S0107 See code J2357
 S0114
 S0118
 S0158 See code J1931
 S0159 See code J0180
 S0168
 S0173
 S2082
 S2090
 S2091
 S2215
 S8004 See code 78804
 S8095
 S8434
 T2006 See code A0998

GENERAL INFORMATION

Termination of Q-Codes for Epoetin Alfa and Darbepoetin Alfa

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

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for services related to the administration of epoetin alfa and darbepoetin alfa to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4206, which terminates the Q codes for epoetin alfa and darbepoetin alfa and replaces them with J codes.

CAUTION – What You Need to Know

Effective January 1, 2006: HCPCS code Q0136 – epoetin alfa for non-ESRD use is replaced with HCPCS code J0885; HCPCS code Q0137 – darbepoetin alfa for non-ESRD use is replaced with HCPCS code J0881; HCPCS code Q4054 darbepoetin alfa for ESRD use is replaced with HCPCS code J0882; and HCPCS code Q4055 epoetin alfa for ESRD use is replaced with J0886.

GO – What You Need to Do

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

Background

The annual Healthcare Common Procedure Coding System (HCPCS) update effective January 1, 2006, changes the HCPCS for reporting and billing epoetin alfa and darbepoetin alfa. CR 4206 terminates Q codes for epoetin alfa and darbepoetin alfa and replaces them with the J codes shown below, effective January 1, 2006:

J0881	Injection, darbepoetin alfa, 1 mcg (non-ESRD use). Replaces Q0137 (darbepoetin alfa for non-ESRD use)
J0882	Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis). Replaces Q4054 (darbepoetin alfa for ESRD use)
J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units. Replaces Q0136 (epoetin alfa for non-ESRD use)
J0886	Injection, epoetin alfa, 1000 units (for ESRD on dialysis). Replaces Q4055 (epoetin alfa for ESRD use).

Note: CR 4108, Transmittal 737, dated October 31, 2005, (<http://www.cms.hhs.gov/transmittals/downloads/R737CP.pdf>) instructs providers to begin billing the new HCPCS effective January 1, 2006. The corre-

sponding Medlearn Matters article (MM 4108) may be found at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4108.pdf>.

All billing and payment instructions currently required for the Q codes in the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 8, Section 60 (Separately Billable ESRD Items and Services), found on the CMS website at <http://www.cms.hhs.gov/manuals/downloads/clm104c08.pdf>, will be applied to the new J codes upon implementation of this instruction.

According to CR 4206, there are no other changes to the reporting and payment of epoetin alfa and darbepoetin alfa.

Implementation

The implementation date for the instruction is April 3, 2006. Claims submitted on types of bills 12x, 13x, and 85x that contain J0882 and/or J0886 between the effective date and the April 3, 2006, implementation date will be paid on a reasonable cost basis.

However, the Medicare intermediaries will automatically adjust these claims after the implementation date and correct the payment and pay affected claims based on the appropriate fee.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R772CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4206
 Related Change Request (CR) Number: 4206
 Related CR Release Date: December 2, 2005
 Related CR Transmittal Number: 772
 Effective Date: January 1, 2006
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 772, CR 4206

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Therapy Caps To Be Effective January 1, 2006

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

Provider Types Affected

Therapists and providers who bill Medicare carriers or fiscal intermediaries (FIs) for therapy services for their patients

Provider Action Needed**STOP – Impact to You**

Beginning January 1, 2006, financial limitation of therapy services (therapy caps) will be implemented. **The dollar amount for the 2006 limitation on physical therapy and speech-language pathology services from January 1, 2006, through December 31, 2006, will be \$1,740.00. The limitation on occupational therapy services is also \$1,740.00. The limits do not apply to outpatient Part B therapy services in outpatient hospital or hospital emergency room settings.**

CAUTION – What You Need to Know

Please be aware of the January 1, 2006 therapy services caps.

GO – What You Need to Do

Remember that services must meet the Medicare policies in the Medicare Benefit Policy Manual (publication 100-02), Chapter 15, Sections 220 and 230. This manual is available on the CMS website at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

Background

Financial limitations on therapy services (therapy caps) are currently described in the Medicare Claims Processing Manual (Pub. 100-04), chapter 5, section 10.2, which is available on the CMS website at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

The dollar amount for the limitations in 2006 is based on the Medicare economic index that is published in the final rule for the Medicare physician fee schedule in November 2005.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, required payment under a prospective payment system for outpatient rehabilitation services (physical therapy, including outpatient speech-language pathology, and occupational therapy). Section 4541(c) of the BBA required the application of a financial limitation to all outpatient rehabilitation services (except outpatient departments of hospitals). These limits were in effect in 1999, but were removed by law in 2000-2002. The statutory limits went back into effect September 1, 2003. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 re-enacted the moratorium and extended it until December 31, 2005.

Additional Information

There is additional information located on the Rehabilitation Therapy Information Resource for Medicare website located on the CMS website at http://new.cms.hhs.gov/TherapyServices/01_overview.asp#TopOfPage.

The official instruction issued to your FI or carrier regarding this change may be found by going to CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R759CP.pdf>.

Please refer to your local FI or carrier if you have any questions. To find the toll free phone number, go to CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4115
Related Change Request (CR) Number: 4115
Related CR Release Date: November 18, 2005
Related CR Transmittal Number: 759
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 759, CR 4115

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Update to Medicare Deductible, Coinsurance, and Premium Rates for 2006

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 4132, which updates the Centers for Medicare & Medicaid Services (CMS) claim processing systems and the *Medicare General Information, Eligibility, and Entitlement Manual*

(Pub.100-01) with the new Medicare deductible, coinsurance, and premium rates for 2006.

Background

Medicare beneficiaries using covered Part A services (inpatient hospital services, skilled nursing facilities (SNFs), home health services, and hospice care) and Part B services (physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies) may be subject to deductible and coinsurance requirements.

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2006 (continued)

Beneficiaries are responsible for an inpatient hospital deductible amount (which is deducted from the amount payable by the Medicare program to the hospital) for inpatient hospital services furnished during a spell of illness.

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

After the 90th day spent in the hospital during a spell of illness, the beneficiary may elect to use his or her 60 lifetime reserve days of coverage. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

For SNF services furnished during a spell of illness, the beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the **21st-100th day in an SNF**.

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for health insurance (HI) benefits without a premium payment.

The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a ten percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

Under Supplementary Medical Insurance (SMI), all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute.

When SMI enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent ten percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

The following includes Medicare Part A and Part B deductible, coinsurance, and premium amounts for 2006:

A. Medicare Part A Deductible, Coinsurance, and Premium Amounts for 2006:

- **Deductible:** \$952.00 per benefit period or spell of illness
- **Coinsurance:**
 - ♦ \$238.00 a day for days 61-90 in each period
 - ♦ \$476.00 a day for days 91-150 for each "Lifetime Reserve" day used
 - ♦ \$119.00 a day in an SNF for days 21-100 in each benefit period

- **Premium:**
 - ♦ \$393.00 per month for those who must pay a premium
 - ♦ \$432.30 per month for those who must pay a premium **and** must pay a 10 percent increase
 - ♦ \$216.00 per month for those who have 30-39 quarters of coverage
 - ♦ \$237.60 per month for those who have 30-39 quarters of coverage **and** must pay a 10 percent increase.

The table below compares deductible and coinsurance amounts for 2005 and 2006:

	2005	2006
Inpatient Hospital Deductible, 1st – 60 Days	\$912	\$952
Inpatient Hospital Coinsurance, 61st – 90th Days	\$228	\$238
60 Lifetime Reserve Days Coinsurance	\$456	\$476
SNF Coinsurance	\$114	\$119

B. Medicare Part B Deductible, Coinsurance, and Premium Amounts for 2006:

- **Deductible:** \$124.00 per year
- **Coinsurance:** 20 percent
- **Premium:** \$88.50 per month.

Implementation

The implementation date for the instruction is January 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://new.cms.hhs.gov/transmittals/downloads/R31GI.pdf>.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found on the CMS website at

<http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4132
 Related Change Request (CR) Number: 4132
 Related CR Release Date: November 4, 2005
 Related CR Transmittal Number: 31
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-01, Transmittal 31, CR 4132

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Payment Allowances for Influenza Virus and Pneumococcal Vaccine Based on 95 Percent of the Average Wholesale Price

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

Provider Types Affected

Physicians, nonphysician practitioners, providers, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for these vaccines

Provider Action Needed

STOP – Impact to You

Effective September 1, 2005, when payment is based on 95 percent of the average wholesale price (AWP), the Medicare Part B payment allowance for the influenza virus vaccines are as follows:

CPT 90655	\$14.678
CPT 90656	\$15.818
CPT 90657	\$6.028
CPT 90658	\$12.056

Payment for the pneumococcal vaccine – CPT 90732 is \$24.57 (when payment is based on 95 percent of the AWP).

CAUTION – What You Need to Know

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. Also, remember that all physicians, nonphysician practitioners, and suppliers who administer the influenza virus vaccination or the pneumococcal vaccination must take assignment on the claim for that vaccine.

GO – What You Need to Do

Please take note of this pricing information to ensure accurate claims processing. Your carrier or FI will not search their files to adjust claims that were processed prior to the November 21, 2005, implementation date unless you bring such claims to their attention.

Additional Information

The official instructions issued to your carrier/intermediary regarding this change may be found on the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R1850TN.pdf>.

If you have questions regarding this issue you may also contact your carrier or FI at their toll free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Related Change Request (CR) Number: 4109

Related CR Release Date: October 21, 2005

Related CR Transmittal Number: 185

Effective Date: September 1, 2005

Implementation Date: November 21, 2005

Source: CMS Pub. 100-20, Transmittal 185, CR 4109

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Influenza/Flu Season and Available Resources for Providers

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

Provider Types Affected

Physicians, non-physician practitioners, providers and other health care professionals who bill Medicare carriers or fiscal intermediaries (FIs) for flu vaccines and vaccine administration.

Provider Action Needed

Special Edition 0580 is published by the Centers for Medicare & Medicaid Services (CMS) to alert providers to influenza resources that are available to them and their patients. While some of these resources are not CMS-sponsored websites or products, they are respected informational sites and products sponsored by health care professionals.

CMS Resources

The following are CMS web-based resources:

Immunization Educational Resource Web Guide

The Immunization Educational Resource Web Guide is one-stop shopping for informational and educational

resources related to CMS immunization initiatives and is available on the CMS website at <http://www.cms.hhs.gov/medlearn/refimmu.asp>.

Available resources include the following:

Medlearn Articles

- Article MM3936 provides guidelines for payment of vaccines and their administration at renal dialysis facilities.
- Article MM3618 provides information about billing vaccines.

Brochures

Adult Immunizations and Hepatitis Vaccine Benefits.

This is a two-sided brochure that may be downloaded and printed.

Provider Education

The following publications address Medicare preventative services:

Influenza/Flu Season and Available Resources for Providers (continued)

- How to Bill Medicare for Influenza and Pneumococcal Vaccinations
- Medicare Preventive Services Educational Resource Web Guide
- Quick Reference Information: Medicare Preventive Services
- Medlearn Matters – articles intended to explain or clarify program memoranda (pre-10/01/2003) and change requests (10/01/2003 to present)
- Downloadable Publications Electronic versions of publications designed to aid in understanding the Medicare program
- Web-Based Training Modules (WBTs) – Training courses covering various Medicare topics, including general program information, payment policy, preventive services, and office management information

Other CMS Resources

Other helpful CMS resources include the following:

- **2005 Administrative Fee Allowances.** This publication describes the fees Medicare pays for flu vaccine administration.
- **Medicare Preventive Services Influenza/Pneumococcal Immunizations Web Page.** This Web page contains information and resources related to adult immunizations including immunization data, billing and coding instructions, and other resources.
- **Fact Sheets and News Releases Regarding Medicare and Preventive Services**
- **Frequently Asked Questions**

Other Resources

The following are resources that are not CMS websites but providers may find them useful.

American Lung Association (ALA) Flu Center

The ALA flu center site is located at <http://www.flucliniclocator.org/>.

This site enables individuals to input their zip code and find a flu clinic location in their area.

Providers are able to add their flu clinic to this site on the Internet by visiting <http://lungusa2.org/embargo/flucliniclocator05/>.

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New CMS National Provider Identifier Web Page

Announcing the new CMS Web page dedicated to providing the latest national provider identifier (NPI) news for fee-for-service (FFS) Medicare providers!

On CMS website, visit <http://www.cms.hhs.gov/NationalProvIdentStand/>.

While this page is dedicated to the Medicare FFS community, it contains helpful information and links that may benefit all health care providers.

Reminder: Health care providers are required by law to apply for an NPI. To apply online, visit: <https://nppes.cms.hhs.gov>. ❖

Source: CMS Joint Signature Memorandum 06033, November 2, 2005

2-1-1 Information and Referral Service

The Consumer Education Working Group would like health care providers to know about another new resource to help citizens find a flu shot this fall. It is anticipated that this service will go hand-in-hand with the ALA's flu locator site. Those who do not have Internet access may call the 2-1-1 information and referral service and the operator can then use the flu locator site to help the person find a nearby influenza clinic.

2-1-1 is an easily remembered telephone number that helps callers find critical health and human services available in their community. Callers can get answers to questions such as shelter locations after a natural disaster, traveler aid, emergency funding, or flu vaccination clinic locations.

2-1-1 serves approximately 139 million Americans – over 46 percent of the US population. One hundred and seventy-one (171) active 2-1-1 systems cover all or part of 32 states (including 14 states with 100 percent coverage) plus Washington, DC and Puerto Rico.

When this system is connected nationwide, it will provide easy access to social service resources for everyone. The technology ensures that a real person will answer every time – no recorded messages. Anyone with flu vaccine can register with a local 2-1-1 call center. The call center will include that information in their database and make it available to the community.

For more information about 2-1-1, go to the Internet to <http://www.211.org> or <http://www.airs.org>.

Influenza Pocket Guides/Information about Vaccines

Although hard copy versions of the Influenza Pocket Guides are no longer available, electronic and camera-ready versions are available, copyright free and may be found on the Internet at <http://www.immunize.org/influenza/pocketguide.htm>.

Comprehensive information about vaccines and vaccine-preventable diseases may be found on the Internet at <http://www.vaccineinformation.org>.

Medlearn Matters Number: SE0580

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: Special Edition Medlearn Matters Article SE0580

Telehealth Originating Site Facility Fee Payment Amount Update

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

Provider Types Affected

All providers who bill Medicare for the telehealth originating site facility fee

Provider Action Needed

CR 4201, upon which this article is based, provides the calendar year 2006 telehealth originating site facility fee payment update. Beginning on and after January 1, 2006, the telehealth originating site facility fee is \$22.47.

Background

Section 1834(m) of the Social Security Act (the Act) established the amount Medicare paid as the telehealth originating site facility fee for services provided from October 1, 2001, through December 31 2002. The amount was set at \$20.

For such services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee was increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI).

The 2006 MEI increase is 2.8 percent. Thus, for calendar year 2006, the payment amount for HCPCS code Q3014 (telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or \$22.47 (2.8 percent times \$21.86 [the 2005 fee – see below] + \$21.86).

Note that the beneficiary is responsible for any unmet deductible amount or coinsurance. For reference, the Medicare telehealth originating site facility fees and MEI increases by the applicable time period are shown in the following table:

Telehealth Originating Site Facility Fee	MEI Increase	Period
\$20.00	N/A	10/01/2001-12/31/2002
\$20.60	3 percent	01/01/2003-12/31/2003
\$21.20	2.9 percent	01/01/2004-12/31/2004
\$21.86	3.1 percent	01/01/2005-12/31/2005
\$22.47	2.8 percent	01/01/2006-12/31/2006

Additional Information

You can find more information about the telehealth originating site facility fee payment amount by going to CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R41BP.pdf>.

Finally, 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/apps/contacts/>.

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

Medlearn Matters Number: MM4201
 Related Change Request (CR) Number: 4201
 Related CR Release Date: December 16, 2005
 Related CR Transmittal Number: 41
 Effective Date: January 1, 2006
 Implementation Date: January 18, 2006

Source: CMS Pub. 100-2, Transmittal 41, CR 4201

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Payment for Medicare Part B Radiopharmaceuticals Not Paid on a Cost or Prospective Payment Basis

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

Provider Types Affected

All providers billing carriers, fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs), for Medicare Part B radiopharmaceuticals

Provider Action Needed

STOP – Impact to You

Medicare Part B radiopharmaceuticals payment allowance limits are not subject to the average sales price (ASP), effective January 1, 2005.

CAUTION – What You Need to Know

Effective January 1, 2005, the payment allowance limits for radiopharmaceuticals are determined by the payment methodology in place under Part B as of November 2003.

GO – What You Need to Do

If you require adjustments on radiopharmaceuticals claims processed prior to January 1, 2005, contact your carrier, FI, or RHHI.

Background

In accordance with section 303(c) of the Medicare Modernization Act (MMA) of 2003, effective January 1, 2005, drugs and biologicals not paid on a cost or prospective basis are paid based on the ASP.

However, section 303(h) of the MMA of 2003 provided for the continuation of the payment methodology under Medicare Part B, prior to the MMA for radiopharmaceuticals, effective January 1, 2005. Therefore, the payment allowance limits for radiopharmaceuticals are based on the payment methodology under Part B, as of November 2003.

This article and related CR 4053 supersede instructions provided in CR 3783, transmittal 528, dated April 22, 2005, which stated that Medicare carriers, FIs, and RHHIs will determine payment allowance limits for radiopharmaceuticals based on the ASP. The payment allowance limits for radiopharmaceuticals are not subject to the ASP.

Payment for Medicare Part B Radiopharmaceuticals Not Paid on a Cost or Prospective Payment Basis (continued)**Additional Information**

Medlearn Matters article MM3783, titled “MMA – July 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective July 1, 2005,” may be viewed on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3783.pdf>.

The official instruction issued to your carrier/FI/RHHI regarding this change may be viewed by going on the CMS website to <http://new.cms.hhs.gov/transmittals/downloads/R738CP.pdf>.

From that Web page, look for CR 4053 in the CR NUM column on the right and click on the file for that CR.

If you have any questions, please contact your Medicare carrier/FI/RHHI at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Related Change Request (CR) Number: 4053

Related CR Release Date: November 1, 2005

Related CR Transmittal Number: 738

Effective Date: January 1, 2005

Implementation Date: December 5, 2005

Source: CMS Pub. 100-4, Transmittal 738, CR 4053

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Supplying Fee and Inhalation Drug Dispensing Fee Revisions and Clarifications

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

Provider Types Affected

Physicians, providers, and suppliers billing oral anti-cancer chemotherapeutic drugs, oral anti-emetic drugs, immunosuppressive drugs, or inhalation drugs to Medicare durable medical equipment regional carriers (DMERCs) or fiscal intermediaries (FIs).

Provider Action Needed

This article is based on information contained in change request (CR) 3990, which clarifies and revises the policies and fees related to the supply fee and dispensing fee, and outlines changes to Healthcare Common Procedure Coding System (HCPCS) codes used for those fees.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 303(e) (2)) authorized Medicare to pay a supplying fee for the following drugs:

- Immunosuppressive drugs
- Oral anti-cancer chemotherapeutic drugs
- Oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen.

Supplying Fees

Effective January 1, 2006, Medicare will pay the following supplying fees to a pharmacy for each of the above listed drugs:

- **\$24.00 for the first prescription** supplied to a beneficiary during a 30-day period. Each pharmacy that supplies the above listed drugs to a beneficiary during a 30-day period will be eligible for one \$24 supplying fee in that period.
- **\$16.00 for each subsequent prescription** of the above listed drugs supplied to a beneficiary in the same 30-day period.

Notes:

- For a refill prescription, Medicare will allow payment of a \$24.00 supplying fee up to seven days before the end of the 30-day period for which the last \$24.00 supplying fee was paid.
- A pharmacy will be limited to one \$24 fee per 30-day period even if the pharmacy supplies more than one category of the above-mentioned drugs (for example, an oral anti-cancer drug and an oral anti-emetic drug) to a beneficiary. A supplier will not be allowed more than twelve \$24 supplying fees per beneficiary per year.
- Medicare will pay a supplying fee for each prescription (including prescriptions for different strengths) of the same drug supplied on the same day. For example, Medicare will pay a supplying fee for both 1) a prescription for 100 mg tablets and 2) a prescription for 5 mg tablets of the same drug supplied on the same day.
- This change does not alter the one-time \$50 supplying fee (code Q0510 – replacement code for G0369) for the first immunosuppressive prescription after a transplant.

Dispensing Fees

Medicare also pays a dispensing fee for inhalation drugs, in accordance with Section 1842(o)(2) of the Social Security Act. Effective January 1, 2006, Medicare will pay one dispensing fee to a pharmacy amounting to:

- **\$57.00 for an initial dispensing fee** to a pharmacy for the initial 30-day period of inhalation drugs furnished through DME regardless of the number of shipments or drugs dispensed during that time and regardless of the number of pharmacies used by a beneficiary during that time
- **One dispensing fee of \$33.00 for a 30-day period of inhalation drugs** furnished through DME regardless of the number of shipments or drugs dispensed during that time

Supplying Fee and Inhalation Drug Dispensing Fee Revisions and Clarifications (continued)

- **One dispensing fee of \$66.00 for each dispensed 90-day period of inhalation drugs** furnished through DME regardless of the number of shipments or drugs dispensed during that time.

One Dispensing Fee Payment for 90-Day Period

Only **one** dispensing fee payment will be made for the 90-day period, regardless of the number of pharmacies used by a beneficiary. A supplier cannot be paid for more than one of the following for a beneficiary for the same period:

- An initial dispensing fee (G0333)
- A 30-day dispensing fee (Q0153)
- A 90-day dispensing fee (Q0514).

Refill Prescriptions/Supply and Dispensing Fees

For a refill prescription, Medicare will allow payment of the dispensing fee no sooner than seven days before the end of usage for the current 30-day or 90-day script for which a dispensing fee was previously paid. An inhalation drug supplier will not be allowed more than 12 months of dispensing fees per beneficiary per year.

Note: The supply fee and dispensing fee must continue to be billed on the same claim as the drug supplied or dispensed. Also, note that a supply fee and a dispensing fee is not appropriate for one drug because:

- The supply fee is for immunosuppressives, oral anti-cancer drugs, and oral anti-emetic drugs
- The dispensing fee is for inhalation drugs only.

HCPCS Code Changes

DMERCs and FIs are instructed by CR 3990 to recognize the following Healthcare Common Procedure Coding System (HCPCS) codes for:

- Supply fees for immunosuppressive, oral anti-cancer, and oral anti-emetic drugs:
 - ♦ **Code Q0510** (replaces G0369) – First immunosuppressive prescription after a transplant. (\$50.00)
 - ♦ **Code Q0511** (replaces G0370) – Pharmacy supplying fee for immunosuppressive, oral anticancer, and oral anti-emetic drugs, first prescription in a one-month period. Each pharmacy may receive this fee once in a 30-day period. (\$24.00)
 - ♦ **Code Q0512** (replaces G0370) – Pharmacy supplying fee for immunosuppressive, oral anticancer, and oral anti-emetic drugs – each subsequent prescription in a 30-day period. (\$16.00)

- Dispensing fee for inhalation drugs(one per month) - Pay the first claim received for inhalation drugs:
 - ♦ **Code G0333** – Pharmacy dispensing fee for initial inhalation drug(s); initial 30 day supply to a beneficiary
 - ♦ **Code Q0513** (replaces G0371) – Pharmacy dispensing fee for inhalation drug(s); per 30-days. (\$33.00)
 - ♦ **Code Q0514** (replaces G0374) – Pharmacy dispensing fee for inhalation drugs(s); per 90-days. (\$66.00)

A supplier cannot be paid for more than one of the above fees (G0333, Q0513, Q0514) for a beneficiary for the same period.

Note: Effective January 1, 2006 Medicare will no longer recognize codes G0369, G0370, G0371, and G0374. Also, the Medicare DMERC or FI will downcode G0333 to Q0513 and pay on the basis of Q0513 if a prior claim has been paid to any supplier for that beneficiary for inhalation drugs. Similarly, Medicare will downcode Q0511 to Q0512 if more than one claim for Q0511 is received from the supplier for a beneficiary during the 30-day period (except allowing for the refill within seven days of the end of the 30-day period).

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your FI or DMERC regarding this change. That instruction may be viewed by going to the CMS website <http://new.cms.hhs.gov/transmittals/downloads/R754CP.pdf>.

If you have any questions, please contact your DMERC or FI at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM3990
Related Change Request (CR) Number: 3990
Related CR Release Date: November 10, 2005
Related CR Transmittal Number: 754
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 754, CR 3990

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Appeals of Claim Decisions: Redeterminations and Reconsiderations

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare for services

Provider Action Needed

Medicare providers who appeal claims decisions made by Medicare carriers and fiscal intermediaries (FIs), including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs), need to be aware of the new appeals processes.

Background

The purpose of CR 3944 is to notify Medicare contractors (FIs or carriers, including DMERCs) and Medicare providers about the upcoming transition to the new second level of the appeals process.

The “**redetermination**” is the first level of appeal. It is a second look at the Part A or B claim and supporting documentation by an employee of the contractor (Medicare carrier or intermediary) who was not involved in the initial claim determination. In performing a redetermination of the services requested by the appellant, Medicare contractor personnel must examine all issues in the claim.

The Medicare claims appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new, second level in the administrative appeals process, called a “**reconsideration.**” This new “**reconsideration**” is different from the previous first level of appeal for Part A claims performed by FIs. These appeals are processed by Qualified Independent Contractors (QICs).

Additional Information

Rather than repeat the extensive details of CR3944 in this article, the Centers for Medicare & Medicaid Services (CMS) encourages physicians, providers, and suppliers who wish to appeal an initial determination of a Medicare claim made by a Medicare carrier or FI to review CR 3944. The new/revised manual sections of Chapter 29 of the *Medicare Claims Processing Manual* that are attached to CR3944 contain many important details for those wishing to file claims determination appeals. You can find CR 3944 by going to CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R688CP.pdf>.

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Claim Decision Appeals—Modification to Medicare Fiscal Intermediary Shared System

In the First Quarter 2006 Medicare A Bulletin (pages 14-15) we published a Medlearn Matters article titled “Claim Decision Appeals—Modification to Medicare’s Fiscal Intermediary Shared System” informing providers of the availability of viewing reports within the direct data entry (DDE) system to verify that their redetermination request(s) had been received by the fiscal intermediary.

First Coast Service Options, Inc. will not provide this optional feature through the DDE system. Providers may obtain a status of their appeals by contacting the Medicare Part A Customer Service Center toll-free number 1-877-602-8816. ❖

Source: CMS Pub. 100-20, Transmittal 174, CR 3970

If you bill a Medicare FI, you may also wish to review Medlearn Matters article MM3530 and/or CR 3530. They are available as follows:

Med learn Matters article MM3530 MMA, “Revisions to Medicare Appeals Process for Fiscal Intermediaries” (CR Title-Appeals Transition – BIPA 521 Appeals), is available on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3530.pdf>.

CR 3530, “Revisions to Medicare Appeals Process for Fiscal Intermediaries” (CR Title-Appeals Transition – BIPA 521 Appeals), is available on the CMS website at http://www.cms.hhs.gov/manuals/pm_trans/R1460TN.pdf.

In addition, if the Medicare contractor dismisses your request for a redetermination, you may wish to understand your appeal rights with regard to that dismissal. These rights are discussed in CR 3939, which may also be found on the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R724CP.pdf>.

Once at that page, look for CR 3944 in the CR NUM column on the right and click on the file for that CR.

Please refer to your local FI, carrier, or DMERC if you have questions on this issue. To find their toll-free phone numbers, go to the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Related Change Request (CR) Number: 3944

Related CR Release Date: September 23, 2005

Related CR Transmittal Number: 688

Effective Date: May 1, 2005, for appeals of claims submitted to Medicare intermediaries and January 1, 2006, for appeals of claims submitted to carriers

Implementation Date: December 16, 2005, for Medicare intermediaries and January 1, 2006, for Medicare carriers

Source: CMS Pub. 100-4, Transmittal 688, CR 3944

Appeals of Claim Decisions: Redetermination, Reconsideration and Appeal Rights for Dismissals

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

Provider Types Affected

Physicians, providers, and suppliers who appeal initial claims determinations by Medicare

Provider Action Needed

The purpose of CR 3939 is to notify Medicare contractors (fiscal intermediaries (FIs) or carriers, including durable medical equipment regional carriers (DMERCs)) and Medicare providers about the upcoming transition to the new second level of the appeals process.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amended the Medicare claim appeal process. Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a “reconsideration.” This new “reconsideration” is different from the previous first level of appeal for Part A claims performed by FIs. The qualified independent contractors (QICs) will process reconsiderations.

Rather than repeat the extensive details of CR 3939 in this article, the Centers for Medicare & Medicaid Services (CMS) encourages physicians, providers, and suppliers who wish to appeal an initial determination of a Medicare claim made by a Medicare carrier or FI to review CR 3939. The new/revised manual sections of Chapter 29 of the Medicare Claims Processing Manual that are attached to CR 3939 contain many important details for those wishing to file claims determination appeals. You may find CR 3939 by going to the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R724CP.pdf>.

The key new or revised sections contained in CR 3939 include information on:

- Filing a request for redetermination
- Appeal rights for dismissals of redetermination requests, including sample dismissal letters and notices
- Filing requests for reconsiderations, the second level of appeal

- Time limits for filing reconsideration requests
- How reconsideration decisions are effectuated.

If you bill a Medicare FI, you may also wish to review Medlearn Matters article MM3530 and/or CR 3530. They are available as follows:

Medlearn Matters article MM3530 MMA – Revisions to Medicare Appeals Process for Fiscal Intermediaries (CR Title-“Appeals Transition – BIPA 521 Appeals”) is available on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3530.pdf>.

CR 3530 Revisions to Medicare Appeals Process for Fiscal Intermediaries (CR Title-“Appeals Transition – BIPA 521 Appeals”) is available on the CMS website at http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf.

Please refer to your local FI, carrier, or DMERC if you have questions on this issue. To find their toll free phone numbers go to the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Related Change Request (CR) Number: 3939

Related CR Release Date: October 21, 2005

Related CR Transmittal Number: 724

Effective Date: January 1, 2006, for appeals of initial determination of claims by Medicare carriers; May 1, 2005, for initial claim determinations by Medicare FIs

Implementation Date: December 16, 2005, for FIs and January 1, 2006, for carriers

Source: CMS Pub. 100-4, Transmittal 724, CR 3939

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Change in the Amount in Controversy Requirements for Administrative Law Judge and Federal District Court Appeals

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an administrative law judge (ALJ) hearing or federal district court review. The amount in controversy increases by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved.

Based on this regulation, **effective January 1, 2006**, the amount in controversy for an ALJ hearing request will increase to \$110.00, and the amount in controversy for a federal district court review will increase to \$1,090.00.

For ALJ hearing requests made **before January 1, 2006**, the amount in controversy remains \$100.00, and the amount in controversy for a federal district court review requested **prior to January 1, 2006**, remains \$1,050.00. ❖

Source: CMS Pub. Joint Signature Memorandum 06034, October 31, 2005

General Appeal Process in Initial Determinations

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this article on November 10, 2005, to clarify the entry in section 4 of the chart to show that appeals to the Departmental Appeals Board are only to be made to the Board and not to the ALJ hearing office. This article was published in the First Quarter 2006 *Medicare A Bulletin* (pages 18-20).

Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B fee-for-service claims to Medicare

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

CR 4019 focuses on the general appeals process in initial determinations. CR 4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals, and focuses specifically on the additions of sections 200 to 260 to chapter 29 of the *Medicare Claims Processing Manual*.

Key Points

Centers for Medicare & Medicaid Services (CMS) Decisions Subject to the Administrative Appeals Process

The Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. These decisions are subject to appeal with the SSA.

Minor Errors and Omissions

Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing the claim, which, in turn, caused the claim to be denied. In the case where a minor error or omission is involved, the provider can request that the Medicare contractor reopen the claim so the error or omission can be

corrected, rather than having to go through the appeals process.

Who May Appeal

CR 4019 (Additions to Chapter 29) defines and describes the individuals and entities who have the right to appeal a Medicare contractor’s initial determination. (Medicare contractors are carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs).) An individual who has a right to appeal is referred to as a “party.”

Provider or Supplier Appeals When the Beneficiary Is Deceased

When a provider or supplier appeals on behalf of a deceased beneficiary, and the provider or supplier otherwise does not have the right to appeal, it is the contractor’s responsibility to determine whether another party is available to appeal. CR 4019 describes what must be done in this situation.

Parties to an Appeal

Any of the persons/entities who may appeal Medicare’s decision to deny or reduce payment are parties to an appeal of a claim for items or services payable under Part A or Part B.

Steps in the Appeals Process: Overview

The process of appeal described in CR 4019 is effective for all redeterminations issued on or after May 1, 2005, by Medicare FIs and all redeterminations issued on or after January 1, 2006, by carriers. The appeals process consists of five levels. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal. No appeal can be accepted until an initial determination has been made for the claim. The following chart outlines the steps in the Medicare appeal process:

The Medicare Fee-for-Service Appeals Process

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold To Be Met or Amount in Controversy
1. Redetermination			
<ul style="list-style-type: none"> Performed by the Medicare Contractor 	120 days from date of receipt of the notice initial determination (MSN or RA). (The notice of initial determination is presumed to be received five days from the date of the notice unless there is evidence to the contrary.)	Part A – FI (MAC) Part B – Carrier (MAC)	None

GENERAL INFORMATION

General Appeal Process in Initial Determinations (continued)

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold To Be Met or Amount in Controversy
2. Reconsideration			
<ul style="list-style-type: none"> Performed by QIC Case file prepared by the Medicare contractor and forwarded to the QIC.** Medicare contractor may have effectuation responsibilities for decisions made by the QIC. 	180 days from date of receipt of the redetermination	Part A and B – QIC	None
3. Administrative Law Judge (ALJ) Hearing			
<ul style="list-style-type: none"> Case file prepared by the QIC and forwarded to the HHS Office of Medicare Hearings and Appeals (OMHA). Medicare contractor may have effectuation responsibilities for decisions made at the ALJ level. 	60 days from the date of receipt of the reconsideration notice	Part A and B – HHS OMHA Field Office	At least \$100 remains in controversy*** <i>For requests made on or after January 1, 2006, at least \$110 remains in controversy</i>
4. Departmental Appeals Board (DAB) Review			
<ul style="list-style-type: none"> Contractor may have effectuation responsibilities for decisions made at the DAB level. 	60 days from the date of receipt of the ALJ hearing decision/dismissal	Part A and B – DAB	None
5. Federal Court (Judicial) Review			
<ul style="list-style-type: none"> Medicare contractor may have effectuation responsibilities for decisions made at the Federal Court level. 	60 days from date of receipt of DAB decision or declination of review by DAB		At least \$1,050 remains in controversy*** <i>For requests made on or after January 1, 2006, at least \$1,090 remains in controversy</i>

*Where to Appeal – Part A includes Part B claims filed with the FI.

** In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).

***Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy (AIC) requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of \$10 will be rounded to the nearest multiple of \$10.

Where to Appeal

Where a party must file an appeal depends on the level of appeal. The above chart indicates where appellants should file appeal requests for each level of appeal.

When to Appeal – Time Limits for Filing Appeals and Good Cause for Extension of the Time Limit for Filing Appeals

The time limits for filing appeals vary according to the type of appeal. The table above indicates the time limits for filing appeal requests for each level of appeal. These time limits may be extended if good cause for late filing is shown.

Good Cause – General Procedure to Establish Good Cause for Late Filing

Procedures to establish good cause are effective for all requests for redeterminations received by FIs on or after May 1, 2005, and all requests for redeterminations received by the carrier on or after January 1, 2006. The new Section 240 of Chapter 29 of the *Medicare Claims Processing Manual* lists the general procedure for establishing good cause for late filing; when a favorable decision for good cause is made; and when an unfavorable decision for good cause is made. A listing of conditions and examples that may establish good cause for late filing by beneficiaries or by providers, physicians, and suppliers, may be found in Section 240, which is attached to CR 4019.

Amount in Controversy Requirements

The amount in controversy requirements apply only to the ALJ and federal court levels. The chart above indicates the amount in controversy (AIC) as well as the method of calculating the AIC, for the Medicare appeals process.

*General Appeal Process in Initial Determinations (continued)***Additional Information**

The official instruction issued to your FI or carrier regarding this change may be found by going to the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/B695CP.pdf>.

From that web page, look for CR4019 in the CR NUM column on the right, and click on the file for that CR. All of the new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR4019. These sections provide excellent detail that explains the revised appeals process.

Please refer to your local FI or carrier for more information about this issue. To find their toll-free phone number,

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go to the CMS website

<http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number MM: 4019 – Revised

Related Change Request (CR) Number: 4019

Related CR Release Date: October 7, 2005

Related CR Transmittal Number: 695

Effective Date: May 1, 2005

Implementation Date: January 9, 2006

Source: CMS Pub. 100-4, Transmittal 695, CR 4019

Requirements for Voided, Canceled, and Deleted Claims

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this article on November 10, 2005, to clarify the language in item 4 under “Acceptable Claim Deletions section. All other information remains the same. This article was published in the First Quarter 2006 *Medicare A Bulletin* (pages 6-7).

Provider Types Affected

All Medicare physicians, providers, and suppliers billing Medicare carriers, durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs)

Provider Action Needed

This Medlearn Matters article is based on information contained in change request (CR) 3627, which describes the new Centers for Medicare & Medicaid Services (CMS) procedures and specific instructions to Medicare contractors (carriers, intermediaries, and DMERCs) for voiding, canceling, and deleting claims.

As a result of these changes, providers should note that some claims they were able to delete in the past will no longer be deleted from Medicare’s systems, but will instead become denied claims.

Background

The Department of Health & Human Services (DHHS) Office of the Inspector General (OIG) has verified instances in which Medicare claims have been voided, cancelled, or deleted by Medicare carriers, DMERCs, and FIs. Further, the Medicare contractors have not traditionally maintained an audit trail for the voided, cancelled, or deleted claims. The OIG has indicated that Medicare must maintain an audit trail for voided, cancelled, and deleted claims.

CMS is therefore implementing requirements for Medicare contractors (carriers/FIs, including DMERCs and regional home health intermediaries (RHHIs)) to:

- Deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons
- Cancel, void, or delete claims that are unprocessable for acceptable reasons
- Return as unprocessable claims that meet conditions mentioned below for the return of unprocessable claims.

- Maintain an audit trail for all cancelled, voided, or deleted claims that Medicare systems have processed far enough to have assigned a claim control number (CCN) or document control number (DCN).

Note: CR 3627 requires that Medicare carriers, intermediaries, and DMERCs keep an audit trail on these claims once a CCN or DCN has been assigned to the claim.

Acceptable Claims Deletions

Below is a list of acceptable reasons a Medicare contractor may cancel, delete, or void a claim:

1. The current CMS 1500 form or the current CMS 1450 form is not used.
2. The front and back of the CMS 1500 (12/90) claim form are required on the same sheet and are not (claims submitted to carriers only).
3. A breakdown of charges is not provided, i.e., an itemized receipt is missing.
4. Only six line items may be submitted on each CMS 1500 claim form (Part B only).
5. The patient’s address is missing.
6. An internal clerical error was made.
7. The certificate of medical necessity (CMN) was not with the claim (Part B only).
8. The CMN form is incomplete or invalid (Part B only).
9. The name of the store is not on the receipt that includes the price of the item (Part B only).

Note: The Medicare contractor must keep an audit trail for all claims in the above “Acceptable Claims Deletions” category if a CCN or a DCN was assigned to the claim.

Requirements for Voided, Canceled, and Deleted Claims (continued)

Unacceptable Claims Deletions

The following are unacceptable reasons for Medicare contractors to void, cancel, or delete claims:

1. A provider notifies the Medicare contractor that claim(s) were billed in error and requests the claim be deleted (carrier claims only).
2. The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (type of bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review. (FI claims only)
3. The patient's name does not match any health insurance claim number (HICN).
4. A claim meets the criteria to be returned as unprocessable under the incomplete or invalid claims instructions in the *Medicare Claims Processing Manual*, Chapter 1, Section 80.3.2.ff, which is available on the CMS website at <http://www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage>.

Medicare contractors must deny or reject claims in the above "Unacceptable Claims Deletions" category.

Return as Unprocessable Claims

Medicare contractors may return a claim as unprocessable for the following reasons:

1. Valid procedure codes were not used and/or services are not described (e.g., block 24D of the CMS 1500) (Part B only).
2. The patient's HICN is missing, incomplete, or invalid (e.g., block 1A of the CMS 1500).
3. The provider number is missing or incomplete.
4. No services are identified on the claim.
5. Block 11 (insured policy group or FECA Number) of the CMS 1500 is not completed to indicate whether an insurer primary to Medicare exists (Part B only).
6. The beneficiary's signature information is missing (Part B only).
7. The ordering physician's name and/or UPIN is missing/invalid (blocks 17 and 17A of the CMS 1500).
8. The place of service code is missing or invalid (block 24B of the CMS 1500 – Part B only).
9. A charge for each listed service is missing (e.g., block 24F of the CMS 1500).
10. The days or units are missing (e.g., block 24G of the CMS 1500).
11. The signature is missing from block 31 of the CMS 1500 (Part B only).
12. Dates of service are missing or incomplete (block 24A of the CMS 1500).

13. A valid HICN is on the claim, but the patient's name does not match the name of the person assigned that HICN.

Summary

In summary, CMS believes the following:

- The problems listed under the "Acceptable Claims Deletions" heading are valid reasons to void/delete/cancel a claim if the Medicare contractor maintains an audit trail.
- Claims with problems listed under the "Unacceptable Claims Deletions" heading should be denied or rejected by Medicare, and the decision to deny/reject the claim should be recorded in the Medicare contractor's claims processing system history file.

If a Medicare contractor determines that a claim is unprocessable before the claim enters that contractor's claims processing system (i.e., the claim processing system **did not assign a CCN or DCN** to the claim):

- The claim may be denied
- The contractor does not have to keep a record of the claim or the deletion.

If a Medicare contractor determines that a claim is unprocessable after the claim enters their claims processing system (i.e., the claim processing system **did assign a CCN or DCN** to the claim):

The denied or rejected claim will not be totally deleted from Medicare's claims processing system. The Medicare contractor must maintain an audit trail for all deleted claims that have entered the claims processing system (i.e., the system assigned a CCN or DCN to the claim).

Implementation

The implementation date for the instruction is October 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/RI590TN.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/apps/contacts/>.

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

Medlearn Matters Number MM: 3627 – Revised
Related Change Request (CR) Number: 3627
Related CR Release Date: June 17, 2005
Related CR Transmittal Number: 159
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

Source: CMS Pub. 100-20, Transmittal 159, CR 3627

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Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs)

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this article on October 28, 2005, due to a revision to CR 3953. The changes to the article are the new CR release date and transmittal number. The other changes made are: 1.) The Visiting Nurse Service of New York/EverCare program has been cancelled. 2.) The contact information for the CIGNA Healthcare program in Georgia has been corrected. 3.) The Start Date for the XL Health program in Tennessee has been updated from November 2005 to January 2006. All other information from transmittal 27 remains the same. Please note that the important date for the provider is the date that the program starts in your area. The first revision to this article was published in the First Quarter 2006 *Medicare A Bulletin* (pages 35-39).

Provider Types Affected

Physicians and providers in any one of the nine geographic area described below.

Organization Selected by CMS to Provide Program	Geographic Areas to Be Served
1. Aetna Life Insurance Company, LLC	Chicago, Illinois counties
2. American Healthways	Maryland and the District of Columbia
3. CIGNA Health Support	Northwest Georgia
4. Health Dialog Services Corporation	Western Pennsylvania
5. Humana, Inc.	Central and South Florida
6. LifeMasters Supported SelfCare, Inc.	Oklahoma
7. McKesson Health Solutions	Mississippi
8. XLHealth Corporation	Selected counties in Tennessee

Provider Action Needed

STOP – Impact to You

This article includes information from change request (CR) 3953 that describes the new Medicare Health Support programs (MHSPs), formally known as Chronic Care Improvement programs, and identifies the nine organizations selected by the Centers for Medicare & Medicaid Services (CMS) to provide MHSPs to certain beneficiaries enrolled in the traditional fee-for-service (FFS) Medicare program.

CAUTION – What You Need to Know

CMS is implementing phase I: Developmental of the Medicare health support initiative. The nine MHSOs selected by CMS will serve approximately 180,000 Medicare beneficiaries who have congestive heart failure and/or diabetes among their chronic conditions. Eligible beneficiaries do not have to change plans or providers to participate, and participation is totally voluntary. Participation in an MHSP does not restrict access to other Medicare services and will be provided at no extra cost to beneficiaries.

GO – What You Need to Do

See the Background and Additional Information sections for more information on this new program.

Background

This article provides information on the CMS’ implementation of the Medicare Health Support program, formally known as Chronic Care Improvement program. Section 721 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) adds a new section 1807, “Voluntary Chronic Care Improvement Under Traditional Fee-for-Service (FFS) Medicare” to the Social Security Act. This requires Medicare to provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs (now known as MHSPs) and to proceed with expansion regionally or possibly nationwide if the pilot programs (or program components) are successful.

This initiative represents one of the multiple strategies developed by the Department of Health & Human Services (DHHS) to help chronically ill beneficiaries stay healthier, accelerate the adoption of health information technology, reduce avoidable costs and diminish health disparities among Medicare beneficiaries nationally.

Some key points about of MHS initiative are as follows:

- The MHSPs will test whether or not providing additional health education and support services for targeted chronically ill Medicare beneficiaries who are in traditional FFS Medicare will lead to improved clinical quality and satisfaction and lower costs to Medicare.
- CMS has entered into agreements with selected organizations (MHSOs) to provide MHSPs to targeted Medicare FFS beneficiaries (about 20,000 beneficiaries serviced by each MHSO) who have congestive heart failure and/or diabetes.
- The first MHSPs will be phased in during 2005, operate for three years, and be tested through comparative analysis to beneficiaries randomly assigned to regional control groups. The statute provides for expansion of the MHS initiative if the pilot programs or program components are successful.
- The programs will offer support services—such as self-care guidance and answers to questions about medications—for chronically ill beneficiaries who are invited by CMS to participate. The goal is to help them adhere to their prescribed treatment plans and ensure that they seek the medical care they need to reduce their health risks. Coordination and collaboration with participants’ healthcare providers to enhance communication of relevant clinical information are also key components of the MHSPs.

GENERAL INFORMATION

Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs (continued))

- Participation in MHSPs will not restrict access to care and will be provided at no cost to eligible beneficiaries. Such beneficiaries do not have to change from their existing plans, nor do they have to change physicians or providers in order to participate. Further, they may stop participating at any time.
 - MHSOs will be paid by CMS, outside of the Medicare FFS claims payment system, a fixed administrative fee per participant per month.
 - The MHSOs will not focus on any single disease, but will help participants manage their health holistically.
 - The MHSOs will *not* pay any claims on behalf of enrolled beneficiaries and a beneficiary's participation will not affect how claims from their physicians/providers are processed by Medicare.
- The following chart identifies the MHSO, provides information about selected program features of the MHSPs to be offered, and delineates the geographic areas served by the MHSOs:

MHSO	Selected Program Features	Geographic Area
Aetna, Life Insurance Company, LLC	<ul style="list-style-type: none"> • Advance practice nursing program for home health and nursing homes • Customized care plans • Caregiver education • Blood pressure monitors and weight scales provided based on participant need • Physician communication • Physician Web access to clinical information • 24-hour nurse line 	Chicago Illinois counties
American Healthways	<ul style="list-style-type: none"> • Personalized care plans • Direct-mail and telephonic messaging • Supplemental telephonic coaching • Gaps in care generate physician prompts • Intensive case management services as necessary • Remote monitoring devices (weight, blood pressure, and pulse) based on participant need • Physician Web access to clinical information • Physician communication • 24-hour nurse line 	Maryland and the District of Columbia
CIGNA Health Support, LLC	<ul style="list-style-type: none"> • Personalized plan of care • Telephonic nurse interventions • Oral and written communication in addition to telephonic coaching • Home monitoring equipment (weight, blood pressure and glucometers) based on participant need • Intensive case management for frail elderly and institutionalized participants, as required • Data exchange with physicians • 24-hour nurse line 	Northwest Georgia
Health Dialog Services Corporation	<ul style="list-style-type: none"> • Personal health coaches develop individual care management plans • Health education materials (Web-based, faxed or mailed) • In-home biometric monitoring • Behavioral health case management and intensive case management as needed • Data exchange with physicians • Active involvement of other community agencies • 24-hour nurse line 	Western Pennsylvania

Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs (continued))

MHSO	Selected Program Features	Geographic Area
Humana, Inc.	<ul style="list-style-type: none"> • Trademarked Personal Nurse program model • Group education and support sessions • Biometric monitoring equipment, including glucometers and weight scales as necessary • Core telephonic support supplemented with RNs, social workers and pharmacists in the field interacting with providers and beneficiaries with complex needs • Data exchange with physicians • On-site meetings with physicians and CME (continuing medical education) programs • Physician Web access to clinical information • Electronic medical record keeping systems will be piloted in five small physician-group practices • Active involvement of other community agencies • 24-hour nurse line 	Central and South Florida
Lifemasters Supported SelfCare	<ul style="list-style-type: none"> • Single nurse as primary contact for beneficiary • Supported self-care model including education, medication compliance, behavior change • Home visits as appropriate • Team of local and call center-based nurses, physicians, pharmacists, and health educators • Digital weight scale and blood pressure monitors • Physician communication including customized care plans, alerts, decision support applications; access to patient care record and biometric monitoring data • Physician outreach includes in-person orientation for high volume physician practices • Physician Web access to clinical information • Active involvement of other community agencies • 24-hour nurse line 	Oklahoma
McKesson Health Solutions	<ul style="list-style-type: none"> • Extensive physician involvement, including on-site staff support • Data exchange with physicians, • Physician Web access to clinical information • Telephonic outreach • Mail, fax, workbooks • Remote monitoring and biometric equipment for selected high-risk participants • Pharmacist review of medications and collaboration with physicians • Management of long-term care residents and intensive case management, including end-of-life • 24-hour nurse line 	Mississippi
XL Health Corporation	<ul style="list-style-type: none"> • Biometric monitoring including glucometers and weight scales as necessary • RNs, social workers, and pharmacists in the field, interacting with providers and beneficiaries with complex needs • Medication counseling sessions by pharmacists at retail pharmacies • Specialized program for higher risk patients • Medication management and compliance • Data exchange with physicians, • Physician Web access to clinical information • 24-hour nurse line 	Selected counties in Tennessee

Physicians and providers with questions regarding the program can find additional information at <http://www.cms.hhs.gov/medicarereform/ccip/> on the CMS website, or they may direct their inquiries directly to the following MHSO contacts:

GENERAL INFORMATION

Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs (continued))

<p>Aetna Life Insurance Company Kathleen Giblin Aetna Health Management, LLC 151 Farmington Avenue, RT11 Hartford, CT 06156 Or call 888-713-2836 or visit http://www.aetna.com</p>	<p>LifeMasters Supported SelfCare: Ron Lau, c/o Mel Lewis LifeMasters Supported SelfCare 5000 Shoreline Court S#300 South San Francisco, CA 94080 Or call 888-713-2837 or visit http://www.lifemasters.com</p>
<p>American Healthways: Michael Montijo, M.D., American Healthways American Healthways, Inc. 3841 Green Hills Village Drive Nashville, TN 37215 Or call 866-807-4486 or visit http://www.medicarehealthsupport.com</p>	<p>McKesson Health Solutions: Sandeep Wadhwa McKesson Health Solutions 335 Interlocken Parkway Broomfield, CO 80021 Or call 800-919-9110 or visit http://www.mckesson.com</p>
<p>Health Dialog Services Corporation: Molly Doyle Health Dialog Services Corporation 60 State Street, Suite 1100 Boston, MA 02109 Or call 800-574-8475 or visit http://www.myhealthsupport.com (available August 2005)</p>	<p>XL Health Corporation: Paul Serini XLHealth Corporation 351 West Camden Street, Suite 100 Baltimore, Maryland 21201 Or call 877-717-2247</p>
<p>Humana, Inc.: Heidi Margulis Humana, Inc. 500 West Main Street, 6th Floor Louisville, KY 40202 Or call 800-372-8931 or visit http://www.greenribbonhealth.com</p>	
<p>CIGNA Health Support: Elizabeth Sanford CIGNA TLP 11H 1601 Chestnut Street Philadelphia PA 19355 Or call 866-563-4551 or visit http://www.mhsgeorgia.com (available August 2005)</p>	

Note: The start date for the XL Health program in Tennessee is January 2006. The start date for the Humana program is November 2005. All other programs started in August or September of 2005.

Implementation

The implementation date for this instruction is October 20, 2005.

Additional Information

For complete details of CR 3953, please see the official instruction issued by going to CMS website: <http://www.cms.hhs.gov/transmittals/downloads/R30DEMO.pdf>.

The Medicare fact sheet that describes the Medicare Health Support programs may be found on the CMS website at: <http://www.cms.hhs.gov/medicarereform/ccip/>.

This document is an excellent overview of the program. Medlearn Matters Article MM3410 provides some background information on the "Use of Group Health Plan Payment System to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries Under Section 721 of the MMA" and may be viewed by going to CMS website: <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3410.pdf>.

Medlearn Matters Number: MM3953 – Revised
Related Change Request (CR) Number: 3953
Related CR Release Date: October 28, 2005
Related CR Transmittal Number: 30
Effective Date: October 20, 2005
Implementation Date: October 20, 2005

Source: CMS Pub. 100-19, Transmittal 30, CR 3953

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New G Code for Power Mobility Devices

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this article on November 6, 2005, to reflect a revision made to change request (CR 4121). That CR was revised to show that the changes impact physician services only and do not impact claims billed to Medicare fiscal intermediaries (FIs). This article was published in the First Quarter 2006 *Medicare A Bulletin* (pages 24-25).

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers for services related to power mobility devices (PMDs).

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4121, which announces that a new G Code (G0372) has been established to recognize the additional physician service and resources required to establish and document the need for PMDs.

CAUTION – What You Need to Know

The new G code is only payable if all of the information necessary to document the PMD prescription is included in the medical record after a face-to-face examination of the beneficiary, and the prescription is received by the PMD supplier within 30 days after the face-to-face examination.

GO – What You Need to Do

Please see the *Background* section of this article for further details.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 302(a)(2)(E)(iv)) details the revised conditions for Medicare payment of PMDs. It states that payment for motorized or power wheelchairs may not be made unless a face-to-face examination of the beneficiary has been conducted, and a written prescription (order) for the PMD has been provided by one of the following providers:

- Physician (as defined in Section 1861(r)(1) of the Social Security Act)
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist (as those terms are defined in Section 1861(aa)(5) of the Social Security Act).

Note: Payment for the history and physical examination will be made through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient.

New G Code

Due to the MMA requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the durable medical equipment supplier, the Centers for Medicare & Medicaid Services (CMS) has established the new G Code (G0372), to recognize additional physician services and resources required to establish and document the need for a PMD.

CMS believes that the typical amount of additional physician services and resources involved is equivalent to

the physician fee schedule relative values established for a level 1 office visit for an established patient (*Current Procedural Terminology (CPT) code 99211*).

The payment amount for such a visit is \$21.60; therefore, the payment amount for G0372 for 2005 will be \$21.60, adjusted by the geographic area where the services is provided, and based on the physician fee schedule values for a level 1 established patient office visit (CPT 99211).

Code G0372 indicates that:

- All of the information necessary to document the PMD prescription is included in the medical record.
- The prescription, along with the supporting documentation, has been received by the PMD supplier within 30 days after the face-to-face examination.

Effective October 25, 2005, G0372 will be used to recognize additional physician services and resources required to establish and document the need for the PMD, and it will be added to the Medicare physician fee schedule.

G0372 Physician service required to establish and document the need for a power mobility device
Short Descriptor = MD service required for PMD
Procedure Status = A
WRVU = 0.17
Non-Facility PE RVU = 0.39
Facility PE RVU = 0.06
Malpractice RVU = 0.01
PC/TC = 0
Site of Service = 1
Global Surgery = XXX
Multiple Procedure Indicator = 0
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 0
Co-Surgery Indicator = 0
Team Surgery Indicator = 0
Diagnostic Supervision = 0
Type of Service = 1

Reimbursement

The following fee schedules are effective for G0372 for services provided **on or after October 25, 2005**.

Code	Loc 01/02	Loc 03	Loc 04
G00372	\$20.82	\$21.91	\$22.86

Implementation

The implementation date for the instruction is October 25, 2005.

Additional Information

For full details regarding wheelchair coverage, visit the CMS page for wheelchairs on the CMS website at http://www.cms.hhs.gov/CoverageGenInfo/06_wheelchair.asp#TopOfPage.

For complete details on the new G code, please see the official instruction issued to your carrier/intermediary

New G Code for Power Mobility Devices (continued)

regarding this change. That instruction may be viewed on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R748CP.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/apps/contacts/>.

The toll-free number for First Coast Service Options,

Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Medlearn Matters Number: 4121

Related Change Request (CR) Number: 4121

Related CR Release Date: November 4, 2005

Related CR Transmittal Number: 748

Effective Date: October 25, 2005

Implementation Date: October 25, 2005

Source: CMS Pub. 100-4, Transmittal 748, CR 4121

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Modification to Online Medicare Secondary Payer Questionnaire—Full Replacement of and Rescinding Change Request 3504

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

Provider Types Affected

Medicare providers who, upon inpatient or outpatient admissions of Medicare beneficiaries, use a questionnaire to determine other insurance coverage that may be primary to Medicare.

Provider Action Needed

STOP – Impact to You

CR 4098 clarifies recent changes made to the “Medicare Secondary Payer Questionnaire.”

CAUTION – What You Need to Know

This change request (CR) identifies all of the changes that were made to CR 3504 **and** makes additional changes to the model questionnaire. These changes will assist providers in identifying other payers that may be primary to Medicare.

GO – What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified.

Background

The Centers for Medicare & Medicaid Services (CMS) received information that a prior instruction (CR3504) did not specifically mention all of the changes that were made to the “Medicare Secondary Payer (MSP) Questionnaire.” CR4098 identifies all of the changes made as part of CR3504 and makes additional changes to the model questionnaire.

The *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1, available as an attachment to CR4098, provides a model: “Admission Questions to Ask Medicare Beneficiaries.” The model contains questions that may be printed out and used as a guide to help identify other payers. (The website for accessing CR4098 is provided in the *Additional Information* section of this article.)

The following bullets identify the changes within the model MSP Questionnaire:

- **Parts IV** and **V** of the model questionnaire adds the response: “No, Never Employed.”
- In **Parts IV, V, and VI** of the model questionnaire,

providers should use “Policy Identification Number” to mean a number that is sometimes referred to as the health insurance benefit package number.

- **Parts IV, V, VI** of the model questionnaire adds “Membership Number” and it refers to the unique identifier assigned to the policyholder/patient.
- **Part V**, question 2 of the model questionnaire uses “spouse” instead of “family member.”
- **Part V**, question 4 changes the model questionnaire to read:

*Are you covered under the group health plan of a family member other than your spouse? _____Yes
_____No.*

Name and address of your family member’s employer: _____

- **Part V** of the old question 4 is changed to ask whether the beneficiary is covered under a group health plan (GHP) and a question number 5 is added to gather the pertinent information about the GHP.
- In **Part VI**, question 6 now reads: “Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?”

Providers who use the model questionnaire to elicit MSP information from their Medicare patients should take special note of these changes.

Implementation

The implementation date for the instruction is January 21, 2006.

Additional Information

The official instructions issued to your Medicare carrier or intermediary regarding this change and the model questionnaire may be found on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R41MSP.pdf>.

If you have 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/apps/contacts/>.

Modification to Online MSP Questionnaire—Full Replacement of and Rescinding CR 3504 (continued)

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

Medlearn Matters Number: MM4098
Related Change Request (CR) Number: 4098

Related CR Release Date: October 21, 2005
Related CR Transmittal Number: 41
Effective Date: January 21, 2006
Implementation Date: January 21, 2006

Source: CMS Pub. 100-5, Transmittal 41, CR 4098

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Physician's Role in Certifying and Planning Care for Partial Hospitalization Programs

The Medicare law requires that payment from Medicare be made only if the physician certifies the need for services and establishes the plan of care for outpatient partial hospitalization services. The certification requirements follow:

Partial Hospitalization Program (PHP) Requirements

PHYSICIAN CERTIFICATION

The certification by the physician identifying the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. This certification indicates that PHP is "in lieu" of continued inpatient treatment, or those patients who, would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided.

Upon admission the physician must make a certification that must be signed, and maintained in the patient's record, to include the following information:

(It is generally expected that the physician certification will be completed within 24 hours of the patient's admission to the partial hospitalization program.)

- A physician who is treating the patient and has knowledge of the patient's response to treatment must sign the physician certification.
- A physician trained in the diagnosis and treatment of psychiatric illness must certify that the patient being admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization services are not provided.
- The certification should identify the diagnosis and psychiatric need for the partial hospitalization.
- Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in Section 1861 of the Social Security Act, that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

PHYSICIAN RECERTIFICATION

- The first recertification is required by the 18th calendar day following admission to the PHP.
- Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.
- Recertification should be based on a thorough re-evaluation of the treatment plan in relation to the reason for admission and the progress of the patient.

Certifications and recertifications may use any format desired and may be part of the treatment plan. **However, the following statement must be used.**

"I certify that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization services, and services will be furnished under the care of a physician, and under a written plan of treatment."

Physician signature: _____
Date: _____

Certifications are prospective; the physician (M.D./D.O.) certifies that future services are required. A physician certification must cover all periods of service. A physician certification is required to be made and maintained in the patient's file, but does not guarantee approval of services. A psychologist is not considered a physician for the purpose of establishing a certification or recertification.

References

- Medicare Benefit Policy Manual, Chapter 6 – Hospital Services Covered Under Part B **70.3 – Partial Hospitalization Services**
- First Coast Service Options, Florida Medicare Part A, local coverage determination (LCD) name **APHPPROG/ LCD Database ID Number L1212/ LCD Title Psychiatric Partial Hospitalization Program**

See the Medicare Claim Processing Manual, Chapter 4, "Hospital Outpatient Services," Section 100, for billing instructions for partial hospitalization services.

Eligibility criteria and documentation requirements may be found in the Coverage Determination Manual

Termination of the Existing Eligibility File-Based Crossover Process at All Medicare Contractors

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

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 services to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4231, which informs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) about their responsibilities regarding the discontinuance of the current eligibility file-based crossover process effective January 3, 2006. **The impact of CR4231 is primarily on CMS trading partners as defined later in this article. The article is primarily informational for providers.**

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) will discontinue the current eligibility file-based crossover process effective January 3, 2006, and CR 4231 outlines the processes that Medicare contractors must follow when trading partners request a waiver to enable them to move into crossover production with the CMS coordination of benefits contractor (COBC) beyond January 3, 2006.

GO – What You Need to Do

This article is informational only for providers, so they may be aware of the potential for changes in how their claims are forwarded to CMS trading partners for coordination of benefits activities. See the Background section of this article for further details regarding the termination of the existing eligibility file-based crossover process.

Background

CMS has been testing its national Coordination of Benefits Agreement (COBA) consolidated crossover process with over 120 trading partners starting in July 2004. During this time, CMS and its coordination of benefits contractor (COBC) have brought the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 coordination of benefits (COB) claim files into high degrees of compliancy with the version 4010-A1 837 Institutional and Professional Claim Implementation Guides. Starting in June 2005, CMS has been moving trading partners into crossover production with the COBC, and this trend has recently been accelerating.

Note: “Trading Partner” is defined as an issuer of an insurance policy that supplements Medicare or a state agency responsible for administration of Title XIX of the Social Security Act. It is also defined as a federal agency, or contractor thereof, that administers and provides health care benefits for its eligible beneficiaries or an entity working under contract with a self-insured employer plan or an insurer to adjudicate claims and perform other insurance functions. A trading partner does not include entities that merely receive, route, and/or translate files, such as health

care clearinghouses, network service vendors, data transmission services, and billing services. CMS and its COBC may, however, transmit crossover claims to trading partners through one of these entities.

CMS recently provided guidance to all Medicare contractors (carriers, DMERCs, FIs, and RHHIs) regarding the discontinuance of the existing eligibility file-based crossover process effective December 31, 2005 (JSM-06026), and described a waiver process that trading partners who will not be moving into COBA crossover production by December 31, 2005, must follow.

In addition, CR 4231 is being issued to:

- Clarify all Medicare contractor requirements as they relate to the discontinuance of the existing eligibility file-based crossover process.
- Update the end date for the existing Medicare eligibility file-based crossover process to January 3, 2006, for Medicare contractor purposes.

This will enable the Medicare contractors to initiate the termination process for those trading partners **that have not moved** to COBA production by December 31, 2005.

Note: The “eligibility file” is the data file provided by the trading partner containing the records required to identify Medicare beneficiaries for purposes of receiving Medicare Part A and B crossover claims and reporting existing prescription drug coverage by the trading partner.

CMS Medicare contractors will not cross claims over to trading partners beyond January 3, 2006, pursuant to signed crossover agreements and the submission of COB eligibility files. As of January 3, 2006, CMS’ COBC will exclusively cross over all claims to trading partners in the HIPAA ANSI X12-N 837 COB (version 4010-A1) formats via the COBA eligibility file-based crossover process, unless:

1. Medicare contractors have submitted waiver requests to CMS on behalf of their current trading partners no later than December 16, 2005 (Note: Trading partners would need to have submitted these requests to the Medicare contractors no later than December 7, 2005), and
2. CMS has approved the trading partners’ waiver requests in advance of January 3, 2006. (**Note:** CMS plans to reach a decision on all waiver requests no later than December 21, 2005, unless late waiver requests must be addressed.)

Termination Process Notifications to Trading Partners That Have Not Requested a Waiver

All Medicare contractors will begin the termination of the existing eligibility file based crossover process with each individual trading partner that has not requested and received a waiver no sooner than January 3, 2006.

Impact on Mandatory Medigap (“Claim-Based”) Crossovers

The January 3, 2006, end date **does not apply** to mandatory Medigap (“claim-based”) crossovers, which are

Termination of the Existing Eligibility File-Based Crossover Process at All Medicare Contractors (continued)

authorized by the Omnibus Budget Reconciliation Act of 1987 [Public Law 100-203, Section 4081(a)(B)], and currently supported by Part B and DMERC contractors.

Implementation

The implementation date for this instruction is January 9, 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://new.cms.hhs.gov/transmittals/downloads/R198OTN.pdf>.

If you have any questions, please contact your carrier/

DMERC/intermediary at their toll-free number, which may be found on the CMS website at

<http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4231

Related Change Request (CR) Number: 4231

Related CR Release Date: December 9, 2005

Related CR Transmittal Number: 198

Effective Date: January 9, 2006

Implementation Date: January 9, 2006

Source: CMS Pub. 100-20, Transmittal 198, CR 4231

Erroneous Guidance—Basis to Waive Penalty

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare and who face penalties as a result of such billings

Provider Action Needed**STOP – Impact to You**

Providers and suppliers may not be subject to a penalty if the basis for the penalty that would have otherwise been applicable was that the provider acted in accordance with erroneous guidance from the Medicare program.

CAUTION – What You Need to Know

Medicare can grant a waiver of a penalty when **ALL of the following conditions are present:**

- The guidance was erroneous.
- The guidance was issued by the Secretary of the Department of Health & Human Services or was issued by a Medicare contractor (carrier, fiscal intermediary, durable medical equipment regional carrier [DMERC] or regional home health intermediary [RHHI]) acting within the scope of the contractor’s Medicare contract authority.
- The guidance was in writing.
- The guidance related to the furnishing of an item or service or to the submission of a claim for benefits for furnishing such item or service with respect to the provider or supplier submitting such claim.
- The guidance was issued timely.
- The provider or supplier accurately and fully presented the circumstances relating to such items, services, and claim to the Medicare contractor or to the Centers for Medicare & Medicaid Services (CMS), and did so in writing.
- The provider or supplier followed the guidance provided by the Medicare contractor (or by CMS).

GO – What You Need to Do

Review CR 3898 if you feel you are being subjected to a penalty for acting in accordance with erroneous guidance from the Medicare program.

Background

Section 903[©] of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to as MMA, establishes a basis for waiving penalties and interest charges levied on providers and suppliers who incurred such penalties and/or interest as a result of following Medicare guidance, which turned out to be erroneous. **CR 3898 details the conditions under which a provider or supplier may seek a waiver of a penalty due to such erroneous guidance. CR 3898 does not address the waiver of interest charges.**

Additional Information

Full details of the process for seeking and obtaining a waiver may be found in Chapter 33 (Miscellaneous Hold Harmless Provisions), Section 10 (Erroneous Program Guidance: Basis to Waive Penalty) of the *Medicare Claims Processing Manual*. That material is attached to CR 3898, which may be found on the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R739CP.pdf>.

For additional information relating to this issue, please refer to your local carrier or intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Related Change Request (CR) Number: 3898

Related CR Release Date: November 1, 2005

Related CR Transmittal Number: 739

Effective Date: July 24, 2003

Implementation Date: January 19, 2006

Source: CMS Pub. 100-4, Transmittal 739, CR 3898

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2006 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

Provider Types Affected

Clinical laboratories

Provider Action Needed

This article and related change request (CR 4144) contain important information regarding:

- The 2006 annual updates to the clinical laboratory fee schedule
- Mapping for new codes for clinical laboratory tests
- Laboratory costs related to services subject to reasonable charge payments.

It is important that affected laboratories understand these changes to ensure correct and accurate payments from Medicare.

Background

Update to Clinical Laboratory Fees

In accordance with section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by section 628 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2006 is zero (0) percent.

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA).

Note: The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge.

The 2006 national minimum payment amount is \$14.76 (\$14.76 plus zero percent update for 2006). The affected codes for the national minimum payment amount include the following *Current Procedure Terminology (CPT)* and HCPCS codes:

88142	88143	88147	88148	88150	88152	88153
88154	88164	88165	88166	88167	88174	88175
G0123	G0143	G0144	G0145	G0147	G0148	P3000

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with section 1833(h)(4)(B)(viii) of the Act.

Access to 2006 Clinical Laboratory Fee Schedule

Internet access to the 2006 clinical laboratory fee schedule data file should be available after November 18, 2005, on the CMS website at <http://www.cms.hhs.gov/suppliers/clinlab>.

Interested providers should use the Internet to retrieve the 2006 clinical laboratory fee schedule. It will be available in multiple formats: Excel™, text, and comma-delimited.

Public Comments

On July 18, 2005, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input regarding the payment relationship between 2005 codes and new 2006 CPT codes. The meeting announcement was published in the *Federal Register* on May 27, 2005, and on the CMS website on June 20, 2005.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the CMS website at <http://www.cms.hhs.gov/suppliers/clinlab>.

Additional written comments from the public were accepted until September 23, 2005.

Comments after the release of the 2006 laboratory fee schedule may be submitted to the address listed below so that CMS may consider them for the development of the 2007 laboratory fee schedule. Comments should be in written format and include clinical, coding, and costing information. To make it possible for CMS and its contractors to meet a January 3, 2007 implementation date, comments must be submitted before August 1, 2006 to:

Centers for Medicare & Medicaid Services (CMS)
 Center for Medicare Management Division of Ambulatory Services
 Mail stop: C4-07-07
 7500 Security Boulevard
 Baltimore, Maryland 21244-1850

Additional Pricing Information

The 2006 laboratory fee schedule includes separately payable fees for certain specimen collection methods (CPT and HCPCS codes 36415, P9612, and P9615).

For dates of service on or after September 1, 2005, the fee for clinical laboratory travel HCPCS code P9603 is \$0.935 per mile and for code HCPCS P9604 is \$9.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. The standard mileage rate for transportation costs was increased by the federal government’s Treasury Department to 48.5 cents a mile effective September 1, 2005 and this increase is incorporated into the fees for travel HCPCS codes P9603 and P9604. If the federal government revises the standard mileage rate for calendar year 2006 or a portion of 2006, CMS will issue a separate notice regarding the change.

The 2006 laboratory fee schedule also includes codes that have a ‘QW’ modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2006 pricing amounts for certain organ or disease panel codes and evocative/suppress-

2006 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services ... (continued)

sion test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping Information for New and Revised Codes

This information is shown below:

New Code Is Priced At The Same Rate As

80195	80197
82271	82270
82271QW	82270
82272	82270
82272QW	82270
83631	The sum of 83520 and 87015
83695	83520
83700	Deleted code 83715
83701	Deleted code 83716
83704	The sum of deleted codes 83716 and 85004
83721QW	83721
83880QW	83880
83900	83901 (x 2)
83907	87015 (x 2)
83908	83898
83909	83904
83914	83904
85576QW	85576
86200	83520
86355	Deleted code 86064
86357	Deleted code 86379
86367	Deleted code 86587
86480	The sum of the rates of 86353 and 83520
86586	Deleted code 86587
86703QW	86703
87209	87207 (x 3)
87807QW	87807
87900	87904 (x 5)

Laboratory Costs Subject to Reasonable Charge Payment in 2006

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with section 42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update.

The inflation-indexed update for year 2006 is 2.5 percent.

Manual instructions for determining the reasonable charge payment may be found in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23, Section 80-80.8. (The Web address for this manual is provided in the *Additional Information* section below.)

If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 8, Section 60.3 instructs that payment is made on a reasonable charge basis. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis.

Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Transmittal 496, Billing for Blood and Blood Products (CR 3681), issued March 4, 2005, provided instructions and established a new HCPCS modifier BL (Special acquisition of blood and blood products) to better specify the blood product charge in the hospital outpatient setting.

Because blood product services may also be performed in physician offices, independent laboratories, renal dialysis facilities, and other outpatient settings, contractors and shared system maintainers must update their files to accept the modifier BL as a valid modifier for Medicare Part B claims. Providers should submit a separate blood product charge for application of the blood deductible (modifier BL) from a blood product charge to which the blood deductible should not apply.

Transmittal 496 and *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 17, Section 231, provides further instructions on billing for blood products using modifier BL. (See the *Additional Information* section below for CMS website access to *Medlearn Matters* article MM3681, which discusses CR 3681.)

Those codes paid on a reasonable charge basis (as qualified by the above text) are:

Blood Products

P9010	P9011	P9012	P9016	P9017	P9019	P9020
P9021	P9022	P9023	P9031	P9032	P9033	P9034
P9035	P9036	P9037	P9038	P9039	P9040	P9044
P9050	P9051	P9052	P9053	P9054	P9055	P9056
P9057	P9058	P9059	P9060			

Also, the following codes should be applied to the blood deductible, as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Pub. 100-01, Chapter 3, Section 20.5-20.54:

P9010	P9011	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058	

Biologic products not paid on a cost or prospective payment basis are paid based on section 1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for HCPCS codes P9041 P9043 P9045 P9046 P9047 P9048, should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine

86850	86860	86870	86880	86885	86886	86890
86891	86900	86901	86903	86904	86905	86906
86920	86921	86922	86923	86927	86930	86931
86932	86945	86950	86960	86965	86970	86971
86972	86975	86976	86977	86978	86985	G0267

Reproductive Medicine Procedures

89250	89251	89253	89254	89255	89257	89258
89259	89260	89261	89264	89268	89272	89280
89281	89290	89291	89335	89342	89343	89344
89346	89352	89353	89354	89356		

Implementation

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

2006 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services ... (continued)

Additional Information

Instructions for calculating reasonable charges are located in the *Medicare Claims Processing Manual* (Pub. 100-04) Chapter 23, Sections 80-80.8 on the CMS website at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp.

Information on the blood deductible is available in the *Medicare General Information, Eligibility, and Entitlement Manual*, Pub. 100-01, Chapter 3, Section 20.5-20.54. That manual is available on the CMS website at http://www.cms.hhs.gov/manuals/101_general/ge101index.asp.

The official instructions issued to the carrier/intermediary regarding this change can be found on the CMS website at: <http://new.cms.hhs.gov/transmittals/downloads/R750CP.pdf>.

To review a *Medlearn Matters* article about CR 3681,

go to CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3681.pdf>.

If you have 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/apps/contacts/>.

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

Medlearn Matters Number: MM4144
Related Change Request (CR) Number: 4144
Related CR Release Date: November 10, 2005
Related CR Transmittal Number: 750
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 750, CR 4144

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Revised October 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective October 1, 2005

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

Provider Types Affected

All Medicare providers who bill Medicare for Part B drugs

Provider Action Needed

STOP – Impact to You

Change request (CR) 4160 revises the payment allowance limits in the October 2005 Medicare Part B drug pricing files.

CAUTION – What You Need to Know

The revised October 2005 payment allowance limits apply to dates of service October 1, 2005, through December 31, 2005.

GO – What You Need to Do

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

Background

The Medicare Modernization Act of 2003 (MMA), Section 303(c), revises the methodology for paying for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs are paid based on the new average sales price (ASP) drug payment methodology.

The ASP file, used in the ASP methodology, is based on data CMS receives quarterly from manufacturers. Each quarter, the Centers for Medicare & Medicaid Services (CMS) will update your carrier and fiscal intermediary (FI) payment allowance limits with the ASP drug pricing files based on these manufacturers' data.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP, and CMS will update the payment allowance limits quarterly.

Exceptions to General Rule

However, there are exceptions to this general rule as summarized below:

- For **blood and blood products** (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the Average Wholesale Price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
- For **infusion drugs** furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted. **The payment allowance limits will not be updated in 2005.** The payment allowance limits for infusion drugs furnished through a covered item of DME that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP.

Revised October 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File... (continued)

- For **influenza, pneumococcal, and hepatitis B vaccines**, payment allowance limits are 95 percent of the AWP as reflected in the published compendia.
- For **drugs, other than new drugs, not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file**, payment allowance limits are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, carriers/FIs will follow the methodology specified in Chapter 17 of the *Medicare Claims Processing Manual* for calculating the AWP, but substitute WAC for AWP. Chapter 17 (Drugs and Biologicals) is available on the CMS website at http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf.
The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting carrier/FI or by posting an MS Excel file on the CMS website. If the payment limit is available from CMS, carriers/FIs will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- For **new drugs and biologicals not included in the ASP Medicare Part B drug pricing file or NOC pricing file**, payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Payment limits for radiopharmaceuticals are based on the methodology in place as of November 2003.
Your carrier/FI will not search and adjust claims that are

processed prior to implementation of this change unless you bring such claims to their attention.

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

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Implementation

The implementation date for the instruction is November 28 2005

Additional Information

The official instructions issued to the intermediary regarding this change may be found on the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R729CP.pdf>.

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR4160. Click on the link to open and view the CR.

If you have 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/apps/contacts/>.

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

Related Change Request (CR) Number: 4160

Related CR Release Date: October 28, 2005

Related CR Transmittal Number: 729

Effective Date: October 1, 2005

Implementation Date: November 28, 2005

Source: CMS Pub. 100-4, Transmittal 729, CR 4160

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Timely Claim Filing Guidelines for Medicare Providers

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

<i>Dates of Service</i>	<i>Last Filing Date</i>
October 1, 2003 – September 30, 2004	by December 31, 2005*
October 1, 2004 – September 30, 2005	by December 31, 2006*
October 1, 2005 – September 30, 2006	by December 31, 2007
October 1, 2006 – September 30, 2007	by December 31, 2008

*If December 31 falls on a federal nonworking day, the last filing date is extended to the next succeeding workday. A federal nonworking day is considered a Saturday, Sunday, legal holiday, or a day declared by statute or executive order as a nonworking day for federal employees.

Periodic interim payment (PIP) providers must submit claims by the last day of the year following the year of the discharge date.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned to provider (RTP) for correction, is not protected from the timely filing guidelines. ❖

Emergency Update to the 2006 Medicare Physician Fee Schedule

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4268, which amends payment files issued to Medicare carriers based upon the November 21, 2005, MPFS final rule.

CAUTION – What You Need to Know

CR 4268 includes a new G-code for intravenous infusion of immunoglobulin (G0332), new G-codes for the 2006 Oncology Demonstration Project, and changes to CPT code status indicators, global periods, and relative value units.

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) issued payment files to carriers based upon the MPFS final rule published in the November 21, 2005, *Federal Register* (http://www.access.gpo.gov/su_docs/fedreg/a051121c.html), and the Social Security Act (Section 1848(c)(4)) (http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) authorizes CMS to establish ancillary policies necessary to implement relative values for physicians’ services.

CR 4268 amends the November 21, 2005, MPFS final rule payment files and includes a new G-code (G0332 – Intravenous infusion of immunoglobulin) and additional new G-codes for the 2006 Oncology Demonstration Project. There are corrected descriptors for codes G0332, G9050-G9130, 0137T, 0001F, 0005F, and J7640. The coverage indicator on the HCPCS files should be a “C” for category

III codes 0144T-0154T. In addition, CR 4268 includes changes to several *Current Procedural Terminology* (CPT) codes with respect to:

- Status indicators
- Global periods
- Relative value units.

See Attachment 1 of CR 4268 for the complete list of changes to G-codes and CPT codes included in this Emergency Update to the 2006 MPFS Database.

Implementation

The implementation date for this instruction is January 3, 2006.

Additional Information

For complete details, please see CR 4268, 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/R798CP.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/apps/contacts/>.

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

Medlearn Matters Number: MM4268
 Related Change Request (CR) Number: 4268
 Related CR Release Date: December 30, 2005
 Related CR Transmittal Number: R798CP
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 798, CR 4268

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2006 Holiday Schedule

First Coast Services Options, Inc. will observe the following holiday schedule in 2006:

January 2, (Monday)	New Year’s Day
January 16, (Monday)	Martin Luther King Jr. Day
April 14, (Friday)	Good Friday
May 29, (Monday)	Memorial Day
July 4, (Tuesday)	Independence Day
September 4, (Monday)	Labor Day
November 23, (Thursday)	Thanksgiving Holiday
November 24, (Friday)	Thanksgiving Holiday
December 25, (Monday)	Christmas Holiday
December 26, (Tuesday)	Christmas Holiday. ❖

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

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

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 services paid under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule

Provider Action Needed

This article is based on change request (CR) 4194, and it provides specific information regarding the annual update for the 2006 DMEPOS fee schedule.

Background

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

- Implement fee schedule amounts for new codes
 - Revise any fee schedule amounts for existing codes that were calculated in error.
- Payment on a fee schedule basis is required for:
- Durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i))
 - Parenteral and enteral nutrition (PEN) by regulations contained in the *Code of Federal Regulations* (42 CFR 414.102).

Note: DMERCs will use the 2006 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2006 through December 31, 2006.

The 2006 DMEPOS fee schedule update factors for Health Care Common Procedure Codes (HCPCS) items furnished from January 1, 2006, through December 31, 2006, and are as follows:

- A5120** Modifier “AV” is added for billing items furnished for facial prosthetics. Modifier “AU” is added for billing items furnished for urological supplies.
- L2005** Is being revised effective January 1, 2006, to ensure that the code’s allowable amount is representative of a full knee, ankle, foot orthosis (KAFO), including the joint component.
- L8609** and **L8685** through **L8689** Describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPCS effective January 1, 2006. These codes fall under the jurisdiction of the local carriers rather than the DMERCs. The Centers for Medicare & Medicaid Services (CMS) will be calculating the fee schedule amounts for these items using the standard gap filling process. The description for these codes can be obtained from the 2006 HCPCS file as soon as it becomes available on the CMS website at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCList.asp#TopOfPage>.

The following codes are being **deleted** from the HCPCS, effective January 1, 2006, and are therefore being removed from the DMEPOS and PEN fee schedule files:

A4254	A4643 thru A4647	A5119
A5509	A5511	B4184
B4186	E0169	E0752
E0754 thru E0759	E0953	E0954
E0972	E0996	E1000
E1001	E1019	E1021
E1025 thru E1027	E1210 thru E1213	E1239
K0064	K0066	K0067
K0068	K0074	K0075
K0076	K0078	K0102
K0104	K0106	K0415
K0416	K0452	K0600
K0618 thru K0620	K0628 thru K0649	K0670
K0671	K0731	K0732
L0860	L1750	L3963
L8100	L8110	L8120
L8130	L8140	L8150
L8160	L8170	L8180
L8190	L8195	L8200
L8230	L8239	L8620

The HCPCS codes listed below are being added to the HCPCS on January 1, 2006:

A4218	A4233 thru A4236	A4363
A4411	A4412	A4604
B4185	E0170 thru E0172	E0485
E0486	E0641	E0642
E2212 thru E2226	E2371	E2372
L0491	L0492	L0621 thru L0640
L3961	L3967	L3971
L3973	L3975 thru L3978	L5703
A5120	A5512	A5513
A6457	A6513	A6530
A6531	A6532	A6533 thru A6544
A6549	A9275	A9281
A9282	E0705	E0762
E0764	E0911	E0912
E1392	E1812	E2207 thru E2210
E2211	E2212	L0859
L2034	L2387	L3671 thru L3673
L3702	L3763 thru L3766	L3905
L3913	L3919	L3921
L3933	L3935	L5858
L5971	L6621	L6677
L6883 thru L6885	L7400 thru L7405	L7600
L8609	L8623	L8624
L8680 thru L8689		

The Medicare DMERCs will gap-fill base fee schedule amounts for each state in their region for the following new HCPCS codes that will be subject to the DMEPOS fee schedules in 2006:

Ostomy, Tracheostomy, or Urological Supplies (OS)
A4363 A4411 A4412

Fee Schedule Update for 2006 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (continued)

Inexpensive or Routinely Purchased DME (IN)

A4233 A4234 A4235 A4236 A4604 E0485 E0486
 E2216 E2217 E2218 E2222 E2223 E2225 E2226
 E2371 E2372

Capped Rental DME (CR)

E0170 E0171 E0911 E0912 E1812

Prosthetics and Orthotics (PO)

L0624 L0629 L0632 L0634 L2034 L2387 L3671
 L3672 L3673 L3702 L3763 L3764 L3765 L3766
 L3905 L3913 L3919 L3921 L3933 L3935 L3961
 L3967 L3971 L3973 L3975 L3976 L3977 L3978
 L5703 L5971 L6621 L6677 L6883 L6884 L6885
 L7400 L7401 L7402 L7403 L7404 L7405

Surgical Dressings (SD)

A6513

Suppliers should remember to add HCPCS modifier **AV** when billing code A5120 for facial prosthetic items only when furnished in conjunction with a facial prosthesis. Also, add modifier **AU** when billing code A5120 for urological items only when furnished in conjunction with urological supplies.

Implementation

The implementation date for the instruction is January 3, 2006

Additional Information

The official instruction issued to your carrier, intermediary, or DMERC regarding this change, can be found on the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R770CP.pdf>.

If you have questions regarding this issue, you may also contact your carrier, FI, or DMERC at their toll free number, which may be found on the CMS website at: <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4194
 Related Change Request (CR) Number: 4194
 Related CR Release Date: December 2, 2005
 Related CR Transmittal Number: 770
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 770, CR 4194

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Reasonable Charge Update for 2006 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Ocular Lenses

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) for services/supplies related to splints, casts, dialysis supplies and equipment, and certain intraocular lenses

Provider Action Needed

This article is based on change request (CR) 4131, which provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year (CY) 2006. The 2006 payment limits for splints and casts will be based on the 2005 limits, increased by 2.5 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2005.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses in CY 2006 as required by regulations contained in 42 CFR 405.501, which may be reviewed at http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr405_02.html.

For splints and casts, the HCPCS Q-codes are to be used when supplies are indicated for cast and splint purposes. The CPT codes should be used as indicated in the

CPT section “Application of Casts and Strapping” for the specified CPT procedure codes in the 29XXX series.

For dialysis supplies, Healthcare Common Procedure Coding System (HCPCS) codes A4215, A6216, and A6402 have been added to the dialysis supplies that require an AX modifier for payment. Therefore, suppliers must attach modifier AX to these codes when they are used to bill for dialysis supplies. HCPCS codes A6216 and A6402, when billed with the HCPCS modifier AX, should be reported as type of service (TOS) “L.” HCPCS codes A4215, A6216, and A6402, when billed without the HCPCS modifier AX, should be reported as TOS “S.”

HCPCS Code/Modifier Description

Code A4215 Needle, sterile, any size, each
 Code A6216 Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border
 Code A6402 Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border
 Modifier AX Item furnished in conjunction with home dialysis services

For intraocular lenses, dialysis supplies, and dialysis equipment, the 2006 customary and prevailing charges will be computed using actual charge data from July 1, 2004, through June 30, 2005.

Remember that for intraocular lenses, payment is made only on a reasonable charge basis for lenses implanted while the patient is in a physician’s office.

Reasonable Charge Update for 2006 for Splints, Casts, Dialysis Supplies, Dialysis Equipment... (continued)**Implementation**

The implementation date for this instruction is January 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web page, look for CR 4131 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/

DMERC at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4131
Related Change Request (CR) Number: 4131
Related CR Release Date: November 8, 2005
Related CR Transmittal Number: 749
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 749, CR 4131

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January 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File, and Revisions to 2005 Files

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

Provider Types Affected

All Medicare providers who bill Medicare for Part B drugs

**Provider Action Needed
STOP – Impact to You**

CR 4140 provides notice of the updated payment allowance limits in the January 2006, January 2005, April 2005, July 2005, and October 2005 drug pricing files.

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

According to Section 303 (c) of the Medicare Modernization Act of 2003 (MMA), the Centers for Medicare & Medicaid Services (CMS) will update the payment allowances for Medicare Part B drugs on a quarterly basis. Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the ASP.

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter, CMS will update your carrier/fiscal intermediary (FI) payment allowance limits with the ASP files. On or after December 19, 2005, revised January 2005, April 2005, July 2005, and October 2005 ASP and NOC payment files and the January 2006 ASP and NOC files will be available for download.

- The revised January 2005 payment allowance limits apply to dates of service January 1, 2005 through March 31, 2005.
- The revised April 2005 payment allowance limits apply to dates of service April 1, 2005 through June 30, 2005.
- The revised July 2005 payment allowance limits apply to dates of service July 1, 2005 through September 30, 2005.
- The revised October 2005 payment allowance limits apply to dates of service October 1, 2005 through December 31, 2005.
- The January 2006 payment allowance limits apply to dates of service January 1, 2006 through March 31, 2006.

Exceptions

There are, however, exceptions to the general rule and they were summarized in MM3846, effective July 1, 2005, and may be viewed on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3846.pdf>.

Implementation

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

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found on the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R746CP.pdf>.

CMS will also update the Microsoft Excel files on the CMS website to reflect these revised payment limits. Those files may be found on the CMS website at <http://www.cms.hhs.gov/providers/drugs/asp.asp>.

January 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File, and Revisions to 2005 Files (continued)

Medlearn Matters Number: MM4140
 Related Change Request (CR) Number: 4140
 Related CR Release Date: November 4, 2005
 Related CR Transmittal Number: 746
 Effective Date: January 1, 2005
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 746, CR 4140

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Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

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

Provider Types Affected

All Medicare providers billing carriers, including durable medical equipment regional carriers (DMERCs), regional home health intermediaries (RHHIs), or fiscal intermediaries (FIs), for medical supply or therapy services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2006. Affected providers should be aware of these changes.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA). As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes.

Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately

on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians
- Supplies incidental to physician services
- Supplies used in institutional settings.

Medicare periodically publishes routine update notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Additional Information

Change request 4114 provides the annual HH consolidated billing update effective January 1, 2006. The following table describes the HCPCS codes and the specific changes to each that this notification is implementing on January 3, 2006:

Code	Description of Code	Type Change	Replacement Code or Code Being Replaced
Non-Routine Supplies			
A4656	Needle, any size each	Delete	Replacement code: A4215 with revised definition (code A4215 is already on HH CB list.)
A5119	Skin barrier wipes box pr	Delete	Replacement code: A5120
A6025	Gel sheet for dermal or epidermal application (e.g., silicone, hydrogel, other)	Delete	
A6457	Tubular dressing with or without elastic, any width, per linear yard	Add	
A4412	Ostomy pouch, drainable, high output, for use on a barrier with flange (two-piece system), without filter, each	Add	
A5120	Skin barrier, wipes or swabs, each	Add	Replaces code A5119
A4363	Ostomy clamp, any type, replacement only, each	Add	
A4411	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each	Add	
Therapies – No Update			

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (continued)

The last update to the HH consolidated billing was issued under Transmittal 340, CR 3525. The related *Medlearn Matters* article, MM3525, may be found on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3525.pdf>.

For complete details, please see the official instruction issued to your carrier/DMERC/RHHI/intermediary regarding this change. That instruction may be found by going to the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R710CP.pdf>.

A complete historical listing of codes subject to HH consolidated billing may be found on the CMS website at <http://www.cms.hhs.gov/providers/hhapps/>.

The last bullet on this page contains a link to download the list.

If you have any questions, please contact your carrier/DMERC/RHHI/intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4114
Related Change Request (CR) Number: 4114
Related CR Release Date: October 14, 2005
Related CR Transmittal Number: 710
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 710, CR 4114

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

CMS has issued the following “*Medlearn Matters... Information for Medicare Providers*” article.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs)

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

CMS will no longer allow a freestanding provider that enters the Medicare program to express a preference for a particular FI. CMS regional offices (ROs) must assign the new provider to the local Blue Cross plan that serves the state in which the provider is located.

GO – What You Need to Do

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

Background

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

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

Therefore, effective immediately:

CMS will no longer allow a freestanding provider that enters the Medicare program to express a preference for a particular FI. The CMS regional offices (ROs) must assign the new provider to the local Blue Cross plan that serves the state in which the provider is located.

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

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

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

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

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

- Freestanding specialty providers such as (but not limited to) home health agencies (HHAs) and hospices will continue to be assigned to their designated specialty FIs.

Sunset of the Provider Nomination Provision and the Policy to Assign Providers to the Local FI (continued)

- Provider-based facilities will continue to be assigned to the audit FI that serves the parent provider.
- New providers that belong to CMS-recognized chains have the option to be assigned to the local Blue Cross plan or to the FI that serves the chain home office.
- Providers involved in CHOWs where the new owner accepts assignment of the existing provider agreement will remain with their current FI.

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

Additional Information

If you have any questions, please contact your FI on their toll free number, which is available on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Related CR Transmittal Number: N/A

Effective Date: Effective immediately

Implementation Date: N/A

Source: Special Edition Medlearn Matters Article SE0582

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CMS Makes First Awards to Medicare Administrative Contractors

Contracting Reform Will Lower Administrative Costs, Improve Quality and Service for Durable Medical Equipment Benefits

The Centers for Medicare & Medicaid Services (CMS) announced today that it has awarded contracts for four specialty contractors who will be responsible for handling the administration of Medicare claims from suppliers of durable medical equipment, prosthetics and orthotics. The new contracts awarded represent a first step in CMS' initiatives designed to improve service to beneficiaries and providers, support the delivery of coordinated and quality care, and provide greater administrative efficiency and effectiveness for fee-for-service Medicare.

To view the entire press release, please visit <http://www.cms.gov/apps/media/press/release.asp?counter=1749>. ❖

Source: CMS Provider Education Resources Listserv, Message 200601-02

Hurricanes Katrina and Rita—Transportation of Evacuees with Medical Needs

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

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 transportation services provided to evacuees of hurricanes Katrina and Rita

Provider Action Needed STOP – Impact to You

This special edition article provides a summary of the Department of Health and Human Services (DHHS) fact sheet regarding the transportation of hurricanes Katrina and Rita evacuees with medical needs.

CAUTION – What You Need to Know

If you made your own medical transportation arrangements, prior to or after the DHHS established the HHS Medical Travel Center services contract, then the normal Medicare coverage rules apply

GO – What You Need to Do

As you receive inquiries from providers or beneficiaries seeking to discharge a patient (or to help those patients return home), you should provide them with the information contained in this special edition article. Please review the questions and answers at the end of this special edition

article, and take appropriate action to use the instructions in your claims submissions.

Background

The Centers for Medicare & Medicaid Services (CMS) is providing this special edition article to give you important information regarding the transportation of hurricanes Katrina and Rita evacuees with medical needs. This special edition article:

- Explains the HHS Medical Travel Center services.
- Defines which individuals are eligible for medical transportation.
- Provides information for beneficiaries.
- Defines the role of the discharge planner.
- Describes the different types of transfers.
- Provides a list of transportation-related questions and answers directed to patients, providers, Medicare carriers and FIs, and discharge planners.

Hurricane Evacuation

Because of hurricanes Katrina and Rita, many people were forced to evacuate their homes and health care facilities in Texas, Mississippi, and Louisiana.

Hurricanes Katrina and Rita—Transportation of Evacuees with Medical Needs (continued)

Evacuees included many Medicare beneficiaries, including some with serious and/or ongoing medical needs, and assisting these evacuees has included dealing with significant difficulties and has raised questions regarding:

- The logistics of transporting the patients back to their home states.
- The costs and billing for these medical transportation services.

In response to these and many more questions, DHHS created a fact sheet to provide information and answer frequently asked questions regarding certain issues resulting from hurricanes Katrina and Rita.

The DHHS fact sheet provides instructions and answers questions pertaining to the provision of transportation for evacuees from Texas, Louisiana, and Mississippi who:

- Are currently patients in health care facilities,
- Have out-patient/on-going medical needs, or
- Were evacuated by air lift out of their home state.

Note: The DHHS fact sheet may be viewed on the DHHS website at <http://www.hhs.gov/katrina/factsheet.html>.

In many counties and parishes in Texas, Mississippi, and Louisiana, the health care infrastructure will not support the return of evacuees with medical needs. Evacuees may need to continue to shelter in their host state, or travel to an interim location to be closer to friends and family until Texas, Mississippi, and Louisiana can support their return.

Texas is currently accepting the return of patients and those evacuees with ongoing medical needs to select counties in Texas.

Mississippi is currently accepting the return of patients and those evacuees with ongoing medical needs to select counties in Mississippi.

Louisiana is:

- Accepting the return of evacuees who are currently patients in health care facilities on a case-by-case basis only. All health care facilities in Louisiana are responsible for gaining approval from the Louisiana Department of Health and Hospitals before accepting the transfer of evacuees into the state. If there is not a receiving facility available, the evacuee may access transportation to an interim location in another state where family and friends may reside.
- NOT accepting the return of evacuees with medical needs who are not patients at health care facilities. When Louisiana determines it is able to support the return of evacuees with out-patient/on-going medical needs, additional guidance will be disseminated.

HHS Medical Travel Center

The DHHS established a transportation program to support the return of evacuees with medical needs from Texas, Mississippi and Louisiana. The HHS Medical Travel Center is under contract with HHS to arrange transportation for evacuees who require en-route medical care and/or medical transport to include a non-medical attendant to an institution or to a private residence, as appropriate.

If the evacuee's originating medical facility is not available in their home state or if their residence and

community medical infrastructure is not suitable, evacuees will be allowed to travel to an interim location in the continental United States.

The HHS Medical Travel Center will then return the evacuee to their home of record when a medical facility there is available, or they can return to a safe community/home environment.

The HHS Medical Travel Center provides transportation services without cost to providers. Providers (and patients) who use the HHS Medical Travel Center services will not incur any charge, and they should not bill Medicare. The HHS Medical Travel Center will be paid directly by HHS as per its contract.

The HHS Medical Travel Center may be reached at 1-866-753-9344. The phone lines are open everyday 7:00 a.m. to 5:00 p.m. Central Daylight Time (CDT).

Before contacting the HHS Medical Travel Center or their home state, all medical evacuees must register with the Federal Emergency Management Agency (FEMA) and obtain a disaster registration number from the FEMA Registration Center at 1-800-621-FEMA. This phone line is operational 24 hours a day, 7 days a week.

Important Information for Discharge Planners

For evacuees in health care facilities or special needs shelters with a discharge planner, the discharge planners are responsible for:

- Determining if an evacuee must be transferred to a receiving facility or can be discharged to a private residence.
- Identifying a receiving facility/residence in the evacuee's home state or an interim state if necessary.
- Determining the evacuee's medical requirements during transport.
- Arranging for a FEMA registration number for the evacuee and any non-medical assistants.

Facility to Facility Transfer

Once the discharge planner has completed these tasks, they may contact the HHS Medical Travel Center to arrange for medical transportation. In order to complete the transportation process, discharge planners must complete and submit a documentation of medical necessity form provided by the HHS Medical Travel Center. This form will be provided planners when they call the HHS Medical Travel Center, and it is available on the HHS website at <http://www.hhs.gov/katrina>.

Facility to Non-Facility Transfer

If the discharge planner determines that the evacuee can be discharged to a residence, the discharge planner must call the evacuee's home state, which will be acting as a receiving point of contact. Please see below for information on how to contact the evacuee's home state.

Evacuees in a Shelter, Hotel, or Private Home

Evacuees should call their home state to access transportation if they:

- Have medical needs, and
- Are sheltering in a hotel, private residence, or other facility that **cannot provide discharge planning**.

Hurricanes Katrina and Rita—Transportation of Evacuees with Medical Needs (continued)

Guidance from the Home State

The evacuee's home state will determine if the evacuee can ride commercial transportation and if their state medical system can support their ongoing medical needs. If the state medical system cannot support the evacuee's ongoing medical needs, the home state will help the evacuee find an interim location in another state, if appropriate.

Texas

Texas evacuees with medical needs may contact the 2-1-1 telephone service (if calling within Texas) or 1-888-312-4567 (if out-of-state) to initiate access to appropriate transportation and receive an evaluation of the community medical infrastructure to support the return. The Texas phone lines are open everyday 8:00 a.m. to 5 p.m., Central Daylight Time (CDT).

Mississippi Department of Health

Mississippi evacuees with medical needs may contact the Mississippi State Health Department at 601-576-7300 to initiate access to appropriate transportation. The Mississippi phone lines are open Monday to Friday 8:00 a.m. to 5 p.m., Central Daylight Time (CDT).

Louisiana Department of Health and Hospitals

Louisiana is not currently accepting the return of evacuees with outpatient and/or ongoing medical needs. Evacuees from Louisiana with medical needs sheltering in a hotel, residence or other facility that cannot provide discharge planning must have their current medical attendant or family member contact the HHS Medical Travel Center to initiate access to appropriate transportation.

The evacuee's medical attendant must complete and submit a documentation of medical necessity form provided by the HHS Medical Travel Center to complete the transportation process. This form will be provided for the evacuee's medical attendant when they call the HHS Medical Travel Center or is available online on the HHS website at <http://www.hhs.gov/katrina>.

If a family member is completing this form for the patient, it must be signed by the patient's current local health care provider.

Questions and Answers (Q&As)

Below are frequently asked questions about the transportation of hurricane Katrina and Rita evacuees. CMS will be posting these Q & As on the CMS website at <http://www.cms.hhs.gov/hki>:

Q1. What is the first step in the process no matter what category of evacuee I am?

A1. Register for Disaster Assistance and obtain a FEMA Disaster Registration number via 1- 800-621-FEMA.

Q2. What if the evacuee or patient I am arranging care for doesn't have a FEMA Disaster Registration number?

A2. Call the FEMA Registration Center at 1-800-621-FEMA to register for Disaster Assistance and obtain a FEMA Disaster Registration number.

Q3. Will this travel system arrange transportation for National Disaster Medical System (NDMS) patients as well as those persons who became

patients in similar facilities after evacuating?

A3. Yes, the HHS Medical Travel Center will arrange transportation for all evacuees that currently require en-route medical care and/or medical transport, back to their home state or to an interim state. Discharge planners at medical facilities/shelters should contact the HHS Medical Travel Center to arrange for transportation of their evacuees.

Evacuees from Texas and Mississippi with medical needs who do not have a discharge planner should contact their home state. Evacuees from Louisiana with medical needs who do not have a discharge planner should contact the HHS Medical Travel Center and will need their health care provider to complete the forms.

Q4. Will evacuees or medical facilities incur any transportation costs using this travel system?

A4. The HHS Medical Travel Center covers all transportation costs; there will be neither bills nor co-pays and no insurance forms will be necessary.

Evacuees who can travel via commercial transportation must make their own arrangements to the airport or station.

Q5. Can a health care facility be reimbursed by the HHS Medical Travel Center for transportation arrangements already made? Can a health care facility make transportation arrangements for evacuees in the future and be reimbursed by the HHS Medical Travel Center?

A5. No. The HHS Medical Center will not reimburse facilities or states that have already made transportation arrangements for evacuees. All future transportation arrangements for evacuees should be made through the HHS Medical Travel Center or appropriate state system.

Q6. What are the criteria for deciding if an evacuee needs enroute medical care and/or medical transportation, and who makes this determination?

A6. If the evacuee is currently a patient at a medical facility and has a discharge planner coordinating their transportation, the health care facility discharge planner will determine if the evacuee requires medical transportation.

If the evacuee is not sheltering at a facility with discharge planning, the evacuee's home state or, in the case of Louisiana, the evacuee's medical attendant or accompanying family member, will determine if the evacuee is able to travel via commercial air or ground transportation.

Commercial airlines are very flexible in accepting people with such medical needs as oxygen and wheelchairs. If that is all that is required, a routine commercial flight will be arranged by FEMA for the evacuee and their family members if the evacuee meets the necessary qualifications.

Q7. Will the HHS Medical Travel Center perform discharge planning or provide clinical validation of evacuees?

Hurricanes Katrina and Rita—Transportation of Evacuees with Medical Needs (continued)

- A7.** No. The discharge planners in the health care facilities and/or the evacuee's home state will provide that function PRIOR to movement. The HHS Medical Travel Center will provide safe, efficient, and effective medical transport en-route.
- Q8. Who arranges for the discharge planning of evacuees, including destination, special medical equipment required, or other relevant transportation concerns?**
- A8.** The discharge planners of the health care facility in which the evacuee resides should coordinate all arrangements for the evacuee with the receiving institution.
- This includes working with the evacuee's home state, hospital, and/or nursing home to identify a receiving institution if the originating facility is not able to receive patients. Evacuees without discharge planners will need to contact their home state for assistance.
- Q9. What if an evacuee requires en-route medical care and/or medical transport and has multiple accompanying family members (who are also evacuees) who must return with the evacuee?**
- A9.** The HHS Medical Travel Center will provide a medical attendant to support en-route medical care if required. The HHS Medical Travel Center will make all reasonable efforts to accommodate at least one family member during medical transport. If the HHS Medical Travel Center is unable to do so, a separate transportation program will attempt to ensure family members will travel to the destination along a similar schedule. Both of these systems require all travelers to have a FEMA Disaster Registration Number.
- Q10. If an evacuee is living in a hotel or a home (and therefore does not have a discharge planner) and has medical needs (e.g., requires oxygen or stabilized transport), how does the evacuee arrange for travel home?**
- A10.** With the exception of Louisiana citizens, evacuees can call their home state to access travel arrangements. Their home state will act as their discharge planner and will determine if the evacuee can travel via commercial air or ground transportation and work with the evacuee to ensure that the medical infrastructure in their home community is ready to accept them. If the evacuee's home state determines that they can travel via commercial means, a separate transportation program will arrange their transportation. If the evacuee cannot travel by commercial means, the HHS Medical Travel Center will arrange for their transportation.
- If the evacuee is a citizen of Louisiana and is living in a hotel or a home in a host state, he or she will not be able to return to Louisiana at this time. If their medical attendant or a family member determines that they can travel via commercial means, a separate transportation program will arrange their travel to an interim state. If the evacuee cannot travel by commercial means, the HHS Medical Travel Center will arrange for their transportation to an interim state and the evacuee's medical attendant should complete the necessary paperwork for the travel.
- Q11. What if the evacuee wants to return to his or her original health care facility and that facility is not able to receive patients?**
- A11.** There are three potential options if the originating facility is not able to receive patients:
- The evacuee's discharge planner can identify another facility within the evacuee's home state. Transportation will be provided to another suitable facility within the home state with final transportation to the originating facility to be arranged by the HHS Medical Travel Center when the originating facility is able to receive patients.
 - The evacuee's discharge planner can identify a facility in an interim state where family members or other relatives or relations of the evacuee reside.
 - The HHS Medical Travel Center will provide transportation to the interim state facility with final transportation to the originating facility to be arranged when it is able to receive patients; or
 - The evacuee must continue to be cared for by the current host state with final transportation to the originating facility to be arranged by the HHS Medical Transport Center when the originating facility is able to receive patients.
- Q12. As a discharge planner, do I have to arrange for transportation from my health care facility to the airfield (if aeromedical transportation is being used)?**
- A12.** No. The HHS Medical Travel Center provides door-to-door service. See question Q4.
- Q13. As a discharge planner, do I need to fill out and submit a particular discharge planning form when making travel arrangements for my patient evacuee?**
- A13.** Yes. The HHS Medical Travel Center will fax or email you a documentation of medical necessity form to complete. The information you provide on this form will help the HHS Medical Travel Center provide the necessary medical care enroute for your evacuee. This form is also available on the HHS website at <http://www.hhs.gov/katrina>.
- Q14. What if a discharge planner needs to move an evacuee within the state? Do these travel systems arrange that transportation?**
- A14.** Yes. All of these travel systems arrange for intra- and inter-state transportation.
- Q15. How will hospitals and other providers be reimbursed for the medical care they provided to evacuees?**
- A15.** Remember, with the use of the HHS Medical Travel system, there are no transportation costs associated with the return of evacuees to their home state or an

Hurricanes Katrina and Rita—Transportation of Evacuees with Medical Needs (continued)

interim state. However, there are many ways for providers to be reimbursed for services provided to evacuees:

Existing Health Care Insurance

Many evacuees have existing health insurance coverage. Providers should bill an evacuee's private health insurer, if one exists.

Medicare

Many evacuees are covered under the Medicare program. Providers should contact their local Medicare carrier or fiscal intermediary, if they have questions regarding Medicare reimbursement for evacuee health care.

On January 1, 2006, the Medicare prescription drug benefit begins. CMS will work closely with evacuees and those who provide insurance counseling to the elderly to ensure that those evacuees who want to enroll in a drug plan will be able to do so. We are also taking steps to let those elderly evacuees who qualify for extra help in paying for their drug costs know about the availability of this program.

National Disaster Medical System (NDMS)

Some evacuees received medical treatment via the NDMS. At the request of FEMA, CMS and DHHS is developing payment mechanisms for those patients who entered NDMS hospitals via the Federal Coordinating Centers as part of the NDMS evacuation. Specifics about how to submit claims for these patients will be made available on the CMS website (<http://www.cms.gov>).

Medicaid

Many evacuees will qualify for Medicaid, either because they were eligible in their home state, or because they are now eligible because of a loss of income and/or resources. CMS has approved Medicaid waivers for many states. Under these waivers, effective retroactively to August 24, 2005, evacuees who have been displaced from their home as a result of hurricane Katrina will be provided the opportunity to enroll through a streamlined process to receive services under the Medicaid or SCHIP programs in whatever state they are now physically present.

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Medicaid and SCHIP providers should work with their states to submit claims and receive payment. States are putting in place modifications to their current claims processing systems to accept such claims, and all payments for Medicaid and SCHIP eligible persons will be handled through the states.

Uncompensated Care

Through the waiver process mentioned above, CMS is working with states with large numbers of evacuees to put in place processes for handling those claims, which would otherwise have been uncompensated. Providers should contact their state for information on how those claims will be submitted and how payments will be processed.

CMS will be providing information on these payment mechanisms on the CMS website (<http://www.cms.hhs.gov/emergency/>).

CMS will also be sharing information with provider and patient-based national and state trade and professional associations, and the states via the state Emergency Operations Centers.

Note: All HHS press releases, fact sheets, and other press materials are available on the HHS website at <http://www.hhs.gov/news>.

Additional Information

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Related CR Transmittal Numbers: N/A

Effective Date: N/A

Implementation Date: N/A

Source: Special Edition Medlearn Matters Article SE0579

Redesigned of the National Provider Identifier Web Page

Announcing the redesigned CMS Web page dedicated to providing all the latest National Provider Identifier (NPI) news for health care providers. Visit the Web page <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 new fact sheet with answers to questions that health care providers may have regarding the NPI is now available on the web page; 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 06184, January 23, 2006
Provider Education Resources Listserv, Message 200601-07

AMBULANCE SERVICES

Ambulance Inflation Factor for CY 2006

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

Provider Types Affected

Providers and suppliers of ambulance services billing Medicare carriers and fiscal intermediaries (FIs) for those services

Provider Action Needed

None. This article is for your information only. It provides the ambulance inflation factor (AIF) for calendar year (CY) 2006. The AIF for CY 2006 is 2.5 percent.

Background

Section 1834(l)(3)(B) of the Social Security Act (SSA) provides the basis for updating the payment limits that carriers and FIs use to determine how much to pay you for the claims that you submit for ambulance services. The national fee schedule for ambulance services has been phased in over a five-year transition period beginning April 1, 2002. The ambulance inflation factor (AIF) updates payments annually and is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year.

The AIF for calendar year (CY) 2006 will be 2.5 percent. This follows the CY 2005 AIF of 3.3 percent, the CY 2004 AIF of 2.1 percent, and the CY 2003 AIF of 1.1 percent.

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

Payment will not be less than this “floor,” which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule to calculate a regional conversion factor and a regional mileage payment. Some key issues related to the AIF are discussed below:

Payments Based on Blended Methodology

During this five-year transition period, your payments are based on a blended methodology. Before January 1, 2006, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional) and to the reasonable cost/charge portion. Then, these two amounts were added together to determine each provider or supplier’s total payment amount. As of January 1, 2006, the total payment amount for ground ambulance providers and suppliers will be based on either 100 percent of the national

ambulance fee schedule, or 60 percent of the national ambulance fee schedule added to 40 percent of the regional ambulance fee schedule. **The total payment amount for air ambulance providers and suppliers will be based on 100 percent of the national ambulance fee schedule.**

National or Regional Fee Schedules

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate.

Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division’s fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate. For CY 2006, this blend will be 40 percent regional ground base rate and 60 percent national ground base rate.

Part B Coinsurance and Deductible Requirements

Part B coinsurance and deductible requirements apply.

Additional Information

More information about the CY 2006 ambulance inflation factor is available on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R762CP.pdf>.

Also useful is the *Medicare Claims Processing Manual*, 100.04, Chapter 15, Section 20.6 (Update Charges), Subsection 20.6.1 (Ambulance Inflation Factor – AIF), which is included as an attachment to CR 4061. Finally, 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/apps/contacts/>.

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

Medlearn Matters Number: MM4061
 Related Change Request (CR) Number: 4061
 Related CR Release Date: November 25, 2005
 Related CR Transmittal Number: 762
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 762, CR 4061

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2006 Ambulance Fee Schedule and Inflation Factor

Section 1834(l)(3)(A) of the Act provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2006 that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF). The AIF for calendar year (CY) 2006 is 2.5 percent.

2006 Ambulance Fee Schedule

The following fee schedule rate is effective for services provided **on or after January 1, 2006**.

The AFS rates for 2006 for Florida based on localities are provided below. Part B coinsurance and deductible requirements apply to these services.

2006 Ambulance Fee Schedule Rates

HCPCS Code	Loc 01/02		Loc 03		Loc 04	
	Urban	Rural	Urban	Rural	Urban	Rural
A0425	\$6.05	\$6.11	\$6.05	\$6.11	\$6.05	\$6.11
A0426	\$220.87	\$223.05	\$229.62	\$231.89	\$239.02	\$241.39
A0427	\$349.71	\$353.17	\$363.56	\$367.16	\$378.45	\$382.20
A0428	\$184.06	\$185.88	\$191.35	\$193.24	\$199.18	\$201.16
A0429	\$294.49	\$297.40	\$306.16	\$309.19	\$318.69	\$321.85
A0430	\$2,507.32	\$3,760.99	\$2,577.33	\$3,866.00	\$2,652.53	\$3,978.79
A0431	\$2,915.13	\$4,372.69	\$2,996.52	\$4,494.78	\$3,083.95	\$4,625.92
A0432	\$322.10	\$325.29	\$334.86	\$338.18	\$348.57	\$352.02
A0433	\$506.15	\$511.16	\$526.21	\$531.42	\$547.76	\$553.18
A0434	\$598.18	\$604.10	\$621.89	\$628.04	\$647.35	\$653.76

Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that service.

Additional information about the CY 2006 ambulance inflation factor is available on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4061.pdf>. ❖

Source: CMS Pub. 100-4, Transmittal 762, CR 4061

Reminder Notice of Implementation of the Ambulance Transition Schedule

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

Provider Types Affected

Ambulance providers and suppliers

Provider Action Needed

STOP – Impact to You

During the calendar year (CY) 2005, year four of a five-year transition to the ambulance fee schedule implementation, payment for ambulance services is based on a blend of 80 percent of the fee schedule amount plus 20 percent of the provider’s reasonable cost or the supplier’s reasonable charge for the service. As of **January 1, 2006**, the Medicare **allowed amount is based solely on the ambulance fee schedule (100 percent)** for ambulance services furnished and mileage incurred on or after January 1, 2006.

CAUTION – What You Need to Know

The fee schedule applies to **ALL** ambulance services furnished as a benefit under Medicare Part B. Ambulance providers and suppliers are required to accept assignment and must accept Medicare allowed charges as payment in full. They may not bill or collect from the beneficiary any amount other than an unmet Part B deductible and the Part B coinsurance amounts.

GO – What You Need to Do

Be aware that the next phase of the fee schedule payment process goes into effect on January 1, 2006 and adjust accounts receivable processes as necessary.

Background

Section 4531 (b) (2) of the Balanced Budget Act (BBA) of 1997 added a new section 1834 (l) to the Social Security Act, which mandates implementation of the national fee schedule for ambulance services furnished as a benefit under Medicare Part B. The fee schedule applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, critical access hospitals and skilled nursing facilities. Section 1834 (l) also requires mandatory assignment for all ambulance services. Ambulance providers and suppliers must accept the Medicare allowed charge as payment in full and not bill or collect from the beneficiary any amount other than any unmet Part B deductible and the Part B coinsurance amounts. Effective January 1, 2006, the full fee schedule comprises the entire Medicare allowed amount and no portion of the provider’s reasonable cost or the supplier’s reasonable charge will be considered.

Providers and suppliers are reminded that the ambulance fee schedule was implemented on a five-year transition period and that transition period is complete as of January 1, 2006.

Reminder Notice of Implementation of the Ambulance Transition Schedule (continued)

Year	Fee Schedule Percentage	Cost/Charge Percentage
Year 1 (4/1/02 – 12/31/02)	20 percent	80 percent
Year 2 (CY 2003)	40 percent	60 percent
Year 3 (CY 2004)	60 percent	40 percent
Year 4 (CY 2005)	80 percent	20 percent
Year 5 (CY 2006 and thereafter)	100 percent	0 percent

Note also that temporary Q codes (Q3019 (ALS vehicle used, emergency transport, no ALS services furnished) and Q0320 (ALS vehicle used, non-emergency transport, no ALS level services furnished)) and HCPCS code A0800 (Ambulance night differential charges) may no longer be used for claims with dates of service on or after January 1, 2006. These codes were only for use during the transition period for the fee schedule.

Implementation

The implementation date for this change is January 3, 2006

Additional Information

Suppliers should also note that Medicare carriers and intermediaries will deny claims for separately billed supplies

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and ancillary services furnished during an ambulance transport on or after January 1, 2006. Supplies and ancillary services are considered part of the fee schedule base rate and are not separately billable after December 31, 2005.

The official instruction issued to your carrier/intermediary regarding this change may be found by going to CMS website <http://www.cms.hhs.gov/Transmittals/downloads/R799CP.pdf>.

For additional information relating to this issue, please refer to your local carrier/intermediary. To find that toll-free phone number, go to CMS website <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4217
 Related Change Request (CR) Number: 4217
 Related CR Release Date: December 30, 2005
 Related CR Transmittal Number: R799CP
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 799, CR 4217

MEDICARE PROVIDER SURVEY

Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) today announced a new initiative designed to measure how satisfied providers in the fee-for-service (FFS) program are with the services of the contractors that are responsible for processing their claims, educating them about changes in Medicare policies, and responding to provider inquiries.

The initiative, the Medicare Contractor Provider Satisfaction Survey (MCPSS) will be administered on an annual basis. It is designed to garner quantifiable data on provider satisfaction levels with key services performed by the 42 FFS contractors that process and pay more than \$280 billion in Medicare claims each year.

“The Medicare program depends on health care providers all over the country to serve our beneficiaries, and this new survey will help us work with the Medicare contractors to help us serve our providers as effectively as possible,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. “As we implement the most significant contractor reforms in the history of the Medicare program, provider satisfaction will be one of the key considerations.”

The MCPSS is one of the tools CMS will use to measure provider satisfaction levels, as a result of the Medicare Modernization Act (MMA) of 2003. It was developed with extensive input from providers, and informa-

tion about the survey has been disseminated to providers through a variety of channels, including Open Door Forum conference calls with providers, and Medlearn Matters articles posted on the CMS website. CMS will conduct ongoing outreach to providers throughout the survey process.

“We are bringing satisfaction measures and other quality measures to many aspects of Medicare, to get the best possible performance for the dollars we spend,” added Dr. McClellan. “This survey is very important provider feedback, and so we are identifying ways in which we can get the maximum provider participation.”

The MCPSS will query 25,000 randomly selected providers (e.g., physicians, suppliers, healthcare practitioners, and institutional providers), a statistically valid and representative sample of the 1.2 million who serve Medicare beneficiaries. Those providers selected to participate in the survey will be notified by mail during the first week of January 2006. The survey is designed so that it can be completed in less than a half hour. Survey responses can be submitted via a secure website, mail or fax and will be accepted through January 25, 2006.

The survey questions will focus on seven key areas of provider-contractor interactions, including:

Medicare Contractor Provider Satisfaction Survey (continued)

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

CMS will use the MCPSS results for Medicare contractor oversight. Contractors will be able to use the survey results to improve the services they offer to providers. CMS plans to make the survey results available via an online reporting system in early July 2006. Further information about the MCPSS is available at: <http://www.cms.hhs.gov/MCPSS/>. ❖

Source: CMS Joint Signature Memorandum 05563, October 11, 2005
Provider Education Resources Listserv, Message 200601-01

Centers for Medicare & Medicaid Services Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

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

Provider Types Affected

Sample of 25,000 Medicare providers served by 42 Medicare fee-for-service (FFS) contractors, including fiscal intermediaries (FIs), carriers, durable medical equipment regional carriers (DMERCs), and rural home health intermediaries (RHHIs)

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your FFS contractors. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to garner quantifiable data on provider satisfaction with the performance of FFS contractors. The MCPSS is one of the tools CMS will use to carry out the measurement of provider satisfaction levels, a requirement of the Medicare Modernization Act (MMA). Specifically, the survey will enable CMS to gauge provider satisfaction with key services performed by the 42 contractors that process and pay the more than \$280 billion in Medicare claims each year. Those Medicare contractors will use the results to improve service. CMS will use the results to improve its oversight of and increase the efficiency of the administration of the Medicare program.

CAUTION – What You Need to Know

The first national implementation of the MCPSS will begin January 2006. If you have been selected, you will receive a notification packet in the mail with background information about the survey, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet website. The letter will also include a phone number that you can mail or fax, if you prefer to do so.

GO – What You Need to Do

Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the time to complete and submit your survey responses as soon

as possible. The data collection period for the pilot will continue through the end of April.

Background

The 2006 survey will query approximately 25,000 randomly selected providers – those physicians, health care practitioners, and facilities that serve Medicare beneficiaries across the country – on the seven key areas of the provider contractor interface:

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

It contains a total of 76 questions and takes approximately 22 minutes to complete. The deadline for survey submission is January 25, 2006. CMS will analyze the data and release a summary report in July that will be made available on the Internet. Each contractor will also receive an individual report on their performance in June. The MCPSS will be conducted on an annual basis. CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS.

Additional Information

For questions or additional information about the MCPSS, please visit on the CMS website <http://www.cms.hhs.gov/MCPSS/>.

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Related CR Transmittal Number: N/A

Effective Date: January 3, 2006

Implementation Date: January 3, 2006

Source: Special Edition Medlearn Matters Article SE0602

LOCAL COVERAGE DETERMINATIONS

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

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

Medical Policy – 19T
 First Coast Service Options, Inc.
 P.O. Box 2078
 Jacksonville, FL 32231-0048
 or call 1-904-791-8465

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

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ADDITIONS/REVISIONS TO LMRPs/LCDs

A76070: Bone Mineral Density Studies—Revision to Policy

The local coverage determination (LCD) for bone mineral density studies was last updated June 9, 2005. This LCD has been revised to indicate additional medical circumstances where Medicare may cover a bone mass measurement for a patient more frequently than every two years, if medically necessary. These revisions include:

- Monitoring a patient to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy if the result is being used to determine the need for continued treatment of osteoporosis. Agents approved by the FDA for osteoporosis prevention and/or treatment include:

Estrogen therapy (for purposes of this policy, the estrogen must be specifically used for treatment of osteoporosis)
 Alendronate sodium (Fosamax®)
 Calcitonin-salmon (Miacalcin®-nasal spray or injection)

Raloxifene HCL (Evista®)
 Risedronate sodium (Actonel®)
 Teriparatide (Forteo®) injection
 Ibandronate sodium (Boniva®)

- To determine a patient's response to pharmacologic therapy when the therapy has been changed to another family of therapeutic agents.

In addition, revisions have been made in the 'Indications and Limitations of Coverage and/or Medical Necessity' and 'Utilization Guidelines' sections accordingly.

Effective Date

This revision is effective for services provided **on or after November 21, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

AEPO: Epoetin alfa—Revision to Policy

The local coverage determination (LCD) for epoetin alfa was last updated on October 1, 2005. Since that time, the "ICD-9 Codes that Support Medical Necessity" section for HCPCS code Q0136 was revised to remove the benign neoplasm ICD-9-CM diagnosis codes 210.0-229.9. These ICD-9-CM diagnosis codes are not supported as medically necessary in the indication and limitation section of this LCD. In addition, the EPO indication #6 – neoplastic disease was revised to read malignant neoplastic disease. The coding guideline for this LCD was revised accordingly.

Effective Date

This revision is effective for services provided **on or after January 13, 2006**.

The full-text for this policy may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

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

The local coverage determination (LCD) for darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) was last updated on October 1, 2005. Since that time, the "ICD-9 Codes that Support Medical Necessity" section for HCPCS code Q0137 was revised to remove the benign neoplasm ICD-9-CM diagnosis codes 210.0-229.9. These codes are not supported as medically necessary in the indication and limitation section of the LCD. The coding guideline for this LCD was revised accordingly.

Effective Date

This revision is effective for services provided **on or after January 13, 2006**.

The full-text for this policy may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

Correction to Effective Date for Local Coverage Determination A72192—Computed Tomography of the Pelvis

An article was published in the First Quarter 2006 *Medicare A Bulletin* (page 63) for the local coverage determination (LCD) A72192 – Computed Tomography of the Pelvis. The effective date published for the addition of diagnosis codes 593.9 and 752.41 was for services provided on or after October 1, 2005. The correct effective date is for services provided **on or after October 20, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

ADDITIONAL MEDICAL INFORMATION

Billing Unlisted/non-Specific Procedure Codes to Medicare Part A

Effective January 1, 2006, First Coast Service Options, Inc. (FCSO) will implement a new process for bills submitted for payment where one or more services are reported with an unlisted/non-specific CPT/HCPCS code. The following situations may occur:

- Type of bills subject to the outpatient prospective payment system with ambulatory payment classification assigned to the unlisted/non-specific CPT/HCPCS code will be processed according to the assigned APC.
- Type of bills not subject to the outpatient prospective payment system with ambulatory payment classification assigned to the unlisted/non-specific CPT/HCPCS code will generate an additional development request (ADR) letter to the provider, with reason code 77700.
- Claims billed with unlisted/non-specific CPT/HCPCS that are not paid based on an APC will generate an ADR letter to the provider, with reason code 77700.

The ADR will ask for documentation to substantiate the unlisted/non-specific code being billed.

Action Required by Providers

Providers may follow these instructions within 30 days of receiving an ADR letter:

- If you use the Direct Data Entry (DDE) system, you will be able to see the ADR letter on page 7 of your claim. Once you are on page 7, F8 to get the rest of the information. Follow the instructions on the ADR and provide the requested information and/or documentation.
- If you are not a DDE user, you will receive the ADR letter in the mail. Follow the instructions on the ADR and provide the requested information and/or documentation.

Note: When returning the documentation, be sure to include a copy of the ADR letter.

If a response is not received within 30 days, the entire claim will be rejected under reason code 39721. When the claim is rejected, you may rebill the claim as a new claim with a more specific CPT/HCPCS code.

If the additional information/documentation submitted is insufficient to warrant a medical review consideration, the

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Applicable FARS/DFARS apply.

line item for the unlisted/non-specific procedure code will be rejected with reason code 77720.

Unlisted Reason Codes

77720

The claim or adjustment has been submitted with an unlisted (non-specific) CPT/HCPCS code. Please contact your internal coding area to determine a more specific code to be billed. If a more specific code is identified, please correct the claim or adjustment by submitting a new transaction with the coding correction. If the claim has been rejected, submit a new claim with corrections. If a portion of the claim was paid and one or more lines were rejected with reason code 77720, submit an adjustment transaction to correct the unlisted (non-specific) CPT/HCPCS code. If the service rendered does not have a specific CPT/HCPCS code, additional documentation (ADR) will be requested upon submission of a corrected claim or adjustment. The intermediary cannot process a transaction with an unlisted (non-specific) CPT/HCPCS code without medical documentation to support the service being rendered.

Once the line item for the unlisted/non-specific procedure code has been rejected, you may adjust the claim with the correct CPT/HCPCS code. If you do not resubmit the claim correctly the second time, the claim will be submitted through the review process and the additional required documentation will have to be submitted again.

Additional information

If a claim or one or more line items is rejected, the provider may receive payment if the claim is submitted with a more specific code. A rejected claim would be resubmitted as a new claim with corrections to coding and a partially paid claim would be submitted as an adjustment correcting the CPT/HCPCS coding from the unlisted/non-specific code to a more specific code.

For additional information on how to select the correct CPT/HCPCS code, refer to the *Current Procedural Terminology, Fourth Edition (CPT®)* and the *Healthcare Common Procedure Coding System (HCPCS) Level II reference manuals*. ❖

Medicare Coverage of Anti-Cancer Drugs

This article is based on Medicare law, rules, and regulations. It defines the criteria that must be met for the payment for anti-cancer drugs upon initial claim submission. Claims not meeting these standards will be denied. Currently, Medicare does not provide pre-authorization for drugs and biologicals. Denials may be appealed by means of the prescribed process.

Indications – Labeled and Unlabeled

An anti-cancer drug that meets all general program requirements may be considered medically reasonable and necessary for its FDA (Food and Drug Administration) approved indications and its “off-label” indications, as supported by the Centers for Medicare & Medicaid Services (CMS) approved compendia, unless there is a national or local statement to the contrary.

Regulatory Background and Rationale:

FDA approval is one of the standards for Medicare coverage. The CMS Manual System, Pub 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.5 (<http://www.cms.hhs.gov/manuals/>) refers to the unlabeled use for anti-cancer drugs. An important criterion is support by one or more citations in at least one of the two drug compendia listed below, and the use is not listed as “not indicated” in any of the two compendia: American Hospital Formulary Service (AHFS) Drug Information, and United States Pharmacopoeia Drug Information (USPDI).

The CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.5 D states that the “compendium process for making decisions concerning unlabeled uses is very thorough and continuously updated.” To avoid undue bureaucratic burden, First Coast Service Options (FCSO) will accept the endorsement of the editorial panels of these compendia as expert opinion and as a proxy for the review of clinical research that appears in peer reviewed medical literature.

This contractor has local coverage determinations (LCDs) on specific anti-cancer drugs. There are national coverage determinations (NCDs) on certain anti-cancer drugs.

An anti-cancer drug that meets all program requirements for coverage of items as incident to a physician’s services will be considered reasonable and necessary for the treatment of the illness or injury for which it is administered if:

1. It is FDA approved.
2. It is FDA approved for the treatment of the illness or injury for which it is administered.
3. Its use is supported by one or more citations in at least one of the two drug compendia listed above, and the use is not listed as “not indicated” in any of the two compendia.
4. A NCD has established its medical reasonableness and necessity for the indication used.
5. A LCD has established its medical reasonableness and necessity for the indication used.

Note: Contractor LCDs are developed based on the strongest evidence available as instructed in the CMS Manual System, Pub. 100-8, Medicare Program Integrity Manual, Chapter 13, Section 7.1, specifically published authoritative evidence derived from definitive randomized clinical trials or other definitive studies.

Unless stated otherwise by CMS or this contractor, a presumption of coverage may be made if condition #1 and one of the conditions #2 through #5 apply. All other claims not meeting these criteria will be denied.

This article is subordinate to any NCD or LCD of this contractor. For example, even if an agent is supported in the compendia for a given indication but an NCD or one of this contractor’s LCDs restricts or does not allow its use for that indication, the statement in the NCD or LCD supersedes.

Under the above provisions, this contractor will consider an unlabeled indication beginning with 45 days after receipt of a copy of its official publication in the CMS authorized compendium. Claims for such services rendered on preceding dates will continue to be denied and may be reviewed individually by means of the appeal process.

In this article, the statements about labeled and unlabeled uses of anti-cancer drugs are limited to the treatment of malignant neoplastic conditions. Other drugs and biologicals and/or the use of anti-cancer drugs for non-cancerous conditions are outside the scope of this publication.

Dosage and Frequency

Doses that exceed the accepted standard of recommended dosage and/or frequency, as described in the package insert are not reimbursable, as they represent an unapproved unlabeled use.

Regulatory Background and Rationale:

The CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.1 addresses medical reasonableness and necessity based on the FDA approval and labeling: “Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling.” The labeling spells out the safe and effective, i.e. medically reasonable and necessary dosage and frequency.

The dosage for a compendia supported unlabeled indication can at times be different than the dosage in the package insert. This may be considered based on the studies that were submitted to the respective compendium and accepted in support of the unlabeled indication.

Wastage

Payment for wastage may only be made when single-use vials have to be utilized. No reimbursement will be made for wastage in the case of multi-use vials.

Regulatory Background and Rationale:

This is based on the CMS Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 17, Section 40, Discarded Drugs and Biologicals that addresses wastage: “CMS encourages physicians to schedule patients in such a

Medicare Coverage of Anti-Cancer Drugs (continued)

way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered. NOTE: The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug.”

Route of Administration

For agents administered parenterally, the mode of administration (IV, IM, SQ) must be in keeping with the instructions in the package insert, as approved by the FDA. If a drug is available in both oral and injectable forms and both forms are equally effective, the oral preparation shall be used, unless there is a medical reason not to do so.

Regulatory Background and Rationale:

The CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.1 addresses medical reasonableness and necessity based on the FDA approval and labeling: “Drugs or biologicals approved for

marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling.” This statement extends to the mode of administration that is considered safe and effective, i.e., medically reasonable and necessary by Medicare’s criteria.

The CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.2 K - Reasonable and Necessary, stipulates that “Carriers and fiscal intermediaries will make the determination of reasonable and necessary with respect to the medical appropriateness of a drug to treat the patient’s condition. Contractors will continue to make the determination of whether the intravenous or injection form of a drug is appropriate as opposed to the oral form.”

This notification becomes effective for services provided on or after March 1, 2006. Claims for dates of service prior to March 1, 2006 cannot be filed retrospectively and paid under these provisions, even if an agent might have had compendia support for an unlabeled indication prior to this date. ❖

GENERAL COVERAGE

Lung Volume Reduction Surgery

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

Provider Types Affected

All Medicare providers who submit claims to Medicare carriers or fiscal intermediaries (FIs) for lung volume reduction surgery (LVRS)

Provider Action Needed

STOP – Impact to You

CR 4149 outlines the newly modified requirements for facilities eligible to perform LVRS and the updated manual paragraphs on the National Emphysema Treatment Trial (NETT) published by the Centers for Medicare & Medicaid Services (CMS).

CAUTION – What You Need to Know

Beginning November 17, 2005, CMS will allow facilities certified under the disease specific care certification program for LVRS by the Joint Commission of Health Care Organizations (Joint Commission) to be Medicare approved LVRS facilities. Hospitals that are Medicare approved for lung or heart lung transplant will continue to be approved for LVRS. NETT facilities are no longer automatically approved for LVRS. These hospitals will have 18 months to become approved under one of the other existing mechanisms.

GO – What You Need to Do

Be aware of the new requirements for LVRS facilities.

Background

Between 1997 and 2003, CMS covered LVRS when provided under the protocol of the National Emphysema Treatment Trial (NETT), a clinical trial sponsored by the National Heart Lung and Blood Institute and CMS. On January 1, 2004, a national coverage determination became effective that allowed coverage of LVRS, outside of a trial, for patients with certain clinical indications and when performed at approved hospitals (CR 2688).

CR 4149 updates the requirements for hospitals to become approved as Medicare LVRS facilities. CMS will maintain an updated listing of approved LVRS facilities on the CMS website at http://www.cms.hhs.gov/MedicareApprovedFacilitie/04_lvrs.asp#TopOfPage.

Note: The NETT has ended and CR 4149 removes outdated language from the Medicare National Coverage Determinations Manual that refers to coverage for LVRS under the protocol of that trial.

Medicare will consider LVRS reasonable and necessary only when the following requirements are met:

- Effective for services performed on or after November 17, 2005, LVRS is performed at a facility that is:

- Certified by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) under the LVRS Disease Specific Care Certification Program (program standards and requirements as printed in the Joint Commission’s October 25, 2004, Disease Specific Care Certification Program packet); or
- Performed at facilities that are Medicare-approved for lung or heart-lung transplantation.

CMS further determines that LVRS performed between January 1, 2004 and May 17, 2007, may be performed at facilities that:

- Were approved by the National Heart Lung and Blood Institute to participate in the National Emphysema Treatment Trial
- Are Medicare-approved for lung or heart-lung transplantation.

Implementation

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

Additional Information

The official instructions issued to your carrier/intermediary regarding this change may be found on the CMS website at

<http://www.cms.hhs.gov/transmittals/downloads/R768CP.pdf>.

The changes to Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, section 240.1, are attached to CR 4149.

If you have 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/apps/contacts/>.

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

Medlearn Matters Number: MM4149
 Related Change Request (CR) Number: 4149
 Related CR Release Date: December 2, 2005
 Related CR Transmittal Number: 768
 Effective Date: November 17, 2005
 Implementation Date: March 2, 2006

Source: CMS Pub. 100-4, Transmittal 768, CR 4149

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

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for clinical diagnostic laboratory services.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4161, which announces the implementation of changes to the list of codes associated with the 23 negotiated laboratory national coverage determinations (NCDs).

CAUTION – What You Need to Know

These changes to the list of codes are a result of revised NCD and coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs. They are necessary for the correct processing of claims using the most current negotiated laboratory NCDs and code lists.

GO – What You Need to Do

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

Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in the *Federal Register* as a final rule on November 23, 2001. (See below for links to the final rule.)

The Centers for Medicare & Medicaid Services (CMS) funded the development of software (laboratory edit module) to be incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003. (See below for more information contained in the *Medicare Claims Processing Manual*.)

Note: 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.

Change Request (CR) 4161 announces the changes that will be included in the January 2006 release of the edit module for clinical diagnostic laboratory services.

Changes are being made to the NCD code lists (as described below) to accommodate changes to the list of codes that have been made through the NCD and/or coding analysis process as explained in the final *Federal Register* notice. (See reference below.)

The final rule, *Federal Register* Volume 66, Number 226, may be found at http://www.access.gpo.gov/su_docs/fedreg/a011123c.html.

The *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 16, Section 120.2) is available on the CMS website at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

The final *Federal Register* notice, Volume 70, Number 37, dated February 25, 2005, may be found at http://www.access.gpo.gov/su_docs/fedreg/a050225c.html.

Code Changes

CR4161 announces the following changes:

- **ICD-9-CM code V76.44** (special screening for malignant neoplasms, prostate) will be removed from the list of ICD-9-CM codes not covered by Medicare. This list of codes affects all 23 negotiated laboratory NCDs.
- **ICD-9-CM code V76.44** (special screening for malignant neoplasms, prostate) will be added to the list of ICD-9-CM codes that do not support medical necessity in the blood counts NCD.
- **ICD-9-CM codes 158.8** (malignant neoplasms, specific parts of peritoneum) and **158.9** (malignant neoplasms, peritoneum, unspecified) will be added to the list of ICD-9-CM codes covered by Medicare in the tumor antigen by immunoassay CA 125 NCD.

Decision memoranda explaining these changes can be found by going to <http://cms.hhs.gov/coverage> on the CMS website and clicking on the National Coverage Analysis in the Coverage Database section of the Web page. These changes become effective for services furnished on or after January 1, 2006.

Implementation

The implementation date for the instruction is January 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/R758CP.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/apps/contacts/>.

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

Medlearn Matters Number: MM4161
 Related Change Request (CR) Number: 4161
 Related CR Release Date: November 18, 2005
 Related CR Transmittal Number: 758
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 758, CR 4161

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Auditory Osseointegrated and Auditory Brainstem Devices

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

Provider Types Affected

Physicians and providers billing Medicare carriers or fiscal intermediaries (FIs) for auditory osseointegrated and auditory brainstem devices.

Provider Action Needed

STOP – Impact to You

The definition of “hearing aids” in the Medicare Claim Processing Manual was modified to exclude certain implanted devices from the category of hearing aid.

CAUTION – What You Need to Know

Medicare contractors will not pay for any part A or part B expenses incurred for items or services related to “hearing aids or examination for the purpose of prescribing, fitting, or changing hearing aids.” (42 CFR 411.15(d)). These items and services are excluded from coverage. However, the definition of hearing aids now indicates that **auditory osseointegrated (HCPCS code L8699) devices and auditory brainstem (HCPCS code L8614) devices are prosthetic devices that are eligible for Medicare payment.**

GO – What You Need to Do

Be aware that Medicare contractors **will pay** for osseointegrated auditory and brainstem auditory devices as prosthetic devices but only when indicated: where hearing aids are medically inappropriate or cannot be used due to congenital malformations, chronic disease, severe sensorineural hearing loss, or surgery.

Background

Medicare now defines hearing aids as follows:

Hearing aids are amplifying devices that compensate for impaired hearing. Hearing aids include air conduction devices that provide acoustic energy to the cochlea via stimulation of the tympanic membrane with amplified sound. They also include bone conduction devices that provide mechanical energy to the cochlea via stimulation of the scalp with amplified mechanical vibration or by direct contact with the tympanic membrane or middle ear ossicles.

Certain devices that produce perception of sound by replacing the function of the middle ear, cochlea, or auditory nerve are payable by Medicare as prosthetic devices. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformations, chronic disease, severe sensorineural hearing loss, or surgery.

The following are prosthetic devices:

- Cochlear implants and auditory brainstem implants; that is, devices that replace the function of cochlear structures or auditory nerves and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays.

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- Osseointegrated implants; that is, devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer.

Notes: Hospital outpatient departments and physicians should bill related implantation services using the current codes for osseointegrated implantation (such as CPT codes 69714, 69715, 69717, and 69718) for device HCPCS code L8699. In addition, physicians should bill the appropriate services for implantation of the auditory brainstem device (HCPCS code L8614), using the codes for tumor resection (CPT codes 61520, 61530, 61598), if indicated, and also a code for cranial neurostimulators (CTP 61875).

Additional Information

Additional information about coverage for cochlear implantation may be found in CR 3796 and the accompanying Medlearn Matters article, MM3796. The *Additional Information* section of MM3796 also outlines the policy guidelines for cochlear implantation coverage, and a listing of Healthcare Common Procedural Coding System (HCPCS) codes associated with cochlear implantation.

To view CR 3796, Transmittal #601: Cochlear Implantation, go to CMS website at http://www.cms.hhs.gov/manuals/pm_trans/R601CP.pdf.

To view the associated Medlearn Matters article, MM3796, on cochlear implantation, go to CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3796.pdf>.

The official instruction issued to your carrier/intermediary regarding this change may be found by going to CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R39BP.pdf>.

For additional information relating to this issue, please refer to your local carrier or FI. To find the toll free phone number for your local carrier or FI, go to CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4038
 Related Change Request (CR) Number: 4038
 Related CR Release Date: November 10, 2005
 Related CR Transmittal Number: 39
 Effective Date: November 10, 2005
 Implementation Date: December 12, 2005
 Source: CMS Pub. 100-2, Transmittal 39, CR 4038

Stem Cell Transplantation

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services related to stem cell transplantation

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4173, which includes clarifying language specific to the current national coverage policy on stem cell transplantation.

CAUTION – What You Need to Know

CR 4173 clarifies that stem cell transplantation and high-dose chemotherapy are both integral to the course of treatment and are covered as a single entity.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) has a coverage policy for stem cell transplantation, and the *Medicare National Coverage Determination (NCD) Manual* (Pub. 100-03, Section 110.8) states that stem cell transplantation is a process in which stem cells are harvested from either a patient’s or donor’s bone marrow or peripheral blood for intravenous infusion. Autologous stem cell transplants (AuSCT) must be used to affect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies. Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor’s stem cell or bone marrow is obtained and prepared for intravenous infusion and may also be used to restore function.

CR 4173 clarifies existing NCD policy language and corresponding claims processing language as follows:

“Bone marrow and peripheral blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high dose

chemotherapy or radiotherapy prior to the actual transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow or peripheral blood stem cell transplantation is non-covered, none of the steps are covered.”

Note: There is no change to existing CMS coverage policy or claims processing instructions.

Implementation

The implementation date for this instruction is January 3, 2006, and will be effective for dates of service on or after November 28, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. Those instructions are in two parts. The first part is the actual change to the *Medicare National Coverage Determinations (NCD) Manual*, which includes the actual policy language regarding stem cell transplantation. That part may be viewed on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R45NCD.pdf>.

The second part contains the changes to the *Medicare Claims Processing Manual*. Those changes are available on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R766CP.pdf>.

If you have 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/apps/contacts/>.

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

Medlearn Matters Number: MM4173
 Related Change Request (CR) Number: 4173
 Related CR Release Date: December 6, 2005
 Related CR Transmittal Numbers: 45 and 776
 Effective Date: November 28, 2005
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 776, CR 4173

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Coverage by Medicare Advantage Plans for Implantable Automatic Cardiac Defibrillator Services Not Previously Included in MA Capitation Rates

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

Provider Types Affected

All Medicare providers billing either a Medicare carrier or fiscal intermediary (FI) for ICDs for Medicare beneficiaries who are also members of Medicare Advantage (MA) plans

Provider Action Needed

STOP – Impact to You

Be aware that, effective for services provided on and after January 1, 2006, your Medicare carrier or FI will no longer pay fee-for-service (FFS) claims for the expanded coverage of ICD services rendered to MA beneficiaries.

*Coverage by Medicare Advantage Plans for Implantable Automatic Cardiac Defibrillator Services... (continued)***CAUTION – What You Need to Know**

Related CR 4133 instructs Medicare carriers and FIs to no longer pay FFS claims for the expanded coverage of ICD services (described in CR 3604) that you provide to MA beneficiaries. These services are now part of the MA capitation rates.

GO – What You Need to Do

Make sure that your billing staffs are aware of these changes and also the basis for billing Medicare.

Background

In CR 3604 (January 27, 2005), Medicare expanded ICD coverage for the following new indications:

- Patients with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) class II and III heart failure, and measured left ventricular ejection fraction (LVEF) \leq 35%.
- Patients with nonischemic dilated cardiomyopathy (NIDCM) $>$ 9 months, NYHA class II and III heart failure, and measured LVEF \leq 35%.
- Patients who meet all current Centers for Medicare & Medicaid Services (CMS) coverage requirements for a cardiac resynchronization therapy (CRT) device and have NYHA class IV heart failure.
- Patients with NIDCM $>$ 3 months, NYHA class II or III heart failure, and measured LVEF \leq 35%.

At that time, because this new coverage exceeded the significant cost threshold for managed care organizations, services related to these newly covered indications for Medicare Advantage (MA) beneficiaries were not part of the MA capitation rates, but rather were paid on a FFS basis.

See *Medlearn Matters* article MM3604 regarding this issue on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3604.pdf>.

Adjustment in MA Rates

Beginning January 1, 2006, the MA rates are appropriately adjusted to account for the expanded coverage of ICD services, and MA plans are now liable for payment relating directly to providing these services. Thus CR 4133:

- Instructs your carriers and FIs to no longer pay FFS for the expanded coverage of ICD services that you provide to MA beneficiaries, effective for services performed on and after January 1, 2006.
- Requires MA plans to furnish, arrange, and/or make appropriate payment for these services.
- Notes that MA enrollees are liable for the MA plan's cost sharing of these services.

Conditions for Denying Claims

CR 4133 provides that Medicare systems will now deny, for beneficiaries in MA plans, claims that meet all of the conditions described in the following categories:

Outpatient Claims Processed by Your FI

- Date(s) of service on or after January 1, 2006; **and**
- Condition code 78 (New coverage not implemented by HMO); **and**
- One of the following HCPCS codes: G0297, G0298, G0299, or G0300.

Hospital Inpatient Claims

- Discharge date is on or after January 1, 2006; **and**
- Condition code 78; **and**
- ICD-9 CM 37.94.

Professional Part B Claims

- Date(s) of service is/are on or after January 1, 2006; **and**
- Modifier KZ (New coverage not implemented by managed care); **and**
- CPT code 33249.

Finally, CR 4133 instructs your carriers and FIs, when denying these services, to use:

- Medicare Summary Notice (MSN) 11.3 (“Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them”); **and**
- Claim adjustment reason code 24 (“Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan”).

Additional Information

You can find more information about billing for ICD services for MA Plan beneficiaries by going to CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R186OTN.pdf>.

Indications and limitation of coverage for ICDs are located in the *Medicare National Coverage Determinations Manual* (Pub. 100-03), Chapter 1, Part 1, Section 20.4 (Implantable Automatic Defibrillators).

Finally, 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/apps/contacts/>.

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

Related Change Request (CR) Number: 4133

Related CR Release Date: October 28, 2005

Related CR Transmittal Number: 186

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-20, Transmittal 186, CR 4133

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Payment Correction for PET Scan HCPCS Codes G0253, G0254 and G0336

Effective January 1, 2005, the following Healthcare Common Procedure Coding System (HCPCS) codes for PET scans G0253, G0254, and G0336 were incorrectly mapped to ambulatory payment classification (APC) 1516.

These codes should have been mapped to APC 1513.

The incorrect APC assignment resulted in overpayments to hospitals reimbursed under outpatient prospective payment system (OPPS). First Coast Service Options (FCSO) will correct the overpayment via a mass adjustment and no action is required by the providers.

Claims that contain these HCPCS codes with dates of service from January 1, 2005, through January 27, 2005, and that were processed to payment between January 1, 2005, and April 3, 2005, were overpaid and must be reprocessed to correct payments.

The correction to the OPPS APC assignment was made in the October 2005 outpatient code editor (OCE) re-release and will allow for correct reimbursement for claims adjusted with dates of service from January 1, 2005, through January 27, 2005.

HCPCS codes G0253, G0254, and G0336 were terminated with the issue of change request 3741 and replaced with new *Current Procedural Terminology (CPT)* codes effective January 28, 2005. FCSO is canceling the payment made to providers via a mass adjustment for claims containing these HCPCS with dates of service January 28, 2005, through April 3, 2005, allowing the providers to resubmit the claims with the corresponding new *CPT* codes provided in CR 3741. This provision has been incorporated in CMS online manual Pub. 100-04, Claims Processing Manual, Chapter 13, Section 60.3.1.

Action Required by Providers

After receiving the canceled claims for HCPCS codes G0253, G0254, and G0336, please resubmit the claims for dates of service **on or after January 28, 2005, through April 3, 2005**, with the corresponding new *CPT* for PET scans. ❖

Source: CMS Joint Signature Memorandum 05519, September 19, 2005

Expansion of Coverage for Percutaneous Transluminal Angioplasty

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

Note: CMS has revised this Medlearn Matters article on November 23, 2005, to add important information regarding diagnostic coding under the “Coding for Carotid Artery Stents—IMPORTANT INFORMATION” section of this article. All other information remains the same. This article was originally published in the [Fourth Quarter 2005 Medicare A Bulletin](#) (pages 40-42).

Provider Types Affected

Hospitals, physicians, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for percutaneous transluminal angioplasty (PTA) services provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

MM 3811 and related CR 3811 announce the expansion of Medicare coverage for PTA of the carotid artery.

CAUTION – What You Need to Know

Effective March 17, 2005, Medicare revised its coverage of PTA of the carotid artery as detailed in this article and CR 3811.

GO – What You Need to Do

If you are a provider of PTA services, be aware of the coverage changes and make certain that your billing staff is aware of the expanded national coverage allowed to Medicare beneficiaries receiving PTA services

Background

Medicare covers PTA of the carotid artery concurrent with carotid stent placement when all the requirements stipulated by the Food and Drug Administration (FDA)-approved policies for category B investigational device exemption (IDE) clinical trials are met, effective for dates of service on or after July 1, 2001.

PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent for an FDA-approved indication is covered, when all the requirements stipulated by the FDA-approved policies for post approval studies are met, for dates of service on or after October 12, 2004.

Expanded Coverage

Effective March 17, 2005, the Centers for Medicare & Medicaid Services (CMS) expanded the coverage of PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent with embolic protection for the following:

- Patients who are at high risk for carotid endarterectomy (CEA) and who also have symptomatic carotid artery stenosis = 70 percent. Coverage is limited to procedures performed using FDA-approved carotid artery stenting systems and embolic protection devices.
- Patients who are at high risk for CEA and have symptomatic carotid artery stenosis between 50 percent and 70 percent in accordance to the category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (Medicare National Coverage Determination (NCD) Manual, Section 310.1), or according to the NCD on carotid artery stenting (CAS) post-approval studies (Medicare NCD Manual, Section 20.7).
- Patients who are at high risk for CEA and have asymptomatic carotid artery stenosis = 80 percent (according to the Category B IDE clinical trials regulation (42 CFR 405.201)), as a routine cost under the clinical trials policy (Medicare NCD Manual 310.1), or according to the NCD on CAS post-approval studies (Medicare NCD Manual, Section 20.7).

CMS defines high-risk patients as those having significant comorbidities and/or anatomic risk factors and are considered by a surgeon to be poor candidates for CEA.

Expansion of Coverage for Percutaneous Transluminal Angioplasty (continued)

The significant comorbidities, include, but are not limited to, those listed in Section 20.7 of the Medicare NCD Manual as follows:

- Congestive heart failure (CHF) class III/IV
- Left ventricular ejection fraction (LVEF) < 30 percent
- Unstable angina
- Contralateral carotid occlusion
- Recent myocardial infarction (MI)
- Previous CEA with recurrent stenosis
- Prior radiation treatment to the neck
- Other conditions that were used to determine patients at high risk for CEA in the prior CAS trials and studies, such as ARCHER, CABERNET, SAPPHIRE, BEACH, and MAVERIC II.

Symptoms of carotid artery stenosis include carotid transient ischemic attack (distinct focal neurologic dysfunction persisting less than 24 hours), focal cerebral ischemia producing a non-disabling stroke (modified Rankin scale < 3 with symptoms for 24 hours or more), and transient molecular blindness (amaurosis fugax). Patients who have had a disabling stroke (modified Rankin > 3) would be excluded from coverage.

The appropriate documentation confirming that a patient is at high risk for CEA and records of the patient's symptoms of carotid artery stenosis should be available in the patient medical records prior to performing any procedure.

The degree of carotid artery stenosis should be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the patient medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70 percent by angiography, the CAS should not proceed.

- Carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes. All facilities must at least meet the minimum standards outlined in Pub 100-03, Section 20.7 of the NCD Manual in order to receive coverage for CAS for high-risk patients. Briefly, facilities must have high quality X-ray imaging equipment, device inventory, staffing, and infrastructure to support a dedicated CAS program.
- Advanced physiologic monitoring, including real time and archived physiologic, hemodynamic, and cardiac rhythm monitoring equipment, and associated support staff capable of interpreting findings and responding appropriately.
- Readily available emergency management equipment and systems, such as resuscitation equipment, a defibrillator, vasocative and antiarrhythmic drugs, endotracheal intubation capability, and anesthesia support.

- A clearly delineated program for granting CAS privileges and for monitoring the quality of the individual interventionists and the program as a whole. The oversight committee for this program is encouraged to apply published standards from national specialty societies recognized by the American Board of Medical Specialties to determine appropriate physician qualifications.

Examples of standards and clinical competence guidelines include those published in the December 2004 edition of the American Journal of Neuroradiology and those published in the August 18, 2004, Journal of the American College of Cardiology.

- A data collection system maintained by the facility or its contractor on all CAS procedures done at that facility. The data must be analyzed routinely to ensure patient safety (to be determined by the facility but should not be less frequent than 6-month intervals), will be used in re-credentialing the facility, and must be made available to CMS upon request.

For evaluation purposes, all facilities must provide written documentation to CMS indicating it meets one of the following criteria:

- Was an FDA-approved site that enrolled patients in prior CAS IDE trials, such as SAPPHIRE, and ARCHER;
- Is an FDA-approved site that is participating and enrolling patients in ongoing CAS IDE trials, such as CREST;
- Is an FDA-approved site for one or more FDA post-approval studies; or
- Has provided a written affidavit to CMS affirming that the facility meets the minimum facility standards.

The affidavit must include the facility's name and complete address, Medicare provider number, point of contact name and telephone number, CAS procedure data collection mechanism, and a senior facility administrative official's signature. (Note that a new affidavit is required every two years.)

The affidavit should be sent to:

Director, Coverage and Analysis Group
7500 Security Boulevard, Mail-stop C1-09-06
Baltimore, MD 21244

- Note:** Performance of PTA to treat obstructive lesions of the vertebral and cerebral arteries remains noncovered. All other indications of PTA for which CMS has not specifically indicated coverage remain noncovered.

Additional Information

All providers should note that the following relate to services on or after March 17, 2005:

- FIs and carriers will only pay CAS claims from providers who are listed on the approved facility list, which is at: <http://www.cms.hhs.gov/coverage/carotid-stent-facilities.asp>.

Expansion of Coverage for Percutaneous Transluminal Angioplasty (continued)

- Carriers will pay claims containing ICD-9-CM diagnosis code 433.10 and any of the following procedure codes: 37215, 37216, 0075T, or 0076T, for beneficiaries meeting the high-risk criteria previously specified.
- FIs will pay claims containing ICD-9-CM diagnosis code 433.10 and both procedure codes 00.61 and 00.63.
- FIs will reject claims that do not have both procedure codes 00.61 and 00.63.
- FIs and carriers will deny CAS services for patients at high risk if the appropriate diagnosis code is not on the claim and use the appropriate Medicare summary notice (MSN) message and claim adjustment reason code in doing so.
- FIs and carriers will deny claims where the service was performed in an unapproved facility and use the appropriate MSN message and claim adjustment reason code in doing so.

Note: Providers must also bill V70.7 (Exam – clinical trial) as a secondary diagnosis for claims with “From” dates before October 1, 2005. Providers must bill V70.7 in order to avoid unintentional Medicare code editor (MCE) editing. For claims that have “From” dates on or after October 1, 2005, hospitals are not required to bill V70.7 as the unintentional MCE editing will be corrected.

Coding for Carotid Artery Stents—IMPORTANT INFORMATION

In the American Hospital Association’s (AHA’s) publication *Coding Clinic for ICD-9-CM*, First Quarter 2002, page 10 (and corrected in Second Quarter 2002, page 19), there is a Q&A regarding coding of bilateral carotid artery stenosis. The answer said, “Assign only code 433.10, (Occlusion and stenosis of precerebral arteries, Carotid artery, without mention of cerebral infarction) as the principal diagnosis.”

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The correction notice changed that advice to use code 433.30 (Occlusion and stenosis of precerebral arteries, multiple and bilateral, without mention of cerebral infarction) instead of 433.10.

In an effort to reduce the confusion, CMS has decided to allow hospitals to be able to code both 433.30 and 433.10, in either principal diagnosis or secondary diagnosis positions, on the claim. Code 433.30 will identify the bilateral condition, while 433.10 will specifically identify the carotid vessel.

You may also want to review the following Medlearn Matters article MM3489 and CR 3489 for additional information relating to Medicare coverage of PTA. They are available on CMS website at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3489.pdf> and http://www.cms.hhs.gov/manuals/pm_trans/R314CP.pdf.

The official instruction issued to your FI/carrier regarding this change may be found on CMS website at: <http://www.cms.hhs.gov/transmittals/downloads/R531CP.pdf>.

You will see two versions of CR 3811. One version identified by transmittal number 33 contains the NCD Manual revision, and transmittal number 531 contains the revisions to the Medicare Claims Processing Manual.

If you have questions regarding this issue, contact your intermediary/carrier on their toll free number, which is available at: <http://www.cms.hhs.gov/apps/contacts/>.

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

Related Change Request (CR) Number: 3811
 Related CR Release Date: April 22, 2005
 Related CR Transmittal Number: 33 and 531
 Effective Date: March 17, 2005
 Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 531, CR 3811

Medical Nutrition Therapy Added to the Medicare Telehealth Service List

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

Provider Types Affected

Registered dietitians, nutrition professionals, and other providers of Medicare telehealth services billing Medicare carriers or fiscal intermediaries (FIs) for such services

Provider Action Needed**STOP – Impact to You**

The Centers for Medicare & Medicaid Services (CMS) has added individual medical nutrition therapy (MNT) to the list of Medicare telehealth services.

CAUTION – What You Need to Know

CR 4204, from which this article is taken, expands the list of Medicare telehealth services to include individual MNT (as represented by HCPCS codes G0270, 97802 and 97803); and adds registered dietitians and nutrition professionals to the list of practitioners eligible to furnish, and receive payment, for telehealth.

GO – What You Need to Do

Make sure that your billing staffs are aware of these changes in telehealth services.

Medical Nutrition Therapy Added to the Medicare Telehealth Service List (continued)**Background**

The use of a telecommunications system may substitute for a face-to-face, “hands on” encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, and end-stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site).

In the calendar year 2006 Physician Fee Schedule-Final Rule (CMS-1502-FC), CMS expanded the list of Medicare telehealth services to include individual MNT as described by HCPCS codes G0270, 97802, and 97803. Therefore, effective January 1, 2006, the telehealth modifiers “GT” (via interactive audio and video telecommunications system) and modifier “GQ” (via asynchronous telecommunications system) are valid when billed with these HCPCS codes.

Additionally, since certified registered dietitians and nutrition professionals (as defined in 42 CFR, Section 410.134) are the only practitioners permitted by law to furnish MNT, registered dietitians and nutrition professionals have been added to the list of practitioners who may furnish and receive payment for a telehealth service.

Publication 100-02 (*Medicare Benefit Policy Manual*), Chapter 15, Sections 270.2 and 270.4, and Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12, Section 190, have been revised to implement this addition to the list of Medicare telehealth services.

Be aware, nonetheless, that this expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in these manuals. For example, originating sites must be located in either a non-MSA county or rural health professional shortage area, and can only include a physician’s or practitioner’s office, hospital, critical access hospital (CAH), rural health clinic, or federally qualified health center.

Further, you must use an interactive audio and video telecommunications system that permits real-time communication between the distant site physician, or practitioner, and the Medicare beneficiary, and as a condition of payment, the patient must be present and participating in the telehealth visit.

The only exception to this interactive telecommunication requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In these circumstances, Medicare payment is permitted for telehealth services when asynchronous store-and-forward technology is used.

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Finally, you should remember that if the distant site is a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to this CAH, it should bill its regular fiscal intermediary for the professional telehealth services provided, using any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

Additional Information

You can find more information about telehealth services by going to CMS website <http://www.cms.hhs.gov/Transmittals/downloads/R790CP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R43BP.pdf>.

These Web addresses contain CR 4204. You might also want to look at the following manuals:

- Online manual 100-02 (*Medicare Benefit Policy Manual*), Chapter 15 (Covered Medical and Other Health Services), Sections 270.2 (List of Medicare Telehealth Services) and 270.4 (Payment – Physician/Practitioner at a Distant Site)
- Manual 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Practitioner Billing), Sections 190.3 (List of Medicare Telehealth Services), 190.5 (Payment Methodology for Physician/Practitioner at the Distant Site), 190.6 (Originating Site Facility Fee Payment Methodology), and 190.7 (Contractor Editing of Telehealth Claims).

You can find these revised manual sections as attachments to CR 4204.

Finally, 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/apps/contacts/>.

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

Medlearn Matters Number: MM4204
 Related Change Request (CR) Number: 4204
 Related CR Release Date: December 23, 2006
 Related CR Transmittal Number: R790CP and R43BP
 Effective Date: January 1, 2006
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 790, CR 4204
 CMS Pub. 100-2, Transmittal 43, CR 4204

Instructions for Reporting New HCPCS Code V2788 for Presbyopia-Correcting Intraocular Lenses

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for intraocular lenses (IOLs)

Provider Action Needed

This instruction provides guidance regarding the new Healthcare Common Procedure Coding System (HCPCS) code, V2788 (Presbyopia-correcting function of an intraocular lens). It is being established as a code for reporting noncovered charges associated with the insertion of a presbyopia-correcting lens.

Providers may report this code on claims to reflect the PC-IOL when inserted in lieu of the conventional IOL in conjunction with correcting cataract surgery. The new HCPCS code will be part of the annual HCPCS update and is not a payable service for Medicare on the HCPCS file for 2006.

Background

The Centers for Medicare & Medicaid Services (CMS) announce that Section 120 has been added to Publication 100-04, Chapter 32, which outlines general policy, payment, and billing procedures for PC-IOLs. Much of this information was previously released in change request (CR) 3927 in August 2005.

A *Medlearn Matters* article (MM3927) on the subject may be viewed on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3927.pdf>.

As stated in CR 3927, the new coverage policy was effective for dates of service on and after May 3, 2005.

CR 4184 provides a new HCPCS code, effective January 1, 2006, for reporting **noncovered** charges associated with the insertion of a presbyopia-correcting lens. That code is V2788. Medicare carriers and intermediaries will use an appropriate claim adjustment reason code such as 96 (non-covered charges) when denying noncovered PC-IOL charges. The carrier or intermediary will also send an appropriate message to the beneficiary via a Medicare summary notice to inform the beneficiary of the denial.

CPT Codes

Physicians and hospitals are to report one of the following *Current Procedure Terminology* (CPT) codes on these claims:

66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage proce-*

sure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic development stage.
66983 *Intracapsular cataract with insertion of intraocular lens prosthesis (one stage procedure).*
66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification).*
66985 *Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract extraction.*
66986 *Exchange of intraocular lens*

Implementation

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

Additional Information

For complete details, please see CR4184, the official instruction issued to your carrier or intermediary regarding this change, which may be found on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R801CP.pdf>.

If you have any questions, please contact your Medicare carrier or intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4184
Related Change Request (CR) Number: 4184
Related CR Release Date: December 30, 2005
Related CR Transmittal Number: R801CP
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 801, CR 4184

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HOSPITAL SERVICES

Providing Medicare with Data for Certain Implantable Cardioverter Defibrillators

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

Provider Types Affected

Physicians and other providers needing to register Medicare patients receiving the implantable cardioverter defibrillator (ICD) as primary prevention of sudden cardiac death

Provider Action Needed STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) has entered into an agreement with the American College of Cardiology National Cardiac Data Registry (ACC-NCDR) and determined that its ICD registry satisfies Medicare’s requirements for reporting data on primary prevention ICDs.

CAUTION – What You Need to Know

Because the ACC-NCDR is now available, CMS will stop accepting data on the ICD abstraction tool through the Quality Network Exchange (QNet) on April 30, 2006.

GO – What You Need to Do

In order for providers to continue to satisfy the national coverage determination (NCD) requirements for primary prevention ICDs, they will need to transition out of QNet and begin using the ACC-NCDR. CMS recommends that hospitals contact ACC-NCDR by January 1, 2006, to ensure that enrollment is complete by April 2006.

Background

When CMS expanded coverage for ICDs in January 2005, one of the requirements was for data to be reported by the provider for beneficiaries receiving ICDs for the primary prevention of sudden cardiac arrest. Information regarding this policy is available on the CMS website at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf.

CMS established the ICD abstraction tool through Qnet (<http://qnetexchange.org/public>), a system used by hospitals to report quality data to Medicare, to make available a data reporting system for providers that meets the data reporting requirements outlined in the NCD.

CMS intended for the ICD abstraction tool to be temporary until a more complete registry became available; the result is the ACC-NCDR.

Additional Information

Because the ACC-NCDR is now available, **the ICD abstraction tool through Qnet will stop accepting data on April 30, 2006.** For providers to continue to satisfy the NCD requirements for primary prevention ICDs, they will need to transition out of QNet and begin using ACC-NCDR. CMS recommends that hospitals contact ACC-NCDR by January 1, 2006, to ensure that enrollment is complete by April 2006.

Hospitals will need to work with the ACC-NCDR directly regarding participation.

Information is available on the web at <http://www.accncdr.com/webncdr/ICD> or by telephone at 1-800-253-4636, ext. 451.

Although the ACC-NCDR only enrolls hospitals, all provider types are responsible for ensuring that data is reported to the registry. Physicians and hospitals will need to work closely to ensure that all data elements are available for abstraction and entry into the registry.

Use of modifier QR for physician and hospital outpatient claims remains the same. Modifier QR should continue to be appended to claims for ICD insertion when data is reported on the procedure. Data reporting, and therefore modifier QR, is required for claims of primary prevention ICDs.

Reporting data for primary prevention of ICD implants 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.

Medlearn Matters Number: SE0578

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: Special Edition Medlearn Matters Article SE0578
CMS Pub. 100-20, Transmittal 200, CR 4249

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Billing for Cardiac Catheterization Codes in Ambulatory Payment Classification 80

Beginning April 1, 2005, the Centers for Medicare & Medicaid Services (CMS) implemented edits in the hospital outpatient prospective payment system (OPPS) outpatient code editor (OCE) that causes claims submitted by hospitals on types of bill 12x and 13x to be returned when hospitals report charges for certain specified procedures, but do not also report on the same claim applicable (Healthcare Common Procedure Coding System) HCPCS codes and charges for devices associated with those procedures. Change request (CR) 4035, Transmittal 662, issued August 26, 2005, expanded the device edits to apply to additional procedure codes, effective for services furnished on or after October 1, 2005. The Medlearn Matters article related to CR 4035 was published in the First Quarter 2006 *Medicare A Bulletin* (pages 108-111).

Hospitals do not always use guide wires or guiding catheters when they perform cardiac catheterizations. Therefore, with the implementation of the January 2006 OCE, CMS is withdrawing the edit requiring HCPCS code C1769 (guide wire) or C1887 (guiding catheter) to be reported on the same claim whenever services billed by CPT codes that are assigned to the ambulatory payment classification (APC) 80 are provided, effective for services furnished on or after October 1, 2005. (For additional information about device edits in the OCE, refer to CR 4017, Transmittal 658, issued August 26, 2005; CR 4007, Transmittal 683, issued September 22, 2005; and, Pub 100-04, Medicare Claims Processing Manual, Chapter 4, Section 61.). The Medlearn Matters articles related to CR 4017 and CR 4007 were published in the First Quarter 2006 *Medicare A Bulletin*, pages 106-107 and page 105 respectively.

Action Required by Providers Billing for Cardiac Catheterization Codes in APC 80

Providers are requested to hold claims with dates of service **October 1, 2005, through December 31, 2005**, that contain codes for the following procedures only if hospitals did not use a guide wire or guiding catheter when they furnished the service.

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If hospitals **did** use a guide wire or guiding catheter, the hospital may submit the claim with the C-code for the appropriate device and the edit will not result in the claim being returned to the provider.

The CPT codes for the services to which this policy applies are:

93501	93508	93510	93511	93514	93524	93526
93527	93528	93529	93530	93531	93532	93533

After the successful implementation of the January 2006 OPPS OCE, scheduled for January 3, 2006, providers may then submit these claims for payment. Hospitals using guide wires or guiding catheters for procedures assigned to APC 80 should continue to report the appropriate device C-codes on their claims, even after January 1, 2006, when the edit is withdrawn.

Providers furnished other services on the same date of service as a procedure that is assigned to APC 80 and for which a guide wire or guiding catheter was not used, may submit the claim for the other services, along with all charges associated with those services, in order to receive payment for the remaining services that are unrelated to the procedure assigned to APC 80. In this instance, the provider must submit an adjustment claim for the procedure assigned to APC 80 for which the guide wire or guiding catheter was not used in order to receive payment for these items/services.

Please note that timely filing requirements applies also to adjustment claims.

Claims already submitted for these services might have been returned to the provider. If these claims have been already returned to their location, hospitals may re-submit the claim following the steps above for adjustment claims. ❖

Source: CMS Joint Signature Memorandum 06060, November 29, 2005

Submission of Hemophilia Clotting Factor Claims

The Centers for Medicare & Medicaid Services (CMS) will be providing clarification of payment rules when hemophilia-clotting factors are billed on inpatient claims for which the beneficiary does not have a covered diagnosis associated with the hemophilia charges. As a result of this clarification, CMS is anticipating the issuance of a change request by February 2, 2006 addressing the coding changes that will have to be made to the fiscal intermediary standard system. In the meantime, CMS has directed fiscal intermediaries to allow payment for the diagnosis related group (DRG) charges when the above situation occurs.

Action Required by Providers

Hospitals may submit inpatient claims **without** the hemophilia-clotting factor services to receive payment for the payable DRG charges.

Once the original claim has been processed, providers may submit a corrected bill for the hemophilia-clotting factor services. The adjustment will suspend in the Medicare system until the standard system changes are successfully implemented.

Adjustment for hemophilia-clotting factor services will be held under reason code 31591 in status location SMSPR6. ❖

Source: CMS Joint Signature Memorandum 06063, November 30, 2005

Changes to Skilled Nursing Facility Consolidated Billing Edits for Evaluation and Management Services Billed by Hospitals

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

Provider Types Affected

Hospitals billing affected services to Medicare fiscal intermediaries (FIs)

Provider Action Needed

STOP – Impact to You

This article is based on information from change request (CR) 3910, which revises the claims processing procedures to follow when a hospital bills for “facility charges” (overhead expenses) in connection with clinic services of hospital-based physicians.

CAUTION – What You Need to Know

Currently, when a hospital bills for these facility charges and the beneficiary involved is a Part A skilled nursing facility (SNF) resident, Medicare is rejecting the claim for the facility charge and the SNF is responsible for the charge. CR 3910 changes this, effective January 1, 2006, although the change will not be implemented until April 3, 2006, in the Medicare systems.

GO – What You Need to Do

Hospitals, including critical access hospitals (CAHs), billing for these facility charges must bill them on types of bill 13x or 85x with revenue code 0510 (clinic visit) when an evaluation and management (E & M) code in the *CPT* code range of 99201-99245 is appropriate. Also, because of Medicare implementation date of April 3, 2006, **hospitals should wait until that date before submitting such charges for dates of service on or after January 1, 2006.**

Background

These instructions revise the claim processing procedures to follow when a hospital submits an outpatient claim containing “facility charges” (overhead expenses) in connection with hospital-based physicians. When the beneficiary receiving these clinic services performed by a physician is a Part A resident of a SNF, the associated hospital claim for a facility charge is currently being rejected, due to the SNF CB edits. (SNF CB is the provision that requires the SNF itself to assume the Medicare billing responsibility for all of the services that its Part A residents receive during the course of a covered stay, other than those services, such as physician services, that are specifically excluded from this provision.) While the physician in this situation would bill his or her own professional services for the clinic visit directly to the Part B carrier, the physician would be reimbursed at the facility rate of the Medicare physician fee schedule, which does not include overhead expenses. The hospital historically has submitted a separate Part B “facility charge” for the associated overhead expense to its FI. The hospital’s facility charge **does not** involve a separate service (such as a diagnostic test) being furnished **in addition to** the physician’s clinic service; rather, it represents solely the overhead expense associated with

furnishing the clinic service itself. Accordingly, hospitals bill for facility charges under the physician E&M *CPT* codes. As noted above, however, when the beneficiary who receives the physician clinic services is a Part A SNF resident, the associated hospital claim for a facility charge is currently being rejected, and the SNFs have been responsible for these charges.

Accordingly, CR 3910 revises the existing procedures so that the SNF CB edits will no longer reject such claims. This change in policy is effective January 1, 2006, with an implementation date of April 3, 2006. Hospitals should refrain from submitting their claims, with the clinic visit charges identified below, to the FIs until the Medicare system is updated on April 3, 2006.

Hospital providers, including CAHs, billing for the clinic visits identified above must submit the charges on types of bill 13x or 85x. In addition, the common working file (CWF) will bypass CB edits only when billed with revenue code 0510 (clinic visit) with an E&M *CPT* code in the range of 99201-99245.

Note: Unless otherwise excluded in one of the five major categories for billing services to FIs, the physician bills the carrier for physician service codes. Facility charges associated with the physician’s clinic visit must be reported as explained above and will be excluded from SNF CB edits.

Implementation

The implementation date for this instruction is April 3, 2006, although the change is effective for services provided on or after January 1, 2006. For affected claims to be processed correctly, hospitals should not submit claims with these services until April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R740CP.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/apps/contacts/>.

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

Related Change Request (CR) Number: 3910
 Related CR Release Date: November 1, 2005
 Related CR Transmittal Number: 740
 Effective Date: January 1, 2006
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 740, CR 3910

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Applicable FARS/DFARS apply.

CRITICAL ACCESS HOSPITAL SERVICES

January 2006 Non-Outpatient Prospective Payment System Outpatient Code Editor Specifications Version 21.1

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

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for outpatient services that are not paid under the outpatient prospective payment system (OPPS)

Provider Action Needed

This article is based on change request (CR) 4236, which informs your fiscal intermediary (FI) that the January 2006 non-OPPS OCE has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System (HCPCS) codes and procedure codes in order to ensure correct billing.

Background

The non-OPPS OCE is used to process bills from hospitals not paid under the OPPS, and change request (CR) 4236 updates the non-OPPS OCE with new additions, changes, and deletions to Healthcare Common Procedure Coding System/Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) codes.

Because of the numerous code changes, refer to the attachments of CR 4236.

These may be reviewed on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R783CP.pdf>.

Key attachments to CR 4236 include the following:

- **Appendix A** includes HCPCS/CPT codes **added** to the list of valid codes in the non-OPPS OCE.
- **Appendix B** includes HCPCS/CPT codes **deleted** from the non-OPPS OCE.
- **Appendix C** includes HCPCS/CPT codes **added** to the list of Non-Reportable procedures in the non-OPPS OCE.

Procedures for Females Only

The following codes have been **added** to the procedures for females only list, **effective January 1, 2006**:

Code	Description
01965	Anesth, inc/missed ab proc
01966	Anesth, induced ab procedure
57295	Change vaginal graft
58110	Bx done w/colposcopy add-on

Procedures for Males Only

The following code has been **added** to the procedures for males only list, **effective January 1, 2006**:

Code Description
0137T Prostate saturation sampling

Non-Covered List

The following code has been **removed** from the non-covered list (NCL), **effective August 1, 2000**, or when the

code was placed on the NCL, if more recent:

Code Description

A0888 Non-covered ambulance mileage

Non-Reportable List

The following codes have been removed from the Non-Reportable list, **effective January 1, 2006**:

Code	Description
L3000	Ft insert ucb berkeley shell
L3001	Foot insert remov molded spe
L3002	Foot insert plastazote or eq
L3003	Foot insert silicone gel eac
L3031	Foot lamin/prepreg composite
L3040	Ft arch suprt premold longit
L3050	Foot arch supp premold metat
L3060	Foot arch supp longitud/meta
L3070	Arch suprt att to sho longit
L3080	Arch supp att to shoe metata
L3090	Arch supp att to shoe long/m
L3100	Hallus-valgus nght dynamic s
L3140	Abduction rotation bar shoe
L3150	Abduct rotation bar w/o shoe
L3160	Shoe styled positioning dev
L3170	Foot plastic heel stabilizer
L3201	Oxford w supinat/pronator inf
L3202	Oxford w/ supinat/pronator c
L3203	Oxford w/ supinator/pronator
L3204	Hightop w/ supp/pronator inf
L3206	Hightop w/ supp/pronator chi
L3207	Hightop w/ supp/pronator jun
L3208	Surgical boot each infant
L3209	Surgical boot each child
L3211	Surgical boot each junior
L3212	Benesch boot pair infant
L3213	Benesch boot pair child
L3214	Benesch boot pair junior
L3215	Orthopedic ftwear ladies oxf
L3216	Orthoped ladies shoes dpth i
L3217	Ladies shoes hightop depth I
L3219	Orthopedic mens shoes oxford
L3221	Orthopedic mens shoes dpth I
L3222	Mens shoes hightop depth inl
L3230	Custom shoes depth inlay
L3250	Custom mold shoe remov prost
L3251	Shoe molded to pt silicone s
L3252	Shoe molded plastazote cust
L3253	Shoe molded plastazote cust
L3254	Orth foot non-standard size/w
L3255	Orth foot non-standard size/
L3257	Orth foot add charge split s
L3265	Plastazote sandal each
L3300	Shoe lift taper to metatarsal

January 2006 Non-Outpatient Prospective Payment System Outpatient Code Editor... (continued)

L3310 Shoe lift elev heel/sole neo
 L3320 Shoe lift elev heel/sole cor
 L3330 Lifts elevation metal extens
 L3332 Shoe lifts tapered to one-ha
 L3334 Shoe lifts elevation heel /I
 L3340 Shoe wedge sach
 L3350 Shoe heel wedge
 L3360 Shoe sole wedge outside sole
 L3370 Shoe sole wedge between sole
 L3380 Shoe clubfoot wedge
 L3390 Shoe outflare wedge
 L3400 Shoe metatarsal bar wedge ro
 L3410 Shoe metatarsal bar between
 L3420 Full sole/heel wedge between
 L3430 Sho heel count plast reinfor
 L3440 Heel leather reinforced
 L3450 Shoe heel sach cushion type
 L3455 Shoe heel new leather standa
 L3460 Shoe heel new rubber standar
 L3465 Shoe heel thomas with wedge
 L3470 Shoe heel thomas extend to b
 L3480 Shoe heel pad & depress for
 L3485 Shoe heel pad removable for
 L3500 Ortho shoe add leather insol
 L3510 Orthopedic shoe add rub insl
 L3520 O shoe add felt w leath insl
 L3530 Ortho shoe add half sole
 L3540 Ortho shoe add full sole
 L3550 O shoe add standard toe tap
 L3560 O shoe add horseshoe toe tap
 L3570 O shoe add instep extension
 L3580 O shoe add instep velcro clo

L3590 O shoe convert to sof counte
 L3595 Ortho shoe add march bar
 L3600 Trans shoe calip plate exist
 L3610 Trans shoe caliper plate new
 L3620 Trans shoe solid stirrup exi
 L3630 Trans shoe solid stirrup new
 L3640 Shoe dennis browne splint bo
 L3649 Orthopedic shoe modifica NOS

Implementation

The implementation date for CR 4236 is January 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 CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R783CP.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/apps/contacts/>.

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

Medlearn Matters Number: MM4236
 Related Change Request (CR) Number: 4236
 Related CR Release Date: December 16, 2005
 Related CR Transmittal Number: 783
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 783, CR 4236

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Update to the 2006 Ambulatory Surgical Center Master Listing

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

Provider Types Affected

Ambulatory surgical centers (ASCs) providing services to Medicare beneficiaries and billing Medicare carriers or fiscal intermediaries (FIs) for those services

Provider Action Needed

Be aware of the ASC HCPCS codes that are being added to and deleted from the ASC list, effective January 1, 2006.

Background

The Centers for Medicare & Medicaid Services (CMS) is updating the ASC HCPCS codes list as a result of changes in the American Medical Association (AMA) Physician's *Current Procedural Terminology (CPT)* for 2006.

Implementation Date

The implementation date is January 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/FI regarding this change. Attachment A of that instruction (CR 4082) is included below and it contains the ASC list of both HCPCS deletions and additions, effective January 1, 2006.

CR 4082 may be viewed by going to the CMS website <http://www.cms.hhs.gov/transmittals/downloads/R720CP.pdf>.

If you have any questions, please contact your Medicare carrier/FI at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Attachment A from CR 4082

The following is the ASC list of approved procedures HCPCS code changes (deletions/additions) for January 1, 2006, effective for services performed on or after January 1, 2006:

Update to the 2006 Ambulatory Surgical Center Master Listing (continued)

Deletions

CPT Code	Short Descriptor	Payment Group	Payment Amount
15350	Skin homograft	2	446.00
15351	Skin homograft add on	2	446.00
16015	Treatment of burn(s)	2	446.00
21493	Treat hyoid bone fracture	3	510.00
21494	Treat hyoid bone fracture	4	630.00
31585	Treat larynx fracture	1	333.00
31586	Treat larynx fracture	2	446.00
37720	Removal leg vein	3	510.00
37730	Removal leg veins	3	510.00
42325	Create salivary cyst drain	2	446.00

Additions

CPT Code	Short Descriptor	Payment Group	Payment Amount
15040	Harvest cultured skin graft 2		446.00
15110	Epidrm autogrft trnk/arm/leg	2	446.00
15111	Epidrm autogrft t/a/l add-on	1	333.00
15115	Epidrm a-grft face/nck/hf/g	2	446.00
15116	Epidrm a-grft f/n/hf/g addl	1	333.00
15130	Derm autograft, trnk/arm/leg	2	446.00
15131	Derm autograft t/a/l add-on	1	333.00
15135	Derm autograft face/nck/hf/g	2	446.00
15136	Derm autograft, f/n/hf/g add	1	333.00
15150	Cult epiderm grft t/arm/leg	2	446.00
15151	Cult epiderm grft t/a/l addl	1	333.00
15152	Cult epiderm graft t/a/l +%	1	333.00
15155	Cult epiderm graft, f/n/hf/g	2	446.00

Additions

CPT Code	Short Descriptor	Payment Group	Payment Amount
15156	Cult epidrm grft f/n/hfg add	1	333.00
15157	Cult epiderm grft f/n/hfg +%	1	333.00
15300	Apply skinallogrft, t/arm/lg	2	446.00
15301	Apply sknallogrft t/a/l addl	1	333.00
15320	Apply skin allogrft f/n/hf/g	2	446.00
15321	Aply sknallogrft f/n/hfg add	1	333.00
15330	Apply acell alogrft t/arm/leg	2	446.00
15331	Aply acell grft t/a/l add-on	1	333.00
15335	Apply acell graft, f/n/hf/g	2	446.00
15336	Aply acell grft f/n/hf/g add	1	333.00
15420	Apply skin xgraft, f/n/hf/g	2	446.00
15421	Apply skn xgrft f/n/hf/g add	1	333.00
15430	Apply acellular xenograft	2	446.00
15431	Apply acellular xgraft add	1	333.00
16025	Dress/debrid p-thick burn, m	2	446.00
16030	Dress/debrid p-thick burn, l	2	446.00
37718	Ligate/strip short leg vein	3	510.00
37722	Ligate/strip long leg vein	3	510.00
45990	Surg dx exam, anorectal	2	446.00

Medlearn Matters Number: MM4082
 Related Change Request (CR) Number: 4082
 Related CR Release Date: October 21, 2005
 Related CR Transmittal Number: 720
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006
 Source: CMS Pub. 100-4, Transmittal 720, CR 4082

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Billing for the Administration of Drugs and Biologicals (specifically Low Osmolar Contrast Material) in a Method II CAH

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

The Centers for Medicare & Medicaid Services has rescinded change request (CR) 3911 on November 8, 2005. The Medlearn Matters article was published in the Fourth Quarter 2005 *Medicare A Bulletin* (pages 65-66).

Source: CMS Pub. 100-4, Transmittal 617, CR 3911

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Health Professional Shortage Area Listing

The following are counties (all census tracts) designated as geographic health professional shortage area (HPSA) (and therefore eligible for the HPSA bonus payment) for primary care (as of November 21, 2005) and mental health (as of November 3, 2005) for Florida.

Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Clay/Keystone Heights		Rural
Collier/Imokalee/Everglades		Rural
Dixie		Rural
Escambia/Altmore	0038.00, 0039.00, 0040.00	Rural
Gadsden		Urban
Glades		Rural
Hamilton		Rural
Hardee		Rural
Hendry/Labelle	9604.00, 9604.00	Rural
Holmes (terminated November 21, 2005)		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown		Rural
Sumter		Rural
Suwannee		Rural
Wakulla		Rural
Walton (terminated January 1, 2005)		Rural
Washington (terminated November 21, 2005)		Rural

Mental Health

County	Type
Bradford	Rural
Columbia	Rural
Dixie	Rural
Gilchrist	Rural
Hamilton	Rural
Hillsborough. Ruskin/Wimauma-Lithia (effective November 3, 2005)	Urban
Holmes	Rural
Jackson	Rural
Lafayette	Rural
Martin/Indiantown (effective September 27, 2005)	Rural
Monroe	Rural
Putnam	Rural
St Johns	Urban
Suwannee	Rural
Union	Rural
Walton	Rural
Washington	Rural

Additional HPSA information was published in the Fourth Quarter 2006 *Medicare A Bulletin* (pages 63-64). ❖

Source: CMS Atlanta Regional Office Memorandum December 19, 2005

ESRD SERVICES

2006 Pricing Update for Blood and Blood Related Services

Blood and blood related services provided to end-stage renal disease patients in an independent dialysis facility may be paid in addition to the composite rate. Payment is made at the lower of the actual charge on the bill or a reasonable charge that the fiscal intermediary (FI) determines annually. In establishing the reasonable charge, the FI considers price lists of independent blood banks that offer services to providers in the area.

Blood and blood related services are billed to Medicare Part A on a type of bill 72x, using claim Form CMS-1450 (UB-92) or its electronic equivalent.

The following 2006 fees are effective for blood and blood related services provided **on and after January 1, 2006**. Providers may use this pricing update to reconcile Medicare payments for applicable services provided **on and after January 1, 2006**.

Blood Product Services

Description	HCPCS Code	Revenue Code	2006 Fee
Blood (whole), for transfusion, per unit*	P9010	382/39x	\$160.82
Blood (split unit), specify amount*	P9011	382/39x	\$82.35
Cryoprecipitate, each unit	P9012	387/39x	\$52.08
Red blood cells, leukocytes reduced, each unit*	P9016	385/39x	\$169.96
Fresh frozen plasma, single donor, frozen within 8 hours of collection, each unit	P9017	383/39x	\$67.47
Platelets, each unit	P9019	384/39x	\$94.08
Platelet rich plasma, each unit	P9020	384/39x	\$43.00
Red blood cells, each unit*	P9021	381/39x	\$138.27
Red blood cells, washed, each unit*	P9022	380/39x	\$208.74
Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	P9023	383/39x	\$60.00
Platelets, leukocytes reduced, each unit	P9031	384/39x	\$172.50
Platelets, irradiated, each unit	P9032	384/39x	\$93.18
Platelets, leukocytes reduced, irradiated, each unit	P9033	384/39x	\$126.33
Platelets, pheresis, each unit	P9034	384/39x	\$529.20
Platelets, pheresis, leukocytes reduced, each unit	P9035	384/39x	\$493.49
Platelets, pheresis, irradiated, each unit	P9036	384/39x	\$605.91
Platelets, pheresis, leukocytes reduced, irradiated, each unit	P9037	384/39x	\$553.61
Red blood cells, irradiated each unit*	P9038	381/39x	\$187.90
Red blood cells, deglycerolized, each unit*	P9039	381/39x	\$323.86
Red blood cells, leukocytes reduced, irradiated, each unit*	P9040	381/39x	\$230.65
Plasma, cryoprecipitate reduced, each unit	P9044	383/39x	\$52.42
Granulocytes, pheresis, each unit	P9050	386/39x	\$807.75
Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit*	P9051	381/382/39x	\$204.29
Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit*	P9052	384/39x	\$792.74
Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit	P9053	384/39x	\$600.69
Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit*	P9054	381/382/39x	\$270.00
Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit	P9055	384/39x	\$529.99
Whole blood, leukocytes reduced, irradiated, each unit*	P9056	382/39x	\$238.50
Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, (each unit)*	P9057	381/39x	\$361.80
Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit*	P9058	381/39x	\$267.33
Fresh frozen plasma between 8-24 hours of collection, each unit	P9059	383/39x	\$46.17
Fresh frozen plasma, donor retested, each unit	P9060	383/39x	\$56.38

*Blood deductible applied

2006 Pricing Update for Blood and Blood Related Services (continued)

Transfusion Medicine Services

Description	CPT/HCPCS Code	Revenue Code	2006 Fee
<i>Antibody screen, RBC, each serum technique</i>	86850	390	\$43.97
<i>Antibody elution, (RBC), each elution</i>	86860	390	\$59.80
<i>Antibody identification, RBC antibodies, each panel for each serum technique</i>	86870	390	\$108.34
<i>Antihuman globulin test, (Coombs test), direct, each antiserum</i>	86880	390	\$32.23
<i>indirect, qualitative, each antiserum</i>	86885	390	\$31.19
<i>indirect, titer, each antiserum</i>	86886	390	\$62.96
<i>Autologous blood or component, collection processing and storage, predeposited</i>	86890	390	\$140.63
<i>intra-or postoperative salvage</i>	86891	390	Individual consideration
<i>Blood typing; ABO</i>	86900	390	\$24.11
<i>Rh (D)</i>	86901	390	\$23.81
<i>antigen screening for compatible blood unit using reagent serum, per unit screened</i>	86903	390	\$45.95
<i>antigen screening for compatible unit using patient serum, per unit screened</i>	86904	390	\$26.39
<i>RBC antigens, other than ABO or Rh (D), each</i>	86905	390	\$50.77
<i>Rh phenotyping, complete</i>	86906	390	\$162.25
<i>Compatibility test each unit, Immediate spin technique</i>	86920	390	\$64.01
<i>incubation technique</i>	86921	390	\$66.17
<i>antiglobulin technique</i>	86922	390	\$70.25
<i>electronic</i>	86923	390	\$55.83
<i>Fresh frozen plasma, thawing, each unit</i>	86927	390	\$32.63
<i>Frozen blood, each unit, freezing (includes preparation)</i>	86930	390	\$212.60
<i>thawing</i>	86931	390	\$81.13
<i>freezing (includes preparation) and thawing</i>	86932	390	\$141.00
<i>Irradiation of blood product, each unit</i>	86945	390	\$60.55
<i>Leukocyte transfusion</i>	86950	390	\$28.00
<i>Volume reduction of blood or blood product (eg, red blood cells or platelets), each unit</i>	86960	390	\$170.08
<i>Pooling of platelets or other blood products</i>	86965	390	\$40.41
<i>Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing, incubation with chemical agents or drugs, each</i>	86970	390	\$72.75
<i>incubation with enzymes, each</i>	86971	390	\$82.67
<i>by density gradient separation</i>	86972	390	\$135.00
<i>Pretreatment of serum for use in RBC antibody identification, incubation with drugs, each</i>	86975	390	\$203.67
<i>by dilution</i>	86976	390	\$107.50
<i>incubation with inhibitors, each</i>	86977	390	\$203.67
<i>by differential red cell absorption using patient RBCs or RBCs of known phenotype, each absorption</i>	86978	390	\$139.25
<i>Splitting of blood or blood products, each unit</i>	86985	390	\$30.97
<i>Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g. T cells, metastatic, carcinoma)</i>	G0267	386	\$882.00

Source: CMS Pub. 100-4, Transmittal 750, CR 4144

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Pricing Update for Blood and Blood Related Services for Calendar Years 2003 – 2005

Blood and blood related services provided to end-stage renal disease patients in an independent dialysis facility may be paid in addition to the composite rate. Payment is made at the lower of the actual charge on the bill or a reasonable charge that the fiscal intermediary (FI) determines annually. In establishing the reasonable charge, the FI considers price lists of independent blood banks that offer services to providers in the area.

Blood and blood related services provided to end-stage renal disease patients in an independent dialysis facility are billed to Medicare Part A on a type of bill 72x, using claim Form CMS-1450 (UB-92) or its electronic equivalent.

The pricing lists for calendar years 2003, 2004 and 2005 have been updated for services provided to end-stage renal disease patients in a renal disease facility as follows:

- The revised 2005 prices are effective for services provided on or after January 1, 2005.
- The revised 2004 prices are effective for services provided from January 1, 2004 through December 31, 2004.
- The revised 2003 prices are effective for services provided from January 1, 2003 through December 31, 2003.

First Coast Service Options will adjust all impacted claims by the end of this year. Therefore, we are anticipating minimal impacts to the provider community.

If you are a direct data entry (DDE) system provider you may view the pricing in the DDE system and you will be able to monitor the status of your claims through the adjustment process.

Providers may use these pricing updates to reconcile Medicare payments for applicable services.

Blood Product Services

Description	HCPCS Code	Revenue Code	2003 Fee	2004 Fee	2005 Fee
Blood (whole), for transfusion, per unit	P9010	382/39x	\$108.66	\$110.94	\$144.18
Blood (split unit), specify amount	P9011	382/39x	I. C.	I. C.	\$119.14
Cryoprecipitate, each unit	P9012	387/39x	\$38.23	\$39.03	\$55.46
Red blood cells, leukocytes reduced, each unit	P9016	385/39x	\$125.15	\$127.78	\$160.76
Fresh frozen plasma, single donor, frozen within 8 hours of collection, each unit	P9017	383/39x	\$57.11	\$58.31	\$64.00
Platelets, each unit	P9019	384/39x	\$57.74	\$58.95	\$63.03
Platelet rich plasma, each unit	P9020	384/39x	\$53.93	\$55.06	\$56.88
Red blood cells, each unit	P9021	381/39x	\$95.52	\$97.53	\$128.76
Red blood cells, washed, each unit	P9022	380/39x	\$149.88	\$153.03	\$172.36
Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	P9023	383/39x	I. C.	I. C.	I. C.
Platelets, leukocytes reduced, each unit	P9031	384/39x	I. C.	I. C.	\$86.39
Platelets, irradiated, each unit	P9032	384/39x	I. C.	I. C.	\$101.61
Platelets, leukocytes reduced, irradiated, each unit	P9033	384/39x	I. C.	I. C.	\$103.28
Platelets, pheresis, each unit	P9034	384/39x	I. C.	I. C.	\$461.51
Platelets, pheresis, leukocytes reduced, each unit	P9035	384/39x	I. C.	I. C.	\$489.31
Platelets, pheresis, irradiated, each unit	P9036	384/39x	I. C.	I. C.	\$554.39
Platelets, pheresis, leukocytes reduced, irradiated, each unit	P9037	384/39x	I. C.	I. C.	\$533.39
Red blood cells, irradiated each unit	P9038	381/39x	I. C.	I. C.	\$174.64
Red blood cells, deglycerolized, each unit	P9039	381/39x	I. C.	I. C.	\$246.17
Red blood cells, leukocytes reduced, irradiated, each unit	P9040	381/39x	\$365.98	\$373.67	\$208.14
Plasma, cryoprecipitate reduced, each unit	P9044	383/39x	I. C.	I. C.	\$55.50
Granulocytes, pheresis, each unit	P9050	386/39x	I. C.	I. C.	\$460.00
Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit	P9051	381/382/39x	I. C.	I. C.	\$188.51
Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit	P9052	384/39x	I. C.	I. C.	\$727.51
Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit	P9053	384/39x	I. C.	I. C.	\$559.85
Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit	P9054	381/382/39x	I. C.	I. C.	\$220.00

END STAGE RENAL DISEASE

Pricing Update for Blood and Blood Related Services for Calendar Years 2003 – 2005 (continued)

Description	HCPCS Code	Revenue Code	2003 Fee	2004 Fee	2005 Fee
Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit	P9055	384/39x	I. C.	I. C.	\$510.85
Whole blood, leukocytes reduced, irradiated, each unit	P9056	382/39x	I. C.	I. C.	\$182.27
Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, (each unit)	P9057	381/39x	I. C.	I. C.	\$305.00
Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit	P9058	381/39x	I. C.	I. C.	\$224.51
Fresh frozen plasma between 8-24 hours of collection, each unit	P9059	383/39x	I. C.	I. C.	\$58.00
Fresh frozen plasma, donor retested, each unit	P9060	383/39x	I. C.	I. C.	\$55.00

Transfusion Medicine Services

Description	CPT/HCP CS Code	Revenue Code	2003 Fee	2004 Fee	2005 Fee
<i>Antibody screen, RBC, each serum technique</i>	86850	390	I. C.	I. C.	\$39.08
<i>Antibody elution, (RBC), each elution</i>	86860	390	\$80.36	\$82.05	\$62.17
<i>Antibody identification, RBC antibodies, each panel for each serum technique</i>	86870	390	I. C.	I. C.	\$91.33
<i>Antihuman globulin test, (Coombs test), direct, each antiserum</i>	86880	390	\$7.58	\$7.74	\$25.67
<i>indirect, qualitative, each antiserum</i>	86885	390	\$8.08	\$8.25	\$35.00
<i>indirect, titer, each antiserum</i>	86886	390	\$7.31	\$7.46	\$49.25
<i>Autologous blood or component, collection processing and storage, predeposited</i>	86890	390	I. C.	I. C.	\$130.11
<i>intra-or postoperative salvage</i>	86891	390	I. C.	I. C.	I. C.
<i>Blood typing; ABO</i>	86900	390	\$4.22	\$4.30	\$21.38
<i>Rh (D)</i>	86901	390	I. C.	I. C.	\$21.56
<i>antigen screening for compatible blood unit using reagent serum, per unit screened</i>	86903	390	\$8.55	\$8.73	\$59.00
<i>antigen screening for compatible unit using patient serum, per unit screened</i>	86904	390	\$13.43	\$13.71	\$49.33
<i>RBC antigens, other than ABO or Rh (D), each</i>	86905	390	\$5.40	\$5.51	\$53.00
<i>Rh phenotyping, complete</i>	86906	390	\$10.95	\$11.18	\$71.45
<i>Compatibility test each unit, Immediate spin technique</i>	86920	390	I. C.	I. C.	\$57.60
<i>incubation technique</i>	86921	390	\$36.95	\$37.73	\$38.97
<i>antiglobulin technique</i>	86922	390	\$42.21	\$43.10	\$61.75
<i>Fresh frozen plasma, thawing, each unit</i>	86927	390	I. C.	I. C.	\$30.60
<i>Frozen blood, each unit, freezing (includes preparation)</i>	86930	390	I. C.	I. C.	\$132.50
<i>thawing</i>	86931	390	I. C.	I. C.	\$100.00
<i>freezing (includes preparation) and thawing</i>	86932	390	I. C.	I. C.	\$220.00
<i>Irradiation of blood product, each unit</i>	86945	390	I. C.	I. C.	\$72.20
<i>Leukocyte transfusion</i>	86950	390	I. C.	I. C.	I. C.
<i>Pooling of platelets or other blood products</i>	86965	390	\$170.86	\$174.45	\$30.60
<i>Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing, incubation with chemical agents or drugs, each</i>	86970	390	I. C.	I. C.	\$31.00
<i>incubation with enzymes, each</i>	86971	390	I. C.	I. C.	\$26.50
<i>by density gradient separation</i>	86972	390	I. C.	I. C.	\$72.00

Pricing Update for Blood and Blood Related Services for Calendar Years 2003 – 2005 (continued)

Description	CPT/HCP CS Code	Revenue Code	2003 Fee	2004 Fee	2005 Fee
<i>Pretreatment of serum for use in RBC antibody identification, incubation with drugs, each</i>	86975	390	I. C.	I. C.	\$29.00
<i>by dilution</i>	86976	390	I. C.	I. C.	\$27.00
<i>incubation with inhibitors, each</i>	86977	390	I. C.	I. C.	\$29.00
<i>by differential red cell absorption using patient RBCs or RBCs of known phenotype, each absorption</i>	86978	390	I. C.	I. C.	\$22.00
<i>Splitting of blood or blood products, each unit</i>	86985	390	I. C.	I. C.	\$45.67
Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g. T cells, metastatic, carcinoma)	G0267	386	I. C.	I. C.	I. C.

I.C. = Individual consideration

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Use of Value Codes 48 and 49 on End Stage Renal Disease Bills

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

Provider Types Affected

Providers billing fiscal intermediaries (FIs) for services provided at renal dialysis facilities (RDFs)

Provider Action Needed

This article is based on change request (CR) 4087, which instructs end stage renal disease (ESRD) facilities billing Medicare to report the most recent hemoglobin or hematocrit reading before the start of the billing period for dialysis claims submitted on type of bill (TOB) 72x (renal dialysis facility).

This provides ample opportunity for ESRD facilities to respond to hematocrit/hemoglobin readings in titrating the dose of erythropoietin (epoetin alfa [Procrit]; EPO) for ESRD patients.

Background

The National Uniform Billing Committee (NUBC) previously defined the use of value codes (VCs) 48 and 49 as the most recent hemoglobin and hematocrit readings **before the end of the billing period**, where:

- VC 48 is used to collect hemoglobin information
- VC 49 is used to collect hematocrit information on institutional outpatient dialysis bills.

However, reporting of hemoglobin and hematocrit readings at the end of the billing period does not provide an opportunity for facilities to respond to the results of testing in titrating their dosage for the billing period. Therefore, at their August, 2005 meeting, the NUBC changed the specific definitions of VCs 48 and 49 for the institutional bill to provide for the reporting of hemoglobin and hematocrit readings before the **start** of the billing period.

To provide ample opportunity for ESRD facilities to respond to the hematocrit/hemoglobin reading in titrating the dose of erythropoietin (EPO) for the period, CR 4087 instructs ESRD facilities billing Medicare to report the most recent hemoglobin (VC 48) or hematocrit (VC49) reading before the **start** of the billing period for dialysis claims submitted on TOB 72x.

Implementation

The implementation date for the instruction is January 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 CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R721CP.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/apps/contacts/>.

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

Related Change Request (CR) Number: 4087
 Related CR Release Date: October 21, 2005
 Related CR Transmittal Number: 721
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 751, CR 4087

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Clarification and Update to Hospital Billing Instructions and Payment for Epoetin (EPO) alfa (Epoetin®) and Darbepoetin alfa (Aranesp®) for Beneficiaries with End-Stage Renal Disease

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

Provider Types Affected

Hospitals billing Medicare fiscal intermediaries (FIs) for epoetin (EPO) alfa (Epoetin®) and darbepoetin alfa (Aranesp®) for beneficiaries with end-stage renal disease (ESRD).

Provider Action Needed STOP – Impact to You

This article is based on change request (CR) 4103, which clarifies and updates hospital billing instructions and payment for epoetin (EPO) alfa (Epoetin®) and darbepoetin alfa (Aranesp) for beneficiaries with ESRD.

CAUTION – What You Need to Know

Change request (CR) 4103 corrects current system problems with the reporting and payment for EPO and Aranesp on inpatient Part B claims. Effective January 1, 2006, hospitals will no longer be required to report the value code 49 when submitting claims for EPO or Aranesp. In addition, when billing EPO under the inpatient Part B benefit on type of bill 12x, hospitals will begin using revenue code 0634 for EPO less than 10,000 units and revenue code 0635 for EPO over 10,000 units. Also, effective January 1, 2006, the current HCPCS codes for EPO (Q4055) and Aranesp (Q4054) are being terminated and replaced by HCPCS code J0886 for EPO and HCPCS code J0882 for Aranesp.

GO – What You Need to Do

See the *Background* section of this article for further details regarding this clarification and update.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR 3184 (Transmittal 197, dated June 4, 2004) with instructions for emergency hospital outpatient billing of epoetin alfa and darbepoetin alfa.

CR 3184 included the requirement for hospitals to report:

- Healthcare Common Procedure Coding System (HCPCS) code Q4055 (EPO) with revenue codes 0634 and 0635 for EPO administered to beneficiaries with ESRD in the emergency room setting.
- Value code 49 with the latest hematocrit reading **taken during the current billing period** for outpatient claims with HCPCS codes Q4054 (Aranesp) and Q4055 (EPO).

Value Code 49

Since that time, the National Uniform Bill Committee (NUBC) has changed the definition of value code 49 to report the following: Value code 49 with the most recent hematocrit reading **taken before the start of the billing period** (effective January 1, 2006).

Note: Since hospitals are not expected to have a reading before the start of their billing period, hospitals will no longer be required to report the value code 49 when submitting claims for EPO or Aranesp.

Revenue Codes 0634 and 0635

The CMS *Medicare Benefit Policy Manual 100-2*, Chapter 6, Section 10, provides for the coverage of epoetin alfa under the inpatient Part B benefit. Currently, when hospitals bill for HCPCS code Q4055 (EPO) on their inpatient Part B claims (type of bill 12x), it must be reported under the revenue code 0636.

This is contrary to their billing of HCPCS code Q4055 (EPO) on the hospital outpatient claims (type of bill 13x), which requires the use of the revenue codes 0634 and 0635.

Therefore, for consistency (with the implementation of CR4103) when billing HCPCS code J0886 (EPO) under the inpatient Part B benefit on type of bill 12x, hospitals will begin using:

- Revenue code 0634 for EPO less than 10,000 units
- Revenue code 0635 for EPO over 10,000 units.

Note: The total number of units as a multiple of 1000 units is placed in the units field.

Hospitals should continue to report HCPCS code Q4054 or J0882, depending on the date of service (darbepoetin alfa, Aranesp), under revenue code 0636 for their outpatient and inpatient Part B claims.

CMS is aware of a current problem with the inpatient Part B claims (type of bill 12x) containing HCPCS code Q4054 for Aranesp. **The processing of those claims will be permitted with the implementation of CR 4103.**

Billing for Beneficiaries with ESRD

Upon implementation of CR 4103, the following changes will be applied to hospitals billing EPO and Aranesp for beneficiaries with ESRD:

- Effective for claims with dates of service **on or after January 1, 2004**, hospitals billing for HCPCS code Q4054 or J0882, depending on the date of service and under the inpatient Part B benefit (type of bill 12x), will be reimbursed under the same methodology applicable to the outpatient Part B setting using the payment allowance limit for Medicare Part B drugs.
- Effective for claims (types of bill 12x, 13x, or 85x) with dates of service **on or after January 1, 2006**, hospitals are no longer required to report the value code 49 when submitting claims with Aranesp and EPO.
- Effective for claims with dates of service **on or after April 1, 2006**, hospitals billing for J0886 (EPO) under the inpatient Part B benefit (type of bill 12x), will:
 - ♦ Report the charges under the revenue code 0634 for EPO units under 10,000 and revenue code 0635 for EPO units over 10,000.
 - ♦ Report the total number of units as a multiple of 1000 units in the units field.
 - ♦ Be reimbursed under the same methodology applicable to the outpatient Part B setting using the payment allowance limit for Medicare Part B drugs.

Clarification and Update to Hospital Billing Instructions and Payment for Epoetin (EPO) alfa... (continued)

Note: All other rules for EPO and Aranesp not mentioned in CR 4103 are still applicable.

Implementation

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

To ensure that claims are processed correctly, it is important that hospitals note that:

- When billing for EPO HCPCS J0886 as applicable on types of bill 13x and 85x with dates of service from January 1, 2006 through March 31, 2006, to submit those claims on or after April 1, 2006; and
- To submit claims on type of bill 12x containing Q4054 or J0882, as applicable, on or after April 1, 2006. (Timely filing rules for such claims will be bypassed for six months following the April 1, 2006, implementation date.)

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R736CP.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/apps/contacts/>.

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

Related Change Request (CR) Number: 4103

Related CR Release Date: October 31, 2005

Related CR Transmittal Number: 736

Effective Date: January 1 and April 1, 2006, as noted in article

Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 736, CR 4103

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SKILLED NURSING FACILITY SERVICES

Requirements for Long-Term Care Pharmacies

The Centers for Medicare & Medicaid Services (CMS) seeks to clarify confusion surrounding the requirements for pharmacies, under Medicare Part D, serving residents in long-term care facilities and has provided the following notification.

“It has been brought to the attention of CMS’ Prescription Drug Program Officials that some nursing facilities have distributed letters to their patients falsely asserting that CMS has placed a requirement on facilities to contract only with long-term care (LTC) pharmacies that currently meet all of the performance and service criteria for LTC network providers under Medicare Part D. We understand that this is causing some LTC facilities to exclude some pharmacies from servicing Part D patients resident in their LTC facilities.

Please be advised that this is an inappropriate reading of the CMS requirements. On November 8, 2005, CMS issued the “Long-Term Care (LTC) Convenient Access Standard Statement” stating the following: “We also

reiterate our previous guidance that any pharmacy – whether it is a LTC or retail pharmacy – that can meet the ten performance and service criteria outlined in our March 2005 LTC Guidance and is willing to accept any other standard contracting terms and conditions established by the plan for its network pharmacies can participate as a LTC network pharmacy. As clarified in previous guidance, this means that network LTC pharmacies must have the capability to meet the performance and service criteria, either directly or through a subcontractor. It does not mean that prospective LTC network pharmacies must show that they currently provide such services or that they could provide all these service directly. The actual services that must be provided by the LTC network pharmacy will depend on the specific needs of the specific LTC facilities serviced by the pharmacy.” ❖

Source: CMS Joint Signature Memorandum 06132, December 20, 2006

Important Message to Nursing Home Administrators About Medicare Prescription Drug Coverage

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

The Tenth article in a series of: Information for Providers, Physicians, Pharmacies and their Staff About Medicare Prescription Drug Coverage

Provider Types Affected

Skilled nursing facilities (SNFs) and nursing homes with Medicare residents

Impact on Providers

This article contains information on Medicare prescription drug coverage as it applies to nursing home residents. The Centers for Medicare & Medicaid Services (CMS) will continue to use *Medlearn Matters* articles, where appropriate, to supplement the minimum data set (MDS) channel to communicate important information and recommended action steps.

The goal is to ensure that the long-term care population has a seamless transition to Medicare prescription drug coverage beginning January 2006.

Important Points to Remember

Key points to remember about the new Medicare prescription drug coverage include the following:

- On January 1, 2006, new prescription drug coverage, also known as Part D, will be available to all of your Medicare residents. It will cover brand name and generic drugs.
- Everyone with Medicare is eligible to join a Medicare drug plan in his or her area.
- Your residents can first enroll in a Medicare drug plan from November 15, 2005 – May 15, 2006.

- This new drug coverage requires all persons with Medicare to make a decision this fall. As a trusted source, your residents may turn to you for information about this new coverage.
- Please encourage your Medicare residents to learn more about this new coverage because it may save them money on prescription drugs.
- There is extra help for people with limited income and resources.

If your Medicare residents ask you questions about the new coverage, you may refer them to

<http://www.medicare.gov>

and 1-800-MEDICARE for additional information and assistance.

Background

At the end of October 2005, CMS mailed a letter to nursing home residents with Medicare and full Medicaid coverage (full-benefit dually eligible beneficiaries). This letter explained that Medicare, instead of Medicaid, will start paying for their prescription drugs beginning January 1, 2006.

The letter explained that if they don’t enroll in a plan by December 31, 2005, Medicare will enroll them in a plan to make sure they don’t miss a day of coverage.

Important Message to Nursing Home Administrators About Medicare Prescription Drug Coverage (continued)

The letter provided the name and contact information for the plan in which Medicare would enroll them.

A sample copy of this letter can be found on the CMS website at: <http://www.cms.hhs.gov/medicarereform/Enrollment-Q&A-10-20-05-withcover-sheet.pdf>.

Generally, residents with full Medicaid coverage who are enrolled in a Medicare Advantage plan or the Program of All-Inclusive Care for the Elderly (PACE) will receive their Medicare drug coverage through that plan.

CMS is establishing a Web-based system through which nursing homes can access residents' plan enrollment information. This will enable the nursing facility, with the resident's permission, to identify the Medicare drug plan in which the resident is enrolled.

Everyone with Medicare is eligible to join a Medicare drug plan in their area. Many of your residents may want to join a plan to help with the high costs of medications. Your residents can first enroll in a Medicare prescription drug plan from November 15, 2005 – May 15, 2006.

Action Item

Residents with limited income and resources can apply for extra help paying for their prescription drugs. They can apply for this extra help through the Social Security Administration or their State Medical Assistance Office.

For more information on who can get extra help with prescription drug costs and how your residents can apply for that help, call the Social Security Administration at 1-800-

772-1213. TTY users should call 1-800-325-0778. You may also find this information on the Web at <http://www.socialsecurity.gov/>.

Remember, your facility may request applications for the extra help and help residents who may qualify apply. It is important to submit applications for the extra help for new residents who are "Medicaid pending." Residents who have Medicare and full Medicaid coverage, get help from Medicaid paying their Medicare premiums, or receive Supplemental Security Income (SSI) benefits, automatically qualify for extra help and **do not need to apply** for it.

Additional Information

More information concerning Medicare prescription drug coverage and the nursing home population will continue to be supplied through articles such as these and through the MDS channel. Additional information and resources are available on the CMS website at <http://www.cms.hhs.gov/medicarereform/pdbma/>.

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Related Change Request (CR) Number: N/A

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Source: CMS Special Edition Medlearn Matters Article SE0575

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THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Addition of Hospice Data to HIPAA 270/271 Eligibility Inquiry and Response Transactions—Revision to Chapter 31

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

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 hospice services

Provider Action Needed

This article is based on change request (CR) 4193, which adds hospice data to the Centers for Medicare & Medicaid Services (CMS) Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry and Response transaction (270/271). Hospice will be part of the core data elements returned on the 271 response.

Background

CMS is making changes to its information technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response in real-time.

CMS is using a phased approach for providing this eligibility transaction on a real-time basis:

- **Extranet:** Clearinghouses, certain providers, and trading partners (as described below) will be permitted to submit 270s via the CMS AT&T communication Extranet (the Medicare Data Communication Network or MDCN). This Extranet is a secure closed private network currently used to transmit data between Medicare fee-for-service (FFS) contractors and CMS.
- **Internet:** CMS expects to provide limited Internet access to the 270/271 transaction this year. Instructions on accessing eligibility data via this method will be provided prior to the time Internet access becomes available.

All electronic 270 files will be processed at the CMS data center, and the CMS data center will use a single consolidated national eligibility database to respond to the eligibility inquiries.

CR 4193 revises the *Medicare Claims Processing Manual* (Pub. 100-04) Chapter 31 (ANSI X12 Formats Other than Claims or Remittance), Section 10.2 (Eligibility Extranet Workflow), by adding the following hospice data to the CMS HIPAA Health Care Eligibility Benefit Inquiry and response transaction (270/271).

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271 Response Data Elements

If a service type code is submitted in a 270 that does not trigger additional Medicare data elements, the following data elements will be returned in the 271 as applicable:

271 Information Returned	Loop	Segment	Element	Data Value
		EB	EB01	X
			EB03	45
			EB04	MA
Hospice Data	2110C		EB06	26
		DTP	DTP01	292
			DTP02	D8 or RD8
			DTP03	Dates

Implementation

The implementation date for the instruction is January 23, 2006.

Additional Information

Medlearn Matters Article MM3883 provides information regarding the access process for beneficiary eligibility inquiries and replies (HIPAA 270 and 271 transactions, Extranet Only). It can be reviewed on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3883.pdf>.

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/R793CP.pdf>.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Related Change Request (CR) Number: 4193
 Related CR Release Date: December 29, 2005
 Related CR Transmittal Number: R793CP
 Effective Date: January 23, 2006
 Implementation Date: January 23, 2006

Source: CMS Pub. 100-4, Transmittal 793, CR 4193

ELECTRONIC DATA INTERCHANGE

Medical Review Matching of Electronic Claims and Additional Documentation in the Medical Review Process

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

STOP – Impact to You

Other than certain limited exceptions, such as for providers that employ very few employees, the Centers for Medicare & Medicaid Services (CMS) currently instructs all initial claims to be filed electronically. This is true even when the claim will be subjected to prepayment medical review.

CAUTION – What You Need to Know

Generally, Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), cannot require or permit the voluntary submission of paper claims. If any supporting paper documentation is necessary for medical review, it can only be solicited by the contractor and submitted through the additional documentation request (ADR) or alternate contractor process that permits matching. This supporting documentation must be submitted separately from an electronic claim, at the contractors’ request.

Exception: At their discretion, some contractors accept unsolicited paper supporting documentation, if they can match the electronic claim and paper documentation.

GO – What You Need to Do

File initial claims electronically when subjected to prepayment medical review unless you are in an “excepted” category. Unless your contractor informs you that they accept supporting paper documentation with the electronic claim, submit all supporting documentation through the regular ADR process, or alternate contractor process that permits matching.

Background

Although Medicare contractors may use any information they deem necessary to make a prepayment or post-payment claim review determination, contractors may not require providers or suppliers to file initial claims on paper to Medicare when the claim requires additional documenta-

tion. The Administrative Simplification Compliance Act requires providers, with very few exceptions, to submit claims electronically. Medicare contractors may not require or request of any provider the submission of supporting documentation with the initial claim(s) through contractor developed forms, local policies, or any other communication with providers. Medicare contractors may only request supporting documentation through the ADR process or alternate contractor process that enables matching of the documentation to the initial claim.

Additional Information

The *Medicare Claims Processing Manual*, Chapter 24, Section 90, contains information regarding the limited circumstances under which your contractor may request paper claims. The manual is available on the CMS website at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

The official instruction issued to your carrier/intermediary/DMERC/RHHI regarding this change may be found by going to the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R131PI.pdf>.

You may also wish to refer to *Medlearn Matters* article MM3440 on the requirements to submit claims electronically. That article is available on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3440.pdf>.

If you have any questions, contact your carrier/DMERC/FI/RHHI at their toll free number, which is available on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4052
 Related Change Request (CR) Number: 4052
 Related CR Release Date: November 10, 2005
 Related CR Transmittal Number: 131
 Effective Date: February 10, 2006
 Implementation Date: February 10, 2006

Source: CMS Pub. 100-8, Transmittal 131, CR 4052

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Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

The complete list, including changes made from March 1, 2005 through June 30, 2005, of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 Health Care Claim Adjustment Reason Codes may be found at <http://www.wpc-edi.com/codes>.

CAUTION – What You Need to Know

Please refer to the *Additional Information* section of this article for remark and reason code changes approved June 30, 2005.

GO – What You Need to Do

Be sure your staff is aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination of benefits transactions.

The remittance advice remark code list is maintained by CMS, and used by all payers. Additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities. This list is updated three times a year, and posted at <http://www.wpc-edi.com/codes>.

The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets three times a year when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes. This updated list is posted three times per year.

Additional Information

The following lists summarize changes made from March 1, 2005 through June 30, 2005:

Remittance Advice Remark Code Changes

Code	Status	Current Narrative	Comment
N348	New	You chose that this service/supply/drug would be rendered/supplies and billed by a different practitioner/supplier.	Medicare Initiated
N349	New	The administration method and drug must be reported to adjudicate this service.	Not Medicare Initiated
N350	New	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.	Not Medicare Initiated
N351	New	Service date outside of the approved treatment plan service dates.	Not Medicare Initiated
N352	New	There are no scheduled payments for this service. Submit a claim for each patient visit.	Not Medicare Initiated
N353	New	Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.	Not Medicare Initiated
N354	New	Incomplete/invalid invoice	Not Medicare Initiated
N355	New	The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.	Medicare Initiated

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

Code	Status	Current Narrative	Comment
N356	New	This service is not covered when performed with, or subsequent to, a non-covered service.	Not Medicare Initiated
N21	Modified	Your line item has been separated into multiple lines to expedite handling.	Modified effective August 1, 2005
M25	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	Modified effective August 1, 2005
M26	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	Modified effective August 1, 2005
M27	Modified	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified effective August 1, 2005
MA01	Modified	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.	Modified effective August 1, 2005
MA02	Modified	The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days	Modified effective August 1, 2005
MA03	Modified	If you do not agree with the approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time. At the reconsideration, you must present any new evidence, which could affect our decision.	Modified effective August 1, 2005
MA83	Modified	Did not indicate whether we are the primary or secondary payer.	Modified effective August 1, 2005
MA94	Modified	Did not enter the statement "Attending physician not hospice employee" on the claim form to certify that the rendering physician is not an employee of the hospice	Modified effective August 1, 2005
N122	Modified	Add-on code cannot be billed by itself.	Modified effective August 1, 2005

ELECTRONIC DATA INTERCHANGE

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

Code	Status	Current Narrative	Comment
N125	Modified	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.	Modified effective August 1, 2005
N29	Modified	Missing documentation/orders/notes/ summary/report/chart.	Modified effective August 1, 2005
N225	Modified	Modify N225 – Incomplete/invalid documentation/orders/notes/summary/report/chart.	Modified effective August 1, 2005
M23	Modified	Missing invoice.	Modified effective August 1, 2005

Reason Code Changes

Code	Status	Current Narrative	Comment
167	New	This (these) diagnosis(es) is (are) not covered.	New as of June, 2005
168	New	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	New as of June, 2005
169	New	Payment adjusted because an alternate benefit has been provided.	New as of June, 2005
170	New	Payment is denied when performed/billed by this type of provider.	New as of June, 2005
171	New	Payment is denied when performed/billed by this type of provider in this type of facility.	New as of June, 2005
172	New	Payment is adjusted when performed/billed by a provider of this specialty.	New as of June, 2005
173	New	Payment adjusted because this service was not prescribed by a physician.	New as of June, 2005
174	New	Payment denied because this service was not prescribed prior to delivery.	New as of June, 2005
175	New	Payment denied because the prescription is incomplete	New as of June, 2005
176	New	Payment denied because the prescription is not current.	New as of June, 2005
177	New	Payment denied because the patient has not met the required eligibility requirements.	New as of June, 2005
178	New	Payment adjusted because the patient has not met the required spend-down requirements.	New as of June, 2005
179	New	Payment adjusted because the patient has not met the required waiting requirements.	New as of June, 2005
180	New	Payment adjusted because the patient has not met the required residency requirements.	New as of June, 2005
181	New	Payment adjusted because this procedure code was invalid on the date of service.	New as of June, 2005
182	New	Payment adjusted because the procedure modifier was invalid on the date of service.	New as of June, 2005
183	New	The referring provider is not eligible to refer the service billed.	New as of June
184	New	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	New as of June, 2005

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

Code	Status	Current Narrative	Comment
185	New	The rendering provider is not eligible to perform the service billed.	New as of June, 2005
186	New	Payment adjusted since the level of care changed.	New as of June, 2005
187	New	Health Savings account payments	New as of June, 2005
188	New	This product/procedure is only covered when used according to FDA recommendations.	New as of June, 2005
189	New	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	New as of June, 2005
D21	New	This (these) diagnosis(es) is (are) missing or are invalid.	New as of June, 2005
23	Modified	Payment Adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.	Modified June, 2005
47	Retired	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	Inactive as of February, 2006
30	Retired	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	Inactive as of February, 2006
B6	Retired	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	Inactive as of February, 2006

Note: In September 2005, the Claim Adjustment Status Code Maintenance Committee approved a new reason code of 192 (Non-standard adjustment code from paper remittance advice), effective January 1, 2006. Reason code 192 will be used by providers who must submit claims electronically under the Administrative Simplification Compliance Act when:

- Medicare is not the primary payer
- Providers have received paper remittance advice containing proprietary codes from the previous payer(s).

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* on the CMS website.

The official instruction issued to your FI/carrier/DMERC/RHHI regarding this change may be found by going to CMS website <http://www.cms.hhs.gov/Transmittals/downloads/R743CP.pdf>.

If you have any questions, please contact your FI/carrier/DMERC/RHHI at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4123

Related Change Request (CR) Number: 4123

Related CR Release Date: November 4, 2005

Related CR Transmittal Number: 743

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

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EDUCATIONAL RESOURCES

Coverage of Drugs under Part B and the New Medicare Prescription Drug Coverage (Part D), and Vaccines Administered in a Physician's Office

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

The Ninth article in a series of: Information for Providers, Physicians, Pharmacies and their Staff About Medicare Prescription Drug Coverage

Provider Types Affected

Physicians, healthcare professionals, providers, suppliers, and their staff

Key Points to Remember

- Drugs covered under fee-for-service (FFS) Medicare Parts A/B that are paid to institutional providers (hospitals, SNFs, etc.) as part of a bundled payment are paid by fiscal intermediaries (FIs).
- Drugs covered under FFS Medicare Part B that are billed by physicians and suppliers are paid by carriers (including DMERCs).
- FIs and carriers do not, and will not, pay claims for Part D drugs. Providers should not submit claims for Part D covered drugs to FIs or carriers.
- Drugs covered under Part D are paid by Medicare Part D drug plans, such as prescription drug plans (PDPs) or Medicare Advantage prescription drug plans (MA-PDs), for enrolled beneficiaries.
- Providers must have a contractual relationship with a Medicare Part D drug plan to bill these plans for drugs provided to enrolled beneficiaries. A state specific list of Medicare Part D drug plans may be found on the CMS website at <http://www.medicare.gov/medicarereform/map.asp>.

Highlights

This article highlights the differences in how drugs are covered and which drugs are covered by Medicare Part B and the new Medicare prescription drug coverage (Part D). It also offers additional guidance on the effect of Part D on vaccines given to Medicare patients in a physician's office. Those currently billing Medicare Part B for drugs or for vaccines may wish to pay particular attention to this article.

Drugs Covered Under Part B and Part D Part A/B Covered Drugs Set by Statute

Traditional Part A/B Medicare does not cover most outpatient prescription drugs. Under Part A, Medicare bundled payments made to hospitals and skilled nursing facilities (SNFs) generally cover all drugs provided during a covered Part A stay. (An exception is clotting factor supplied during a stay, which is paid separately from the bundled payment.)

Medicare also makes payments under Part B to physicians for drugs or biologicals that are **not** usually self-administered. Coverage is usually limited to drugs or biologicals **administered by infusion or injection**. If the injection is self-administered (e.g., Imitrex), it is not covered.

Physicians, healthcare professionals, providers, and

suppliers may also bill Medicare Part B for other limited types of drugs as follows:

Durable Medical Equipment (DME) Supply Drugs

These are drugs that require administration by the use of a piece of covered durable medical equipment (DME) (e.g., a nebulizer, or external or implantable pump). The statute does not explicitly cover DME drugs; they are covered as a supply necessary for the DME to perform its function.

The largest Medicare expenditures for drugs furnished as a DME supply are for inhalation drugs, (e.g., albuterol sulfate, ipratropium bromide) which are administered in the home through the use of a nebulizer. The other category of drugs Medicare covers as a DME supply are drugs for which administration with an infusion pump in the home is medically necessary (e.g., some chemotherapeutic agents).

Immunosuppressive Drugs

These include drugs used in immunosuppressive therapy (such as cyclosporine) for a beneficiary who has received a Medicare covered organ transplant.

Hemophilia Clotting Factors

These include hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors.

Oral Anti-Cancer Drugs

These are drugs taken orally during cancer chemotherapy, provided they have the same active ingredients and are used for the same indications as are chemotherapy drugs that would be covered if they were not self-administered but were administered instead as incident to a physician's professional service.

Oral Anti-emetic Drugs

These are oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen as a full therapeutic replacement for an intravenous anti-emetic drug within 24 or 48 hours of chemotherapy administration depending on the drug.

Pneumococcal Vaccine

This refers to the vaccine and its administration to a beneficiary if ordered by a physician.

Hepatitis B Vaccine

This includes the vaccine and its administration to a beneficiary who is at high or intermediate risk of contracting Hepatitis B. High-risk groups include the following:

- Individuals with ESRD
- Individuals with hemophilia who received factor VIII or IX concentrates

Coverage of Drugs under Part B and the New Medicare Prescription Drug Coverage (Part D)... (continued)

- Clients of institutions for mentally handicapped individuals
- Persons who live in the same household as a Hepatitis B Virus (HBV) carrier
- Homosexual men
- Illicit injectable drug abusers.

Intermediate risk groups include staff in institutions for the mentally handicapped and workers in healthcare professions who have frequent contact with blood or blood-derived body fluids during routine work.

Influenza Vaccine

This refers to the vaccine and its administration when furnished in compliance with any applicable state law. The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Antigens

These are prepared by a physician (usually an allergist) for a specific patient. The physician or physician's nurse generally administers them in the physician's office. In some cases, the physician prepares antigens and furnishes them to a patient who has been taught to self-administer them at home.

Erythropoietin (EPO)

EPO is used for treating anemia in persons with chronic renal failure who are on dialysis.

Parenteral Nutrition

Parenteral nutrients are covered under the prosthetic benefit. They are available to beneficiaries who cannot absorb nutrition through their intestinal tract. Parenteral nutrition is administered intravenously and is regulated as a drug by the Food and Drug Administration (FDA).

Intravenous Immune Globulin Provided in the Home

The MMA created a benefit for the provision of intravenous immune globulin (IVIG) for beneficiaries with a diagnosis of primary immune deficiency disease. Coverage is provided if a physician determines that the administration of IVIG in the patient's home is medically appropriate. Payment is limited to that for the IVIG itself and does not cover items and services related to administration of the product.

Part B Covered Drugs in the Context of a Professional Service

Drugs Furnished "Incident to" a Physician's Service

These are injectable or intravenous drugs that are administered predominantly by a physician or under a physician's direct supervision as "incident to" a physician's professional service. The statute limits coverage to drugs that are not usually self-administered. (If a drug is not self-administered by more than 50 percent of Medicare beneficiaries, it is considered "not usually self-administered.")

Separately Billable ESRD Drugs

Most drugs furnished by dialysis facilities are separately billable. The largest Medicare expenditures for such drugs are for erythropoietin (EPO), which is covered for dialysis beneficiaries when it is furnished by independent and hospital-based ESRD facilities, as well as when it is furnished by physicians.

Separately Billable Drugs Provided in Hospital Outpatient Departments

For calendar year 2005, Medicare continues to pay separately for drugs, biologicals, and radiopharmaceuticals whose median cost per administration exceeds \$50, while packaging the cost of drugs, biologicals, and radiopharmaceuticals whose median cost per administration is less than \$50 into the procedures with which they are billed.

Drugs Covered as Supplies or – "Integral to a Procedure"

Some drugs are covered as supplies that are an integral part of a procedure that is a diagnostic or therapeutic service, including radiopharmaceuticals (both diagnostic and therapeutic) and low osmolar contrast media. Other examples of drugs covered under the "integral to a procedure" provision include eye drops administered before cataract surgery.

Blood

Medicare does make separate payment for blood and blood products and these products are regulated as biological agents by the FDA.

Drugs Furnished as a Part of a Service in Provider Settings

Also covered are drugs furnished as a part of a service in the following provider settings:

- Drugs packaged under the hospital outpatient prospective payment system
- Drugs furnished by ESRD facilities and included in Medicare's ESRD composite rate
- Osteoporosis drugs provided by home health agencies under certain conditions
- Drugs furnished by critical access hospitals' (CAH) outpatient departments
- Drugs furnished by a rural health clinic (RHC)
- Drugs furnished by federally qualified health centers (FQHC)
- Drugs furnished by community mental health centers (CMHC)
- Drugs furnished by ambulances
- Separately billable drugs provided in comprehensive outpatient rehabilitation facilities (CORF).

Part D Covered Drugs

Definition of a Part D Covered Drug

A Part D covered drug is a drug that is:

- Available only by prescription
- Approved by the FDA (or is a drug described under section 1927(k)(2)(A)(ii) or (iii) of the Social Security Act)
- Used and sold in the United States
- Used for a medically accepted indication (as defined in section 1927(k)(6) of the Act).

A covered Part D drug includes prescription drugs, biological products, insulin as described in specified paragraphs of Section 1927(k) of the Act, and vaccines licensed

Coverage of Drugs under Part B and the New Medicare Prescription Drug Coverage (Part D)... (continued)

under Section 351 of the Public Health Service Act. The definition also includes “medical supplies associated with the injection of insulin (as defined in regulations of the Secretary).” CMS defines those medical supplies to include syringes, needles, alcohol swabs, and gauze.

Part D Excluded Drugs

The definition of a covered Part D drug excludes any drug for which, as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual, even though a deductible may apply.

In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Medicaid under section 1927(d)(2) of the Act, with the exception of smoking cessation agents.

The drugs or classes of drugs that may currently be otherwise restricted under Medicaid include the following:

- Agents when used for anorexia, weight loss, or weight gain.
- Agents when used to promote fertility.
- Agents when used for cosmetic purposes or hair growth.
- Agents when used for the symptomatic relief of cough and colds.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Nonprescription drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.
- Barbiturates
- Benzodiazepines.

While these drugs or uses are excluded from basic Part D coverage, Medicare Part D drug plan sponsors can generally include them as part of supplemental benefits, provided they otherwise meet the definition of a Part D drug.

Because non-prescription drugs do not otherwise meet the definition of a Part D drug, the Part D drug plans may not include such drugs as part of supplemental benefits; however, under certain conditions as part of a plan utilization management program (including a step-therapy program), non-prescription drugs can be provided at no cost to enrollees. The cost of these drugs to the plan would be treated as administrative costs under such programs.

For more detailed information about Part B drugs and Part D coverage, please refer to the report on the CMS website at <http://www.cms.hhs.gov/pdps/PartBandPartDdoc-revised7-27-05.pdf>.

This report provides excellent detail on the overall issue of Part B and Part D drugs. For example, this report discusses the following:

- Situations in which a billing entity would have to decide whether, for a given drug, to bill Part B or Part D, based

on characteristics of the beneficiary or medical use of the drug.

- Situations where the form of the drug determines where it is covered.
- Situations where Part B coverage is in the context of another service.

Vaccines Administered in a Physician’s Office

This section discusses the vaccines currently covered by Medicare Part B, and includes a few commonly asked questions regarding vaccine coverage under Medicare Part B and Part D. Basically, if a vaccine is currently covered under Part B, the vaccine will remain covered under Part B when the new Part D goes into effect on January 1, 2006.

Medicare Part B currently covers the following immunizations (as discussed earlier in this article):

- Pneumococcal pneumonia vaccine
- Hepatitis B vaccine
- Influenza virus vaccine
- Other vaccines (e.g., tetanus toxoid) when directly related to the treatment of an injury or direct exposure to a disease or condition.

Key Questions

Will All Vaccines be Covered under Part D, Effective January 1, 2006?

No. As just mentioned, if a vaccine was previously covered under Part B, it will continue to be covered under Part B. If it was previously **not** covered, then it will need to be covered under Part D. Pneumococcal and influenza vaccines are not covered under Part D because of Part B coverage.

Hepatitis B vaccine is covered under Part B for individuals at high or intermediate risk; for all other individuals, it would be covered under a Part D benefit. All other currently available vaccines and all future vaccines would be covered under Part D, but could be subject to plan prior authorization requirements to determine medical necessity.

If a Company That Offers Medicare Part D Drug Plans Determines, Through a Prior Authorization Program, that a Hepatitis B Vaccine is Going to be Administered by a Physician, Can This Company Deny the Claim Based on Part B Coverage in the Setting?

No. Since the Part B benefit for Hepatitis B vaccine is separate from the “incident to” benefit, the determination about whether it is a Part D drug depends solely on characteristics of the beneficiary. However, if the plan sponsor determines based on Medicare Part B guidelines that the individual is at high or medium risk for Hepatitis B, the company should deny the claim. For all other individuals, the vaccine would be a “Part D drug,” and would be covered unless the plan had otherwise established medical necessity criteria for the vaccine as part of its approved prior authorization program. In this case, only low risk individuals who meet the plan’s criteria would be eligible to receive the vaccine.

*Coverage of Drugs under Part B and the New Medicare Prescription Drug Coverage (Part D)... (continued)***Additional Information****Websites for Part B and Part D Coverage Information**

Medicare Claims Processing Manual <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>

Medicare Benefit Policy Manual <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>

Medicare Coverage Database <http://www.cms.hhs.gov/mcd/search.asp>

Carrier, DMERC, and Fiscal Intermediary Contacts by Region <http://www.cms.hhs.gov/apps/contacts/>

Medicare Drug Information Resource <http://www.cms.hhs.gov/providers/drugs/default.asp>

Hospital Outpatient Prospective Payment System 2005 <http://www.cms.hhs.gov/providers/hoppps/fr2005.asp>

Palmetto GBA <http://www.palmettogba.com>

AdminaStar <http://www.adminastar.com>

CIGNA <http://www.cignamedicare.com>

National/Local Coverage Determinations <http://www.cms.hhs.gov/coverage>

Medicare Part B versus Part D Coverage Issues <http://www.cms.hhs.gov/pdps/PartBandPartDdoc-revised7-27-05.pdf>

Medicare Prescription Drug Coverage Information for Providers <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>

Prescription Drug Plans <http://www.cms.hhs.gov/pdps/>

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Medicare Prescription Drug Coverage Information

Reminder: Please join the Centers for Medicare & Medicaid Service (CMS) officials every Tuesday at 2p.m. EST for the Physician/Part D implementation Open Q&A conference call. 1-800-619-2457. Pass code: RBDML.

This call is intended for physicians and other prescribers. CMS has similar weekly conference calls for pharmacies and long-term care.

Medicare prescription drug coverage is here. Retail pharmacies filled several hundred thousand Medicare prescriptions on January 1, 2006, alone. CMS staff and the prescription drug plans (PDPs) have been working around the clock to fix problems and refine processes. Pharmacists have become "Part D experts" and have made the benefit work despite the inevitable challenges associated with the first few days of a huge new program. CMS recognizes the important role physicians and other health care professionals have played in helping people learn about the new benefit and CMS appreciates your efforts this fall to help raise awareness and educate people with Medicare about this new program.

To help you care for your patients and easily obtain information about Part D formularies and whether a specific drug is covered by a Part D plan, Epocrates, Inc. has provided Part D formulary information through their free Epocrates Rx[®] software, which is available through their Web-based system or hand-held personal digital assistant

(PDA) system. This is online and operational as of now and can be accessed through <http://www.epocrates.com>.

For those physicians and office managers that don't use PDAs, Epocrates also has an easy to use Web interface. This free feature allows anyone to review formularies using any computer with an Internet connection. <http://www2.epocrates.com/products/online/>.

CMS has also created a Web-based formulary finder: <http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp>.

The CMS formulary finder provides a list of all Part D plans in a given state and links directly to a plan's home page for a complete formulary. It also provides general information about a plan's drug utilization and appeals process. In mid-January the CMS formulary finder will be linked directly to individual plan formularies.

It is important to note that during January all plans will have a transition process that will allow enrollees to continue their current drugs. During this period, the physician can work with their patients to adjust drugs to new formularies or request formulary exceptions. We sincerely appreciate your efforts in helping us provide important prescription drug coverage to people with Medicare. ❖

Source: Provider Education Resources Listserv, Message 200601-02

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

Addresses**CLAIMS STATUS****Coverage Guidelines****Billing Issues Regarding****Outpatient Services, CORE, ORF, PHP**

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)**Information on Hospital Protocols****Admission Questionnaires****Audits**

Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

General MSP Information**Completion of UB-92 (MSP Related)****Conditional Payment**

Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Automobile Accident Cases**Settlements/Lawsuits****Other Liabilities**

Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

PROVIDER EDUCATION

Medicare Education and Outreach
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 Government Benefit Administrators – Gulf Coast
34650 US Highway 19 North, Suite 202
Palm Harbour, FL 34684-2156

RAILROAD MEDICARE**Railroad Retiree Medical Claims**

Palmetto Government 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 Government Benefit Administrators
P. O. Box 100141
Columbia, SC 29202-3141



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

*** ATTENTION BILLING MANAGER ***

