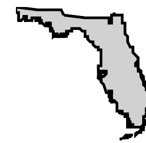
Medicare A Bulletin
A Newsletter for Florida Medicare Part A Providers



In This Issue...

Emergency Preparedness Communication
CMS Is Strengthening the Communication Infrastructure for the Nation's Health Care Providers and Encouraging Providers to Subscribe to Contractors' Listservs 7

National Provider Identification
Information, Clarification, Reminders and Educational Products Available Regarding the Usage of National Provider Identifier on Medicare Claims 10

Psychological and Neuropsychological Tests
Revisions to CPT Codes and other Important Points Related to these Tests 11

2007 Inpatient Prospective Payment System
Fiscal Year Changes to the IPPS for Long-term Care and Psychiatric Facilities 14

2007 Prospective Payment System PRICER
Fiscal Year Changes to the PPS Pricer for Inpatient Rehabilitation Facilities 17

Local Coverage Determinations
Notification of Additions/Revisions to Local Coverage Determinations 23

October 2006 Update to Outpatient Code Editor System
Changes to Outpatient Services Not Subject to Outpatient Prospective Payment System .. 16

Skilled Nursing Facility Consolidation Billing
2007 Annual Update to the HCPCS Codes Affected by the SNF CB Initiative 28

Features

About This Bulletin 3
General Information 4
General Coverage 11
Hospital Services 14
Local Coverage Determinations 23
Critical Access Hospital 26
Skilled Nursing Facilities 28
Outpatient Prospective Payment System 30
Electronic Data Interchange 33
Educational Resources 34

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
- ☐ ________________
- ☐ ________________
- ☐ ________________

November 2006 Volume 8, Number 8

Table of Contents

In This Issue 1
About the *Medicare A Bulletin* 3

General Information
CMS Announces Part D Low Income Subsidy Redetermination Information 4
"Own Your Future:" Long-Term Care Campaign ... 6
CMS Strengthens Emergency Preparedness Communication 7
Flu Shot Reminder 7
Medicare Part A Provider Call Center Holiday Closure 7
Medicare Part A Provider Call Center Training Hours and Scheduled Closings 8
Medicare Secondary Payer Recovery Contractor Addresses 8
Will You Be Ready?—NPI Reminder 9
NPI Claim Processing Information 10
New NPI Educational Products Available 10

General Coverage
Psychological and Neuropsychological Tests 11
Termination of HCPCS Code G0107, Colorectal Cancer Screening, Fecal-Occult Blood Tests, 1-3 Simultaneous Determination 13

Hospital Services
Fiscal Year 2007 Inpatient Prospective Payment System, Long-Term Care Hospital, and Inpatient Psychiatric Facility PPS Changes 14
Inpatient Rehabilitation Facility Annual Update: Prospective Payment System PRICER Changes for Fiscal Year 2007 17
Notifying Medicare Patients About Lifetime Reserve Days 18
Holding of Pancreas Transplant Alone Claims—Amendment to *MLN Matters* Article MM5093 20
Pancreas Transplant Alone 21

Local Coverage Determinations
LCD Table of Contents 23
Health Professional Shortage Area Listing 27

Critical Access Hospital Services
October 2006 Non-Outpatient Prospective Payment System Outpatient Code Editor—Specifications Version 22.0 26
Health Professional Shortage Area Listing 27

Skilled Nursing Facility Services
2007 Annual Update of HCPCS Codes for Skilled Nursing Facility Consolidated Billing . 28
SNF Consolidated Billing Web-based Training Course Is Now Available 29

Outpatient Prospective Payment System
October 2006 Update of the Hospital Outpatient Prospective Payment System—Summary of Payment Policy Changes 30

Electronic Data Interchange
Ending the Contingency Plan for Remittance Advice and Charging for PC Print, Medicare Remit Easy Print, and Duplicate RAs 33

Educational Resources
Upcoming Provider Outreach and Educational Events 34
Medicare Preventive Services Provider Education Products 35
October Is National Breast Cancer Awareness Month 35
Order Form - Part A Materials 37
Important Addresses, Telephone Numbers and Websites 39

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

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

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About the *Medicare A Bulletin*

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

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

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

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

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Who Receives the *Bulletin*?

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

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

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

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

What Is in the *Bulletin*?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

Editor, *Medicare A Bulletin*
Medicare Publications – 10T
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

CMS Announces Part D Low Income Subsidy Redetermination Information

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

Provider Types Affected

Physicians, suppliers, providers, and their staff who serve Medicare beneficiaries.

Background

The purpose of this special edition (SE) article is to alert providers that Medicare and Social Security are making decisions about whether some people who qualify for extra help (also referred to as the low-income subsidy) in 2006 will continue to qualify in 2007. People affected by these changes will receive information from Medicare or Social Security. The information provided in this SE is intended to help you counsel your patients affected by these changes and help them understand their options for getting help paying for Medicare prescription drug coverage.

Key Points

Changes In Qualifying for Extra Help in 2007

A person will no longer **automatically** qualify for extra help in 2007 if he or she no longer:

- Has both Medicare and Medicaid (full-benefit dual-eligible),
- Belongs to a Medicare savings program (partial dual-eligible), or
- Receives Supplemental Security Income (SSI) benefits.

People who will no longer automatically qualify for extra help in 2007 will receive a notice and an application for extra help in the mail from Medicare by the end of September.

If in the coming months a person's situation changes so that they again automatically qualify for extra help, Medicare will send them another notice letting them know that they qualify.

Medicare is also mailing notices to people who will continue to automatically qualify for extra help in 2007 but whose copayment levels will change as of January 1, 2007. Medicare will mail these notices by early October to let people know their new copayment level. A change in co-payment level could result when there is a change in someone's Medicaid eligibility.

For example, if someone with both Medicare and Medicaid no longer resides in a nursing home, then he or she will no longer qualify for a $0 co-payment effective January 1, 2007.

People with no changes who continue to automatically qualify for extra help as of January 1, 2007, will not receive a notice.

Beneficiaries Might Still Save on Their Medicare Prescription Drug Coverage Costs Even if They Don't Qualify for Extra Help

The good news is, even if a person no longer automatically qualifies for extra help, they may still be able to save on Medicare prescription drug coverage costs. A person who no longer automatically qualifies may still qualify for extra help based on their income and resources, but will need to apply to Social Security or their state Medical Assistance (Medicaid) office to find out. Applying early is important so their extra help can be effective as early as January 1, 2007. Social Security's application for extra help and a self-addressed postage free envelope will be included in the mailing they receive. And if they don't qualify, there are still other ways to save on drug costs, as mentioned below.

A person should **apply and qualify** for extra help if:

- Yearly income is less than $14,700 (single) or $19,800 (married and living with their spouse), and
- Resources are less than $11,500 (single) or $23,000 (married and living with their spouse). Resources include savings and stocks but not home or car.

The above amounts are for 2006 and may change in 2007. If a beneficiary lives in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How To Apply for Extra Help

Use the Web, phone, mail, or in person but apply as soon as possible:

- Apply for extra help online through Social Security on the Web at *http://www.socialsecurity.gov/*.

  To apply by phone, get a paper application mailed, or make an appointment at the local Social Security office, call 1-800-772-1213. TTY users should call 1-800-325-0778.
- To apply for extra help through the state medical assistance (Medicaid) office, visit *http://www.medicare.gov/* or call 1-800-MEDICARE (1-800-633-4227) for their telephone number. TTY users should call 1-877-486-2048.
- Remind beneficiaries to apply or reapply for extra help if income and/or resources change.

If patients still don't qualify for extra help, encourage them to review the following options for lowering prescription drug coverage costs:

- The state may have programs that provide help paying prescription drug costs. The patient should contact their State Medical Assistance (Medicaid) office for more information. They can call 1-800-MEDICARE or visit *http://www.medicare.gov/* for the Medicaid telephone number.
- There may be Medicare drug plans available in your area for 2007 with no premiums and no deductibles.

CMS Announces Part D Low Income Subsidy Redetermination Information (continued)

Encourage patients to compare these plans to their current plan. New Medicare drug plans can begin advertising as of October 1. Beneficiaries have the opportunity to switch Medicare drug plans from November 15 through December 31 each year. New coverage would begin January 1 of the following year.

Encourage patients to enroll early. If they're switching plans, joining the new Medicare drug plan as soon as possible gives the plan time to mail a membership card, acknowledgement letter, and welcome package before the new coverage becomes effective.

People Who Applied and Qualified for Extra Help in 2006

The Social Security Administration (SSA) is reviewing the eligibility of people who applied and qualified for extra help prior to May 2006. This review will ensure these people are still eligible and receiving the appropriate amount of extra help. SSA mailed these individuals a letter at the end of August telling them what Social Security's records show for their income, resources and household size. A cost of living increase in their Social Security benefit will not be considered a change in their situation.

- People who have no changes to their income, resources or household size should do nothing.
- People who have any changes to their income, resources, or household size will need to return a one-page letter (L1026) in the envelope enclosed with the mailing within 15 days. SSA will then mail them a form called "Social Security Administration Review of Your Eligibility for Extra Help" (Form 1026B). If these individuals fill out and return the form within 30 days, any change to the amount of extra help they qualify for will be effective in January 2007 unless their marital status changed. Changes in marital status may result in changes to the amount of extra help in the following month.

SSA will also send the eligibility review form (1026B) directly to some people to complete because SSA already has information about a change in their income, resources or household composition. The Medicare beneficiary needs to return that form to the SSA within 30 days.

SSA will review the eligibility review form (1026B) and send the person a letter explaining its decision. SSA may decide a person:

- Has no change in the amount of extra help they receive, or
- Has an increase in the amount of extra help they receive, or
- Has a decrease in the amount of extra help they receive, or
- No longer qualifies for extra help.

If a beneficiary believes that SSA's decision is incorrect, they have the right to appeal it. The decision letter will explain their appeal rights. The following web links at the SSA website provide more information:

- Fact Sheet – *http://www.socialsecurity.gov/pubs/10111.html*
- Mailing (L1026) on the Social Security website *http://www.ssa.gov/prescriptionhelp/L1026%20Redetermination%20English%20SAMPLE%20_08-25-06%20Systems_.pdf*.
- "Social Security Administration Review of Your Eligibility for Extra Help" (1026B) *http://www.ssa.gov/prescriptionhelp/SSA-1026B-OCR-SM-INST.pdf*.

Additional Information

The bulletins and sample notices that will be sent to Medicare beneficiaries may be reviewed by looking at the following documents at:

Changes in Qualifying for Extra Help in 2007: Materials for Partners and People with Medicare [PDF, 47KB] on the CMS website.

Re-deeming Notice: Loss of (Extra Help) Status Version [PDF, 58KB] on the CMS website.

Re-deeming Notice: Change in (Extra Help) Copayment Level Version [PDF, 55KB] on the CMS website.

Information Partners Can Use on: Changes in Qualifying for Extra Help in 2007 [PDF, 48KB] on the CMS website.

You might still save on your Medicare prescription drug coverage costs even if you don't automatically qualify for extra help [PDF, 427KB]

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

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

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Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0668

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"Own Your Future:" Long-Term Care Campaign

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

Provider Types Affected

Physicians, providers and their staff who provide health care to individuals between the ages of 45 – 65.

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to inform you about the Long-Term Care Awareness Campaign "Own Your Future" – the first effort of its kind designed to increase public awareness about the need to plan for future long-term care needs. Providers in Georgia, Massachusetts, Michigan, Nebraska, South Dakota, and Texas, may want to take special note as consumers in those states will receive letters over the next year alerting them of the campaign to promote long-term care planning and of the availability of a free long-term care planning kit. You may want to reinforce the importance of such planning as you counsel your patients.

Background

Components of the U.S. Department of Health and Human Services (HHS), including the Office of the Assistant Secretary for Planning & Evaluation (ASPE), the Centers for Medicare & Medicaid Services (CMS), and the Administration on Aging (AoA), are working with the National Governors Association to sponsor the Long-Term Care Awareness Campaign, "Own Your Future." The LTC Awareness Campaign represents a unique partnership between the federal government and the states to offer an important message to consumers about planning ahead for long-term care.

The LTC Awareness Campaign is an effort to increase public awareness of the need to plan for future long-term care needs. Many people today do not think about their future long-term care needs and therefore fail to plan appropriately. It is strongly felt that if individuals and families are more aware of their potential need for long-term care, they will be more likely to take steps to prepare for the future and determine how they would like their needs to be met.

The LTC Awareness Campaign includes evaluation activities designed to identify communication strategies that prove most effective in increasing awareness and promoting increased long-term care planning activities. The lessons learned from this campaign will be used in the design of future long-term care awareness campaigns in other states.

The campaign is now entering a third phase and builds upon the successes achieved in the first two phases in which nine states participated (Arkansas, Idaho, Kansas, Maryland, Nevada, New Jersey, Rhode Island, Virginia and Washington). It is supported with additional funds made available by Congress under the Deficit Reduction Act of 2005.

Additional Information

The LTC Awareness Campaign uses long-term care awareness materials that were designed, tested, and approved as part of an earlier awareness effort, and the materials include the following:

- Brochure (with business reply card) offering the Long-Term Care Planning Kit.
- Long-Term Care Planning Kit featuring:
  - A brochure describing what is, and what is not, covered by public programs related to long-term care. The brochure also describes several ways to plan ahead, addressing legal issues, assessing services, and assessing private financing options. An audio CD with interviews of persons engaged in several different types of long-term care planning activities. Consumers in campaign states may order the free planning kit by telephone (1-866-PLAN LTC), business reply card, or at a newly created consumer website (*http://www.aoa.gov/ownyourfuture*).

    Individuals outside the LTC Awareness Campaign states may download the planning kit at the consumer website (*http://www.aoa.gov/ownyourfuture*), or they may order and receive the free "Own Your Future" Planning Kit by calling 1-866-PLAN-LTC.

Additional important materials associated with the "Own Your Future" campaign are available on the CMS website at *http://www.cms.hhs.gov/center/longtermcare.asp*.

The materials present issues and decisions that anyone thinking about long-term care may encounter such as:

- Home modification(s)
- Family care-giving dynamics
- Financing of care.

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Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0671

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CMS Strengthens Emergency Preparedness Communication

The Centers for Medicare & Medicaid Services (CMS) is working to strengthen its emergency preparedness communication infrastructure for the nation's health care providers. As part of this emphasis, CMS is encouraging all health care providers to subscribe to their contractor's listserv in order to remain informed in case of either a regional or national emergency.

You may access First Coast Service Options, Inc. (FCSO) *eNews* mailing lists through the provider educational website (*www.floridamedicare.com*). Click on the "eNews" on the top navigational menu of the home page. 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

Providers should have a designated employee subscribed to monitor the Florida Medicare listserv and a contingency plan in effect on how to deliver the necessary information throughout the provider's organization. CMS also recommends that there be at least one alternate employee who also subscribes to serve as a backup.

This communication tool is an effective and rapid way to disseminate critical information in the case of a regional or national emergency. ❖

Source: CMS Pub. 100-20, Transmittal 239, CR 5336

Flu Shot Reminder

Flu season is upon us! Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu, and encourage them to get their flu shot. It's their best defense against combating the flu this season. *(Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)* And don't forget, health care professionals need to protect themselves also.

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

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

Note: **I**nfluenza vaccine is **not** a Medicare Part D covered drug.

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

Source: CMS Provider Education Resource 200610-01

Medicare Part A Provider Call Center Holiday Closure

The Medicare Part A Call Center will be closed on the following holidays listed below:

November 10, 2006, (Friday)	Veterans' Day Observance
November 23, 2006, (Thursday)	Thanksgiving Holiday
November 24, 2006, (Friday)	Thanksgiving Holiday
December 25, 2006, (Monday)	Christmas Holiday
December 26, 2006, (Tuesday)	Christmas Holiday
January 1, 2007, (Monday)	New Year's Day
January 15, 2007, (Monday)	Martin Luther King Jr. Day
February 19, 2007, (Monday)	President's Day Observance
April 6, 2007, (Friday)	Good Friday
May 28, 2007, (Monday)	Memorial Day
July 4, 2007, (Wednesday)	Independence Day
September 3, 2007, (Monday)	Labor Day
October 8, 2007, (Monday)	Columbus Day Observance
November 12, 2007, (Monday)	Veterans' Day Observance
November 22, 2007, (Thursday)	Thanksgiving Holiday
November 23, 2007, (Friday)	Thanksgiving Holiday
December 24, 2007, (Monday)	Christmas Holiday
December 25, 2007, (Tuesday)	Christmas Holiday. ❖

Medicare Part A Provider Contact Center Training Hours and Scheduled Closings

Florida Part A Provider Contact Center will continue closing for training purposes most Fridays, between the hours of 2:00 p.m. and 4:00 p.m. Our customer service representatives are participating in training programs designed to increase their expertise and enhance the service they deliver for our provider community.

As always, the Medicare Part A IVR (Interactive Voice Response) will be available via toll-free telephone number 1-877-602-8816.

For specific claim information, the IVR hours are: **6:00 a.m. – 6:00 p.m. Monday through Friday.**

For recorded information on current Medicare issues, the IVR hours are: **24 hours a day, 7 days a week.**

We apologize for any inconvenience this may cause. First Coast Service Options, Inc. (FCSO) is committed to continuous improvement and to provide the best service for our customers.

Part A Provider Contact Center Scheduled Closings

Please see the attached schedule below for closing times for the remainder of 2006.

November 3, 2006, 2 p.m. – 4 p.m.

November 10, 2006, 2 p.m. – 4 p.m.

November 17, 2006, 2 p.m. – 4 p.m.

November 24, 2006, Closed (Thanksgiving)

December 1, 2006, 2 p.m. – 4 p.m.

December 8, 2006, 2 p.m. – 4 p.m.

December 15, 2006, 2 p.m. – 4 p.m.

December 29, 2006, 2 p.m. – 4 p.m. ❖

Medicare Secondary Payer

Medicare Secondary Payer Recovery Contractor Addresses

The Centers for Medicare & Medicaid Services (CMS) has notified Medicare fee-for-service contractors of the new addresses for the national Medicare Secondary Payer Recovery Contractor (MSPRC). The MSPRC is accepting mail for the following addresses since **September 25, 2006.**

Address all liability insurance or no-fault insurance MSP recovery inquiries to:

MSPRC Auto, No-fault and Liability
P O Box 33828
Detroit, MI 48232-3828

Address Group Health Plan insurance MSP recovery inquiries to:

MSPRC GHP
P O Box 33829
Detroit, MI 48232-3829

Address Workers' Compensation MSP recovery inquiries to:

MSPRC WC
P O Box 33831
Detroit, MI 48232-3831

The MSPRC's dedicated call center toll-free telephone number is 1-866-MSP-RC20 (1-866-677-7220), available from 8:00 a.m. to 8:00 p.m. Eastern Standard Time, Monday through Friday, with the exception of holidays. For the hearing and speech impaired, the toll-free telephone number is 1-866-677-7294.

Additional information regarding the national Medicare Secondary Payer Recovery Contractor initiative may be found on the CMS website at *http://www.cms.hhs.gov/MSPRGenInfo/*. ❖

Source: CMS Update to Joint Signature Memorandum 06686,September 21, 2006

NATIONAL PROVIDER IDENTIFICATION

Will You Be Ready?—NPI Reminder

National Provider Identifier: Get It. Share It. Use It.

GET IT. The compliance date, May 23, 2007, is only **eight months** away. It's every provider's responsibility to make sure that an NPI is obtained if the provider is required to do so. If you're not sure, it's time to investigate. Get your NPI now so you have time to prepare **before** the compliance date. This includes sharing your NPI and appropriately testing it with payers to avoid a disruption in cash flow. To learn more on how to apply visit on the CMS website www.cms.hhs.gov/NationalProvIdentStand/.

SHARE IT. Have your NPI and don't know what to do with it? Share it. Share it with health plans you bill and the colleagues who rely on having your NPI to submit their claims (e.g. those who bill for ordered or referred services). You should also share it with your billing service, vendor, or clearinghouse, if you have any of them as business associates. Find out when and how the health plans with which you do business will begin accepting the NPI in claims and other standard transactions.

USE IT. Once your health plans have informed you that they are ready to accept NPIs, begin the testing process. It is important to test **before** May 23, 2007 to avoid a disruption in your cash flow. Consider sending only a few claims at first as you test the ability of plans to accept the NPI. Fewer claims will make it easier to keep track of status and payment, as well as troubleshooting any potential problems that may arise during the testing process.

Information on Covered Entities Under HIPAA

CMS has posted a new "Frequently Asked Question" to the CMS website that addresses whether a health care provider is a covered entity under HIPAA if they receive health information electronically (e.g. an electronic remittance advice), but do not transmit any health information electronically. The link is listed below or you may go to the CMS.gov website and click on "Questions" in the blue banner.

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=7906&p_created=1158786931&p_sid=fYkZcii&p_accessibility=0&p_lva=&p=cF9zcmNoPSZwX3NvcnRfYnk9JnBfZ3JpZHNvcnQ9MjoyJnBfcm93X2Nud.

Clarification of the Taxonomy Requirement Outlined in CR 5243

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 fiscal intermediary. CMS posted a FAQ that clarifies this requirement. The link is listed below or you may go to the CMS.gov website and click on "Questions" in the blue banner.

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=7896&p_created=1158064263&p_sid=KiZrwii&p_accessability=0&p_lva=&p_sp=cF9zcmNoPTEmcF9zb3J0X2JJ5PSZwX2dyaWRzb3J0PSZwX3Jvd19jbnQ9m.

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 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. ❖

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

Source: CMS Provider Education Resource 200609-13

NPI Claim Processing Information

National Provider Identifier: Get It. Share It. Use It.

As noted in previous announcements by the agency and our contractors, CMS plans to begin testing the new software that has been developed to use the national provider identifier (NPI) in the existing Medicare fee-for-service claims processing systems. Providers have **until May 23, 2007,** before you are required to submit claims with only an NPI.

Until testing is complete within the Medicare processing systems, CMS urges providers, billers, clearinghouses and vendors to continue submitting Medicare fee-for-service claims in one of two ways:

- Use your legacy number, such as your provider identification number (PIN), NSC number, OSCAR number or UPIN; or
- Use both your NPI and your legacy number.

Until testing of the new software that uses the NPI in the Medicare systems is complete and until further notice from CMS, the following may occur if you submit Medicare claims with only an NPI:

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

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

Providers may apply for an NPI online at https://nppes.cms.hhs.gov or may 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 Joint Signature Memorandum 06701, September 28, 2006
CMS Provider Education Resource 200609-15

New NPI Educational Products Available

National Provider Identifier: Get It. Share It. Use It.

NPI Training Package: Module 5 Available Now

Module 5, Medicare Implementation, provides the national provider identifier (NPI) requirements specific to Medicare providers. This module will be updated as new requirements are announced or changes are made. Module 5 is now posted on the CMS NPI Page at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Training_Package.pdf*.

September 26, 2006, NPI Roundtable Transcript Available Now

In addition, the transcript for the September 26, 2006, NPI roundtable is now available and may be found on the CMS website at *http://www.cms.hhs.gov/EducationMaterials/Downloads/NationalProviderIdentifierRoundtable.pdf*.

More information and education on the NPI may be found on the CMS website at the CMS NPI page *http://www.cms.hhs.gov/NationalProvIdentStand*.

Providers may apply for an NPI online at *https://nppes.cms.hhs.gov* or may 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 200610-07

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

General Coverage

Psychological and Neuropsychological Tests

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

Provider Types Affected

Providers who bill Medicare carriers or fiscal intermediaries (FIs) for the provision of diagnostic psychological and neuropsychological tests.

Provider Action Needed

STOP – Impact to You

Effective January 1, 2006, carriers and FIs will pay (under the Medicare physician fee schedule [MPFS] database) for diagnostic psychological and neuropsychological tests that are within the *CPT* code range of *96101* through *96120*.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) announces the revision of the *CPT* codes for psychological and neuropsychological tests (*CPT* codes *96101* through *96120*) to include tests performed by technicians and computers (*CPT* codes *96102, 96103, 96119* and *96120*) in addition to those performed by physicians, clinical psychologists, independently practicing psychologists and other qualified nonphysician practitioners (as described in Background, below).

GO – What You Need to Do

Make sure that your billing staffs are aware of the *CPT* code changes.

Background

Medicare Part B coverage of psychological tests and neuropsychological tests is authorized under section 1861(s)(2)(C) of the Social Security Act, and payment for these tests is authorized under section 1842(b)(2)(A) of the Social Security Act.

The *CPT* codes for these tests are included in the range of codes from *96101* to *96120*. The appropriate codes when billing for psychological tests are: *96101, 96102, 96103, 96105, 96110,* and *96111*; and when billing for neuropsychological tests are: *96116, 96118, 96119* and *96120*. All of the tests under this *CPT* code range *96101-96120* are covered and indicated as active codes under the MPFS database.

More specifically, CR 5204, from which this article is taken, provides that (effective January 1, 2006) the *CPT* codes for psychological and neuropsychological tests include tests performed by technicians and computers (*CPT* codes *96102, 96103, 96119* and *96120*) in addition to tests performed by physicians, clinical psychologists, independently practicing psychologists and other qualified nonphysician practitioners.

These changes, made in accordance with the final physician fee schedule regulation, were published in the *Federal Register* on November 21, 2005, at 70 FR 70279 and 70280 under Table 29 (AMA, Relative Value Update Committee (RUC) and Health Care Professional Advisory Committee (HCPAC) Recommendations and CMS Decisions for New and Revised 2006 *CPT* Codes).

You should be aware of some supervision requirements for diagnostic psychological and neuropsychological tests. First, under the diagnostic tests provision, all diagnostic tests are assigned a certain level of supervision. Generally, regulations governing the diagnostic tests provision allow only physicians to provide the assigned level of supervision for such tests; however, for diagnostic psychological and neuropsychological tests, there is a regulatory exception that allows either a clinical psychologist (CP) or a physician to perform the assigned general supervision.

Moreover, nonphysician practitioners such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs), who personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the supervision requirements of the diagnostic psychological and neuropsychological tests benefit, that is, under the general supervision of a physician or a CP.

In fact, rather than providing them under the requirements for diagnostic psychological and neuropsychological tests, NPs and CNSs must perform such tests under the requirements of their respective benefit. Therefore, NPs and CNSs must perform them in collaboration (as defined under Medicare law at section 1861(aa)(6) of the Act) with a physician. Likewise, PAs must perform these tests under the general supervision of a physician as required for services furnished under the PA benefit.

To continue, physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill three test codes (*96105, 96110*, and *96111*) as "sometimes therapy" codes. However, when PTs, OTs and SLPs perform these three tests, they must do so under the general supervision of a physician or a CP.

You should also note that expenses for diagnostic psychological and neuropsychological tests are not subject to the outpatient mental health treatment limitation, which is the payment limitation on treatment services for mental, psychoneurotic and personality disorders as authorized under Section 1833(c) of the Social Security Act. Further, the payment amounts that are billed for tests performed by a technician or a computer reflect a site of service payment differential for the facility and non-facility settings.

Remember that CPs, NPs, CNSs and PAs are required by law to accept assigned payment for psychological and neuropsychological tests. And although independently practicing psychologists (IPPs) are not required to accept assigned payment for these tests, they must report the name and address of the physician who ordered the test on the claim form when billing for tests. (An IPP is any psychologist who is licensed (or certified) to practice psychology in the state or jurisdiction where furnishing services or, if the

Psychological and Neuropsychological Tests (continued)

jurisdiction does not issue licenses, if provided by any practicing psychologist. Examples of psychologists [other than CPs] whose psychological and neuropsychological tests are covered under the diagnostic tests provision include, but are not limited to, educational psychologists and counseling psychologists.) Additionally, there is no authorization under Medicare law for payment for diagnostic tests when performed on an "incident to" basis.

Following is a summary of who may bill for diagnostic psychological and neuropsychological tests, and references for the review of qualifications, when appropriate.

Providers that May Bill for Diagnostic Psychological and Neuropsychological Tests

Clinical Psychologist

See qualifications under Chapter 15, section 160 of the *Medicare Benefits Policy Manual.*

Nurse Practitioners – to the extent authorized under state scope of practice.,

See qualifications under Chapter 15, section 200 of the *Medicare Benefits Policy Manual.*

Clinical Nurse Specialists – to the extent authorized under state scope of practice.

See qualifications under Chapter 15, section 210 of the *Medicare Benefits Policy Manual.*

Physician Assistants – to the extent authorized under state scope of practice.

Independently Practicing Psychologists

See qualifications under Chapter 15, section 190 of the *Medicare Benefits Policy Manual*.

Physical Therapists, Occupational Therapists and Speech-Language Pathologists

See qualifications under Chapter 15, sections 220-230.6 of the *Medicare Benefits Policy Manual*.

The *Medicare Benefits Policy Manual* is available on the CMS website at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

Here are some other important things that you should know:

- The technician and computer *CPT* codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Therefore, *CPT* psychological test code *96101* will not be paid if you include it in the bill for the same tests or services performed under psychological test codes *96102* or *96103*.

  Similarly, *CPT* neuropsychological test code *96118* will not be paid when included in the bill for the same tests or services performed under neuropsychological test codes *96119* or *96120*. Note, however, *CPT* codes *96101* and *96118* can sometimes be paid separately, when billed on the same date of service **for different and separate tests from *96102, 96103, 96119* and *96120*.**
- Under the MPFS, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by *CPT* codes *96102* and *96119*, when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under *96102* or the neuropsychological test under *96119*.
- FIs will continue to pay claims from providers of outpatient Part B therapy services (including physical therapy, occupational therapy, and speech-language pathology) for *CPT* codes *96105*, *96110* and *96111* with revenue codes and corresponding therapy modifiers (42x with GP, 43x with GO, and 44x with GN, respectively).
- Finally, your carriers and FIs do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims to January 1, 2006; they will adjust claims that you bring to their attention.

Additional Information

You can find more information about psychological and neuropsychological tests by reading CR 5204, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R55BP.pdf*.

As an attachment to this CR, you will find updated relevant portions of Publication 100.02 (*Medicare Benefit Policy Manual*), Chapter 15 (Covered Medical and Other Health Services), Section 80.2, (Psychological Tests and Neuropsychological Tests).

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

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

MLN Matters Number: MM5204
Related Change Request (CR) Number: 5204
Related CR Release Date: September 29, 2006
Related CR Transmittal Number: R55BP
Effective Date: January 1, 2006
Implementation Date: December 28, 2006

Source: CMS Pub. 100-02, Transmittal 55, CR 5204

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Termination of HCPCS Code G0107, Colorectal Cancer Screening, Fecal-Occult Blood Tests, 1-3 Simultaneous Determinations

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 carriers or fiscal intermediaries (FIs), including Part A/B Medicare administrative contractors (A/B MACs) for fecal occult blood tests (FOBTs) administered to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Do not use HCPCS code G0107 for screening FOBTs **on or after January 1, 2007.** As of that date, that code is being deleted and replaced by *current procedural terminology* (*CPT*) code *82270*.

CAUTION – What You Need to Know

Effective January 1, 2007, HCPCS code G0107 for screening FOBT is being terminated and replaced by *CPT* code *82270*. If you use HCPCS code G0107 for FOBT on or after this date, your reimbursement could be impacted as the claim will be returned as unprocessable.

GO – What You Need to Do

Make sure that your billing staffs are aware of this coding change for screening FOBT.

HCPCS code G0107 will be retired at the next annual release of the clinical diagnostic laboratory fee schedule **effective January 1, 2007**, and replaced with *CPT* code *82270*.

Prior to January 1, 2007 use HCPCS code G0107 for billing Medicare for screening FOBT; however on or after January 1, 2007 (the effective date of the 2007 clinical diagnostic lab fee schedule) use *CPT* code *82270* for billing Medicare for screening FOBT.

Additional Information

The official instruction issued to you carrier, FI, or A/B MAC is CR 5292, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1062CP.pdf*.

Revised *Medicare Claims Processing Manual* (Publication 100.04), Chapter 18 (Preventive and Screening Services), Section 60 (Colorectal Cancer Screening), Subsections 60.1-60.7 are included as an attachment to that CR. If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found 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: MM5292
Related Change Request (CR) Number: 5292
Related CR Release Date: September 22, 2006
Related CR Transmittal Number: R1062CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1062, CR 5292

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Hospital Services

Fiscal Year 2007 Inpatient Prospective Payment System, Long-Term Care Hospital, and Inpatient Psychiatric Facility PPS Changes

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

Provider Types Affected

Hospitals billing Medicare fiscal intermediaries (FIs), including Part A/B Medicare administrative contractors (A/B MACs), for services paid under the inpatient prospective payment system (IPPS), the long term care hospital (LTCH), or inpatient psychiatric facility (IPF) PPS.

Provider Action Needed
STOP – Impact to You

This article includes information from change request (CR) 5276 that announces changes to the fiscal year 2007 IPPS, LTCH and IPF PPS based on the FY 2007 IPPS final rule.

CAUTION – What You Need to Know

This article outlines FY 2007 IPPS changes for hospitals, which were published in the *Federal Register* on August 18, 2006 and announced in a notice that will be published on the CMS website. It also addresses new GROUPER and diagnosis related group (DRG) changes that are effective October 1, 2006, for hospitals paid under the LTCH PPS and ICD-9-CM changes that affect the comorbidity adjustment under the IPF PPS.

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) published the FY 2007 IPPS final rule in the August 18, 2006, *Federal Register* (*http://www.access.gpo.gov/su_docs/fedreg/a060818c.html*), and change request (CR) 5276 outlines the changes to the FY 2006 IPPS.

CR 5276 also addresses new GROUPER and DRG changes that are effective October 1, 2006 for hospitals paid under the IPPS, as well as under LTCH PPS. LTCH PPS rate changes occurred on July 1, 2006. Please refer to transmittal 981, CR 5202 (*http://www.cms.hhs.gov/transmittals/downloads/R981CP.pdf*), published on June 15, 2006, for LTCH policy changes.

The MLN Matters article corresponding to CR 5202 may be found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5202.pdf*.

All items covered in CR 5276 are effective for hospital discharges occurring on or after October 1, 2006, unless otherwise noted. You may also wish to review the IPF update issued in July 2006. The *MLN Matters* article, MM5129, relates to that update and it is available on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5129.pdf*.

ICD-9-CM Changes

ICD-9-CM coding changes are effective October 1, 2006. The new ICD-9-CM codes are listed, along with their DRG classifications, in Tables 6A and 6B of the August 18, 2006, *Federal Register* (*http://www.access.gpo.gov/su_docs/fedreg/a060818c.html*).

The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6C and 6D. The revised code titles are in Tables 6E and 6F.

GROUPER V24.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2006. The Medicare code editor (MCE) 23.0 uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2006.

1. **IPPS Rates for FY 2007 are as follows:**

Standardized amount update factor	1.034 1.014 (for hospitals that do not submit quality data)
Hospital specific update factor	1.034 1.014 (for hospitals that do not submit quality data)
Common fixed loss cost outlier threshold	$24,485.00
Federal capital rate	$427.03
Puerto Rico capital rate	$203.03
Outlier offset-operating national	0.948968
Outlier offset-operating Puerto Rico	0.967303
Outlier offset-operating national PR blend	0.953551
IME formula	1.32*[(1 + resident-to-bed ratio)**.405-1]
MDH/SCH budget neutrality factor	0.997395

Operating Rates
Rates with Wage Index Greater than 1 and Full Market Basket

	Labor Share	Non-Labor Share
National (NTL)	3397.52	1476.97
Puerto Rico (PR)	1436.12	880.20
Natl/PR (NPR)	3397.52	1476.97

Fiscal Year 2007 Inpatient PPS, Long Term Care Hospital, and Inpatient Psychiatric Facility PPS Changes (continued)

Rates with Wage Index Less than 1 and Full Market Basket

	Labor Share	Non-Labor Share
National (NTL)	3022.18	1852.31
Puerto Rico (PR)	1359.68	956.64
Natl/PR (NPR)	3022.18	1852.31

Rates with Wage Index Greater than 1 and Reduced Market Basket

	Labor Share	Non-Labor Share
National (NTL)	3331.80	1448.40
Puerto Rico (PR)	1408.34	863.18
Natl/PR (NPR)	3331.80	1448.40

Rates with Wage Index Less than 1 & Reduced Market Basket

	Labor Share	Non-Labor Share
National (NTL	2963.73	1816.48
Puerto Rico (PR)	1333.38	938.14
Natl/PR (NPR)	2963.73	1816.48

The revised hospital wage indices and geographic adjustment factors are contained in Tables 4A (urban areas), 4B (rural areas) and 4C (redesignated hospitals) of the August 18, 2006, *Federal Register* (*http://www.access.gpo.gov/su_docs/fedreg/a060818c.html*).

2. Postacute Care Transfer Policy

On October 1, 1998, CMS established a post-acute care transfer policy which paid as transfers all cases which assigned to one of 10 DRGs if the patient was discharged to a psychiatric hospital or unit, an inpatient rehabilitation hospital or unit, a long term care hospital, a children's hospital, a cancer hospital, a skilled nursing facility, or a home health agency. As of October 1, 2004, that list was expanded to 29 DRGs. As of October 1, 2005, the list was again expanded.

Effective October 1, 2006, the following DRGs are added to the post-acute care transfer list:

398 399 562 563 565 566 567 568
569 570 572 573 575 576 578 579

The following DRGs are deleted from the post-acute care transfer list:
20 24 25 148 154 415 416 475

3. New Technology Add-On Payment

Effective for discharges on or after October 1, 2006, there is one "new" new technology add-on payment, X STOP interspinous process decompression system, in addition to GORE TAG and restore rechargeable implantable neurostimulator, which were effective October 1, 2005. Kinetra® is no longer included. Under 42 CRF 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, if the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for indirect medical education, disproportionate share, transfers, etc., but excluding outlier payments.) (CR 5276 contains an explanation of how the PRICER calculates total covered costs for this purpose. CR 5276 is located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1067CP.pdf*.)

In order to pay the add-on technology payment for the restore rechargeable implantable neurostimulator, PRICER will look for the presence of ICD-9-CM procedure code, 86.98. The maximum add-on payment for the neurostimulator is $9,320.00.

In order to pay the add-on technology payment for GORE TAG, PRICER will look for the presence of ICD-9-CM procedure code 39.73. The maximum add-on payment for GORE TAG is $10,599.00.

In order to pay the add-on technology payment for X STOP, PRICER will look for the presence of ICD-9-CM procedure code 84.58. The maximum add-on payment is $4,400.00.

It is possible to have multiple new technologies on the same claim. Should multiple new technologies be present, PRICER will calculate each separately and then total the new technology payments. The total is in the field labeled "PPS-New-Tech-Payment-Add-On" returned from PRICER.

4. Medicare Dependent Hospital (MDH) Changes

Nonrural referral center (RRC) MDHs (provider type 14) are relieved of the 12 percent cap on DSH payments. Previously, only RRC MDHs (provider type 15) were relieved of the 12 percent cap on DSH payments.

Additionally, MDHs have the option to rebase their hospital specific rates to their FY 2002 cost report (cost reports beginning on or after October 1, 2002, and on or before September 30, 2003) if this FY 2002 hospital specific rate results in a payment increase. CR 5276 contains details on how your FI or A/B MAC handles this issue.

MDHs will also receive a 75 percent differential add-on to the federal payment for FY 07. Currently, MDHs receive 50 percent of the difference between their HSP rate and the federal rate (assuming HSP rate exceeds the federal rate).

Other Changes

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under Section 412.103 for Purposes of Capital PPS Payments

In the FY 2007 IPPS final rule, CMS revised the capital PPS large-urban add-on and DSH adjustment regulations at sections 412.316(b) and 412.320(a)(1), respectively, to clarify that, beginning in FY 2007, hospitals reclassified as rural under se4ction 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment since these hospitals are considered rural under the capital PPS. CMS also made a technical change in the regulations at section 412.316(a) to clarify that the same wage index that applies to hospitals under the operating PPS is used to determine the geographic adjustment factor (GAF) under the capital PPS. In the case of hospitals reclassified as rural under section 412.103, the GAF is determined from the applicable statewide rural wage index.

Reclassification (for IPPS Only)

For FY 2006, FY 2007, or FY 2008, for a campus of a multicampus hospital that wishes to seek reclassification to a geographic wage area where another campus(es) is located, CMS will allow the campus of a multicampus

Fiscal Year 2007 Inpatient PPS, Long Term Care Hospital, and Inpatient Psychiatric Facility PPS Changes (continued)

hospital to use the average hourly wage data submitted on the cost report for the entire multicampus hospital as its wage data under 412.230(d)(2). The deadline for multicampus hospitals to reclassify is the same as all other hospitals; that is, they must submit their application to the Medicare Geographical Classification Review Board (MGCRB) by September 1 of each year.

LTCH Changes

LTCH PPS Cost-to-Charge Ratios (CCR)

In the FY 2007 IPPS final rule, CMS revised the methodology for determining the annual LTCH PPS CCR ceiling and statewide average CCRs. Under this revised methodology, CMS now computes a single "total" LTCH CCR ceiling and applicable statewide average LTCH CCRs using IPPS data rather than adding the separate IPPS operating and capital CCR ceilings or statewide average CCRs as was done previously. For FY 2007, the LTCH PPS total CCR ceiling is **1.321**, and the applicable LTCH PPS statewide average CCRs are presented in Table 8C of the Addendum of the FY 2007 IPPS final rule.

LTCH PRICER, DRGs, and Relative Weights

The annual update of the long-term care diagnosis-related groups (LTC-DRGs), relative weights and GROUPER software for FY 2007 are published in the annual IPPS final rule. The same GROUPER software developed for the hospital inpatient PPS will be used for the LTCH PPS.

The LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay effective for discharges on or after October 1, 2006, may be found in Table 11 of this final rule and are in the LTCH PPS PRICER program.

Inpatient Psychiatric Facility Changes

Comorbidity Adjustment

Based on the changes to the ICD-9-CM codes effective October 1, 2006, the following changes are being made to the comorbidity codes in the IPF PPS.

Invalid ICD-9-CM Code Title

238.7 Other lymphatic and hematopoietic tissues (Oncology treatment)

New ICD-9-CM Code and Descriptor

052.2 Postvaricella myelitis (Infectious diseases)
053.14 Herpes zoster myelitis (Infectious diseases)
238.71 Essential thrombocythemia (Oncology treatment)
238.72 Low grade myelodysplastic syndrome lesions (Oncology treatment)
238.74 Myelodysplastic syndrome with 5 q deletion (Oncology treatment)
238.76 Myelofibrosis with myeloid metaplasia (Oncology treatment)
238.75 Myelodysplastic syndrome, unpsecified (Oncology treatment)
238.79 Other lymphatic and hematopoietic tissues (Oncology treatment)

Revised ICD-9-CM Code Descriptor (title changes)

403.01 Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease
403.11 Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease
403.91 Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease
404.02 Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease
404.03 Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
404.12 Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease
Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
404.92 Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease
404.93 Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease

TEFRA Update

The final excluded hospital market basket increase for FY 2007 is 3.4 percent.

Additional Information

For complete details, please see the official instruction issued to your intermediary or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1067CP.pdf*.

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

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

MLN Matters Number: MM5276
Related Change Request (CR) Number: 5276
Related CR Release Date: September 25, 2006
Related CR Transmittal Number: R1067CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1067, CR 5276

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Inpatient Rehabilitation Facility Annual Update: Prospective Payment System PRICER Changes for Fiscal Year 2007

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 inpatient rehabilitation facility (IRF) prospective payment system (PPS) services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5273, which provides details about the changes that will be required as part of the annual IRF PPS update for fiscal year (FY) 2007, and it highlights several of the major refinements from the FY 2007 IRF PPS final rule.

CAUTION – What You Need to Know

Updated rates are effective for claims with discharges that fall on or after October 1, 2006, and on or before September 30, 2007.

GO – What You Need to Do

See the *Background* section of this article for further details regarding this IRF annual update.

Background

On August 7, 2001, the Centers for Medicare & Medicaid Services (CMS) published a final rule in the *Federal Register* (*http://www.access.gpo.gov/su_docs/fedreg/a010807c.html*) that established the PPS for IRFs as authorized under the Social Security Act (Section1886(j)). In that final rule, CMS set forth per discharge federal rates for federal fiscal year 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002, and annual updates to the IRF PPS rates are required by the Social Security Act (Section 1886(j)(3)(C)). On August 18, 2006, CMS published the FY 2007 IRF PPS final rule in the *Federal Register* (*http://www.access.gpo.gov/su_docs/fedreg/a060818c.html*), which provides the prospective payment rates applicable for IRFs for FY 2007.

A new IRF PRICER software package will be released prior to October 1, 2006 that will contain the updated rates that are effective for claims with discharges that fall on or after October 1, 2006 through September 30, 2007. Your FI will install the new revised PRICER program in a timely fashion to ensure you receive accurate payments for IRF PPS claims with discharges occurring on or after October 1, 2006 through September 30, 2007.

PRICER Updates: For IRF PPS FY 2007, (October 1, 2006 – September 30, 2007)

Standard federal rate	$12,981
Fixed loss amount	$5,534
Labor-related share	75.612%
Nonlabor related share	24.388%
Urban national average CCR	0.484
Rural national average CCR	0.600

Hold Harmless

There were 32 IRFs identified in FY 2006 that received a hold harmless adjustment of as much as 12.76 percent. For FY 2007, these same 32 providers (see IRF PPS final rule data files at *http://www.cms.hhs.gov/InpatientRehabFacPPS/07_DataFiles.asp*) will get a hold harmless adjustment of as much as 6.38 percent.

One of the 32 IRFs above (49T005) qualifies for the hold harmless policy, but would experience higher payments with the second year of the hold harmless adjustment of 6.38 percent than they would have experienced had they been paid under their rural designation in FY 2006, including the FY 2005 rural adjustment of 19.14 percent. Thus, this facility will receive a special wage index value to reduce the amount of its hold harmless adjustment. In other words, CMS is capping this facility's payments under the hold harmless policy at what this facility would have been paid under their rural designation in FY 2006, including the FY 2005 rural adjustment of 19.14 percent. CMS will provide FIs with the applicable special wage index value for this IRF (and for any other IRFs CMS may later discover would receive higher payments as a result of the hold harmless policy). This special wage index value will be used instead of the FY 2007 CBSA wage index value for determining FY 2007 IRF PPS payments for this IRF.

Implementation

The implementation date for CR 5273 is October 2, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1053CP.pdf*.

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

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

MLN Matters Number: MM5273
Related Change Request (CR) Number: 5273
Related CR Release Date: September 8, 2006
Related CR Transmittal Number: R1053CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1053, CR 5273

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Notifying Medicare Patients About Lifetime Reserve Days

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

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for inpatient hospital services furnished during a spell of illness.

Provider Action Needed

This special edition article is for informational purposes only and reflects no change in Medicare policy. The article is based on information contained in the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 5, Sections 30 – 30.4). This manual is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

Background

Under the Social Security Act (Section 1861; *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*), a Medicare beneficiary is entitled to an unlimited number of benefit periods, each of which includes 90 days of covered inpatient hospital services. A benefit period, or "spell of illness," begins on the first day the beneficiary is furnished inpatient hospital services, inpatient critical access hospital services or extended care services. The benefit period ends with the close of the first period of 60 consecutive days thereafter on each of which he/she is neither an inpatient of a hospital or a critical access hospital nor an inpatient of a skilled nursing facility. The Social Security Act (Section 1812; *http://www.ssa.gov/OP_Home/ssact/title18/1812.htm*) further defines the scope of inpatient hospital benefits for Medicare beneficiaries and includes an additional provision regarding 60 nonrenewable lifetime reserve days (LRDs) that a beneficiary may draw upon if hospitalized for more than 90 days in a benefit period.

For inpatient hospital services furnished during a spell of illness, Medicare beneficiaries are responsible for an inpatient hospital deductible amount (which is deducted from the amount payable by the Medicare program to the hospital). For the first 60 days of covered care during a spell of illness the beneficiary is not liable for paying a co-insurance.

After the 60th day that beneficiaries receive inpatient hospital services (during a spell of illness), they are responsible for a coinsurance amount equal to **one-fourth (25 percent)** of the inpatient hospital deductible per day for the 61st – 90th day spent in the hospital.

After the 90th day spent in the hospital during a spell of illness, beneficiaries may elect to use their 60 LRDs of coverage. Their **coinsurance amount is then equal to *one-half (50 percent)*** of the benefit period inpatient hospital deductible as a daily copayment for LRDs (42CFR409.83 – Inpatient hospital coinsurance [*http://www.gpoaccess.gov/cfr/retrieve.html*]).

In 2006, the inpatient hospital deductible is $952.00 per benefit period or spell of illness; therefore, beneficiaries pay the following daily coinsurance amounts for 2006:

- $238.00 a day for days 61-90 in an ACH **in each period**
- $476.00 a day for days 91-150 **for each LRD used**

Election Not to Use Lifetime Reserve Days

An election not to use LRDs may be made by the beneficiary (or by someone who may act on his or her behalf) at the time of admission to a hospital or at any time thereafter, subject to the limitations on retroactive elections described below in the Section II (election made retroactively).

Hospitals are required to notify patients who have already used or will use 90 days of benefits in a benefit period that they can elect not to use their LRDs for all or part of a stay.

The hospital should give notice of the option to elect to not use LRDs **when the beneficiary has five regular coinsurance days left** and is expected to be hospitalized beyond that period. Where the hospital discovers **the patient has fewer than five regular coinsurance days left**, it should **immediately notify the patient of this option (if notice was not provided earlier).**

The hospital should:

- Annotate its records at the time that it informed the patient of this option; and
- Make available an appropriate election statement or form to be included in the patient's hospital record if the patient elects not to use LRDs. (See the *Medicare Benefit Policy Manual* (Chapter 5, Section 40.1; [*http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf*] for sample election format).

If a patient elects not to use LRDs, covered Part B services are billed to the intermediary on Form CMS-1450 or the electronic equivalent.

Note: A Medicare beneficiary who is **eligible for medical assistance (Medicaid) under a state plan should be advised that such assistance would not be available if the beneficiary elects not to use the LRDs.** However, this restriction on medical assistance payments does not apply to cases where the beneficiary is deemed to have elected not to use LRDs.

Beneficiary Deemed to Have Elected not to use LRDs

A Medicare beneficiary will be deemed to have **elected not to use LRDs** in the following situations:

1. The average daily charge for covered services furnished during a lifetime reserve billing period **is equal to or less than the coinsurance amount for LRDs**; **and**
   - The hospital is reimbursed on a cost reimbursement basis; **or**
   - The hospital is reimbursed under a prospective payment system (PPS) and LRDs are needed to pay for all or part of the outlier days. (See *Section IIIB (Hospitals Reimbursed Under the Prospective Payment System*) below and the *Medicare Benefit Policy Manual* (Chapter 5, Section 10.2; *http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf*).
2. **For the nonoutlier portion of a stay in a hospital** reimbursed under a PPS if the beneficiary has **one or**

Notifying Medicare Patients about Lifetime Reserve Days (continued)

more regular days (non-LRDs) remaining in the benefit period upon admission to the hospital [i.e. an acute care hospital (ACH) PPS, inpatient rehabilitation facility (IRF) PPS, and a normal stay under long term care hospital (LTCH) PPS)]. (See *Section IIIB (Hospitals Reimbursed Under the Prospective Payment System)* below.)

Note: The exception to this rule is the short stay outlier policy under LTCH PPS.

3. **The beneficiary has no regular days available at the time of admission** to a hospital reimbursed under the prospective payment system and t**he total charges** for which the beneficiary would be liable (if LRDs are not used) **is equal to or less than** the **charges for which the beneficiary would be liable** if LRDs were used (i.e., the sum of the coinsurance amounts for the LRDs that would be used **plus** the total charges for outlier days (if any) for which no LRDs would be available because LRDs are exhausted. (See Section IIIB *[Hospitals Reimbursed Under the Prospective Payment System]* below.)

Exception: Even though a beneficiary would otherwise be deemed to have elected not to use LRDs, they will not be so deemed where:

- Benefits are available from another third party payer to pay some or all of the charges, and
- The third party requires (as a condition for payment) that LRDs be used.

In such cases, LRDs will be used unless the beneficiary specifically elects not to use them.

I. Election Made Prospectively

Ordinarily, an election **not to use LRDs will apply prospectively**. If the election is filed at the time of admission to a hospital, it may be made effective **beginning** with **the first day of hospitalization**, or **any day thereafter**. If the election is filed later, it may be made effective **beginning** with any day **after the day it is filed**.

II. Election Made Retroactively

A beneficiary may retroactively elect not to use LRDs provided when:

- The beneficiary (or some other source) offers to pay the hospital for any of the services not payable under Part B, **and**
- The hospital agrees to accept the retroactive election.

In this case, the hospital will contact the fiscal intermediary (FI) for procedures for correcting any claims already submitted.

A retroactive election not to use the LRDs must be filed **within 90 days following the beneficiary's discharge** from the hospital **unless**:

- Benefits are available from a third party payer to pay for the services, and
- The hospital agrees to the retroactive election.

In this case, the beneficiary may file an election not to use the LRDs later than 90 days following discharge.

EXAMPLE 1

Prior to July 1, Mr. Jones had used 90 days of inpatient hospital services in a benefit period. Beginning July 1, he was hospitalized for 10 additional days in that same benefit period. He was informed of his election right on July 1 at the time of admission, and he indicated that he wanted to use his LRDs for that stay. One month after being discharged from the hospital, Mr. Jones informed the hospital's billing office that he now wished to save his LRDs for a future stay. Mr. Jones agreed to pay the hospital for the services he received during the 10 days of hospitalization, which were not payable under Part B, and he was permitted to file a retroactive election not to use his LRDs, effective July 1.

EXAMPLE 2

On July 1, Mrs. Smith was discharged from a hospital after being hospitalized for 105 days. The hospital billed Medicare for 90 regular days plus 15 LRDs. On October 20 (more than 90 days following discharge), Mrs. Smith learned that a private insurer could pay for the last 15 days of the stay. She informed the hospital that she wished to file a retroactive election not to use LRDs for the last 15 days of the stay. The hospital agreed to the request, and Mrs. Smith filed an election form. The hospital refunded the Medicare payment and billed the private insurer instead.

III. Period Covered by Election

A. Hospitals Not Reimbursed Under Prospective Payment System

A beneficiary election not to use LRDs for a particular hospital stay:

- May apply to the entire stay, or
- May apply to a single period of consecutive days in the stay, but
- Cannot apply to selected days in a stay.

If an election not to use LRDs (whether made prospectively or retroactively) is made effective:

- Beginning with the first day for which LRDs are available, it may be terminated at any time; (After termination of the election, all hospital days would be covered to the extent that LRDs are available. Thus, an individual who has private insurance that covers hospitalization beginning with the first day after 90 days of benefits have been exhausted, may terminate the election as of the first day not covered by the insurance plan.); or
- Beginning with any day after the first day for which LRDs are available, it must remain in effect until the end of that stay unless the entire election is revoked in accordance with the *Medicare Benefit Policy Manual* (Pub. 100-02, Chapter 5, Section 40.2; [*http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf*]).

Notifying Medicare Patients About Lifetime Reserve Days (continued)

B. Hospitals Reimbursed Under Prospective Payment System
The rules described in Section III A above apply. For PPS discharges on and after October 1, 1997, involving cost outlier status, a beneficiary whose 90 days of benefits are exhausted before cost outlier status is reached must elect to use LRDs for the hospital to be paid cost outlier payments.

Cost outlier status is reached on the day that charges reach the cost outlier status for the applicable DRG for inpatient PPS and LTCH PPS or CMS in the case of IRF PPS. Use of LRDs must begin on the day following that day, to permit payment for outlier charges.

If the beneficiary elects not to use LRDs where benefits are exhausted, the hospital may charge the beneficiary for the charges that would have been paid as cost outlier.

Additional Information

If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.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: SE0663
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 SE0663

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Holding of Pancreas Transplant Alone Claims—Amendment to *MLN Matters* Article MM5093

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

Provider Types Affected

Providers who bill Medicare fiscal intermediaries (FIs) or A/B Medicare administrative contractors (MACs) for PA services to Medicare beneficiaries.

Key Points

- The held PA claims, described above, **will not process correctly** through the claims processing system beginning on October 2, 2006.
- **Until further notice, PA claims will be held**. Once the PA claims may be released for processing you will be notified.

Background

The Centers for Medicare & Medicaid Services (CMS) is publishing this special edition (SE) article to amend a prior notice to providers on May 19, 2006, change request (CR) 5093 (see *Additional Information* section for the Web address). That prior notice announced that PA claims for discharges on or after April 26, 2006 through September 30, 2006, would be held until further notice. The PA claims **were scheduled** to be released October 2, 2006.

Additional Information

The *MLN Matters* article on CR 5093 may be found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5093.pdf*.

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

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

MLN Matters Number: SE0674
Related Change Request (CR) Number: 5093
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 SE0674

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Pancreas Transplants Alone

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

Note: CMS has revised this MLN Matters article on October 5, 2006, to include this statement alerting affected providers to review the special edition *MLN Matters* article SE0674 for important information regarding the continued hold of affected claims. *MLN Matters* article SE0674 is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0674.pdf*.

The *MLN Matters* article MM5093 was originally published in the July 2006 *Medicare A Bulletin* (page 38-39).

Provider Types Affected

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

Background

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

Key Points

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

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

Billing and Claims Processing

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

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

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

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

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

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

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

Remittance Advice Message – Claim adjustment reason code 50 (These are noncovered services because this is not deemed a 'medical necessity' by the payer)

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

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

Implementation

The implementation date for this instruction is no later than:

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

Pancreas Transplants Alone (continued)

Additional Information

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

If you have questions, please contact your Medicare FI or carrier at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.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: MM5093 – Revised
Related Change Request (CR) Number: 5093
Related CR Release Date: May 19, 2006
Related CR Transmittal Number: R56NCD and R957CP
Effective Date: April 26, 2006
Implementation Date: July 3, 2006 for carriers; October 2, 2006 for FIs

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

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LOCAL COVERAGE DETERMINATIONS

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

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

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

Local Coverage Determination Table of Contents

Additions/Revisions to Existing LCDs

AJ2430: Pamidronate (Aredia®) 24
AJ9000: Antineoplastic Drugs 24

Additional Medical Information

Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased 25

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ADDITIONS/REVISIONS TO LCDS

AJ2430: Pamidronate (Aredia®)—Revision to the LCD

The local coverage determination (LCD) for pamidronate (Aredia®) was last updated on April 13, 2006. Since that time, the LCD has been revised. A request was received to allow for the off-label coverage of pamidronate IV for the treatment of postmenopausal osteoporosis and for the prevention of glucocorticoid-induced osteoporosis. A review of current literature supported this request and the LCD was revised to allow for the off-label treatment of postmenopausal osteoporosis and for the prevention of glucocorticoid-induced osteoporosis when there has been a failed attempt of treatment with oral biphosphonates or when there is a valid medical reason to use parenteral administration over oral administration. The indications and limitations section of this LCD was revised to reflect the new off-label coverage mentioned above. In addition, the documentation requirements and utilization guidelines sections were revised accordingly for these coverage additions. The ICD-9-CM codes that support medical necessity were revised to include ICD-9-CM codes 733.01 and 733.09.

Effective Date

This revision to the LCD is effective for services provided **on or after October 12, 2006.**

The full text for this LCD (L1064) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ9000: Antineoplastic Drugs—Revision to the LCD

The local coverage determination (LCD) for antineoplastic drugs was last updated on October 1, 2006. Since that time, following revisions were made based on reconsiderations for carboplatin and paclitaxel and the USP DI.

Additional indications were added under the "Indications and Limitations of Coverage and/or Medical Necessity" section for the following HCPCS codes:

J9045 (carboplatin)
- Added the off-label indication of malignant neoplasm of the pleura (mesothelioma).

J9170 (docetaxel)
- Added additional off-label indications to ovarian carcinoma stating "after platinum-based therapy has failed, or as first-line treatment in combination with carboplatin."

J9206 (irinotecan)
- Added additional off-label indications to small-cell lung carcinoma stating "extensive-stage small-cell lung cancer, first line treatment, in combination with cisplatin."

J9265 (paclitaxel)
- Added the off-label indication of when "used in combination with carboplatin for the treatment of malignant melanoma."

In addition to the above, references were updated and the following HCPCS codes had additional ICD-9-CM codes added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD:

J9045 (carboplatin)
- Added ICD-9-CM code range 163.0-163.9 (Malignant neoplasm of pleura (mesothelioma)

J9265 (paclitaxel)
- Added ICD-9-CM code range 172.0-172.9 (Malignant melanoma of skin)

Effective Dates

The revisions are effective for services provided **on or after November 9, 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. ❖

ADDITIONAL MEDICAL INFORMATION

Billing for Ground Ambulance Services when the Beneficiary Is Pronounced Deceased

Some ambulance providers are incorrectly billing for transports for deceased beneficiaries. According to Pub. 100-02, Chapter 10, Section 10.2.6, reimbursement of ambulance services provided to a deceased Medicare beneficiary depends on when the beneficiary is pronounced deceased by an individual authorized to do so.

- If the beneficiary is pronounced deceased at the scene by an authorized individual after the ambulance is dispatched and prior to loading, the claim is billed with a QL modifier and no mileage is billed.
- If the beneficiary is dead at the scene but has not been pronounced by an authorized individual, services are not paid unless the ambulance waits at the scene for an authorized individual to arrive and pronounce death. The claim is billed with a QL modifier and no mileage is billed.

  Medicare reimbursement for the above situations is based on the appropriate Basic Life Support rate using HCPCS codes A0428 or A0429.
- When the beneficiary is dead at the scene but has not been pronounced by an authorized individual and the ambulance transports the body to the hospital for pronouncement of death, services are billed and reimbursed at the appropriate level of service furnished.
- If the beneficiary is pronounced deceased by an authorized individual prior to ambulance being dispatched no payment is made. ❖

Critical Access Hospital Services

October 2006 Non-Outpatient Prospective Payment System Outpatient Code Editor—Specifications Version 22.0

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

Provider Types Affected

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

Impact on Providers

This article is based on change request (CR) 5256, which announces that the October 2006 non-OPPS outpatient code editor (OCE) has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System (HCPCS) codes and procedure codes.

Background

CR 5256 informs your FIs and RHHIs that the non-OPPS OCE used to process claims from hospitals not paid under the OPPS has been updated with new additions, changes, and deletions to *Current Procedural Terminology (CPT)*/HCPCS codes and descriptions.

To view the specific code updates, which are numerous, please see CR 5256 on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1061CP.pdf*.

Implementation

The implementation date for CR 5256 is October 2, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1061CP.pdf*.

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

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

MLN Matters Number: MM5256
Related Change Request (CR) Number: 5256
Related CR Release Date: September 18, 2006
Related CR Transmittal Number: R1061CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1061, CR 5256

Disclaimer – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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.

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 September 8, 2006.

Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Clay/Keystone Heights		Rural
Collier/Imokalee/Everglades		Rural
Columbia		Rural
Dixie		Rural
Escambia/Atmore (AL/FL)	0038.00, 0039.00, 0040.00	Rural
Gadsden		Urban
Glades		Rural
Hamilton		Rural
Hardee		Rural
Hendry		Rural
Jefferson		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown		Rural
Okeechobee		Rural
Palm Beach	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	Rural
Columbia	Rural
Dixie	Rural
Franklin	Rural
Gilchrist	Rural
Gulf	Rural
Hamilton	Rural
Hillsborough. Ruskin CCD/Wimauma-Lithia CCD	Urban
Holmes	Rural
Indian River/Fellsmere	Rural
Jackson	Rural
Jefferson	Rural
Lafayette	Rural
Lake	Rural
Liberty	Rural
Madison	Rural
Martin/Indiantown	Rural
Monroe/Upper Keys	Rural
Okeechobee	Rural
Putnam	Rural
St Johns	Urban
Sumter (effective September 8, 2006)	Rural
Suwannee	Rural
Union	Rural
Walton	Rural
Washington	Rural

Source: CMS Atlanta Regional Office Memorandum, October 9, 2006

Skilled Nursing Facility Services

2007 Annual Update of HCPCS Codes for Skilled Nursing Facility Consolidated Billing

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs) or DME Medicare administrative contractors (DME MACs), and fiscal intermediaries (FIs) for services provided to Medicare beneficiaries in skilled nursing facilities (SNFs).

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5283, which provides the 2007 annual update of HCPCS codes for SNF consolidated billing (CB) and how the updates affect edits in Medicare claim processing systems.

CAUTION – What You Need to Know

CR 5283 provides updated to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manua*l (Publication 100-04), Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

GO – What You Need to Do

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

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, DMERCs/DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by carriers and\or FIs.

- **For physicians and providers billing carriers:** By the first week in December 2006, new code files will be posted on the CMS website at *http://www.cms.hhs.gov/SNFConsolidatedBilling/*.
- **For those providers billing FIs:** By the first week in December 2006, new Excel® and PDF files will be posted on the CMS website at *http://www.cms.hhs.gov/SNFConsolidatedBilling/*.

Note: It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the CMS website in order to understand the major categories including additional exclusions not driven by HCPCS codes.

Implementation

The implementation date for CR 5283 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC or FI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1068CP.pdf*.

If you have any questions, please contact your carrier, DMERC, DME MAC, or intermediary at their toll-free number, which may be 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: MM5283
Related Change Request (CR) Number: 5283
Related CR Release Date: September 29, 2006
Related CR Transmittal Number: R1068CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1068, CR 5283

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Skilled Nursing Facility Consolidated Billing Web-based Training Course Is Now Available

The *Skilled Nursing Facility Consolidated Billing Web-based Training Course* is now available on the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network (MLN)*. The course provides general information about skilled nursing facilities (SNF), SNF consolidated billing, and "under arrangement" agreements between SNFs and other providers or suppliers. To access the course, visit *http://www.cms.hhs.gov/mlngeninfo/01_overview.asp*. Scroll down to "Related Links Inside CMS," and select "Web-Based Training Modules."

The *Skilled Nursing Facility Prospective Payment System Fact Sheet*, which is the first in an upcoming series of payment fact sheets, is now available in downloadable format on the CMS ***MLN***. To access the fact sheet, visit *http://www.cms.hhs.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf*.

The fact sheet will be available for ordering through the ***MLN*** in approximately six weeks. ❖

Source: CMS Provider Education Resource 200610-03

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 2006 Update of the Hospital Outpatient Prospective Payment System—Summary of Payment Policy Changes

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for outpatient services furnished under the hospital outpatient prospective payment system (OPPS).

Impact on Providers

This article is based on change request (CR) 5304, which describes changes to the hospital OPPS to be implemented in the October 2006 OPPS update.

Background

CR 5304 describes changes to, and billing instructions for, various payment policies implemented in the October 2006 OPPS update. The October 2006 OPPS outpatient code editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 5304. In addition, the October 2006 revisions to OPPS OCE data files, instructions and specifications are provided in CR 5244, "October 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.3." CR 5244 may be found on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.hhs.gov/Transmittals/downloads/R1045CP.pdf*.

Key changes in CR 5304 include the following:

1. **Device Edit Changes and Questions**
   a. **Addition of HCPCS code C1820, generator, neurostimulator (implantable), with rechargeable battery and charging system as an allowed device for *CPT* code *64590*, insertion or replacement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling**

The HCPCS code C1820 has been added as an allowed device for *CPT* code *64590*, based on newly received information that the rechargeable neurostimulator can be implanted for the purpose of stimulating peripheral nerves. This change is effective for services furnished on and after January 1, 2006, the effective date of HCPCS code C1820.

   b. **Clarification regarding reporting devices for pacemakers**

Claims containing *CPT* codes *33206, 33207, 33208, 33213* and *33214* for insertion of pacemakers and leads require both:

- A device code for a pacemaker, and
- A device code for pacemaker leads, which includes:
  - C1779, Lead, pacemaker, transvenous VDD single pass, or
  - C1898, Lead, pacemaker, other than transvenous VDD single pass).

In other words, in order to pass the OCE device edit, a claim for these procedure codes must have at least two devices on the claim: 1) a pacemaker from the column A list of allowed pacemakers for the procedure code being billed and 2) either C1779 or C1898 from column B devices.

2. **List of Device Category Codes for Present or Previous Pass-through Payment and Related Definitions**

CMS has posted a document on the OPPS website (*http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage*) that provides a complete list of the device category codes used presently or previously for pass-through payment, along with their expiration dates, and definitions that were published for certain device category C-codes.

CMS posted this list to facilitate the ability to track all present and previous categories for pass-through payment. Once on the CMS website (*http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage*) select "Pass Through Payment Device Category Codes [PDF…]" from the Downloads section.

Note: This list does not include all device codes reportable in the OPPS; there are additional HCPCS codes for devices that were not eligible for pass-through payment. The *Medicare Claims Processing Manual* (Publication 100-04, Chapter 4, Section 61; *http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf*) provides detailed information on requirements for reporting device codes and satisfying device to procedure edits in the OPPS.

October 2006 Update of the Hospital OPPS—Summary of Payment Policy Changes (continued)

3. **New Services**
   The following new service is assigned for payment under the OPPS:

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9727	October 1, 2006	S	1510	Insert palate implants	Insertion of implants into the soft palate; minimum of three implants	$850.00	$170.00

4. **Drugs and Biologicals**
   a. **Drugs and biologicals with payment rates based on average sales price (ASP), effective October 1, 2006**

In the CY 2006 OPPS final rule published in the *Federal Register* November 10, 2005 (70 FR 68643; *http://www.access.gpo.gov/su_docs/fedreg/a051110c.html*), it was stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in the October 2006 release of the OPPS PRICER. The updated payment rates effective October 1, 2006, will be included in the October 2006 update of the OPPS Addendum A and Addendum B, which will be posted at the end of September on the CMS website at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage*.

   b. **Newly-approved drug eligible for pass-through status**

The following drug has been designated as eligible for pass-through status under the OPPS effective October 1, 2006. The payment rate for this item may be found in the October 2006 update of OPPS Addendum A and Addendum B, which will posted on the CMS website at the end of September, 2006 (*http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage*).

HCPCS Code	APC	SI	Long Description
C9231	9231	9231	Injection, decitabine, per 1 mg

   c. **Updated payment rate for HCPCS C9227, injection, micafungin sodium, per 1 mg, effective April 1, 2006 through June 30, 2006**

The payment rate for HCPCS Code C9227 was incorrect in the April 2006 OPPS PRICER. The corrected payment rate listed below has been installed in the October 2006 OPPS PRICER, effective for services furnished on April 1, 2006, through implementation of the July 2006 update.

HCPCS Code	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9227	9227	Injection, micafungin sodium	$1.89	$0.38

   d. **Updated payment rate for HCPCS C9230, injection, abatacept, per 10 mg, effective July 1, 2006 through September 30, 2006**

The payment rate for HCPCS Code C9230 was incorrect in the July 2006 OPPS PRICER. The corrected payment rate listed below has been installed in the October 2006 OPPS PRICER, effective for services furnished on July 1, 2006, through implementation of the October 2006 update.

HCPCS Code	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9230	9230	Injection, abatacept	$19.08	$3.82

   e. **Payment rate for *CPT* code *90736*, zoster (shingles) vaccine, live, for subcutaneous injection, becomes effective on its date of FDA approval**

Currently, *CPT* code *90736* is not payable under OPPS and is assigned to status indicator ‘E’. The product described by this code was approved by the Food and Drug Administration (FDA) on May 25, 2006. Therefore, in the October 2006 OCE update, the status indicator for *CPT* code *90736* will be changed from ‘E’ to ‘K’ to become payable under OPPS effective May 25, 2006.

CPT code *90736* will map to APC 0745. The payment rate for APC 0745 may be found in the October 2006 update of OPPS Addendum A and Addendum B, which was posted on the CMS website at the end of September.

October 2006 Update of the Hospital OPPS—Summary of Payment Policy Changes (continued)

f. Correct reporting of units for drugs

Note: Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 50 mg but 200 mg of the drug was administered to the patient, the units billed should be 4.

Note: Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg, and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. HCPCS short descriptors are limited to 28 characters, which include spaces, so short descriptors do not always capture the complete description of the drug.

Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

The full descriptors for the Level II HCPCS codes may be found in the latest code books or from the latest Level II HCPCS file, which is available for downloading on the CMS website at: *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage*.

Providers are reminded to check HCPCS descriptors for any changes to the units when HCPCS definitions or codes are changed.

5. Transitional Outpatient Payments

Effective January 1, 2005, CMS transitioned from metropolitan statistical areas (MSAs) to core based statistical areas (CBSAs).

CR 3214 (Transmittal 82, issued on May 14, 2004; *http://www.cms.hhs.gov/transmittals/Downloads/R82OTN.pdf*) instructed FIs to refer to the inpatient provider specific file to determine whether a hospital was rural for purposes of transitional outpatient payments (TOPs). It also instructed FIs to populate both the geographic/actual MSA field and wage index MSA field in the outpatient provider specific file (OPSF) using data from the inpatient regulations that were effective on and after October 1, 2004. (An *MLN Matters* article on CR 3214 is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3214.pdf*.)

CR 3214 instructed that:

- Changes to wage index classifications that apply to the inpatient PPS, on or after October 1 of any year, do not apply to the OPPS until January 1 of the next year; and
- FIs should use the OPSF to determine whether a provider was eligible for the TOPs, beginning January 1, 2005.

CMS received several inquiries related to the transition from MSAs to CBSA and would like to clarify that it was anticipated FIs would automatically transition from MSAs to CBSAs as of January 1, 2005.

Therefore, effective January 1, 2005, a hospital is considered rural for purposes of TOPs if either the geographic/actual CBSA field or the wage index CBSA field is rural.

A hospital that was rural under MSAs but is urban under CBSAs is no longer eligible for TOPs as of January 1, 2005.

Note: Interim TOPs Calculation: If mutually agreed upon by both the FI and the provider, the FI can pay less than the monthly interim TOP (85 percent of the full hold harmless amount) to that provider to avoid significant overpayments throughout the year that must be paid back to the FI at cost report settlement. The interim TOPs would be reconciled at cost report settlement, as usual.

6. Coverage Determinations

The fact that a drug, device, procedure, or service is assigned 1) a HCPCS code and 2) a payment rate under the OPPS does not imply coverage by the Medicare program. It only indicates how the drug, device, procedure, or service may be paid if covered by the Medicare program.

FIs determine whether a drug, device, procedure, or service meets all Medicare program requirements for coverage, and whether:

- The drug, device, procedure, or service is or is not reasonable and necessary to treat the beneficiary's condition, or
- The drug, device, procedure, or service is included in or excluded from payment.

Implementation

The implementation date for CR 5304 is October 2, 2006.

Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1060CP.pdf*.

If you have any questions, please contact your FI/RHHI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.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: MM5304
Related Change Request (CR) Number: 5304
Related CR Release Date: September 18 2006
Related CR Transmittal Number: R1060CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 1060, CR 5304

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Electronic Data Interchange

Ending the Contingency Plan for Remittance Advice and Charging for PC Print, Medicare Remit Easy Print, and Duplicate RAs

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

Provider Types Affected

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

Impact on Providers

This change request (CR) updates the *Medicare Claims Processing Manual* (Publication 100-04) for ending the contingency plan for electronic remittance advice (ERA), and instructs contractors about charging for PC Print, Medicare Remit Easy Print (MREP), and duplicate remittance advice (RA).

Background

This article is based on CR 5308 which:

- Updates the *Medicare Claims Processing Manual* (Chapters 22 and 24) to include the end of the contingency period for ERA effective October 1, 2006
- Provides instructions to Medicare contractors (A/B MACs, carriers, DMERCs, DME MACs, FIs, and RHHIs) regarding charging for:
  - Generating and mailing provider requested duplicate remittance advices (RAs). There is no current CMS instruction for contractors to charge for generating duplicate remittance advice (when provider has already been sent a remittance advice – either in electronic or paper format) and mailing in case of paper remittance advice. Therefore, CR 5308 informs Medicare contractors that they are now allowed to charge to recoup their cost to generate a duplicate RA if the request comes from a provider or any entity working on behalf of the provider.
  - Making PC Print or Medicare Remit Easy Print software available to providers by CD/DVD or any other means when the requested software is available for free to download. Contractors may charge up to $25.00 for each mailing to cover their cost(s).

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, an ERA sent to a provider **on or after October 16, 2003** is required to be a standard HIPAA compliant ERA, and the ERA standard adopted under HIPAA was ANSI ASC X12N transaction 835, version 004010A1.

CMS implemented a contingency plan (as of October 16, 2003) to continue to accept and send HIPAA-compliant and non-HIPAA-compliant transactions from/to trading partners beyond October 16, 2003, for a limited time.

CMS ended the contingency period *for claims* in **October 2005**, and in a Joint Signature Memorandum (JSM/TDL-06518) issued on June 28, 2006, CMS instructed Medicare contractors that it **is ending the contingency period *for ERAs*** on **September 30, 2006**.

CR 5308 instructs Medicare contractors that, on or after October 1, 2006, all ERAs must be provided in the standard HIPAA (ANSI ASC X12N 835 version 004010A1) format.

Implementation

The implementation date for CR 5308 is October 23, 2006.

Additional Information

For complete details, please see the official instruction issued to your A/B MAC, carrier, FI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1063CP.pdf*.

The revised sections of the *Medicare Claims Processing Manual* are attached to CR 5308.

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

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

MLN Matters Number: MM 5308
Related Change Request (CR) Number: CR 5308
Related CR Release Date: September 22, 2006
Related CR Transmittal Number: R1063CP
Effective Date: October 1, 2006
Implementation Date: October 23, 2006

Source: CMS Pub. 100-04, Transmittal 1063, CR 5308.

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Educational Events

Upcoming Provider Outreach and Educational Events

November – December 2006

Hot Topics Based on Various Data Analysis and Therapy Cap

When: **Thursday, November 9, 2006**

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

Type of Event: **Teleconference**

Ask the Contractor

When: **Tuesday, November 14, 2006**

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

Type of Event: **Teleconference**

NPI CMS Module-3, Sub-Parts

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

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

Type of Event: **Webcast**

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

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

What Is a Webcast?

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

Online Registration

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

Registrant’s Name: ______________________________

Registrant’s Title: ______________________________

Provider’s Name: ______________________________

Telephone Number: ______________ Fax Number: ______________

Provider Address: ______________________________

City, State, ZIP Code: ______________________________

PREVENTIVE SERVICES

Medicare Preventive Services Provider Education Products

An Overview of Medicare Preventive Services Video

The Medicare Learning Network is pleased to announce the availability of the latest provider education resource on Medicare's coverage of preventive benefits, *An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* video program. This educational video program provides an overview of preventive services covered by Medicare including the newest preventive services that became effective January 2005 as a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This program provides information on risk factors associated with various preventable diseases and highlights the importance of prevention, detection, and early treatment of disease. The information presented in this program is useful for physicians, providers, suppliers, and other health care professionals involved in providing preventive services to Medicare beneficiaries. The program runs approximately 75 minutes in length.

The Centers for Medicare & Medicaid Services (CMS) has approved this educational video program for 0.1 of CEUs (continued education units) to participants who successfully complete this program. This program is appropriate for use by a single individual or may be shown to a large group. To order your DVD or VHS copy of the video program, go to *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

Preventive Services Web-based Training Course

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 approved this Web-based training course for 0.1 of CEUs to participants who successfully complete this program.

Disclaimer – The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington, DC 20006. The authors of these programs have no conflicts of interest to disclose. These courses were developed without the use of any commercial support.

Flu Season Resources for Health Care Professionals

The Medicare Learning Network has developed the ***2006 – 2007 Influenza (Flu) Season Educational Products and Resources*** online PDF document. This online document includes links to flu-related educational products developed by CMS for provider use and links to other resources where clinicians may find useful information and tools for the 2006 – 2007 flu season. The resource document will be updated as new flu information becomes available. The ***2006 – 2007 Influenza (Flu) Season Educational Products and Resources*** online document may be accessed by going to the downloads section of the *MLN Preventive Services Educational Products* Web page, located at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*. ❖

Source: CMS Provider Education Resource 200610-10

October Is National Breast Cancer Awareness Month

In conjunction with National Breast Cancer Awareness Month (NBCAM), the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join with us in helping to promote increased awareness of the importance of early detection of breast cancer, and ensure that all eligible women with Medicare know that Medicare provides coverage of screening mammograms and clinical breast exams for the early detection of breast cancer.

Next to skin cancer, breast cancer is the most common form of cancer diagnosed in women in the U.S., and it is the second leading cause of cancer death in women. According to the American Cancer Society, in 2006 about 212,920 women in the U.S. will be found to have invasive breast cancer and about 40,970 will die from the disease. The earlier breast cancer is detected, the better the treatment outcome. Regular screening mammograms can help women detect breast cancer early.

Although screening mammograms and clinical breast exams are services covered by Medicare, the data indicates that these services are being underutilized. There are eligible women with Medicare who have never taken advantage of these preventive benefits and others who do

October is National Breast Cancer Awareness Month (continued)

not get screening mammograms and/or clinical breast exams at regular intervals.

Barriers to Getting Mammograms*

The top four barriers, in women's words, are:

- "I don't need a mammogram because my doctor has never recommended I have one."
- "I've never thought about it."
- "I have no breast problems, so mammography isn't necessary."
- "I don't have enough time."

Other barriers include:

- Fear about pain from the procedure.
- Fear of a diagnosis of breast cancer.
- Concerns about screening costs.
- Living a distance from the screening site.
- Source: *The Manual of Intervention Strategies to Increase Mammography Rates*, Centers for Disease Control and Prevention with the Prudential Center for Health Care Research.

Medicare Coverage

The good news is that mammography rates for women age 50 and older are increasing and breast cancer deaths are in decline. The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination, every one-two years for women aged 40 and older.

Medicare provides coverage of an annual screening mammogram for all female beneficiaries age 40 and older. Medicare also provides coverage of clinical breast exams, (the clinical breast exam is a Medicare-covered service which is included as part of the pelvic screening exam) every 12 or 24 months depending on risk level for the disease.

How Can You Help?

As a trusted source, your recommendation is the most important factor in increasing utilization of breast cancer screening services among eligible women with Medicare. CMS needs your help to ensure that all women with Medicare take full advantage of the preventive services and screenings for which they may be eligible. These services could save their lives.

- Help your patients understand the nature of breast cancer, benefits of breast cancer screening and encourage them to get screening mammograms at regular intervals.
- Encourage your patients to talk about any barriers that may keep them from obtaining mammography services on a routine basis and help them overcome those barriers.

For More Information

For more information about Medicare's coverage of screening mammography, visit the CMS website at *http://www.cms.hhs.gov/Mammography/*.

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 Matters* article "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. 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.

For more information about NBCAM, please visit *http://www.nbcam.org*.

Thank you for joining with CMS to promote increased awareness of early breast cancer detection and mammography and clinical breast exam services covered by Medicare. ❖

Source: CMS Provider Education Resource 200610-02

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

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

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NOTE: *The Medicare A Bulletin is available* ***free of charge*** *online at* ***www.floridamedicare.com***.

Sign up to our *eNews* electronic mailing list

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

IMPORTANT ADDRESSES , TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

PROVIDER EDUCATION

Provider Outreach and Education
P. O. Box 45157
Jacksonville, FL 32232-5157

Provider Event 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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