Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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

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

Routing Suggestions:

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

CMS Centers for Medicare & Medicaid Services

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

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The *Medicare A Bulletin* is published monthly by Medicare Communication and Education, to provide timely and useful information to Medicare Part A providers in Florida.

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

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P.O. Box 45270
Jacksonville, FL
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About the *Medicare A Bulletin*

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

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

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

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

Who Receives the *Bulletin*?

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

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

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

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

What Is in the *Bulletin*?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

Editor, *Medicare A Bulletin* – 10T
Medicare Communication & Education
P.O. Box 45270
Jacksonville, FL 32232-5270

Sign up to our *eNews* electronic mailing list

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

GENERAL INFORMATION

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

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

UB-04

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

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

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

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

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

Additional Information

You may find more information about the UB-04 (Form CMS-1450) by going to CR 5072, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1018CP.pdf*.

Included with this CR are the following:

- A copy of the UB-04 form (front and back) in PDF format (Attachment E)
- The UB-92-to-UB-04 crosswalk (Attachment B)
- UB-04 mapping to the HIPAA institutional 837 (Attachment C)
- The revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill – Form CMS-1450 [UB-04]) and 71 (General Instructions for Completion of Form CMS-1450 [UB-04]) (Attachment A). These sections contain very detailed instructions for completing the form.

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

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.
MLN Matters Number: MM5072
Related Change Request (CR) Number: 5072
Related CR Release Date: July 28, 2006
Related CR Transmittal Number: R1018CP
Effective Date: March 1, 2007
Implementation Date: March 1, 2007

Source: CMS Pub. 100-04, Transmittal 1018, CR 5072

Non-Application of Deductible for Colorectal Cancer Screening Tests

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

Provider Types Affected

Physicians and providers who provide colorectal cancer screening services to Medicare beneficiaries

Impact on Providers

Effective January 1, 2007, Medicare will waive the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS codes listed in the following chart. While the deductible will be waived, and will not apply for colorectal cancer screening test services furnished on or after January 1, 2007, the Medicare Part B coinsurance still applies for these screening tests.

HCPCS Code	Descriptor
G0104	Colorectal cancer screening: flexible sigmoidoscopy
G0105	Colorectal cancer screening: colonoscopy on individual at high risk;
G0121	Colorectal cancer screening: colonoscopy on individual not meeting criteria for high risk
G0106	Colorectal cancer screening: barium enema as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening: barium enema as an alternative to G0105, screening colonoscopy

Currently (prior to January 1, 2007, for colorectal cancer screening test services furnished before January 1, 2007), **the annual Medicare Part B deductible AND coinsurance apply to the above codes**.

Please note that the annual Medicare Part B deductible and coinsurance **do not apply** for the following tests**.**

- **G0107** (colon cancer screening; fecal occult blood tests (FOBT), 1-3 simultaneous determinations)
- **G0328** (colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations).

Background

This policy is directed by Section 5113 of the Deficit Reduction Act (DRA) of 2005.

It amends Section 1833(b) of the Social Security Act (SSA) by eliminating the requirement of the annual Part B deductible for colorectal cancer screening tests furnished on or after January 1, 2007.

Additional Information

SE0613 "Colorectal Cancer: Preventable, Treatable, and Beatable: Medicare Coverage and Billing for Colorectal Cancer Screening" contains pertinent information. It may be found on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0613.pdf*.

This special edition also includes links to other resources related to colorectal cancer screening and Medicare-covered preventive services.

The manual attachment to CR 5127 (*Medicare Claims Processing Manual*, Chapter 18, "Preventive and Screening Services", Section 60.1 "Colorectal Cancer Screening; Payment") contains additional information about colorectal cancer screening. CR 5127 is the official instruction issued to your Medicare carrier or fiscal intermediary (FI) regarding changes mentioned in this article. CR 5127 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1004CP.pdf*.

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

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

MLN Matters Number: MM5127
Related Change Request (CR) Number: 5127
Related CR Release Date: July 21, 2006
Related CR Transmittal Number: R1004CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1004, CR 5127

Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims

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

Provider Types Affected

Institutional providers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for their services

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

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

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

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

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

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

- Report the service facility locator loop (2310E) in an 837-I claim whenever the service was furnished at an address other than the address reported on the claim for the billing or pay-to provider.
- Input the taxonomy code in the 837-I provider loop 2000A, but do not report taxonomy in this loop if there is data reported in the service facility locator loop of the claim.
- Submit separate batches of claims for each subpart identified by a different taxonomy code.
- Providers submitting claims for their primary facility and its subparts must submit a nine-digit ZIP code on their claims.
- CMS recommends submitting both the OSCAR number and the NPI on claims submitted through May 22, 2007. (Note that failure to report and OSCAR number that corresponds to your NPI could result in a payment delay.)

Implementation Date

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

Additional Information

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

CR 5243 is the official instruction issued to your Medicare FI/RHHI regarding changes mentioned in this article. CR 5243 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1024CP.pdf*.

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

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

MLN Matters Number: MM5243
Related Change Request (CR) Number: 5243
Related CR Release Date: August 4, 2006
Related CR Transmittal Number: R1024CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1024, CR 5243

Deficit Reduction Act of 2005–Nine-Day Payment Hold

This message is a reminder for all providers and physicians who bill Medicare contractors for their services. A brief hold will be placed on Medicare payments for all claims during the last nine days of the 2006 federal fiscal year (September 22 through September 30, 2006).

These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments.

All claims held during this time will be paid on October 2, 2006.

This policy only applies to claims subject to payment. It does not apply to full denials, no-pay claims, and other nonclaim payments such as periodic interim payments, home health requests for anticipated payments, and cost report settlements.

Please note that payments will not be staggered and no advance payments will be allowed during this nine-day hold.

For more information, please view the MLN Matters article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf*. ❖

Source: CMS Joint Signature Memorandum 06549, July 12, 2006

Impact to Providers Under the Healthcare Integrated General Ledger Accounting System Due to Medicare Payment Hold

Section 5203 of the Deficit Reduction Act of 2006 mandates a **one-time hold** on Medicare payments for the **last-nine days** of the federal fiscal year (FY) 2006 as a method to reduce the Medicare trust fund draws for the FY 2006.

The Centers for Medicare & Medicaid Services (CMS) has instructed Medicare contractors to place a brief hold on Medicare claims subject to payment during the period **of September 22, 2006, through September 30, 2006.**

As stipulated within the law, claims held as a result of this one-time policy will be released for payment on the first business day of October, **which will be October 2, 2006.**

CMS issued change request (CR) 5047 – Hold on Medicare Payments – as the official guidelines regarding the implementation of this mandate.

Impact on Providers under the Healthcare Integrated General Ledger Accounting System

This notification explains the impacts that providers receiving payment under the Healthcare Integrated General Ledger Accounting System (HIGLAS) may encounter with the implementation of CR 5047.

Providers may continue to submit claims as usual for processing and continue to make any corrections through the direct data entry (DDE) process during the timeframe of September 22, 2006, through September 30, 2006. However any payments due and remittance notifications that would have generated during this period will be temporarily held**.** The normal schedule for payments and sending remittance advices will resume after the hold on Medicare payments is completed **on October 2, 2006.**

Payments

All claims processed with a payment **due date as of September 19, 2006,** will be released for payment.

Payments, both checks and electronic fund transfers (EFTs), that would have been issued between **September 22 and September 30, 2006,** will be held.

The following table is a date activity summary scheduled for HIGLAS providers.

HIGLAS Schedule	Date Activity Summary
September 20, 2006	Last payment before HIGLAS hold on Medicare payments.
September 22, 2006	The cycle scheduled for September 22, 2006, will have the pay date **of October 2, 2006.**
September 22, through September 30, 2006	No payments (checks or EFTs) or RAs issued to providers/beneficiaries in compliance with CR 5047 – Hold on Medicare Payments. **Four** financial/HIGLAS cycles scheduled from September 22, through September 30, 2006, will have the payment date **of October 2, 2006.**
September 29, 2006	Financial **HOLD** terminated, cycles/payments return to normal. The payment scheduled for September 29, 2006, will have the payment date **of October 3, 2006.**
October 2, 2006	All held payments (checks and EFTs) as well as RAs will be released to providers/beneficiaries. All payments will be issued under normal processing and in accordance with the regular schedule.

Financial Reporting and Month-End Closing

The October 2, 2006, payment will include all claims eligible to be paid from September 22 through September 30, 2006. As a result, providers can expect to receive some payments later than normal. This may give the appearance that expenditures have decreased in September 2006. Likewise, because all Medicare payments will have been held from September 22, 2006, through September 30, 2006, and paid on October 2, expenditures may appear to be higher than normal in October of 2006, when normal payment processing is reinstated.

Remittance Advices

Since payments are not being issued, electronic remittance advices (ERAs) and paper remittance advices will **not** be available **from September 22, 2006, through September 30, 2006.** Providers will be able to retrieve their ERAs as usual on October 2, 2006.

Voided/Reissued Checks

During the hold on Medicare payments, if a check needs to be voided and subsequently reissued this transaction will take place in HIGLAS, and be processed as normal; **however, no reissued payment will be released prior to October 2, 2006.**

Impact to Providers Under HIGLAS Due to Medicare Payment Hold (continued)

Cost Report Settlements

During the hold on Medicare payments, from September 22, 2006, through September 30, 2006, all cost report settlements and related activities will continue to be processed and entered into the system, **however, payments due to the providers will be held until October 2, 2006.**

Recoupments from Providers

HIGLAS will continue to create payment files using all existing business processes, the key distinction are that all payment files from September 22, 2006, through September 30, 2006, will have a payment date of October 2, 2006, therefore offsets to providers and affiliates will continue to be processed in accordance with HIGLAS business processes. There will be no impact to providers in delays to the recoupment of payable funds applied against Medicare accounts receivables.

Periodic Interim Payments (PIP)

HIGLAS contractors will hold **ALL** payments. This includes periodic interim payments (PIPs) scheduled between September 22, 2006, and September 30, 2006. The payment scheduled for September 29, 2006, will have the payment date **of October 3, 2006.** ❖

Source: CMS Joint Signature Memorandum 06613, August 11, 2006

Planned Release of a Request for Information Concerning the Next Medicare Administrative Contractor Procurements

The Centers for Medicare & Medicaid Services (CMS) announced on July 31, 2006, the awarding of the first of 15 contracts for the combined administration of Part A and Part B claim activities in a multi-state jurisdiction. That first Medicare administrative contractor (MAC) award was for the six-state jurisdiction of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming (Jurisdiction 3).

CMS has 14 more Part A/Part B MAC contracts to acquire through the competitive process. These procurements will be conducted in two cycles. Cycle one of the A/B MAC acquisitions will be for seven jurisdictions, accounting for approximately 45 percent of the Part A/Part B fee-for-service claim workload. CMS will conduct these seven competitions in two rounds.

The first round of competitions under cycle one will cover three jurisdictions:

- Jurisdiction 4 (J4) – Colorado, Oklahoma, New Mexico, and Texas
- J5 – Iowa, Kansas, Missouri, and Nebraska
- J12 – Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania

The request for proposal for this first round of competitions under cycle one will include mandatory options for the following specialty activities:

- Indian health services for J4
- Veterans Affairs Medicare equivalent remittance advice for J4
- Centralized billing for mass immunizers and for J4
- Rural community hospitals, which will also be required for J4 and J5.

On Wednesday, August 9, 2006 CMS published on the Federal Business Opportunities website (http://www.FedBizOpps.gov) a request for information (RFI) containing the planned SOW (scope of work) for the second round of competitions under cycle one. Public comments will be due on Thursday, August 31. CMS encourages everyone to review the RFI and provide comments or questions.

You will find guidance on how/where to submit comments and questions about the RFI on that same FedBizOpps site.

The second round of competitions under cycle one will include the remaining jurisdictions:

- J1 – American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands
- J2 – Alaska, Idaho, Oregon and Washington
- J7 – Arkansas, Louisiana and Mississippi
- J13 – Connecticut and New York

The RFP for this second round of competition will include the following mandatory options:

- Competitive acquisition program (CAP) for Part B Drugs
- Rural community hospital for J1, and J2

To learn more about the transition to the A/B MAC environment, please visit the Medicare Contracting Reform website at: http://www.cms.hhs.gov/MedicareContractingReform/. ❖

Source: CMS Provider Education Resource 200608-03

CMS Awards the First of 15 Medicare Administrative Contractors To Process Part A and Part B Medicare Claims

The Centers for Medicare & Medicaid Services (CMS) has announced the award of the first of 15 contracts for the combined handling in six states of both Part A and Part B Medicare claims.

The winning contractor is Noridian Administrative Services, LLC, (NAS), headquartered in Fargo, N.D.

As the new Part A/Part B Medicare administrative contractor (A/B MAC), NAS will serve as the first point-of-contact for processing and paying fee-for-service claims from hospitals and other institutional providers, physicians, and other practitioners in Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming.

"The contract award is a major step to improved Medicare service for beneficiaries and providers, and significant cost savings from greater efficiency in managing the original fee-for-service Medicare program," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "Noridian Administrative Services was selected through a full and open performance-based competition to administer the program as effectively and efficiently as possible."

The A/B MAC contract, which has a value of $28.9 million for the first year of performance, is the first of 15 to be awarded by 2011 to fulfill requirements of the contracting reform provisions of the Medicare Modernization Act of 2003. NAS will immediately begin implementation activities and will assume full responsibilities for the claims processing work in its six-state jurisdiction no later than March 2007.

For more information, see: *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1919*. ❖

Source: CMS Provider Education Resource 200607-17

Role of a Medicare Fiscal Intermediary Versus a Medicare Carrier

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that runs the Medicare program and ensures that the Medicare beneficiaries are able to get high quality health care. CMS contracts with private companies to administer the primary parts of the program: the hospital insurance – commonly known as Medicare Part A, and the medical insurance – commonly known as Medicare Part B.

A **contractor** having an agreement with CMS to administer Medicare Part A is designated as a **fiscal intermediary** (FI) and a **contractor** administering Medicare Part B is known as a **carrier**.

Role of a Medicare Fiscal Intermediary

Any organization and institution that provides health care services to Medicare beneficiaries can bill their designated **FI** for institutional benefits. Providers billing institutional medical services to **FIs** are:

- Hospital (acute and critical care)
- Skilled nursing facilities (SNFs)
- End-stage renal disease facilities (stand-alone clinics and hospital-based renal dialysis units)
- Rural health clinics
- Hospice centers
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Outpatient rehabilitation facilities (ORFs)
- Community mental health centers (CMHCs)
- Home health agencies (HHAs).

All requests for payment submitted to a **FI** must be billed on the uniform institutional claim form CMS-1450 or its electronic equivalent format.

For electronic claim submission, Part A claims must follow the billing guidelines established by ANSI 837 as specified in the *ANSI 4010A1x096 Institutional Implementation Guide*.

Role of a Medicare Carrier

Any medical professional individual or organization that provides health care services to Medicare beneficiaries can bill their designated **carrier** for medical benefits. Providers billing medical services to Medicare **carrier** are:

- Physicians and nonphysician practitioners (individual and group centers)
- Ambulatory surgical centers (ASCs)
- Ambulance services centers
- Anesthesiologist centers
- Clinical laboratory centers
- Durable medical equipment suppliers
- Prosthetic and orthotic providers
- Pharmacy centers

Medicare Part B coverage helps pay for medically necessary physicians' services, nonphysician practitioners' services and a variety of other medical services such as:

- Medical and surgical services, including anesthesia
- Diagnostic tests and procedures which are part of a normal course of treatment
- Radiology and pathology services
- Screening mammographies and pelvis examinations
- Colorectal cancer screenings
- Drugs and biological substances that cannot be self-administered
- Medical supplies
- Physical/occupational therapy and speech therapy services
- Ambulance transportation
- Hepatitis B, pneumococcal and influenza vaccines
- Durable medical equipment.

Role of a Medicare Fiscal Intermediary Versus a Medicare Carrier (continued)

All requests for payment submitted to a Medicare **carrier** must be billed on the uniform professional claim form CMS-1500 or its electronic equivalent format.

For electronic claim submission, Part B claims must follow the billing guidelines established by ANSI 837 as specified in the *ANSI 4010A1x098 Professional Implementation Guide*.

For additional information contact First Coast Service Options, Inc. Medicare Part A Customer Service Center toll-free number at 1-877-602-8816. ❖

Source: CMS Joint Signature Memorandum 06604, August 3, 2006

Avoid Errors that Delay Reimbursement

Many problems are encountered with **cost outlier** claims due to incorrect billing. When billing a cost outlier claim, it is very important to have all the following billing elements correct, if applicable:

- Covered accommodation units
- Benefit days
- Applicable occurrence codes
- Correct covered charges
- Correct noncovered charges

If it is necessary to bill noncovered accommodation units, there should also be noncovered ancillary charges that correspond to the noncovered units. If you are unsure about these elements, submit your outlier claim as fully covered and allow the fiscal intermediary (FI) to return the claim after processing through the Fiscal Intermediary Shared System (FISS). Also, when conducting research on the benefit period via EMC or DDE, it is important to use the ELGA inquiry screen and not the HIQA inquiry screen due to the HIQA inquiry screen not reflecting the most current benefit period information.

Save money and reduce rework – Provide accurate information and submit your claims timely.

The time limit is *two* years after the year in which the services were furnished.

Note: A short narrative explaining why the time limit should be bypassed is required for the claim to be considered for payment.

Claim Processing Requirements

Transition Plans for Medicare Part A Providers To a National Provider Identifier (NPI) Number

- The NPI will be the standard unique health identifier for **all** health care providers.
- The NPI will take the place of the OSCAR number (legacy number) and eventually eliminate the use of the unique physician identification number (UPIN).

Dates To Remember

- **January 3, 2006 – October 1, 2006**
  NPI optional, but legacy number required
- **October 2, 2006 – May 22, 2007**
  NPI and legacy number
- **May 23, 2007 – Forward**
  NPI **only** (except for small health plans)

Where To Obtain More Information

- *https://nppes.cms.hhs.gov/NPPES/Welcome.do*
  - Web-based applications
  - Paper applications
- 1-800-465-3203 or TTY 1-800-892-2326
- *http://www.cms.hhs.gov/MLNGenInfo/*
  - Explains NPI
  - Provides description of the system
  - Navigates you through the application
- Special Edition MLN Matters articles
  - SE0528 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0528.pdf) – CMS Announces the National Provider Identifier Enumerator Contractor and Information on Obtaining NPIs
  - SE0555 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf*) – Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities. ❖

Disclosure Desk Reference for Provider Contact Centers

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

Provider Types Affected

All physicians, providers, and suppliers billing Medicare

Provider Action Needed

STOP – Impact to You

When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

CAUTION – What You Need to Know

CR 5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

GO – What You Need to Do

Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

Background

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare PCCs must first authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

CR 5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request beneficiary protected health information.
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements. Below is the authentication guidance that the PCCs will be using:

Telephone Inquiries
Provider Authentication

CSR Telephone Inquiries – Through May 22, 2007, customer service representatives (CSR) will authenticate providers using provider number and provider name.

Interactive Voice Response Telephone Inquiries – Through May 22, 2007, IVRs will authenticate providers using only the provider number.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007.

Written Inquiries
Provider Authentication

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007.

At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider's official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider's name and address are included in the letterhead and clearly establish the provider's identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on Remittance Advice (RAs) or Medicare summary notices (MSNs), will be authenticated the same as written inquiries,(explained above) using provider name and the provider number.

Insufficient or Inaccurate Requests

You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information will be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms, will be returned in their entirety by regular mail, with a note stating that the

Disclosure Desk Reference for Provider Contact Centers (continued)

requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record.

Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

Beneficiary Authentication

Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

1) Last name
2) First name or initial
3) Health insurance claim number
4) Either date of birth (eligibility, next eligible date, certificate of medical necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) [pre-claim]) **or** date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR 5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR 5089 is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf*.

Special Instances

Below are three special instances that you should know about.

Overlapping Claims

Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

Sometimes this happens when the provider is seeking to avoid have a claim be rejected, for example:

- When some end state renal disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or
- Skilled nursing facility and inpatient hospital stays.

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

Pending Claims

A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including Internal Control Number (ICN), pay date/amount or denial, as long as all authentication requirements are met.

Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

Deceased Beneficiaries

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

Final Note: More information will be provided in a future MLN Matters article about authentication on and after May 23, 2007, the implementation date for the National Provider Identifier or NPI.

Additional Information

You can find more information about provider contact center guidelines concerning authentication by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf*.

Attached to that CR, you will find the updated *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100.09), Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information); and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information).

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

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

MLN Matters Number: MM5089
Related Change Request (CR) Number: 5089
Related CR Release Date: July 21, 2006
Related CR Transmittal Number: R16COM
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-09, Transmittal 16, CR 5089

Health Care Quality Leaders Join Forces

AQA and HQA Collaborate to Expedite National Quality Strategy

Two key health care quality alliances, the AQA alliance and the Hospital Quality Alliance (HQA), have formed a new national Quality Alliance Steering Committee to better coordinate the promotion of quality measurement, transparency and improvement in care.

Through the joint efforts of the AQA – an alliance of 135 physician organizations, consumers, employers and health plan representatives that makes available quality information about physician care – and the HQA – a coalition of hospitals, nurses, physician organizations, accrediting agencies, government, consumers and business that shares quality information about key aspects of hospital care – Americans will have helpful information on health care available through the Internet.

The new steering committee will work closely with the Centers for Medicare & Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ), which are key members of both the AQA and HQA.

As a first step, this new steering committee will coordinate and expand several ongoing pilot projects that are designed to combine public and private information to measure and report on performance in a way that is fully transparent and meaningful to all stakeholders.

In March 2006, the AQA alliance announced six pilot projects charged with the responsibility of identifying, collecting and reporting data on the quality of physician performance across care settings. The joint steering committee will explore options for expanding these pilots to include hospital and cost-of-care measures. The committee also will develop a strategy to expand the number of pilots.

The HQA has been providing meaningful and useful information on the quality of heart attack, heart failure and pneumonia care to patients in more than 4,000 of the nation's hospitals since April 2005. In September 2005, the HQA expanded its Web site to include information on prevention of surgical wound infections, and has plans to add many additional aspects of care over the next couple of years.

"This collaborative effort is an important step toward the critical goals of enabling consumers to make more informed health care decisions and supporting improvements in the quality and cost of health care in the United States," said Dr. Mark McClellan, administrator of the Centers for Medicare & Medicaid Services.

A key responsibility of the steering committee will be to consider how best to expand the scope, speed and adoption of the work of AQA and HQA.

"This new steering committee will help coordinate efforts across a broad spectrum of crosscutting issues as the two organizations continue working toward a more uniform approach to measuring and reporting hospital and physician performance nationwide," said Dr. Carolyn Clancy, AHRQ director.

The new joint steering committee comprises physicians, hospitals, consumers, and employers and includes Janet Corrigan, National Quality Forum; Robert Dickler, Association of American Medical Colleges; Karen Ignagni, America's Health Insurance Plans; Chip Kahn, Federation of American Hospitals; Peter Lee, Pacific Business Group on Health; Debra Ness, National Partnership for Women & Families; Nancy Nielsen, American Medical Association; Margaret O'Kane, National Committee for Quality Assurance; Jeff Rich, Society of Thoracic Surgeons; Gerry Shea, AFL- CIO; John Tooker, American College of Physicians; and Rich Umbdenstock, American Hospital Association.

About the AQA Alliance

The AQA alliance is a broad-based national coalition of more than 135 organizations that seeks to improve health care quality through a process in which key stakeholders agree on a strategy for measuring, reporting, and improving performance at the physician level. These 135 organizations represent physicians, consumers, employers, government, health insurance plans, and accrediting and quality organizations. For further information, visit *http://www.aqaalliance.org*.

About the Hospital Quality Alliance

The Hospital Quality Alliance (HQA) is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. The goal of the voluntary program is to collect and report data on a robust set of standardized and easy-tounderstand hospital quality measures. The hospital quality information is available on the Web at *http://www.hospitalcompare.hhs.gov/*. ❖

Source: CMS Provider Education Resource 200607-13

Sign up to our *eNews* electronic mailing list

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

New Site for Medicare Provider Service Toll Free Numbers

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Impact on Providers

This article is mainly for informational purposes and discusses a new and more convenient web address and site that houses toll-free numbers that physicians, providers, and suppliers can use to contact their Medicare contractor (carriers, including durable medical equipment (DME) regional carriers and DME Medicare administrative contractors (DME MACs), and fiscal intermediaries, including regional home health intermediaries (RHHIs).

Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce to all Medicare physicians, providers, and suppliers a new and improved website for accessing Medicare Contractor Provider Call Center toll-free number information.

The new site is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

This change is a result of replacing the previous "Provider Call Center Toll-Free Numbers Directory" (with map) document with an Excel® file that contains all of the information previously available plus many improvements.

The original document proved difficult to update and download while keeping the functionality of the map intact. The new Excel smaller file size allows for a significantly faster download, and the improved functionality, provided by the pull down menus, makes more targeted contact information available while filtering the displays appearing on the screen.

Additionally, a "Coverage Area" column has been added to the original four columns of information (i.e., State Served, Call Center, Program, and Toll-Free Number) and each column has a menu allowing users to filter the information displayed on the screen. Selecting the menus to "ALL" resets the spreadsheet to display all available information.

Many of the existing *MLN Matters* articles contain links to the previous map document, which was on the CMS website **at** *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf*.

As you can see, the new address is almost identical, except for the last three characters, "*pdf*," which are now "*zip*."

Please be aware that articles already housed on the MLN Matters pages will not be updated with the new link, except where such articles are revised in the future for other reasons. However, those providers who have been using the map document directory should already know where to find it within the CMS website and should, therefore, be able to locate the new document.

The directory is also prominent on all MLN pages and should be easy to find. In fact, now might be a good time to bookmark the new address or add it to your "Favorites" list:

http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.

The new spreadsheet directory will be updated approximately once every three months—more often if necessary.

As previously mentioned, you can access the new file from all major MLN Web pages, including the main section pages at:

http://www.cms.hhs.gov/MLNGenInfo/

http://www.cms.hhs.gov/MLNProducts/

http://www.cms.hhs.gov/MLNMattersArticles/

http://www.cms.hhs.gov/MLNEdWebGuide/

The new file may be downloaded directly from the CMS website *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

CMS hopes you find this new site to be useful and we invite your comments and feedback on this and other Medicare Learning Network Web-based products. You can provide such feedback by going to the CMS website *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/site_fdbck.php*.

MLN Matters Number: SE0655
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0655

Revised 2006 Durable Medical Equipment Prosthetics, Orthotics and Supplies Fee Schedule Files—Correction

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment (DME) regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), 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.

Revised 2006 DMEPOS Fee Schedule Files—Correction (continued)

Background

The purpose of this special edition article is to **alert providers to the revision regarding the DME fee schedule amounts for** transcutaneous electrical joint stimulation device system – **HCPCS** (Healthcare Common Procedure Coding System) **code E0762.**

Key Points

- In accordance with Transmittal 928 (CR 5017), July Quarterly Update for 2006 DMEPOS Fee Schedule, DMEPOS fee schedule files, which included fee schedule amounts for HCPCS code E0762 were released for claims with dates of service on or after January 1, 2006. (There is an *MLN Matters* article associated with CR 5017 on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5017.pdf*.)
- To allow for additional time to address technical concerns raised regarding the calculation of fee schedule amounts for code E0762, CMS is revising the files to remove the fee schedule amounts for code E0762.
- Until further notice, Medicare contractors (carriers, FIs, DMERCs and DME MACs) will determine the Medicare allowed payment amount for claims submitted using a HCPCS code based on their individual consideration of each claim. This code remains in the DME category for inexpensive or routinely purchased items in accordance with Transmittal 928.

Additional Information

Transmittal 928 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R928CP.pdf*.

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

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

MLN Matters Number: SE0650
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0650

MEDICARE SECONDARY PAYER

Medicare Secondary Payer Liability/Workers' Compensation Telephone Service Availability

On March 10, 2006, the Centers for Medicare & Medicaid Services (CMS) announced its plan to transition Medicare Secondary Payer (MSP) post-payment activities to a new national MSP Recovery Contractor (MSPRC). In preparation for this transition, CMS has instructed fiscal intermediaries to discontinue offering a telephone option with regard to MSP post-payment inquiries.

Based on the CMS MSPRC initiative, CMS is further directing that the current MSP Liability telephone service line (1-904-791-6181) be discontinued **effective August 7, 2006.**

Although FCSO can no longer accept or respond to these calls, the following services remain available:

- To provide Medicare with **settlement information**, please fax the documentation to 1-904-791-8337.
- To request the Medicare **conditional payment amount** for your case, please submit your request in writing to:

  FCSO MSP Liability
  P.O. Box 44179
  Jacksonville, FL 32231-4179
- To notify Medicare about **a new liability case**, please call the Coordination Of Benefits contractor at 1-800-999-1118 (COBC).
- For **general liability inquiries**, please submit your request in writing to:

  FCSO MSP Liability
  P.O. Box 44179
  Jacksonville, FL 32231-4179

Note: These inquiries will be handled in order of receipt.

On behalf of CMS, FCSO apologies for any inconvenience this may cause. ❖

Source: CMS Joint Signature Memorandum 06598, August 3, 2006

NATIONAL PROVIDER IDENTIFICATION

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims

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

Provider Types Affected

Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries

Provider Action Needed

STOP – Impact to You

You must report your national provider identifier (NPI) correctly on all electronic data interchange (EDI) transactions that you submit, as well as on paper claims you send to Medicare and telephone interactive voice response (IVR) queries **by no later than May 23, 2007, or your transactions will be rejected.**

CAUTION – What You Need to Know

Carriers have reported errors on claims (see Background, below) that will impact your payment when you begin to submit NPIs. Although not mandated until May 23, 2007, providers are currently allowed to submit NPIs in Medicare transactions other than paper claims. NPI will be accepted on the revised paper claim CMS-1500 (0805) and UB-04 forms early in 2007.

GO – What You Need to Do

Make sure that your billing staffs are using your NPI correctly when they submit your claims for services provided to Medicare beneficiaries or submit electronic beneficiary or claim status queries to Medicare.

Background

All HIPAA covered health care providers who would either bill Medicare; render care to Medicare beneficiaries; order durable medical equipment, supplies, or services for beneficiaries; refer beneficiaries for other health care services; act as an attending physician when a beneficiary is hospitalized; prescribe covered retail prescription drugs for beneficiaries; operate on beneficiaries; or could otherwise be identified on a claim submitted to Medicare for payment **must** obtain an NPI. This applies whether providers are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, managed care organizations, suppliers of durable medical equipment, pharmacies, etc.) **must** obtain an NPI for use to identify themselves in HIPAA standard transactions.

Although the NPI requirement applies by law to covered entities such as health care providers, health care clearinghouses, and health plans in the U.S. when exchanging electronic transactions for which a national standard has been adopted under HIPAA, HIPAA permits healthcare plans to elect to require reporting of NPIs in paper claims and for non-HIPAA transaction purposes.

Medicare will also require NPIs for identification of all providers listed on the UB-04 institutional paper claim form and of physicians and suppliers listed on the revised CMS-1500 (08-05) professional paper claim form by May 23, 2007.

Medicare will reject paper claims received after May 22, 2007, that do not identify each provider, physician or supplier listed on a paper or electronic claim with an NPI. Medicare will also begin to require an NPI in interactive voice response (IVR) queries effective May 23, 2007.

Retail pharmacies are required to use the NCPDP format adopted as a HIPAA standard for submission of prescription drug claims to Medicare. Since that format permits entry of only one provider identifier each for a pharmacy and the physician who prescribed the medication, retail pharmacies that use the NCPDP HIPAA format can use either their National Supplier Clearinghouse (NSC) number or their NPI to identify themselves, and either the unique provider identification number (UPIN) or the NPI to identify the prescribing physician prior to May 23, 2007.

May 23, 2007 and later, only an NPI may be reported for identification of pharmacies and prescribing physicians. NCPDP claims received by Medicare after May 22, 2007 that lack an NPI for either the pharmacy or the prescribing physician will be rejected.

This being said, Medicare carriers and fiscal intermediaries (FIs) have reported receiving X12 837-P (professional) and X12-837–I (institutional) claims containing errors that will result in claim rejection, and/or processing delays, if they continue to occur once NPI reporting begins.

Some of the errors seen by Medicare carriers include the following:

Incorrect information in the 2010A/A Billing Provider Loop in X12 837-P Claims

Prior to May 23, 2007, carriers will reject claims when the NPI in a loop does not belong to the owner of the PIN or UPIN that should also be reported in REF02 of the same loop, or if the name and address of the provider in that loop do not correlate with either the NPI, PIN or UPIN in the same loop. The same edits will also be applied to NPIs when received on paper claims prior to May 23, 2007.

Carriers have also detected claims where the rendering physician's or supplier's NPI is reported in the 2010A/A NM1 segment when the claim was submitted by a group to which the physician belongs or the home office of a chain to which a supplier belongs. The 2010A/A loop of an 837-P claim must contain the identifier that applies to the groups/chains (NPI entity 2) that submitted the claims. This rule also applies to identification of the billing provider on a paper claim. Information concerning a billing agent or a healthcare clearinghouse may never be reported in the billing provider loop for a Medicare claim.

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims (continued)

To prevent this error, you must report the rendering physician's or supplier's NPI in the NM109 data element in the rendering provider claim level loop (2310B), unless multiple services were furnished by different members of the group/chain.

If multiple rendering providers were involved, the information for each must be reported in the service level 2420A loop along with the service(s) each of them rendered.

To facilitate claim processing prior to May 23, 2007, you should also report the rendering provider(s) PIN(s) as the REF02 data element with 1C in REF01 in that same rendering provider loop (2310B for the claim or 2420A for individual services, as applicable).

Reporting of the Pay-to Address in the Billing Provider (2010A/A) Loop

Once NPI reporting begins, carriers will reject claims when the pay-to-address, if different than the actual practice location address, is in the 2010A/A (billing provider) loop, rather than in the 2010A/B (pay-to-provider) loop.

> **When groups or organizations submit claims, and the billing and the pay-to providers are different individuals or entities, the pay-to information must always be reported in the 2010A/B loop and the billing provider information in the 2010A/A loop.**

Reporting of the Name and Address of a Billing Provider in the 2010A/A Loop of an X12 837-I (Institutional) Electronic Claim

FIs will reject claims in which the billing provider and the rendering provider are different entities, and you report the billing provider's name and address in the 2010A/A loop of an X12 837-I (institutional) electronic claim, and the OSCAR number of the rendering provider in that same loop.

If the home office of a chain has obtained one NPI for all facilities it owns, or one of a chain's facilities bills for all (or other) facilities owned by that chain, or a hospital bills for its special units, the home office, hospital or other facility submitting those claims is considered a form of billing agent for Medicare purposes.

In this instance, you must identify the specific provider, for whom the claim is being submitted, as the billing provider for that claim. If a provider that furnished the care had a separate OSCAR (online survey certification and reporting) system number than the entity submitting its claims, the provider that furnished the care must be identified in the billing provider loop. You must also report the name of the facility for whom the claim is being submitted, that facility's address, and should report applicable NPI (when obtained prior to May 23, 2007), as well as the Medicare OSCAR number assigned to that provider in the 2010A/A (billing provider) loop of the claim.

If the home office, hospital or other entity that prepared the claim is to be sent payment for the claim, you must report the name and address, and should report the NPI if issued, and the applicable OSCAR number associated with that entity in the 2010A/B (pay-to-provider) loop prior to May 23, 2007.

However, you should note that Medicare will not issue payment to a third party for a provider solely as result of completion of the 2010A/B loop of an electronic claim.

The facility that furnished the care, or the established owner of that facility, must have indicated on their CMS-855 provider enrollment form filed when that facility enrolled in Medicare (or via a subsequent CMS-855 used to update enrollment information) that payments for that facility are to be issued to that home office, hospital, other facility or an alternate third party.

For those providers still permitted to submit any paper claims under the restrictions imposed by the Administrative Simplification Compliance Act, Medicare plans to begin accepting paper claims on the revised CMS-1500 (08-05 version) beginning January 2, 2007 (allowing you to report a provider's NPI as well as the applicable PIN or UPIN); and on the revised UB-04 (CMS-1450) form beginning March 1, 2007 (allowing you to report a provider's NPI as well as the applicable OSCAR or UPIN). Medicare carriers plan to reject "old" CMS-1500 forms received after March 31, 2007, and FIs plan to reject UB-92 forms received after April 30, 2007.

Note: Medicare does not accept NPIs on the "old" versions of the CMS-1500 or UB-92 forms. There are no fields on those forms designed for NPI reporting.

CMS highly recommends that for electronic or paper Medicare claims that you submit during the transition period to full NPI implementation on May 23, 2007, you include both the NPI and the Medicare legacy identifier of each provider for whom you report information.

- When you report an NPI on a claim sent to a carrier for a referring, ordering, purchased service or supervising physician, or for a provider listed in the service facility locator loop, use a UPIN as the Medicare legacy identifier.
  Furthermore, if any of those physicians are not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007, you should report OTH000 as the UPIN.
- When you report an NPI on a claim sent to an FI for an attending, operating or other physician, or in the service facility locator loop (when those loops apply), you should also report the provider's UPIN. And as above, you may report OTH000 as the surrogate UPIN if any of those providers is not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007.
- Finally, when you report an NPI for a billing, pay-to, or rendering provider identified on a claim sent to a carrier, you should also report the valid Medicare PIN that applies to that physician or supplier. Additionally, you should always report an OSCAR number for each billing, pay-to, or possibly a service facility locator loop provider identified on a claim sent to an FI, as well as the NPI if issued to each of those providers, prior to May 23, 2007.

Remember that failure to report information as described here may result in delayed processing or rejection of your claims.

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims (continued)

You may find more information about NPI by going to the NPI page on the CMS website at *http://www.cms.hhs.gov/apps/npi/01_overview.asp*.

In addition, if you have any questions on the NPI, you may call your carrier or FI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: SE0659
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0659

Additional Information Regarding National Provider Identifier as Contained in Change Request 4320

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors – carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)

Impact on Providers

This article is based on change request CR 5217, which instructs your Medicare carrier/DMERC/DME MAC, or FI/RHHI to provide specific national provider identifiers (NPIs) for those providers identified in electronic claims, such as a billing, pay-to, rendering or other provider, that have already obtained NPIs.

Prior to May 23, 2007, providers should report the Medicare legacy identifiers of those providers enrolled to submit claims to Medicare, as well as their NPI.

Note: Pending Medicare implementation of the UB-04 and the revised CMS-1500, providers are not to report NPIs on the current paper claim forms.

If not already available, the following information will be posted on your local Medicare contractor's website, or included in provider newsletters from your local Medicare contractor:

- Adjustments to edits to be applied when an NPI is included in an electronic data interchange (EDI) transaction.
- Actions that can be taken by claim and 276 submitters to avoid rejection of their transactions as result of these edits, and information about how to correct and resubmit a transaction if the transactions are rejected as result of these edits.

Additional Information

CR 4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" may be located on the CMS web site at *http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf*.

MM4320, the similarly titled Medicare Learning Network (MLN) article associated with CR 4320, is found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf*.

CR 5217 is the official instruction issued to your Medicare carrier/DMERC/DME MAC/FI/RHHI regarding changes mentioned in this article. CR 5217 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R235OTN.pdf*.

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

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

MLN Matters Number: MM5217
Related Change Request (CR) Number: 5217
Related CR Release Date: August 18, 2006
Related CR Transmittal Number: R235OTN
Effective Date: January 1, 2006
Implementation Date: November 20, 2006

Source: CMS Pub. 100-20, Transmittal 235, CR 5217

National Provider Identifiers Are Free

NPI: Get It. Share It. Use It.

As the industry transitions to the National Provider Identifier (NPI) compliance, remember that there is no charge to get an NPI.

Providers may apply online for their NPI, free of charge, by visiting *https://nppes.cms.hhs.gov* or by calling 1-800-465-3203 to request a paper application.

The CMS NPI page, located at *http://www.cms.hhs.gov/NationalProvIdentStand/*, is the only source for official CMS education and information on the NPI initiative; all products located on this site are free of charge.

CMS continues to urge providers to include legacy identifiers on their NPI applications, not only for Medicare but also for all payers. If reporting a Medicaid number, include the associated state name. If providers have already applied for their NPI, the Centers for Medicare & Mediciad (CMS) asks them to go back into the NPPES and update their information with their legacy identifiers. This information is critical for payers in the development of crosswalks to aid in the transition to the NPI.

Getting an NPI is free—not having one can be costly. ❖

Source: CMS Provider Education Resource 200607-15

National Provider Identifier Roundtable

NPI: Get It. Share It. Use It

The Centers for Medicare & Medicaid Services (CMS) will host a national provider identifier (NPI) roundtable; open to all health care professionals:

Date: Tuesday, September 26, 2006

Time: 2:00-3:30 p. m. EST

Conference Phone Number: 1-877-203-0044

Pass Code: 4795739

Deadline for Questions: Friday, September 8, 2006

CMS will address common questions related to Medicare's guidance on subparts. While CMS will only address questions from a Medicare perspective, this information may be helpful to all providers. Questions received after the deadline date will not be considered.

Where to Send Questions

Medicare providers who bill a fiscal intermediary:
NPIQuestionsfromFIBillers@cms.hhs.gov

Medicare providers who bill a carrier:
NPIQuestionsfromCarrierBillers@cms.hhs.gov

Medicare providers who bill a durable medical equipment regional carrier (DMERC):
NPIQuestionsfromDMERCBillers@cms.hhs.gov.

Think You Don't Need an NPI? Think Again

Even those providers who do not bill for services may need to disclose their NPIs to those providers who do (e.g., physicians who order lab tests or refer patients for diagnostic testing must be identified on the lab's or testing facility's claims).

Even if you plan to retire in April, but know that some of your claims will not be submitted until after the May 23, 2007, compliance date, you still need an NPI. Without the NPI, those claims may be adversely affected, with payment delayed or possibly even denied.

Reminder to Supply Legacy Identifiers on NPI Application

CMS continues to urge providers to include legacy identifiers on their NPI applications.

This will help all health plans, including Medicare, to get ready for May 23, 2007. If reporting a Medicaid legacy number, include the associated state name. If providers have already been assigned NPIs, CMS asks them to consider going back into the NPPES (national plan and provider enumeration system) and updating their information with their legacy identifiers if they did not include those identifiers when they applied for NPIs. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

New NPI Slogans and Partnership with WEDI

Recently, CMS and the Workgroup for Electronic Data Interchange (WEDI) agreed to common NPI slogans for use in outreach campaigns. These slogans appear at the beginning and end of this listserv message, and will continue to appear on our messages and products. A recent WEDI press release, found at *http://www.wedi.org/npioi/public/articles/dis_viewArticle.cfm?ID=537*, discusses the slogans and partnership in more detail.

Special Information for Medicare Providers

Designation of Subparts

CMS reminds Medicare providers to visit Medicare's Subparts Expectation Paper (located at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf* on the CMS NPI Web page) for more suggestions on how to determine their subparts. Remember, no health plan, not even Medicare, can instruct a provider on how to enumerate subparts. This is a business decision that the organization provider must make considering its unique business operations.

Medicare Provider Enrollment and NPIs

CMS requires that providers and suppliers obtain their NPIs prior to enrolling in Medicare or updating their Medicare enrollment information. Providers and suppliers must enter their NPIs on the CMS-855 Medicare provider enrollment applications and submit a copy of their NPI notifications with each CMS-855 application that they submit.

Required Use of NPI on Medicare Paper Claim Forms

Medicare will require the NPI on its paper claim forms. To learn more visit a recent *MLN Matters* article on this topic on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm4023.pdf*.

Medicare DME Suppliers and NPIs

CMS issued a special communication regarding DME suppliers and the NPI that may be viewed on the CMS website at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/npi_dme_comm.pdf*.

Medicare to Require Taxonomy Codes on Institutional Claims

Effective January 1, 2007, institutional Medicare providers (e.g., hospitals, HHAs, SNFs) who submit claims for their primary facility and its subparts must report a taxonomy code on all claims submitted to their fiscal intermediary. To learn more, visit a recent MLN Matters article on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5243.pdf*.

Use of NPI on Medicare Claims on October 1st

Beginning October 1, 2006 Medicare can accept claims that only have an NPI on them, however, to facilitate further testing, Medicare strongly encourages its providers to submit **both** legacy identifiers and their NPI on claims.

As always, more information and education on the NPI may be found on the CMS website at the CMS NPI page *http://www.cms.hhs.gov/apps/npi/*.

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

Getting an NPI is free – not having one can be costly. ❖

Source: CMS Provider Education Resource 200608-10

Sign up to our *eNews* electronic mailing list

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

GENERAL COVERAGE

Medicare Provides Coverage for Diabetes-screening Tests for Eligible Medicare Beneficiaries—Reminder

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals who provide referrals for and/or file claims for Medicare-covered diabetes-screening tests

Provider Action Needed

This article serves as a reminder that Medicare provides coverage of diabetes-screening tests for eligible Medicare beneficiaries. We need your help in ensuring that Medicare beneficiaries are assessed for and informed about their risks factors for diabetes or prediabetes, and that those who are eligible take full advantage of the Medicare diabetes screening benefit.

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) expanded preventive services covered by Medicare to include diabetes-screening tests, effective for services provided on or after January 1, 2005, for beneficiaries at risk for diabetes or those diagnosed with prediabetes.

The information in this special edition *MLN Matters* article reminds health care professionals about the coverage, eligibility, frequency, and coding guidelines for diabetes-screening tests so that you can talk with your Medicare patients about this preventive benefit and file claims properly for the screening service.

Tests Included

Coverage includes the following diabetes-screening tests:

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

Note: Other diabetes screening blood tests for which the Centers for Medicare & Medicaid Services (CMS) has not specifically indicated national coverage continue to be noncovered.

Eligibility

Medicare beneficiaries who have any of the following risk factors for diabetes are eligible for this screening benefit:

- Hypertension
- Dyslipidemia
- Obesity (a body mass index equal to or greater than 30 kg/m2), or
- Previous identification of elevated impaired fasting glucose or glucose tolerance.

OR

Medicare beneficiaries who have a risk factor consisting of at least two of the following characteristics are eligible for this screening benefit:

- Overweight (a body mass index > 25, but < 30 kg/m2)
- A family history of diabetes
- Age 65 years or older
- A history of gestational diabetes mellitus, or delivering a baby weighing > nine pounds.

Note: No coverage is permitted under the MMA benefit for beneficiaries previously diagnosed with diabetes since these individuals do not require screening.

Frequency

- Beneficiaries diagnosed with prediabetes:
  - Medicare provides coverage for two diabetes-screening tests per year (once every six months) for beneficiaries diagnosed with pre-diabetes.
- Beneficiaries not previously diagnosed with pre-diabetes:
  - Medicare provides coverage for one screening per year for beneficiaries who were previously tested who were not diagnosed with prediabetes, or who have never been tested.

Note: A physician or qualified nonphysician practitioner must provide the Medicare beneficiary with a referral for the diabetes-screening test (s).

Claim Filing Information

The following *CPT (Current Procedural Terminology)* codes, diagnosis code, and modifier **must** be used when filing claims for diabetes-screening tests:

***CPT* Codes**	**Code Descriptors**
82947	*Glucose; quantitative, blood (except reagent strip)*
82950	*Glucose; post glucose dose (includes glucose)*
82951	*Glucose; tolerance test (GTT), three specimens (includes glucose)*

Diagnosis Code V77.1

To indicate that the purpose of the test(s) is for diabetes screening for a beneficiary that *does not* meet the *definition of prediabetes, screening diagnosis code V77.1 is required in the header diagnosis section of the claim.

To indicate that the purpose of the test (s) is for diabetes screening for a beneficiary that meets the *definition of prediabetes, screening diagnosis code

Medicare Provides Coverage for Diabetes-screening Tests for Eligible Medicare Beneficiaries (continued)

V77.1 is required in the header diagnosis section of the claim **and** modifier "TS" (follow-up service) is to be reported on the line item.

***Definitions**

Diabetes: Diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on two different occasions; a two-hour post-glucose challenge > 200 mg/dL on two different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

Prediabetes: Abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to 125 mg/dL, or a two-hour post-glucose challenge of 140 to 199 mg/dL. The term "prediabetes" includes impaired fasting glucose and impaired glucose tolerance.

Payment for Diabetes-screening Tests

Medicare will pay for diabetes-screening tests under the Medicare clinical laboratory fee schedule. Medicare beneficiaries can receive the diabetes-screening test at no cost to them. There is no coinsurance, co-payment, or deductible for this benefit.

For More Information

For more information about Medicare's diabetes screening benefit, visit the CMS diabetes screening Web page on the CMS website at *http://www.cms.hhs.gov/DiabetesScreening/*.

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

- The MLN Preventive Services Educational Products Web page provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- The CMS website provides information for each preventive service covered by Medicare. Visit *http://www.cms.hhs.gov*, select "Medicare," and scroll down to "Prevention."

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

Medicare beneficiaries may obtain information about Medicare preventive benefits at *http://www.medicare.gov* and then click on "Preventive Services."

Medicare beneficiaries may also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

MLN Matters Number: SE0660
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE060

HOSPITAL SERVICES

Modification to CWF Editing of the Existing Interrupted Stay Policy Under Long Term Care Hospital Prospective Payment System

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) for services to Medicare beneficiaries in long-term care hospitals (LTCHs)

Impact on Providers
STOP – Impact to You

This article is based on change request (CR) 5073, which modifies Medicare's common working file (CWF) editing of the existing interrupted stay policy under the long-term care hospital (LTCH) prospective payment system (PPS).

CAUTION – What You Need to Know

Currently, CWF is editing some LTCH claims incorrectly as an interrupted stay when a patient returns to the LTCH after the fixed-day threshold. CR 5073 modifies CWF edits to correctly count the number of days applicable to interrupted stays to allow for two separate payments when the patient returns to the same LTCH after the applicable fixed-day threshold.

This is not a change in Medicare policy, but a correction of Medicare's claim processing system to conform to existing policy.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) defines "interruption of a stay" as a stay at a LTCH during which a Medicare inpatient is:

- Discharged from the LTCH
- Readmitted to the same LTCH **within a specified period of time**.

Note: For payment purposes, all interrupted stays are treated as one discharge from the LTCH.

Originally (at the start of the LTCH PPS for FY 2003), the CMS interrupted stay policy addressed the situation where a LTCH patient returns to the same LTCH for additional care after he/she had been admitted to:

- An acute care hospital (ACH)
- An inpatient rehabilitation facility (IRF)
- A skilled nursing facility (SNF); or
- A swing bed.

This original interrupted stay policy is now defined as **"greater than 3-day interruption of stay."**

LTCH Interrupted Stay Timeframes at the Start of the LTCH PPS

Provider Type Fixed-Day Period

ACH 1-9 days if surgical DRG is present on acute care hospital claim ACH 4-9 days if no surgical DRG present on acute care hospital claim IRF 4-27 days SNF 4-45 days The day-count of the applicable fixed-day period of an interrupted stay begins on the day of discharge from the LTCH.

Example

- If a patient was discharged from the LTCH on January 1, 2006, to an ACH, and returns to the same LTCH on January 9, 2006, this would be considered an interrupted stay; but
- If a patient was discharged from the LTCH on January 1, 2006, to an ACH, and returns to the same LTCH on January 10, 2006 (10 day period), this would ***not*** be considered an interrupted stay. In this instance, the LTCH would receive two separate Medicare payments.

In the May 7, 2004, Final Rule (42CFR412) for the LTCH PPS, CMS revised the interrupted stay policy to include a discharge and readmission to the same LTCH within three days, regardless of where the patient goes upon discharge.

You may find the May 7, 2004 final rule at the following GPO website: *http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-10039.pdf.*

Medicare payment for any tests, procedure, or care provided would be the responsibility of the LTCH "under arrangements" **with one exception**: if treatment in an ACH would be grouped to a surgical DRG, a separate payment would be made to the ACH.

Currently, CWF is editing some LTCH claims incorrectly when the patient is discharged to an acute care hospital and returns to the same LTCH after the fixed-day threshold of nine days.

CR 5073 modifies CWF edits applicable to acute care discharges to correctly count the number of days applicable to interrupted stays to allow for two separate payments when the patient returns to the same LTCH from an ACH after the applicable fixed-day threshold of nine days.

CR 5073 also instructs intermediaries to:

- Allow providers to adjust previously processed LTCH interrupted stay claims to allow for two separate payments if they were determined to have been processed incorrectly due to the incorrect counting of the days; and

Modification to CWF Editing of the Existing Interrupted Stay Policy Under LTCH PPS (continued)

- Override timely filing for adjusted claims when reprocessing to correct the interrupted stay when received within six months of the implementation date of CR 5073 (January 2, 2007).

Implementation

The implementation date for CR 5073 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1001CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: MM5073
Related Change Request (CR) Number: 5073
Related CR Release Date: July 21, 2006
Related CR Transmittal Number: R1001CP
Effective Date: October 1, 2002
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1001, CR 5073

LOCAL COVERAGE DETERMINATIONS

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

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

For more information, or to obtain a hardcopy of a specific 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

Local Coverage Determination Table of Contents

New Local Coverage Determination Implementation

Additions/Revisions to Existing LCDs

Additional Medical Information

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

NEW LCD IMPLEMENTATION

A36470: Treatment of Varicose Veins of the Lower Extremities—New LCD

Varicose veins are caused by venous insufficiency as a result of valve reflux (incompetence). The venous insufficiency results in dilated, tortuous, superficial vessels that protrude from the skin of the lower extremities. Spider veins (telangiectasias) are dilated capillary veins that are most often treated for cosmetic purposes and are not covered by Medicare. Sclerotherapy (liquid or foam) is preformed for signs and symptoms of diseased vessels and may be used as an adjunct to surgical or ablative therapy (radiofrequency or laser). Sclerotherapy for cosmetic purposes is not considered medically reasonable and necessary. Ligation and stripping of varicose veins is a treatment option that aims to eliminate reflux at the saphenofemoral or saphenopopliteal junction. Endovenous radiofrequency and laser ablation is a minimally invasive alternative to vein ligation and stripping. Endovenous **radiofrequency** ablation (ERFA) (VENUS® closure system) is FDA-approved for endovascular coagulation of blood vessels with superficial vein reflux. Endovenous **laser** ablation is FDA approved for the treatment of varicose veins and varicosities associated with superficial reflux of the greater saphenous vein.

This new local coverage determination (LCD) incorporates indications and limitations, documentation guidelines, utilization guidelines, ICD-9-CM codes that support medical necessity, ICD-9-CM codes that do not support medical necessity and a coding guideline for the following *CPT* codes:

36470	*36471*	*36475*	*36476*
36478	*36479*	*37700*	*37718*
37722	*37735*	*37760*	*37765*
37766	*37780*	*37799*	*93965*
93970	*93971*		

Effective Date

This new LCD is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L23082) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A61885: Vagal Nerve (VNS) Stimulation for Intractable Depression—New LCD

Vagal nerve stimulation (VNS) therapy involves the direct delivery of intermittent retrograde electrical impulses to the left vagus nerve via a surgically attached bipolar electrode that has been subcutaneously tunneled to the nerve from a small electrical generator implanted in the left chest wall. Like a pacemaker, the device may be turned on and off or adjusted noninvasively

The Food and Drug Administration (FDA) originally approved VNS for the treatment of refractory epilepsy. On July 15, 2005, the FDA granted premarket approval to Cyberonics, Inc. for their VNS therapy system for the adjunctive long-term treatment of chronic or recurrent depression for patients 18 years of age or older who are experiencing a major depressive episode and have not had an adequate response to four or more antidepressant treatments.

The current available evidence based on publications in peer-reviewed literature and other pertinent sources, is insufficient to permit conclusions regarding the efficacy and safety of VNS as an adjunct therapy in treatment-resistant major depression and bipolar disorder. Therefore, a local coverage determination (LCD) was developed to noncover reimbursement for VNS therapy for intractable depression at this time.

The following *CPT* codes will **not** be covered for VNS when used for intractable depression:

61885	*Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array*
61888	*Revision or removal of cranial neurostimulator pulse generator or receiver*
64573	*Incision for implantation of neurostimulator electrodes; cranial nerve*
64585	*Revision or removal of peripheral neurostimulator electrodes*
95970	*Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming*
95974	*complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour*
95975	*complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)*

A61885: Vagal Nerve Stimulation (VNS) for Intractable Depression (continued)

Effective Date

This new LCD is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L23084) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A82550: Creatine Kinase (CK), (CPK)—New LCD

Creatine kinase (CK or CPK) is an enzyme found in heart muscle (CK-MB), skeletal muscle and heart (CK-MM), and brain (CK-BB). The MM fraction is present in both cardiac and skeletal muscle, but the MB fraction is much more specific for cardiac muscle. Therefore, elevation in total CK is not specific for myocardial injury, because most CK is located in skeletal muscle. Elevations in total CK are possible from a variety of noncardiac conditions, such as muscle disease, stroke, hypothyroidism, and side effects from the use of statin medications.

Statins are low-density lipoprotein (LDL) lowering drugs that are widely used in clinical practice. The use of statins may produce muscle toxicity under some circumstances. Therefore, it would be expected that a baseline measurement of CK would be done prior to initiating statin therapy, as well as, titration of statin therapy or with clinical signs and symptoms of myopathy (i.e., muscle discomfort, weakness, brown urine, etc.). However, medical literature does not support routine monitoring of CK in the absence of clinical signs and symptoms.

This local coverage determination (LCD) has been developed to define the indications and limitations of coverage, utilization, and documentation requirements for creatine kinase.

Effective Date

This new LCD is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L23091) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A86803: Hepatitis C Antibody in the ESRD and non-ESRD Setting—New LCD

Hepatitis C virus is a leading cause of chronic liver disease. It is also the leading indication for liver transplantation. Complications from chronic liver disease include cirrhosis, hepatic decompensation and hepatocellular carcinoma. The incubation period of hepatitis C is approximately seven weeks. Hepatitis C is an uncommon cause of acute hepatitis in the United States. It is not an easily transmitted disease. It is transmitted through contact with blood and blood products. The leading risk factor for hepatitis C infection is injection drug use, occupational exposure, sexual transmission, intranasal cocaine use, tattooing, body piercing and maternal-infant spread.

Medicare will consider testing for the hepatitis C antibody medically reasonable and necessary when performed for the purpose of identifying the presence of the hepatitis C virus (HCV) and testing is not performed for the purpose of routine screening.

This local coverage determination (LCD) identifies coverage criteria and utilization guidelines when testing for hepatitis C antibody.

Effective Date

This new LCD is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L23093) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A0145T Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries—New LCD

Multislice or multidetector computed tomography (MDCT) angiography with its advanced spatial and temporal resolution has opened up new possibilities in the imaging of the major vessels of the chest, including aorta, pulmonary arteries, and coronary arteries.

MDCT technology for cardiac and coronary artery assessment requires thin (less than 1 mm) slices 0.5 to 0.75 mm reconstructions, multiple simultaneous images (e.g. 40-64 or more slices) and cardiac gaiting (often requiring beta blockers for ideal heart rate). There is significant post processing, depending on the number of slices for image generation. For coronary artery imaging, the resulting images show a high correlation with stenotic lesions noted on diagnostic cardiac catheterization but more importantly, with atheromas on intracoronary ultrasound. Additionally, the technique may be helpful in defining the vascularity of chest or lung lesions.

CPT category III codes for computed tomographic angiography of the chest, heart and coronary arteries (*CPT codes 0144T-0151T*) were effective January 1, 2006. Prior to this CT angiography procedures were billed with *CPT* code *71275* or

A0145T Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries (continued)

an unlisted procedure code. *CPT category III* codes are different from typical *CPT* codes in that they are for services that may have limited use by health care professionals, and the service or procedure may not have proven clinical efficacy in the peer-reviewed literature.

Note: *CPT category III* code *0144T* is locally noncovered as investigational.

This LCD has been developed to provide indications and limitations of coverage and/or medical necessity and documentation requirements for *CPT category III* codes *0145T-0151T* and *CPT* code *71275*. In addition, ICD-9-CM codes that support medical necessity have been identified.

Effective Date

This new LCD is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L23080) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ0740: Ganciclovir and Cidofovir—New LCD

Ganciclovir (Cytovene IV) is a synthetic guanine derivative and an active antiviral agent for cytomegalovirus (CMV) infections. The ganciclovir (Vitrasert) implant is a synthetic nucleoside analogue of 2'- deoxyguanosine, which inhibits assembly of virons. Ganciclovir is not a cure for CMV. Cidofovir (Vistide) is an antiviral used to treat the symptoms of CMV infection of the eye. Cidofovir is available in IV form only. Cidofovir will not cure CMV infection.

Ganciclovir (J1570 and J7310)

Medicare will cover ganciclovir for the following FDA-approved indications:

IV form

- Cytovene-IV is indicated for the induction and maintenance in the treatment of CMV retinitis in immunocompromised patients, including patients with acquired immunodeficiency syndrome (AIDS).
- Cytovene-IV is also indicated for the prevention of CMV disease in transplant recipients at risk for CMV disease.

Implant form

- Ganciclovir (Vitrasert) implant is indicated for CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS). The intravitreal implant is designed to release ganciclovir over a period of five to eight months. The implant provides localized treatment only and will not have any effect on extraocular CMV infection.

Cidofovir (J0740)

Medicare will cover cidofovir (Vistide) for the following FDA approved indications:

- Cidofovir is indicated, in combination with probenecid, for the treatment of CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS).

This local coverage determination (LCD) was developed based on data analysis. Indications and limitations, utilization guidelines, documentation guidelines and appropriate ICD-9-CM codes were incorporated into this LCD for procedure codes J0740, J1570 and J7310. A coding guideline was also developed

Effective Date

This new LCD is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L23097) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ1080: Testosterone Cypionate and Testosterone Enanthate—New LCD

Testosterone cypionate and testosterone enanthate, for IM injection, are oil-soluble 17 (beta) – cyclopentylpropionate esters of the androgenic hormone testosterone. Testosterone esters are less polar than free testosterone. Testosterone esters in oil, injected intramuscularly, are absorbed slowly from the lipid phase; thus, they can be given at intervals of two to four weeks.

FDA-approved Indications Covered by Medicare

Testosterone cypionate and testosterone enanthate are indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone:

- Primary hypogonadism (congenital or acquired) – testicular failure due to cyrptorchidism, bilateral torsion, orchitis, vanishing testes syndrome; or orchidectomy
- Hypogonadadotropic hypogonadism (congenital or acquired) – idiopathic gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma or radiation.

AJ1080: Testosterone Cypionate and Testosterone Enanthate (continued)

In addition to the FDA approved indications, Medicare will cover testosterone cypionate and testosterone enanthate for the following off-label indication:

- Hypogonadism in patients who are infected with HIV, particularly those whose disease has progressed to AIDS and who have developed wasting syndrome. Wasting syndrome is an AIDS defining condition. Wasting is evidence of symptomatic HIV infection. Wasting syndrome is defined as unintentional weight loss > 10 percent and the presence of chronic weakness and documented fever lasting at least 30 days. Wasting is defined as unintentional weight loss >10 percent. Wasting syndrome and wasting must be differentiated from lipoatrophy, which is isolated fat loss and is seen in patients who are on a successful course of antiretroviral therapy.

This local coverage determination (LCD) was developed based on data analysis. Indications and limitations, utilization guidelines, documentation guidelines and appropriate ICD-9-CM codes were incorporated into this LCD for procedure codes J1070, J1080, J3120 and J3130. A coding guideline was also developed.

Effective Date

This new LCD is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L23119) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ2325: Nesiritide (Natrecor®)—New LCD

Nesiritide was approved by the Food and Drug Administration (FDA) for the short-term intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea (shortness of breath) at rest or with minimal activity. Recent published studies of nesiritide have highlighted safety concerns, specifically increased mortality and decreased renal function in patients treated with nesiritide.

Because nesiritide is only indicated for acute decompensated heart failure, and because of the risks involved during its administration, a new local coverage determination (LCD) was developed to restrict the administration of this drug to inpatient admission, emergency department, or hospital outpatient observation settings.

This LCD includes ICD-9-CM diagnosis codes and indications and limitations of coverage for patients diagnosed with acutely decompensated CHF for the inpatient setting

Effective Date

This new LCD is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L23123) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ9213: Interferon, alpha 2-a (Roferon®-A)—New LCD

Interferon alfa-2a, recombinant (Roferon®-A) is a sterile protein product for use by injection. It is manufactured by recombinant DNA technology that employs a genetically engineered E. coli bacterium containing DNA that codes for the human protein. The mechanism by which interferon, alfa-2a or any other interferon, exerts antitumor or antiviral activity is not clearly understood. It is believed that direct antiproliferative action against tumor cells, inhibition of virus replication and modulation of the host immune response play important roles in antitumor and antiviral activity.

Interferon, alfa-2a was evaluated for addition to the self-administered drug (SAD) list. However, the evaluation results revealed that intramuscular injection of this drug may be required for certain medical conditions. Therefore, this LCD was developed to define indication and limitation criteria and to provide utilization guidelines for interferon, alfa-2a. In addition, ICD-9-CM codes that support medical necessity have been identified.

Effective Date

This new LCD is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L23131) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ADDITIONS/REVISIONS TO LCDS

A43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy—Addition to the LCD

The local coverage determination (LCD) for diagnostic and therapeutic esophagogastroduodenoscopy was last updated on October 27, 2005. Since that time, an external request was received to add a diagnosis code for the removal of percutaneous gastrostomy tube (PEG) after the patient no longer has a diagnosis that supports the reason for placement of the PEG.

The LCD supports esophagogastroduodenoscopy (EGD) for assisting in the placement of a feeding tube. Therefore, it was determined that removal of the PEG is reasonable when it is no longer required. The LCD has been revised to add ICD-9-CM code V55.1 (Attention to artificial openings, gastrostomy) to the"ICD-9 Codes that Support Medical Necessity" section of the LCD. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was expanded to include follow-up for removal of the PEG. The "Utilization Guidelines" section of the LCD has been updated to include verbiage regarding provider qualification requirements when rendering this service.

Effective Date

These additions are effective for services provided **on or after August 24, 2006.**

The full text for this LCD (L3016) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A78459: Myocardial Imaging, Positron Emission Tomography (PET) Scan—Revision to the LCD

Positron Emission Tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceutical) such as FDG (2-{flourine-18}-fluoro-2-dexoy-D-glucose), nitrogen N13 ammonia and rubidium RB-82.

This local coverage determination (LCD) was last revised on January 1, 2006. Since that time, this LCD has been revised to add the following ICD-9-CM codes to the "ICD-9 Codes that Support Medical Necessity" section of the LCD:

411.0	412	413.1	414.10	414.12	414.19
426.2	426.3	426.4	426.50-426.54	426.6	427.31
428.0	428.1	428.20-428.23	428.30-428.33	428.40-428.43	428.9

In addition, the "Documentation Requirements" section of the LCD has been revised for clarification.

Effective Date

These revisions are effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L1144) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A91110: Wireless Capsule Endoscopy—Revision to the LCD

Wireless capsule endoscopy utilizes the use of a small capsule containing a disposable light source, miniature color video camera, battery, antenna and a data transmitter. The patient swallows the capsule and images taken by the camera contained within the capsule are relayed to the data transmitter. The data transmitter is connected to a computer workstation where the images are downloaded, reviewed, and interpreted by the physician.

First Coast Service Options, Inc. (FCSO) developed a local coverage determination (LCD) for wireless capsule endoscopy of the *small bowel*, which has been in effect since March 24, 2003. The purpose of this LCD revision is to provide coverage guidelines for wireless capsule endoscopy of the *esophagus*.

Effective Date

This revision is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L13716) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A93875: Non-invasive Extracranial Arterial Studies—Addition to the LCD

The local coverage determination (LCD) for noninvasive extracranial arterial studies was last updated on August 7, 2006. Since that time the LCD has been updated to include type of bill (TOB) 85x (critical access hospital) and revenue code 30x (laboratory).

Effective Date

These additions are effective for services provided **on or after August 7, 2006.**

The full text for this LCD (L942) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A0067T: Computed Tomographic Colonography—Revision to the LCD

Computed tomographic colonography (CT colonography) also known as virtual colonoscopy utilizes helical computed tomography of the abdomen and pelvis to visualize the colon lumen. The test requires colonic preparation similar to that required for conventional colonoscopy (instrument colonoscopy), and air insufflation to achieve colonic distention**.** When polyps are detected with CT colonography, patients could presumably undergo subsequent conventional colonography, which may require another bowel preparation. CT colonography is not endorsed for screening by the American Cancer Society, the U.S. Preventive Services Task Force, the Center for Medicare & Medicaid Services (CMS), nor, to date, any professional bodies.

This local coverage determination (LCD) became effective January 1, 2006. Since that time, the LCD has been revised to expand coverage indications, identify equipment requirements, and define physician qualifications for performing CT colonography. Also, the "Documentation Requirements" and "Sources of Information and Basis for Decision" sections were updated.

Effective Date

These revisions are effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L21613) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ1566: Intravenous Immune Globulin—Revision to the LCD

The local coverage determination (LCD) for intravenous immune globulin was last revised January 1, 2006. intravenous immune globulin (IVIG) is a solution of human immunoglobulin specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens. The use of intravenous immune globulin should be reserved for patients with serious defects of antibody function. The goal is to provide immunoglobulin G (IgG) antibodies to those who lack them.

This LCD revision provides updates to the following sections; "Indications and Limitations of Coverage and/or Medical Necessity," "ICD-9 Codes that Support Medical Necessity," and "Documentation Requirements." In addition coding guidelines were developed.

A new requirement for dual diagnoses was added for human immunodeficiency virus [HIV] disease (042). For the pediatric population < thirteen, there is a requirement for a dual diagnosis; 042, Human immunodeficiency virus [HIV] disease **plus** V15.9, Unspecified personal history presenting hazards to health **OR** 042, Human immunodeficiency virus [HIV] disease **plus** V49.89, other specified conditions influencing health status. For adults ≥ 13, there is a dual diagnosis requirement for administering IVIG for thrombocytopenia associated with HIV disease; primary diagnosis of 287.5, Thrombocytopenia, unspecified and a secondary diagnosis of 042, Human immunodeficiency virus [HIV] disease

Effective Date

This revision is effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L1405) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ2505: Pegfilgrastim (Neulasta®)—Coding Guideline Addition

A coding guideline was created for this local coverage determination (LCD) based on information communicated through Change Request 4380, Transmittal 949, dated May 12, 2006. The recommended dosage of Neulasta® is a single subcutaneous injection of 6 mg administered once per chemotherapy cycle. Neulasta should not be administered within 14 days before or 24 hours after administration of cytotoxic chemotherapy. Medicare will return to providers claims received for 6 units of J2505. Medicare will only make payment for **one** unit for every 6 MG of pegfilgrastim (Neulasta) administered. Providers should make certain that when billing procedure code J2505 they show the correct number of multiples of 6 MG not the number of MGs.

Effective Date

The coding guideline for this LCD is effective for services provided **on or after August 14, 2006.**

The full text for this LCD (L14001) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ9000: Antineoplastic Drugs—Correction to the LCD

A revision to the local coverage determination (LCD) for antineoplastic drugs was published in the August 2006 *Medicare A Bulletin* (pg. 40). The effective date of June 29, 2006 for the addition of the following indications and ICD-9-CM codes for J9310 was incorrect. The correct date is February 28, 2006 for rituximab (J9310).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section for J9310:

- Added the FDA approved indication for rheumatoid arthritis and verbiage of other approved indications based on the FDA label.

Under the "ICD-9 Codes that Support Medical Necessity" section for J9310 added the following diagnosis codes:

714.0 – Rheumatoid arthritis

714.1 – Felty's syndrome (Rheumatoid arthritis with splenoadenomegaly and leukopenia)

714.2 – Other rheumatoid arthritis with visceral or systemic involvement

Effective Date

This correction is effective for **claims processed on or after August 17, 2006, for services provided on or after February 28, 2006.**

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

AJ9000: Antineoplastic Drugs—Revision to the LCD

This local coverage determination (LCD) for antineoplastic drugs was last updated on June 29, 2006. Since that time, the following revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-9 Codes that Support Medical Necessity" sections for the following HCPCS codes:

J9263 (oxaliplatin)

- Added the off-label indication of oxaliplatin for the treatment of advanced/metastatic gastric carcinoma in combination with irinotecan or fluorouracil with leucovorin or folinic acid.
- Added diagnosis code range 151.0 – 151.9 for J9263 (oxaliplatin).

J9350 (topotecan)

- Added the FDA approved indication of topotecan in combination with cisplatin for the treatment of Stage IV-B, recurrent, or persistent carcinoma of the cervix which is not amenable to curative treatment with surgery and/or radiation therapy.

Terminology for other FDA approved indications to correspond with the USP DI terminology for J9350 (topotecan) was updated.

J9201 (gemcitabine)

- Added the FDA approved indication of gemcitabine in combination with carboplatin for the treatment of patients with advanced ovarian cancer that has relapsed at least 6 months after completion of platinum-based therapy.

In addition, updated terminology for other FDA approved indications for J9201 to correspond with the USP DI terminology. References were also updated

Effective Dates

The revisions for HCPCS codes J9263 and J9350 are effective for services provided **on or after August 10, 2006.**

The revision for HCPCS codes J9201 is effective for services provided **on or after July 14, 2006.**

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

AJ9015: Aldesleukin (Proleukin®, Interleukin-2, Recombinant, and RIL-2)—Revision to the LCD

Aldesleukin (J9015) is in the antineoplastic drugs (J9000) local coverage determination (LCD). The LCD for antineoplastic drugs was last updated on August 10, 2006.

The only FDA indications for aldesleukin are metastatic renal cell carcinoma and metastatic melanoma for adults. FDA label warnings state this drug should be administered in a hospital setting under the supervision of a qualified physician experienced in the use of anticancer agents. The recommended FDA high dosage is 600,000 IU/kg administered every eight hours by a 15 minute IV infusion for a maximum of 14 doses, which is repeated following nine days of rest.

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, terminology for the FDA approved indications was changed stating aldesleukin is FDA approved for treatment of adults with metastatic renal cell carcinoma, and treatment of adults with metastatic melanoma. In addition, the off-label indications of acute and chronic

AJ9015: Aldesleukin (Proleukin®, Interleukin-2, Recombinant, and RIL-2) (continued)

myeloid leukemia were added, as well as FDA dosages, warnings, and contraindications for aldesleukin. The "Documentation Requirements" section was revised to include "If a provider departs from the recommended high dose label recommendations and gives a reduced dosage (off-label) and/or different route of administration in an alternate setting, the rationale for such administration should be documented in the medical record."

Under the "ICD-9 Codes that Support Medical Necessity" section, diagnosis code 190.6 – Malignant neoplasm of choroid (use this code for ocular melanoma) was added.

Effective Date

These revisions are effective for services provided **on or after October 30, 2006.**

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

ASKINSUB: Skin Substitutes—Revision to the LCD

The local coverage determination (LCD) for skin substitutes was last updated on January 1, 2006. Since that time, a major revision was made to the LCD to include additional skin substitute products. The final revisions included the addition of Integra, TransCyte, and OASIS products to the LCD. The skin substitutes were arranged in alphabetical order. The "Indications and Limitations of Coverage and/or Medical Necessity" section was updated to include these products, as well as a "Note" at the end of this section for preparation and application of graft codes with range of corresponding *CPT* codes. This "Note" was also added to the "Coding Guidelines" under "Other Comments." Under the "ICD-9 Codes that Support Medical Necessity" section, ICD-9-CM codes were added for OASIS, Integra, and TransCyte, and additional diagnosis codes were added for OrCel (J7343). Diagnosis code707.10 (Ulcer of lower limb, unspecified) was added to Xenograft. Documentation requirements were added for Integra and OASIS and general applicable FDA labeling requirements for all products. The "Sources of Information and Basis for Decision" section was updated.

Effective Date

These revisions are effective for services provided **on or after October 30, 2006.**

The full text for this LCD (L13688) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AVISCO: Viscosupplementation Therapy for Knee—Revision to the LCD

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised January 1, 2006. This LCD revision is for the purpose of removing the brand name of all preparations of sodium hyaluronate and related substances. Providers are to use the HCPCS code that accurately describes the preparation they are administering. The HCPCS codes and their descriptors are as follows:

C9220	Sodium hyaluronate per 30 mg dose, for intra-articular injection
J3590	Unclassifed biologics (use for high molecular weight hyaluronan)
J7317	Sodium hyaluronate, per 20 to 25 mg dose for intra-articular injection
J7320	Hylan G-F 20, 16 mg, for intra-articular injection

In addition to the above changes, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated by adding statements defining medical reasonableness and necessity of drugs/biologicals and procedures, based on Medicare Benefit Policy Manual (Pub. 100-02, Chapter 15, Section 50.2k) and the Program Integrity Manual (Pub. 100-08, Chapter 13, Section 5.1), respectively. Also, a statement regarding the use of the appropriate HCPCS code when billing for a hyaluronic preparations was added to the coding guidelines.

Effective Date

These revisions are effective for services processed **on or after August 3, 2006.**

The full text for this LCD (L1600) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ADDITIONAL MEDICAL INFORMATION

Lucentis™ (ranibizumab injection) for Neovascular Age-Related Macular Degeneration

Lucentis™ (ranibizumab injection) was FDA-approved on June 30, 2006 for the treatment of age-related macular degeneration (AMD).

When all program requirements are met, Medicare generally reimburses for a drug that is FDA-approved for the indication for which it is being used, and there are no applicable policies – such as a local coverage determination (LCD) or a national coverage determination (NCD) – that would preclude coverage. This is not an all-inclusive list.

Lucentis is FDA-approved for the treatment of AMD. Currently, there is no LCD on this subject matter in Florida, and we are unaware of an NCD that would restrict coverage for the FDA-approved indication. Although all services reimbursed by Medicare are subject to review, an overwhelming majority of claims are being paid based on these principles.

Providers billing for intravitreal Lucentis (ranibizumab injection) administered in an outpatient hospital setting should use *CPT* code *67028* for the intravitreal injection and HCPCS code C9399 (Unclassified drugs or biologicals) for the Lucentis (ranibizumab injection) (CMS change request 3287, dated May 28, 2004).

Providers billing for intravitreal Lucentis (ranibizumab injection) administered in an office (nonhospital) setting should use *CPT* code *67028* for the intravitreal injection and HCPCS code J3490 (Unclassified drugs) for the Lucentis (ranibizumab injection).

The applicable ICD-9-CM code is 362.52 (exudative senile macular degeneration). When billing Medicare, the intravitreal injection and the drug injected should be billed on the same claim. Remember to use the appropriate modifiers when performing the service on both eyes.

Documentation in the medical record must support the following:

- The diagnosis of wet AMD (ICD-9 code 362.52) with leakage/fluid in the macula has been confirmed by optical coherence tomography (OCT) or fluorescein angiography.
- Actual dose administered.

Providers should not submit this information with the claim. First Coast Service Options, Inc. (FCSO) may request it separately with an additional documentation request (ADR) letter. ❖

Vertebral Fracture Assessment—*CPT* Code *76077*—Revised Article

Note: This is a revision to an article published in the Third Quarter 2006 *Medicare A Bulletin* (pages 73-74).

Background

First Coast Service Options, Inc. (FCSO) currently has a local coverage determination (LCD) for bone mineral density studies. This LCD is based on 42 CFR, Section 410.31 and the CMS Manual System. Therefore, vertebral fracture assessment (VFA) (*CPT* code *76077*) is outside the scope of this LCD, and this LCD does not apply to it. It is the intent of this article to inform provider's about FCSO's approach to this service.

Description of the Service

Lateral spine dual energy X-ray absorptiometry (DXA), *CPT* code *76077*, or vertebral fracture assessment, is a relatively recently developed technique for imaging vertebral fractures that are not clinically evident. It assists in the diagnosis of prevalent vertebral fractures using less radiation than the anterior-posterior technique. If it is accurate in identifying vertebral fractures, when combined with bone mineral density measurement, it potentially could offer a method for more accurately determining risk of future fracture. Such risk assessment may help determine whether a patient is an appropriate candidate for pharmacologic treatment.

Regulatory Information

Medicare coverage of bone density measurements is defined in 42 CFR, Section 410.31 as reflected in First Coast Service Option local coverage determinations (LCDs) on this subject matter. There are five qualifying criteria:

- A patient with vertebral abnormalities as demonstrated by an X-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture.
- A patient being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.
- A patient with known primary hyperparathyroidism.
- A patient receiving (or expecting to receive) glucocorticoid (steroid) therapy greater than three months, on the equivalent dose of 30 mg cortisone or 7.5 mg prednisone or greater per day.
- A woman who has been determined by the physician or a qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

Vertebral Fracture Assessment—CPT Code 76077 (continued)

The local contractor does not have discretion of decision or authority to expand or contract this list.

According to 42 CFR, Section 410.31, "Bone mass measurement…is performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality" and does not include a provision for diagnosing a fracture. Therefore, vertebral fracture assessment is outside the scope of Medicare bone mass measurement benefit, as defined by the law. It is a separate modality.

Contractor's (FCSO) Observations

It is the standard of practice to identify and evaluate vertebral fractures with traditional radiologic techniques. However, screening for detection of vertebral fractures is generally not performed. As a result, diagnosis occurs either incidentally or as a result of symptoms. Traditional radiologic evaluations for signs and symptoms have not been considered as a screening test. Importantly, screening for vertebral fractures is not a Medicare covered benefit. Therefore, VFA performed for screening for vertebral fractures is never covered.

Current literature has not demonstrated that treatment decisions based on VFA, along with bone mineral density measurements, have resulted in better patient outcomes than treatment based solely on bone mineral density and clinical risk factors. There is a lack of clinical trial evidence showing that patients with vertebral fractures on DXA but with bone mineral density levels above treatment thresholds benefit from pharmacologic treatment. There have not been an adequate number of closely controlled clinical trials conducted to date or studies focusing on comparison with other modalities generally available, and currently publications in peer-reviewed literature, as well as position statements by technology assessment organizations are not sufficient to issue a positive coverage statement by way of a local coverage determination (LCD).

FCSO Medicare will consider coverage of VFA under the following circumstance:

- When used as a diagnostic test for the evaluation of symptoms and findings suggestive of a vertebral fracture.

Note: The medical record must reflect the rationale for selecting VFA over other time-tested techniques for each individual patient.

Limitations

- VFA is never covered when used as screening for vertebral fractures.
- VFA cannot be duplicative of other diagnostic modalities for a patient during an episode of illness.

Because in situations when there is no national coverage determination (NCD) or local coverage determination (LCD), services are evaluated individually based on Medicare general medical reasonableness and necessity criteria, claims for VFA will be given individual consideration on a case-by-case basis until appropriately designed and powered studies are published and evaluated.

Providers should not interpret the process of individual consideration as synonymous with coverage and payment by Medicare. This means only that the claims will be reviewed against the background of the presently available evidence and specific patient circumstances.

Any time there is a question whether Medicare medical reasonableness and necessity criteria would be met; we recommend the use of an advance beneficiary notice (ABN) and appending **modifier GA** to the billed *CPT* code. For further details about CMS' Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*.

Please note that services that lead up to or are associated with noncovered services are not covered as well.

Billing and Coding

The applicable *CPT* code is *76077* – Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment.

Documentation

Providers should not submit any medical record documentation with the claim. First Coast Service Options will request this by means of an additional documentation request (ADR) letter. The required information will include details for the current episode of care about symptoms, signs, and findings suggestive of the presence of a vertebral fracture, other diagnostic modalities utilized, and the rationale for choosing VFA. Like any diagnostic test, the VFA must be specifically ordered by the treating physician, for which there must be documentation in the medical record. ❖

CRITICAL ACCESS HOSPITAL SERVICES

2007 Annual Update for the Health Professional Shortage Area Bonus Payments

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

Provider Types Affected

Physicians and providers submitting claims to Medicare carriers and fiscal intermediaries (FIs) for services provided in a health professional shortage area (HPSA)

Impact on Providers

This article is based on change request (CR) 5237, which alerts affected physicians, providers, carriers, and FIs that the new HPSA bonus payment information for 2007 will soon be available.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Section 413(b)) mandated an annual update to the automated HPSA bonus payment files, and the Centers for Medicare & Medicaid Services (CMS) creates these new automated HPSA bonus payment files annually.

CR 5237 instructs carriers and FIs to use the new HPSA bonus payment file for the automated bonus payment for claims with dates of service on or after January 1, 2007, through December 31, 2007.

In addition, CMS is notifying affected physicians/providers that it will post the new HPSA information to the CMS website on or about October 1, 2006.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier or FI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1021CP.pdf*.

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

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

MLN Matters Number: MM5237
Related Change Request (CR) Number: 5237
Related CR Release Date: August 4, 2006
Related CR Transmittal Number: R1021CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1021, CR 5237

Health Professional Shortage Area Listing

The following are counties (all census tracts) designated as geographic health professional shortage areas (HPSAs) and therefore eligible for the bonus payment, as of July 5, 2006.

Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Clay/Keystone Heights		Rural
Collier/Imokalee/Everglades		Rural
Columbia (effective March 3, 2006)		Rural
Dixie		Rural
Escambia/Atmore (AL/FL)	0038.00, 0039.00, 0040.00	Rural
Gadsden		Urban
Glades		Rural
Hamilton		Rural
Hardee		Rural
Hendry (revised March 3, 2006)		Rural
Jefferson (effective March 3, 2006)		Rural
Lafayette		Rural
Liberty		Rural

Health Professional Shortage Area Listing (continued)

Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Madison		Rural
Martin/Indiantown		Rural
Okeechobee (effective March 3, 2006)		Rural
Palm Beach (effective July 5, 2006)	0080.01, 0080.02, 0081.01, 0081.02, 0082.01, 0082.02, 0082.03, 0083.01, 0083.02	Rural
Sumter		Rural
Suwannee		Rural
Wakulla		Rural

Mental Health

County	Type
Bradford	Rural
Calhoun (effective March 3, 2006)	Rural
Columbia	Rural
Dixie	Rural
Franklin (effective July 5, 2006)	Rural
Gilchrist	Rural
Gulf (effective March 3, 2006)	Rural
Hamilton	Rural
Hillsborough. Ruskin CCD/Wimauma-Lithia CCD (effective November 3, 2005)	Urban
Holmes	Rural
Indian River/Fellsmere (effective July 5, 2006)	Rural
Lafayette	Rural
Lake (effective July 5, 2006)	Rural
Liberty (effective July 5, 2006)	Rural
Jefferson (effective July 5, 2006)	Rural
Lafayette	Rural
Lake (effective July 5, 2006)	Rural
Liberty (effective July 5, 2006)	Rural
Jefferson (effective July 5, 2006)	Rural
Madison (effective July 5, 2006)	Rural
Martin/Indiantown (effective September 27, 2005)	Rural
Monroe/Upper Keys (revised July 5, 2006)	Rural
Okeechobee (effective March 3, 2006 – July 5, 2006)	Rural
Putnam	Rural
St Johns	Urban
Suwannee	Rural
Union	Rural
Walton	Rural
Washington	Rural

Source: CMS Atlanta Regional Office Memorandum, July 31, 2006

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

ESRD SERVICES

Change in HCPCS Code for Renal Dialysis Facilities and Hospitals Billing for ESRD Related Epoetin Alfa Effective January 1, 2007

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

Provider Types Affected

Renal dialysis facilities and hospitals billing Medicare fiscal intermediaries (FIs) for renal dialysis services

Provider Action Needed

STOP – Impact to You

Effective for services on or after January 1, 2007, you must include the new Healthcare Common Procedure Coding System (HCPCS) code Q4081 (Injection, epoetin alfa, 100 units (for ESRD on dialysis)) when you bill for an injection of epoetin alfa (EPO) for your ESRD patients on dialysis.

CAUTION – What You Need to Know

A new HCPCS code (Q4081) has been established for the injection of epoetin alfa, 100 units (for ESRD patients on dialysis), submitted on bill type 72x, 12x, 13x and 85x, effective January 1, 2007. Renal dialysis facilities and hospitals previously billing for ESRD related EPO with the 1000 unit code J0886 should begin using the new 100-unit code effective January 1, 2007.

GO – What You Need to Do

Make sure that your billing staffs are aware of the requirement to use this new HCPCS code for the use of 100 units of epoetin alfa by injection, effective January 1, 2007.

Background

CR 5216, upon which this article is based, provides that a new HCPCS code has been established for an injection of epoetin alfa, 100 units (for ESRD patients on dialysis). The new code, Q4081, will be effective for services on or after January 1, 2007 when submitted on bill type 72x, 12x, 13x and 85x (see Table 1, below).

Renal dialysis facilities and hospitals previously billing for ESRD related EPO with the 1000 unit code J0886 should begin using the new 100-unit code for all claims with dates of service on or after January 1, 2007.

Billing and payment instructions for renal dialysis facilities previously applicable to J0886, as defined in the *Medicare Claims Processing Manual* (publication 100-4), Chapter 8, Section 60, will be applicable to Q4081. There are no other billing or payment changes for renal dialysis facilities.

Change in Revenue Code Reporting for Hospitals

Hospitals will report Q4081 with revenue code 0636 for bill types 12x, 13x and 85x.

Table 1. Epoetin Alfa Injection HCPCS Codes, Descriptions, and Applicable Billing Periods

HCPCS Codes	HCPCS Description	Applicable Billing Period
Q4055	Injection, epoetin alfa, 1,000 units (for ESRD on dialysis)	January 1, 2004 through December 31, 2005
J0886	Injection, epoetin alfa, 1,000 units (for ESRD on dialysis)	January 1, 2006 through December 31, 2006
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)	January 1, 2007 to current

Additional Information

You may find more information about new HCPCS code (Q4081) for the injection of epoetin alfa, 100 units (for ESRD patients on dialysis) by going to CR 5216, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1007CP.pdf*.

CR 5216 includes the revised pages of the *Medicare Claims Processing Manual* affected by the change request. Those pages also manualize instructions released in CR 2503 for those who wish a refresher on those instructions.

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

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

MLN Matters Number: MM5216
Related Change Request (CR) Number: 5216
Related CR Release Date: July 28, 2006
Related CR Transmittal Number: R1007CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1007, CR 5216

Disaster Response Plan Announcement for Individuals with Kidney Failure

The Centers for Medicare & Medicaid Services (CMS) today announced that CMS and other federal agencies have joined with organizations and health care providers in the kidney community to form the Kidney Community Emergency Response Coalition and to develop a nationwide disaster response plan.

"The Kidney Community Emergency Response Coalition is an excellent example of effective collaboration," said CMS Deputy Administrator Leslie Norwalk. "This is a model of how we can work together to ensure that health care needs of individuals with kidney disease are met, even in a time of a disaster."

The Coalition will ensure that national resources are in place to assist state and local response efforts in meeting the life saving medical needs of individuals with kidney failure in the event of a disaster.

Kidney failure (end-stage renal disease, or ESRD) is a life threatening condition. As of March 2006, there were nearly half a million individuals with ESRD in the United States. Individuals with ESRD require medications to prevent rejection of a kidney transplant if they have received one, or regular repeated dialysis treatments to clean the blood supply, as frequent as three to four times a week, if they have not. Going without dialysis for even a short time can result in severe illness or even death for an individual with ESRD.

Dialysis is dependent on the availability of electricity, gas, supplies, and water – commodities that, without proper planning, are difficult to access in the event of a disaster. One dialysis treatment alone requires a minimum of 100 gallons of pressurized, clean water.

"Other health care provider groups, in preparing for disasters, can learn a great deal from the kidney community, Barry Straube, M.D., CMS Chief Medical Officer and a nephrologist. "This effort will help save lives by making sure critical needs such as supplies, medications and services are available."

The kidney community understands the continued need for improved processes. Toward this end, representatives from over 50 health care organizations across 25 states and the District of Columbia participated in a national summit hosted by CMS in January to review lessens learned in recent disasters, and use these lessons to plan for the future. The Kidney Community Emergency Response Coalition was formed, at the summit, with the National Kidney Foundation serving as the administrative coordination lead for Coalition activities.

The Coalition is comprised of partners representing kidney patient and professional organizations; practitioners such as nurses, technicians, dieticians, social workers, surgeons and physicians; independent dialysis and transplant facilities; large dialysis organizations; hospitals; medical equipment suppliers; ESRD Networks; state representatives; the Renal Leadership Council (RLC); as well as the CMS and other federal agencies such as the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NHI).

Phase I of the Coalition work has been completed with the development and initial dissemination of tools and resources and a national kidney community response plan to help patients, facilities, emergency responders, and coalition members plan for, and respond to, emergencies and disasters.

CMS will assume the administrative coordination lead as the Coalition moves into Phase II. Coalition activities will focus on making individuals with ESRD and the state and local response workers aware of the tools and materials available, as well as testing and refining the national kidney community response plan. ESRD networks, healthcare practitioners, dialysis facilities, industry, and patient representatives will play a critical role as the Coalition moves into Phase II, and in the event of a disaster, will be at the forefront of implementation of the response plan.

CMS has a number of additional activities including education campaigns, and contractual (e.g., ESRD networks) and regulatory (e.g., proposed ESRD Conditions for Coverage) changes underway to supplement the work of the Coalition, as well as activities to ensure all Medicare beneficiaries have access to health care services in the event of a disaster, including the possibility of a flu pandemic.

For more information and links to CMS disaster planning activities and resources, please visit *http://www.cms.hhs.gov/Emergency/*.

The National Kidney Foundation is host of a clearinghouse of Coalition activities that may be accessed at *http://www.kidney.org/help*. ❖

Source: CMS Provider Education Resource 200607-14

SKILLED NURSING FACILITY SERVICES

Correction to Skilled Nursing Facility Consolidated Billing Enforcement if SNF Inpatient Claims Are Partially Noncovered

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

Provider Types Affected

Skilled nursing facilities (SNFs) that bill Medicare fiscal intermediaries (FIs) for SNF services

Provider Action Needed

STOP – Impact to You

If you submit 22x bill type claims to your FI that contain **therapy services** (physical therapy, speech language pathology services, and occupational therapy) subject to SNF consolidated billing (CB), the claims may be rejected inappropriately by SNF CB when they fall within partially noncovered periods identified on inpatient SNF bill types (i.e., 21x bill types).

CAUTION – What You Need to Know

To address this issue, under certain conditions (outlined below) the Centers for Medicare & Medicaid Services (CMS) systems will bypass line item dates of service reported on 22x bill types from the SNF CB therapy edit.

GO – What You Need to Do

Please refer to the *Background* and section of this article for further information.

Background

When Part A program payment is not possible (e.g., the beneficiary's benefits have been exhausted or the inpatient SNF stay is partially noncovered), some or all services provided in these noncovered periods may be medically necessary and may be covered as ancillary services under Part B.

Section 1888 of the Social Security Act requires SNF consolidated billing. Under the SNF CB provision, therapy services are subject to SNF CB during noncovered SNF stays and are only billable on a 22x (SNF inpatient part B) bill type.

To ensure that 22x bill type claims containing therapy services subject to SNF CB will not be rejected as a result of the circumstance described above, the CMS systems will bypass line item dates of service reported on 22x bill types from the SNF CB therapy edit when the dates of service:

- Fall within reported noncovered periods on overlapping SNF 21x bill types (identified by occurrence span codes 74, 76 or 77, 79 and/or M1).
- Are greater than the benefit exhaust date or date active care ended reported on overlapping SNF 21x bill types (greater than the occurrence code A3, B3, C3, or 22 reported on the 21x SNF inpatient claim).

Please note that your FI will not search their files to retroactively pay claims that were incorrectly rejected. However, they will adjust claims that you bring to their attention.

Implementation

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

Additional Information

CR 5220, containing the attached manual revision to Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing), Section 20.5 (Therapy Services), is the official instruction issued to your Medicare FI regarding changes mentioned in this article. CR 5220 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1009CP.pdf*.

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

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

MLN Matters Number: MM5220
Related Change Request (CR) Number: 5220
Related CR Release Date: July 28, 2006
Related CR Transmittal Number: R1009CP
Effective Date: October 1, 2005
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1009, CR 5220

Medicare Part A Skilled Nursing Facility Prospective Payment System PRICER Update for Fiscal Year 2007

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

Provider Types Affected

Skilled nursing facilities (SNFs) billing Medicare fiscal intermediaries (FIs)

Background

Annual updates to the PPS rates are required by the Social Security Act, as amended by the Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug Improvement and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs. The Centers for Medicare & Medicaid Services (CMS) published the SNF payment rates for fiscal year (FY) 2006 (October 1, 2005 through September 30, 2006) in the *Federal Register* on August 5, 2005 (70 FR 40526).

Note: The rule is available at *http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/05-15221.htm*.

Correction Notice to SNF Payment Rates for FY 2006

CMS published a correction notice to the SNF payment rates for FY 2006 on September 30, 2005 (70 FR 57164). The update methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with AIDS.

The statute mandates an update to the federal rates using the latest SNF full market basket.

Note: A market basket is a group of products or services in a specific market. Classic market-basket analysis treats the purchase of a number of items (for example, the contents of a shopping basket) as a single transaction. Input prices are the pure prices of inputs used by an SNF in providing services, and these include labor, capital, and materials (such as drugs). By definition, an input price reflects prices faced by the SNF in purchasing these inputs, whereas an output price reflects the prices faced by buyers of SNF services. CMS currently can measure input prices using the SNF input price index, or "market basket."

CR 5209 – Key Points

- The FY 2007 SNF payment rates will be effective October 1, 2006, through September 30, 2007.
- The update methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with AIDS.

Implementation

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

Additional Information

Market Basket Definitions and General Information may be found on the CMS website at *http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf*.

The official instruction, CR 5209, issued to your Medicare FI regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1008CP.pdf*.

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

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

MLN Matters Number: MM5209
Related Change Request (CR) Number: 5209
Related CR Release Date: July 28, 2006
Related CR Transmittal Number: R1008CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1008, CR 5209

Medicare Nursing Home Payments To Increase in 2007

Medicare payments to nursing homes will increase by approximately $560 million in 2007, the Centers for Medicare & Medicaid Services (CMS) announced today. The annual update notice of the new payment rates is on display today at the offices of the *Federal Register*.

The 3.1 percent increase will be reflected in Medicare payment rates to nursing facilities that furnish certain skilled nursing and rehabilitation care to Medicare beneficiaries recovering from serious health problems.

For further information, please click below to view the press release: *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1918*.

The SNF PPS update notice is available on the CMS website at *http://www.cms.hhs.gov/providers/snfpps*. ❖

Source: CMS Pub. Provider Education Resource 200607-16

CORF SERVICES

Additional Deficit Reduction Act Mandated Service Edits—Outpatient Therapy

Note: CMS has rescinded transmittal 1016 and replaced it with transmittal 1019 to correct typographical errors in the business requirement section addressed to contractors. This replacement does not affect the instructions provided in the CMS Internet-only-manual Pub 100-04, Medicare Claim Processing, and the information in section 20.2 – Reporting of Service Unit with HCPCS remains the same.

The Centers for Medicare & Medicaid Services (CMS) has issued instructions that provide additional limitations on outpatient therapy services, consistent with the provisions of the Deficit Reduction Act of 2005 Section 5107 requires limitations on outpatient therapy services, for the purpose of identifying and eliminating improper payments.

Certain services are limited to certain numbers of units per day for physical therapy, occupational therapy and speech-language pathology, separately to control inappropriate billing. CMS Internet-only-manual Pub 100-04, *Medicare Claim Processing*, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services, Section 20.2, Reporting of Service Units with HCPCS has been revised to incorporate these instructions and proper billing examples.

20.2 – Reporting of Service Units with HCPCS

A. General

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS-1450 were required to report the number of units for outpatient rehabilitation services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500, and CORFs were required to report their full range of CORF services on the Form CMS-1450. These unit-reporting requirements continue with the standards required for electronically submitting health care claims under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) – the currently adopted version of the ASC X12 837 transaction standards and implementation guides. The Administrative Simplification Compliance Act mandates that claims be sent to Medicare electronically unless certain exceptions are met.

B. Timed and Untimed Codes

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).

Example: A beneficiary received a speech-language pathology evaluation represented by HCPCS "untimed" code 92506. Regardless of the number of minutes spent providing this service only one unit of service is appropriately billed on the same day.

Providers billing to FIs and RHHIs should report value code 50, 51, or 52, the total number of physical therapy, occupational therapy, or speech–language pathology visits provided from start of care through the billing period. This item is visits, not service units. Value codes do not apply to claims sent to carriers.

Several *CPT* codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any single calendar day** using *CPT* codes and the appropriate number of 15-minute units of service.

Example: A beneficiary received occupational therapy (HCPCS "timed" code 97530 which is defined in 15-minute units) for a total of 60 minutes. The provider would then report revenue code 043x and 4 units.

C. Counting Minutes for Timed Codes in 15 Minute Units

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed *CPT* code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

Units	Number of Minutes
1 unit:	= 8 minutes through 22 minutes
2 units:	= 23 minutes through 37 minutes
3 units:	= 38 minutes through 52 minutes
4 units:	= 53 minutes through 67 minutes
5 units:	= 68 minutes through 82 minutes
6 units:	= 83 minutes through 97 minutes
7 units:	= 98 minutes through 112 minutes
8 units:	= 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.

Additional Deficit Reduction Act Mandated Service Edits—Outpatient Therapy (continued)

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of units billed.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If more than one 15 minute timed *CPT* code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

Pub. 100-02, chapter 15, section 230.3B Treatment Notes indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

Example 1

24 minutes of neuromuscular reeducation, *CPT* code *97112*
23 minutes of therapeutic exercise, *CPT* code *97110*
Total timed code treatment time was 47 minutes.

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of *CPT* code *97110*, assigning more timed units to the service that took the most time.

Example 2

20 minutes of neuromuscular reeducation (*97112*)
20 minutes therapeutic exercise (*97110*)
40 Total timed code minutes.

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3

33 minutes of therapeutic exercise (*97110*)
7 minutes of manual therapy (*97140*)
40 Total timed minutes.

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of *CPT* code *97110* and 1 unit of *CPT* code *97140*. Count the first 30 minutes of *97110* as two full units. Compare the remaining time for *97110* (33-30 = 3 minutes) to the time spent on *97140* (7 minutes) and bill the larger, which is *97140*.

Example 4

18 minutes of therapeutic exercise (*97110*)
13 minutes of manual therapy (*97140*)
10 minutes of gait training (*97116*)
8 minutes of ultrasound (*97035*)
49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of *97110*, *97116*, and *97140*. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5

7 minutes of neuromuscular reeducation (*97112*)
7 minutes therapeutic exercise (*97110*)
7 minutes manual therapy (*97140*)
21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub 100-02/15, sec. 220) shall select one appropriate *CPT* code (*97112*, *97110*, *97140*) to bill since each unit was performed for the same amount of time and only one unit is allowed.

Note: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes – including minutes spent providing services represented by untimed codes – are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 230.3: Documentation, Treatment Notes.

D. Specific Limits for HCPCS

The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)). Denied claims may be appealed and an ABN is appropriate to notify the beneficiary of liability.

This chart does not include all of the codes identified as therapy codes; refer to section 20 of this chapter for further detail on these and other therapy codes. For example, therapy codes called "always therapy" must always be accompanied by therapy modifiers identifying the type of therapy plan of care under which the service is provided.

Additional Deficit Reduction Act Mandated Service Edits—Outpatient Therapy (continued)

Use the chart in the following manner:

- The codes that are allowed one unit for "Allowed Units" in the chart below may be billed no more than once per provider, per discipline, per date of service, per patient.
- The codes allowed 0 (zero) units in the column for "Allowed Units", may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).
- When physicians/NPPs bill "always therapy" codes they must follow the policies of the type of therapy they are providing e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units on the chart below for PT, OT or SLP depending on the plan. A physician/NPP shall not bill an "always therapy" code unless the service is provided under a therapy plan of care. Therefore, NA stands for "Not Applicable" in the chart below.
- When a "sometimes therapy" code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.

***CPT* Codes**	**Code Description and Claim Line Outlier/Edit Details**	**Timed or Untimed**	**PT Allowed Units**	**OT Allowed Units**	**SLP Allowed Units**	**Physician/NPP NOT under Therapy POC**
92506	*Speech/hearing evaluation*	Untimed	0	0	1	NA
92597	*Oral speech device eval*	Untimed	0	1	1	NA
92607	*Ex for speech device rx, 1hr*	Timed	0	1	1	NA
92611	*Motion fluroscopy/swallow*	Untimed	0	1	1	1
92612	*Endoscope swallow test (fees)*	Untimed	0	1	1	1
92614	*Laryngoscopic sensory test*	Untimed	0	1	1	1
92616	*Fees w/laryngeal sense test*	Untimed	0	1	1	1
95833	*Limb muscle testing, manual*	Untimed	1	1	0	1
95834	*Limb muscle testing, manual*	Untimed	1	1	0	1
96110	*Developmental test, lim*	Untimed	1	1	1	1
96111	*Developmental test, extend*	Untimed	1	1	1	1
97001	*PT evaluation*	Untimed	1	0	0	NA
97002	*PT re-evaluation*	Untimed	1	0	0	NA
97003	*OT evaluation*	Untimed	0	1	0	NA
97004	*OT re-evaluation*	Untimed	0	1	0	NA

Source: CMS Pub. 100-04, Transmittal 1019, CR 5253

The Health Insurance Portability and Accountability Act (HIPAA)

End of Contingency for Electronic Remittance Advice (ERA)—ACTION

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

Provider Types Affected

Providers and physicians who bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers, including durable medical equipment regional carriers (DMERCs)

Background

This special edition article clarifies for providers the information issued by the Centers for Medicare & Medicaid Services (CMS) regarding the date to end the contingency plan for electronic remittance advices (ERAs).

Key Points

Effective October 1, 2006, Medicare will only generate Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice – transaction 835 version 004010A1 – to all electronic remittance advice receivers. In addition, CMS issued instructions in change request (CR) 5047 that required a one-time hold of Medicare payments for the period of September 22, 2006, to September 30, 2006, for claims that would have been paid during the last **nine** business days of fiscal year 2006. (See the *MLN Matters* article on CR 5047 on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf*.)

CMS has further instructed that on or after October 1, 2006:

- Any ERA for claims that would be held per CR 5047 or for any other reason shall be created in the HIPAA compliant format.
- Any duplicate remittance advice per provider request shall be created in the HIPAA compliant, if electronic, or paper format.

Current figures indicate that 99 percent of all ERA receivers (providers and other entities that receive the ERA on behalf of providers) are receiving a HIPAA compliant ERA format and they are unaffected by the end of the contingency plan. The remaining **1 percent of legacy ERA receivers need to transition to a HIPAA compliant ERA format** between now and October 1, 2006. The following are the **options available** to you as a legacy ERA receiver:

- Start receiving HIPAA compliant ERAs beginning **on October 1, 2006.**
- Request to switch to standard paper remittance (SPR) advice.
- If you are already receiving an SPR, and do not want to receive the HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier to stop sending any ERA.
- If providers are not currently receiving SPR, and do not wish to switch to HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier that you would like to start receiving SPR and not receive any ERA.

There are tools available to providers to view and print the remittance advice information using free Medicare software (PC Print for institutional providers and Medicare Remit Easy Print (MREP) for professional providers and suppliers).

These free software packages are 835 version 004010A1 compatible and will not work with any legacy ERA. Both software packages have important advantages over the SPR. Both packages can also be used to generate a hard copy remittance to be sent for secondary/tertiary billing, and for accounts receivable reconciliation. See the additional information section of this article for MREP details.

Additional Information

To learn about more MREP benefits, download the brochure available on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/remit_easy_print.pdf* .

Or, you can view special edition MLN Matters article SE0611 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf* or a related MLN Matters article (MM4376) on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.pdf*.

For more information about the MREP software and how to receive the HIPAA 835, please contact your FI, RHHI, carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartBEDIHelpline.pdf* on the CMS website. Those billing for Part A services may find the appropriate toll free number on the CMS website at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartAEDIHelpline.pdf*.

MLN Matters Number: SE0656
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0656
CMS Joint Signature Memorandum 06599, August 2, 2006

ELECTRONIC DATA INTERCHANGE

Urgent Message: Problem with 270/271

Between Monday, July 24, and Thursday, July 27, 2006, the CMS 270/271 health care eligibility inquiry and response transaction used by providers to obtain beneficiary eligibility information was returning "Patient Not Found" response for beneficiaries that are actually entitled to Medicare.

This problem had to do with a large number of beneficiaries that had been inadvertently deleted from the data extract used by the 270/271 transaction. This problem did not impact the provider IVRs, it only impacted the CMS 270/271 eligibility inquiry and response transaction.

If you received a "Patient Not Found" response after inputting the correct beneficiary information for the 270/271 transaction, the Centers for Medicare & Medicaid Services apologizes for this problem and informs you that the problem was correct on July 27, 2006.

Approximately two million 270/271 transactions are processed each week and it is unclear how many transactions returned bad data. ❖

Source: CMS Provider Education Resource 200608-01

EDUCATIONAL RESOURCES

Provider Educational Opportunities Now Available

First Coast Service Options, Inc. (FCSO) offers a variety of educational programs on a range of subjects using multiple delivery methods. The following is a listing of upcoming courses and events. You may obtain additional information for each of these courses through FCSO's dedicated Medicare website at *http://www.floridamedicare.com*.

Web-based Training Courses

These online courses are available 24 hours a day, seven days a week, at no charge, through our provider education website. After accessing *http://www.floridamedicare.com,* click on "Education" on the top navigation menu. Select "eLearning" on the left navigation menu. Courses currently available are:

- Beneficiary Name and Medicare Number Mismatch
- Coding Inpatient Cost Outlier Claims
- Comprehensive Error Rate Testing (CERT)
- Determining Medicare Part A Benefit Period
- Medical Documentation Requests
- MSP Beyond the Basics
- Progressive Corrective Action
- Verifying Beneficiary Eligibility in DDE (Direct Data Entry)

Web-based Training Courses Under Development

The following Web-based training courses will be available in the near future:

- National Provider Identifier
- Provider Enrollment

Be sure to check regularly our provider education website regulary for these upcoming online courses.

Webcasts

Webcasts offer the opportunity to learn from your office while interacting with a member of the Provider Outreach and Education team. This educational format uses an internet site to share presentations live while audio is provided through the telephone. These brief sessions are an excellent way to learn about important topics without having to leave the office. Since the first webcast offered in May, feedback has been overwhelmingly positive. The following webcasts are scheduled for delivery during the month of September 2006:

- **Website Navigation**
  September 13, 2006
- **Part A Small Provider – Rehabilitation Services**
  September 14, 2006

  September 20, 2006

To register online for the above webcasts access *http://www.floridamedicare.com,* click on "Education" on the top navigation menu. Select "Event List" on the left navigation menu, or use the following link *http://www.floridamedicare.com/edu_local_events_2%20Event%20List.asp*. Then, navigate to the date of the webcast and click on the event title to register.

Educational Seminars

For a list and calendar of upcoming educational events, and registration policies, access *http://www.floridamedicare.com/Education.asp#TopOfPage*.

A summary of these events is provided on pages 52-56 of this publication.

Providers Lacking Internet Access

Medicare providers lacking Internet access who are interested in learning about educational programs offered by FCSO may contact us by:

- Telephone

  Florida Provider Education Event Hotline – 1-904-791-8103
- Electronic-mail address – eventsfl@fcso.com. ❖

Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program Facilitator Kit now Available

The *Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program Facilitator's Kit,* which includes everything facilitators, trainers, educators, and physicians need to prepare for and present a Medicare training course, is now available.

To order your free facilitator's kit, visit the Medicare Learning Network the Centers for Medicare & Medicaid Services website at *http://www.cms.hhs.gov/mlngeninfo*.

Select "MLN Product Ordering Page" under the "Related Links Inside CMS" section to place your order. ❖

Source: CMS Provider Education Resource 200608-08

Updated Versions of Web-Based Training Courses and Medicare Appeal Process Brochure now Available

The Centers for Medicare & Medicaid Services (CMS) has updated of the following free-of-charge educational products:

- Preventive services Web-based training courses
- Brochure on the Medicare appeal process.

Preventive Services Web-Based Training Courses

The updated Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based training course is now available on the Medicare Learning Network (MLN) Product Ordering Page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.

The course provides information about Medicare coverage for the following adult immunizations:

- Influenza
- Pneumococcal
- Hepatitis B

CMS has awarded 0.1 of CEUs (continued education units) to participants who successfully complete this program.

The updated Medicare Preventive Services Series: Part 2 Women's Health Web-based training course is now available on the Medicare Learning Network (MLN) Product Ordering Page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

The course provides information about Medicare coverage for the following preventive services:

- Mammography
- Pap test and pelvic exam
- Colorectal cancer screening
- Bone mass measurements

CMS has awarded .2 of CEUs to participants who successfully complete this program. The *Medicare Preventive Services: Part 3 Expanded Benefits* Web-based training course is now available on the Medicare Learning Network (MLN) Product Ordering Page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

The course provides information about Medicare coverage for the following preventive services:

- Initial preventive physical examinations
- Diabetes screenings
- Cardiovascular disease screenings
- Diabetes self management training
- Medical nutrition therapy and other diabetes supplies
- Colorectal, prostate, and glaucoma screenings
- Bone mass measurements.

CMS has awarded 0.2 of CEUs to participants who successfully complete this program.

The information presented in these Web-based training courses will be helpful for physicians, nurses, medical administrators and other health care professionals who provide these preventive services and screening to Medicare patients.

CMS has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, suite 615, Washington DC 20006.

The authors of these programs have nothing to disclose.

The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers

The brochure The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers has been updated and is now available in downloadable format on the MLN Publications page located at http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf.

This brochure provides an overview of the Medicare Part A and Part B administrative appeal process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries. Print copies will be available in approximately six weeks. ❖

Source: CMS Provider Education Resource 200608-04

Updated Website Wheel now Available for Ordering

The Centers for Medicare & Medicaid Services (CMS) has updated the *CMS Website Wheel* document and is now available for ordering through the Medicare Learning Network website at *http://www.cms.hhs.gov/MLNProducts/Downloads/MLNCatalog0506.pdf*.

This website wheel is an informational resource tool that provides a variety of CMS Medicare-related websites. The Web addresses are listed by topic. The available format is in hard copy only (ICN #006212). ❖

Source: CMS Provider Education Resource 200608-06

Medicare Immunization Billing Quick Reference now Available

Quick Reference Information: Medicare Immunization Billing
This two-sided job aid gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. This product is available to view, download, and print from the CMS Medicare Learning Network Preventive Services Educational Products Web page located on the CMS website at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp.

Print copies will be available in early Fall, 2006. ❖

Source: CMS Provider Education Resource 200608-05

FCSO *eNews* Notices

We encourage you to register for our *eNews* mailing lists to receive urgent, critical, and new information. By signing up, you will receive regular messages providing you with updates to the provider educational website (*www.floridamedicare.com*) and key program alerts, critical program changes, seminar schedules, publications, and educational tips. Sign up today by clicking on "eNews" on the top navigational menu. Select "FCSO eNews Lists/Interest Groups" on the FCSO eNews Electronic Mailing List Service main page, or use the following link:

http://lb.bcentral.com/ex/manage/subscriberprefs.aspx?customerid=8380

The following is the list of interest groups currently available:

- ❑ FL: Part A (General)
- ❑ FL: Part A ESRD
- ❑ FL: Part A LMRP/LCD
- ❑ FL: Part A SNF
- ❑ FL: Part A Critical Access Hospitals
- ❑ FL: Part B (General)
- ❑ FL: Part B Anesthesia
- ❑ FL: Part B Cardiology
- ❑ FL: Part B Chiropractic
- ❑ FL: Part B LMRP/LCD
- ❑ FL: Part B Vision
- ❑ FL: Ambulance
- ❑ FL: ASC (Ambulatory Surgical Center)
- ❑ FL: EDI (Technical)
- ❑ FL: Podiatry
- ❑ FL: Rehabilitation Services

If you have signed up for this service in the past but have not received **regular** *eNews* notices, we ask that you please use the "Comment Form" by accessing the "Contacts" section on the top navigational menu. Select "eNews Help" in the drop-down subject box, and indicate the interest groups for which you have registered in the "Comment" box. We are asking this to ensure your e-mail address is not one for which we are unable to deliver messages.

Because some organizations have enhanced their firewalls or security settings, we are not able to successfully transmit our *eNews* notices to individuals within those organizations. You may also wish to check with your organization's IT staff to determine how they can identify our organization as an allowable sender to your individual e-mail address. ❖

PREVENTIVE SERVICES

August is National Immunization Awareness Month

While many consider this to be a time to ensure that children are immunized for school, it also provides a good opportunity to speak with your Medicare patients about their immunizations.

Medicare covers both the cost of pneumococcal and influenza vaccine and their administration by recognized providers. No beneficiary co-insurance or co-payment applies and a beneficiary does not have to meet his or her deductible to receive an influenza or pneumococcal immunization. Medicare also covers hepatitis B vaccination for persons at high or intermediate risk. The coinsurance or co-payment applies for hepatitis B vaccination after the yearly deductible has been met.

Despite Medicare coverage, the use of these benefits is not optimal. In 2004, Medicare survey data indicate a 73 percent influenza vaccination rate for facility and community-dwelling Medicare beneficiaries, and a 67 percent pneumococcal vaccination rate for the same population.

Additionally, dialysis patients are under-immunized. Vaccines are one of public health's great triumphs. With the exception of safe water, no other health strategy has had such a tremendous effect on reducing disease and improving health. Maintaining high immunization rates protects the entire community and is an important public health matter.

Why Immunize Adults? An average of 36,000 Americans die from influenza or its complications each year. The National Center for Health Statistics reported influenza and pneumonia to be the primary causes of death for more than 57,000 older adults in 2003.

Pneumococcal disease occurs year round and accounts for approximately 40,000 cases of invasive disease and 5,000 deaths per year in the United States.

August is National Immunization Awareness Month (continued)

For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Medicare will cover a booster pneumococcal vaccine for high-risk persons if **five** years have passed since their last vaccination.

What's New?

- Nursing home residents are especially vulnerable to influenza and pneumonia and their complications. **Beginning September 1, 2006,** influenza and pneumococcal vaccination assessments will be included as part of the minimum data set (MDS) for nursing homes.
- **As of January 2005,** all newly enrolled Medicare beneficiaries are covered for an initial physical examination that includes immunization for pneumococcal disease and influenza.
- **As of January 2005,** physicians can be paid for injections and immunizations administered to people with Medicare, even when administered during a visit, which includes other Medicare-covered services.
- **As of October 2002,** hospitals, long-term care facilities and home health agencies participating in Medicare and Medicaid programs can administer influenza and pneumococcal vaccinations according to a standing orders protocol without the need for a physician's examination or direct order.
- Quality Improvement Organizations in each state are working to increase immunization rates in hospitals, physicians' offices, home health care settings and nursing homes.

How Can You Help? As a trusted source, your recommendation is the most important factor in increasing immunization rates among adults.

For More Information

For more information about Medicare's adult immunization benefits, billing Medicare for vaccinations, and other helpful information, visit the CMS website: http://www.cms.hhs.gov/AdultImmunizations/01_Overview.asp#TopOfPage.

National Immunization Awareness Month is the perfect time to remind patients, health care employees, family members, friends, co-workers and others to get up-to-date on their vaccinations. To paraphrase a quote from the great hockey player Wayne Gretzky, "Your patients will miss 100 percent of the shots they never take." Let's protect people with Medicare by making sure that each August they have received their lifetime pneumococcal immunization, they have been assessed for their risk for hepatitis B, and they have an appointment to obtain their influenza vaccination in the fall.

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

- The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.
- The CMS website provides information for each preventive service covered by Medicare. Click on *http://*www.cms.hhs.gov, select "Medicare", and scroll down to "Prevention".

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

As always, thanks so much for helping CMS spread the word about immunizations and all preventive services covered by Medicare. ❖

Source: CMS Provider Education Resource 200608-02

Medicare Part A Teleconference Invitation

Tuesday, September 12, 2006

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

The Medicare Communication and Education Department of
First Coast Service Options, Inc. cordially invites you to attend:

"Ask the Contractor"

This teleconference is the latest installment of educational efforts designed to support and inform the provider community by answering the questions that are on your mind. The session will begin with a presentation on the following:

- **National Provider Identifier and Provider Enrollment**

Get first-hand answers to your questions on these topics by Medicare subject matter experts. Please join us from 11:30 a.m. – 12:30 p.m. for this very informative training session. Don't miss out on this opportunity to interact directly with the experts!

If you would like to participate in the teleconference:

(1) Register on line at www.floridamedicare.com by September 11, 2006. Don't wait! Space is limited to 50 phone lines. (To register, select Education and Training from the Site Map and continue to Event Registration Online.)

(2) Join the teleconference on September 12, 2006 by dialing 1-800-860-2442.

(3) The "Ask the Contractor" Teleconference presentation will be emailed to all registered participants the morning of on September 11, 2006 along with an evaluation form. Please complete the evaluation form at the conclusion of the teleconference and fax it to 904-791-6035.

MEDICARE 101 for Part A

Join the Medicare Communication and Education Department

September 15, 2006

for a half-day educational extravaganza at the

Jacksonville Marriott
4670 Salisbury Road, Jacksonville, Florida 32256
904-296-2222

Session times are 8:00 a.m. to 12:00 p.m.!

Course	Description
Pre-Assessment	• Used to determine your current knowledge of the Medicare Program
Overview of Medicare	• Describe participation regulations • Identify enrollment forms applicable to your situation • Describe beneficiary eligibility requirements, premiums, and deductibles
UB-92 Claim Form and the new UB-04 Claim Form	• Review the purpose • Explain mandatory claim submission rule and billing requirements • Explain transition to the UB-04 • Review timeframes to move to the UB-04
Post-Assessment	• Determines your knowledge of the Medicare Program after the session
Certificate of Completion	• A certificate of completion will be issued at the end of the session

Want to know more? Call us at 904-791-8103 or visit our web site at **www.floridamedicare.com**. To register on line, click on the Education Tab; Event List and choose the Part A session. There is no charge for this seminar.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Note: This is a Part A Basic course that is geared for medical office staff new to the Medicare billing process or for those needing a refresher course.

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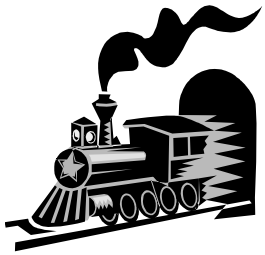


DON'T MISS OUT!

Stay on track with

"MEDICARE MADE EASY"

Join the Medicare Communication and Education Department at First Coast Service Options, Inc., for a one day educational extravaganza!

September 19, 2006

Wyndham Miami Airport
3900 Northwest 21st Street, Miami, FL 33142

Class schedules are as follows:

(Please mark only one class per time slot)

Track 1

- ☐ **8:00 a.m. – 10:00 a.m.** "Incident to" Services
- ☐ **10:15 a.m. – 12:15 p.m.** Transitioning from UB-92 to UB-04
- ☐ **1:20 p.m. – 3:20 p.m.** Podiatry Services
- ☐ **3:30 p.m. – 5:30 p.m.** Provider Enrollment/NPI

Track 2

- ☐ **8:00 a.m. – 10:00 a.m.** Skilled Nursing Facility (SNF)
- ☐ **10:15 a.m. – 12:15 p.m.** Correct Coding Initiative (CCI)
- ☐ **1:20 p.m. – 3:20 p.m.** Claims Resolution
- ☐ **3:30 p.m. – 5:30 p.m.** Radiology

The $89.00 registration fee includes sessions of your choice, lunch, and refreshments during break sessions.

Want to know more? Call us at 904-791-8103 or visit our web site at www.floridamedicare.com.
For full class descriptors, visit the online registration form at www.floridamedicare.com.

Medicare Made Easy Registration Form

Wyndham Miami Airport

3900 Northwest 21st Street, Miami, FL 33142

Please contact hotel for directions and/or reservations (305) 871-3800

Registrant's Name _____

Telephone Number _____

Email Address _____

Fax Number _____

Provider's Name _____

Street Address _____

City, State, ZIP Code _____

Cost for Medicare Made Easy

1 day only $89.00

FAXED REGISTRATION	CANCELLATIONS AND REFUNDS	SUBSTITUTIONS	CONFIRMATION NOTICE	HOTEL INFORMATION
1. Fax registration form to **(904) 791-6035.** 2. A confirmation and invoice will be faxed to you. 3. Make checks payable to: **FCSO Account #700390** 4. Mail the forms (after you have faxed them) and payment to: **Medicare Made Easy Registration P.O. Box 45157 Jacksonville, FL 32231** 5. Bring your confirmation notice to the event.	All cancellation requests must be received 7 days prior to the event. All refunds are subject to a $25.00 cancellation fee per person. (Rain checks will not be issued for cancellations.)	If you are unable to attend, your company may send one substitute to take your place for the entire seminar. Remember: Registration must be information of all changes. Once you have signed in at the registration desk, substitutions will not be permitted during the remainder of the event.	**Faxed registration**: A confirmation notice will be faxed or e-mailed to you within 7 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Communication and Education), please contact us at **(904) 791-8103.** **On-line registration:** When registering on-line for an education event, you will automatically receive your confirmation via e-mail notification.	**Wyndham Miami Airport** **3900 Northwest 21st Street, Miami, FL 33142** **(305) 871-3800**

FIRST COAST SERVICE OPTIONS, INC.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Teleconference Invitation

The Medicare Communication and Education Department of
First Coast Service Options, Inc. cordially invites you to participate!

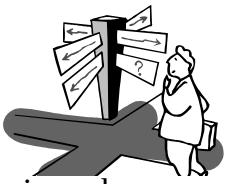
Part A Quarterly Update

What's New in Medicare for the 4th quarter 2006

Tuesday, September 26, 2006

11:30 AM – 12:30 PM

This conference call is designed to educate and inform the provider community by discussing changes that go into effect in August, September, and October 2006.



Don't miss this informative session where you will learn about new Medicare initiatives and how to avoid common provider inquiries and claim denials!

If you would like to participate in the teleconference, please register by close of business on September 22, 2006. Space is limited to 50 phone lines.

How To Register:

- Online - Go to www.floridamedicare.com to complete and submit the online registration form (located under "Event List" on the left navigation bar of the Education page). Upon successful completion of the form, you will receive a confirmation e-mail, which will include a link to the webcast. We will forward handouts and the evaluation form to you on September 25, 2006, via e-mail.
- Fax - Providers without Internet access are still welcome to participate. To register, please call our Registration Hotline at 904-791-8103 to have a registration form faxed to you. We will fax the handouts and the evaluation form to you the morning of the teleconference.

The teleconference phone number is 1-800-860-2442. On the day of the teleconference, please dial in to the phone line and sign on to the webcast a few minutes before 11:30 A.M.

ORDER FORM - PART A MATERIALS

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

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
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IMPORTANT ADDRESSES , TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

PROVIDER EDUCATION

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

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION

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

OVERPAYMENT COLLECTIONS

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

MEDICARE REGISTRATION

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

Telephone Numbers

PROVIDERS

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

BENEFICIARY

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

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Websites

PROVIDERS

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

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

RAILROAD MEDICARE

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

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

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