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The Medicare A Bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Publications issued after October 1, 1997, are available at no-cost from our provider website at www.floridamedicare.com.

Routing Suggestions:

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

☐ ______________
☐ ______________
☐ ______________

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Publication Staff
Millie C. Perez
Kimberly McCaw
Terri Drury
Betty Alix

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Questions concerning this publication or its contents
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Medicare Part A
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Jacksonville, FL
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Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria

I
n addition to national and local coverage determinations (NCDs and LCDs), there are certain principles that apply to all Medicare claims. These are rooted in the Medicare laws and regulations. By drawing the attention of our provider community to these topics, we anticipate reducing the claim payment error rate and reimbursing for medically necessary services correctly and expeditiously. This is not an all-inclusive list, but it does represent frequent observations from our Medical Review and Medical Policy departments. The focus of this article is on professional services that are usually but not always billed to the carrier (Part B funds) as opposed to the fiscal intermediary (FI – Part A and B funds). However, the principles apply to FI services unless specific differences are noted in the Medicare manuals. We hope that this publication will be useful to our providers and their teams by facilitating the correct filing of claims and the submission of supportive information.

Documentation

General Information

Below are some key points:

- Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24-48 hrs.) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.

- The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.

- Every note must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered. They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.

- If the provider elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter must be documented in the medical record. Generally, the time must be documented when billing for all time-based codes, such as critical care, prolonged services, hospital discharge services, and others.

- All entries must be legible to another reader to a degree that a meaningful review may be conducted. All notes should be dated, preferably timed, and signed by the author. In the office setting, initials are acceptable as long as they clearly identify the author. If the signature is not legible and does not identify the author, a printed version should be also recorded.

Responding to Additional Documentation Request Letters and Requests from the Comprehensive Error Rate Testing Contractor

Although the terminology of these letters may vary, it is important to send all information that will support the claim. For non-laboratory services, this is the billing provider’s responsibility, regardless if she or he has created it. For example, when seeking reimbursement for a diagnostic test, the performing (billing) provider should not only submit the report but also the order and the referring provider’s office notes that document the medical necessity for the study. If the information received fails to support the coverage or coding of the claim, in full or in part, the contractor must deny the claim, in full or in part (CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 3, Section 3.4.1.2A).

There are situations where test reports or other elements of the documentation are housed at a different location from the performing provider’s office, for instance an EKG or X-ray read in the hospital. Because it is the performing provider who is required to submit this documentation upon request, it would be best practice if providers kept a copy of this information in their records so that it is readily available. This is a very important issue, as it continues to generate a high error rate in CMS’ CERT (comprehensive error rate testing) program and results in numerous recoupments of payments already made.
Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)

Cloning of Medical Notes

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Evaluation and Management Coding

Procedure Code/Diagnosis Code Linking

It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure to be paid.

Volume of Documentation vs. Medical Necessity

The Social Security Act, Section 1862 (a)(1)(A) states: “No payment will be made … for items or services …not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member.” This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. Providers frequently “over document” and consequently select and bill for a higher-level E/M code than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the “carry over” and repetitive “fill in” of stored information. Even if a “complete” note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient’s situation at that specific time cannot be counted.

Shared Visits

Shared visits with non-physician providers (NPPs) may be reported as one visit, if each provider sees the patient separately and each documents separately. Each component of the visit must be medically necessary.

In the office/clinic setting:

- Providers may bill under the physician’s provider identification number (PIN), if all “incident to” requirements are met (follow-up visit, direct supervision, etc.).
- The service must be billed under the non-physician provider’s PIN if any of the “incident to” requirements are not met (example: new patient and/or physician not in the office suite).

In the hospital inpatient/outpatient/ER setting:

- Providers may bill under the physician’s or NPP’s PIN if the physician provides any face-to-face portion of the E/M encounter with the patient.
- The services must be billed under the NPP’s PIN if there is no face-to-face encounter by the physician.

The medical necessity of a service is the overarching criterion of payment. All interventions must be aimed at benefiting the patient and not only satisfying a billing requirement. It must be apparent that the face-to-face encounter with the physician is medically necessary and benefits the patient (impacts evaluation, treatment, and outcome). Shared visits cannot be reported in the skilled nursing facility (SNF) or nursing facility (NF) settings.

Scribing

If a nurse or non-physician practitioner (PA, NP) acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note “written by xxxx, acting as scribe for Dr. yyyy.” Then, Dr. yyyy should co-sign, indicating that the note accurately reflects work and decisions made by him/her.

It is inappropriate for an employee of the physician to make rounds at one time and make entries in the record, and then for the physician to make rounds several hours later and note “agree with above,” unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.

Record entries made by a “scribe” should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement. Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to be the one delivering the services and creating the record. There is no carrier Part B “incident to” billing in the hospital setting (inpatient or outpatient). Thus, the scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently, and there is no payment for this activity.

It is acceptable for a physician to use a scribe, but current documentation guidelines must be followed. The physician is ultimately accountable for the documentation, and should sign and note after the scribe’s entry the affirmation above that the note accurately reflects work done by the physician.
Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)

Provider Qualification

Training and Expertise

CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 13, Section 5.1 (http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf) outlines that “reasonable and necessary” services are “ordered and/or furnished by qualified personnel.” Services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

This training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty or must reflect extensive continued medical education activities. If these skills have been acquired by way of continued medical education, the courses must be comprehensive, offered or sponsored or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA) as category I credit.

Drugs and Biologicals

General

In order to be covered under Medicare, use of a drug or biological must be safe and effective and otherwise reasonable and medically necessary. The medical reasonableness and necessity of drugs and biologicals are extensively discussed in the Medicare manuals.

First Coast Service Options, Inc. (FCSO) has published numerous local coverage determinations (LCDs) and educational articles about drugs and biologicals, specifically anti-cancer agents. Please refer to these publications for more detailed information. The training requirements listed under “Provider Qualification” apply.

Dosage and Frequency

Drugs or biologicals approved for marketing by the FDA are considered safe and effective when used for indications specified on the labeling. The labeling lists the safe and effective, i.e. medically reasonable and necessary dosage and frequency. Therefore, doses and frequencies that exceed the accepted standard of recommended dosage and/or frequency, as described in the package insert, are considered not medically reasonable and necessary and, therefore, not reimbursable.

Route of Administration

CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.1 addresses medical reasonableness and necessity based on the FDA approval and labeling: “Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling.” This statement extends to the mode of administration that is considered safe and effective, i.e., medically reasonable and necessary by Medicare’s criteria. Furthermore, the CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.2 K – Reasonable and Necessary, stipulates that “carriers and fiscal intermediaries will make the determination of reasonable and necessary with respect to the medical appropriateness of a drug to treat the patient’s condition. Contractors will continue to make the determination of whether the intravenous or injection form of a drug is appropriate as opposed to the oral form.”

Based on the above, for agents administered parenterally, the mode of administration (IV, IM, SQ) must be in keeping with the instructions in the package insert, as approved by the FDA. If a drug is available in both oral and injectable forms and both forms are equally effective, the oral preparation shall be used, unless there is a medical reason not to do so.

Wastage

CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 17, Section 40, Discarded Drugs and Biologicals addresses wastage as: “CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered.

Note: The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug.”

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

Place of Service and Patient Safety

In situations when life threatening and other severe adverse reactions could be expected as a result of the administration of certain drugs or the performance of other services, the administration/performance of these services must take place in a facility equipped and staffed for cardiopulmonary resuscitation and where the patient can be closely monitored by qualified personnel for an appropriate period of time based on his or her health status. For specific services, FCSO may proscribe a place of service (POS) by way of an LCD or other publication.

Unit Dose and Decimal Point Errors

The number of billable units may not be equal to the dose administered. For example, if a HCPCS code descriptor calls for 100 mg of a given agent, the number of units for 1000 mg administered would be 10 and not 1000. Similarly, if the descriptor reads 50 mg and 100 mg are administered, the correct number of units to bill is 2.

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Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)

Diagnostic Tests

Medical Necessity and Documentation

Code of Federal Regulations (CFR), Title 42, part 410.32, specifies that all diagnostic tests must be ordered by a provider who is the treating provider for the patient and who will use the test results in the patient’s care (in regards to the treating provider, there may be exceptions for the diagnostic radiologist in certain institutional inpatient or outpatient patient settings). For laboratory tests, additional documentation of medical necessity may be requested of the referring (treating) provider (CMS Online Manual System, Pub. 100-08, Chapter 3, Section 3.4.1.2).

Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. Like with any service reimbursed by Medicare, to support medical necessity there must be documentation in the medical record as to why a certain modality was chosen/ performed. This entire documentation - not just the test report or the finding/diagnosis on the order – must be available to Medicare upon request (please see also under “Responding to Additional Documentation Request (ADR) Letters and Requests from the Comprehensive Error Rate Testing (CERT) Contractor” in this article).

Portable Diagnostic Equipment

Medicare recognizes that the miniaturization of electronic devices is an on-going trend that may be associated with either improved or diminished test performance. Hand-carried diagnostic equipment ranges in complexity and capability from lightweight pocket-sized units completely contained within the examiner’s hand, to complex equipment systems where only a part, such as the ultrasonic probe itself, is hand-held. The appropriate assignment of a specific ultrasound CPT code is not solely determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. To be reimbursable by Medicare, a diagnostic ultrasound test must meet at least these minimum criteria (this is not an all inclusive list):

- It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
- It should be done for the same purpose as a reasonable physician would order a standard ultrasound examination.
- It must be billed using the CPT code that accurately describes the service performed.
- The technical quality of the exam must be in keeping with accepted national standards and not require a follow-up ultrasound examination to confirm the results.
- The study must be performed and interpreted by qualified individuals.
- The medical necessity, images, findings, interpretation and report must be documented in the medical record.

Purchased Interpretations

According to the CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 1, Section 30.2.9.1 “A person or entity that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity purchases from an independent physician or medical group if:

- The tests are initiated by a physician or medical group, which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;
- The physician or medical group providing the interpretations does not see the patient; and
- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary.”

Furthermore, it is noted in the Final Rule of 2005 that “Arrangements involving reassignment must not violate any other applicable Medicare laws or regulations governing billing or claims submission, including, but not limited to, those regarding “incident to” services, payment for purchased diagnostic tests, and payment for purchased test interpretations.

Consequently, a provider who initiates (orders) a test cannot purchase the interpretation and bill it to Medicare as professional component. For example, if a physician or a group perform testing on their patients with their own ultrasound equipment, and a radiologist, who is not a member of the practice, reads the tests, the group can bill only for the technical component (modifier TC). The radiologist must bill Medicare separately for the interpretation (professional component, modifier 26).

Eugene J. Winter, M.D.
Medical Director
About The Medicare A Bulletin

The Medicare A Bulletin is a comprehensive magazine published quarterly for Medicare Part A providers in Florida. In accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters, the approximate delivery dates are:

<table>
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<tr>
<th>Publication Name</th>
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<th>Effective Date of Changes</th>
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<tbody>
<tr>
<td>First Quarter 2006</td>
<td>Mid-November 2005</td>
<td>January 1, 2006</td>
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<td>Second Quarter 2006</td>
<td>Mid-February 2006</td>
<td>April 1, 2006</td>
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<td>Third Quarter 2006</td>
<td>Mid-May 2006</td>
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<tr>
<td>Fourth Quarter 2006</td>
<td>Mid August 2006</td>
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Important notifications that require communication in between these dates will be posted to the First Coast Service Options, Inc. (FCSO) Florida provider education website http://www.floridamedicare.com. In some cases, additional unscheduled special issues will also be published.

Who Receives the Bulletin?

Anyone may view, print or download the Bulletin from our provider education website. Providers who cannot obtain the Bulletin from the Internet are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form on page 90). Distribution of the Medicare Part A Bulletin in hardcopy format is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed hardcopy registration form to us.

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

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

What Is in the Bulletin?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?
The publications staff welcomes your feedback on the Bulletin and appreciates your continued support. Please mail comments to:

Editor, Medicare A Bulletin – 10T
Medicare Communication & Education
P.O. Box 45270
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Join our eNews mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website http://www.floridamedicare.com. It’s very easy to do. Simply go to the website, click on the “eNews” link on the navigational menu and follow the prompts.
Distribution of the **Medicare A Bulletin**

Use of the Internet has become an accepted standard of communication throughout the world. Publications produced by First Coast Service Options, Inc. (FCSO) for our Medicare Part A customers are available on our provider education website [http://www.floridamedicare.com](http://www.floridamedicare.com).

We post our Medicare publications to our provider education website in PDF (portable document format) and you may view, print, or download them free of charge. By contrast, hardcopy publications cost the Medicare program a substantial amount of money for printing and postage nationally. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better used elsewhere. In addition, enhancements to online publications can be made that are not possible in print.

**Providers Must Qualify and Register to Receive the **Medicare A Bulletin** in Hardcopy or CD-ROM Format**

Hardcopy or CD-ROM distribution of the **Medicare A Bulletin** is limited to individual providers and medical facilities billing at least one Part A claim to Florida Medicare fiscal intermediary for processing during the twelve months prior to the release of each issue. **Medicare providers who meet these criteria have to register with us to receive the **Bulletin** in hardcopy or CD-ROM format.**

Qualifying providers may be eligible to receive one hardcopy or CD-ROM of that issue, *if* a valid reason is given indicating why the electronic publication available on the Internet cannot be used. “I just prefer hardcopy” is an invalid reason – a valid reason might be lack of a personal computer with Internet access, lack of a CD-ROM drive, or similar technical barrier.

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- **Third-Party Websites** – All third-party websites referenced within articles include hyperlinks to the applicable information on that website. (Online publications only.)

- **References within the Contractor Websites** – All additional resources or reference materials mentioned in the newsletter include hyperlinks to that information within the Medicare provider education website (e.g., full-text versions of local coverage determinations, prior publications, forms, online registration, etc.). Additionally, links to unique Web pages allow access to information applicable to the user’s type of facility. (Online publications only.)

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Please note that you are not obligated to complete this form to obtain information published in the Medicare A Bulletin – issues published beginning in 1997 are available free of charge on our provider education website http://www.floridamedicare.com.

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________________________________________________________________________

Medicare Provider Identification Number (PIN):

________________________________________________________________________

Address:

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City, State, ZIP Code:

________________________________________________________________________

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________________________________________________________________________

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Please let us know your concerns or questions regarding this initiative:

________________________________________________________________________

________________________________________________________________________

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Please do not contact our customer service call center regarding this initiative. Additional questions or concerns may be submitted via the website in the “contact us” section.
Use of Type of Bill 12x for Billing Screening Mammography, Screening Pelvic Examinations, and Screening Pap Smears

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

Provider Types Affected
Providers who submit screening mammography, screening pelvic examinations, and screening pap smear claims to Medicare fiscal intermediaries (FIs)

Background
Screening mammography, screening pelvic examinations, and screening pap smears provided to inpatients of a hospital are covered under Part B, even though the patient has Part A coverage for the hospital stay, if applicable conditions of coverage are met and the applicable frequency limitations have not been exceeded by the patient.

Providers currently bill for these services using type of bill (TOB) 13x, since 12x TOB has not, up to this point, been a valid TOB for the billing of screening mammography, screening pelvic examinations, and screening pap smears, when provided to hospital inpatients under Part B.

Key Points
Effective for claims submitted to FIs on or after July 1, 2006, providers must use TOB 12x in place of TOB 13x to bill for the following services provided to hospital inpatients:

- Screening mammography
- Screening pelvic examinations
- Screening pap smears.

TOBs used for billing of screening mammographies, screening pelvic examinations, and screening pap smears, when provided to other than hospital inpatients under Part B, remain unchanged. These TOBs are 13x, 14x, 22x, 23x, and 85x.

For additional information about this policy, please refer to the revised Medicare Claims Processing Manual attachments to CR 4243 (Publication 100-04, Chapter B).

The revised sections attached to CR 4243 include the following:

- Section 20.4 – Billing Requirements – FI Claims
- Section 20.4.1.2 – RHC/FQHC (Rural Health Center/Federally Qualified Health Center) Claims With Dates of Service on or After January 1, 2002
- Section 30.7 – Type of Bill and Revenue Codes for the Centers for Medicare & Medicaid Services (CMS) Form CMS-1450
- Section 40.6 – Revenue Code and HCPCS (Healthcare Common Procedure Coding System) Codes for Billing.

Relevant Links
CR 4243 is the official instruction issued to your FI (fiscal intermediary) regarding this change. CR4243 may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R827CP.pdf.

Please refer to your local FI if you have questions about this issue. To find the FI’s toll free phone number, go to CMS website http://www.cms.hhs.gov/apps/contacts/.

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

MLN Matters Number: MM4243
Related Change Request (CR) Number: 4243
Related CR Release Date: February 1, 2006
Related CR Transmittal Number: R827CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006
Source: CMS Pub. 100-4, Transmittal 827, CR 4243,

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Revision to the 2006 Medicare Physician Fee Schedule
The Centers for Medicare & Medicaid Services (CMS) released a revised Medicare physician fee schedule (MPFS) file for 2006. The Medicare claim processing systems were updated with the revised 2006 MPFS file. As of February 10, 2006, First Coast Service Options, Inc. (FCSO) began releasing the suspended claims, for services provided on or after January 1, 2006, based on the revised 2006 fee schedules.

In addition, FCSO has adjusted all claims that were previously processed.

FCSO apologizes for any inconveniences this may have caused.

Source: CMS Joint Signature Memorandum 06280, February 8, 2006
Modification of Roster Billing for Mass Immunizers Billing for Inpatient Part B Services—Type of Bills 12x and 22x)

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

Note: Change request (CR) 4242 rescinds and replaces CR 3735.

Provider Types Affected
Providers billing Medicare fiscal intermediaries (FIs) for mass immunization services

Provider Action Needed
STOP – Impact to You
This article is based on CR 4242, which replaces CR 3735 (Transmittal 542, dated April 29, 2005).

CAUTION – What You Need to Know
CR 3735 incorrectly instructed providers to include the discharge date on the roster billing for mass immunizers. CR 4242 removes this requirement and adds instructions to report the following additional (HIPAA required) data elements on the roster when billing for inpatient Part B services (type of bills 12x and 22x) effective October 1, 2005: admission date, admission type, admission diagnosis, patient status code, and admission source code.

GO – What You Need to Do
See the Background section of this article for further details regarding this change.

Background
CR 4242 replaces CR 3735 (Transmittal 542, dated April 29, 2005) and removes the requirement for reporting the discharge date on roster billing for mass immunizers billing for inpatient Part B services.
Because the current roster billing process for mass immunizers billing inpatient Part B services utilizing TOBs 12x (hospitals) and 22x (skilled nursing facilities) does not require the reporting of additional data elements that are mandated by the Health Insurance Portability and Accountability Act (HIPAA), CR 4242:
• Updates the roster billing to include these HIPAA mandated data elements
• Instructs your FI to inform providers that mass immunize to report the following additional data elements on the roster when billing for inpatient Part B services (TOBs 12x and 22x) effective October 1, 2005:
  • Admission date
  • Admission type
  • Admission diagnosis
  • Patient status code
  • Admission source code.

Implementation
The implementation date for this instruction is July 3, 2006.

Additional Information
For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R829CP.pdf.

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

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

MLN Matters Number: MM4242
Related Change Request (CR) Number: 4242
Related CR Release Date: February 2, 2006
Effective Date: October 1, 2005
Related CR Transmittal Number: R829CP
Implementation Date: July 3, 2006
Source: CMS Pub. 100-4, Transmittal 829, CR 4242

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Mammography Facility Certification File—Updated Procedures and Content
CMS has issued the following “MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected
Providers (facilities certified by the Food and Drug Administration [FDA]), who submit screening and diagnostic mammography claims to Medicare fiscal intermediaries (FIs) and to carriers

Key Points
• This article is related to CR 4303. It provides guidelines for carriers/intermediaries to download the most recent Mammography Quality Standards Act (MQSA) file on a weekly basis and use it to adjudicate claims.
• Currently, the FDA file does not contain information on terminated facilities. The Centers for Medicare & Medicaid Services (CMS) will be populating a new file, however, with terminated facilities to enable carriers/intermediaries to pay for services prior to the date of termination and to deny services rendered after the date of termination.

Background
The Mammography Quality Standards Act (MQSA) ensures that all facilities that provide mammography services meet national quality standards.
The FDA, Center for Devices and Radiological Health, is responsible for collecting certificate fees and surveying mammography facilities (screening and diagnostic).
FDA provides CMS with a file, which contains a listing of all facilities that have been issued certificates to perform mammography services. CMS then provides the list to
Medicare carriers and FIs, which also contains information about terminated facilities.

Additional Information

Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000, “Modernization of Screening Mammography Benefit,” provided new payment methodologies for both diagnostic and screening mammograms that utilize digital technology.

For Medicare to determine whether the mammography facility is certified to perform digital mammography (due a higher payment rate), the FDA sends an updated file via the CMS mainframe telecommunications system (CMST) on a weekly basis.

Effective July 1, 2006, CMS will be populating a new Mammography Quality Standards Act (MQSA) file with terminated FDA-certified facilities (designated with a “T” value). This will enable carriers/intermediaries to pay for screening and diagnostic mammography services for terminated facilities prior to the date of termination and to deny services furnished after the date of termination. By doing so, it will enable the payment of claims that come into Medicare from a terminated facility if the date of service occurred before the facility was terminated.

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Change in the Long Descriptor for HCPCS Code Q4080

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

CR 4324 provides clarification on the change in the long descriptor for HCPCS code Q4080 effective January 1, 2006.

Implementation

The implementation date for the instruction is March 13, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary/RHII regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R209OTN.pdf.

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

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

MLN Matters Number: MM4324
Related Change Request (CR) Number: 4324
Related CR Release Date: February 2, 2006
Related CR Transmittal Number: R828CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006
Source: CMS Pub. 100-04, Transmittal 828, CR 4303

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Revision to Instructions Regarding Election Claim for Beneficiaries with Religious Nonmedical Health Care Institution Care

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

Provider Types Affected

Physicians, providers, and suppliers who may treat Medicare patients who have elected religious nonmedical health care institution (RNHCI) care and bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) for those services.

Provider Action Needed

STOP – Impact to You

This change request (1) replaces the current process that develops claims via telephone inquiry for beneficiaries with RNHCI elections with a letter using “yes” or “no” questions; (2) places into the Medicare Claims Processing Manual RNHCI claim processing instructions; (3) restructures much of the existing RNHCI manual material to be more complete and accessible; (4) defines the RNHCI; and (5) lists the qualifying criteria for RNHCI benefits.

CAUTION – What You Need to Know

Note the business requirements in this CR that apply to your billing area.

GO – What You Need to Do

For providers other than RNHCIs, use the letter issued by your contractor that asks questions key to determining excepted versus nonexcepted care. For RNHCIs, incorporate the new claim submission instructions into your billing procedures.

Background

The transmittal publishes enhancements to Medicare manuals to more clearly explain the RNHCI benefit. The majority of these manual changes do not create any new business requirements. However, the transmittal revises instructions from Program Memorandum (PM) AB-03-145.

That PM changed the development process for claims for beneficiaries with RNHCI elections from a review of medical records to a telephone contact process.

The intent of PM AB-03-145 was to simplify the development process.

Since the issuance of PM AB-03-145, a number of Medicare contractors (i.e., carriers and FIs) other than the RNHCI specialty contractor have expressed sufficient concerns about the telephone contact process to cause the Centers for Medicare & Medicaid Services (CMS) to revise that process.

Non-specialty contractors with high volumes of RNHCI-related claim rejects reported difficulty contacting providers. In addition, they reported beneficiaries were not willing or able to supply the necessary information to enable the contractor to determine whether the care was excepted or nonexcepted care under RNHCI benefit policies.

These contractors also expressed concerns about the lack of written documentation from the provider in the telephone-based process. To address these concerns without reverting to a review of medical records, CMS has developed the requirements listed below that will be incorporated into the letter issued to providers.

Briefly, if you bill Medicare for services provided to a patient who has elected RNHCI coverage, the following requirements of CR 4218 will apply.

Requirements of Change Request 4218 Development Letters for Providers Other than RNHCIs

Upon receipt of a claim rejected by Medicare systems due to an RNHCI election on file for that Medicare beneficiary, contractors must issue a development letter designed to determine whether care was excepted or nonexcepted.

Contractors must issue RNHCI development letters that ask questions about the following:

- Whether the beneficiary paid for the services out of pocket in lieu of requesting payment from Medicare
- Whether the beneficiary was unable to make his/her beliefs and wishes known before receiving the services that have been billed
- Whether, for a vaccination service, the vaccination performed was required by a government jurisdiction

The letters will phrase questions in RNHCI to be answered with a “yes” or “no” response. The wording and format of this letter will be based on the experience of your contractor in effectively communicating with their community of providers.

Determinations Based on Development Letter

- Contractors will make determinations of excepted or nonexcepted care based on provider responses to development letters.
- Contractors will make determinations within 30 days of receipt of the provider’s response.
- Contractors will make determinations of excepted care when a provider responds ‘Yes’ to any of the questions in the letter.
- Contractors will make determinations of nonexcepted care when a provider responds ‘No’ to all of the questions in the letter.
- Contractors will make an excepted/nonexcepted determination based on the evidence presented by the claim itself if the provider does not reply in a timely manner to the development letter.
- For claims for which no timely response was received, contractors will make a determination of nonexcepted care if the claim contains durable medical equipment or prosthetic/orthotic devices.
- For claims for which no timely response was received, contractor staff with a clinical background will use the diagnoses and procedures reported on the claim to make their best determination whether the services were excepted or nonexcepted care.
- For claims for which no timely response was received, contractors will make determinations of excepted or nonexcepted care within 30 days of the end of the timely response period.
**Revision to Instructions Regarding Election Claim for Beneficiaries with RNHCI Care (continued)**

**For RNHCI Providers**
CR 4218 provides complete instructions for completion of claims to Medicare.
RNHCIs should review the instructions in CR 4218 and ensure their current billing processes are consistent with these instructions. The “Related Instructions” section of this article provides information on accessing the transmittals that comprise CR 4218.

**Implementation**
The implementation date for the instruction is May 11, 2006.

**Related Instructions**
For a beneficiary to receive benefits under section 1821 of the Social Security Act (the Act) and payment under the Medicare program upon admission to a RNHCI and prior to the RNHCI billing for services, the beneficiary must make a written election.

The document detailing the process for a beneficiary to elect RNHCI care or to terminate that election is attached to transmittal R45BP of CR 4218. CR 4218 may be viewed on the CMS website at [http://www.cms.hhs.gov/Transmittals/downloads/R45BP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R45BP.pdf).

The ten qualifying provisions that must be met for a provider to be defined as an RNHCI, as contained in Section 1861 (ss) (1) of the Act for RNHCIs, are defined in transmittal R35GI of CR 4218. The transmittal may be viewed on the CMS website at [http://www.cms.hhs.gov/Transmittals/downloads/R35GI.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R35GI.pdf).

**Chapter 3 of the Medicare Claims Processing Manual**, Inpatient Hospital Billing, was also completely revised and is contained in transmittal R851CP of CR 4218.

**Additional Information**
The official instructions issued to the RNHCI intermediary regarding this change may be found in three parts, i.e., the transmittals parts as shown in the web addresses provided above.

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

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

**MLN Matters Number:** MM4218
**Related Change Request (CR) Number:** 4218
**Related CR Release Date:** February 10, 2006
**Effective Date:** May 11, 2006
**Related CR Transmittal Number:** R35GI, R45BP, and R851CP
**Implementation Date:** May 11, 2006
**Source:** CMS Pub. 100-4, Transmittal 851, CR 4218

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**Update of Radiopharmaceutical Imaging Agents Healthcare Common Procedure Coding System Codes Applicable to Positron Emission Tomography Scan Services**

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

**Provider Types Affected**
Providers who submit claims to Medicare fiscal intermediaries (FIs) for positron emission tomography (PET) scan services provided to Medicare beneficiaries.

**Background**
This article is based on CR 4270, which updates the Medicare Claims Processing Manual (Publication 100-04), Chapter 13, Section 60.3.2 (Tracer Codes Required for PET Scans) to include two new HCPCS codes for radiopharmaceutical [diagnostic] imaging agents (tracers) applicable to PET scan services.

**Key Points**
Effective for claims dates of service on or after January 1, 2006:
- HCPCS code A9555 replaces HCPCS code Q3000
- HCPCS code A9552 replaces HCPCS code C1775.
- Effective for dates of service on or after January 1, 2006:
  - HCPCS codes Q3000 and C1775 are deleted.

**Additional Information**

**Tracer Codes Required for PET Scans for Institutional Providers Billing Their Fiscal Intermediary**

The following are tracer codes applicable to CPT 78491 and 78492:

**HCPCS Description**
- **A9555** Supply of radiopharmaceutical diagnostic imaging agent, rubidium RB-82, diagnostic, per study dose, up to 60 millicuries
- **Q3000** Supply of radiopharmaceutical diagnostic imaging agent, rubidium RB-82 (Deleted effective 12/31/05)
- **A9526** Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13

**Note:** For claims with dates of service prior to January 1, 2006, providers should report HCPCS code Q3000 for supply of radiopharmaceutical diagnostic imaging agent, rubidium RB-82. For claims with dates of service January 1, 2006 and later, providers report HCPCS code A9555 for radiopharmaceutical diagnostic imaging agent, rubidium RB-82 in place of HCPCS code Q3000.
Update of Radiopharmaceutical Imaging Agents HCPCS Codes Applicable to PET Scan Services (continued)

The following are tracer codes applicable to CPT 78459, 78608, 78609, 78811-78816:

HCPCS Description
*A9552  (OPPS Only) Supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18, FDG, diagnostic, per study dose, up to 45 millicuries
*C1775  Supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18 (Deleted effective 12/31/05)
A4641  Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified

*Note: For claims with dates of service prior to January 1, 2006, providers report HCPCS code C1775 for supply of radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F1. For claims with dates of service January 1, 2006 and later, providers report HCPCS code A9552 for radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18 in place of HCPCS code C1775.

Implementation Date
 This change will be implemented in Medicare systems on July 3, 2006.

Relevant Links
CR 4270 is the official instruction issued to your FI regarding this change. CR 4270 may be found by going to CMS website http://www.cms.hhs.gov/Transmittals/downloads/R822CP.pdf.

Please refer to your local FI if you have questions about this issue. To find their toll free phone number, go to CMS website  http://www.cms.hhs.gov/apps/contacts/.

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

MLN Matters Number: MM4270
Related Change Request (CR) Number: 4270
Related CR Release Date: February 1, 2006
Related CR Transmittal Number: R822CP
Effective Date: January 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-4, Transmittal 822, CR 4270

April Update to the 2006 Medicare Physician Fee Schedule Database

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

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

Provider Action Needed
This article is based on change request (CR) 4399, which informs your carrier/intermediary that payment files were issued to carriers based upon the November 21, 2005, Medicare physician fee schedule final rule. CR 4399 amends those payment files and includes new G-codes for the Low Vision Rehabilitation Demonstration project and new category II codes 3046F through 3050F and 3076F through 3080F.

Background
The Social Security Act (Section 1848(c)(4); http://www.ssa.gov/OP_Home/ssact/title18/1848.htm), authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians’ services. CMS issued payment files to carriers/intermediaries based upon the November 21, 2005, MPFS final rule.

Note: CR 4399 amends those payment files and includes new G-codes for the Low Vision Rehabilitation Demonstration project and new category II codes 3046F through 3050F and 3076F through 3080F.

In the October 2005 update to the Medicare physician fee schedule database (MPFSDB) the multiple procedure indicators were inadvertently changed from a “0” to “2” effective January 1, 2006. Also, in the October 2005 update to the MPFSDB, the bilateral surgical indicators were inadvertently changed from “1” to “0” for CPT codes 63035, 63043, 63044, 64480, and 64484. This CR reinstates the bilateral surgical indicators for these codes to a “1” effective January 1, 2006.

Your carrier will not search their files for claims paid incorrectly from October 1, 2005, through December 31, 2005, but will adjust claims brought to their attention.

In addition, your carrier will manually adjust their systems and the 2005 MPFSDB to reflect a multiple procedure indicator of a “0” for CPT codes 20931, 20937, and 20938. The emergency update to the 2006 MPFSDB reinstated the multiple procedure indicators for these codes to a “0” effective January 1, 2006. Also, in the October 2005 update to the MPFSDB, the bilateral surgical indicators were inadvertently changed from “1” to “0” for CPT codes 63035, 63043, 63044, 64480, and 64484. This CR reinstates the bilateral surgical indicators for these codes to a “1” effective January 1, 2006.

• Your carrier/intermediary should restate the bilateral surgical indicators for CPT codes 63035, 63043, 63044, 64480, and 64484 for a “1” effective January 1, 2006.
• For services performed on or after March 17, 2005, Medicare will not pay for carotid artery stenting (CAS) with embolic protection claims that have CPT code

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Italicized and/or quoted material is excerpted from the American Medical Association Current Procedural Terminology, CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.
April Update to the 2006 Medicare Physician Fee Schedule Database (continued)

37216 (Transcatheter placement of intravascular stent(s) without distal embolic protection).

- **CPT** code 43842 (Gastric restrictive procedure, without gastric bypass, vertical banded gastroplasty) is noncovered for Medicare effective for services on or after February 21, 2006.

- Your carrier/intermediary should manually update the HCPCS file to reflect a coverage indicator of “C” for **CPT** codes 0001F through 4018F.

- The descriptors for category II modifiers 1P and 2P have been modified, effective for dates of service on or after January 1, 2006, as follows:
  - 1P – Performance Measure Exclusion Modifier due to Medical Reasons
  - 2P – Performance Measure Exclusion Modifier due to Patient Reasons

- Effective for dates of service on or after April 1, 2006, the category II modifier 3P (Performance Measure Exclusion Modifier due to System Reasons) is recognized. Those system reasons include resources to perform the services were unavailable, insurance coverage/payer-related limitations, and other reasons attributable to the health care delivery system.

**Note:** Your carrier/intermediary will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, your carrier/intermediary will adjust claims brought to their attention.

- Unless otherwise stated in CR 4399, changes are retroactive to January 1, 2006.

**Implementation**

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

**Additional Information**

Other changes included in the April update of the MPFS are attached to CR 4399.


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

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

MLN Matters Number: MM4399
Related Change Request (CR) Number: 4399
Related CR Release Date: March 17, 2006
Related CR Transmittal Number: R897CP
Effective Date: January 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 897, CR 4399

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

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

**Provider Types Affected**

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

**Provider Action Needed**

This article is based on change request (CR) 4335 and provides specific information regarding the quarterly update for the April 2006 DMEPOS fee schedule.

**Background**

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

- Implement fee schedule amounts for new codes.
- Revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for:

- Durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)); and
- Parenteral and enteral nutrition (PEN), by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Changes made in this update include the following:

- The fee schedule amounts for HCPCS code K0730, *Controlled dose inhalation drug delivery system*, were added to the fee schedule file on April 1, 2006, and are effective for claims with dates of service on or after April 1, 2005. If processed claims for code K0730 with dates of service on or after April 1, 2005, are resubmitted as adjustments after April 1, 2006, carriers and DMERCs will adjust the claim.
April Quarterly Update for 2006 DMEPOS Fee Schedule (continued)

- The fee schedule amounts for HCPCS code E1010, Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, were inadvertently dropped from the January fee schedule file and are being added back to the file as part of the April 2006 update.
- The payment categories for codes E0471 and E0472 are being revised to move respiratory assist devices from the DME category for frequently serviced items to the DME payment category for capped rental items, effective on April 1, 2006.

Implementation

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

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.

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Supplying Fee and Inhalation Drug Dispensing Fee Revisions and Clarifications

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 February 22, 2006, to show in all places that the correct code for the 30-day dispensing fee is HCPCS Code Q0510. This article was originally published in the January 2006 Medicare A Bulletin Special Issue (pages 17-18).

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

Supplying Fees

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

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

Notes:

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

Dispensing Fees

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

- $57.00 for an initial dispensing fee to a pharmacy for the initial 30-day period of inhalation drugs furnished through DME regardless of the number of shipments or

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Additional Information

The official instructions issued to your intermediary, carrier, or DMERC regarding this change may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R880CP.pdf.

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

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

Source: CMS Pub. 100-04, Transmittal 880, CR 4335
One dispensing fee of $33.00 for a 30-day period of inhalation drugs furnished through DME regardless of the number of shipments or drugs dispensed during that time.

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

**One Dispensing Fee Payment for 90-Day Period**

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

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

**Refill Prescriptions/Supply and Dispensing Fees**

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

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

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

**HCPCS Code Changes**

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

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

- Code Q0512 (replaces G0370) – Pharmacy supplying fee for immunosuppressive, oral anticancer, and oral anti-emetic drugs – each subsequent prescription in a 30-day period. ($16.00)

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

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

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

**Implementation**

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

**Additional Information**

For complete details, please see the official instruction issued to your FI or DMERC regarding this change. That instruction may be viewed by going to the CMS website [http://www.cms.hhs.gov/Transmittals/downloads/R754CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R754CP.pdf).

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

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

MLN Matters Number: MM3990 – Revised
Related Change Request (CR) Number: 3990
Related CR Release Date: November 10, 2005
Related CR Transmittal Number: R754CP
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Source: CMS Pub. 100-04, Transmittal 754, CR 3990

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Appeals of Claim Decisions: Redeterminations and Reconsiderations—
Changes to Chapter 29

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 February 21, 2006, to update the language regarding the appeals process. In addition, the article now contains Web addresses that conform to the new CMS website. This article was originally published in the First Quarter 2006 Medicare A Bulletin (pages 17-18).

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

Provider Action Needed
The new second level in the administrative appeals process is called “reconsideration.” Reconsiderations are processed by qualified independent contractors (QICs).

Background
The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, now requires a new second level in the administrative appeals process called “reconsideration.”

Requests for reconsiderations of appeal decisions (redeterminations) should go either to the qualified independent contractor (QIC), or the hearing officer (HO), when the redetermination was issued by a carrier prior to January 1, 2006.

Time Limit for Filing a Request for Reconsideration
A request for reconsideration must be filed within 180 days of the date of receipt of the notice redetermination. For requests filed in writing – the date received is defined as the date received by the QIC in the corporate mailroom.

Please refer to the following table for clarification.

<table>
<thead>
<tr>
<th>Appeal Rights for Requests for Reconsiderations</th>
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<td><strong>The Second Level of Appeal</strong></td>
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</tr>
<tr>
<td>Part B</td>
<td>Carrier</td>
<td>Before January 1, 2006</td>
<td>Hearing Officer</td>
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Additional Information


The official instruction issued to your FI, DMERC, or carrier regarding this change may be found by going to the CMS website [http://www.cms.hhs.gov/Transmittals/downloads/R697CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R697CP.pdf).

The new sections of Chapter 29 of the Medicare Claims Processing Manual are attached to CR 3942. Please refer to your local carrier/DMERC/FI for more information about this issue. To find the toll free phone number, go to the CMS website [http://www.cms.hhs.gov/apps/contacts/](http://www.cms.hhs.gov/apps/contacts/).

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

MLN Matters Number: MM3942 – Revised
Related Change Request (CR) Number: 3942
Related CR Release Date: October 7, 2005
Related CR Transmittal Number: 697
Effective Date: May 1, 2005
Implementation Date: January 9, 2006

Source: CMS Pub. 100-4, Transmittal 697, CR 3942

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.
Appeals of Claim Decisions: Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review

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

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

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

The purpose of this article is to notify you about changes to the manual provisions that address administrative law judge, departmental appeals board, and U.S District Court review levels of appeal.

Key Points
Administrative Law Judge (ALJ) – The Third Level of Appeal
Parties to an appeal who are not satisfied with decisions made by the QIC at the second level of appeal (reconsideration) have the right to request an ALJ hearing as long as all of the ALJ hearing request requirements are met (see Medicare Claims Processing Manual, Chapter 29, Section 330 for details). Outlined below is some pertinent information about the ALJ level of the appeal process.

ALJ Hearing Amount in Controversy
Parties requesting an ALJ hearing must meet the amount in controversy requirements:

- The amount remaining in controversy requirement for requests made before January 1, 2006 is $100.
- The amount remaining in controversy will increase to $110 for requests made on or after January 1, 2006.
- Beginning in 2005, for requests made for an ALJ hearing or judicial court review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Time Limits and Responsibilities
Decisions: The official ALJ decision is a signed copy of the ALJ decision. When issuing decisions, the ALJ will either:

- Issue a decision based on the request for ALJ hearing;
- Issue an order of dismissal of the appellant’s request for ALJ hearing.

Effectuation (No Agency Referral): Often, the ALJ’s decision will require an effectuation action (payment of the claim) on the Medicare contractor’s part. Contractors will effectuate ALJ decisions within 30 days of the receipt of the official ALJ decision if:

- The decision is partially or wholly favorable.
- The decision gives a specific amount to be paid.
- There is no agency referral to the DAB.

Computation of the Amount (No Agency Referral): If the Medicare contractor must compute the amount, the decision must be effectuated within 30 days after the contractor computes the amount to be paid to the appellant. The computation should be done as soon as possible, but no later than 30 calendar days of the date of receipt of the official ALJ decision or effectuation notice.

Clarification (No Agency Referral): If clarification from the ALJ is necessary, then the date of the clarification is considered to be the final determination for purposes of effectuation.

- If clarification is needed from the physician/supplier (e.g., splitting charges), this clarification should be requested as soon as possible and the amount payable should be computed within 30 calendar days after the receipt of the necessary clarification. The date of receipt of the clarification is considered to be the final determination for purposes of effectuation.

Departmental Appeals Board (DAB) – The Fourth Level of Appeal
The DAB evaluates requests for review, and makes final decisions whether to review, or to decline to review, decisions of ALJs as well as orders of dismissal by ALJs.

DAB Effectuation Time Limits: DAB decisions requiring contractor effectuation must be initiated within 30 days of receipt of a DAB decision. Effectuation must be completed within 60 days.

U.S. District Court: The Fifth Level of Appeal
A party may request court review of the DAB’s decision. Medicare contractors are not responsible for reviewing ALJ decisions issued by the Department of Health & Human Services (HHS) ALJs to determine if an agency referral is appropriate, and will not accept a request for U.S District Court review by a party.

Relevant Links
The official instruction issued to your FI including regional home health intermediaries (RHHIs), or carrier including DMERCs, regarding this change may be found by going to the CMS website http://www.cms.hhs.gov/Transmittals/downloads/R862CP.pdf.

The new sections of Chapter 29 of the Medicare Claims Processing Manual are attached to CR4152.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find the toll free phone number, go to the CMS website http://www.cms.hhs.gov/apps/contacts/.
Payment of Federally Qualified Health Centers for Diabetes Self-Management Training Services and Medical Nutrition Therapy Services

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 diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services

Provider Action Needed

STOP – Impact to You
This article is based on a change request (CR) 4385, which provides basic instructions for payment of federally qualified health centers (FQHCs) for DSMT and MNT services.

CAUTION – What You Need to Know
Effective for services furnished on or after January 1, 2006, FQHCs that are certified providers of DSMT and MNT services can receive per visit payments for covered services rendered by registered dietitians or nutrition professionals. If all relevant program requirements are met, DSMT and/or MNT services are included as billable visits under the FQHC benefit.

GO – What You Need to Do
See the Background section of this article for further details regarding these changes.

Background

The FQHC Services include all of the RHC services listed as included in section 30.1 as well as preventive primary services, as described in section 40. As a result of section 5114 of the DRA of 2005, FQHCs certified as DSMT and MNT providers were allowed to bundle the cost of such services into their FQHC payment rates. However, prior to the DRA of 2005, these services would not generate an FQHC visit payment.

Therefore, in order to implement the new FQHC coverage changes, the Centers for Medicare & Medicaid Services (CMS) is amending the Medicare Benefit Policy Manual (Pub. 100-02, Chapter 13).


The manual revision specifies that DSMT and MNT services are now considered core FQHC services and are reimbursable as a visit under the FQHC all-inclusive payment rate when rendered by qualified practitioners.

Section 30 of Chapter 13 of the Medicare Benefit Policy Manual has been revised to show that section 5114 of the DRA expanded the FQHC definition of a face-to-face encounter to include encounters with qualified practitioners of outpatient DSMT and MNT services when the FQHC meets all relevant program requirements for the provision of such services.

Your FIs will make per visit payments to FQHCs for covered services furnished to Medicare beneficiaries as described in the amended version of the Medicare Benefit Policy Manual (Pub. 100-02, Chapter 13, Section 30.2) and included below (amendment bolded and italicized):

“The FQHC services include all of the RHC services listed as included in section 30.1 as well as preventive primary services, as described in section 40. As a result of section 5114 of the DRA of 2005, FQHC services now include Outpatient DSMT and MNT services as billable FQHC visits when the FQHC meets all relevant program requirements for the provision of such services as set forth in Federal regulations at part 410, subpart H for DSMT and in part 410, subpart G for MNT. The DRA amendment is effective for services furnished on or after January 1, 2006.

The Medicare program makes payment directly to the FQHCs for covered services furnished to Medicare beneficiaries. The FQHC services are covered when
Payment of FQHCs for Diabetes Self-Management Training Services and MNT Services (continued)

furnished to a patient at the clinic or center, the patient’s place of residence, or elsewhere (e.g., at the scene of an accident)."

Effective for services furnished on or after January 1, 2006, FQHCs that are certified providers of DSMT and MNT services can receive per visit payments for covered services rendered by registered dietitians or nutrition professionals. In other words, if all relevant program requirements are met, these services are included under the FQHC benefit as billable visits.

**Your FI will:**

- Make per visit payments to FQHCs for DSMT and MNT services using the FQHCs all-inclusive encounter rate when the services meet all relevant program requirements for the provision of such services, and
- Adjust claims for services on or after January 1, 2006 that were not processed prior to implementation of this change if you bring those claims to the attention of your FI.

**Note:** Documentation requirements are the same as those currently required of hospitals when receiving approval from their FIs for provision of DSMT and MNT services.

**Implementation**

The implementation date for this instruction is June 29, 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/R49BP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R49BP.pdf).

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

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

MLN Matters Number: MM4385
Related Change Request (CR) Number: 4385
Related CR Release Date: March 31, 2006
Related CR Transmittal Number: R49BP
Effective Date: January 1, 2006
Implementation Date: June 29, 2006

Source: CMS Pub. 100-02, Transmittal 49, CR 4385

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**Medicare Supplemental Payments to Federally Qualified Health Centers under Contract with Medicare Advantage Plans**

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this article on March 2, 2006, to add the bold, italicized phrase in the fourth bullet point under the “Background” section. This article was previously published in the Second Quarter 2006 Medicare A Bulletin (pages 9-10).

**Provider Types Affected**

Federally qualified health centers (FQHCs) under contract with Medicare Advantage (MA) plans

**Provider Action Needed**

FQHCs should be aware of the instructions for calculating and billing the new supplemental payments due to FQHCs who contract with the MA program effective for services furnished on or after January 1, 2006.

**Background**

This article and related CR 3886 provide details regarding the calendar year (CY) 2006 supplemental payments that augment the direct payments made by the MA organization to FQHCs for all covered FQHC services. Title II of the Medicare Modernization Act (MMA) established the MA program. The MA program replaces the Medicare + Choice (M+C) program established under Part C.

The MA program retains many of the key features of the M+C program and includes several new features, such as the introduction of regional MA plans that will be organized as preferred provider organizations.

Section 237 of the MMA requires the Centers for Medicare & Medicaid Services (CMS) to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X.

The Medicare all-inclusive payment, which continues to be made for all covered FQHC services furnished to Medicare beneficiaries participating in the original Medicare program, is based on the FQHC’s unique cost-per-visit as calculated by the Medicare fiscal intermediary (FI) based on the Medicare cost report.

**Note:** FQHCs seeking payment under Section 237 of the MMA must submit to their FI copies of their contracts under each MA plan.

To implement this new supplemental payment provision, CMS must determine if the Medicare cost-based payments that the FQHC would be entitled to exceed the
amount of payments received by the FQHC from the MA organization and, if so, pay the difference to the FQHC at least quarterly. In determining the supplemental payment, the statute also excludes in the calculation of the supplemental payments any financial incentives provided to FQHCs under their MA arrangements, such as risk pool payments, bonuses, or withholds.

Following are the basic instructions for calculating the supplemental payments for FQHCs under contract with MA plans.

- The FQHC supplemental payment is based on the per-visit calculation, subject to a yearly reconciliation.

- Supplemental payments are calculated by determining the difference between 100 percent of the FQHCs all inclusive cost-based per visit rate and the average per visit rate received by the FQHC from the MA organization for payment under the MA plan, less the co-pay the FQHC charges the MA enrollees. Also, the FI will not apply the original Medicare deductible and coinsurance in calculating the interim supplemental payment rate.

- Each eligible FQHC seeking the supplemental payment is required to submit (for the first two rate years) to the FI an estimate of the average MA payments (per visit basis) for covered FQHC services.

- Every eligible FQHC seeking the supplemental payment is required to submit a documented estimate of their average per visit payment for their MA enrollees for each MA plan they contracted with and any other information as may be required to enable the FI to accurately establish an interim supplemental payment, e.g., cost sharing amounts set forth in the formal contract with the MA plan.

- Expected payments from the MA organization will be used until actual MA revenue and visits collected on the FQHC’s cost report can determine the amount of the supplemental payment.

- Effective January 1, 2006, eligible FQHCs will report actual MA revenue and visits on their cost reports. At the end of each cost reporting period the FI will use actual MA revenue and visit data along with the FQHC’s final all-inclusive payment rate, to determine the FQHC’s final actual supplemental per visit payment.

This amount (per visit basis) will serve as the interim rate for the subsequent rate year. Actual aggregated supplemental payments will then be reconciled with aggregated interim supplemental payments, and any underpayment or overpayment will then be accounted for in determining final Medicare FQHC program liability at cost settlement.

- An FQHC is only eligible to receive this supplemental payment when FQHC services are provided during a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, or clinical social workers. The supplemental payment is made directly to each qualified FQHC through the FI.

- Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the FI on type of bill 73x with revenue code 0519. Also, FQHCs must not report revenue codes 0520 and/or 0900 on the same claim that contained revenue code 0519 when submitting claims for these qualifying visits by MA enrollees. Healthcare Common Procedure Coding System (HCPCS) coding is not required.

Implementation

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

Additional Information

The official instruction issued to your intermediary regarding this change may be found by going to CMS website at http://www.cms.hhs.gov/transmittals/downloads/R794CP.pdf.

For additional information relating to this issue, please refer to your intermediary.

To find their toll free phone numbers go to CMS website at http://www.cms.hhs.gov/apps/contacts/.

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

MLN Matters Number: MM3886 – Revised
Related Change Request (CR) Number: 3886
Related CR Release Date: December 29, 2005
Related CR Transmittal Number: R794CP
Effective Date: January 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-4, Transmittal 794, CR 3886
April 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File and Revisions to Previous Pricing Files

**Provider Types Affected**
All Medicare providers who bill Medicare for Part B drugs

**Provider Action Needed**

**STOP – Impact to You**


**CAUTION – What You Need to Know**

Be aware that certain Medicare Part B drug payment limits have been revised and that the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised average sales price (ASP) and not otherwise classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR 4319.

**GO – What You Need to Do**

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

**Background**

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

Additionally, in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS), will be paid based on the ASP methodology. The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

**Exceptions to General Rule**

There are exceptions to this general rule as summarized below:

**Blood and Blood Products**

For blood and blood products (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003.

The payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.

**Infusion Drugs**

For infusion drugs furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted.

The payment allowance limits were not updated in 2005. For infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, regardless of whether or not the DME was implanted, the payment allowance limits are 95 percent of the first published AWP.

**Influenza, Pneumococcal, Hepatitis B Vaccines**

For influenza, pneumococcal, and hepatitis B vaccines, payment allowance limits are 95 percent of the AWP as reflected in the published compendia.

**Drugs Not Included in ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File**

For drugs (other than new drugs) not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file, payment allowance limits are based on the published wholesale acquisition cost (WAC) or invoice pricing.

In determining the WAC-based payment limit, Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries, including regional home health intermediaries (RHHIs)) will follow the methodology specified in the *Medicare Claims Processing Manual* for calculating the AWP, but substitute WAC for AWP. (See Publication 100-04, Chapter 17, Drugs and Biologicals) on the CMS website at [http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf).

The payment limit is 100 percent of the lesser of the lowest brand or median generic WAC.

Your Medicare contractor may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting contractor or will post them in an MS Excel file on the CMS website. If the payment limit is available from CMS, contractors will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.
Radiopharmaceuticals

The payment allowance limits for radiopharmaceuticals are not subject to ASP. Your carrier/FI will determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003.

New Drugs Produced or Distributed under a New Drug Application Approved by the Food and Drug Administration

The payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.

How the ASP is Calculated

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter, CMS will update your carrier payment allowance limits with the ASP files. On or after March 20, 2006, revised January 2005, April 2005, July 2005, October 2005, and January 2006 ASP and NOC payment files and the April 2006 ASP and NOC files will be available for download.

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

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations. For any drug or biological not listed in the ASP or NOC drug pricing files, your Medicare contractor will determine the payment allowance limits in accordance with the policies described in CR 4319 and fiscal intermediaries will seek payment allowances from the local Medicare carrier.

Implementation

The implementation date for the instruction is April 3, 2006

Additional Information

The official instructions issued to your carrier/FI/RHFI/DMERC regarding this change may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R876CP.pdf.

More information is available on the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.

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

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

MLN Matters Number: MM4319
Related Change Request (CR) Number: 4319
Related CR Release Date: February 24, 2006
Related CR Transmittal Number: R876CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 876, CR 4319

Sunset of the Provider Nomination Provision

A special edition MLN Matters article (SE0582) titled “Sunset of the Provider Nomination Provision and the Policy to Assigned Providers to the Local Fiscal Intermediary” was published in the January 2006 Medicare A Bulletin Special Issue (pages 43-44).

In that article, we notified providers that the Centers for Medicare & Medicaid Services (CMS) will no longer allow a freestanding provider that enters the Medicare program to express a preference for a particular fiscal intermediary (FI). The CMS regional offices (ROs) must assign the new provider to the FI that serves the state in which the provider is located. Providers shall no longer be able to request a change in of their fiscal intermediary. They must remain with the FI to which they have been assigned.

Source: CMS Pub. 100-04, Transmittal 861, CR 4286
January 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File, and Revisions to 2005 Files

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 February 17, 2006, to delete references to the revised January 2005 pricing file. Change request (CR) 4140 was revised by CMS to delete the same references since the revised January 2005 pricing file was not provided as indicated in the original CR 4140. Also, the CR transmittal number, Web address, and release date were also changed. Other Web addresses were changed to conform to the new CMS Web site. All other information remains the same. This article was originally published in the January 2006 Medicare A Bulletin Special Issue (pages 41-42).

Provider Types Affected
All Medicare providers who bill Medicare for Part B drugs

Provider Action Needed
STOP – Impact to You

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

GO – What You Need to Do
Make certain that your billing staffs are aware of these changes.

Background
According to Section 303 (c) of the Medicare Modernization Act of 2003 (MMA), the Centers for Medicare & Medicaid Services (CMS) will update the payment allowances for Medicare Part B drugs on a quarterly basis. Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the ASP. The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter, CMS will update your carrier/fiscal intermediary (FI) payment allowance limits with the ASP files.

On or after December 19, 2005, revised April 2005, July 2005, and October 2005 ASP and NOC payment files and the January 2006 ASP and NOC files will be available for download.

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

Exceptions
There are, however, exceptions to the general rule and they were summarized in MM3846, effective July 1, 2005, and may be viewed on the CMS website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3783.pdf.

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

Additional Information
The official instruction issued to your carrier/intermediary regarding this change may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R856CP.pdf.

CMS will also update the Microsoft Excel files on the CMS web site to reflect these revised payment limits. Those files may be found on the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/

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

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

MLN Matters Number: MM4140 – Revised
Related Change Request (CR) Number: 4140
Related CR Release Date: February 15, 2006
Related CR Transmittal Number: R856CP
Effective Date: January 1, 2005
Implementation Date: January 3, 2006
Source: CMS Pub. 100-4, Transmittal 856, CR 4140

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New 2006 Payment Rate for Services Paid Under the Medicare Physician Fee Schedule

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, regional home health intermediaries (RHHIs), and fiscal intermediaries (FIs)) for services paid under the MPFS provided to Medicare beneficiaries

Important Points to Remember

• This article is based on change request (CR) 4313, which states that Congress has amended the physician update from a negative 4.4 percent (-4.4%) update to a zero-percent (0%) update for services provided on or after January 1, 2006, and paid under the MPFS.
• Within two days of the enactment of the new legislation, Medicare contractors (i.e., carriers, FIs, and RHHIs) will begin to automatically reprocess those claims paid at the -4.4% update.
• New MPFS fees will be posted on the carrier sites as soon as possible after the bill is signed by the President. Your carrier may charge a reasonable fee for mailing a hardcopy version of the MPFS if you choose not to access the MPFS via the Internet.
• The Centers for Medicare & Medicaid Services (CMS) will create another participation enrollment period that will begin after the President signs the bill and the enrollment period will run for 45 days.

Background

Congress has passed the Deficit Reduction Act (DRA) of 2005, which, among other things, changes the update to the 2006 conversion factor for services paid under the Medicare physician fee schedule (MPFS). The DRA replaces the previously announced -4.4 percent reduction with a zero-percent increase for services paid under the MPFS. The change is effective retroactive for service on or after January 1, 2006.

Because of the change in the 2006 MPFS rates, CMS will create another participation enrollment period that will run for 45 days. More specific information concerning a second participation enrollment period will be appear in a forthcoming change request (CR) and related MLN Matters article.

This CR only addresses the change in payment rates related to the new zero percent update to the conversion factor and reprocessing of claims that were paid using the -4.4 percent update rates.

Claims processed with the -4.4 percent rates will be reprocessed with the new rates and adjustments will be made. Medicare contractors will complete the necessary adjustments no later than July 1, 2006. In the event your claims are not adjusted by your carrier/FI/RHHI, contact them to bring the issue to their attention and they will make the adjustments.

Note: Services not paid under the MPFS, i.e., DME, Lab, ambulance etc., are not affected by CR4313.

Implementation

Medicare carriers and intermediaries will have two business days from the date of enactment of the Deficit Reduction Act to begin to process claims using the new fees as well as to begin reprocessing claims using those new fees.

Additional Information

The official instructions issued to your intermediary or carrier regarding this change may be found on CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R207OTN.pdf.

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

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

MLN Matters Number: MM4313
Related Change Request (CR) Number: 4313
Related CR Release Date: February 1, 2006
Related CR Transmittal Number: R207OTN
Effective Date: January 1, 2006
Implementation Date: See “Implementation” section of article.

Source: CMS Pub. 100-20, Transmittal 207, CR 4313

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Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration

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

Provider Types Affected

Hospitals, home health agencies (HHAs), skilled nursing facilities (SNFs), critical access hospitals (CAHs), provider-based renal dialysis facilities (RDFs), comprehensive outpatient rehabilitation facilities (CORFs), and freestanding RDFs that bill Medicare fiscal intermediaries (FIs) for vaccine administration

Provider Action Needed

STOP – Impact to You

CR 4240 clarifies and provides guidelines for Medicare FIs payment of vaccine administration and payment for these vaccines.

Note:
For claims with dates of service prior to January 1, 2006, outpatient prospective payment system (OPPS) and non-OPPS hospitals report HCPCS code G0010 for hepatitis B vaccine administration. For claims with dates of service January 1, 2006, and later, OPPS hospitals report CPT codes 90471 or 90472 for hepatitis B vaccine administration as appropriate in place of G0010.

CAUTION – What You Need to Know

Recognize the type of bill (TOB) and payment method, CPT/HCPCS codes, and their definitions for vaccine administration.

GO – What You Need to Do

Use the appropriate TOB and CPT/HCPCS codes when billing for the vaccines using the information listed within this article.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding payment for vaccine administration. This instruction clarifies and provides guidelines for the payment of vaccine administration in various institutional provider settings. In addition, CMS is updating payment for vaccines (pneumococcal pneumonia virus, influenza virus, and hepatitis B virus) provided in comprehensive outpatient rehabilitation facilities (CORFs) and renal dialysis facilities (RDFs).

Section 10.2.2.1 of the Medicare Claims Processing Manual: “FI Payment for Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus Vaccines and Their Administration” has been updated and payment for the vaccines is as follows:

### Payment for the Influenza Virus and PPV Vaccines

<table>
<thead>
<tr>
<th>Facility</th>
<th>Type of Bill</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals, other than Indian Health Service (IHS) hospitals and critical access hospitals (CAHs)</td>
<td>12x, 13x</td>
<td>Reasonable cost</td>
</tr>
<tr>
<td>IHS Hospitals</td>
<td>12x, 13x, 83x</td>
<td>Medicare physician fee schedule (MPFS) as indicated in guidelines below</td>
</tr>
<tr>
<td>IHS CAHs</td>
<td>85x</td>
<td>MPFS as indicated in guidelines below</td>
</tr>
<tr>
<td>CAHs Method I and Method II</td>
<td>85x</td>
<td>Reasonable cost</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>22x, 23x</td>
<td>Reasonable cost</td>
</tr>
<tr>
<td>Home Health Agencies</td>
<td>34x</td>
<td>Reasonable cost</td>
</tr>
<tr>
<td>Comprehensive Outpatient Rehabilitation Facilities</td>
<td>75x</td>
<td>Lower actual charge or 95 percent of the AWP</td>
</tr>
<tr>
<td>Independent Renal Dialysis Facilities</td>
<td>72x</td>
<td>Lower actual charge or 95 percent of the AWP</td>
</tr>
<tr>
<td>Hospital-based Renal Dialysis Facilities</td>
<td>72x</td>
<td>Reasonable cost</td>
</tr>
</tbody>
</table>

### Payment for the Administration of Influenza Virus and PPV Vaccines

<table>
<thead>
<tr>
<th>Facility</th>
<th>Type of Bill</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals, other than Indian Health Service (IHS) Hospitals and critical access hospitals (CAHs)</td>
<td>12x, 13x</td>
<td>Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS</td>
</tr>
<tr>
<td>IHS Hospitals</td>
<td>12x, 13x, 83x</td>
<td>MPFS as indicated in guidelines below</td>
</tr>
<tr>
<td>IHS CAHs</td>
<td>85x</td>
<td>MPFS as indicated in guidelines below</td>
</tr>
<tr>
<td>CAHs Method I and Method II</td>
<td>85x</td>
<td>Reasonable cost</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>22x, 23x</td>
<td>MPFS as indicated in the guidelines below</td>
</tr>
<tr>
<td>Home Health Agencies</td>
<td>34x</td>
<td>OPPS</td>
</tr>
<tr>
<td>Comprehensive Outpatient Rehabilitation Facilities</td>
<td>75x</td>
<td>*See note and chart below</td>
</tr>
<tr>
<td>Independent RDFs</td>
<td>72x</td>
<td>MPFS as indicated in the guidelines below</td>
</tr>
<tr>
<td>Hospital-based RDFs</td>
<td>72x</td>
<td>Reasonable cost</td>
</tr>
</tbody>
</table>
*Note*: If a physician provides the vaccine, the service is billed to the carrier using CPT codes indicated in the chart below. Payment is under the MPFS. If a nurse provides the vaccine, the service is billed to the FI using HCPCS code G0128. Payment is made under the MPFS.

### Guidelines for Pricing PPV and Influenza Virus Vaccine Administration Under the MPFS

FIs make reimbursement based on the rate in the MPFS associated with the CPT code 90782 or 90471 as follows:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Effective prior to March 1, 2003</th>
<th>Effective on and after March 1, 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0008</td>
<td>90782</td>
<td>90471</td>
</tr>
<tr>
<td>G0009</td>
<td>90782</td>
<td>90471</td>
</tr>
</tbody>
</table>

See the *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.2.2, for information on payment to independent and provider based rural health centers (RHCs) and Federally Qualified Health Clinics (FQHCs). That manual may be found at on the CMS website [http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

Payment for the administration of hepatitis B virus vaccine is as follows:

<table>
<thead>
<tr>
<th>Facility</th>
<th>Type of Bill</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals, other than IHS hospitals and CAHs</td>
<td>12x, 13x</td>
<td>OPPS for hospitals subject to OPPS. Reasonable cost for hospitals not subject to OPPS</td>
</tr>
<tr>
<td>IHS Hospitals</td>
<td>12x, 13x, 83x</td>
<td>MPFS as indicated in guidelines below</td>
</tr>
<tr>
<td>IHS CAHs</td>
<td>85x</td>
<td>MPFS as indicated in guidelines below</td>
</tr>
<tr>
<td>CAHs Method I and Method II</td>
<td>85x</td>
<td>Reasonable cost</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>22x, 23x</td>
<td>MPFS as indicated in the guidelines below</td>
</tr>
<tr>
<td>Home Health Agencies</td>
<td>34x</td>
<td>Reasonable cost</td>
</tr>
<tr>
<td>Comprehensive Outpatient Rehabilitation Facilities</td>
<td>75x</td>
<td>*See note and chart below</td>
</tr>
<tr>
<td>Independent RDFs</td>
<td>72x</td>
<td>MPFS as indicated in the guidelines below</td>
</tr>
<tr>
<td>Hospital-based RDFs</td>
<td>72x</td>
<td>Reasonable cost</td>
</tr>
</tbody>
</table>

*Note*: If a physician provides the vaccine, the service is billed to the carrier using CPT codes indicated in the chart below. Payment is under the MPFS. If a nurse provides the vaccine, the service is billed to the fiscal intermediary using HCPCS code G0128. Payment is made under the MPFS.

### Guidelines for Pricing Hepatitis B Virus Vaccine Administration under the MPFS

FIs will make reimbursement based on the rate in the MPFS associated with the CPT code 90782 or 90471 as follows:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Effective prior to March 1, 2003</th>
<th>Effective on and after March 1, 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0010</td>
<td>90782</td>
<td>90471</td>
</tr>
</tbody>
</table>

See the *Medicare Claims Processing Manual*, Chapter 18, section 10.2.2.2 for payment to independent and provider based RHCs and FQHCs. That manual may be found at [http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

### Implementation

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

### Additional Information

The revised portions of the *Medicare Claims Processing Manual* are attached to CR 4240, which is the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to the CMS website at [http://www.cms.hhs.gov/Transmittals/downloads/R890CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R890CP.pdf).
Guidelines for Payment of Vaccine Administration (continued)

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

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

MLN Matters Number: MM4240
Related Change Request (CR) Number: 4240
Related CR Release Date: March 17, 2006
Related CR Transmittal Number: R890CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 890, CR 4240

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Denial of Claims Not Timely Filed
CMS has issued the following “MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected
Providers billing fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) for services provided to Medicare beneficiaries

Provider Action Needed
STOP – Impact to You
This article is based on information contained in CR 4041, which clarifies that a determination relating to the untimely submission of a Medicare claim by a provider or supplier is not an initial determination and cannot be appealed.

CAUTION – What You Need to Know
Claims that are filed after the “timely filing period” will be denied as specified in the Medicare Claims Processing Manual, Publication 100-4, Chapter 1, Section 70.1. When a claim is denied because it was filed after the timely filing period, the denial will not constitute an “initial determination.” As such, the determination that a claim was not filed timely cannot be appealed.

GO – What You Need to Do
Be aware of the time limits for filing Medicare claims and the consequences of untimely filing.

Background
The Centers For Medicare & Medicaid Services (CMS) issued a technical correction to the June 30, 2005 Federal Register, Interim Final Rule, “Medicare Program: Changes to the Medicare Claims Appeal Procedures (42 CFR Parts 401 and 405),” that clarified that a determination regarding the untimely submission of a Medicare claim is not an initial determination and cannot be appealed.

Specifically, 42 CFR Section 405.926(n) indicates that a determination that a provider or supplier failed to submit a claim timely or failed to submit a timely claim, despite being requested to do so by the beneficiary or the beneficiary’s subrogee, is not an initial determination and cannot be appealed.

CR 4041 informs all Medicare providers of the above technical correction to the June 30, 2005 interim final rule, “Medicare Program: Changes to the Medicare Claims Appeal Procedures” and revises the Medicare Claims Processing Manual, Publication 100-4, Chapter 1 (General Billing Requirements), Sections 70.4 and 70.8.6 to incorporate these changes.

Additional Information
For complete details, including the revised sections of the Medicare Claims Processing Manual and a table that illustrates the timely filing limit for dates of service in each calendar month, please see the official instruction issued to your carriers, FIs, DMERCs, or RHHIs regarding this change. That instruction may be viewed by going to the CMS website http://www.cms.hhs.gov/Transmittals/downloads/R830CP.pdf.

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

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

MLN Matters Number: MM4041
Related Change Request (CR) Number: 4041
Related CR Release Date: February 2, 2006
Effective Date: July 1, 2006
Related CR Transmittal Number: R830CP
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 830, CR 4240

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.
Eliminate the Use of Surrogate UPIN OTH000 on Medicare Claims—Change Request 4177 Rescinded

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

Provider Types Affected
Physicians, nonphysician practitioners, suppliers, and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs) for diagnostic, radiology, consultation services, and equipment.

Provider Action Needed
This article is based on CR 5019, which rescinds CR 4177.
CR 4177 eliminated the use of the surrogate unique physician identification number (UPIN) OTH000 on claims submitted by billers, suppliers, physicians and nonphysician practitioners. CR 5019 instructs Medicare contractors to discontinue all work to eliminate the use of the surrogate UPIN “OTH000” in claims processing, and continue to use surrogate UPIN “OTH000” for submitted claims and other internal purposes.

Background
The Social Security Act (Section 1833(q); http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) requires that:

- All physicians meeting the definition of a physician (Section 1861(r); http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) must have a UPIN, and
- All claims for services ordered or referred by one of these physicians must include the names and UPINs of the ordering/referring physician.

Currently, durable medical equipment (DME) suppliers, physicians, and nonphysician practitioners are allowed to use a surrogate UPIN to bill for the following:

- Diagnostic services
- Radiology services
- Consultation services
- Durable medical equipment.

CR 4177 (Transmittal R752CP, dated November 10, 2005) instructed Medicare affiliated contractors (carriers, DMERCs, FIs, and RHHIs) not to accept the surrogate UPIN “OTH000” on Medicare claims submitted by billers, suppliers, physicians, and non-physician practitioners. However, because of the possibility that this will adversely impact the ability of providers to bill the Medicare program, the Centers for Medicare & Medicaid (CMS) is rescinding CR 4177.
Surrogate UPINs are intended to be used during an interim period when a UPIN has been requested but has not yet been received. Currently, durable medical equipment (DME) suppliers, physicians, and nonphysician practitioners are allowed to use a surrogate UPIN to bill for:

- Diagnostic services
- Radiology services
- Consultation services
- Durable medical equipment.

CR 5019 instructs your Medicare contractor(s) to:
- Discontinue all work to eliminate the use of the surrogate UPIN “OTH000” in claim processing; and
- Continue to use surrogate UPIN “OTH000” for submitted claims and other internal purposes.

Implementation
The implementation date for CR 5019 is April 3, 2006.

Additional Information
For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R145PI.pdf on the CMS website.

Inquirers can obtain providers’ UPINs at http://www.upinregistry.com/.

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

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

MLN Matters Number: MM5019
Related Change Request (CR) Number: 5019
Related CR Release Date: March 31, 2006
Related CR Transmittal Number: R145PI
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-08, Transmittal 145, CR 5019

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Eliminate the Use of Surrogate UPIN OTH000 on Medicare Claims—Change Request 4177 Rescinded

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

Note: The Centers for Medicare & Medicaid Services (CMS) has rescinded change request (CR) 4177 and the related MLN Matters article MM4177 on March 21, 2006. CR 5019 replaces CR 4177 and the MLN Matters article MM5019 replaces MM4177. MLN Matters article MM4177 was originally published in the Second Quarter 2006 Medicare A Bulletin (page 9).

MLN Matters Number: MM4177 – Revised
Related Change Request (CR) Number: 4177 – Rescinded
Related CR Release Date: November 10, 2005
Related CR Transmittal Number: R752CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 752, CR 4177

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.


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

Provider Types Affected
Providers and physicians who submit claims to Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services provided to Medicare beneficiaries

Background
The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing the healthcare integrated general ledger accounting system (HIGLAS), which is the main focus of a long-term project to modernize Medicare’s accounting systems. A few Medicare FIs have already transitioned to this system, and others will be phased in shortly.

Key Points
• Some of the FIs who have already transitioned to HIGLAS reported problems identifying specific adjustments at the provider level as shown on the standard paper remittance (SPR).
• The underlying problem is that HIGLAS has a very detailed breakdown of provider level adjustments that need to be properly mapped to Health Insurance Portability and Accountability Act (HIPAA) compliant provider adjustment codes (PLB codes) included in the transaction 835 version 004010A1 IG.
• Mapping of the HIGLAS PLB X 01 codes to the corresponding standard PLB codes included in the ASC X12 N version 004010A1 835 IG are listed in the spreadsheet attachment to CR4288.
• Only the standard PLB codes can be used in the HIPAA-compliant electronic remittance advice (ERA).

The SPR fields must be populated with adjustment amounts that correspond to the ERA adjustment amounts under the HIPAA PLB codes listed in the above-mentioned attachment. SPRs may not provide additional or more detailed information than that provided by electronic remittance advices (ERAs).
• Please refer to CR 4288 and its attachment for specific information about the ERA and hard copy instructions regarding the provider codes used by HIGLAS, and the corresponding provider codes per 004010A1 IG.

Relevant Links
CR 4288 is the official instruction issued to your FI/RHHI, regarding this change.
CR 4288 may be found by going to the CMS website http://www.cms.hhs.gov/Transmittals/downloads/R878CP.pdf.

Please refer to your local FI/RHHI if you have questions about this issue. To find their toll free phone number, go to the CMS website http://www.cms.hhs.gov/apps/contacts/.

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

MLN Matters Number: MM4288
Related Change Request (CR) Number: 4288
Related CR Release Date: February 24, 2006
Related CR Transmittal Number: R878CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006
Source: CMS Pub. 100-04, Transmittal 878, CR 4288

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.
Hold on Medicare Payments

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

A brief hold will be placed on Medicare payments for all claims for the last nine days of the federal fiscal year, i.e., September 22, 2006 – September 30, 2006. Claims held as a result of this one-time policy will be paid on October 2, 2006. No interest or late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.

CAUTION – What You Need to Know

Additionally, Medicare contractors will continue to apply the Centers for Medicare & Medicaid Services (CMS) regulations for the 14-day electronic claim payment floor and the 29-day paper claim payment floor.

GO – What You Need to Do

Please note that this policy applies only to claims subject to payment. It does not apply to full denials and no-pay claims.

Essentially, no payments on claims will be made from September 22-30, 2006, and providers should be aware of these payment delays, which are mandated by section 5203 of the Deficit Reduction Act of 2006.

Additional Information

CR 4349 is the official instruction issued to your FI, RHHI, or carrier regarding changes mentioned in this article. CR 4349 may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R847CP.pdf.

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

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

MLN Matters Number: MM4349
Related Change Request (CR) Number: 4349
Related CR Release Date: February 10, 2006
Related CR Transmittal Number: R847CP
Effective Date: September 22, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 847, CR 4349

Modify Common Working File Edit 51#L

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

Provider Types Affected

Certain providers who bill Medicare fiscal intermediaries (FIs) for outpatient services

Provider Action Needed

STOP – Impact to You

Please be aware that the Centers for Medicare & Medicaid Services (CMS) will modify the edit in Medicare systems that prevents payment on claims with units of service for observation (revenue code 0762) greater than 48 hours, unless the type of bill (TOB) is 85x, or TOB is 13x from an Indian health services facility, or TOB is 13x from a Maryland waiver hospital (21), or TOB is 13x from a TEFRA facility (those in American Samoa (state code [SC] 64), the Northern Marianas Islands (SC 66), Guam (SC 65), or the Virgin Islands [SC 48]).

CAUTION – What You Need to Know

This is not a change in policy, but a change to Medicare systems to allow payment for these claims.

GO – What You Need to Do

For claims with dates of service on or after May 1, 2006, please resubmit claims that were not paid because of the inadvertent application of this edit in Medicare systems.

Additional Information

CR 4382 is the official instruction issued to your FI regarding changes mentioned in this article, MM4382. CR4382 may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R907CP.pdf.

Please refer to your local FI/RHHI or carrier if you have questions about this issue. To find their toll-free phone number, go to CMS website http://www.cms.hhs.gov/apps/contacts/.

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

MLN Matters Number: MM4382
Related Change Request (CR) Number: 4382
Related CR Release Date: April 19, 2006
Effective Date: May 15, 2006
Related CR Transmittal Number: R907CP
Implementation Date: May 15, 2006

Source: CMS Pub. 100-04, Transmittal 907, CR 4382
The Centers for Medicare & Medicaid Services Recovery Audit Contractor Initiative

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

Provider Types Affected
Physicians, providers, and suppliers, especially in California, Florida, and New York

Provider Action Needed
Based on comments received during provider open door forums and community meetings, CMS has amended the payment methodology for the recovery audit contractors to include payment for the identification of Medicare underpayments.

Background
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Section 306, directs the Secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in: 1) identifying underpayments and overpayments; and 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

Update
The RACs are paid on a contingency basis; that is, the RACs receive a portion of what they identify and collect. Beginning with underpayments identified on or after March 1, 2006, the RACs will receive an equivalent percentage for all underpayment and overpayment identifications.

The RACs will use the same methodologies of automated and complex reviews to identify potential Medicare underpayments.

Important Things Providers Need to Know About the Underpayment Identification Portion of the Recovery Audit Contractor Demonstration

- The RAC may request a medical record for an underpayment determination. However, the medical record request letter will not indicate if the medical record is being requested for overpayment or underpayment review. When responding to a medical record request from the RAC, the provider may attach its own opinion regarding an underpayment. However, the findings from the RAC may differ from that of the provider.
- Upon identification of a potential underpayment, the RAC will forward the claim and all supporting documentation to the appropriate Medicare fiscal intermediary, carrier or durable medical equipment regional carrier (DMERC) for their review. Underpayment identification will not be final unless the fiscal intermediary, carrier or DMERC agrees with the identification. The RAC or the fiscal intermediary, carrier or DMERC will not ask the provider to correct and resubmit the claim. Under the RAC demonstration, the RAC contractors have no authority to make refunds. Therefore, once the underpayment has been validated by the appropriate fiscal intermediary, carrier or DMERC, the RAC will send the provider written notice of the underpayment determination. This notice will include claim and beneficiary details.
- The RACs do not have the authority to review unsolicited cases from providers where underpayment is thought to have occurred. Outside of the RAC program if a provider feels they have received an underpayment they may resubmit a corrected claim if the timely filing limit has not yet passed.
- The provider does not have any official appeals rights in relation to an underpayment determination. The provider may utilize the RAC rebuttal process and discuss the underpayment determination within the RAC. If the provider disagrees with the RAC that an underpayment exists, the RAC will defer to the billing provider’s judgment.

Definition of an Underpayment
For purposes of the RAC demonstration, a Medicare underpayment is defined as those lines or payment groups (APC, RUG) on a claim that were billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group.

If changes to the diagnosis, procedure or order of diagnoses would change a line or payment group on the claim from a low level of payment to a higher level of payment (and the medical record supports such a change), an underpayment exists. Service lines or payment groups that a provider failed to include on a claim are not considered underpayments for the purposes of this demonstration.

Note: CMS has excluded the review of physician evaluation and management codes relevant to the level of an office visit or the medical necessity of the level of office visit from the RAC demonstration. This includes the review of overpayments and underpayments.

Examples of an Underpayment
The following are considered underpayments:

- The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided. (This provider type is paid based on a fee schedule that pays more for 30 minutes of therapy than for 15 minutes of therapy.)
- The provider billed for a particular service and the amount the provider was paid was lower than the amount on the CMS physician fee schedule.
- A diagnosis/condition was left off the MDS but appears in the medical record. Had this diagnosis or condition been listed on the MDS, a higher payment group would have been the result.
- The physician submitted a claim for a surgical procedure using a code for a simpler procedure when in fact the procedure was a more complex one such as in the case of skin repair which can be billed at a simple, intermediate, or complex level depending upon size and complexity.

The following are not considered underpayments:
The Centers for Medicare & Medicaid Services Recovery Audit Contractor Initiative (continued)

- The medical record indicates that the provider performed additional services such as an EKG, but did not bill for the service.
- The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided; however, the additional minutes do not affect the grouper or the PRICER. (This provider type is paid based on a prospective payment system that does not pay more for this much additional therapy.)
- The medical record indicates that the provider implanted a particular device for which a device APC exists (and is separately payable over and above the service APC), but the provider did not bill for the device APC.

Questions concerning the recovery audit contractor demonstration may be directed to a special email address CMS has established specifically for the demonstration: cms.recoveryauditdemo@cms.hhs.gov.

Additional Information


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

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

MLN Matters Number: SE0617
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 SE017

Assignment of Physicians, Providers, and Suppliers to the Medicare Administrative Contractors

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

Provider Types Affected

Providers, physicians and suppliers who bill Medicare contractors (fiscal intermediaries [FIs] including regional home health intermediaries [RHHIs], and carriers, including durable medical equipment regional carriers [DMERCs]) for their services

Key Points

The Centers for Medicare & Medicaid Services (CMS) is implementing significant changes to the Medicare fee-for-service program’s administrative structure. This Medicare Contracting Reform (MCR) will:

- Integrate and simplify the administration of Medicare Parts A and B with primary A/B Medicare administrative contractors (MACs), which will process both Part A and Part B claims for the fee-for-service benefit.
- Make contracting dynamic, competitive and performance-based, resulting in more accurate claims payments and greater consistency in payment decisions.
- Centralize information, creating a platform for advances in the delivery of comprehensive care.

Under MCR, there will be 23 Medicare administrative contractors (MACs) with no national MAC. These new MACs will include:

- Fifteen primary A/B MACs to serve the majority of all types of providers for Part A and Part B.
- Four specialty MACs to serve home health and hospice providers.
- Four specialty MACs to serve durable medical equipment (DME) suppliers.

MACs will serve as the primary point of contact for provider enrollment, Medicare coverage and billing requirements training for providers, and the receipt, processing and payment of Medicare fee-for-service claims for Medicare providers’ respective jurisdictions.

Medicare providers will be assigned to the local designated MAC based on their geographic location to the MAC that has jurisdiction for that benefit category and location.

Note: Please be aware that in the event that your current FI does not win the contract to serve the area where you are located, you will be required to be reassigned to the MAC that has won the jurisdiction for your area.

The new MAC jurisdictions will be more similar to each other in size than the existing fiscal intermediary and carrier jurisdictions. The workload allocation and the number of fee-for-service beneficiaries and providers in each MAC jurisdiction will be reasonably balanced. The jurisdictions of the eight specialty MACs will overlay the boundaries of the fifteen primary A/B MAC jurisdictions.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173) allows CMS to take appropriate steps to transition from agreements under Section 1816 of the Social Security Act to contracts with Medicare administrative contractors (MACs) under section 1874A. The changes to Medicare’s administration are designed to increase the efficiency of Medicare’s claims processing and related functions. They will benefit Medicare providers and Medicare’s enrollee population.
Assignment of Physicians, Providers, and Suppliers to the Medicare Administrative Contractors (continued)

Additional Information
During the initial implementation phase (2005-2011) of the Medicare fee-for-service administrative contracting reform, CMS intends to issue requests for proposals (RFPs) to compete and award contracts for 23 MACs (four DME and four home health/hospice MACs, and 15 primary A/B MACs).

The transition to the MAC administrative structure will be implemented through a series of acquisition cycles (9-12 months from solicitation to award). The subsequent workload transition to the new MAC system is projected to take 6-13 months after contract award.

Medicare’s MAC Jurisdictions

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<td>Specialty MAC Jurisdictions (DME and Home Health/Hospice)</td>
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<td>DME January 2006</td>
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<tr>
<td>B</td>
<td>Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin</td>
<td>Home Health/Hospice September 2008</td>
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<tr>
<td>C</td>
<td>Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia</td>
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<tr>
<td>D</td>
<td>Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Marianas Islands, Oregon, South Dakota, Utah, Washington, and Wyoming</td>
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<tr>
<th>Jurisdiction</th>
<th>Primary A/B MAC Jurisdictions</th>
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<td>American Samoa, California, Guam, Hawaii, Nevada, and Northern Marianas Islands</td>
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<td>Alabama, Georgia, and Tennessee</td>
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<td>North Carolina, South Carolina, Virginia and West Virginia</td>
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<td>15</td>
<td>Kentucky and Ohio</td>
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For additional information about the MCR process, please refer to CMS website [http://www.cms.hhs.gov/MedicareContractingReform/](http://www.cms.hhs.gov/MedicareContractingReform/).


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Cultural Competency: A National Health Concern

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

Provider Types Affected

This article is for informational purposes only and does not affect Medicare billing processes.

Background

The increasing diversity of the racial, ethnic, and linguistic composition of the U.S. challenges providers as they strive to deliver health care services. Cultural and language differences between patients and providers may generate miscommunication of critical health care information, a lack of compliance with prescribed treatment or medication, or other factors that negatively influence clinical situations and health outcomes. The existence of racial and ethnic disparities in health has been well documented by organizations such as the Institute of Medicine and the Agency for Healthcare Research and Quality.

Cultural competency, or the ability of health care providers to work effectively with colleagues and patients in cross-cultural situations, is a vital component of professional competence. Culturally competent practice can offer a variety of benefits to health care providers and their organizations, including:

- Improved patient care and satisfaction
- Decreased malpractice risk
- Enhanced operational efficiency
- Increased compliance with State and Federal regulations
- Reduction in health disparities

Highlights of the Centers for Medicare & Medicaid Services (CMS) Activities to Address Health Disparities

To ensure that providers are prepared for the challenges they face to deliver the right care to every person every time, CMS’s quality improvement organizations (QIOs) are working with health care providers to become more effective and culturally aware of how they provide care to diverse populations. As part of a national initiative, QIOs are recruiting health providers to participate in a FREE online (Web-based) program A Family Physician’s Practical Guide to Culturally Competent Care to ensure that Medicare providers are prepared to effectively serve the increasingly diverse patient population. QIOs have adopted the Guide as the “Program of Choice” for health care provider cultural competency education. The Guide is an innovative educational product designed to equip health care providers with the cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities.

A Family Physician’s Practical Guide to Culturally Competent Care is anchored in the three themes of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) and serves a key initiative in helping the Department of Health & Human Services Office of Minority Health to achieve its mission of “improving the health of racial and ethnic minority populations’ through the development of effective health policies and programs that help to eliminate disparities in health care.”

A Family Physician’s Practical Guide to Culturally Competent Care is a case study based curriculum, featuring video vignettes and a diverse group of providers and clinic staff at a fictional practice setting that reinforce learning points throughout the modules. Participants can also share their reactions to the case studies in an online bulletin-board feature. This program was designed with the busy health care provider in mind, offering “anytime, anywhere” continuing education credit in an engaging and innovative format.

This curriculum is available to all health care providers at http://www.thinkculturalhealth.org. The program is accredited for Continuing Medical Education (CME) credits for physicians and Continuing Education Units (CEUs) for nurses and pharmacists.

Please visit http://www.thinkculturalhealth.org to access the free accredited continuing education program, A Family Physician’s Practical Guide to Culturally Competent Care, and to view updates about the nursing program.

Additional Information

To access the free program, A Family Physician’s Practical Guide to Culturally Competent Care, please visit http://www.thinkculturalhealth.org.


For more information about the QIO cultural competency initiative, please visit http://www.qsource.org/qiojscsl/.

Additional information about the Office of Minority Health is available at http://www.omhrc.gov/.

MLN Matters Number: SE0621
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: Special Edition MLN Matters Article SE0621
Centers for Medicare & Medicaid Services Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this article on March 17, 2006, to show the data collection period continued through April 2006 and to conform to the new CMS website. Also, to show they are now MLN Matters articles. All other information remains the same. This article was previously published in the January 2006 Medicare A Bulletin Special Issue (page 52).

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

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

CAUTION – What You Need to Know
The first national implementation of the MCPSS will begin January 3, 2006. If you have been selected, you will receive a notification packet in the mail with background information about the survey, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet website. The letter will also include a phone number that you can mail or fax, if you prefer to do so.

GO – What You Need to Do
Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the time to complete and submit your survey responses as soon as possible. The data collection period will continue through April 2006.

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

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

It contains a total of 76 questions and takes approximately 21 minutes to complete. The target date to respond is approximately three weeks after receipt of the notification packet. CMS will analyze the data and release a summary report in July that will be made available on the Internet. Each contractor will also receive an individual report on their performance in June. The MCPSS will be conducted on an annual basis.

CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS.

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

MLN Matters Number: SE0602 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: January 3, 2006
Implementation Date: January 3, 2006
Source: Special Edition MLN Matters Article SE0602

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. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

CMS Electronic Mailing Lists (listservs)
The Division of Provider Information Planning and Development (DPIPD) within the Centers for Medicare & Medicaid Services (CMS) has developed a mailing list fact sheet informing providers about the advantage of receiving Medicare updates through the listservs.

CMS electronic mailing lists (listservs) can help you with your business! For more details, download the fact sheet from the following URL: http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf.

Source: CMS Joint Signature Memorandum 06403, April 20, 2006
Provider Enrollment in the Medicare Program

Provider Types Affected
All Medicare physicians, providers, and suppliers

What You Need To Know
- You must enroll in the Medicare program in order to receive Medicare payment for covered services that you provide to Medicare beneficiaries.
- The Medicare enrollment application and process are used to collect information about you and to secure the necessary documentation to ensure you are qualified and eligible to enroll in the Medicare program.
- This special edition article (SE 0612) contains helpful information about the Medicare enrollment process.

Background
Physicians, providers, and suppliers must enroll in the Medicare program in order to receive Medicare payment for services provided to its beneficiaries.

You can accomplish this enrollment by completing the Medicare enrollment application, in which you provide the information and supporting documentation needed to ascertain your qualifications for, and your eligibility to enroll in, the Medicare program.

When submitted, a designated Medicare fee-for-service contractor (known as a carrier or fiscal intermediary [FI]) will process your application and verify the information that you have provided.

Note: To ensure timely processing of your application, you must completely fill out the application and provide all required supporting documentation at the time of filing. Section 17 of the Medicare enrollment application lists the types of supporting documentation that you will need to submit with your enrollment application.

To obtain a list of specific supporting documentation that you must submit with your enrollment application, call or visit the Medicare fee-for-service contractor serving your area (see Additional Information section below.)

Be aware that, at any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application.

Applicants are responsible for providing this documentation in a timely manner. Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

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

MLN Matters Number: SE0612
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A
Source: Special Edition MLN Matters Article SE0612

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Ambulance Fee Schedule Calendar Year 2006 Update—Correction to CR 4061

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

Provider Action Needed
This article is for your information only. It references change request (CR) 4362, which provides the correct ambulance fee schedule file for calendar year (CY) 2006.

Background
CR 4362, from which this article is taken, corrects that file name. It also amends the Medicare Claims Processing Manual, Chapter 15 (Ambulance), Section 20.6 (Update Charges), Sub Section 20.6.1 (Ambulance Inflation Factor [AIF]), to reflect this correction.

Your carriers and FIs will use this corrected file to determine the payment limit for ambulance services that you furnish during CY 2006. Of most importance to providers/suppliers, rather than process CY 2006 ambulance service claims using the incorrect file name contained in CR 4061, the carriers and FIs will hold these claims until the corrected file can be downloaded and used. In the event they processed any CY 2006 ambulance claims using the incorrect file, the carriers and FIs will do mass adjustments of those claims to correct the payments.
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 telephone number 1-877-602-8816 (toll-free).

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.

The hours of operation for the Florida Medicare Part A call center are 8:00 a.m. to 4:00 p.m. Monday through Friday, Eastern and Central time, excluding holiday closings and the indicated training schedule.

We apologize for any inconvenience this may cause. First Coast Service Options (FCSO) is committed to continuous improvement and to provide the best service for our customers. Please see the attached schedule for closing times.

Source: CMS Pub. 100-04, Transmittal 852, CR 4362

MLN Matters Number: MM4362
Related Change Request (CR) Number: 4362
Related CR Release Date: February 10, 2006
Related CR Transmittal Number: R852CP
Effective Date: January 1, 2006
Implementation Date: February 24, 2006
Source: CMS Pub. 100-04, Transmittal 852, CR 4362

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Part A Provider Contact Center Scheduled Closings

Please see the attached schedule for closing times

March 3, 2006 2:00 p.m. – 4:00 p.m.
March 10, 2006 2:00 p.m. – 4:00 p.m.
March 17, 2006 2:00 p.m. – 4:00 p.m.
March 24, 2006 2:00 p.m. – 4:00 p.m.
March 31, 2006 2:00 p.m. – 4:00 p.m.
April 7, 2006 2:00 p.m. – 4:00 p.m.
April 14, 2006 2:00 p.m. – 4:00 p.m.
April 21, 2006 2:00 p.m. – 4:00 p.m.
April 28, 2006 2:00 p.m. – 4:00 p.m.
May 5, 2006 2:00 p.m. – 4:00 p.m.
May 12, 2006 2:00 p.m. – 4:00 p.m.
May 19, 2006 2:00 p.m. – 4:00 p.m.
May 26, 2006 2:00 p.m. – 4:00 p.m.
June 2, 2006 2:00 p.m. – 4:00 p.m.
June 9, 2006 2:00 p.m. – 4:00 p.m.
June 16, 2006 2:00 p.m. – 4:00 p.m.
June 23, 2006 2:00 p.m. – 4:00 p.m.
June 30, 2006 2:00 p.m. – 4:00 p.m.
July 7, 2006 2:00 p.m. – 4:00 p.m.
July 14, 2006 2:00 p.m. – 4:00 p.m.
July 21, 2006 2:00 p.m. – 4:00 p.m.
July 28, 2006 2:00 p.m. – 4:00 p.m.
Medicare Policy on Subpart Designation

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

Provider Types Affected

Provider types affected include organization health care providers and suppliers who are covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and who are enrolled in the Medicare program. These are certified providers and suppliers, supplier groups and supplier organizations, and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

(This information does not apply to health care providers who are enrolled in Medicare as individual practitioners, such as physicians and nurse practitioners, nor does it apply to sole proprietors.)

Key Points

- Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions to the new national provider identifier, or NPI.
- For Medicare organization health care providers, the current identifiers could include:
  - Online survey certification and reporting (OSCAR) system numbers
  - National supplier clearinghouse (NSC) numbers
  - Provider identification numbers (PINs)
  - Unique physician identification numbers (UPINs) used by Medicare.

These numbers are now considered legacy identifiers or legacy numbers. Medicare is transitioning from these legacy identifiers to national provider identifiers, or NPIs.

Note: When applying for an NPI, Medicare providers are urged to include their legacy numbers, particularly their Medicare legacy number, on the NPI application form.

- By regulation, Medicare organization health care providers who are HIPAA covered entities must obtain NPIs. The NPIs will replace the identifiers currently in use in standard transactions with Medicare and with other health plans. Additionally, these health care providers must determine if they have subparts that need to be uniquely identified in standard transactions with their own NPIs.

Background

Organization health care providers are corporations, partnerships, or other types of businesses that are considered separate from an individual by the state in which they exist. Subparts of such organization health care providers are also organizations. All of these health care providers would apply for NPIs as organizations (entity type 2).

Note: In terms of NPI assignment, an Individual is an entity type 1 (individual), and is eligible for a single NPI. As an Individual, a physician or nurse practitioner, for example, as well as a sole proprietor/sole proprietorship, cannot have subparts and cannot designate subparts.

Most Medicare organization health care providers (entity type 2 providers) send electronic claims to Medicare (standard transactions), making them covered health care providers (HIPAA covered entities).

Subpart Designation Guidelines

Covered organization health care providers are responsible for determining if they have “subparts” that need to have NPIs. If they do, the covered organization health care providers must ensure that the subparts obtain their own unique NPIs, or they must obtain them for them.

Below are some guidelines to help determine if an enrolled Medicare organization health care provider has a subpart, which will need its own unique NPI.

Regarding all of the entities that could be considered subparts:

- A subpart is not itself a separate legal entity, but is a part of a covered organization healthcare provider that is a legal entity. (All covered entities under HIPAA are legal entities.)
- A subpart furnishes health care as defined at 45 CFR 160.103. (This information may be found on the Department of Health & Human Services website at http://www.hhs.gov/ocr/legtext.html.)

Regarding some or all of the entities that a Medicare covered organization health care provider could consider as subparts:

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.
- A subpart may or may not have a taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.

Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI final rule. If such statutes or regulations exist, the health care providers to whom they apply would need NPIs in order to ensure they can continue to be uniquely identified.

- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

Medicare Organization Subpart Examples

Enrolled Certified Providers and Suppliers

An enrolled provider (a hospital) owns ten home health agencies, all operating under the TIN (tax identification
Medicare Policy on Subpart Designation (continued)

number) of the hospital. Because the hospital and each of the ten home health agencies is separately surveyed and enters into its own provider agreement with Medicare, Medicare encourages that the hospital mirror its Medicare enrollment and obtain a total of 11 unique NPIs in order to help avoid claims processing delays (one NPI for the hospital, and one for each of the ten home health agencies).

Enrolled Supplier Group or Supplier Organization

An enrolled independent diagnostic testing facility (IDTF) has four different locations, and the carrier must separately inspect each location. All four locations operate under a single TIN. Because each location is separately inspected in order to enroll in Medicare, Medicare encourages the IDTF to mirror its Medicare enrollment and obtain a total of four unique NPIs in order to help avoid claims processing delays (one NPI for each location).

Enrolled Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI. Federal regulations require that each location of a Medicare DMEPOS supplier have its own unique billing number.

In order to comply with that regulation, each location must have its own unique NPI.

Note: Regardless of how subparts are determined and NPIs obtained, Medicare payments, by law, may be made only to an enrolled Medicare provider or supplier.

Important Medicare NPI Implementation Dates

January 3, 2006 – October 1, 2006

Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI.

Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

October 2, 2006 – May 22, 2007

CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider’s NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim.

Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.

Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

May 23, 2007 – Forward

CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

Final Notes About NPIs

With regard to enrolled organization health care providers or subparts who bill more than one Medicare contractor:

- An enrolled organization health care provider or subpart is expected to use a single (the same) NPI when billing more than one Medicare contractor.
- For example, a physician group practice billing a Maryland carrier and also billing a Pennsylvania carrier would use a single (the same) NPI to bill both carriers.

With regard to enrolled organization health care providers or subparts who bill more than one type of Medicare contractor:

- Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor who processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type (fiscal intermediary, carrier, RHHI, DMERC) of Medicare contractor.
- In certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as more than one type of provider.

For example, an ambulatory surgical center enrolls in Medicare as a Certified Supplier, and bills its services to a carrier. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of DME and bill the DME to a DMERC. This ambulatory surgical center would obtain a single NPI and use it to bill the carrier and the DMERC.

- Medicare expects that this ambulatory surgical center would report two different taxonomies when it applies for its NPI:
  - Ambulatory Health Care Facility—Clinic/Center - Ambulatory Surgical (261QA1903X); and
  - Suppliers—Durable Medical Equipment & Medical Supplies (332B00000X) or the appropriate sub-specialization under the 332B00000X specialization.

With regard to enrolled organization health care providers who determine subparts for reasons unrelated to Medicare statutes, regulations or policies:

- Consistent with the NPI Final Rule, covered organization health care providers may designate subparts for reasons that are not necessarily related to Medicare statutes or regulations.
- If a Medicare organization health care provider designates as subparts entities other than those who are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, those NPIs will not identify enrolled Medicare providers. Medicare is not required to enroll them.
Medicare Policy on Subpart Designation (continued)

NPI Final Rule, page 3441 says the following: “If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls.”

Additional Information
Medicare’s NPI Responsibilities

Medicare will:

• Use NPIs to identify health care providers and subparts in HIPAA standard transactions.

NPI final rule, page 3469: section 162.412(a): “A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider’s identifier is required.”

• Ensure that the NPIs it receives in HIPAA standard transactions are valid.

• Reject HIPAA standard transactions that contain invalid NPIs.

Valid NPIs, however, like the provider identifiers used today, must be “known” to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers, nor is it permitted to reimburse providers who are not enrolled in the Medicare program. Medicare will return, with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.

Related Links

In preparation for the release of the Electronic File Interchange (EFI) system, CMS released several documents on the EFI process. EFI, also referred to as “bulk enumeration,” is a process by which a health care provider or group of providers can have a particular organization (the “EFIO”) apply for NPIs on their behalf.

EFI documents posted to the web include a summary, user’s guide, and technical companion manual. To download these new items, visit http://www.cms.hhs.gov/NationalProvIdentStand/07 EFI.asp.

NPI-related information, including how to apply for an NPI and a new fact sheet for health care providers who are individuals, is available on the CMS website at http://www.cms.hhs.gov/NationalProvIdentStand/.


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

MLN Matters Number: SE0608
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 SE0608

New Educational Products on National Provider Identifier

National Provider Identifier Tip

When applying for your NPI, CMS urges you to include your legacy identifiers, not only for Medicare but for all payers. If reporting a Medicaid number, include the associated state name. This information is critical for payers in the development of crosswalks to aid in the transition to the NPI.

New Educational Products

CMS has released three new educational products on the National Provider Identifier (NPI):

Suitable for All Health Care Providers

• A subparts fact sheet that contains high-level information on Medicare’s guidance on subpart designation. Although the guidance is geared toward Medicare organization providers, non-Medicare organization providers may find it helpful.

• An electronic file interchange (EFI) fact sheet that contains basic information and links to helpful resources that will prepare providers and their staff for the release of the EFI system. This information is essential for organizations that wish to submit electronic files for bulk enumeration, and may be of interest to any health care provider for whom an organization will be submitting NPI application data.

Suitable for Medicare Providers

• A MLN Matters Article – SE0608 that takes a detailed look at Medicare’s guidance on subpart designation and the impact on Medicare providers.

Visit the educational resources link at http://www.cms.hhs.gov/NationalProvIdentStand/ to view these new products, as well as existing products such as: four MLN Matters articles, two fact sheets and the NPI Viewlet.

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

Source: CMS Provider Education Resources Listserv, Message 200603-06

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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.
**Tip To Apply for National Provider Identifier**

The Centers for Medicare & Medicaid Services (CMS) urges you to include your legacy identifiers when you apply for your national provider identifier (NPI), not only for Medicare but also for all payers. If reporting a Medicaid number, include the associated state name. This information is critical for payers in the development of crosswalks to aid in the transition to the NPI.

CMS has released three new educational products on NPI:

- **“Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees.”** – This tip sheet contains helpful information for organization health care providers who wish to apply for NPIs, or submit updates using the NPPES Web-based process, on behalf of their employed health care providers. This is not the EFI process.

- **“Tips for Health Care Professionals – Preparing Your Office Staff for NPI.”** This tip sheet provides basic steps to prepare your office staff, and your business, for NPI implementation.

- **“NPI Overview” – PowerPoint Presentation.** This presentation was presented by a CMS staff member at a recent WEDI meeting and contains basic information on the NPI that is suitable for self-education, as well as training purposes.


Source: CMS Provider Education Resources Listserv, Message 200604-17

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**Stage 2 Requirements for Use and Editing of National Provider Identifier Numbers**

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

**Note:** CMS has revised this MLN Matters article on November 29, 2005, to clarify that the end date of the transition period for the revised CMS-1500 form is February 1, 2007. (See the paper claims form section.) See update the language regarding the appeals process. In addition, the article now contains Web addresses that conform to the new CMS website. This article was originally published in the Second Quarter 2006 Medicare A Bulletin (pages 18-20).

**Provider Types Affected**

Physicians, providers, and suppliers who submit claims for services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), to include regional home health intermediaries (RHHIs)

**Provider Action Needed**

The requirements for stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in stage 2 is October 1, 2006.

**Background**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414)).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005.

Applications may be made by mail and also online at [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov).

**NPI and Legacy Identifiers**

The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers.

Legacy provider identifiers include:

- Online survey certification and reporting (OSCAR) system numbers
- National supplier clearinghouse (NSC) numbers
- Provider identification numbers (PINs)
- Unique physician identification numbers (UPINs) used by Medicare.

They do not include taxpayer identifier numbers (TINs) such as:

- Employer identification numbers (EINs)
- Social security numbers (SSNs).

**Primary and Secondary Providers**

Providers are categorized as either “primary” or “secondary” providers:

- **Primary providers** include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- **Secondary providers** include supervising physicians, operating physicians, referring providers, and so on.
**Stage 2 Requirements for Use and Editing of National Provider Identifier Numbers (continued)**

**Crosswalk**

During stage 2, Medicare will utilize a crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this crosswalk include the following:

- Each primary provider’s NPI reported on an inbound claim or claim status query will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI, and from NPI to a legacy identifier.
- The Medicare crosswalk will be updated daily to reflect new provider registrations.

**NPI Transition Plans for Medicare FFS Providers**

Medicare’s implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as shown in the table below:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Medicare Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>May 23, 2005 – January 2, 2006</strong></td>
<td>Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.</td>
</tr>
<tr>
<td><strong>January 3, 2006 – October 1, 2006</strong></td>
<td>Medicare systems will accept claims with an NPI, but an existing legacy Medicare number <strong>must also be on the claim</strong>. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.</td>
</tr>
</tbody>
</table>
| **October 2, 2006 – May 22, 2007 (This is stage 2, the subject of CR4023)** | CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider’s NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim.  

*Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.*  

Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions. |
| **May 23, 2007 – Forward**         | CMS systems will only accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007. |

**Claim Rejection**

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
  - X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only)
  - National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only)
  - Claims submitted using Medicare’s free billing software
  - Electronic claim status request received via X12 276 or DDE screen

- Non-X12 electronic claim status queries
- An NPI reported cannot be located in Medicare files.
- The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI.
- Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare’s free billing software.

**Note:** If only provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.
Stage 2 Requirements for Use and Editing of National Provider Identifier Numbers (continued)

Additional Information

X12 837 Incoming Claims and COB

During stage 2, an X12 837 claim may technically be submitted with only an NPI for a provider, but you are strongly encouraged to also submit the corresponding Medicare legacy identifier for each NPI in X12 837 Medicare claims.

Use of both numbers could facilitate investigation of errors if one identifier or the other cannot be located in the Medicare validation file. When an NPI is reported in a claim for a billing or pay-to provider, a TIN must also be submitted in addition to the provider’s legacy identifier as required by the claim implementation guide.

National Council of Prescription Drug Plans (NCPDP) Claims

The NCPDP format was designed to permit a prescription drug claim to be submitted with either an NPI or a legacy identifier, but not more than one identifier for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

• For stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.
• During stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician’s NPI) in their claims.

When an NPI is submitted in an NCPDP claim, it will be edited in the same way as an NPI submitted in an X12 837 version 4010A1 claim. The retail pharmacy will be considered the primary provider and the prescribing physician as the secondary provider for NPI editing purposes.

Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006 and end February 1, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

Pending the start of submission of the revised CMS-1500 and the UB-04, providers must continue to report legacy identifiers, and not NPIs, when submitting claims on the non-revised CMS-1500 and the UB-92 paper claim forms.

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. “Old” form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI.

Or, if they are not rejected—since some legacy identifiers were also 10-digits in length—could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

Standard Paper Remits (SPRs)

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider’s NPI and legacy identifier when both are available in Medicare’s files. If a provider’s NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was not reported for the billing/pay-to, or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR 4023:

• CR 4023 Attachment 1: FI standard paper remit (SPR) amended format for stage 2
• CR 4023 Attachment 2: carrier/DMERC SPR amended stage 2 format.

Remit Print Software

The 835 PC-Print and Medicare Remit Easy Print software will be modified by October 2, 2006, to enable either the NPI or a Medicare legacy number, or both, if included in the 835, to be printed during stage 2.

Free Billing Software

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim, and to identify whether an entered identifier is an NPI or a legacy identifier.

In-Depth Information

Please refer to CR 4023 for additional detailed NPI-related claim information about the following topics:

• Crosswalk
• X12 837 Incoming Claims and COB
• Non-HIPAA COB Claims
• NCPDP Claims
• DDE Screens
• Paper Claim Forms
• Free Billing Software
• X12 276/277 Claim Status Inquiry and Response Transactions
• 270/271 Eligibility Inquiry and Response Transactions
• 835 Payment and Remittance Advice Transactions
• Electronic Funds Transfer (EFT)
• Standard Paper Remits (SPRs)
• Remit Print Software
• Claims History
• Proprietary Error Reports
• Carrier, DMERC, and FI Local Provider Files, including EDI System Access Security Files
• Med A and Med B Translators
• Other Translators
• Stages 3 and 4

CR 4023, the official instruction issued to your FI/ regional home health intermediary (RHHI) or carrier/ durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to CMS website http://www.cms.hhs.gov/transmittals/downloads/ R1090TN.pdf.

This article contains further details on the NPI and how to obtain one.

Please refer to your local FI/RHII or carrier/DMERC if you have questions about this issue. To find their toll free phone number, go to CMS website [http://www.cms.hhs.gov/apps/contacts/](http://www.cms.hhs.gov/apps/contacts/).

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

MLM Matters Number: MM4023 – Revised
Related Change Request (CR) Number: 4023
Related CR Release Date: November 3, 2005
Effective Date: April 1, 2006
Related CR Transmittal Number: 190
Implementation Date: April 3, 2006

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

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**NPI Applications Through the Electronic File Interchange Capability Started May 1, 2006**

Beginning, May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) announces the capability for health industry organizations to submit health care providers’ applications for National Provider Identifiers (NPIs) to the National Plan and Provider Enumeration System (NPPES) via Electronic File Interchange (EFI). With EFI, a CMS-approved health industry organization can submit a health care provider’s NPI application data, along with the application data of many other health care providers, in a single electronic file in a CMS-specified format.

EFI is an alternative to health care providers having to apply for their NPI via the Web based or paper application process.

After the NPPES processes a file, it makes available to the organization a downloadable file containing the NPIs of the enumerated health care providers.


Source: Provider Education Resources Listserv, Message 200605-04

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Expansion of Glaucoma Screening Services

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

Provider Types Affected

Physicians and providers who submit claims to Medicare fiscal intermediaries (FIs) and carriers for glaucoma screening examinations

Important Points to Remember

• Change request (CR) 4365 provides notice that beginning January 1, 2006, the definition of an eligible beneficiary in a high-risk category is expanded to include Hispanic Americans age 65 and over.

• Because of this revised definition, Medicare will pay for glaucoma screening examinations for Hispanic Americans age 65 and older when they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist who is legally authorized to perform the services under state law.

• If service is denied because the individual does not meet the age-related and/or ethnic-related coverage criteria, Medicare contractors will return Medicare summary notice 21.21 (This service was denied because Medicare only covers this service under certain circumstances).

• If service is denied because the individual is not Hispanic-American age 65 or over, the remittance advice claim will show reason adjustment code 96 (Noncovered charge), and existing remark codes M83 (Services not covered unless the patient is classified as at high risk), and N129. (This amount represents the dollar amount not eligible due to patient’s age.)

• Your Medicare FI or carrier will not search for or adjust claims with dates of service January 1, 2006, that were processed before the April 3, 2006, implementation date of CR4365. They will adjust any such claims that you bring to their attention.

• The following HCPCS codes apply for glaucoma screening:

    G0117 Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist
    G0118 Glaucoma screening for high-risk patients furnished under the direct supervision of an optometrist or ophthalmologist.

Background

On January 1, 2002, CMS implemented regulations at 42 CFR, Section 410.23(a)(2). The regulations set conditions for and limitations on coverage of screening for glaucoma, requiring that the term “eligible beneficiary” be defined to include individuals in the following high-risk categories:

• Individuals with diabetes mellitus;
• Individuals with a family history of glaucoma; or
• African-Americans age 50 and over.

The Medicare physician fee schedule for calendar year 2006 final rule, 70 FR 70270, dated November 21, 2005, expands Medicare coverage of high-risk individuals eligible to receive glaucoma screening services to include Hispanic-Americans age 65 and over.

This expansion of coverage is effective for services performed on or after January 1, 2006, and revises 42 CFR, section 410.23(a)(2) accordingly.

Implementation

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

Additional Information


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/apps/contacts/.

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

MLN Matters Number: MM4365
Related Change Request (CR) Number: 4365
Related CR Release Date: March 24, 2006
Related CR Transmittal Number: R48BP and R895CP
Effective Date: January 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 895, CR 4365

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

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

Provider Types Affected
Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for clinical diagnostic laboratory services.

Provider Action Needed

STOP – Impact to You
This article is based on change request (CR) 4328, which announces the implementation of changes to the list of codes associated with the 23 negotiated laboratory NCDs, and the update of the laboratory edit module for changes in the laboratory NCD code lists for April 2006.

CAUTION – What You Need to Know
The changes to the list of codes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs. Several of the listed changes correct codes to reflect the recent Current Procedural Terminology (CPT) update and are necessary so that the laboratory edit module will appropriately process claims using the most current negotiated laboratory NCDs and code lists.

GO – What You Need to Do
See the Background section of this article for further details regarding these changes.

Background
In accordance with the Balanced Budget Act of 1997 (Section 4554), the Centers for Medicare & Medicaid Services (CMS) entered into negotiated rulemaking proceedings to develop national coverage determinations (NCDs) for clinical diagnostic laboratory services. Under the negotiations, CMS developed 23 laboratory NCDs, and these NCDs are different than most other Medicare NCDs in that they include lists of ICD-9-CM codes. All codes are included on one of the following lists:

- Covered codes
- Not covered codes
- Codes that do not support medical necessity

The NCDs were published under the Administrative Procedures Act in the Federal Register on November 23, 2001 (http://www.access.gpo.gov/su_docs/fedreg/a011123c.html), and the list of 23 laboratory NCDs is included in the Additional Information section of this article. In addition, the CMS website for laboratory NCDs may be found at http://www.cms.hhs.gov/CoverageGenInfo/05_LabNCDs.asp.

Nationally uniform software was developed by Computer Sciences Corporation (CSC) and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003. The laboratory edit module for the NCDs is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

(See the Medicare Claims Processing Manual (Publication 100-4, Chapter 16, Section 120.2, on the CMS website at http://www.cms.gov/Manuals/IOM/list.asp#TopOfPage.)

CMS updates the NCD code list quarterly as necessary to incorporate new codes, correct ministerial errors, incorporate the results of Coding Analysis published elsewhere on this site, and incorporate reconsideration of the NCDs that alter covered indications. The quarterly updates are published in the NCD Coding Policy Manual, and you can download the current and previous coding manuals from this site. Alternatively, you can access individual NCDs from the lab index included on the following CMS website: http://www.cms.hhs.gov/mcd/index_section.asp?ncd_sections=40.

Change request (CR) 4238 announces the changes that will be included in the April 2006 release of the edit module for clinical diagnostic laboratory services. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs. Several of the listed changes correct codes to reflect the current CPT update. CR 4238 communicates requirements to the laboratory edit module to update it for the following changes in laboratory NCD code lists for April 2006:

Blood Count NCD
Add the following ICD-9-CM code to the list of codes that do not support medical necessity for the blood count NCD:
V76.51 Special screening for malignant neoplasms, colon

ICD-9-CM Codes Never Covered by Medicare
Delete the following ICD-9-CM code from the list of ICD-9-CM codes never covered by Medicare:
V76.51 Special screening for malignant neoplasms, colon

Fecal Occult Blood Test NCD
Add the following new CPT code to the list of HCPCS/CPT codes covered by Medicare for fecal occult blood test NCD:
82272 Blood occult peroxidase

Delete the following CPT code from the HCPCS/CPT code list for fecal occult blood test NCD:
82270 Fecal occult blood

Hepatitis Panel/Acute Hepatitis Panel NCD
Add the following ICD-9-CM code to the list of ICD-9-CM codes covered by Medicare for hepatitis panel/acute hepatitis panel NCD:
790.4 Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase

Lipids Testing NCD
Add the following new CPT codes to the list of HCPCS/CPT codes covered by Medicare for lipids testing NCD:
83700 Lipoprotein bld, electrophoretic
Changes to the Laboratory National Coverage Determination Edit Software for April 2006 (continued)

Changes to the Laboratory National Coverage Determination Edit Software for April 2006 (continued)

83701 Lipoprotein bld, hr fraction

Delete the following CPT codes from the HCPCS/CPT code list for lipids testing NCD:

83715 Lipoprotein, blood: electrophoretic separation and quantitation

83716 High resolution fractionation and quantitation of lipoprotein cholesterol

Urine Culture, Bacterial NCD

Delete Coding Guideline 1 in the urine culture, bacterial NCD, and renumber the remaining Coding Guidelines.

Note: Changes included in the April 2006 release of the edit module for clinical diagnostic laboratory services become effective for services furnished on or after April 1, 2006.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R864CP.pdf.

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

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

The following table includes the list of all twenty-three (23) Laboratory National Coverage Determinations, and each NCD can be reviewed on the CMS website at http://www.cms.hhs.gov/mcd/index_section.asp?ncd_sections=40.

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Microvolt T-wave Alternans Diagnostic Testing

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for microvolt T-wave Alternans (MTWA) diagnostic testing services

Provider Action Needed

This article is based on change request (CR) 4351, which announces that effective for dates of service on or after March 21, 2006, MTWA diagnostic testing is covered for the evaluation of patients at risk of sudden cardiac death (SCD), only when the spectral analysis method is used.

Laboratory National Coverage Determination (NCD)

1. Alpha-fetoprotein (AFP) (190.25)
2. Blood Counts (190.15)
3. Blood Glucose Testing (190.20)
4. Carcinoembryonic Antigen (CEA) (190.26)
5. Collagen Crosslinks, any Method (190.19)
6. Digoxin Therapeutic Drug Assay (190.24)
7. Fecal Occult Blood Test (FOBT) (190.34)
8. Gamma Glutamyl Transferase (GGT) (190.32)
9. Glycated Hemoglobin/Glycated Protein (190.21)
10. Hepatitis Panel/Acute Hepatitis Panel (190.33)
11. Human Chorionic Gonadotropin (hCG) (190.27)
12. Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (190.14)
13. Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring) (190.13)
14. Lipid Testing (190.23)
15. Partial Thromboplastin Time (PTT) (190.16)
16. Prostate Specific Antigen (PSA) (190.31)
17. Prothrombin Time (PT) (190.17)
18. Serum Iron Studies (190.18)
19. Thyroid Testing (190.22)
20. Tumor Antigen by Immunoassay – CA 125 (190.28)
21. Tumor Antigen by Immunoassay – CA 15-3/CA 27.29 (190.29)
22. Tumor Antigen by Immunoassay – CA 19-9 (190.30)
23. Urine Culture, Bacterial (190.12)

MLN Matters Number: MM4328
Related Change Request (CR) Number: 4328
Related CR Release Date: February 17, 2006
Related CR Transmittal Number: R864CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 864, CR 4328

Background

MTWA testing is a noninvasive diagnostic test that detects minute electrical activity in a portion of the electrocardiogram (EKG) known as the T-wave. The test is performed by placing highly sensitive electrodes on a patient’s chest prior to a period of controlled exercise.

These electrodes detect very small beat-to-beat voltage fluctuations (on the order of one-millionth of volt) in the EKG T-wave. Spectral analysis (a sensitive mathematical method of measuring and comparing time and the EKG signals) is then used to calculate these minute voltage fluctuations.
The CMS determined that the evidence is adequate to conclude that ECP therapy is reasonable and necessary for (1) Canadian Cardiovascular Society Classification (CCSC) II angina, (2) heart failure (New York Heart Association (NYHA) Class II/III stable heart failure symptoms with an ejection fraction of = 35%, NYHA Class II/III stable heart failure symptoms with an ejection fraction of = 40%, NYHA Class IV heart failure, and acute heart failure), (3) cardiogenic shock, or (4) acute myocardial infarction.

**Implementation**

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

**Additional Information**

For complete details, please see the official instruction (CR 4351) issued to your carrier/FI regarding this change. There are two parts to CR4351, transmittal R894CP, which includes the Medicare claims processing instructions at [http://www.cms.hhs.gov/Transmittals/downloads/R894CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R894CP.pdf) and transmittal R49NCD, which includes the National Coverage Determination Manual revision on the CMS website at [http://www.cms.hhs.gov/Transmittals/downloads/R49NCD.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R49NCD.pdf).

If you have questions, please contact your carrier/FI at their toll-free number, which may be found on the CMS web site at [http://www.cms.hhs.gov/apps/contacts/](http://www.cms.hhs.gov/apps/contacts/).

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

MLN Matters Number: MM4351
Related Change Request (CR) Number: 4351
Related CR Release Date: March 24, 2006
Related CR Transmittal Number: R894CP and R49NCD
Effective Date: March 21, 2006
Implementation Date: April 3, 2006

Source: CMS Pub. 100-04, Transmittal 894, CR 4351

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**Microvolt T-wave Alternans Diagnostic Testing (continued)**

changes. Computer software then analyzes these microvolt changes and produces a report to be interpreted by a physician.

Within patient groups that may be considered candidates for implantable cardioverter defibrillator (ICD) therapy, published literature indicates that a negative MTWA test may be useful in identifying low-risk patients who are unlikely to benefit from, and who may experience worse outcomes from, ICD placement.

Effective for services performed on or after March 21, 2006, the following Current Procedural Terminology (CPT) code will be recognized as nationally payable for MTWA diagnostic testing.

93025  Microvolt T-wave Alternans for assessment of ventricular arrhythmias

This is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act (the Act). NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1064, effective May 1, 2005).

An NCD that expands coverage is also binding on a Medicare Advantage Organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Act.)

**Notes:** MTWA diagnostic testing is noncovered for the evaluation of patients at risk for SCD if measurement is not performed employing the spectral analysis method.

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**Microvolt T-wave Alternans Diagnostic Testing (continued)**

Prior to March 21, 2006, MTWA diagnostic testing was covered at local carrier/FI discretion. Carrier/FI discretion is no longer applicable.

**Implementation**

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

**Additional Information**

For complete details, please see the official instruction (CR 4351) issued to your carrier/FI regarding this change. There are two parts to CR4351, transmittal R894CP, which includes the Medicare claims processing instructions at [http://www.cms.hhs.gov/Transmittals/downloads/R894CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R894CP.pdf) and transmittal R49NCD, which includes the National Coverage Determination Manual revision on the CMS website at [http://www.cms.hhs.gov/Transmittals/downloads/R49NCD.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R49NCD.pdf).

If you have questions, please contact your carrier/FI at their toll-free number, which may be found on the CMS web site at [http://www.cms.hhs.gov/apps/contacts/](http://www.cms.hhs.gov/apps/contacts/).

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

MLN Matters Number: MM4351
Related Change Request (CR) Number: 4351
Related CR Release Date: March 24, 2006
Related CR Transmittal Number: R894CP and R49NCD
Effective Date: March 21, 2006
Implementation Date: April 3, 2006

Source: CMS Pub. 100-04, Transmittal 894, CR 4351

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**External Counterpulsation Therapy**

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

**Provider Types Affected**

Providers, physicians, and suppliers who bill Medicare contractors (fiscal intermediaries (FIs) and carriers) for external counterpulsation (ECP) therapy services

**Key Points**

- The Centers for Medicare & Medicaid Services (CMS) initiated a reconsideration of the National Coverage Determination (NCD) for ECP therapy in response to a request to reconsider that policy and expand coverage to certain additional cardiac conditions.
- Effective March 20, 2006, CMS decided to continue current coverage for ECP therapy, and not to expand coverage to additional cardiac indications.
- The CMS determined that the evidence is not adequate to conclude that ECP therapy is reasonable and necessary for (1) Canadian Cardiovascular Society Classification (CCSC) II angina, (2) heart failure (New York Heart Association (NYHA) Class II/III stable heart failure symptoms with an ejection fraction of = 35%, NYHA Class II/III stable heart failure symptoms with an ejection fraction of = 40%, NYHA Class IV heart failure, and acute heart failure), (3) cardiogenic shock, or (4) acute myocardial infarction.
- Continuing with current policy, effective for services performed on or after July 30, 1999, ECP therapy is considered reasonable and necessary relative to cardiac conditions only when the conditions for coverage identified in Publication 100-3, Section 20.20 of the Medicare National Coverage Determinations Manual (NCD Manual) are met.
- All other cardiac conditions that are not otherwise specified as nationally covered for the use of ECP remain nationally noncovered.

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External Counterpulsation Therapy (continued)

Background

Prior to July 1999, ECP therapy was non-covered for all indications. The coverage policy was amended, effective July 1, 1999, to allow coverage for ECP therapy under certain circumstances. Coverage for ECP was provided only for patients who were diagnosed with disabling angina (Class III or Class IV, CCSC or equivalent classification) and who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical intervention.

Under this policy decision, the therapy was identified as enhanced external counterpulsation. Subsequent reconsiderations of the NCD in February 2000 and October 2001:

• Changed the description of the service back to ECP.
• Removed the requirement limiting coverage to specific ECP systems.
• Clarified that the policy only pertains to ECP devices intended for the treatment of cardiac conditions.

Additional Information

Publication 100-04, The Medicare Claims Processing Manual, Chapter 32, Section 130, is updated to manaulize current billing and payment requirements for both FIs and carriers. The revised section is attached to CR 4350, which is the official instruction issued to your FI or carrier regarding changes mentioned in this article, MM4350. There are two transmittals related to CR4350. The first is the transmittal conveying the NCD, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R50NCD.pdf, and the second, which revises the Medicare Claims Processing Manual, is on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R898CP.pdf.

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

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

MLN Matters Number: MM4350
Related Change Request (CR) Number: 4350
Related CR Release Date: March 31, 2006
Related CR Transmittal Number: R50NCD and R898CP
Effective Date: March 20, 2006
Implementation Date: April 3, 2006

Source: CMS Pub. 100-04, Transmittal 898, CR 4350

Cardiac Rehabilitation Programs

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 for cardiac rehabilitation services

Provider Action Needed

STOP – Impact to You

Effective on and after March 22, 2006, Medicare has expanded coverage for cardiac rehabilitation programs to include three new indications, and has extended the time frame for performing the services to include up to 36 sessions.

CAUTION – What You Need to Know

CR 4401 updates the National Coverage Determination (NCD) Manual, Publication 100-03, Section 20.10, Cardiac Rehabilitation Programs (March 22, 2006), to include three newly covered indications: 1) heart valve repair/replacement; 2) percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; and 3) heart or heart-lung transplant. It also extends the program’s possible duration to a total of 36 sessions (generally, two to three sessions per week for 12 to 18 weeks) and lists the services required to provide a comprehensive program. CR4401 also updates the Medicare Claims Processing Manual, Publication 100-04, Chapter 32, Section 140 to include billing requirements and language regarding physician supervision.

GO – What You Need to Do

Make sure that your billing staffs are aware of these coverage changes in the cardiac rehabilitation program.

Background

Phase II cardiac rehabilitation, as described by the U.S. Public Health Service, is a comprehensive, long-term program including medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Phase II refers to outpatient, medically supervised programs that are typically initiated 1-3 weeks after hospital discharge and provide appropriate electrocardiographic monitoring.

CR 4401 updates National Coverage Determinations (NCD) Manual (100-03), Section 20.10 (effective for cardiac rehabilitation services provided on or after March 22, 2006) to:

• Expand the clinical indications for coverage
• Extend the program’s possible duration.
• Simplify the language regarding physician supervision
• List the services required to provide a comprehensive program
• Update the relevant billing and claims related instructions found in the Medicare Claims Processing Manual (Publication 100.04).

CMS has historically covered cardiac rehabilitation services for patients who have: (1) a documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months; (2) coronary artery bypass surgery; and/or (3) stable angina pectoris. The updated NCD now provides coverage for these three indications and adds three additional ones.
Cardiac Rehabilitation Programs (continued)

Expanded Coverage

Effective for services performed on or after March 22, 2006, Medicare covers cardiac rehabilitation exercise programs for patients who meet the following criteria:

- Have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or
- Have had coronary bypass surgery; or
- Have stable angina pectoris; or
- Have had heart valve repair/replacement; or
- Have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
- Have had a heart or heart lung transplant.

Further, the updated policy also now allows up to 18 weeks for a beneficiary to receive their maximum of 36 cardiac rehabilitation services (Patients generally receive two to three sessions per week for 12 to 18 weeks).

Please note that additional services may be covered at the discretion of the local Medicare contractor, but may not exceed 72 sessions within a 36-week period.

Clarification of Physician and Facility Requirements

The updated policy also clarifies language regarding physician supervision and facility requirements and the physician’s physical location during the rehabilitation services. Specifically the NCD requires that:

- The program must be staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease.
- The facility must have available for immediate use the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary, e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator.

The Medicare Claims Processing Manual instructs that:

- Cardiac rehabilitation programs shall be performed incident to physician’s services in outpatient hospitals, or outpatient settings such as clinics or offices. Follow the policies for services incident to the services of a physician as they apply in each setting. For example, see Pub. 100-02, chapter 6, section 2.4.1, and Pub. 100-02, chapter 15, section 60.1.

Coding Requirements

This CR also changes the Medicare Claims Processing Manual, Publication 100-04, Chapter 32, Section 140, to update the relevant billing and claims related instructions, and points out the following applicable CPT codes:

93798  Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

You should note that your carriers and FIs will apply current payment methodologies, rates, and payments policies for cardiac rehabilitation services when these services are performed according to the new policy stated in this CR. However, they will not search and adjust claims that have already been processed unless brought to their attention.

Additional Information

The revision of Section 20.10 of the Medicare National Coverage Determinations Manual (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act. Remember that:

- NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see 42 CFR 405.1064, effective May 1, 2005).
- An NCD that expands coverage is also binding on a Medicare advantage organization.
- In addition, an administrative law judge may not review an NCD. (See 1869(f)(1)(A)(i) of the Social Security Act.


You may view CR 4401, Transmittal 909, the revised Medicare Claims Processing Manual, Chapter 32 (Billing Requirements for Special Services), Sections 140 (Cardiac Rehabilitation Programs) and 140.1 (Coding Requirements), on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R909CP.pdf.

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

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

MLN Matters Number: MM4401
Related Change Request (CR) Number: 4401
Related CR Release Date: April 21, 2006
Related CR Transmittal Number: R909CP and R52NCD
Effective Date: March 22, 2006
Implementation Date: June 21, 2006
Source: CMS Pub. 100-04, Transmittal 909, CR 4401

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Nesiritide for Treatment of Heart Failure Patients

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

Provider Types Affected

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

Key Points

- Effective for dates of service on or after March 2, 2006, the Centers for Medicare & Medicaid Services (CMS) will deny coverage of nesiritide for the treatment of chronic heart failure in Medicare beneficiaries. For billing guidelines about the noncovered use of nesiritide, please refer to the Additional Information section of this article.

- CMS has determined that there is insufficient evidence to conclude that the use of nesiritide for the treatment of chronic heart failure is reasonable and necessary for Medicare beneficiaries in any setting. This determination does not change local contractor discretion for treatment of acute(ly) decompensated heart failure consistent with the FDA labeled indication in Medicare beneficiaries who may have underlying chronic heart failure. Nor does it affect local contractor discretion for other off-label uses of nesiritide in Medicare beneficiaries who may have underlying chronic heart failure.

- For claims submitted to FIs, the requirement to deny nesiritide for chronic heart failure will only affect type of bill (TOBs) 13x and 85x. TOBs 11x and 12x will be rejected. CMS recommends that FIs create medical policy parameters to deny outpatient claims for nesiritide for chronic heart failure in the absence of acutely decompensated heart failure. CMS recommends that FIs reject inpatient claims where the primary diagnosis is chronic heart failure in the absence of acutely decompensated heart failure (TOBs 11x and 12x) when billed with nesiritide for chronic heart failure.

- For inpatient claims where the beneficiary is admitted with a primary diagnosis other than heart failure and nesiritide is administered under a DRG (diagnosis related group) payment, the administration of nesiritide should not be the sole basis for denial of the entire inpatient claim.

- The provider will be held liable unless occurrence code 32 is present on the claim or modifier GA is present on the line on an outpatient bill.

- All other indications for the use of nesiritide not otherwise indicated as noncovered (other off-label uses or use consistent with the current Food and Drug Administration (FDA) indication for intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea at rest or with minimal activity) are left to local contractor (carrier or FI) discretion.

- This addition to Chapter 1, Section 200.1, of the Medicare National Coverage Determinations Manual (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act (the Act).

- NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1064, effective May 1, 2005).

- An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Act.)

Background

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

Recent published studies of nesiritide have highlighted safety concerns, specifically increased mortality and decreased renal function in patients treated with nesiritide. In addition, an independent advisory panel of cardiac experts sponsored by Scios, manufacturer of Natrecor® (nesiritide), recommends that nesiritide be restricted to the treatment of acute decompensated heart failure in the inpatient hospital setting.

Additional Information

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

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

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

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

Contractors must apply the following Medicare summary notice messages:

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

Contractors will not search for, but may adjust, claims brought to their attention with dates of service March 2, 2006, through implementation.
Nesiritide for Treatment of Heart Failure Patients (continued)

Relevant Links
CR 4312 is the official instruction issued to your FI or carrier, regarding changes mentioned in this article, MM4312. There are two transmittals related to CR 4312. One is transmittal number R51NCD, which relates to the NCD and it may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R51NCD.pdf.

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

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

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

MLN Matters Number: MM4312
Related Change Request (CR) Number: 4312
Related CR Release Date: April 7, 2006
Related CR Transmittal Number: R218OTN and R51NCD
Effective Date: March 2, 2006
Implementation Date: May 22, 2006
Source: CMS Pub. 100-20, Transmittal 218, CR 4312

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Modification to Modifier QR Edit for Automatic Implantable Cardiac Defibrillator Services

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

Provider Types Affected
Providers who bill carriers or fiscal intermediaries for implantable cardiac defibrillator (ICD) services rendered to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
Modifier QR is not required to process claims with ICD-9-CM codes 996.04 (Mechanical complication of cardiac device, implant, and graft, due to automatic implantable cardiac defibrillator) or V53.32 (Fitting and adjustment of other device, automatic implantable cardiac defibrillator) for ICD services with dates of service on or after April 1, 2005. Modifier QR should continue to be used on all claims for ICD device implants when the beneficiary is enrolled in a data collection system such as a registry.

CAUTION – What You Need to Know
Modifier QR is required on claims for primary prevention ICD device implantations (modifier QR signifies that data is being reported on the patient and data reporting is a requirement of primary prevention device insertion).

However, claims submitted for replacement devices do not carry the patient’s previous arrhythmic diagnoses; therefore, these claims look like claims for primary prevention clinical indications. CR 4273, from which this article is taken, adds two new ICD-9-CM codes (addressing ICD replacement due to instrument recall or device complication) to the list of codes that do not require the use of modifier QR for claim processing (effective on or after April 1, 2006, for claims with dates of service on and after April 1, 2005).

GO – What You Need to Do
Make sure that your billing staffs continue to bill ICD implantation and replacement services appropriately according to professional coding guidelines. If claims with dates of service on or after April 1, 2005 were inappropriately denied, they should be brought to the attention of the local Medicare contractor.

Background
Modifier QR identifies services that are being covered under a clinical study (e.g., patients enrolled in a registry), and effective January 27, 2005, is required as a condition for payment on claims for ICD services rendered in the primary prevention of cardiac arrest.

CR 3604, transmittal 497 (released March 8, 2005), provides guidance for the coverage of ICD services under newly expanded coverage. One of the requirements for covering the new ICD indications (effective January 27, 2005) is that the patient be enrolled in a data collection system as indicated by the presence of modifier QR on the claim, which identifies services being covered under a clinical study.

A MLN Matters article on CR3604 is available on the CMS website at http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3604.pdf.

Again, the modifier is used to identify patients who meet the coverage requirement for any indication that is for the primary prevention of sudden cardiac arrest (i.e., no history of induced or spontaneous arrhythmias).

It is not required for ICD services rendered for the secondary prevention of cardiac arrest as documented by the secondary prevention diagnosis codes noted in the table below. (Note, however, that you can use modifier QR for secondary prevention diagnoses if you deem it to be appropriate, i.e., in order to report the data to the data collection system, when this reporting applies).

Two New Diagnosis Codes Added
Since CR 3604 was published, the Centers for Medicare & Medicaid Services (CMS) has become aware that there are other clinical situations for ICD services in which the diagnoses show neither primary nor secondary prevention of cardiac arrest. Such a situation could occur when the patient is having his/her ICD replaced, perhaps due to...
Modification to Modifier QR Edit for Automatic Implantable Cardiac Defibrillator Services (continued)

ICD recall, or to a device complication (such as the end of battery-life).

Since it would be incorrect to deny such claims because they lacked modifier QR, in CR 4273, CMS is adding two new ICD-9-CM diagnosis codes to the list of those that do not require it:

4.4 Mechanical complication of cardiac device, implant, and graft; due to automatic implantable cardiac defibrillator

Use this diagnosis code when the patient is having his/her ICD replaced due to a mechanical complication, as could occur due to ICD recall.

V53.32 Fitting and adjustment of other device; automatic implantable cardiac defibrillator

Use this diagnosis code when there is a fitting or an adjustment, including device removal or replacement; it would be used when the ICD reaches its natural end-of-battery life.

Below is the new list of diagnoses that do not require modifier QR for ICD services in order to be paid (both those indicating the secondary prevention of cardiac arrest, and ICD replacement).

ICD-9-CM Diagnosis Codes Not Requiring Modifier QR

Secondary Prevention Diagnosis

427.1 Ventricular Tachycardia
427.41 Ventricular fibrillation
427.42 Ventricular flutter
427.5 Cardiac arrest
427.9 Cardiac dysrhythmia, unspecified

New “Replacement” Diagnoses

996.04 Mechanical complication of cardiac device, implant, and graft; due to automatic implantable cardiac defibrillator

V53.32 Fitting and adjustment of other device, automatic implantable cardiac defibrillator

Remember: Carriers and FIs will adjust, as appropriate, claims brought to their attention with dates for service on or after April 1, 2005, that were denied because the diagnosis code was 996.04 or V53.32, and lacked modifier QR.

Additional Information

More information about the use of modifier QR for automatic ICD services is available in the official instruction (CR 4723) issued to your carrier/intermediary. That instruction is available on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R819CP.pdf.

Another good source for additional information is MLN Matters article MM 3604, on the CMS website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm3604.pdf.

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

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

MLN Matters Number: MM4273
Related Change Request (CR) Number: 4273
Related CR Release Date: January 27, 2006
Related CR Transmittal Number: R819CP
Effective Date: April 1, 2005
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 819, CR 4273,

Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for ultrasound stimulation for nonunion fracture healing.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4085, which supplements CR 3836 – Coverage and Billing Requirements for Ultrasound Stimulation for Nonunion Fracture Healing.

CAUTION – What You Need to Know

Effective for services performed on or after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgery. Please note that there have been changes made to CR 3836 business requirements.

These changes are discussed in the Additional Information section of this article. All other material and information remain the same as in the original CR 3836.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) determined that evidence is adequate to conclude that it is reasonable and necessary to use noninvasive ultrasound stimulation for the treatment of nonunion bone fractures prior to surgical intervention.
Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing (continued)

Therefore, effective for services performed on or after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgery.

Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing

An ultrasonic osteogenic stimulator is a noninvasive device that emits low intensity, pulsed ultrasound. This device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via a conductive coupling gel to stimulate fracture healing.

Note: Ultrasonic osteogenic stimulators are not to be used concurrently with other noninvasive osteogenic devices.

Coverage Requirements

Effective for dates of service on and after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgical intervention. In demonstrating nonunion fractures, CMS expects a minimum of two sets of radiographs, obtained prior to starting treatment with the osteogenic stimulator, separated by a minimum of 90 days.

Each radiograph set must include multiple views of the fracture site, accompanied with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

Note: For further coverage information, please refer to the Medicare National Coverage Determinations Manual (Pub.100-03), Chapter 1, Section 150.2, which may be found on the CMS website at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf.

Note: Hospitals should note that there are no covered services for ultrasonic osteogenic stimulation for which hospitals can be paid by the FI. Thus, hospitals cannot bill for ultrasonic osteogenic stimulators.

Bill Types When Billing RHHIs

When billed to RHHIs, ultrasonic osteogenic stimulators must be billed on type of bill 32x, 33x, 34x, and is payable under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

Note: Ultrasonic osteogenic stimulators must be in the patient’s home health plan of care if billed on TOBs 32x or 33x.

Billing Instructions When Billing Medicare Carriers

Effective for dates of service on or after April 27, 2005, carriers will allow payment for ultrasonic osteogenic stimulators with the following Current Procedural Terminology (CPT) code:

20979 Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative).

Billing Instructions for Durable Medical Equipment Regional Carriers and Regional Home Health Intermediaries

Effective for dates of service on or after April 27, 2005:

- DMERCs and RHHIs will allow payment for ultrasonic osteogenic stimulators with the following HCPCS codes:
  - E0760 for low-intensity ultrasound (include modifier “KF”); or
  - E1399 for other ultrasound stimulation (include modifier “KF”).
- RHHIs will:
  - Pay for ultrasonic osteogenic stimulators only when services are submitted on type of bills (TOBs) 32x, 33x, or 34x.
  - Pay HHAs on TOBs 32x, 33x, and 34x for ultrasonic osteogenic stimulators on the DMEPOS fee schedule.

Note: Medicare carriers, FIs, and RHHIs will adjust claims with dates of service on and after April 27, 2005, if brought to their attention.

Implementation

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

Additional Information

Some of the differences between CR 3836 and the new CR 4085 include the following:

- A modifier is not needed when billing code 20979 to a carrier as a result of CR4085.
- Modifier “KF” is now to be used when billing code E0760 or code E1399 to a DMERC or RHHI.

For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R816CP.pdf.

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

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

MLN Matters Number: MM4085
Related Change Request (CR) Number: 4085
Related CR Release Date: January 20, 2006
Related CR Transmittal Number: R816CP
Effective Date: April 27, 2005
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 816, CR 4085

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Colorectal Cancer: Preventable, Treatable and Beatable—Coverage and Billing for Colorectal Cancer Screening

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

Provider Types Affected

Physicians, nurse practitioners, physician assistants, clinical nurse specialists, outpatient hospital departments, community surgical centers

Provider Action Needed

STOP – Impact to You

March is National Colorectal Cancer Awareness Month. The Centers for Medicare & Medicaid Services (CMS) would like to remind providers to encourage their eligible Medicare patients, ages 50 and older, to get screened for colorectal cancer. This MLN Matters Special Edition issue reviews Medicare coverage and billing processes for colorectal cancer screening.

CAUTION – What You Need to Know

Medicare has covered colorectal cancer screening since 1998, but the benefit is underused. Claims data from 1998-2002 indicate that less than half of Medicare beneficiaries had any screening test during this five-year period, and less than one-third were tested according to recommended intervals.

GO – What You Need to Do

Encourage your patients to be screened, appropriately bill Medicare for the screening test you provide, and follow up with patients, as needed.

Background

Colorectal cancer is the second leading cause of cancer death in the United States and the third most common type of cancer. In 2005, colorectal cancer was expected to account for 56,290 deaths and 145,290 new cases. Colorectal cancer primarily affects men and women ages 50 and older, and risk increases with age. If detected early, colorectal cancer can be treated and cured.

In January 1998, Medicare began covering colorectal cancer screening. The data currently available (1998 – 2002) indicates that the colorectal cancer screening benefit is underused. Less than half of enrollees had any colorectal cancer test during the five-year period and less than one-third were tested according to recommended intervals.

The U.S. Preventive Services Task Force (USPSTF) evaluates the clinical merits of preventive measures, and strongly recommends (“A” rating) that clinicians screen men and women ages 50 and older for colorectal cancer. The choice of screening strategy should be based on patient preferences, medical contraindications, patient adherence, and resources for testing and follow-up. To read the full recommendation, go to the following link: http://www.ahrq.gov/clinic/uspscl/uspstroke.htm

The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on two criteria—burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer screening was among the services considered to be of the greatest value.

Colorectal Cancer Screening Methods

There are a variety of methods available for colorectal cancer screening, including fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, and screening barium enema. It is important that practitioners follow the practice guidelines for screening and follow-up.

Two studies published in January 2005 in the Annals of Internal Medicine suggest that the office-based single sample screening fecal occult blood test is of limited value, and that many physicians are not following practice guidelines for screening and follow-up. Click on the following link for information on colorectal cancer detection and American Cancer Society screening recommendations and guidelines: http://www.cancer.org/docroot/CRI/content/CRI_2_6X_Colorectal_Cancer_Early_Detection_10.asp?sitearea=&level

Coverage

Medicare covers the following colorectal cancer screening tests and procedures:

Fecal Occult Blood Test (FOBT)

Medicare covers one FOBT annually for beneficiaries 50 and older. A written order from the beneficiary’s attending physician is required. Medicare will pay for an immunoassay-based FOBT as an alternative to the guaiac-based FOBT, but will only pay for one FOBT, not both, per year.

Beneficiaries do not have to pay coinsurance for the FOBT, and don’t have to meet the annual Medicare Part B deductible.

Screening Flexible Sigmoidoscopy

Medicare covers a screening flexible sigmoidoscopy once every four years for beneficiaries 50 and older. If a beneficiary had a screening colonoscopy in the previous 10 years, then the next screening flexible sigmoidoscopy would be covered only after 119 months have passed following the month in which the last screening colonoscopy was performed. A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist may perform a screening flexible sigmoidoscopy.

Screening Colonoscopy

Medicare coverage for a screening colonoscopy is based on beneficiary risk.

• For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every ten years, but not within 47 months of a previous screening flexible sigmoidoscopy.

• For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every two years, regardless of age.

A screening colonoscopy must be ordered and provided by a doctor of medicine or osteopathy.

Screening Barium Enema

Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy or a screening colonoscopy.
Colorectal Cancer: Preventable, Treatable, and Beatable: Colorectal Cancer Screening Coverage and Billing (continued)

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening barium enema every four years.
- For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening barium enema every two years regardless of age.

A screening barium enema must be ordered in writing and provided by a doctor of medicine or osteopathy once it is determined that it is the appropriate screening method for a beneficiary. A double contrast barium enema is preferable, but the physician may order a single contrast barium enema if it is more appropriate for the beneficiary.

The beneficiary is liable for paying 20 percent of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema after meeting the annual Medicare Part B deductible.

For a screening flexible sigmoidoscopy or a screening colonoscopy performed in a hospital outpatient department, the beneficiary is liable for paying the Medicare-approved amount (the coinsurance) after meeting the annual Medicare Part B deductible.

Beneficiaries are considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp.
- A family history of adenomatous polyposis.
- A family history of hereditary nonpolyposis colorectal cancer.
- A personal history of adenomatous polyps.
- A personal history of colorectal cancer.
- A personal history of inflammatory bowel disease, including Crohn’s Disease and ulcerative colitis.

How to Bill Medicare

The following Healthcare Common Procedure Coding System (HCPCS) codes should be used to bill for colorectal cancer screening:

- G0104 Colon cancer screening; flexible sigmoidoscopy
- G0105* Colon cancer screening; colonoscopy on individual at high risk
- G0106 Colon cancer screening; barium enema as an alternative to G0104
- G0107 Colon cancer screening; FOBT, 1-3 simultaneous determinations
- G0120 Colon cancer screening; barium enema as an alternative to G0105
- G0121 Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk
- G0122**Colon cancer screening; barium enema (noncovered)
- G0328 Colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations

**Code G0122 should be used when a screening barium enema is performed not as an alternative to either G0104 or G0105. This service is denied as non-covered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment. Reporting of this noncovered code will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.

If billing Medicare carriers, the appropriate HCPCS and corresponding diagnosis codes must be provided on Form CMS-1500 (or the HIPAA 837 Professional electronic claim record).

If billing Medicare intermediaries, the appropriate HCPCS, revenue, and corresponding diagnosis codes must be provided on Form CMS-1450 (or the HIPAA Institutional electronic claim record). Information on the type of bill and associated revenue code is also provided in the colorectal-cancer screening chapter (page 82) of the Guide to Preventive Services. This guide is available on the CMS website at: http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf.

Reimbursement information is also provided in this guide.

Other Helpful Information

CMS has developed a comprehensive prevention website that provides information and resources for all Medicare preventive benefits. The following link is to the colorectal cancer screening section, and includes website links to information and resources developed by other organizations interested in promoting colorectal cancer screening, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American Cancer Society:

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

Also, visit the Medicare Learning Network (MLN) website at http://www.cms.hhs.gov/MLN/ to access the Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals as well as other educational resources designed for health care professionals to promote and increase national awareness of Medicare-covered preventive services. Once on the MLN site, scroll to the bottom of the page and click on Products, then click on Preventive Services.

MLN Matters Number: SE0613
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0613

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Expansion of Coverage for Percutaneous Transluminal Angioplasty

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 April 3, 2006, to clarify that reporting of both 433.30 and 433.10, in either diagnosis position, needs to be done in the same claim as noted in the “Note” of this article. All other information remains the same. This article was originally published in the January 2006 Medicare A Bulletin Special Issue (pages 63-65).

Provider Types Affected
Hospitals, physicians, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for percutaneous transluminal angioplasty (PTA) services provided to Medicare beneficiaries

Provider Action Needed
STOP – Impact to You
MM 3811 and related CR 3811 announce the expansion of Medicare coverage for PTA of the carotid artery.

CAUTION – What You Need to Know
Effective March 17, 2005, Medicare revised its coverage of PTA of the carotid artery as detailed in this article and CR 3811.

GO – What You Need to Do
If you are a provider of PTA services, be aware of the coverage changes and make certain that your billing staff is aware of the expanded national coverage allowed to Medicare beneficiaries receiving PTA services

Background
Medicare covers PTA of the carotid artery concurrent with carotid stent placement when all the requirements stipulated by the Food and Drug Administration (FDA)-approved policies for category B investigational device exemption (IDE) clinical trials are met, effective for dates of service on or after July 1, 2001.

PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent for an FDA-approved indication is covered, when all the requirements stipulated by the FDA-approved policies for post approval studies are met, for dates of service on or after October 12, 2004.

Expanded Coverage
Effective March 17, 2005, the Centers for Medicare & Medicaid Services (CMS) expanded the coverage of PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent with embolic protection for the following:

- Patients who are at high risk for CEA and have asymptomatic carotid artery stenosis = 80 percent (according to the Category B IDE clinical trials regulation (42 CFR 405.201)), as a routine cost under the clinical trials policy (Medicare NCD Manual 310.1), or according to the NCD on CAS post-approval studies (Medicare NCD Manual, Section 20.7).

- Significant Comorbidities
  CMS defines high-risk patients as those having significant comorbidities and/or anatomic risk factors and are considered by a surgeon to be poor candidates for CEA. The significant comorbidities, include, but are not limited to, those listed in Section 20.7 of the Medicare NCD Manual as follows:
  - Congestive heart failure (CHF) class III/IV
  - Left ventricular ejection fraction (LVEF) < 30 percent
  - Unstable angina
  - Contralateral carotid occlusion
  - Recent myocardial infarction (MI)
  - Previous CEA with recurrent stenosis
  - Prior radiation treatment to the neck
  - Other conditions that were used to determine patients at high risk for CEA in the prior CAS trials and studies, such as ARCHER, CABERNET, SAPPHIRE, BEACH, and MAVERIC II.

Carotid Artery Stenosis
Symptoms of carotid artery stenosis include carotid transient ischemic attack (distinct focal neurologic dysfunction persisting less than 24 hours), focal cerebral ischemia producing a non-disabling stroke (modified Rankin scale < 3 with symptoms for 24 hours or more), and transient molecular blindness (amaurosis fugax). Patients who have had a disabling stroke (modified Rankin > 3) would be excluded from coverage.

The appropriate documentation confirming that a patient is at high risk for CEA and records of the patient's symptoms of carotid artery stenosis should be available in the patient medical records prior to performing any procedure.

The degree of carotid artery stenosis should be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the patient medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70 percent by angiography, the CAS should not proceed.

- Carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in
Expansion of Coverage for Percutaneous Transluminal Angioplasty (continued)

performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes. All facilities must at least meet the minimum standards outlined in Pub 100-03, Section 20.7 of the NCD Manual in order to receive coverage for CAS for high-risk patients. Briefly, facilities must have high quality X-ray imaging equipment, device inventory, staffing, and infrastructure to support a dedicated CAS program.

- Advanced physiologic monitoring, including real time and archived physiologic, hemodynamic, and cardiac rhythm monitoring equipment, and associated support staff capable of interpreting findings and responding appropriately.
- Readily available emergency management equipment and systems, such as resuscitation equipment, a defibrillator, vasocative and antiarrhythmic drugs, endotracheal intubation capability, and anesthesia support.
- A clearly delineated program for granting CAS privileges and for monitoring the quality of the individual interventionists and the program as a whole. The oversight committee for this program is encouraged to apply published standards from national specialty societies recognized by the American Board of Medical Specialties to determine appropriate physician qualifications. Examples of standards and clinical competence guidelines include those published in the December 2004 edition of the American Journal of Neuroradiology and those published in the August 18, 2004, Journal of the American College of Cardiology.
- A data collection system maintained by the facility or its contractor on all CAS procedures done at that facility. The data must be analyzed routinely to ensure patient safety (to be determined by the facility but should not be less frequent than 6-month intervals), will be used in re-credentialing the facility, and must be made available to CMS upon request.

Written Documentation

For evaluation purposes, all facilities must provide written documentation to CMS indicating it meets one of the following criteria:

- Was an FDA-approved site that enrolled patients in prior CAS IDE trials, such as SAPPHIRE, and ARCHER;
- Is an FDA-approved site that is participating and enrolling patients in ongoing CAS IDE trials, such as CREST;
- Is an FDA-approved site for one or more FDA post-approval studies; or
- Has provided a written affidavit to CMS affirming that the facility meets the minimum facility standards.

The affidavit must include the facility’s name and complete address, Medicare provider number, point of contact name and telephone number, CAS procedure data collection mechanism, and a senior facility administrative official’s signature. (Note that a new affidavit is required every two years.)

The affidavit should be sent to:
Director, Coverage and Analysis Group
7500 Security Boulevard, Mail-stop C1-09-06
Baltimore, MD 21244

Note: Performance of PTA to treat obstructive lesions of the vertebral and cerebral arteries remains noncovered. All other indications of PTA for which CMS has not specifically indicated coverage remain noncovered.

Additional Information

All providers should note that the following relate to services on or after March 17, 2005:

- FIs and carriers will only pay CAS claims from providers who are listed on the approved facility list, which is available on the CMS website at http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp#TopOfPage.
- Carriers will pay claims containing ICD-9-CM diagnosis code 433.10 and any of the following procedure codes: 37215, 37216, 0075T, or 0076T, for beneficiaries meeting the high-risk criteria previously specified.
- FIs will pay claims containing ICD-9-CM diagnosis code 433.10 and both procedures codes 00.61 and 00.63.
- FIs will reject claims that do not have both procedure codes 00.61 and 00.63.
- FIs and carriers will deny CAS services for patients at high risk if the appropriate diagnosis code is not on the claim and use the appropriate Medicare summary notice (MSN) message and claim adjustment reason code in doing so.
- FIs and carriers will deny claims where the service was performed in an unapproved facility and use the appropriate MSN message and claim adjustment reason code in doing so.

Note: Providers must also bill V70.7 (Exam – clinical trial) as a secondary diagnosis for claims with “From” dates before October 1, 2005. Providers must bill V70.7 in order to avoid unintentional Medicare code editor (MCE) editing. For claims that have “From” dates on or after October 1, 2005, hospitals are not required to bill V70.7 as the unintentional MCE editing will be corrected.

Coding for Carotid Artery Stents

In the American Hospital Association’s (AHA’s) publication Coding Clinic for ICD-9-CM, First Quarter 2002, page 10 (and corrected in Second Quarter 2002, page 19), there is a Q&A regarding coding of bilateral carotid artery stenosis. The answer said, “Assign only code 433.10, (Occlusion and stenosis of precerebral arteries, Carotid artery, without mention of cerebral infarction) as the principal diagnosis.” The correction notice changed that advice to use code 433.30 (Occlusion and stenosis of precerebral arteries, multiple and bilateral, without mention of cerebral infarction) instead of 433.10.

In an effort to reduce the confusion, CMS has decided...
Expansion of Coverage for Percutaneous Transluminal Angioplasty (continued)

•

to allow hospitals to be able to code both 433.30 and 433.10, in any diagnosis positions, on the same claim. Code 433.30 will identify the bilateral condition, while 433.10 will specifically identify the carotid vessel.

You may also want to review the following MLN Matters article MM3489 and CR 3489 for additional information relating to Medicare coverage of PTA. They are available on the CMS website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf and http://www.cms.hhs.gov/Transmittals/downloads/R314CP.pdf.

The official instruction issued to your carrier/FI regarding this change may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R33NCD.pdf.

That site contains the NCD manual revision. The changes to the Medicare Claims Processing Manual are at

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Positron Emission Tomography Scans for Dementia and Neurodegenerative Diseases

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this MLN Matters article to include Web addresses consistent with the new CMS site. Previously, this article was revised on April 22, 2005, to show that change request (CR) 3426 was revised by CR 3640 (Transmittal 428, dated January 14, 2005). CR 3640 revised billing requirements in CR 3426 for positron emission tomography (PET) scans for Alzheimer’s Disease (AD) by 1) removing the edit for one scan per beneficiary’s lifetime for PET AD scans, and 2) adding requirements for specifying ICD-9-CM diagnosis coding. In addition, Section 60.1 of the Medicare Claims Processing Manual (Pub. 100-04) was updated to include specific payment information for claims for all PET scans for services submitted by critical access hospitals (CAHs). To see CR 3640, go to the following CMS website: http://www.cms.hhs.gov/Transmittals/downloads/R428CP.pdf.

Also, the MLN Matters article related to CR 3640 is located at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3640.pdf.

The revised article related to CR 3640 was published in the Second Quarter 2006 Medicare A Bulletin (page 43).

The article related to CR 3426 was published in the Third Quarter 2005 Medicare A Bulletin (pages 44-45).

Provider Types Affected
Physicians and providers

Provider Action Needed
This instruction notifies physicians and providers that Medicare will provide coverage for 2-deoxy-2-[F-18] fluoro-D-glucose (FDG)-positron emission tomography (PET) scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least six months duration. This service may be covered:

• When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and Alzheimer’s disease (AD) under specific requirements, or

• For use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

Background
Effective for dates of service on or after September 15, 2004, Medicare will provide coverage for FDG-PET for one of the following:

• When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and Alzheimer’s disease; or

• When used in a CMS-approved practical neurodegenerative disease clinical trial.

Clinical trial results are expected to help in determining if PET scans contribute to the effective diagnosis and treatment of Medicare beneficiaries with mild cognitive impairment or early dementia, and add information that will help monitor, evaluate, and improve clinical outcomes of patients with this disease.
Positron Emission Tomography Scans for Dementia and Neurodegenerative Diseases (continued)

The evaluation of the patient has been conducted by a physician experienced in the diagnosis and assessment of dementia.

The patient has had a comprehensive clinical evaluation encompassing a medical history from the patient and a well-acquainted informant (including assessment of activities of daily living), physical and mental status examination (including formal documentation of cognitive decline occurring over at least six months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging (MRI) or computed tomography (CT).

The referring and billing provider(s) have documented the appropriate evaluation of the Medicare beneficiary. Providers should establish the medical necessity of an FDG-PET scan by ensuring that the following information has been collected and is maintained in the beneficiary medical record:

- Date of onset of symptoms
- Diagnosis of clinical syndrome (normal aging; mild cognitive impairment or MCI; mild, moderate or severe dementia)
- Mini mental status exam (MMSE) or similar test score
- Presumptive cause (possible, probable, uncertain AD)
- Any neuropsychological testing performed
- Results of any structural imaging (MRI or CT) performed
- Relevant laboratory tests (B12, thyroid hormone)
- Number and name of prescribed medications.

The billing provider must furnish a copy of the FDG-PET scan result for use by CMS and its contractors upon request.

These services should be billed with HCPCS code of G0336 (Pet imaging, brain imaging for the differential diagnosis of Alzheimer’s disease with aberrant features vs. FTD).

- The evaluation of the patient did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment.

- The FDG-PET scan is performed in a facility that has all the accreditation necessary to operate nuclear medicine equipment. The reading of the scan should be done by an expert in nuclear medicine, radiology, neurology, or psychiatry, with experience interpreting such scans in the presence of dementia.

- A brain single photon emission computed tomography (SPECT) or FDG-PET scan has not been obtained for the same indication. The indication can be considered to be different in patients who exhibit important changes in scope or severity of cognitive decline, and meet all other qualifying criteria listed above and below (including the judgment that the likely diagnosis remains uncertain). The results of a prior SPECT or FDG-PET scan must have been inconclusive or, in the case of SPECT, difficult to interpret due to immature or inadequate technology. In these instances, an FDG-PET scan may be covered after one year has passed from the time the first SPECT or FDG-PET scan was performed.

- The referring and billing provider(s) have documented the appropriate evaluation of the Medicare beneficiary. Providers should establish the medical necessity of an FDG-PET scan by ensuring that the following information has been collected and is maintained in the beneficiary medical record:
  - Date of onset of symptoms
  - Diagnosis of clinical syndrome (normal aging; mild cognitive impairment or MCI; mild, moderate or severe dementia)
  - Mini mental status exam (MMSE) or similar test score
  - Presumptive cause (possible, probable, uncertain AD)
  - Any neuropsychological testing performed
  - Results of any structural imaging (MRI or CT) performed
  - Relevant laboratory tests (B12, thyroid hormone)
  - Number and name of prescribed medications.

The billing provider must furnish a copy of the FDG-PET scan result for use by CMS and its contractors upon request.

These services should be billed with HCPCS code of G0336 (Pet imaging, brain imaging for the differential diagnosis of Alzheimer’s disease with aberrant features vs. FTD).

- The evaluation of the patient did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment.

- The FDG-PET scan is performed in a facility that has all the accreditation necessary to operate nuclear medicine equipment. The reading of the scan should be done by an expert in nuclear medicine, radiology, neurology, or psychiatry, with experience interpreting such scans in the presence of dementia.

- A brain single photon emission computed tomography (SPECT) or FDG-PET scan has not been obtained for the same indication. The indication can be considered to be different in patients who exhibit important changes in scope or severity of cognitive decline, and meet all other qualifying criteria listed above and below (including the judgment that the likely diagnosis remains uncertain). The results of a prior SPECT or FDG-PET scan must have been inconclusive or, in the case of SPECT, difficult to interpret due to immature or inadequate technology. In these instances, an FDG-PET scan may be covered after one year has passed from the time the first SPECT or FDG-PET scan was performed.

- The referring and billing provider(s) have documented the appropriate evaluation of the Medicare beneficiary. Providers should establish the medical necessity of an FDG-PET scan by ensuring that the following information has been collected and is maintained in the beneficiary medical record:
  - Date of onset of symptoms
  - Diagnosis of clinical syndrome (normal aging; mild cognitive impairment or MCI; mild, moderate or severe dementia)
  - Mini mental status exam (MMSE) or similar test score
  - Presumptive cause (possible, probable, uncertain AD)
  - Any neuropsychological testing performed
  - Results of any structural imaging (MRI or CT) performed
  - Relevant laboratory tests (B12, thyroid hormone)
  - Number and name of prescribed medications.

The billing provider must furnish a copy of the FDG-PET scan result for use by CMS and its contractors upon request.

These services should be billed with HCPCS code of G0336 (Pet imaging, brain imaging for the differential diagnosis of Alzheimer’s disease with aberrant features vs. FTD).
FDG-PET Requirements for Use in the Context of a CMS-Approved Neurodegenerative Disease Practical Clinical Trial Utilizing Specific Protocol

With regard to use of the FDG-PET in the context of a CMS-approved clinical trial, the clinical trial must compare patients who do and those who do not receive an FDG-PET scan and have as its goal to monitor, evaluate, and improve clinical outcomes. In addition, it must meet the following basic criteria:

- Written protocol on file
- Institutional Review Board review and approval
- Scientific review and approval by two or more qualified individuals who are not part of the research team
- Certification that investigators have not been disqualified.

Physicians should note that modifier QV must be used when billing Medicare carriers for a CMS-approved neurodegenerative disease practical clinical trial. In addition, on such claims from trials that are billed to Medicare intermediaries, a second diagnosis (ICD-9-CM) of V70.7, along with the appropriate principal diagnosis code and HCPCS code G0336 must be entered on claim Form CMS-1450 or its electronic equivalent. Once the clinical trial facilities have been identified, a list of the participating facilities will be available on CMS website at: http://www.cms.hhs.gov/coverage.

Implementation

The implementation date for this instruction is October 4, 2004.

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 13 – Radiology Services, Section 60 – Positron Emission Tomography (PET) Scans is being updated by this instruction. It includes billing and claim processing requirements for PET scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least six months duration who meet diagnostic criteria for both FTD and AD, or its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

In addition, the Medicare NCD Manual (Pub. 100-03), Chapter 1 – Coverage Determinations Section 220 – Radiology, Subsection 6 – Positron Emission Tomography (PET) Scans, is being updated by this instruction to include complete coverage policy and requirements for related clinical trials.

These updated manual instructions are included in the official instruction issued to your carrier/intermediary, which may be found by going to CMS website http://www.cms.hhs.gov/Transmittals/downloads/R310CP.pdf.

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

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

MLN Matters Number: MM 3426 – Revised
Related Change Request (CR) Number: 3426
Related CR Release Date: October 1, 2004
Related CR Transmittal Number: 24
Effective Date: September 15, 2004
Implementation Date: October 4, 2004

Source: CMS Pub. 100-3, Transmittal 24, CR 3426
CMS Pub. 100-4, Transmittal 310, CR 3426

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

**Electronic Notification**

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

**More Information**

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

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

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

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A11000: Debridement Services—Revision to the LCD

The local coverage determination (LCD) for debridement services was previously revised on January 1, 2006. Since that time, the revenue codes have been updated to include 42x (physical therapy) and 43x (occupational therapy) for CPT codes 97597 and 97598 only. This revision is effective for services provided on or after October 27, 2005.

In addition, it was determined that ICD-9-CM code ranges 946.20-946.29, 946.30-946.39, and 946.40-946.49 were added to the LCD as fifth digit specificity in error. These ICD-9-CM code ranges have been corrected to 946.2, 946.3, and 946.4, respectively. These ICD-9-CM codes are for procedure codes 97597 and 97598 only. This revision is effective for claims processed on or after March 30, 2006, for services provided on or after January 1, 2005.

The following changes have been made to the coding guideline section of the LCD based on change request 4226 – Annual Update to the Therapy Code List: Clarifying therapy modifier usage with CPT codes 97597, 97598, and 97602 and clarification for OPPS providers using the therapy modifiers and revenue codes when a therapist does not provide the services. This revision is effective for services provided on or after January 1, 2006.

The full text for this LCD (L18913) is available through the provider education website http://www.floridamedicare.com on or after these effective date.

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A17304: Mohs Micrographic Surgery (MMS)—Addition to the LCD

The local coverage determination (LCD) for Mohs micrographic surgery (MMS) was previously revised on January 1, 2006. Since that time, it was determined that additional ICD-9-CM codes 173.5, 173.6, 173.7, and 232.0-232.8 would give providers more specific diagnosis codes to bill for the MMS procedures; therefore, these codes have been added to the LCD.

Effective Date

This addition is effective for services provided on or after April 27, 2006.

The full text for this LCD (L862) may be viewed through the provider education website http://www.floridamedicare.com on or after this effective date.

A32491: Lung Volume Reduction Surgery—Revision to the LCD

The local coverage determination (LCD) for lung volume reduction surgery was effective on September 30, 2004. Since that time, the LCD has been updated per CMS Transmittal 768, Change Request 4149, updating the protocol for determining approved facilities for LVRS and removing language regarding the National Emphysema Treatment Trial (NETT) protocol. In addition, the coding guideline section was updated to include national noncovered indications.

Effective Date

This revision is effective for services processed on or after March 2, 2006 for services provided on or after November 17, 2005.

The full text for this LCD (L18129) may be viewed through the provider education website http://www.floridamedicare.com on or after this effective date.

A72141: Magnetic Resonance Imaging of the Spine—Revision to the LCD

The local medical review policy (LMRP) for magnetic resonance imaging (MRI) of the spine was last revised on May 27, 2003. Since that time, the policy was converted to (LCD) local coverage determination format and the LCD has been updated for clarification and revised in the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9-CM Codes removed from the policy
- Sources of Information and Basis for Decision

Effective Date

This revision is effective for services provided on or after October 13, 2005.

The full text for this LCD (L1444) is available through the provider education website http://www.floridamedicare.com on or after this effective date.
The local coverage determination (LCD) for transthoracic echocardiography (TTE) was last updated on October 1, 2005. Since that time, the following ICD-9-CM diagnosis codes have been added to the “ICD-9 Codes that Support Medical Necessity” section of the LCD for CPT codes 93307 and 93308:

V42.1 Heart replaced by transplant
V42.2 Heart valve replaced by transplant
V43.3 Heart valve replaced by other means

These ICD-9-CM codes are secondary diagnosis codes and should not be billed as the primary diagnosis.

**Effective Date**

This addition is effective for services provided on or after April 27, 2006.
The full text for this LCD (L1566) may be viewed through the provider education website [http://www.floridamedicare.com](http://www.floridamedicare.com) on or after this effective date.

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The local coverage determination (LCD) and coding guidelines for epoetin alfa were last updated on January 13, 2006. Since that time, the following sections of the LCD have been revised:

- Type of bill 12x has been added to the “Type of Bill Codes” section. This change was made due to information communicated through change request (CR) 4135.

- The coding guidelines in the “LCD Attachments” section were revised to include information related to CRs 4135 and 4103 as follows:
  - For HCPCS code J0886, effective for services provided on or after January 1, 2006, TOBs 12x, 13x and 85x are no longer required to report value code 49 on claims when submitting for epoetin alfa – J0886.
  - Effective for services provided on or after January 1, 2006, the definition of value codes 48 and 49 will now reflect the most recent hemoglobin or hematocrit taken before the start of the current billing period.
  - Effective for services provided on or after April 1, 2006, on claims with TOB 72x, when value code 49 is greater than 39.0 (or value code 48 is greater than 13.0), modifier GS should be reported with procedure code J0886. Modifier GS indicates that the dosage of Aranesp® has been reduced by 25 percent from the preceding months dosage. When modifier GS is not present, Medicare shall apply a 25 percent reduction in the reported dosage.
  - Effective for services provided on or after April 1, 2006, hospitals billing for epoetin alfa (HCPCS J0886) under the inpatient Part B benefit (TOB 12x), shall report the charges under the revenue code 634 for EPO units under 10,000 and revenue code 635 for EPO units over 10,000 units. Report the total number of units as a multiple of 1000 units in the “serv unit” field.

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

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The local coverage determination (LCD) for leucovorin was last updated on July 28, 2005. Since that time, the LCD was edited for FDA and off-label indications. The following ICD-9-CM code has been added under the “ICD-9 Codes that Support Medical Necessity” section:

186.9 – Malignant neoplasm of other and unspecified testis

In addition, under the “Indications and Limitations of Coverage and/or Medical Necessity” section, “Malignant neoplasm of testis” was added. References were updated under the “Sources of Information and Basis for Decision” section.

**Effective Date**

These revisions are effective for services provided on or after March 1, 2006.
The full text for this LCD (L13775) may be viewed through the provider education website [http://www.floridamedicare.com](http://www.floridamedicare.com) on or after this effective date.
AJ1745: Infliximab (Remicade®)—Revision to the LCD

The local coverage determination (LCD) for infliximab (Remicade®) was last updated on August 18, 2005. Since that time, the “Indications and Limitations of Coverage and/or Medical Necessity” and the “ICD-9 Codes that Support Medical Necessity” sections of the LCD have been revised. The following revisions are effective for services provided on and after February 16, 2006:

- Under the indications and limitations, bullet #2 was revised to include coverage for rectovaginal fistulas and to maintain fistula closure for fistulizing Crohn’s disease. Bullet #3 was revised to read active arthritis in patients with psoriatic arthritis. Bullet #4 was revised to remove the requirement that the patient must have had an inadequate response to methotrexate. A fifth bullet was added that allows coverage for the following:
  - To reduce signs and symptoms, achieve clinical remission and mucosal healing, and eliminate corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.
- The following ICD-9-CM codes were added to the list of “ICD-9 Codes that Support Medical Necessity” section, related to the above revisions:
  556.0  556.1  556.2  556.3  556.5  556.6  556.8  556.9  714.2

For services provided on and after March 23, 2006, the following revision are effective: Bullet #5 was revised to read that patients can receive the infusion at 0, 2, and six weeks and every eight weeks thereafter.

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

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

This local coverage determination (LCD) for pamidronate was last updated on January 01, 2006. Since that time, this LCD has been revised to update the terminology and dosages under the “Indications and Limitations of Coverage and/or Medical Necessity” section to correspond with the FDA indications and recommended dosages.

Under the “ICD-9 Codes that Support Medical Necessity” section, the dual diagnosis requirement for osteolytic lesions of multiple myeloma (code range 203.00 – 203.01) was removed because the involvement of bone and/or bone marrow may be part of this disease process. In addition, the “Sources of Information and Basis for Decision” section was updated.

Effective Date

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

The full text for this LCD (L1064) may be viewed through the provider education website http://www.floridamedicare.com on or after this effective date.

AJ2505: Pegfilgrastim (Neulasta®)—Revision to the LCD

The local coverage determination (LCD) for pegfilgrastim was last updated on October 1, 2005. Based on current literature, this LCD has since been revised to include an additional indication and ICD-9-CM code regarding prophylactic use of Neulasta.

The following statement was added under the “Indications and Limitations of Coverage and/or Medical Necessity” section:

- Prophylactic use of Neulasta in patients undergoing chemotherapy reduces the risk of febrile neutropenia and infections. Prophylactic therapy can be considered for patients receiving myelosuppressive chemotherapy if the risk of febrile neutropenia is 20 percent or greater.

Under List II of the “ICD-9 Codes that Support Medical Necessity” section, the following diagnosis code was added:
  V07.8 Other specified prophylactic measure

Coverage of pegfilgrastim requires the billing of dual diagnoses. Under the “ICD-9 Codes that Support Medical Necessity” section, the appropriate primary diagnosis code under List I, which represents a non-myeloid malignancy, and the appropriate secondary diagnosis code under List II, which represents an encounter for myelosuppressive chemotherapy, must be billed.

In addition to the above, the “Sources of Information and Basis for Decision” section was updated.

Effective Date

These revisions are effective for services provided on or after March 9, 2006.

The full text for this LCD (L14001) may be viewed through the provider education website http://www.floridamedicare.com on or after this effective date.
AJ9000: Antineoplastic Drugs—Revision to the LCD

This local coverage determination (LCD) for antineoplastic drugs was last updated on January 1, 2006. Since that time, based on FDA approved indications and/or off-label indications published in the USP DI, the following revisions were made to the HCPCS codes listed below under the “Indications and Limitations of Coverage and/or Medical Necessity” section:

- J9000 – Doxorubicin HCl – Ewing’s sarcoma was moved from the off-labeled section to FDA approved indications
- J9015 – Aldesleukin – Under off-labeled indications, “acute” was added to chronic myelogenous leukemia.
- J9170 – Docetaxel – FDA approved and off-labeled indications were corrected.
- J9181 & J9182 – Etoposide – Ovarian germ cell tumor was indicated for ovarian carcinoma and Myelodysplastic syndromes (MDS) was added to off-labeled indications.
- J9200 – Fluorouracil – Carcinoma of the ovary and kidney not responsive to other antimotolites was added to the off-labeled indications.
- J9201 – Gemcitabine – FDA indication of GEMZAR in combination with paclitaxel for first line treatment of patients with metastatic breast cancer after failure of prior anthracycline-containing adjuvant chemotherapy, unless contraindicated was added. Off-labeled indications of epithelial for ovarian carcinoma was indicated, and ovarian germ cell tumor was added.
- J9263 – Oxaliplatin – FDA approved indication stating “Oxaliplatin is indicated in combination with 5-FU/LV or capecitabine for first line treatment of nonresectable advanced or metastatic colon or rectal carcinoma” was added.
- J9265 – Paclitaxel – FDA approved indication stating “Adjuvant treatment of node-positive breast cancer when administered sequentially to standard doxorubicin-containing combination chemotherapy” was added. In addition, under off-labeled indications, “First line therapy for treatment of metastatic breast cancer” was added.
- J9300 – Gemtuzumab – Under FDA approved indications, “other” was added to cytotoxic chemotherapy for treatment of patients with CD33 positive acute myeloid leukemia in first relapse who are 60 years of age or older and who are not considered candidates for cytotoxic chemotherapy.

In addition to the above, under the “ICD-9 Codes that Support Medical Necessity” section, the following HCPCS codes had additional diagnoses added:

- J9015 – Aldesleukin – Added diagnosis code range 205.00 – 205.01 – acute myeloid leukemia.
- J9181 & J9182 – Etoposide – Added diagnosis code 238.7 – Other lymphatic and hematopoietic tissue.

The “Sources of Information and Basis for Decision” sections as well as the “Coding Guidelines” section were also updated.

Effective Date

These revisions are effective for services provided on or after March 1, 2006.

The full text for this LCD (L1447) may be viewed through the provider education website http://www.floridamedicare.com on or after this effective date.

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

The local coverage determination (LCD) and the coding guidelines for darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) was last revised on January 13, 2006. Since that time, the following sections of the LCD have been revised:

Type of bill 12x has been added to the “Bill Type Codes” section as a result of information communicated in change request (CR) 4135.

The coding guidelines in the “LCD Attachments” section were revised to include information related to CRs 4135 and 4103 as follows:

- Information for HCPCS code J0882 has been added to the coding guidelines as follows: effective for services provided on or after January 1, 2006, type of bills 12x, 13x and 85x are no longer required to report value code 49 when submitted for Aranesp® – J0882.
- Effective for services provided on or after January 1, 2006, the definition of value codes 48 and 49 will now reflect the most recent hematocrit or hemoglobin taken before the start of the current billing period.
- Effective for services provided on or after April 1, 2006, on claims with type of bill 72x, when value code 49 is greater than 39.0 (or value code 48 is greater than 13.0), modifier GS should be reported with HCPCS code J0882. Modifier GS indicates that the dosage of Aranesp has been reduced by 25 percent from the preceding months dosage. When modifier GS is not present, Medicare shall apply a 25 percent reduction in the reported dosage.

The full text for this LCD (L13796) is available through the provider education website http://www.floridamedicare.com on or after this effective date.
Stereotactic Radiosurgery and Stereotactic Radiotherapy—Correction to a Previously Published Article

Note: This is a correction to an article addressing coding guidelines for stereotactic radiosurgery and stereotactic radiotherapy previous published in the First Quarter 2006 Medicare A Bulletin (pages 73-74).

Coding Guidelines

Stereotactic radiosurgery is a form of external beam radiation that delivers a high dose during a single session to shrink or destroy lesions while leaving tissue surrounding the lesion unaffected. Initially restricted to intracranial lesions, advances in technology have extended interventions to other parts of the body for lesions inaccessible or unsuitable for open surgery. The stereotactic techniques have incorporated single session high-dose, hyper fractionation (currently defined as 2-5 high dose sessions), and conventional fractionation collectively referred to as stereotactic radiotherapy (SRT). SRT relies on reproducible spatial correlation of the target of interest and the radiation source, using computer generated three dimensional simulations. This may be accomplished with several methodologies including specially designed external frames, implanted fiducial markers or imaging techniques. Currently FCSO does not have a local medical policy addressing stereotactic radiotherapy. Specifically, body radiation therapy (therapy outside the CNS) is considered an emerging technology as indicated by the assignment of a category III code in 2005. Review of current literature and discussion with radiation oncologists suggest that there is no consensus on the optimal technology (planning and Rx delivery) for given indications. Currently, there are satisfactory coding and billing guidelines for hospitals to submit claims to the fiscal intermediary for SRT treatment planning and delivery. Free standing facilities that bill the carrier should use this article as a guide to coding and billing the carrier when applicable given there are no active CPT/HCPCS codes with pricing in the Medicare fee schedule for claims administration of SRT
Stereotactic Radiosurgery and Stereotactic Radiotherapy—Correction to a Previously Published Article (continued)

treatment planning and delivery. Claims to the carrier will continue to be developed for documentation and evaluated for coverage and payment on individual consideration. The documentation must show what was done. Also it must support that the intervention was medical necessary and reasonable for the condition as well as superior to conventional radiation therapy or IMRT given the risk and benefit to the beneficiary. This coding article addresses:

- Physician treatment management services: Stereotactic radiation therapy and radiosurgery is an emerging technology and involves a process of care directed by radiation oncologist, in some cases neurosurgeons, and other allied health care professionals.
- SRT and radiosurgery treatment planning and delivery given with either Co 60 gamma rays or with mega voltage photons from a linear accelerator for claims submitted to the carrier from a free standing facility. The goal of these treatments is great accuracy and precision in the delivery of dose to the planned target.

The conduct of a course of radiation therapy includes an episode of care with steps of consultation, clinical treatment planning, establishment of treatment parameters, and treatment delivery & management. All of the coding encompassed in an episode of care is not addressed in this article. However, it is expected that professional and technical components billed to Medicare on behalf of a beneficiary are medically necessary and reasonable with no duplication of services within the episode of care unless the medical necessity of the repeated or duplicated services is clearly documented. If multiple providers are involved in the patient’s episode of care, clinical treatment planning, establishment of treatment parameters, and treatment delivery and management should be appropriately coordinated.

**Coding of CPT/HCPCS Codes**

**SRT Treatment Management:**

77432 Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session):

- Generally reflects the work by the radiation oncologist

61793 Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions.

- Reported for work attributed to neurosurgeon or surgeon
- Same physician cannot report CPT codes 77427-77432

77295-TC Therapeutic radiology simulation-aided field setting; three-dimensional

**LINAC based**

77261-77370 – Linear accelerator based stereotactic radiosurgery plan, including dose volume histograms for target critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment

**Cobalt 60-based**

77261-77370 – Multi-source photon stereotactic radiosurgery (cobalt-60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment

**LINAC based**

0082T Stereotactic body radiation therapy, treatment management, per day

- SRT per day management of non-cerebral lesions
- Do not report 0083T in conjunction with 77427-77432, 61793

**Cobalt 60-based**

0082T Stereotactic body radiation therapy, treatment management, per day

- per course of treatment Or one of the following, as appropriate:

**LINAC based**

G0339 Image guided robotic linear accelerator base stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment

G0340 Image guided robotic linear accelerator base stereotactic radiosurgery, delivery including collimator changes in custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment

**Non-robotic LINAC treatment**

G0173 Stereotactic radiosurgery, complete course of therapy in one session

G0251 Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment

**Cobalt 60-based**

G0243 Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions

The work should reflect the following descriptors currently used in the hospital setting:

**LINAC based**

- Image-guided robotic LINAC treatment

**Non-robotic LINAC treatment**

- Cobalt 60-based

The revised version of the coding guidelines is also available through the provider education website [http://www.floridamedicare.com](http://www.floridamedicare.com) under the article ID A39254. 

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Intravitreal Bevacizumab (Avastin®) for Neovascular Age-Related Macular Degeneration

Bevacizumab, FDA approved for intravenous use in combination with intravenous 5-fluourouracil-based chemotherapy, is indicated for first-line treatment of patients with metastatic carcinoma of the colon or rectum. The United States Pharmacopeia (USP) supports one unlabeled indication: advanced/metastatic non-squamous non-small cell lung cancer.

Early observations indicate that bevacizumab may be useful in the treatment of age-related macular degeneration (AMD). Ophthalmologists have been using intravitreal bevacizumab increasingly in the treatment of wet AMD. Even though the intravitreal administration looks promising and may be cost effective, there are still a number of concerns, specifically about safety.

Currently, publications in peer-reviewed literature are not sufficient to support a positive coverage statement by means of a local coverage determination (LCD).

Until appropriately designed and powered studies are published and evaluated, bevacizumab for the treatment of age-related macular degeneration will be considered on an individual case-by-case basis.

HCPCS code J9035 (injection, bevacizumab, 10 mg) does not apply to the intravitreal administration, as a pharmacist has processed the agent. Providers billing for intravitreal bevacizumab should use CPT code 67028 for the intravitreal injection and HCPCS code J3490 (unclassified drugs) for the bevacizumab. The applicable ICD-9-CM code is 362.52 (exudative senile macular degeneration of retina). Documentation in the medical record must support the following:

- The diagnosis of neovascular (wet) macular degeneration has been firmly established (fluorescein angiogram).
- The patient does not have any contraindications to bevacizumab.
- The patient has been thoroughly educated about the benefits and risks of this therapy and that it is being used “off-label.”
- Actual dose administered in milligrams.

When billing Medicare, the intravitreal injection and the drug injected should be billed on the same claim. Remember to use the appropriate modifiers when performing the service on both eyes.

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

Any time there is a question whether Medicare’s medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN). ✤

Vaginal Nerve Stimulation for Intractable Depression

Effective July 15, 2005, the Food and Drug Administration (FDA) has given post-marketing approval for the use of vagal nerve stimulation (VNS) for intractable or refractory depression in patients 18 years of age or older who have not had an adequate response to four or more “adequate” antidepressant treatments.

There are several CMS national coverage determinations (NCDs) about nerve stimulation procedures; one is related to vaginal nerve stimulation for seizure disorders (160.18 – Vagus Nerve Stimulation for Treatment of Seizures, http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Parr2.pdf); another is related to implantation of neurostimulators for pain control. At this time, there are no NCDs referencing the use of vaginal nerve stimulation for the treatment of depression or other psychiatric disorders.

Currently, publications in peer-reviewed literature, position statements by technology assessment organizations, and the communication released by the manufacturer are not sufficient to issue a positive coverage statement by way of a local coverage determination (LCD) based on Medicare’s medical reasonableness and necessity criteria. There have been no closely controlled clinical trials conducted to date or studies focusing on comparison with other treatments generally available.

Until appropriately designed and powered studies are published and evaluated, claims for vaginal nerve stimulation for depression will be evaluated individually on a case-by-case basis. Any time there is a question whether Medicare’s medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed CPT/HCPCS codes. For further details about CMS’ Beneficiary Notice Initiative (BNI), please point your browser to this link: http://www.cms.hhs.gov/BNI/.

Please note that services that lead up to or are associated with non-covered services are not covered as well. The beneficiary should be thoroughly educated about the benefits and risks of this modality.

Billing and Coding

Providers billing for this procedure should use the following CPT codes, as applicable:

61885 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61888 Revision or removal of cranial neurostimulator pulse generator or receiver
64573 Incision for implantation of neurostimulator electrodes; cranial nerve
64585 Revision or removal of peripheral neurostimulator electrodes
Vagal Nerve Stimulation for Intractable Depression (continued)

95970 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95974 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

95975 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

As there is no specific code for “intractable” or “refractory” depression, ICD-9-CM code 311 – Depressive disorder, not elsewhere specified, should be used.

No Action Required by Providers

Providers should not submit any medical record documentation with the claim. First Coast Service Options will request this by means of an additional documentation request (ADR) letter. The required information will include details about the pharmacotherapy and non-pharmacologic interventions (psychotherapy, ECT, etc.) over the past 18 months, documentation of a second opinion of a psychiatrist who is not involved in the care of the beneficiary, the patient’s compliance, response to treatment, and other factors, as necessary.

Vertebral Fracture Assessment—CPT Code 76077

Background

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

Description of the Service

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

Regulatory Information

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

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

The local contractor does not have discretion of decision or authority to expand or contract this list. According to 42 CFR, Section 410.31, “Bone mass measurement…is performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality” and does not include a provision for diagnosing a fracture. Therefore, vertebral fracture assessment is outside the scope of Medicare bone mass measurement benefit, as defined by the law. It is a separate modality.

Contractor’s (FCSO) Observations

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

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

The wireless capsule of the esophagus is a wireless diagnostic video capsule specifically designed for the visualization of the esophagus. The wireless capsule endoscopy of the esophagus is based on the same clinically proven technology as the wireless capsule endoscopy of the small bowel.

Wireless capsule endoscopy of the small bowel received approval from the Food and Drug Administration (FDA) on August 1, 2001, through a 510(k) approval process. The FDA clearance provided for the use of the capsule “along with” – not as a replacement for other endoscopic and radiologic evaluations of the small bowel. In July of 2003 a supplemental 510 (k) pre-market notification was cleared and the labeled indications were modified by removing the “adjunctive use” qualification. The diagnostic system associated with wireless capsule endoscopy was intended for visualization of the small bowel mucosa. However, in November 2004 the FDA approved the diagnostic system for use with wireless capsule endoscopy for visualization of the esophageal mucosa.

First Coast Service Options (FCSO) currently has a local coverage determination (LCD) for wireless capsule endoscopy. This LCD provides coverage guidelines for the use of wireless capsule endoscopy of the small bowel only. The full text of this LCD may be viewed at http://www.floridamedicare.com.

To date, there have not been an adequate number of closely controlled clinical trials conducted or studies focusing on a comparison between wireless capsule endoscopy of the esophagus and other diagnostic modalities such as conventional endoscopy. Current publications in peer-reviewed literature, position statements by technology assessment organizations, and the communication released by the manufacturer are not sufficient to issue a positive coverage statement by way of a local coverage determination (LCD).

Currently, there is no national coverage determination (NCD) for wireless capsule endoscopy of the esophagus, and FCSO has not published a LCD. When there is no NCD or LCD, services are evaluated individually based on Medicare general medical reasonableness and necessity criteria. Claims for wireless capsule endoscopy of the esophagus will be given individual consideration on a case-by-case basis until appropriately designed and powered studies are published and evaluated. Providers should not interpret the process of individual consideration as synonymous with coverage and payment by Medicare. This means only that the claims will be reviewed against the background of the presently available evidence and specific patient circumstances.

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

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

Billing and Coding

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

Documentation

Providers should not submit any medical record documentation with the claim. FCSO will request this by means of an additional documentation request (ADR) letter. The required information will include details for the current episode of care about symptoms, signs, and findings suggestive of the presence of a vertebral fracture, other diagnostic modalities utilized, and the rationale for choosing VFA. Like any diagnostic test, the VFA must be specifically ordered by the treating physician, for which there must be documentation in the medical record. ❖
AAPBI: Accelerated Partial Breast Irradiation (APBI)—Correction to a Previously Published Article

**Note:** This is a revision to an article published in the First Quarter 2005 Medicare A Bulletin (page 50).

Survival after breast-conservation therapy (BCT) is equivalent to survival after mastectomy for patients diagnosed with tumors categorized as stage I or II. The standard of care for local management is breast-conserving surgery to excise the tumor with adequate margins (lumpectomy), followed by whole-breast external-beam radiation therapy (WB-EBRT).

Accelerated partial breast irradiation (APBI) differs from WB-EBRT in two ways. First, the radiation targets only a segment surrounding the tumor rather than the entire breast. Second, since the duration of treatment is four to five days rather than five to six weeks, radiation is delivered in fewer fractions at larger doses per fraction. APBI comprises several techniques, including interstitial brachytherapy via catheters, the MammoSite radiation treatment system, accelerated external beam radiotherapy, and intra-operative radiotherapy delivery.

When compared with whole breast irradiation, APBI offers the potential advantages of convenience and decreases radiation dose to healthy breast tissue. However, published studies are limited in patient size and follow-up period. Given access to care issues, a local coverage determination (LCD) has been developed to define the indications and limitations of coverage, establish a procedure to diagnosis relationship, and clarify the appropriate use of APBI after breast-conserving surgery for early stage breast cancer. In addition, a coding guideline has also been developed to assist in billing this type of service.

APBI after breast-conserving surgery is considered medically necessary for patients with early stage breast cancer when all of the following criteria are met:

- **Age:** >50 years old
- **Diagnosis:** Invasive ductal carcinoma or ductal carcinoma in situ
- **Size:** Less than or equal to 3 cm.
- **Margin status:** Negative – at least 2 mm in all directions
- **Nodal status:** Negative axillary lymph node dissection or sentinel lymph node evaluation

**Effective Date**

This LCD is effective for services provided on or after January 1, 2005. The full-text for this LCD (L18914) may be viewed through the provider education website http://www.floridamedicare.com on or after this effective date. ♦
Revision for Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

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

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for services related to blood clotting factor administered to hemophilia inpatients.

Provider Action Needed

This article is based on change request (CR) 4311, which includes new “J” codes for hemophilia clotting factors. Effective for dates of service on or after January 1, 2006, old “Q” codes (Q0187 and Q2022) are replaced with new “J” codes (J7189 and J7188) respectively.

Background

Change request (CR) 4311 notifies providers that two Healthcare Common Procedure Coding System (HCPCS) “Q” codes are being replaced with two HCPCS “J” codes for blood clotting factor administered to hemophilia inpatients.

The following table lists the two discontinued “Q” codes and the two new replacement “J” codes.

<table>
<thead>
<tr>
<th>Discontinued “Q” Code</th>
<th>Descriptor</th>
<th>Replacement “J” Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q0187</td>
<td>Factor VIIa (antihemophilic Factor, recombinant)</td>
<td>J7189</td>
</tr>
<tr>
<td>Q2022</td>
<td>Von Willebrand factor complex</td>
<td>J7188</td>
</tr>
</tbody>
</table>

Note: The discontinued “Q” codes (Q0187 and Q2022) can no longer be used after December 31, and effective January 1, 2006, the discontinued “Q” codes will no longer be viable codes.

Implementation

The implementation date for the instruction is March 6, 2006. Because the implementation date is later than the effective date, your intermediary will instruct you on how and when to resubmit claims for dates of service between January 1 and March 5, 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/R203OTN.pdf.

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

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

MLN Matters Number: MM4311
Related Change Request (CR) Number: 4311
Related CR Release Date: February 1, 2006
Related CR Transmittal Number: R203OTN
Effective Date: January 1, 2006
Implementation Date: March 6, 2006
Source: CMS Pub. 100-20, Transmittal 203, CR 4311

New HCPCS Codes for Reporting Hemophilia Clotting Factor Services

Effective March 6, 2006, providers may bill for hemophilia-clotting factor administered to hemophilia inpatients with dates of service on or after January 1, 2006, by reporting the following new HCPCS J codes:

- J7188 Injection, Von Willebrand factor complex, human IU
- J7189 Factor VIIa (antihemophilic Factor, recombinant), per 1 mcg

HCPCS codes J7189 and J7188 replace previous HCPCS “Q” codes. HCPCS codes Q0187 and Q2022 have been discontinued for services provided after December 31, 2005.

Source: CMS Pub. 100-20, Transmittal 203, CR 4311
Submission of Hemophilia Clotting Factor Claims

The Centers for Medicare & Medicaid Services (CMS) has rescinded the temporary billing guidelines for submission of inpatient claims for hemophilia-clotting factor services. CMS has advised fiscal intermediaries to stop the previously established workaround for handling hemophilia-clotting factor charges. Reason code 31591 has been set to return to providers inpatient claims billed with a hemophilia-clotting factor procedure code and no coverable diagnosis. Any current adjustment for hemophilia-clotting factor services held under reason code 31591 in status location SMSPR6 will be returned to the provider for corrections. These guidelines supersede the previous billing instructions published in the January 2006 Medicare A Bulletin (page 69) and posted to our provider education website (http://www.floridamedicare.com) on December 8, 2005.

Action Required by Providers

Hospitals need to revert back to their original billing practice for these services.

Source: CMS Joint Signature Memorandum 06346, April 5, 2006

Prospsective Payment System Payment for Blood Clotting Factors Administered to Hemophilia Inpatients

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

Provider Types Affected

Providers billing fiscal intermediaries (FIs) for services related to blood clotting factors administered to hemophilia inpatients.

Provider Action Needed

This article is based on change request (CR) 4229, which clarifies the pricing methodologies used for blood clotting factors. It is especially important to point out that the provider determines the dosage furnished to the patient and, using the definition of the appropriate HCPCS code, translates the dosage into Units of Services on the claim submitted to Medicare.

Background

The Centers for Medicare & Medicaid Services (CMS) provided CR 4229 to clarify billing practices for providers to ensure that units of service for blood clotting factor are reported accurately. Some Medicare providers have been billing units of drugs and biologicals incorrectly on outpatient bills as well as on inpatient claims for hemophilia clotting factors. The erroneous reporting of units of service has resulted in Medicare overpayments.

The provider must determine the actual dosage furnished to the patient and, using the long version of the description of the HCPCS code, translate the dosage into UNITS OF SERVICE. Note: Not all short version descriptions of HCPCS codes define units for the HCPCS code.

The examples below include the Healthcare Common Procedure Coding System (HCPCS) code, and indicate the dosage amount specified in the descriptor of that HCPCS code. Facilities are instructed to use the units field as a multiplier to arrive at the dosage amount.

Example 1

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Drug</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9355</td>
<td>Trastuzumab</td>
<td>10 mg</td>
</tr>
</tbody>
</table>

Actual dosage: 140 mg

On the bill, the facility shows HCPCS Code J9355 and 14 in the units of service field (140 mg divided by 10 mg equals 14).

Example 2

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Drug</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3100</td>
<td>Tenecteplase</td>
<td>50 mg</td>
</tr>
</tbody>
</table>

Actual Dosage: 40 mg

The provider would bill for one unit, even though less than one full unit was furnished (40 mg divided by 50 mg equals 0.8).

Example 3

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Drug</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9255</td>
<td>Paclitaxel</td>
<td>30 mg</td>
</tr>
</tbody>
</table>

Actual Dosage: 175 mg

The provider would bill for six units, even though less than six full units were furnished (175 mg divided by 30 mg equals 5.83).

At times, a facility provides less than the amount provided in a single use vial and there is waste, i.e., some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital’s pharmacy, it may have a limited shelf life.

Since an individual patient may receive less than the fully reconstituted amount, CMS encourages hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded plus with the amount administered, as illustrated in examples 4 and 5.

Example 4

Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore:
PPS Payment for Blood Clotting Factors Administered to Hemophilia Inpatients (continued)

- **30 units** are billed on behalf of the first patient seen
- **30 units** are billed on behalf of the second patient seen
- **40 units** are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

**Example 5**

**Drug X** is available only in a 100-unit size. An appropriate hospital staff member must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug.

For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient’s condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

**Additional Requirements**

CR 4229 further instructs your intermediary to:

- Calculate the payment amount and subtract the charge from those submitted to PRICER so that the clotting factor charges are not included in cost outlier computations.
- Use the blood-clotting factors HCPCS codes from the Medicare Part B drug pricing file, which is made available on a quarterly basis.
- Use the average sales price (ASP) plus six percent to make payment to facilities that are not paid on cost or prospective payment system (PPS).
- Pay a covered for hemophilia clotting factors during a covered part A stay in a PPS hospital at ASP plus six percent in addition to the diagnosis related group (DRG) payment.
- Pay the ambulatory patient classification (APC) rate to outpatient prospective payment system (OPPS)

**Inpatient Prospective Payment System Proposed Rulemaking**

The Centers for Medicare & Medicaid Services (CMS) has issued a notice of proposed rulemaking that would begin the transition to the first significant revision of the inpatient prospective payment system (IPPS) since its implementation in 1983. When fully implemented, which is planned to occur by fiscal year (FY) 2008 and potentially earlier, the revised IPPS would improve the accuracy of payment rates for inpatient stays by basing the weights assigned to diagnosis related groups (DRGs) on hospital costs rather than charges, and adjusting the DRGs for patient severity.


Source: CMS Provider Education Resources Listserv, Message 200604-06

**Update Versions to the Intern and Resident Information System Programs**

The Centers for Medicare & Medicaid Services (CMS) Office of Financial Management has posted two IRIS (intern and resident information system) programs (version 3.1 of IRISV3 and version 1.1 of IRISEDV3) with updated files (medical school codes, residency type codes, and IRISV3 operating instructions) to the CMS website for downloading by Medicare providers. The Web page address for downloading these programs is: [http://www.cms.hhs.gov/IRIS](http://www.cms.hhs.gov/IRIS)

Teaching hospitals and the provider community may use these programs for collecting and reporting information on resident training in hospital and non-hospital settings.

Source: CMS Joint Signature Memorandum 06380, March 29, 2006
Provider Types Affected

Hospitals that submit claims for take-home oral anti-cancer drugs, take-home oral anti-emetic drugs, and immunosuppressive drugs not included in a procedure performed in the hospital.

Provider Action Needed

For oral anti-cancer, oral anti-emetic, and immunosuppressive, take home drug claims that cover more than a single day’s supply hospitals, including critical access hospitals (CAHs), must:

- Bill multi-day supplies of take home oral anti-cancer, oral anti-emetic, and immunosuppressive drugs to the appropriate durable medical equipment regional carrier (DMERC).
- Bill their fiscal intermediary (FI) for outpatient services when the service includes an oral anti-cancer drug, oral anti-emetic drug or immunosuppressive drug, so long as no more than one day’s drug supply (i.e. only today’s) is given to the beneficiary, and the beneficiary receives additional services.
- Bill the associated supplying and dispensing fees on the same claim as the drug. Claims for a supplying fee or a dispensing fee not billed on the same claim as the drug that was supplied or dispensed will be denied.
- Bill all take-home inhalation drugs to the appropriate DMERC, unless the drug is an integral part of a hospital procedure (inpatient or outpatient).

The appropriate DMERC for claim filing is the DMERC having jurisdiction for the region in which the beneficiary resides. Hard copy claims submitted to an improper jurisdiction, i.e., to a DMERC other than the region in which the beneficiary resides, will be denied. Electronic claims that are sent to the wrong DMERC will be redirected to the correct DMERC.

Please also note that:

- Immunosuppressive drugs and supplying fees provided by a dialysis facility in the state of Washington are paid by the FI.
- When a beneficiary in a hospital or skilled nursing facility (SNF) noncovered stay, or a hospital/SNF inpatient that has exhausted benefits (type of bill (TOBs) 12x or 22x, respectively) is given a covered oral anti-cancer or antiemietic drug, or a covered immunosuppressive drug, the hospital or SNF should bill its regular FI.
- Payment to hospitals is dependent on the applicable payment mechanism for the type of hospital (reasonable cost for Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA) hospitals and CAHs, and ambulatory payment classifications (APCs) for hospitals subject to the hospital outpatient prospective payment system (OPPS).

Background

This article is related to CR 4301. It clarifies and provides new instructions for hospitals about billing the appropriate DMERC for take-home oral anti-cancer drugs, take-home oral anti-emetic drugs, and immunosuppressive drugs (as well as the associated supplying fees), not included in a procedure performed in the hospital.

It is effective July 1, 2006, for claims from hospitals. Chapter 17, Drugs and Biologicals (Sections 80.2.2 and 90.4) of the Medicare Claims Processing Manual, was updated to reflect these changes. The article also relates to CR 2488 program memorandum (PM) Transmittal A-02-123, dated December 13, 2002, which instructed hospitals to bill the appropriate DMERC for immunosuppressive drugs and supplying fees furnished to transplant patients.


Take-Home Drugs versus Drugs Provided to Hospital Inpatients and Outpatients

To separate take-home drugs covered under Part B from drugs provided to hospital inpatients and outpatients, and to permit appropriate payment for drugs included in hospital procedures, the Centers for Medicare & Medicaid Services (CMS) is requiring all hospitals to bill the appropriate DMERC for certain take home drugs.

When hospitals dispense drugs to Medicare beneficiaries for take-home use, they are functioning as retail pharmacies and billing should be as a retail pharmacy, using the national drug code (NDC) number of the drug and the National Council for Prescription Drug Programs (NCPDP) electronic format.

There is a supplying fee associated with these drugs. However, only the DMERC will pay this fee to a hospital outpatient department. Claims billed to the local FI for outpatients will not be paid the supplying fee. The only way a hospital can receive the supplying fee is to bill the appropriate DMERC for the supplying fee and the drug and, if applicable, any administration fee.

Hospitals must bill the appropriate DMERC for the take-home drugs specified in CR 4301 (e.g., multi-day supplies of oral anti-cancer drugs, oral anti-emetic drugs and immunosuppressive drugs, as well as their associated supplying fees).

Suppling fees must be billed on the same claim as the drug.

Additional Information

Supplier Number

Hospitals that do not have a supplier number for billing the DMERC, should complete a form CMS-855S and obtain a supplier number from the National Supplier Clearinghouse (NSC).

There are two ways to obtain a supplier number from the NSC:

- Hospitals can call the NSC directly at 1-866-238-9652, and request an application form. The NSC will send them a CMS-855-S. Once the hospital has completed the CMS-855-S, it should be submitted as soon as possible to the NSC at the address indicated on the form.
Hospital Billing for Take-Home Drugs (continued)

- Alternatively, hospitals may go to http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_overview.asp on the CMS website and download the CMS-855-S in Adobe Acrobat format. The application can be completed as a hard copy, and submitted to the NSC.

Once a hospital has its supplier number, the hospital can proceed to bill the appropriate DMERC using the National Council for Prescription Drug Programs (NCPDP) – Telecommunication Version 5.1 and Batch Standard 1.1 – Retail Pharmacy Claims.

This is the Health Insurance Portability & Accountability Act of 1996 (HIPAA) approved telecommunication format for billing drugs. Alternatively, in exceptional circumstances, a hard copy CMS-1500 may be used.

In both cases, the actual drug must be listed by National Drug Code (NDC) and the claim must show the units given to the beneficiary. The DMERC will provide specific instructions to hospitals on billing requirements.

Relevant Links

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.

Changes in Transitional Outpatient Payments for Rural Sole Community Hospitals and Small Rural Hospitals for 2006

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

Provider Types Affected
Providers (hospitals) billing Medicare fiscal intermediaries (FIs).

Provider Action Needed
STOP – Impact to You
This article is based on change request (CR) 4367, which provides details on the changes in transitional outpatient payments (TOPs) for rural sole community hospitals (SCHs) and small rural hospitals for 2006.

CAUTION – What You Need to Know
In accordance with the provisions of the Deficit Reduction Act (DRA), hold harmless TOPs will continue for services rendered through December 31, 2008, for rural hospitals having 100 or fewer beds that are not SCHs.

GO – What You Need to Do
See the Background section of this article for further details regarding TOPs and interim TOPs for 2006.

Background

CR 4301 is the official instruction issued to your FI or DMERC, regarding the changes mentioned in this article. CR 4301 may be found by going to the CMS website http://www.cms.hhs.gov/Transmittals/downloads/R882CP.pdf.

The revised portions on the Medicare Claims Processing Manual, which provide full details of these changes, are attached to CR 4301.

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

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

MLN Matters Number: MM4301
Related Change Request (CR) Number: 4301
Related CR Release Date: March 3, 2006
Related CR Transmittal Number: R882CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006
Source: CMS Pub. 100-04, Transmittal 882, CR 4301

The MMA (Section 411) also provided that the hold harmless transitional corridor payments apply through December 31, 2005 to sole community hospitals (SCH) located in rural areas. The hold harmless provisions for both of these hospitals expired December 31, 2005. The MMA, Section 5105, reinstated the hold harmless transitional outpatient payments (TOPs) through December 31, 2008, for rural hospitals having 100 or fewer beds that are not SCHs.

Note: Hold harmless transitional outpatient payments (TOPs) will continue for services rendered through December 31, 2008, for rural hospitals having 100 or fewer beds that are not SCHs.

Interim TOP Payments
The interim TOP payments for these hospitals will continue to be calculated as 85 percent of the hold harmless amount, that is:

- TOP = 0.85 x (hold harmless amount)

The hold harmless amount is the amount by which the provider’s charges times the cost-to-charge ratio (CCR), times the payment-to-cost ratio (PCR) exceeds the provider’s OPPS payments. Therefore, the payment calculation is as follows:
Changes in TOP for Rural Sole Community Hospitals and Small Rural Hospitals for 2006 (continued)

• TOP = 0.85 x [( (provider’s charges x CCR x PCR) – provider’s OPPS payments)]

Definition of Sole Community Hospitals (SCH) in Rural Areas
For purposes of receiving TOPs and interim TOPs, a hospital will be treated as an SCH located in a rural area if the hospital qualifies as both:
• A rural hospital having 100 or fewer beds; and
• A sole community hospital (SCH) located in a rural area.

Note: These hospitals are not eligible for TOPs for services furnished on or after January 1, 2006.

For purposes of TOPs, a hospital is considered rural if it is either:
• Geographically rural; or
• Classified as rural for wage index purposes.

For example, for purposes of TOPs:
• A hospital that is geographically rural is always considered rural, even if it is reclassified to urban for wage index purposes; or
• If a hospital is urban, but reclassified to rural for the wage index, it is considered rural.

Note: Your FI will use the inpatient provider specific file (IPSF) to determine if a hospital is rural.

CMS is also instructing your FI to ensure that all qualified rural hospitals have:
• A PCR and CCR entered in their Outpatient Provider Specific File (OPSF)
• Receive interim TOPs payments.

Appropriate interim TOPs payments will be made retroactive to January 1, 2006.

Implementation
The implementation date for CR4367 is March 6, 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/R877CP.pdf.

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

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

MLN Matters Number: MM4367
Related Change Request (CR) Number: 4367
Related CR Release Date: February 24, 2006
Effective Date: January 1, 2006
Related CR Transmittal Number: R877CP
Implementation Date: March 6, 2006
Source: CMS Pub. 100-04, Transmittal 877, CR 4367

Notification Procedures for Hospital Discharges
On April 5, 2006 the Centers for Medicare & Medicaid Services (CMS) published a notice of proposed rulemaking (NPRM), CMS-4105-P, Notification Procedures for Hospital Discharges. This rule proposes to revise the discharge notice requirements in the inpatient hospital setting by establishing a simple, standardized notice for all hospital discharges, both for original Medicare and Medicare Advantage (MA) patients. A more detailed notice would be required only in situations where a patient wishes to dispute the hospital’s discharge decision and contacts the quality improvement organization (QIO) to initiate an appeal.

This proposed process largely parallels the process applicable to other Medicare providers, such as home health agencies (HHAs) and skilled nursing facilities (SNFs) in both original Medicare and Medicare Advantage. These proposed regulations stem from the settlement agreement associated with the Weichardt vs. Leavitt lawsuit. CMS welcomes comments and suggestions related to the proposed process and all aspects of the hospital discharge notice process.

The proposed regulation, CMS-4105-P may be viewed at http://www.gpoaccess.gov/fr/index.html, search on “page 17052”.

There is a 60-day comment period. Comments should be submitted according to the instructions in the regulation.

The announcement regarding the proposed notices (CMS10066) associated with this regulation was also published on April 5 and may be found at http://www.gpoaccess.gov/fr/index.html, search on “page 17104”, under the heading “Agency information collection activities; proposals, submissions and approvals.”

The notices and associated Paperwork Reduction Act documents can be found on CMS’ website at http://www.cms.hhs.gov/PaperworkReductionActof1995/, click on “PRA listing” on the left side of the page and search for “10066”. Comments on these notices should be submitted according to the instructions in the Federal Register Notice.

To be assured consideration, comments and recommendations for the proposed regulation and notices must be received no later than 5 p.m. on June 5, 2006.

Source: Provider Education Resources Listserv, Message 200604-04

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Payment of Same Day Transfer Claims Under the Inpatient Psychiatric Facility Prospective Payment System

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

Provider Types Affected

Inpatient psychiatric facilities billing Medicare fiscal intermediaries (FIs) for services paid under the inpatient psychiatric facility prospective payment system (IPF PPS).

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4264, which includes general policy and billing information to address questions on the IPF PPS.

CAUTION – What You Need to Know

CR 4264 clarifies aspects of the IPF PPS including: payment of same day transfers, calculating the TEFRA limit for IPFs located in critical access hospitals (CAHs) for FYs 1999 through 2002 and the comorbidity category for chronic obstructive pulmonary disease.

GO – What You Need to Do

See the Background section of this article for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) released CR 4264 to clarify issues related to processing claims and address questions on the IPF PPS, and CR4264 includes the following sections:

- Same Day Transfers
- Tax Equity and Fiscal Responsibility Act (TEFRA)
- Comorbidity Category.

Same Day Transfers

A same day transfer occurs when a patient is admitted to an IPF and is subsequently transferred for acute care (or another type facility care) on the same day.

If the patient is admitted to an IPF with the expectation that the patient will remain overnight, but is discharged before midnight, the day is counted as a total day – that is, a cost report day but not a Medicare covered day.

Currently, same-day transfer claims are suspending in the Medicare claims processing system because the IPF PPS PRICER is not programmed to accommodate zero covered days, and there is no transfer policy under IPF PPS.

This day will be considered covered and counted for cost reporting purposes, but will not be counted as a Medicare utilization day for the beneficiary.

Note: Same day transfer IPF PPS claims suspended in FI systems since January 1, 2005 are to be reviewed and will be paid a one day per diem stay according to the payment rules governing IPF PPS, and interest is to be applied.

Tax Equity and Fiscal Responsibility Act (TEFRA)

Limit for IPFs Located in CAHs for FY 1999 through FY 2002

The IPF PPS final rule stated that if the provider ever had a TEFRA limit, the provider would not be a new provider under the IPF PPS, and CMS would use their TEFRA limit updated to current times. This included those providers that previously closed their psychiatric units and then re-opened.

- The rate-of-increase percentage for excluded hospitals and units (42CRF413.40(c), http://www.gpoaccess.gov/cfr/retrieve.html) as is follows:

  - For the cost reporting period beginning FY 1999 through FY 2002, the applicable rate-of-increase percentage is the market basket increase percentage minus a factor based on the percentage by which the hospital’s operating costs exceed the hospital’s ceiling for the most recently available cost reporting period.

- In order to update the TEFRA limit to current times, the provider needs to have had a psychiatric unit in existence during FY 1999 – FY 2002

- To update the TEFRA limit when the psychiatric unit was closed for FY 1999 through FY 2002 and then re-opened, the rate-of-increase for these years would ordinarily be based on a comparison of the hospital or unit’s operating costs to TEFRA limits over that period of time. However, since CAHs were statutorily precluded from having a distinct part psychiatric unit during those years, these units have no operating costs to compare to the TEFRA limit

- If a CAH reopens its psychiatric unit, the rate of increase updates for FY 1999 through FY 2002 would be the full market basket up to the cap on the target amounts under 42CFR413.40(c) for each year. In other words, use the full rate of increase to update the original TEFRA rate per discharge. You can find 42CFR413.40(c) at the following GPO website: http://www.gpoaccess.gov/cfr/retrieve.html.

Chronic Obstructive Pulmonary Disease Comorbidity Category

The IPF PRICER has not yet been updated with the expanded list of ICD-9-CM diagnosis codes (V46.13 and V46.14) that are related to V46.11 and V46.12.

These new codes were effective for discharges on or after October 1, 2005. The revised IPF PRICER will be implemented with the new codes on April 3, 2006. The new codes are:

- V46.13 (Encounter for weaning from respirator [ventilator])
- V46.14 (Mechanical complication of respirator [ventilator]).

The IPF PPS allows for a comorbidity adjustment for certain comorbid conditions, and there are 17 comorbidity groupings as shown in the table at the end of this article. IPFs may be paid multiple comorbidity adjustments, but only one adjustment is allowed per category. The comorbidity category chronic obstructive pulmonary disease has an adjustment factor of 1.12.

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Payment of Same Day Transfer Claims Under the Inpatient Psychiatric Facility PPS (continued)

Note: IPFs are instructed by CR 4264 to resubmit claims with discharges between October 1, 2005 and March 31, 2006, billed with one of the new codes (V46.13 or V46.14), so that the chronic obstructive pulmonary disease comorbidity adjustment factor of 1.12 can be applied. The claims should be resubmitted on or after April 1, 2006, so they will be processed with the revised PRICER.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R868CP.pdf.

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

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

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Source Admission Code ‘D’

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 claims involving inpatient transfers within the same facility.

Impact on Providers

STOP – Impact to You

This article is based on information from change request (CR) 3881 in which the Centers for Medicare & Medicaid Services (CMS) reported that it requested and received a new source of admission code “D.”

CAUTION – What You Need to Know

The new source admission code “D” is needed to specifically identify a source of admission from the same facility. This is especially important to inpatient psychiatric facilities (IPFs). The IPF prospective payment system (PPS) has an emergency department adjustment, but that adjustment is not applicable when the patient is transferred from acute care to an IPF unit in the same hospital and the admission code “D” will identify this situation.

GO – What You Need to Do

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

### Comorbidity Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities</td>
<td>1.04</td>
</tr>
<tr>
<td>Coagulation Factor Deficit</td>
<td>1.13</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>1.06</td>
</tr>
<tr>
<td>Eating and Conduct Disorders</td>
<td>1.12</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>1.07</td>
</tr>
<tr>
<td>Renal Failure, Acute</td>
<td>1.11</td>
</tr>
<tr>
<td>Renal Failure, Chronic</td>
<td>1.11</td>
</tr>
<tr>
<td>Oncology Treatment</td>
<td>1.07</td>
</tr>
<tr>
<td>Uncontrolled Diabetes Mellitus</td>
<td>1.05</td>
</tr>
<tr>
<td>Severe Protein Malnutrition</td>
<td>1.13</td>
</tr>
<tr>
<td>Drug/Alcohol Induced Mental Disorders</td>
<td>1.03</td>
</tr>
<tr>
<td>Cardiac Conditions</td>
<td>1.11</td>
</tr>
<tr>
<td>Gangrene</td>
<td>1.10</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>1.12</td>
</tr>
<tr>
<td>Artificial Openings – Digestive &amp; Urinary</td>
<td>1.08</td>
</tr>
<tr>
<td>Musculoskeletal and Connective Tissue Diseases</td>
<td>1.09</td>
</tr>
<tr>
<td>Poisoning</td>
<td>1.11</td>
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</table>

MLN Matters Number: MM4264
Related Change Request (CR) Number: 4264
Related CR Release Date: February 21, 2006
Effective Date: January 1, 2005
Related CR Transmittal Number: R868CP
Implementation Date: July 3, 2006
Source: CMS Pub. 100-04, Transmittal 868, CR 4264

Background

This article is based on information from CR 3881 which informs Medicare providers that CMS requested and received a new source of admission code from the National Uniform Billing Committee (NUBC) to define transfers from hospital inpatients in the same facility resulting in a separate claim to the payers.

The source of admission code is a required code for Medicare, and it indicates the source of this admission. CR 3881 instructs this new source of admission code to be used wherever it might apply, including transfers involving:

- Distinct part units in an acute care hospital (ACH)
- A unit in a critical access hospital (CAH), or
- A swing bed located in an ACH.

This new source admission code will have some specific consequences for inpatient psychiatric facilities (IPF). For instance, if an IPF has a dedicated emergency department, then the IPF PPS has a payment adjustment to the first day of an inpatient psychiatric stay. This is a facility level adjustment, not a patient level adjustment.

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**Source Admission Code ‘D’ (continued)**

**Note:** The payment adjustment is not to be applied if the patient is transferred from the acute area to the IPF in the same hospital because the costs for the emergency department are already considered in the DRG (diagnosis related group) payment to the acute hospital.

CMS is currently basing decisions on a source of admission code “4” (CMS originally thought the policy applied for any transfer from acute) and code “4” is too broad for this scenario. As a result, CMS will use source of admission code “D” to determine a transfer within a facility.

The following table describes source of admission codes “4” and “D”:

<table>
<thead>
<tr>
<th>Source of Admission</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>“4”</td>
<td></td>
<td>Transfer from a hospital (different facility)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inpatient:</strong> The patient was admitted to this facility as a hospital transfer from a different acute care facility where he/she was an inpatient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Outpatient:</strong> The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) a different acute care facility.</td>
</tr>
<tr>
<td>“D”</td>
<td></td>
<td>Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer.</td>
</tr>
</tbody>
</table>

**Summary**

In summary, CR 3881 provides the following specific instructions for providers and their intermediaries:

- IPF PPS providers should review all claims submitted with source of admission code “4.”
- IPFs should adjust claims submitted with source of admission code “4” that should be coded with the new source of admission code “D.” Payment will remain the same.
- IPFs should resubmit their claims coded correctly with source of admission code “4” that were paid incorrectly (i.e., not given the emergency room adjustment when facility has an emergency department).

**Implementation**

The implementation date for CR 3881 is April 3, 2006.

**Additional Information**

The official instruction issued to your FI, CR 3881, may be viewed on the CMS web site at [http://www.cms.hhs.gov/Transmittals/downloads/R718CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R718CP.pdf). If you have questions, please contact your Medicare intermediary at their toll-free number, which may be found on the CMS web site at [http://www.cms.hhs.gov/apps/contacts/](http://www.cms.hhs.gov/apps/contacts/).

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

MLN Matters Number: MM3881
Related Change Request (CR) Number: 3881
Related CR Release Date: October 21, 2005
Related CR Transmittal Number: R718CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 718, CR 3881

**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 content.

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**Clarification of Payment Policy When Inpatient Admission Is Determined not To Be Medically Necessary, Including the Use of Condition Code 44**

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

**Introduction**

Following issuance of transmittal 299 (change request 3444) on September 10, 2004, the Centers for Medicare & Medicaid Services (CMS) received numerous questions and requests for clarification. This special edition article and the Q & As that follow are intended to address those questions and provide clarification of Medicare policy related to inpatient admissions that are determined not to be medically necessary, as well as Medicare policy related to changing a beneficiary status from inpatient to outpatient, and how the two policies interface.

**Provider Types Affected**

Hospitals, including those for which payment for Medicare Part B services is made under the hospital outpatient prospective payment system (OPPS), as well as hospitals that are not subject to the OPPS for which payment for outpatient services is made under other payment methodologies

**Provider Action Needed**

Be sure to understand Medicare rules and policy when utilization review (UR) determines that an inpatient admission is not medically necessary or when a hospital should report condition code 44 in form locator (FL) 24-30, or its electronic equivalent, on outpatient claims (type of bill 13x, 85x) to signal a change in patient status from inpatient to outpatient.
Clarification of Payment Policy When Inpatient Admission Is Determined not To Be Medically Necessary... (continued)

Background

Hospital Conditions of Participation

The hospital conditions of participation (CoPs) require all hospitals to have an UR plan. A hospital must ensure that all the UR requirements of 42 CFR 482.30 are fulfilled. These requirements can be fulfilled by the hospital directly through its policies, procedures, and UR committee. Alternatively, the hospital may fulfill these UR requirements (including the UR committee’s functions and responsibilities) through a quality improvement organization (QIO) that has assumed binding review. However, in either case the hospital is responsible to ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stay are fulfilled as described in 42 CFR 482.30. Specifically:

- An UR committee consisting of two or more practitioners must carry out the UR function. At least two members of a hospital’s UR committee must be doctors of medicine or osteopathy, and the other members may be any of the other types of practitioners specified in regulation.

- The determination that an admission or continued stay is not medically necessary must either be made by (i) one member of the UR committee if the practitioner(s) responsible for the care of the patient either concurs with the determination or fails to present their views when afforded the opportunity, or (ii) two members of the UR committee in all other cases.

- The UR committee must consult with the practitioner(s) responsible for the care of the patient and allow them to present their views before making the determination.

- If the UR committee determines that the admission is not medically necessary, the committee must give written notification, no later than two days after the determination, to the hospital, the patient, and the practitioner responsible for the care of the patient.

Review of admissions may be performed before, at, or after hospital admission.

Note: Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. “Outpatient” means a person who has not been admitted as an inpatient but who is registered on the hospital records as an outpatient and receives services (rather than supplies alone) directly from the hospital.

The Use of Condition Code 44

In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon subsequent review, it is determined that an inpatient level of care does not meet the hospital’s admission criteria. The National Uniform Billing Committee (NUBC) issued condition code 44, effective April 1, 2004, to identify cases when this occurs. The definition of condition code 44 is as follows:

- Condition code 44 – Inpatient admission changed to outpatient

For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria.

CMS issued transmittal 299 (change request 3444) on September 10, 2004, to implement new section 50.3 in Chapter 1 of the Medicare Claims Processing Manual. Section 50.3 describes when and how a hospital may change a patient’s status from inpatient to outpatient as well as the appropriate use of condition code 44.

In cases where a beneficiary’s status is changed from inpatient to outpatient subsequent to UR determination that the inpatient admission does not meet the hospital’s inpatient criteria, the hospital may submit an outpatient claim (type of bills 13x, 85x) to receive payment for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital.

- The hospital has not submitted a claim to Medicare for the inpatient admission.

- A physician concurs with the utilization review committee’s decision.

- The physician’s concurrence is documented in the patient’s medical record.

Questions and Answers (Q & As)

Q1. Isn’t there a conflict between condition code 44 policy and the standards included in the hospital condition of participation related to review of admissions for medical necessity?

A1. No. The CoP standards in section 482.30 of the regulations are comprehensive and broadly applicable with regard to the medical necessity of admissions to the hospital. CMS set the policy for the use of condition code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances. For such cases, prior to implementation of condition code 44, a hospital could only receive payment for certain nonphysician medical and other health services payable under Part B that were furnished either directly or indirectly to an inpatient for which payment could not be made under Part A. Condition code 44 allows hospitals to treat the entire episode of care as an outpatient encounter, to report as outpatient services whatever services are furnished, and to receive payment under the outpatient prospective payment system as though the patient had been registered as an outpatient.
 Clarification of Payment Policy When Inpatient Admission Is Determined not To Be Medically Necessary... (continued)

Q2. If the hospital complies with the requirement for written notification within two days of the determination, can it still bill for the encounter as an outpatient episode of care and use condition code 44?
A2. Yes, as long as the patient has not yet been released from the hospital, and provided that the other prerequisites for use of condition code 44 are met.

Q3. Can a case manager or utilization management staff member change a patient's status from inpatient to outpatient after determining that the hospital's admission criteria were not met?
A3. CMS has received many questions regarding who may make the status change, and requests for clarification as to whether utilization management staff or a case manager may implement the change. The CoP in section 482.30 of the regulations requires that the utilization review committee be comprised of at least two doctors of medicine or doctors of osteopathy, although it may include other specified practitioners. The CoP provides that the determination concerning the medical necessity of an admission or continued stay must be made by members of the UR committee (or QIO) in consultation with the practitioner(s) responsible for the care of the patient. The CoP in section 482.12(c) provides that patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. If a practitioner not specified in Medicare regulations admits a Medicare patient, the patient must be under the care of a doctor of medicine or osteopathy. Therefore, a case manager or other utilization management staff person who is not a licensed practitioner permitted by the state to admit patients to a hospital or a doctor of medicine or osteopathy would not have the authority to change a patient’s status from inpatient to outpatient. However, we encourage and expect hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or QIO, and to assist the UR committee in the decision making process. Use of condition code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report condition code 44 should become increasingly rare.

Q4. Is the concurrence of any physician or practitioner acceptable when a hospital has determined that a patient's status should be changed from inpatient to outpatient?
A4. One of the requirements for the use of condition code 44 is physician concurrence with the determination that an inpatient admission does not meet the hospital’s admission criteria and that the patient should have been registered as an outpatient. The practitioner(s) responsible for the care of the patient must concur with the hospital’s finding that inpatient admission criteria are not met. This prerequisite for use of condition code 44 is consistent with the requirements in the CoP at section 482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

Q5. How does a hospital bill using condition code 44?
A5. When the hospital has determined that it may submit an outpatient claim according to the conditions applicable to the use of condition code 44, the hospital should report the entire episode of care as an outpatient encounter, as though the inpatient admission never occurred. When a hospital submits a type of bill 13x or 85x for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital must report condition code 44 in one of form locators 24-30, or in the ANSI X12N 837 I in loop 2300, HI segment, with qualifier BG, on the outpatient claim. Condition code 44 will be used by CMS and QIOs to track and monitor these occurrences.

Q6. How should the hospital bill Medicare if the criteria for using condition code 44 are not met, but all requirements in the condition of participation in section 482.30 have been complied with?
A6. If the conditions for use of condition code 44 are not met, the hospital should submit a bill using type of bill 12x for covered Part B only services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about Part B only services is located in the Medicare Benefit Policy Manual (Chapter 6, Section 10). Examples of such services include, but are not limited to, diagnostic X-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and other services. The Medicare Benefit Policy Manual includes a complete list of the payable Part B only services.

Q7. How should the change in patient status from inpatient to outpatient be reported in the patient's medical record? Can the hospital just discard the inpatient record?
A7. Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient’s status changes in accordance with the requirements for use of condition...
Clarification of Payment Policy When Inpatient Admission Is Determined not To Be Medically Necessary... (continued)

code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient’s status.

Q8. Why has CMS required that the patient still be in the hospital when his or her status is changed from that of an inpatient to outpatient? Most hospitals have agreements with QIOs for UR, and determinations about medically unnecessary admissions can be decided days or weeks after the patient leaves the hospital.

A8. The patient rights CoP in section 482.13 of the regulations require a hospital to protect and promote each patient’s rights. Medicare beneficiaries have the right to participate in treatment decisions and to know their treatment choices. Beneficiaries are also entitled to receive information about co-insurance and deductibles. CMS has a duty to protect these rights. Requiring that the decision resulting in a change in patient status be made before the beneficiary is discharged is intended to ensure that the patient is fully informed about the change in status and its impact on the co-insurance and deductible for which the beneficiary would be responsible. For example, if a patient has already met her Part A deductible, informing the beneficiary a month after discharge that she will now be responsible for additional coinsurance as an outpatient could impose a financial hardship. Additionally, the hospital is responsible to ensure that when there is a question regarding the medical necessity of an inpatient admission that the required UR review of that patient’s status is conducted as stated in 42 CFR 482.30. The UR committee’s responsibilities and functions may be conducted by the hospital’s QIO that has assumed binding UR review. However, the hospital is responsible to have either an UR committee or have a QIO that carries out the UR activities as described in 42 CFR 482.30, including the review for medical necessity of an inpatient admission and continued stay.

Q9. HIPAA establishes NUBC as the keeper of the Claim Form UB-92 condition codes. How can CMS place extra requirements on the use of the code? Doesn’t this violate HIPAA?

A9. No, this does not violate HIPAA. CMS has established conditions when this code may be used for payment purposes under Medicare. The CMS policy neither modifies nor contradicts the code descriptor published by NUBC. Instead, it sets additional payment conditions under Medicare. The HIPAA implementation guide is unaffected by payment policy decisions and the other insurers who use the UB-92 codes may continue to rely on the code as they otherwise would.

In another example, CMS and its contractors set payment policy related to CPT and HCPCS codes through national and local coverage determinations (NCDs and LCDs). These determinations include payment policy standards such as when, how, and by whom CPT and HCPCS codes may be used for a particular diagnosis or procedure. CMS pays only for services that meet the requirements of these coverage determinations.

Additional Information

The instructions provided in CR 3444 and the information in this article should be followed within the framework of an individual hospital’s existing policies and procedures and do not override or supersede other CMS policies or procedures on observation services, beneficiary financial liability protections, or other related policies.

If you have questions regarding this issuance, please contact your fiscal intermediary (FI) for additional guidance with regard to CR 3444.

For complete details, please see the official instruction issued to your FI regarding this change. That instruction for Condition Code 44 that affects the Medicare Claims Processing Manual may be found on the CMS website at http://www.cms.hhs.gov/transmittals/downloads/R299CP.pdf.

For details concerning the “Part B Only” rule, see the Medicare Benefit Policy Manual, Chapter 6, Section 10, on the CMS website at http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf.


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

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

MLN Matters Number: SE0622
Related Change Request (CR) Number: 3444
Related CR Release Date: September 10, 2004
Related CR Transmittal Number: R299CP
Effective Date: N/A
Implementation Date: N/A
Source: Special Edition MLN Matters Article SE0622

CMS Pub. 100-04, Transmittal 299, CR 3444

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Inpatient Admission Followed by Discharge/Death Prior to Room Assignment

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

Provider Types Affected

Providers billing fiscal intermediaries (FIs) for hospital room and board charges

Provider Action Needed

This article is based on change request (CR) 4202, which provides billing instructions when there is an inpatient admission and discharge or death prior to a room being assigned and/or occupied.

Background

The Centers for Medicare & Medicaid Services (CMS) is updating the policy for billing room and board charges prior to room assignment. The American Hospital Association (AHA) requested that CMS issue this clarification. CR 4202 revises the Medicare Claims Processing Manual (Publication 100-04, Chapter 3, Section 40.2.2) and directs that a patient of a hospital is considered an inpatient upon issuance of written doctors orders to that effect. If a patient either dies or is discharged prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim. Hospitals are not required to enter a room and board charge, but failure to do so may have a minimal impact on future DRG weight calculations.

CR 4202 instructs your intermediary to pay inpatient hospital claims with room and board charges for a patient who has either died or is discharged prior to being assigned and/or occupying a room, and not deny claims if the hospital does not submit a room and board charge for a patient who has either died or is discharged prior to being assigned and/or occupying a room.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R843CP.pdf.

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

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

MLN Matters Number: MM4202
Related Change Request (CR) Number: 4202
Related CR Release Date: February 9, 2006
Related CR Transmittal Number: R843CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006
Source: CMS Pub. 100-4, Transmittal 843, CR 4202

Do You Have Hospital Outpatient Coding Questions?

In a joint effort to improve billing and data quality, the American Hospital Association (AHA) and the Centers for Medicare & Medicaid Services (CMS) have joined together in establishing the AHA clearinghouse to handle coding questions on established Healthcare Common Procedure Coding System (HCPCS) usage. The American Health Information Management (AHIMA) will also provide input through the Editorial Advisory Board.

The clearinghouse will serve as a centralized point of contact to educate hospitals, policy makers and the public on HCPCS coding. Hospitals and health care professionals have experienced a growing need for greater consistency and improved understanding of HCPCS coding in the wake of implementation of prospective payment methods that utilize HCPCS coding for billing and payment purposes.

The AHA’s Central Office will handle the clearinghouse functions and provide open access to any person or organization that has questions regarding a subset of HCPCS coding, particularly hospitals and other health professionals who bill under the hospital outpatient prospective payment system (OPPS). Inquiries on the application of level I HCPCS codes (CPT-4) for physicians will be referred to the American Medical Association. Level II HCPCS codes related to durable medical equipment, prosthetics, orthotics, and other supplies should be referred to durable medical equipment regional carriers (DMERCs) or their successors, the DME Medicare administrative contractors (DME MACs).

HCPCS-related questions must be submitted in the approved form, which you can download from the AHA website at http://www.ahacentraloffice.org, and either faxed or mailed directly to the AHA Central Office. Be advised that it is difficult to provide coding responses to generic scenarios without specific information. Refer to the form for additional information that should be submitted with your coding question(s).

The mailing address and fax number for HCPCS-related questions are as follows:

Central Office on HCPCS
American Hospital Association
One North Franklin
Chicago, IL 60606
Fax: 312-422-4583

Coding question information is also available on the CMS website at http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp.

For general HCPCS information, go to CMS website at http://www.cms.hhs.gov/MedHCPCSGenInfo/.

Source: Provider Education Resources Listserv, Message 200602-04

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Payment for Emergency Medical Treatment and Labor Act (EMTALA)—
Mandated Screening and Stabilization Services

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this MLN Matters article to include Web addresses consistent with the new CMS site. This article was originally published in the First Quarter 2005 Medicare A Bulletin (page 42).

Provider Types Affected

Hospitals, including critical access hospitals (CAHs)

Provider Action Needed

Although voluntary, it is to the provider’s benefit to bill presenting symptoms or complaints in addition to the principal diagnosis. To ensure you are paid appropriately for your services, you may use form locator (FL) 76 of the UB-92 claim form to bill for the ICD-9-CM code that represents the patient’s reason for the visit.

Although only one diagnosis code for the reason for the visit may be recorded in FL 76, at the provider’s discretion additional diagnoses not inherent in the final diagnosis may be reported in FLs 68 through 75.

Providers may use these fields when billing for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with revenue codes 45x, 0516, or 0526 to ensure appropriate payment. We support hospitals’ efforts to educate physicians on documentation to support correct coding, and contractors should assist hospitals in providing this education when requested.

This instruction is pursuant to Section 1867 of the Social Security Act (EMTALA) for services provided on or after January 1, 2004.

Background

This instruction addresses implementation of provisions contained in the Medicare Modernization Act of 2003 (MMA) regarding payment for EMTALA-mandated screening and stabilization services.

The MMA (Section 944(a)) requires that determinations of whether items and services provided in emergency departments (EDs) are reasonable and necessary 1) be made on the basis of information available to the treating physician or practitioner at the time the item or service was ordered or furnished by the physician or practitioner, and 2) take into consideration the patient’s presenting symptoms or complaint, and not only on the patient’s principal diagnosis. The frequency with which a patient receives a service may not be considered.

To ensure that current local coverage determinations (LCDs)/local medical review policies (LMRPs) do not inappropriately deny ED claims, fiscal intermediaries (FIs) have been instructed as a result of the related change request to discontinue LCD/LMRP frequency edits for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with revenue codes 45x, 0516, or 0526 to ensure appropriate payment.

While the frequency with which a patient receives a service before and after admission may not be considered, medical review can be targeted at potentially aberrant ED billing, but decisions must be based on the information available to the ED physician, including the patient’s presenting conditions, as required by the MMA provision.

In the past some hospitals have been hesitant to submit the full array of diagnosis codes, believing they conflict with existing coverage policies. Consistent with the law, hospitals may now submit the codes related to the patient’s presenting symptoms or complaints. For further discussion of when a claim would be considered fraudulent, see the Medicare Program Integrity manual on the CMS website at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

In summary, providers should be aware that Medicare FIs will, as of the implementation date of the related instruction:

- Consider the diagnoses in FLs 76 and 68-75 for payment decisions and may target medical review at ED billing, when data indicates there may be a problem.
- Make decisions based on the information available to the ED physician or practitioner, including the patient’s presenting conditions, when performing medical review.
- Discontinue automated frequency edits resulting from LMRPs/LCDs with a 45x, 0516, or 0526 revenue code, or for items or services, including diagnostic tests, performed under EMTALA, to ensure that current LMRPs/LCDs do not inappropriately deny ED claims.
- Reopen claims for ED services provided on or after January 1, 2004 that were denied prior to the issuance of this instruction if the provider so requests.

Implementation

The implementation date for this instruction is November 22, 2004.

Additional Information

Hospitals should be aware that the Medicare Program Integrity Manual (Pub 100-08), Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 5.1.1 (Prepayment Edits), is being revised. The updated manual instructions are attached to the official instruction released to your intermediary. The updated manual instructions are attached to the official instruction released to your intermediary. You may view that instruction on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R86PI.pdf.

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

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

MLN Matters Number: MM3437 – Revised
Related Change Request (CR) Number: 3437
Related CR Release Date: October 22, 2004
Related CR Transmittal Number: R86PI
Effective Date: November 22, 2004
Implementation Date: November 22, 2004
Source: CMS Pub 100-8 Transmittal 86, CR 3437
CRITICAL ACCESS HOSPITAL SERVICES

Payment for Power Mobility Device Claims

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

Provider Types Affected

Physicians, providers, and nonphysician practitioners billing Medicare carriers, durable medical equipment regional carriers (DMERCs), regional home health intermediaries (RHHIs), and/or fiscal intermediaries (FIs) for power mobility devices (PMD) and services related to prescribing PMDs.

Important Points to Remember

Options for Submitting HCPCS code G0372 and Evaluation and Management (E/M) Codes

Providers billing a Medicare carrier have the following options for submitting HCPCS code G0372 and the E/M code during January 1, 2006, through March 31, 2006:

- Submit the G0372 code and E/M now on the same claim. Payment for these claims will be held through March 31, 2006.

- Hold all claims containing the G0372 code until after March 31, 2006.

- Submit the E/M service now and bill the G0372 code after March 31, 2006.

The E/M service will be paid now. Note that this is not intended to require that Medicare fiscal intermediaries or carriers split claims submitted with both the E/M and G0372 code. Rather, the physician/provider may choose to submit two separate claims for the individual services.

Providers submitting claims on or after April 1, 2006, must bill the E/M and the G0372 code on the same claim.

Critical access hospitals (CAHs) billing the FI under method II have the following options from January 1, 2006, through July 2, 2006, for submitting HCPCS code G0372 and the E/M code:

- Submit the G0372 and E/M now on the same claim. Payment for these claims will be held by the FI through July 2, 2006.

- Hold all claims containing the G0372 code until after July 2, 2006.

- Submit the E/M service now and bill the G0372 code after July 2, 2006.

The E/M service will be paid now. Note that this is not intended to require that Medicare fiscal intermediaries or carriers split claims submitted with both the E/M and G0372 code. Rather, the physician or treating practitioner must submit pertinent parts of the medical record.

Providers submitting claims on or after July 2, 2006, must bill the E/M and the G0372 code on the same claim.

Background

The Centers for Medicare & Medicaid Services (CMS) published an interim final rule on PMDs to conform its regulations to section 302(a)(2)(E)(iv) of the Medicare Modernization Act (MMA), which is codified at section 1834(a)(1)(E)(iv) of the Social Security Act (SSA). The effective date of the rule was October 25, 2005.

For PMDs, the MMA mandated that:

- A face-to-face examination of the individual be conducted by a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist; and

- That payment may not be made for a motorized or power wheelchair unless the physician or treating practitioner has written a prescription for the item.

By defining the practitioners allowed to conduct the face-to-face examination, it also effectively removed the current requirement that a beneficiary must be seen by a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology in order to get a power-operated vehicle (POV).

Submission of Medical Record and Prescription

Apart from the MMA requirements, the other key change made by this regulation is a requirement that the physician or treating practitioner must submit pertinent parts of the medical record (in lieu of the certificate of medical necessity [CMN]), along with the prescription, to the durable medical equipment (DME) supplier within 30 days of the face-to-face examination.

A separate add-on payment (an add-on payment to the office visit billed with HCPCS code G0372) was established by the rule to recognize the additional physician work and resources required for submitting pertinent parts of the medical record.

Payment for the history and physical examination is made through the appropriate E/M code along with the add-on payment (G0372), which goes to the local Medicare FI or carrier. The PMD claim will go to the DMERC.

Appropriations Act

Title II, Section 222, of the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2006 (H.R. 3010) (the Appropriations Act) was signed into law on December 30, 2005. It states, in part:

SEC. 222. None of the funds made available under this Act may be used to implement or enforce the interim final rule published in the Federal Register by the Centers for Medicare & Medicaid Services on August 26, 2005, (70 Fed. Reg. 50940) prior to April 1, 2006.
Payment for Power Mobility Device Claims (continued)

Although this section of the Appropriations Act does not allow federal funds to implement or enforce the rule, CMS believes that this section does not affect the validity of the rule. Therefore, CMS is instructing DMERCs and/or DME PSCs that, between January 1, 2006, to April 1, 2006, contractors will only pay PDM claims that satisfy the requirements of section 1834(a)(1)(E)(iv) of the SSA.

Based on the Appropriations Act, CMS is instructing FIs and carriers to hold claims that contain HCPCS code G0372. These claims must be held through March 31, 2006. Carriers will begin to release physician claims for processing on April 3, 2006.

Implementation
The implementation date for this instruction is no later than two weeks after release of CR 4372 or March 24, 2006.

Additional Information
For additional information regarding PDMs you may want to review the following MLN Matters articles:

- MM3952: MMA – Evidence of Medical Necessity:

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April 2006 Non-Outpatient Prospective Payment System Outpatient Code Editor Specifications Version 21.2

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

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

Provider Action Needed
This article is based on change request (CR) 4359, which announces that the April 2006 non-OPPS outpatient code editor (OCE) has been updated with new additions, changes, and deletions to HCPCS codes and procedure codes.

Background
Change request (CR) 4359 informs your FIs and RHHIs that the non-OPPS OCE used to process claims from hospitals not paid under the outpatient prospective Payment System has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes.

To view the specific code updates, please see CR 4359 on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R886CP.pdf.

Note that the code and description changes are the same code and description changes specified for the Medicare code editor (MCE).

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Power Wheelchair and Power Operated Vehicle (POV)/Power Mobility Device (PMD) Claim

The official instructions issued to your carrier, DMERC, FI, or RHHI regarding this change may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R215OTN.pdf.

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

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

MLN Matters Number: MM4372
Related Change Request (CR) Number: 4372
Related CR Release Date: March 10, 2006
Related CR Transmittal Number: R215OTN
Effective Date: January 1, 2006
Implementation Date: No later than March 24, 2006

Power Wheelchair and Power Operated Vehicle (POV)/Power Mobility Device (PMD) Claim

The official instructions issued to your carrier, DMERC, FI, or RHHI regarding this change may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R215OTN.pdf.

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

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

MLN Matters Number: MM4372
Related Change Request (CR) Number: 4372
Related CR Release Date: March 10, 2006
Related CR Transmittal Number: R215OTN
Effective Date: January 1, 2006
Implementation Date: No later than March 24, 2006

Implementation
The implementation date for CR 4359 is April 3, 2006.

Additional Information
For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R886CP.pdf.

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

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

MLN Matters Number: MM4359
Related Change Request (CR) Number: 4359
Related CR Release Date: March 10, 2006
Related CR Transmittal Number: R886CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 886, CR 4359
Repeat Tests for Automated Multi-Channel Chemistries for End Stage Renal Disease Beneficiaries

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

Provider Types Affected
Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services provided to Medicare end stage renal disease (ESRD) beneficiaries

Provider Action Needed

STOP – Impact to You
This article is based on change request (CR) 4101 provides details regarding the payment policy for ESRD-related automated multi-channel chemistry (AMCC) tests (i.e., the ESRD 50/50 rule), and clarifies a coding issue concerning repeat tests using the Current Procedure Terminology (CPT) modifier 91.

CAUTION – What You Need to Know
Clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, modifier 91 must be used on any subsequent service being billed if 1) any single service (same CPT code) is ordered (for the same beneficiary), and 2) the specimen is collected more than once in a single day, and the service is medically necessary. Also, any line item on a claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.

GO – What You Need to Do
Please see the Background section of this article for further details.

Background

ESRD 50/50 Rule
The Centers for Medicare & Medicaid Services (CMS) previously issued instructions to Medicare carriers regarding procedures to enforce compliance with the payment policy for ESRD-related AMCC tests (i.e., the ESRD 50/50 rule). The ESRD 50/50 rule requires a count of AMCC tests ordered to capture:

- The number of tests included in the composite payment rate paid to the ESRD facility; or
- The monthly capitation payment made to the furnishing physician;

Versus
- The number of covered noncomposite tests performed for the same beneficiary, on the same date of service.

The proportion of the composite payment rate tests versus the number of covered noncomposite tests calculated by the billing laboratory is used to determine whether separate payment may be made for all tests performed on that day.

In CR 2813, CMS directed Medicare carriers to make the necessary systems changes to implement front-end edits in preparation for the standard system implementation of CR 2813 in the January 2005 release.

Note: The carrier standard system changes needed to implement the new ESRD 50/50 rule compliance guidelines were partially implemented in the October 2004 release. Intermediary billing guidelines for ESRD 50/50 rule compliance have been in effect since October 2003.

CR 2813 also directed the carriers not to post any information concerning the business requirements associated with the implementation of CR 2813 until receiving further guidance from CMS.

Business Requirements Relating to Modifier 91
In June 2005, CMS issued CR 3890, which required the implementation of the ESRD 50/50 rule for carriers, effective January 2006. During the preparation for implementation, the provider community commented that business requirements relating to the use of modifier 91 (Repeat clinical diagnostic laboratory test) were inconsistent with Current Procedural Terminology (CPT) procedures. CMS is adjusting the business requirements for proper use of modifier 91.


Therefore, CR 4101 directs that clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, Modifier 91 must be used on any subsequent service being billed if:

- Any single service (same CPT code) is ordered (for the same beneficiary);
- The specimen is collected more than once in a single day; and
- The service is medically necessary.

In addition, when using CPT modifier 91, it must be used without regard to whether it is a:

- Composite rate test (Healthcare Common Procedure Coding System [HCPCS] modifier CD);
- Composite rate test beyond the normal frequency (HCPCS modifier CE); or
- Noncomposite rate test (HCPCS modifier CF).

Note: Any claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.
Implementation

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

Additional Information

For complete details regarding CR 4101, please see the official instruction issued to your carrier or intermediary regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R733CP.pdf.

From that Web page, look for CR 4101 in the CR NUM column on the right, and click on the file for that CR.

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

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Update to the ESRD Composite Payment Rates

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4291, which supplements CR 4196 (Transmittal 774), dated December 2, 2005, titled “Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year 2006.”

CAUTION – What You Need to Know

Effective January 1, 2006, the base composite payment rates will be increased to $130.40 for independent ESRD facilities, and $134.53 for hospital-based ESRD facilities. Using the updated composite payment rates, the updated drug add-on adjustment is 12.9 percent. The inflation adjustment of 1.4 percent is unchanged. Therefore, the total drug add-on adjustment for 2006 is 14.5 percent instead of the 14.7 percent indicated in CR4196. In addition, effective January 1, 2006, both hospital-based and independent ESRD facilities will be paid average sales price (ASP) plus six percent for all separately billable drugs except vaccines.

GO – What You Need to Do

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

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 623, http://www.cms.hhs.gov/MMAUpdate/) mandates that the composite payment rates, as increased by the 1.6 percent, must also include a drug add-on adjustment in the amount of 8.7 percent for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs as determined by Inspector General reports.

Therefore, Congress has amended the Social Security Act (Section 1881(b)(12), http://www.ssa.gov/OPP_Home/ssact/title18/1881.htm) to provide for a 1.6 percent update to the ESRD composite payment rate, effective for dialysis treatments furnished on or after January 1, 2006.


Because of the short time period from the recently enacted statute and the effective date, this change request is being issued to instruct Medicare FIs to implement the change in the basic composite payment rates for ESRD facilities.

Effective January 1, 2006, the base composite payment rates will be increased to:

- $130.40 for independent ESRD facilities; and
- $134.53 for hospital-based ESRD facilities.

The Centers for Medicare & Medicaid Services (CMS) has also updated the wage adjusted composite rate table that reflects the “old” wage data and core based statistical area (CBSA) designations for purposes of calculating the blended wage adjusted composite payment rates for 2006. (See the table (Composite Payment Rates Effective January 1, 2006) attached to CR 4291).

In addition, because the drug add-on adjustment is determined as a percentage of the composite rate, it was necessary to adjust the drug add-on percentage to account for the 1.6 percent increase in the composite payment rate in order to ensure that the total dollars allocated from the drug add-on adjustment remains constant. Using the updated composite payment rates, the updated drug add-on adjustment is 12.9 percent. The inflation adjustment of 1.4 percent is unchanged.
Update to the ESRD Composite Payment Rates (continued)

Therefore, the total drug add-on adjustment to the composite payment rate for 2006 is 14.5 percent instead of the 14.7 percent indicated in CR 4196.

Hospital-based facilities are paid at cost with applicable coinsurance and deductibles. Independent facilities are paid based on the lower of billed charges or 95 percent average wholesale price (AWP) for the calendar year 2004: coinsurance and deductibles are applied to billed charges. Effective January 1, 2006, both hospital-based and independent ESRD facilities will be paid average sales price (ASP) plus six percent for all separately billable drugs except vaccines.

Implementation

The implementation date for this instruction is February 13, 2006. Once this is implemented, Medicare intermediaries will reprocess 72x claims with dates of service on or after January 1, 2006, that were processed with the old PRICER in order to correct the payment. This reprocessing will be done by July 1, 2006.

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Holding of Epoetin (EPO) Claims on Type of Bill 72x for Dates of Service Prior to January 1, 2005

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 (FI) for services related to the administration of EPO to Medicare beneficiaries on a type of bill (TOB) 72x for dates of service before January 1, 2005

Provider Action Needed

STOP – Impact to You

Because of an internal Medicare systems issue, adjustments are being implemented in order to process claims for EPO services on TOB 72x with a date of service prior to January 1, 2005.

CAUTION – What You Need to Know

If claims are submitted for EPO with a date of service prior to January 1, 2005, they will be held for payment until system changes are implemented on June 5, 2006.

GO – What You Need to Do

Make certain that your billing staffs are aware of this change.

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/R849CP.pdf.

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

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

MLN Matters Number: MM4291
Related Change Request (CR) Number: 4291
Related CR Release Date: February 10, 2006
Related CR Transmittal Number: R849CP
Effective Date: January 1, 2006
Implementation Date: February 13, 2006
Source: CMS Pub. 100-4, Transmittal 849, CR 4291

Holding of Epoetin (EPO) Claims on Type of Bill 72x for Dates of Service Prior to January 1, 2005

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 (FI) for services related to the administration of EPO to Medicare beneficiaries on a type of bill (TOB) 72x for dates of service before January 1, 2005

Provider Action Needed

STOP – Impact to You

Because of an internal Medicare systems issue, adjustments are being implemented in order to process claims for EPO services on TOB 72x with a date of service prior to January 1, 2005.

CAUTION – What You Need to Know

If claims are submitted for EPO with a date of service prior to January 1, 2005, they will be held for payment until system changes are implemented on June 5, 2006.

GO – What You Need to Do

Make certain that your billing staffs are aware of this change.

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/R849CP.pdf.

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

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

MLN Matters Number: MM4291
Related Change Request (CR) Number: 4291
Related CR Release Date: February 10, 2006
Related CR Transmittal Number: R849CP
Effective Date: January 1, 2006
Implementation Date: February 13, 2006
Source: CMS Pub. 100-4, Transmittal 849, CR 4291
Discontinued Use of Additional Level III HCPCS Codes for Part A Services

The Consolidated Appropriations Act of 2001, Public Law 106-554 (enacted December 21, 2000), instructed Medicare contractors to maintain and continue the use of level III codes of the HCPCS coding system (also known as local codes) through December 31, 2003. The Healthcare Insurance and Portability and Accountability Act requires that all level III HCPCS codes be discontinued and providers to use the appropriate level II HCPCS codes (national codes) to report the services furnished.

Effective for claims processed on or after March 31, 2006, for services provided on or after January 1, 2004, and reported using a HCPCS level III code will be returned to the provider.

Below is a list of level III HCPCS codes that were in effect on December 31, 2003. A crosswalk to a level II CPT/HCPCS code is provided where appropriate.

<table>
<thead>
<tr>
<th>Level III HCPCS Code</th>
<th>Level II HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>00047</td>
<td>J0278</td>
</tr>
<tr>
<td>00248</td>
<td>J0278</td>
</tr>
<tr>
<td>00510</td>
<td>J7050</td>
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<td>00511</td>
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<td>J7050</td>
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<tr>
<td>00514</td>
<td>J7040</td>
</tr>
<tr>
<td>00515</td>
<td>J2912</td>
</tr>
<tr>
<td>00623</td>
<td>J3490 (provide the national drug code)</td>
</tr>
<tr>
<td>00739</td>
<td>G0010 (special instructions – cannot bill with E/M codes)</td>
</tr>
<tr>
<td>00971</td>
<td>J3490 (provide the national drug code)</td>
</tr>
<tr>
<td>00987</td>
<td>J3490 (provide the national drug code)</td>
</tr>
<tr>
<td>01231</td>
<td>J2543</td>
</tr>
<tr>
<td>01478</td>
<td>J0595</td>
</tr>
<tr>
<td>01479</td>
<td>J0595</td>
</tr>
<tr>
<td>01671</td>
<td>J3490 (provide the national drug code)</td>
</tr>
<tr>
<td>89991</td>
<td>J1563</td>
</tr>
<tr>
<td>00151</td>
<td>J3490 (provide the national drug code)</td>
</tr>
</tbody>
</table>

Providers are responsible to provide the fiscal intermediary with valid information and codes that best represent the service or procedure provided and billed.

Frequent Hemodialysis Network Payments for Approved Clinical Trial Costs

The Centers for Medicare & Medicaid Services (CMS) is jointly sponsoring with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) two clinical trials to evaluate the effectiveness of more frequent hemodialysis sessions compared with conventional thrice-weekly hemodialysis. One of these trials compares daily in-center hemodialysis (six times per week) with conventional in-center hemodialysis (three-times per week). The other compares nocturnal hemodialysis (six times per week in the home) with conventional in-center hemodialysis.

CMS has agreed to pay for covered patient care-related expenses for Medicare beneficiaries enrolled in these trials. For patients enrolled in the experimental arms of these trials (more frequent in-center or nocturnal hemodialysis), CMS also authorizes payment for one additional composite for the duration of the trial. The duration of the daily in-center hemodialysis trial will be 12 months after patient enrollment. The duration of the nocturnal hemodialysis trial will be 14 months after patient enrollment. For patients enrolled in the experimental arm of the nocturnal hemodialysis trial, CMS also authorizes additional home dialysis training payment at the composite payment rate plus $20 for each training session incurred not to exceed 30 training session payments per patient. The standard Medicare deductibles and co-payments will apply to both composite rate payments and training session payments.

Authority to enter into this agreement is contained in Section 601 of the Economy Act of 1932 as amended (31 USC 1535). CMS’ program authority is CFR 42 USC 1310. The program authority for NIDDK is the Economy Act, as amended (31 USC 1535).

Change request (CR) 4138 and the attachment described below may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R206OTN.pdf.

CR 4138 includes the following attachments:

Attachment 1: Frequent Hemodialysis Network (FHN) Nocturnal Hemodialysis Attestation Form

Attachment 2: Frequent Hemodialysis Network (FHN) Daily In-Center Hemodialysis Attestation Form

Attachment 3: PI’s Centers, Core Centers, Participating Dialysis Units for the Frequent Hemodialysis Network.

Source: CMS Pub. 100-20, Transmittal 206, CR 4138
Processing End Stage Renal Disease Exceptions Under the Composite Rate Reimbursement System

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 February 14, 2006, to add some clarifying words (see bold and italicized words) of this article. This article was originally published in the Second Quarter 2006 Medicare A Bulletin (page 65).

Provider Types Affected
Providers billing fiscal intermediaries (FIs) for pediatric end stage renal disease (ESRD) services

Provider Action Needed
STOP – Impact to You
This article is based on change request (CR) 4188 which implements changes in Medicare’s processes for handling requests by ESRD pediatric facilities for an exception from the composite payment rate.

CAUTION – What You Need to Know
Only those pediatric facilities that did not have an approved exception rate as of October 1, 2002, can now apply for an exception to its updated composite rate. Other changes to the exception process are also covered in this article.

GO – What You Need to Do
See the Background section of this article for further details regarding these changes.

Background
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 623) amended the Benefits Improvement and Protection Act (BIPA 2000) to allow only pediatric ESRD facilities that did not have an approved exception rate as of October 1, 2002, to file for an exception to its updated prospective payment (or composite) rate.

The pediatric facility would have to demonstrate that at least 50 percent of its patients are individuals less than 18 years of age. This statutory amendment to BIPA 2000 lifted the previous prohibition on exceptions and restored the exception process for pediatric facilities.

The Centers for Medicare & Medicaid Services (CMS) believes that pediatric facilities would not qualify for an exception under most of the five previously existing exception criteria because of the uniqueness of their pediatric patient population (at least 50 percent).

In the past, ESRD facilities with high percentages of pediatric patients only qualified for exceptions under the “atypical patient mix” criterion. Therefore, CMS is revising the exception criteria by:

- Retaining and renaming the exception criteria for self-dialysis and training costs.

In accordance with changes made by BIPA 2000 (Section 422) and the MMA (Section 623), CMS has revised instructions in the Medicare Claims Processing Manual. The major changes include the following:

- Only a pediatric ESRD facility that did not have an approved exception rate as of October 1, 2002, can now file for an exception to its updated composite payment rate.

- A pediatric ESRD facility is defined as a renal facility with at least 50 percent of its patients under the age of 18.

- Pediatric ESRD facilities can file for an exception to its composite payment rate at any time it is in operation for 12 consecutive months.

- A pediatric ESRD facility that has been denied an exception rate may immediately file another exception request.

Note: The regulations pertaining to the servicing intermediary’s responsibilities for reviewing ESRD exception requests have not changed.

Implementation
The implementation date for the instruction is January 17, 2006.

Additional Information
The revised portions of the Medicare Claims Processing Manual are attached to CR4188, which is 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/R781CP.pdf.

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

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


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New Skilled Nursing Facility Consolidated Billing Website Address

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

Provider Types Affected
Physicians, non-physician practitioners, institutional providers, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for services provided to skilled nursing facilities (SNF) patients.

Provider Action Needed
The purpose of the instruction in change request (CR) 4297 is to inform affected providers of the new Web address for SNF consolidated billing information. The new address corresponds to the new Web site from the Centers for Medicare & Medicaid Services (CMS), and this new address is also being placed in the Medicare Claims Processing Manual.

Background
The purpose of CR 4297 is to place the following new SNF consolidated billing (CB) website address into the CMS Medicare Claims Processing Manual (Pub. 100-04): http://www.cms.hhs.gov/SNFConsolidatedBilling/.

Provider Types Affected
Physicians, non-physician practitioners, institutional providers, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for services provided to skilled nursing facilities (SNF) patients.

Provider Action Needed
The purpose of the instruction in change request (CR) 4297 is to inform affected providers of the new Web address for SNF consolidated billing information. The new address corresponds to the new Web site from the Centers for Medicare & Medicaid Services (CMS), and this new address is also being placed in the Medicare Claims Processing Manual.

Information regarding SNF consolidated billing at this Web page includes the following:
- Services Beyond the Scope of the Part A SNF Benefit
- Edit for Therapy Services Separately Payable When Furnished by a Physician

NSKilled Nursing Facility Services

Medicare Certified Swing Bed Hospital Services

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

Provider Types Affected
Providers billing Medicare fiscal intermediaries (FIs) for services provided to beneficiaries in Medicare certified swing bed hospitals.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) has prepared this special edition article to remind providers of the criteria for and regulations regarding classification as a Medicare certified swing bed hospital.

Background
Under the Social Security Act (Section 1883(a)(1), [42 U.S.C. 1395tt]), any hospital that has an agreement under section 1866 may enter into an agreement with CMS in which its inpatient hospital facilities may be used for furnishing types of service that, if furnished in a skilled nursing facility (SNF), would constitute extended care services (subject to Section 1883(b)).

Such a hospital is known as a swing bed hospital. Section 1883 (b) of the Social Security Act requires that the hospital be located in a rural area and have less than 100 beds. Also (except as otherwise provided under CMS regulations) under subsection (c), an agreement with a hospital must:
- Be of the same duration and subject to termination on the same conditions as are agreements with SNFs under the Social Security Act (Section 1866); and
- Impose (where not inconsistent with any provision of this section) the same duties, responsibilities, conditions and limitations, as those imposed under such agreements entered into under Section 1866 of the Social Security Act.

Swing Bed Hospital Requirements
A swing bed must:
- Be in substantial compliance (under the Code of Federal Regulations (CFR), Title 42, Part 482, Section 482.66 (b) (42CFR 482.66 (b)) with the following SNF requirements:
  - Resident rights
  - Admission, transfer, and discharge rights

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.
Medicare Certified Swing Bed Hospital Services (continued)

- Resident behavior and facility practices
- Patient activities
- Social services
- Discharge planning
- Specialized rehabilitative services
- Dental services

- Not have in effect a 24-hour nursing waiver granted under 42 CFR 488.54(c).

In addition, a swing bed hospital must:

- Meet all of the conditions of participation applicable to a Medicare-certified hospital set forth in 42 CFR 482.
- Not have had a swing bed approval terminated within the two years previous to the current application for a swing bed agreement.

Note: Social Security Act Section 1883(a)(1) may be found at http://www.ssa.gov/OP_Home/ssact/title18/1883.htm.
Section 1866 may be found at http://www.ssa.gov/OP_Home/ssact/title18/1866.htm.
Also, see the Medicare General Information, Eligibility, and Entitlement Manual (Publication 100-1, Chapter 5, Section 30.3); and the Medicare Benefit Policy Manual (Publication 100-02, Chapter 8, Section 10.3) on the CMS website at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.
Also refer to 42 CFR 482.66 at http://www.gpoaccess.gov/cfr/retrieve.html.

Services Covered in a Medicare Certified Swing Bed

Under the Social Security Act, Section 1883(a)(1), payment for swing bed services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by an SNF under an agreement entered into under Section 1866.

The meaning of the term extended care services is set forth in Section 1861(h) of the Act (http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) and includes such things as nursing care, bed and board, and medical social services.

Coverage of extended care services is subject to:

- Requirements set forth in the Social Security Act (Section 1861(i)); and
- Implementing regulations found in 42 CFR 409 (Subpart D), including that of the three-day qualifying inpatient stay.

Note: Time spent by the beneficiary in observation status or in the emergency room prior to (or in lieu of) a formal inpatient admission to the hospital does not count toward the three-day qualifying inpatient hospital stay. In addition, the beneficiary must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless certain specified exceptions apply.

The level of care criteria set forth in 42 CFR 409.31 requires that the skilled nursing and/or skilled rehabilitation services provided to a beneficiary must:

- Be ordered by a physician.
- Require the skills of technical or professional personnel.
- Be furnished directly by, or under the supervision of, such personnel.
- Be provided on a daily basis for a condition:
  - For which the beneficiary received inpatient hospital or inpatient critical access hospital (CAH) services; or
  - Which arose while the beneficiary was receiving care in a swing bed hospital for which he or she received inpatient hospital or inpatient CAH services.

Noncovered care is any care that does not meet the level of care criteria set forth above. See the Medicare Benefit Policy Manual (Publication 100-02, Chapter 8) on the CMS website at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

How Services are Paid for a Medicare Certified Swing Bed

The Balanced Budget Act (BBA) of 1997 (Section 4432(a), http://www.cms.hhs.gov/SNFPPS/) requires that swing beds located in hospitals (short term, long term, critical access, and rehabilitation) that are certified as swing bed hospitals be subject to payment based upon the provisions of the SNF prospective payment system (PPS), effective with cost reporting periods beginning on or after July 1, 2002.

Regulatory requirements specific to payment of swing bed services under the SNF PPS may be found in 42 CFR 413.114 and 42 CFR 413 (subpart J). Further interpretation of both the Social Security Act and the regulations may be found in the Medicare Provider Reimbursement Manual (CMS Publication 15-1, Section 2831 to Section 2837).

Under the Benefits Improvement and Protection Act (BIPA) of 2000 (Section 203), swing beds in CAHs are exempt from Section 1888(e)(7) of the Social Security Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1888.htm).

This provision applies the SNF PPS to SNF services furnished by swing bed hospitals generally, effective with cost reporting periods beginning on or after the date of the enactment of the BIPA 2000 (December 21, 2000). In addition, this provision established a new reimbursement system for CAHs that provides for full reasonable cost payment for CAH swing-bed services instead of payment based upon SNF PPS.

Providers of swing bed services are eligible for additional payment for services that are excluded from the SNF Part A consolidated billing (CB) requirements.

According to Program Memorandum A-02-060, when a swing bed hospital provides a service (that is excluded from SNF PPS) to a beneficiary receiving SNF-level services, the hospital can submit a separate bill for the service but must use TOB 13x.

Note: See the Medicare Claims Processing Manual (Publication 100-04, Chapter 3, Subsection 30.1.2) on the CMS website at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.
Medicare Certified Swing Bed Hospital Services (continued)

Program Memorandum A-02-060 may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/A02060.pdf.

Note that the bill:

- Will be paid as inpatient Part B services under the outpatient prospective payment system (OPPS); and
- Must include:
  - All appropriate revenue codes
  - Healthcare Common Procedure Coding System (HCPCS) codes
  - Line item date of service billing information.

Likewise, swing bed hospitals may file bills with the fiscal intermediary for Part B ancillary services furnished to beneficiaries who are not in a Part A PPS swing bed stay. These claims are billed as inpatient Part B services and are also paid under OPPS.

Note: See the Medicare Claims Processing Manual (Publication 100-04, Chapter 6, Section 100) on the CMS website at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

Additional Information

You can retrieve any CFR referenced in this special edition article at the following GPO website: http://www.gpoaccess.gov/cfr/retrieve.html.

Once at this GPO website, let the Revision Year remain “Most Recent Available,” and fill in the TITLE, PART, and FILE TYPE (Text, PDF, or Summary) of the CFR document you want to review.

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April Quarterly Update to the 2006 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

CMS has issued the following “MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. You must fill in either a section number or a subpart letter. Next, type the title, part, and section (or subpart) in the boxes provided. Finally, select the type of file you wish to retrieve by using the pull-down menu.

Documents are available as ASCII text and PDF files. Summary files are ASCII text files that include only the first 100 lines of a document. ASCII text files are recommended. Next, select “GO,” which will take you to the desired CFR.

For example, if you want to review 42 CFR 483.12 (a)(1), you would type the following (bolded) into the indicated boxes:

- Title: 42
- Part: 483
- Subpart: 12.

You then select “GO” to be taken to the desired document, at which point you can scroll down to subpart (a)(1).

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

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

MLN Matters Number: SE0606
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 SE0606
Services that appear on this HCPCS code list (that are submitted on claims to both Medicare FIs and carriers, including DMERCs) will not be paid by Medicare to providers (other than an SNF) when included in SNF CB.

For non-therapy services, SNF CB applies only when the services are furnished to an SNF resident during a covered Part A stay. However, SNF CB applies to the following services whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay:

- Physical and occupational therapies
- Speech-language pathology.

Services for beneficiaries that are excluded from SNF PPS and CB may be paid to providers (other than SNFs) even when in an SNF stay. To assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

2006 Annual Update

Each January, CMS publishes a combined instruction for FIs and Carriers/DMERCs for the annual notice on SNF CB. The 2006 annual update file for FIs may be found on the CMS website at http://www.cms.hhs.gov/SNFConsolidatedBilling/01a_SNFCBforFIs.asp#TopOfPage.

This 2006 file will be updated with the changes addressed in CR4298 by March 1, 2006. Information on the 2006 Annual Update for carriers can be found on the CMS website at http://cms.hhs.gov/SNFConsolidatedBilling/.

Note: Quarterly updates apply to FIs and carriers/DMERCs. The update provided by CR 4298 affects claims with dates of service on or after the effective date of CR4298 unless otherwise indicated. The following HCPCS codes are listed as being added or removed from the annual update:

**HCPCS Codes Added or Removed from Annual Update**

**Computerized Axial Tomography (CT) Scans (Major Category I, FI Annual Update, EXCLUSION)**

CPT code removed:

76375 3D/holograph reconstr add-on

**Radiation Therapy (Major Category I, FI Annual Update, EXCLUSION)**

HCPC codes removed:

C9722 KV imaging w/tracking
G0242 Lultisource photon ster plan
G0338 Linear accelerator ster plan

**Angiography, Lymphatic, Venous (Major Category I, FI Annual Update, EXCLUSION)**

CPT code added:

36598 Contrast injection, radiologic eval of existing cent venous access device

Note: This code should be added to the SNF CB file effective April 1, 2006.

**Outpatient Surgery and Related Procedures (Major Category I, FI Annual Update, INCLUSION)**

CPT/HCPCS codes removed:

15810 Salabrasion
15811 Salabrasion
G0345 Intravenous infusion, hydration; initial, up to one hour

**Ambulance Trips w/Application to Major Category II (Major Category I, FI Annual Update, EXCLUSION)**

HCPC codes removed:

Q3019 ALS vehicle used, emergency transport, no ALS service furnished
Q3020 ALS vehicle used, non-emergency transport, no ALS service furnished service furnished

**Dialysis Supplies (Major Category II, FI Annual Update, EXCLUSION)**

HCPC code removed:

A4656 Needle, any size, for dialysis, each

**Chemotherapy Administration (Major Category III, FI Annual Update, EXCLUSION)**

CPT/HCPCS code removed:

96408 Chemotherapy, push technique
96410 Chemotherapy, infusion method
96412 Chemo, infusion method add-on
96414 Chemo, infusion method add-on
96520 Pump refilling, maintenance
96530 Pump refilling, maintenance
G0357 Intravenous, push technique, single or initial substance/drug
G0358 Intravenous, push technique, each additional substance/drug
G0359 Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
G0360 Each additional hour, one to eight hours
G0361 Initiation of prolonged chemotherapy infusion (more than 8 hours)
G0362 Each additional sequential infusion (different substance /drug), up to one hour

CPT/HCPCS code added:

96409 Chemo admin; IV, push; single/initial drug
96411 Chemo admin; IV, push; each add’l drug
96413 Chemo admin; IV, infusion; up to 1 hr; single/initial drug
96415 Chemo admin; IV, infusion; each add’l hr, 1-8 hrs
96416 Chemo admin; IV, infusion; initiation of prolonged chemo, requiring pump
96417 Chemo admin; IV infusion; each add’l sequential infusion, up to 1 hr
C8953 Chemo admin; IV, push
C8954 Chemo admin; IV, infusion; up to 1 hr
C8955 Chemo admin; IV, infusion; each add’l hr

**Implementation**

The implementation date for the instruction is April 3, 2006.
**Access to the Part D Drug Benefit in Long Term Care Settings**

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

**Provider Types Affected**
Skilled nursing facilities (SNFs) and nursing homes with Medicare residents

**Impact on Providers**
To simplify access to the Part D drug benefit in the long-term care (LTC) setting, the Centers for Medicare & Medicaid Services (CMS) recommends that providers take steps to clearly differentiate those drugs which may qualify as Part B drugs and those which may qualify as Part D drugs.

**Important Points to Remember**
CMS released the following information via the minimum data set (MDS) submission system’s Welcome Page on March 14, 2006:

**Drugs Administered Through a Part B Covered Item of Durable Medical Equipment (DME) Such as a Nebulizer or Pump**
Medicare Part B only covers the above categories of drugs when used in conjunction with Part B covered durable medical equipment (DME) in the patient’s home. For those LTC facilities that do not qualify as a patient’s home, CMS recommends for the above categories of drugs that the following be included in the written order:
- The diagnosis and indication for the drug, and
- A statement of status such as “Nursing Home Part D.”

**Note:** See the website listed at the end of this document for more information regarding the definition of a home.

**Certain Infusion and Injectable Drugs**
Medicare Part B covers injectible and infusible drugs that are not usually self-administered and that are furnished incident to a physician’s service. If a LTC who is not in a Medicare Part A stay, CMS recommends including a statement of status such as “Administered by Facility, Nursing Home Part D.”

**Certain Oral and Immunosuppressive Drugs**
At this time, Part B covers three categories of drugs: oral anti-cancer, oral antiemetic, and immunosuppressive drugs listed below under certain circumstances.

**The following are oral anti-cancer drugs paid for by Medicare:**
- Cyclophosphamide – oral
- Cyclosporine – oral
- Cyclosporine – parenteral
- Daclizumab – parenteral
- Lymphocyte immune globulin,
- Antithymocyte globulin – parenteral
- Methotrexate – oral
- Methylprednisolone – oral
- Methylprednisolone sodium guccinate – injection
- Muromonab-Cd – parenteral
- Mycophenolate àcid – oral
- Mycophenolate mofetil – oral
- Oral azathioprine
- Parenteral azathioprine
- Prednisolone – oral
- Prednisone – oral
- Sirolimus – oral
- Tacrolimus – oral
- Tacrolimus – parenteral

The following are the oral anti-cancer drugs paid for by Medicare Part B:
- Busulfan capectabine cyclophosphamide
- Etoposide melphalan
- Methotrexate temozolomide

**The following are oral anti-emetics paid for by Medicare:**
- Granisetron hydrochloride (within 24 hours)
- Dolasetron mesylate (Q0180) (within 24 hours)
- Dronabinol granisetron hydrochloride (Q0166) (within 24 hours)

**The following are immunosuppressive drugs for transplants paid for by Medicare:**
- A 5-HT3 receptor antagonist (Q0166, Q0179, Q0180);
- (3) dexamethasone
- Antithymocyte globulin,
- Daclizumab – parenteral
- Cyclosporine – parenteral
- Cyclosporine – oral
- Antithymocyte globulin,
- Daclizumab – parenteral
- Cyclosporine – oral
- Antithymocyte globulin,
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- Cyclosporine – oral
- Antithymocyte globulin,
- Daclizumab – parenteral
- Cyclosporine – oral
- Antithymocyte globulin,
Access to the Part D Drug Benefit in Long Term Care Settings (continued)

Hydroxyzine pamoate ondansetron hydrochloride (Q0179)
Perphenazine prochlorperazine maleate – oral
Promethazine hydrochloride
Thiethylperazine maleate
Trimethobenzamide hydrochloride

For these categories of drugs, CMS recommends including in the written prescription the diagnosis and the indication as well as the statement of status as “Part B” (for above indications) or for “Part D” (for all other indications).

The definition of “Part D” added to the prescription.

While this guidance does not guarantee payment or coverage, following the process may help pharmacists respond more readily to additional information to support Part D or Part B coverage, and facilitate processing by the appropriate plan.

Note: This Special Edition information does not supersede any existing guidance concerning documentation for Part B prescriptions.

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Revisions Relating to Rural Health Clinic and Federally Qualified Health Center Services Provided in a Skilled Nursing Facility and Certification/Recertification of the Need for a Skilled Level of Care

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

Provider Types Affected

Physicians, nurse practitioners, clinical nurse specialists, RHCs, FQHCs, and SNFs billing Medicare carriers and fiscal intermediaries (FIs) for services supplied to SNF patients

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4079, which includes revisions relating to rural health clinic (RHC) and federally qualified health center (FQHC) services provided in a skilled nursing facility (SNF) and physician certification/recertification of the need for a skilled level of care.

CAUTION – What You Need to Know

Effective January 1, 2005, certain RHC/FQHC services furnished by a physician to a Medicare patient who is in a covered Part A stay in a SNF may not be subject to SNF consolidated billing merely by virtue of being furnished under the RHC/FQHC auspices. The definition of an “indirect employment relationship” as that term relates to the certification and recertification of the need for a skilled level of care included in the SNF PPS final rule for FY 2006 is effective for services provided on and after October 1, 2005.

GO – What You Need to Do

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

Additional Information

For more detailed information on Part B versus Part D coverage, see on the CMS website http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDoc_07.27.05.pdf.

A comprehensive list of links to agency-wide Part D resources for physicians is available at http://www.cms.hhs.gov/center/provider.asp, scroll to “Part D Tools for Health Care Professionals”.

As always, the source for Part D information for Fee-For-Service (FFS) providers is located on the Medicare Learning Network’s drug coverage page on the CMS website at http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp.

MLN Matters Number: SE0614
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 SE0614
Revisions Relating to RHC and FQHC Services Provided in a SNF and Certification/Recertification... (continued)

However, under limited circumstances, these services were considered to be practitioner services that were excluded from SNF consolidated billing and separately billable to Part B.

See the Medicare Benefit Policy Manual, Chapter 13 (Rural Health Clinic (RHC)), and Federally Qualified Health Center (FQHC) Services, Section 50.4.2.B. This manual is available on the CMS website at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

Specifically, visits to SNF residents by an RHC/ FQHC’s physicians and other excluded types of medical practitioners could be separately billed to the Medicare Part B carrier in those situations where the services were furnished off the RHC’s premises and the RHC did not compensate the practitioner for them. In other words, as long as the practitioner was not under agreement with the RHC to provide services at the SNF, the practitioner could bill the Part B carrier directly for those services under his or her own Medicare provider number.

Effective with services furnished on or after January 1, 2005, the MMA (Section 410) amended the law to specify that when an SNF Part A resident receives the services of a physician from an RHC or FQHC, then those services are not subject to consolidated billing merely by virtue of being furnished under the auspices of the RHC or FQHC. This exclusion also applies to any other type of practitioner that the law identifies as being excluded from SNF consolidated billing.

Accordingly, under the MMA (Section 410), services otherwise included within the scope of RHC and FQHC services that are also described in the Social Security Act (Section 1888(e)(2)(A)(ii)) are excluded from consolidated billing, effective with services furnished on or after January 1, 2005. Only this subset of RHC/FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay.

Who May Sign the Certification or Recertification for Extended Care Services?

Payment for covered post-hospital extended care services may be made only if a physician (or one of the other authorized types of practitioners described below) makes the required certification and, where services are furnished over a period of time, the required recertification regarding the services furnished.

The skilled nursing facility is responsible for obtaining the required certification and recertification statements and for retaining them in a file for verifications, if needed, by the intermediary. A certification or recertification statement must be signed by:

- The attending physician or a physician on the staff of the SNF who has knowledge of the case; or
- A nurse practitioner (NP) or clinical nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

In this context, the definition of a “direct employment relationship” is set forth in the Code of Federal Regulations (CFR).

(To go http://www.gpoaccess.gov/cfr/retrieve.html. See 20 CFR 404.1005, 404.1007, and 404.1009.)

Under the CFR (42 CFR 424.20(e)(2)(iii)) an “indirect employment relationship” exists between the NP or CNS and the facility when:

- The NP or CNS has a direct employment relationship with an entity other than the facility; and
- The employing entity has an agreement with the facility that includes the provision of general nursing services under the regulations (42 CFR 409.21).

By contrast, such an indirect employment relationship does not exist if the agreement between the facility and the NP’s or CNS’s employer solely involves the performance of delegated physician tasks under the regulations (42 CFR 483.40(e)).

Ordinarily, for purposes of certification and recertification, a “physician” must meet the definition contained in the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 5, Section 70.

Implementation

The implementation date for this instruction is February 16, 2006.

Additional Information

For a more complete description of SNF PPS provisions, see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 6 (SNF Inpatient Billing). This manual is available on the CMS website at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

For complete details, please see the official instruction (CR4079) issued to your carrier/intermediary regarding this change. This instruction included the revised portions of the Medicare Benefit Policy Manual affected by these changes. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R40BP.pdf.

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

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

MLN Matters Number: MM4079
Related Change Request (CR) Number: 4079
Related CR Release Date: November 18, 2005
Related CR Transmittal Number: R40BP
Effective Date: October 1, 2005
Implementation Date: February 16, 2006
Source: CMS Pub. 100-2, Transmittal 40, CR 4079

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Therapy Cap Exception Process

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

**Provider Types Affected**

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

**Key Points**

- Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims).

Outpatient rehabilitation services include:

- **Physical therapy** – including outpatient speech-language pathology: Combined annual limit for 2006 is $1,740; and

- **Occupational therapy** – annual limit for 2006 is $1,740.

- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, exceptions to therapy caps for services provided during calendar year 2006, if these services meet certain qualifications as medically necessary services (Section 1833(g)(5) of the Social Security Act).

- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.

- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:
  - Meet specific conditions and complexities listed in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 5, (as revised by CR 4364) for exception from the therapy cap; or
  - Meet specific criteria for exception, in addition to those listed in the Medicare Claims Processing Manual, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.

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

You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.

- Please refer to the Additional Information section of this article for more detailed information about the therapy caps exception process.

**Background**

Financial limitations on Medicare-covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997. These caps were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005.

The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to these dollar limitations of $1,740 for each cap in 2006 may be made when provision of additional therapy services is determined to be medically necessary.

**Additional Information**

**Billing Guidelines**

- **Modifier KX** – You must include modifier KX on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.

- **Separate requests** – You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received before the cap is exceeded because the patient is liable for denied services based on caps.

- **Subsequent requests during the same episode of care** – To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, each time the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.
Comprehensive Outpatient Rehabilitation Facilities

Therapy Cap Exception Process (continued)

- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using modifier KX. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process Based Upon Clinical Condition or Complexity

CR 4364 transmittal that contains these codes is the one that revises the Medicare Claims Processing Manual, available on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf.

You may wish to bookmark that link so you may easily reference these codes.

Documentation

Suppliers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the revised Medicare Benefit Policy Manual, Pub. 100-02 Chapter 15, Section 220.3; and the revised Medicare Claims Processing Manual, Pub. 100-04, Chapter 5, Sections 10.2 and 20, with the request for treatment days in excess of those payable under the therapy cap.

These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR 4364. CR 4364 is in three parts, one each for the revised manuals, i.e.:


The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** – 1-2 documents.
2. **Certification** – Physician/NPP approval of the plan required 30 days after initial treatment-or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds ten treatment days or 30 days) – These must be sufficient to explain the beneficiary’s current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.
4. **Treatment Encounter Notes** – The treatment encounter note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for progress reports if they contain the requirements of interval progress reports at least once every ten treatment days or once in the interval.
5. For therapy caps exceptions purposes, records justifying services over the cap, either included in the above or as a separate document.

Please see the revised Section 220.3 of the Medicare Claims Processing Manual located at http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf for more details about the types of documentation required and explanations of what that documentation should contain.

When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary.
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation.
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or reevaluation unless it represents a service.
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

Medicare Contractor Decisions

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology.

It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed.

Your Medicare contractor may also approve additional therapy visits already provided when the request is accompanied by documentation supporting medical necessity of the services.
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES

Therapy Cap Exception Process (continued)

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial.

Note: If your Medicare contractor does not make a decision within ten business days of receipt of the request and documentation, then the decision for therapy cap exception is considered to be deemed approved as medically necessary for the number of future visits requested (not to exceed 15).

Notification
You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision.

This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights. For examples of the standard letters from the Medicare Program Integrity Manual, 100-8, Section 3.3.1.2, please refer to the Attachments to CR 4364. The examples include:

- Letter #1 – Approved
- Letter #2 – Negative Decision-Medical Necessity
- Letter #3 – Denied-Insufficient Documentation

Revised Medicare Summary Notice (MSN) Messages
The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR 4364.

Once again, there are three transmittals that comprise CR 4364. They are:


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

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

MLN Matters Number: MM4364
Related Change Request (CR) Number: 4364
Related CR Release Date: February 15, 2006
Related CR Transmittal Number: R47BP, R140PI, R855CP
Effective Date: January 1, 2006
Implementation Date: No later than March 13, 2006
Source: CMS Pub. 100-4, Transmittal 855, CR 4364

Guidelines for Therapy Cap Exception Process

The Deficit Reduction Act of 2005 (DRA) directed CMS to create a process to allow exceptions to the therapy caps where continued therapy services are medically necessary services provided on or after January 1, 2006.

This article provides:

- Key points of interest to providers submitting claims under the automatic exceptions process.
- Instructions for submitting requests via the manual exceptions process.
- Important tips and reminders.

Key Points of Interest to Providers Submitting Claims Under the Automatic Exceptions Process

- No request is required, simply verify that the patient’s records meet all documentation requirements and submit your claim attaching modifier KX to all therapy line items. (Do not submit documentation unless requested.)
- The following ICD-9-CM codes and ranges describe the conditions (etiology or underlying medical conditions) that may result in excepted conditions and complexities (marked *) that may cause medically necessary therapy services to qualify for the automatic therapy cap exception. If a diagnosis code is not listed here, then the disorder may still qualify for an exception by approval via the manual exceptions request process. The codes apply to all therapy disciplines, but may be used only when the code is applicable to the condition being actively treated. For example, an exception should not be claimed for a diagnosis of hip replacement when the service provided is for an unrelated dysphagia.
### Guidelines for Therapy Cap Exception Process (continued)

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* Complexities

- The following examples are clinical complexities that may also justify an automatic exception to the therapy caps for any condition that necessitates skilled therapy services, regardless of whether it is on the list of diagnosis codes. As in all exceptions, the services rendered above the caps must be documented, covered medically necessary services. The mere existence of one of these complexities does not assure that the services were medically necessary. The clinician’s documentation must justify the use of modifier KX.

- The beneficiary was discharged from a hospital or skilled nursing facility (SNF) within 30 treatment days of starting this episode of outpatient therapy. Indicate date of discharge and name of hospital or SNF.

- The beneficiary has, in addition to another disease or condition being treated, generalized musculoskeletal conditions or conditions affecting multiple sites not listed as automatically excepted by conditions that will directly and significantly impact the rate of recovery.

- The beneficiary has a mental or cognitive disorder in addition to the conditions being treated that will directly and significantly impact the rate of recovery.

For the above complexities, list in your documentation all relevant disorders or conditions and describe the impact. For example: A sprained ankle does not qualify for exception by condition, but if the patient also has a dysfunctional wrist on the opposite side that precludes the use of a cane, it would cause a direct and significant impact on the patient’s need for skilled physical therapy, and might require services that exceed caps.

- The beneficiary requires PT and SLP services concurrently. If the combination of the two services causes the cap to be exceeded for necessary services, the services are excepted from the PT/SLP cap. The OT cap is not affected.

- The beneficiary had a prior episode of outpatient therapy during this calendar year for a different condition. The second condition treated in the year may not be on the list of excepted conditions. If services are medically necessary and would be payable under the cap, an exception is allowed if prior use of services for a different condition caused the cap to be exceeded and the medically necessary services to be denied. In cases where the beneficiary was treated in the same year for the same condition, contractor approval is required for use of modifier KX.

- The beneficiary requires this treatment in order to return to a premorbid living environment. Document what environment and what is needed to return. For example: Patient is progressing (see FIM scores) and has good potential for completing goals for independent toileting, which is required for discharge from the nursing home setting and return to the assisted living facility where she resided prior to the CVA.

- The following therapy evaluation services are excepted from the therapy caps. When submitting claims for evaluation services that exceed the caps, providers and suppliers are instructed to attach modifier KX.

92506 92597 92607 92608 92610
92611 92612 92614 92616 96105
97001 97002 97003 97004
Guidelines for Therapy Cap Exception Process (continued)

Instructions for Submitting Requests Via the Manual Exception Process

Providers need to submit a written request to the contractor for medical review for patients who are expected to exceed the therapy caps, but do not meet one of the conditions for the automatic exception.

- You must submit in writing and complete in its entirety the “Request for Exception from Therapy Cap” form.
- The following documentation must be faxed along with your completed form. If all required documentation is not attached, a decision will be made based solely on the submitted documentation:
  - Evaluation and certified plan of care
  - Certification
  -Clinician’s signed progress reports
  - Treatment encounter notes
  - Medical justification (explanation of medical necessity)
- Requests will only be accepted via the fax number 1-904-791-8006. Requests sent any other way (e.g., mail, appeals etc.) will be returned with instructions on how to correctly submit. In the very near future, the fax number indicated above will change to a toll free fax number. This information will be posted to our website along with a new updated form.

One of the following responses will be faxed within 10 business days of receipt of your request to the fax number provided on the request form:

1. Based on your documentation, the beneficiary does not meet medical necessity requirements for granting the exception.
2. Based on your documentation, the beneficiary meets the medical necessity requirements for granting an exception, for all days requested. You may submit claims using modifier KX for the requested number of days.
3. Based on your documentation, the beneficiary meets medical necessity requirements for granting the exception, but not for all days requested. You may submit claims using modifier KX for the number of days indicated in this letter.
4. We received your request, but did not meet the 10-day requirement; therefore all days requested are granted. You may submit claims using modifier KX for the number of days indicated in this letter.

Important Tips and Reminders

- The automatic exceptions process will be closely monitored via the normal progressive corrective action (PCA) process.
- If you are a Medicare provider currently going through the progressive corrective action process and are on prepayment review due to a high error rate, you are not allowed to participate in the therapy cap exception process. However, if you are a Medicare Part A provider that has been placed on prepayment review as a new provider, you are allowed to participate via the manual exception process only. Each request will be given individual consideration.
- Due to changes required by the Centers for Medicare & Medicaid Services (CMS) implemented with change request 4364 (transmittals 855, 140 and 47), the local coverage determination (LCD) titled “Therapy and Rehabilitation Services” (L1125) has been updated. It is your responsibility to be aware of these changes. To view this LCD, access the provider education website http://www.floridamedicare.com. From the home page, select “Part A” on the top navigational menu. On the next screen, click on “Final” under the local Medical Coverage section on the left navigational menu.
- For all claims submitted with modifier KX during the interim process that may have been rejected in error, you may resubmit your claim for reprocessing.
- It is expected that a manual request for therapy cap exceptions will be submitted prior to the beneficiaries meeting the financial limitation. However, a request for exceptions for services already provided may sometimes be necessary. Please provide the appropriate documentation and justification of the medical necessity for the services provided and include the dates with your manual request as retroactive services in the block titled “First date of denied Services and/or Estimated Date Service Cap is Exceeded” of the “Request for Exception from the Therapy Caps” form. Providers are cautioned against abuse of this process by routinely requesting exceptions for past services.
- You must continue to use modifiers GN, GP, and GO on all therapy services when using modifier KX. There is no specific order that must be followed.

To download the “Request for Exception from Therapy Cap” form, from the home page on the provider education website http://www.floridamedicare.com, select “Forms” under the “Resources” section on the left navigational menu. On the next screen, click on “Request for Exception from the Therapy Caps” under the “Resource Order Forms” section.

Source: CMS Pub. 100-04, Transmittal 855, CR 4364
REQUEST FOR EXCEPTION FROM THE THERAPY CAPS

Attention Provider

You must submit the following types of documentation of therapy services:

1. Evaluation and Certified Plan of Care
2. Certification
3. Clinician-signed Progress Reports
4. Treatment Encounter Notes
5. Justification (Explanation of Medical Necessity)

If all required documentation is not attached, a decision will be made based solely on information received

You must provide documentation that is sufficient to support medical necessity for the additional treatment days, which shall be in accordance with the revised Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, Section 220.3 and the revised Medicare Claims Processing Manual, Pub 100-04, Chapter 5, Sections 10.2 and 20.

It is preferable that all manual requests for exception be submitted before the therapy cap has actually been exceeded. However, in the exceptional circumstance where a timely request is not made before the cap is surpassed, additional treatment days may be approved retroactively if they are deemed medically necessary.

<table>
<thead>
<tr>
<th>Date of Request</th>
<th>Date to Start Requested Exception</th>
<th>First Date of Denied Services and/or Estimated Date Service Cap is Exceeded</th>
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<td>Beneficiary Name &amp; NPI #</td>
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Request is for: (check only one; submit a separate request for each therapy)

- Physical Therapy
- Occupational Therapy
- Speech-language Pathology

Provider Name

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<tr>
<th>Number of Exceptions Already Requested for this Episode of Care (If applicable)</th>
<th>Number of Treatment Days Being Requested (Not to exceed 15 days)</th>
<th>Primary Diagnosis Code (Please list only one)</th>
<th>Secondary/ Additional Diagnosis Codes</th>
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Name, and telephone number of person to contact regarding this request

Fax number for purposes of receiving a response to this request

FAX TO:
Florida Part A (904) 791-8006 Florida Part B (904) 791-8006 Connecticut Part B (904) 791-8006

Medical Review and Education 19 Tower, 532 Riverside Ave, Jacksonville, Florida 32202 Form Date March 10, 2006
Annual Update to the Therapy Code List

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

Provider Types Affected

Private practicing therapists, physicians, suppliers, and providers of therapy services billing Medicare carriers and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for rehabilitation therapy services.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4226, which implements policy changes discussed in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2006 and the Medicare physician fee schedule (MPFS) final rule for CY 2006.

CAUTION – What You Need to Know

CR 4226 describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology. It also updates the list of codes that sometimes or always describe therapy services and their associated policies.

GO – What You Need to Do

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

Background

The Social Security Act (Section 1834(k)(5)) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system.


The uniform coding requirement in the Social Security Act is specific to payment for all CORF services and outpatient rehabilitation therapy services that are provided and billed to carriers and FIs including:

- Physical therapy
- Occupational therapy
- Speech-language pathology.

Note: Section 1834(k)(5) of the Social Security Act may be found at http://www.ssa.gov/OP_Home/ssact/title18/1834.htm.

The Medicare physician fee schedule (MPFS) is used to make payment for these therapy services at the nonfacility rate. The following “providers of therapy services” must bill the FI/RHHI for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A stay)
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF)
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care2 [POC])
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Providers of outpatient physical therapy and speech-language pathology services (OPTs), also known as rehabilitation agencies (previously termed outpatient rehabilitation facilities).

1 The requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A services are bundled into the respective prospective payment system payment; no separate payment is made.

2 For HHAs, HCPCS/CPT coding for outpatient rehabilitation services is required only when the HHA provides such service to individuals that are not homebound and, therefore, not under a home health plan of care.

The following practitioners must bill the carriers for outpatient rehabilitation therapy services using HCPCS/CPT codes:

- Physical therapists in private practice (PTPPs)
- Occupational therapists in private practice (OTTPs)
- Physicians, including MDs, DOs, podiatrists and optometrists
- Certain nonphysician practitioners (NPPs), acting within their state scope of practice, e.g., nurse practitioners and clinical nurse specialists.

Change Request 4226 Requirements

- Describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology.
- Updates the list of codes that sometimes or always describe therapy services and their associated policies.
- Reflects policy changes implemented in (a) the OPPS final rule for CY 2006 and (b) the Medicare physician fee schedule (MPFS) final rule for CY 2006.

Other policies contained in CR 4226 correct or clarify the previous policy noted in CR 3647 (Transmittal 515 dated April 1, 2005).

The therapy code list and associated policies for CY 2006 is updated by CR4226 as described below.

Note: CR 3647 may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R515CP.pdf.

The MLN Matters article that corresponds to CR 3647 may be reviewed on the CMS website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3647.pdf.
Annual Update to the Therapy Code List (continued)

Orthotic Management and Prosthetic Management Services

In order to create a new category under the section for physical medicine and rehabilitation services, HCPCS/CPT modified the descriptors of one of these codes, CPT code 97504 (2005), and renumbered it as well as two other HCPCS/CPT codes.

The new therapy code list removes the CY 2005 CPT codes 97504, 97520 and 97703, and replaces them with CPT codes 97760, 97761 and 97762, respectively, for use in CY 2006. The following table contains a list of the added CY 2006 CPT codes and the new short descriptor for CPT code 97760:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>97760</td>
<td>Orthotic management and training</td>
<td>97504</td>
</tr>
<tr>
<td>97761</td>
<td>Prosthetic training</td>
<td>97520</td>
</tr>
<tr>
<td>97762</td>
<td>C/o for orthotic/prosth use</td>
<td>97703</td>
</tr>
</tbody>
</table>

Active Wound Care Management Services

The therapy code list contains five (5) HCPCS/CPT codes that represent active wound care services: CPT codes 97602, 97605, 97606, 97597 and 97598. Three of these CPT codes for wound care (97602, 97605, and 97606) were previously noted as “bundled” services for payment purposes under the MPFS and represented “always therapy” services.

For CY 2006, these three codes were changed to “sometimes therapy” services. While CPT code 97602 remains a bundled service under the MPFS, CPT codes 97605 and 97606, which represent services for negative pressure wound therapy, are now valued and active codes under the MPFS.

Except as noted below for hospitals subject to the OPPS, the requirements for “sometimes therapy” apply. These requirements are described in more detail in Publication 100-04, Chapter 5, Section 20, of the Medicare Claims Processing Manual. That manual is available on the CMS website at [http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage](http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage).

A new payment policy for hospitals paid under the OPPS is being implemented for these five wound care HCPCS/CPT codes – 97602, 97605, 97606, 97597, and 97598, and the indicator “?” is being added as a note to the code list. The indicator “?” signifies that these codes represent “sometimes therapy” services and will be paid under the OPPS when (a) the service is not performed by a therapist (i.e., under the therapy benefit); and (b) it is inappropriate to bill the service under a therapy plan of care.

Wound care provided, which meets these two requirements, should not be billed with a therapy modifier (e.g., GP, G0, or GN) or a therapy revenue code (e.g., 42x, 43x, or 44x). As for other “sometimes therapy” codes, these services are considered therapy services (i.e.; under the therapy benefit) when rendered by a therapist.

They are also considered therapy services when rendered by physicians and nonphysician practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. When such services are therapy services as noted above, the appropriate therapy modifier is required.

<table>
<thead>
<tr>
<th>2006 Status</th>
<th>HCPCS/CPT Code</th>
<th>Short Descriptor</th>
<th>2005 Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundled service for payment purposes under the MPFS; sometimes therapy service.</td>
<td>97602</td>
<td>Wound (s) care, non-selective</td>
<td>Bundled service for payment purposes under the MPFS; always therapy service.</td>
</tr>
<tr>
<td>Valued and active code under the MPFS; sometimes therapy service.</td>
<td>97605</td>
<td>Neg press wound tx,&lt; 50 cm</td>
<td>Bundled service for payment purposes under the MPFS; always therapy service.</td>
</tr>
<tr>
<td>Valued and active code under the MPFS; sometimes therapy service.</td>
<td>97606</td>
<td>Neg press wound tx, &gt; 50 cm</td>
<td>Bundled service for payment purposes under the MPFS; always therapy service.</td>
</tr>
<tr>
<td>Sometimes therapy service.</td>
<td>97597</td>
<td>Active wound care/20 cm or &lt;</td>
<td>Sometimes therapy service.</td>
</tr>
<tr>
<td>Sometimes therapy service.</td>
<td>97598</td>
<td>Active wound care &gt; 20 cm</td>
<td>Sometimes therapy service.</td>
</tr>
</tbody>
</table>

Carrier Pricing of Unspecified Therapy Codes

The 2006 policy adds Note “?” to HCPCS/CPT codes 97039 and 97139 to indicate that the MPFS payment has changed to carrier-pricing and these two codes will no longer be paid using the relative values units previously listed in Addendum B of the 2006 MPFS final rule.

As with other carrier-priced services, where an existing HCPCS/CPT code does not accurately describe the services performed, the provider submits information, for the contractor’s review, to describe the “unspecified” modality(s) or therapeutic procedure(s) performed.

In addition to a detailed service description for CPT code 97039, information submitted to the contractor must specify the type of modality utilized and, if the modality requires the constant attendance of the therapist, the time spent by the therapist one-on-one with the beneficiary must also be noted.
Annual Update to the Therapy Code List (continued)

For CPT code 97139, the information supplied to the carrier must specify the procedure furnished and also meet the other requirements for therapeutic procedures, i.e., the process of effecting change, through the application of clinical skills or services that attempt to improve function.

CPT codes 97039 and 97139 remain designated as “always therapy” and require the use of modifier GP or GO, as appropriate.

HCPCS/CPT Code Short Descriptor
97039 Physical therapy treatment
97139 Physical medicine procedure

Speech, Language, Voice, Communication and/or Auditory Processing

The 2006 policy creates a “?” indicator to indicate that the CY 2006 code descriptors were revised for the following CPT codes: 92506 and 92507. CPT code 97760 is also flagged with the “?” indicator. Although this code number is new, it reflects a revision to the descriptor of the code it replaces, CPT code 97504. The revised 2006 descriptors for CPT code 95206 and 95207 are the following:

<table>
<thead>
<tr>
<th>2006 Code</th>
<th>2006 Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>92506</td>
<td>Speech/hearing evaluation</td>
</tr>
<tr>
<td>92507</td>
<td>Speech/hearing therapy</td>
</tr>
</tbody>
</table>

Microwave Modality

The 2006 policy removes deleted HCPCS/CPT codes 96115 and 97020. CPT 96115 was deleted for CY 2006. CPT code 97020, for the microwave modality, was combined with CPT code 97024 for diathermy.

<table>
<thead>
<tr>
<th>2006 Code</th>
<th>2006 Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>97024</td>
<td>Diathermy e.g., microwave</td>
</tr>
</tbody>
</table>

Code 0019T

The 2006 policy adds HCPCS/CPT code 0019T, as a “sometimes” therapy service, to replace HCPCS codes G0279 and G0280 that were both deleted for CY2006. This code is carrier priced.

<table>
<thead>
<tr>
<th>2006 Code</th>
<th>2006 Short Descriptor</th>
<th>2006 Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>0019T</td>
<td>Extracorp shock wv tx, ms nos</td>
<td>Sometimes therapy</td>
</tr>
</tbody>
</table>

Diagnostic Services

The 2006 policy clarifies in the Medicare Claims Processing Manual (Publication 100-04, Chapter 5, Section 20, Subsection C (Additional HCPCS Codes)), that the listed HCPCS/CPT codes 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, and 95934 represent diagnostic services, under MPFS, and do not represent therapy services and cannot be billed as such. Those codes and their short descriptors are in the following table:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Status under MPFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>95860</td>
<td>Muscle test, one limb</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95861</td>
<td>Muscle test, 2 limbs</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95863</td>
<td>Muscle test, 3 limbs</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95864</td>
<td>Muscle test, 4 limbs</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95867</td>
<td>Muscle test cran nerv unilat</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95868</td>
<td>Muscle test cran nerve bilat</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95869</td>
<td>Muscle test, thor paraspinal</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95870</td>
<td>Muscle test, nonparaspinal</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95900</td>
<td>Motor nerve conduction test</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95903</td>
<td>Motor nerve conduction test</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95904</td>
<td>Sense nerve conduction test</td>
<td>Diagnostic Service</td>
</tr>
<tr>
<td>95934</td>
<td>H-reflex test</td>
<td>Diagnostic Service</td>
</tr>
</tbody>
</table>

CPT Code 96110

The 2006 policy removes the “?” indicator for CPT code 96110, because it is no longer applicable. The “?” indicator indicated that, effective January 1, 2004, CPT code 96110 became an active code on the Medicare physician fee schedule and that carriers no longer priced this code.

HCPCS/CPT Code Short Descriptor
96110 Developmental test, lim

Summary

In summary, CR 4226 instructs your carrier and/or FI/RHII to change any policies or edits that are not consistent with the policies or list of codes provided in CR 4226.
Annual Update to the Therapy Code List (continued)

The changes noted in CR 4226 are effective for services furnished on or after January 1, 2006. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2006 HCPCS/CPT-4.

Implementation

The implementation date for the instruction is February 6, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/FI/RHHI regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R805CP.pdf.

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

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

MLN Matters Number: MM4226
Related Change Request (CR) Number: 4226
Related CR Release Date: January 6, 2006
Related CR Transmittal Number: R805CP
Effective Date: January 1, 2006
Implementation Date: February 6, 2006
Source: CMS Pub. 100-04, Transmittal 805, CR 4226

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Annual Update to the Therapy Code List (continued)

Therapy Caps Effective January 1, 2006

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this article on March 3, 2006, to include clarifying language (bold, italicized print) in the STOP section under “Provider Action Needed.” This article was previously published in the January 2006 Medicare A Bulletin Special Issue (page 12).

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, required payment under a prospective payment system for outpatient rehabilitation services (physical therapy, including outpatient speech-language pathology, and occupational therapy). Section 4541(c) of the BBA required the application of a financial limitation to all outpatient rehabilitation services (except outpatient departments of hospitals).

These limits were in effect in 1999, but were removed by law in 2000-2002. The statutory limits went back into effect September 1, 2003. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 re-enacted the moratorium and extended it until December 31, 2005.
Therapy Caps Effective January 1, 2006 (continued)

Additional Information

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

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

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

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

MLN Matters Number: MM4115 – Revised
Related Change Request (CR) Number: 4115
Related CR Release Date: November 18, 2005
Related CR Transmittal Number: R759CP
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

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

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Sites of Service Revenue Codes for Rural Health Clinics and Federally Qualified Health Centers to Use When Billing Medicare

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

Provider Types Affected

Rural health clinics (RHCs) and federally qualified health centers and (FQHCs) billing Medicare fiscal intermediaries (FIs) for services

Provider Action Needed

STOP – Impact to You

Effective for dates of service on or after July 1, 2006, providers of RHC and FQHC services must use the revenue codes listed below on all claims for services previously billed for using revenue codes 0520, 0521, and 0522. Failure to use these codes could impact your reimbursement.

CAUTION – What You Need to Know

Effective July 1, 2006, the Centers for Medicare & Medicaid Services (CMS) has redefined certain revenue codes for RHC and FQHC services, and added new ones, in order to provide information needed for the evaluation of any expansion of the RHC/FQHC programs, and also for various reviews to ensure the integrity of the Medicare program.

GO – What You Need to Do

Make sure that your billing staffs are aware of these revenue code changes, and bill accordingly beginning on July 1, 2006.

Background

FQHCs currently bill all FQHC services (except for those subject to the Medicare outpatient mental health treatment limitation and the Medicare FQHC supplemental payment) under a single revenue code (0520).

Similarly, RHCs bill most RHC services, except for those subject to the Medicare outpatient mental health treatment limitation, under revenue code 0521; and optionally use revenue code 0522 to bill when RHC services are provided in the beneficiary’s home.

Note: The telehealth originating site facility fee is not an RHC/FQHC service and continues to be billed using revenue code 0780.

Therefore, in order to provide CMS with information needed to improve the administration of the RHC and FQHC programs, effective for all claims for dates of service on or after July 1, 2006, CMS has redefined codes 0521 and 0522 to include FQHC services as well as RHC services.

CMS has also added revenue codes 0524, 0525, 0527 and 0528 (displayed in Table 1, below). The codes in this table must be used for claims with line item dates of service on or after July 1, 2006.

These revenue code changes will enable CMS to identify a broader array of claim types to facilitate data analyses necessary to ensure RHC/FQHC program integrity and to evaluate any program expansion.

RHC/FQHC Revenue Codes Effective July 1, 2006

0521 Clinic visit by member to RHC/FQHC
0522 Home visit by RHC/FQHC practitioner
0524 Visit by RHC/FQHC practitioner to a member, in a covered Part A stay at the SNF
0525 Visit by RHC/FQHC practitioner to a member in an SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527 RHC/FQHC Visiting Nurse Service(s) to a member’s home when in a home health shortage area
0528 Visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident)
Sites of Service Revenue Codes for RHCs and FQHCs to Use When Billing Medicare (continued)

Note: FIs will continue to accept revenue code 0519 from FQHCs when billing for the FQHC supplemental payment, revenue code 0900 from both RHCs and FQHCs when billing for services subject to the Medicare outpatient mental health treatment limitation, and revenue code 0780 when billing for the telehealth originating site facility fee.

Additional Information


You might also want to look at the revised section of the Medicare Claims Processing Manual, Publication 100.04, Chapter Nine (Rural Health Clinics/Federally Qualified Health Centers), Section 100 (General Billing Requirements), which you can find as an attachment to CR 4210. Finally, if you have any questions, please contact your intermediary at their toll free number, which may be found on the CMS website at [http://www.cms.hhs.gov/apps/contacts/](http://www.cms.hhs.gov/apps/contacts/).

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

MLN Matters Number: MM4210
Related Change Request (CR) Number: 4210
Related CR Release Date: February 1, 2006
Related CR Transmittal Number: R820CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006
Source: CMS Pub. 100-04, Transmittal 820, CR 4210

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April 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 billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services under the hospital OPPS.

Provider Action Needed
This article is based on change request (CR) 5011, which describes changes to the OPPS to be implemented in the April 2006 OPPS update.

Background
CR 5011 describes changes to the hospital outpatient prospective payment system (OPPS) to be implemented in the April 2006 OPPS update. The April 2006 OPPS outpatient code editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) and ambulatory payment classification (APC) additions, changes, and deletions identified in CR 5011.

In addition, the April 2006 revisions to the OPPS OCE data files, instructions, and specifications are provided in CR 4360 (April 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.1. CR 4360 may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R888CP.pdf.

Key changes in CR 5011 are as follows:

Billing Clarification for Intensity Modulated Radiation Therapy
Intensity modulated radiation therapy (IMRT), also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining normal tissue.

IMRT has the ability to deliver a higher dose of radiation within the tumor while delivering a lower dose of radiation to surrounding healthy tissue, and it is provided in two treatment phases, planning and delivery. The two methods by which IMRT can be delivered to patients include:

- Multi-leaf collimator-based IMRT, and
- Compensator-based IMRT.

The Centers for Medicare & Medicaid Services (CMS) has received several inquiries seeking clarification of the appropriate billing of certain radiation oncology services when such services are performed in conjunction with an IMRT planning service. Clarification of CMS billing policy is provided below under subsection (a), and billing instructions are described under subsections (b) through (e).


The MLN Matters article corresponding to CR 4250 may be found on the CMS website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4250.pdf.

Effective January 1, 2006, when IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital OPPS, hospitals should bill according to the following guidelines:

a. Do not report Current Procedural Terminology (CPT) codes 77280-77295, 77305-77321, 77331, 77336, and 77370 when these services are directly linked to and performed as part of developing an IMRT plan that is reported using CPT code 77301 (IMRT treatment planning).

b. When the above-mentioned services are performed as part of developing an IMRT plan, the charges for these services should be included in the charge associated with CPT code 77301, even if the individual services associated with IMRT planning are performed on dates of service other than the date on which CPT code 77301 is reported.

c. Hospitals are not prohibited from using existing CPT code 77301 to bill for compensator-based IMRT planning in the hospital outpatient setting.

d. As instructed in the 2006 CPT manual, hospitals should bill CPT code 77418 for multi-leaf collimator-based IMRT delivery and category III CPT code 0073T for compensator-based IMRT delivery in the hospital outpatient setting.

e. Payment for IMRT planning does not include payment for CPT codes 77332 - 77334 when furnished on the same day. When services described by CPT codes 77332 - 77334 are furnished on the same date of service with CPT code 77301, these services are to be billed in addition to the IMRT planning code CPT codes 77301.

f. Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append modifier 59.

Provider Information on Drug Administration Correct Coding Initiative Edits
Beginning in April 2006, Correct Coding Initiative (CCI) edits will be activated under the OPPS for drug administration services. CMS developed the CCI to promote national correct coding methodologies and to
prevent improper coding that could lead to inappropriate Part B payments. Appropriate CCI edits already apply to many services billed under the OPPS and are based on coding conventions defined in:

- The American Medical Association’s (AMA’s) CPT manual
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practices
- A review of current coding practices.

Reinstatement of Drug Administration CCI Edits

CMS suspended application of the CCI edits for OPPS drug administration codes for a brief period to allow hospitals sufficient time to incorporate a series of coding changes that were being implemented under the OPPS into their systems.

However, the drug administration CCI edits support correct coding, and they are appropriate for the coding of hospital outpatient services. Therefore, CMS is reinstating the drug administration CCI edits in April 2006.

As with other CCI edits that will be implemented beginning in April 2006 (OCE CCI version 12.0), the applicable drug administration edits will be posted on the CMS website at http://www.cms.hhs.gov/ shortly before they are activated.

CMS provides a list of national CCI edits for hospital OPPS on the CMS website at http://www.cms.hhs.gov/ NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage.

Hospitals can refer to the CCI Coding Manual for Medicare Services, posted on the CMS website (http://www.cms.hhs.gov/NationalCorrectCodInitEd/), for a discussion of CCI principles relating to drug administration services.

In addition, hospitals may want to review the CCI edits implemented by Medicare carriers in January 2006 for more information, as OPPS edits are implemented one calendar quarter behind carrier edits. However, it is important to note that specific CCI edits in the OCE may differ from edits used by carriers, both with respect to whether a modifier is allowed with a specific code pair and to whether certain edits are actually incorporated in the OCE.

Note: When an OPPS claim triggers a CCI edit, the entire claim will not be rejected or returned, only the line item will be rejected.

CCI edits identify a pair of codes where the second code should not be payable with the first code unless an edit permits use of a modifier. The CCI edits may not allow payment of the second code (likely a drug administration code), when reported with the first code in the edit pair. The claim will continue to process to payment for the first code. Hospitals may want to review their use of applicable modifiers to ensure that services that are appropriate for separate payment are properly coded.

Note: CMS has posted a series of drug administration questions and answers (Q & As) (CY 2006 OPPS Drug Administration [PDF, 25KB]) on the CMS website at http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/OPPSGuidance.pdf, which includes links to the CCI portion of the CMS website.

Information about the CCI may also be accessed from the CMS website http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp.

If, after reading the posted information, hospitals continue to have questions about the CCI edit process, or specific hospital outpatient billing questions, they should contact the medical director at their local FI. Contact information may be found on the CMS website at http://www.cms.hhs.gov/apps/contacts/.

The contractor medical directors are in the best position to answer provider questions accurately and in a timely manner, taking into account both local and national policies. Hospitals should direct questions about specific CCI edits to the National Correct Coding Initiative at the address listed on the CCI portion of the CMS website.

Drugs and Biologicals

Drugs and Biologicals with Payment Rates Based on Average Sales Price (ASP) Effective April 1, 2006

The calendar year 2006 OPPS final rule (70 FR 68643’), p. 68643, 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 April 2006 release of the OPPS PRICER.

CMS is not publishing the updated payment rates in this program instruction implementing the April 2006 update of the OPPS.

However, the updated payment rates effective April 1, 2006, may be found in the April 2006 update of the OPPS Addendum A and Addendum B on the CMS website at http://www.cms.hhs.gov/HospitalOutpatientPPS/02_Addendums.asp.

1 70 FR 68643 may be found at http://www.access.gpo.gov/su_docs/fedreg/a051110c.html and http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gov/2005/05-22136.htm.

Updated Payment Rate for HCPCS C9129 Effective July 1, 2005 through September 30, 2005

The payment rate for the drug listed below was incorrect in the October 2005 OPPS PRICER.

The corrected payment rate was installed in the January 2006 OPPS PRICER, effective for services furnished on July 1, 2005, through implementation of the October 2005 update.
Updated Payment Rates for Certain Drugs and Biologicals Effective October 1, 2005 through December 31, 2005

The payment rates for the drugs and biologicals listed below were incorrect in the October 2005 OPPS PRICER. The corrected payment rates were installed in the January 2006 OPPS PRICER, effective for services furnished on October 1, 2005 through implementation of the January 2006 update.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>APC</th>
<th>Short Description</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9129</td>
<td>9129</td>
<td>Inj clofarabine</td>
<td>$116.87</td>
<td>$23.37</td>
</tr>
<tr>
<td>C9212</td>
<td>9212</td>
<td>Inj, alefacept, IM</td>
<td>$398.34</td>
<td>$79.67</td>
</tr>
<tr>
<td>J9216</td>
<td>0838</td>
<td>Interferon gamma 1-b inj</td>
<td>$272.44</td>
<td>$54.49</td>
</tr>
<tr>
<td>Q4079</td>
<td>9126</td>
<td>Injection, natalizumab, 1 mg</td>
<td>$6.39</td>
<td>$1.28</td>
</tr>
</tbody>
</table>

Newly-Approved Drugs Eligible for Pass-Through Status

The following drugs have been designated as eligible for pass-through status under the OPPS effective April 1, 2006. Payment rates for these items can be found in the April 2006 update of OPPS Addendum A and Addendum B on the CMS website at http://www.cms.hhs.gov/HospitalOutpatientPPS/02_Addendums.asp.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>APC</th>
<th>SI</th>
<th>Long Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9227</td>
<td>9227</td>
<td>G</td>
<td>Injection, micafungin sodium, per 1 mg</td>
</tr>
<tr>
<td>C9228</td>
<td>9228</td>
<td>G</td>
<td>Injection, tigecycline, per 1 mg</td>
</tr>
</tbody>
</table>

Correct Reporting of Units for Drugs

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 four. 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 one mg, and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only one 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 from the CMS website http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage.

Implementation

The implementation date for CR 5011 is April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R896CP.pdf.

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

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

MLN Matters Number: MM5011
Related Change Request (CR) Number: 5011
Related CR Release Date: March 24, 2006
Related CR Transmittal Number: R896CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 896, CR 5011

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April 2006 Outpatient Prospective Payment System Code Editor
Specifications Version 7.1

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

Provider Types Affected
Providers billing Medicare fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs) for services paid under the OPPS

Provider Action Needed
This article is based on change request (CR) 4360, which informs your fiscal intermediary (FI) that the April 2006 outpatient prospective payment system outpatient code editor (OPPS OCE) specifications have been updated with new additions, deletions, and changes.

Background
Change request (CR) 4360 reflects specifications that were issued for the January revision of the OPPS OCE (version 7.0). The following is the summary of data changes effective April 1, 2006 (version 7.1), and all shaded material in Attachment A of CR 4360 reflects changes that were incorporated into the April version of the revised OPPS OCE (version 7.1).

CR 4360 provides the revised OPPS OCE instructions and specifications that will be utilized under the OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for limited services when provided in a comprehensive outpatient rehabilitation facility (CORF), home health agency (HHS) not under the home health prospective payment system, or to a hospice patient for the treatment of a non-terminal illness.

The modifications of the OPPS OCE for the April 2006 release (V7.1) are detailed in the tables within CR 4360 and that CR is available on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R888CP.pdf.

You should also read through the specifications attached to CR 4360 and note the highlighted sections, which indicate changes from the prior release of the OPPS OCE software.

Note also that some of these modifications have an effective date earlier than April 1, 2006, and such dates are reflected at the beginning of each table in CR 4360.

Other changes in this version of the OPPS OCE include:

• Implementation of version 12.0 of the National Correct Coding Initiative (NCCI) file
• Addition of CPT codes 90471 and 90472 to the list of codes designated as vaccines
• Removal of CPT codes 90740, 90743, 90744, 90746, 90747, and G0010 from the list of codes designated as vaccines.

Implementation
The implementation date for CR4360 is April 3, 2006.

Additional Information
For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R888CP.pdf.

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

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

MLN Matters Number: MM4360
Related Change Request (CR) Number: 4360
Related CR Release Date: March 10, 2006
Related CR Transmittal Number: R888CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 888, CR 4360

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Outpatient Prospective Payment System Hospital Emergency Room Services Exceeding 24 Hours

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

Provider Types Affected

Physicians, providers, and suppliers who submit hospital emergency room claims paid under the outpatient prospective payment system (OPPS) to Medicare fiscal intermediaries (FIs).

Background

This article, based on CR 4252, informs OPPS hospitals about proper billing requirements of emergency room services exceeding 24 hours. This policy may be found in the Medicare Claims Processing Manual, Chapter 4, Part B Hospital (Including Inpatient Hospital Part B and OPPS, Section 180, Accurate Reporting of Surgical/Medical Procedures and Services). This section is attached to CR 4252.

Key Points

Hospital OPPS claims submitted for emergency room services should be billed in the following manner:

- The emergency room is identified with revenue code 045x.
- The service date is the date the service was provided in the emergency room.
- If the patient was in the emergency room after midnight, only one service date should be entered, i.e., the date the patient entered the emergency room.
- Service units should be one.

Relevant Links

The official instruction issued to your Medicare FI regarding this change may be found by going to the CMS website http://www.cms.hhs.gov/Transmittals/downloads/R881CP.pdf.

Please refer to your local FI if you have questions about this issue. To find the FI’s toll free phone number, go to the CMS website http://www.cms.hhs.gov/apps/contacts/.

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

MLN Matters Number: MM4252
Related Change Request (CR) Number: 4252
Related CR Release Date: March 3, 2006
Related CR Transmittal Number: R881CP
Effective Date: April 3, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 881, CR 4252

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**The Health Insurance Portability and Accountability Act (HIPAA)**

2006 Revised American National Standards Institute X12N 837 Institutional Health Care Claim Companion Document

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

**Provider Types Affected**

Providers and physicians who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for service

**Key Points**

- The American National Standards Institute X12N 837 Institutional Health Care Claim Companion Document is being updated to add national provider identifier (NPI) and other information.
- This companion document is a set of statements that supplements the X12N 837 Institutional Implementation Guide, and clarifies Medicare contractor expectations regarding data submission, processing, and adjudication.
- It will be available through your Medicare FI or RHHI via their newsletter and website. Information will also be provided via listserv communication for those who subscribe to their Medicare FI’s or RHHI’s listserv.
- The information contained in the companion document to the Health Insurance Portability and Accountability Act (HIPAA) X12N 837 institutional claim is intended solely for clarification. It describes specific requirements for processing data in your Medicare FI/RHHI’s system. The information in the companion document is subject to change, and any changes will be communicated to you in your FI’s or RHHI’s provider news bulletin and on their website.
- Please note that the companion document supplements, but does not contradict, any requirements in the X12N 837 Institutional Implementation Guide. The descriptions provided in the guide will also indicate whether the specific information is required, optional, or situational (e.g., relevant specifically for RHHIs).

**Key Changes to X12N 837 Institutional Implementation Guide**

The key changes to the X12N 837 Institutional Implementation Guide described in CR 4379 include the following:

- Addition of a new statement indicating “The National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108 = XX).”
- Medicare conversion of all lower case characters submitted on an inbound 837 file to upper case and, consequently, only upper case characters will be sent for coordination of benefits purposes.
- A requirement that all 837 claim data submitted must use the basic character set as defined in the Appendix A of the 837 Institutional Implementation Guide.
- A reminder that Medicare does not require taxonomy codes in order to adjudicate claims, but taxonomy codes will be accepted. However, claims submitted with taxonomy codes that are not valid will be rejected. Valid codes are published at http://www.wpc-edi.com/codes/taxonomy.
- A requirement that all dates submitted on an incoming 837 must be valid calendar dates in the appropriate format based on the respective qualifier or the claim will be rejected.
- Negative values submitted in CLM02 (Total Submitted Charges may not be processed and may cause claim to be rejected).
- Addition of a LIN03 statement “The format for National Drug Codes (NDC) is 5-4-2 [11 positions]. Claims that contain NDC codes in any other format will be rejected.”

**Background**

HIPAA requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health & Human Services.

The X12N 837 implementation guides were established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims.

The implementation guides for each X12 transaction adopted as a HIPAA standard are available electronically at http://www.wpc-edi.com.

The information in the companion guide may not contradict any other items in the companion document or X12N 837 institutional implementation guide.

**Relevant Links**


CR 4379 is the official instruction issued to your FI/RHHI regarding changes mentioned in this article. CR4379 may be found by going to CMS website http://www.cms.hhs.gov/Transmittals/downloads/R217OTN.pdf.
Please refer to your local FI/RHII if you have questions about this issue. To find their toll-free phone number, go to CMS website http://www.cms.hhs.gov/apps/contacts/.

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

MLN Matters Number: MM4379
Related Change Request (CR) Number: 4379
Related CR Release Date: March 31, 2006
Related CR Transmittal Number: R217OTN
Effective Date: June 29, 2006
Implementation Date: June 29, 2006

Source: CMS Pub. 100-20, Transmittal 217, CR 4379

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Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or Paper Claim Forms

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

Provider Types Affected

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

Provider Action Needed

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began accepting applications for and issuing NPIs on May 23, 2005. Applications may be made by mail, and online on the CMS website at https://nppes.cms.hhs.gov. CMS has endorsed the Workgroup for Electronic Data Interchange (WEDI) Dual NPI-Legacy Identifier strategy for cross-health care industry implementation of the NPI. The Dual Use of NPI & Legacy Identifiers paper is available at: http://www.wedi.org/snip/public/articles/

(Once at the site, scroll down and look for the paper issued on January 22, 2006.)

The remainder of this article describes CMS’ current plans for a staged process leading to full implementation of the adoption of the NPI in Medicare transactions involving providers.

Background

Implementation involves acceptance and processing of transactions that use the NPI in lieu of the previously used OSCAR, UPIN, PIN, and national supplier clearinghouse (NSC) numbers. The WEDI strategy provides for four stages during which system change schedules of trading partners will occur independently of each other.

Medicare fee-for-service (FFS) transaction implementation for NPI will occur in the following stages:

Stage 1 (January 1, 2006 – October 1, 2006)

During this stage, the NPI will be accepted on inbound claims, other than NCPDP claims, and other transactions but will not be used for Medicare processing.

CR 4320 focuses primarily on Stage 1 of the NPI implementation process. During stage 1:

Please refer to the CMS website at https://nppes.cms.hhs.gov for details.
The “legacy identifier” (pre-NPI provider identifiers) will be used to identify providers while Medicare carriers, DMERCs, and intermediaries make sure that X12 837 version 4010A1 claims and other X12 HIPAA adopted transactions are not rejected due to the presence of an NPI. (Transactions may be submitted with or without an NPI during stage 1, as long as the Medicare legacy identifier is still reported.)

Additionally, NPIs will be edited to verify that they meet basic structure requirements established for NPIs.

Medicare will allow NPIs on the X12 270 version 4010A1 eligibility inquiry and the 276 claim status inquiry and return them in the respective X12 271 or 277 response, as long as the legacy identifier is also reported in the 270 or the 276.

NPIs, as well as legacy identifiers, will be reported in coordination of benefit claims sent to trading partners when submitted on claims submitted to Medicare.

NPIs will NOT be reported in the following outbound transactions during Stage 1, even if an NPI was submitted on related claims:

- X12 835 claims; or
- SPRs (standard paper remittance) formats.

Medicare carriers, DMERCs, and intermediaries must reject the following transactions if submitted with NPIs, since it is not possible to report both NPIs and legacy identifiers for providers in these transactions:

- NCPDP claims
- DDE claims, claim status and eligibility inquiries
- UB-92 (CMS-1450) paper claims (the National Uniform Billing Committee [NUBC] announced that the use of the UB-04, is able to report the NPI and a legacy identifier for each provider involved with a claim, will begin March 1, 2007, and that May 22, 2007, is the last day that a payer should accept a UB-92 form). Since it is not possible to report both a legacy identifier and an NPI on the UB-92, submitters of the UB-92 will be limited to reporting of their legacy identifier on those claims.
- CMS-1500 paper claims until the National Uniform Claim Committee implements a revised 1500 and CMS announces its implementation of that revised form.

The NUCC has approved a revised CMS-1500 form and has announced that payers should begin to accept the revised form effective October 1, 2006. Between October 1, 2006, and January 31, 2007, payers should accept either the current or the revised CMS-1500 form. Effective February 1, 2007, and later, payers should accept only the revised CMS-1500 form. Both the NPI and the legacy identifier can be reported on the revised CMS-1500 form, but not on the form currently in use. Until a provider begins to use the revised form, that provider will be limited to submission of legacy identifiers on the non-revised CMS-1500 form.

Stage 2: (October 2, 2006 – May 22, 2007)

During this stage:

- Providers, clearinghouses, and billing services will be directed to provide a Medicare legacy identifier as a secondary identifier when NPIs are submitted as the primary provider identifiers in their X12 837 claims.
- The legacy identifier alone can still be used to identify those providers that have not yet obtained an NPI.
- The transitional Dual NPI-Legacy Identifier strategy includes the development of a crosswalk between Medicare legacy numbers and their associated NPIs. The crosswalk should help Medicare validate most NPIs to ascertain that they were actually issued to the providers for which reported, and will help to identify transcription errors in a reported NPI. The Crosswalk will begin operating at the onset of stage 2.
- If you use free billing software supplied by your carrier, DMERC, or intermediary/RHII, it will be modified for stage 2 to permit reporting of your NPI, once received, and your legacy Medicare provider identifier. You will need to download the new version of the software when notified it is available.

The 835 PC-Print and Easy Print software for printing of remittances will also be updated for stage 2 to permit reporting of NPIs as well as legacy numbers when both are reported in an 835 transaction. Be sure to download the new version of that software when notified it is available.

- DDE screens will be modified for this stage to accept and return both NPIs, when available, and legacy identifiers.
- NPIs, when available in Medicare provider files, as well as legacy identifiers will be returned in 835 transactions and SPRs during stage 2.

Stage 3 (May 23, 2007 – and Later)

Stage 3 involves the transition to full use of the NPI for acceptance and processing of transactions, except for coordination of benefits (COB) claims that Medicare sends to small trading partners.

- HIPAA prohibits the reporting of any provider legacy identifiers to other than small health plans during this period (e.g., plans with less than $5 million in annual receipts).
- All claims, including NCPDP claims, and 270, 276, and 277 attachment transactions sent to Medicare, must contain the NPI in lieu of the legacy identifier (please see Stage 4 below regarding claims). Those that do not are to be rejected.
- Legacy identifiers will no longer be sent to coordination of benefits (COB) trading partners or on outbound electronic or paper Medicare transactions or correspondence.
**Stage 4 (May 23, 2007 – May 22, 2008)**

Stage 4 involves completion of transition to the full use of NPI by all small trading partners. NPIs, rather than legacy identifiers, will be reported in all 837 version 4010A COB and NCPDP claims sent to small trading partners.

**Additional Information**

CR 4320 is the official instruction issued to your FI, including RHHI, or carrier, including DMERC, regarding changes mentioned in this article. CR 4320 may be found on the CMS website at [http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf).

You may also want to review MLN Matters Special Edition SE0555, concerning the NPI. That article is available on the CMS website at [http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0555.pdf](http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0555.pdf).

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**Shared Systems Medicare Secondary Payer Balancing Edit and Administrative Simplification Act Enforcement Update**

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

**Provider Types Affected**

Physicians, suppliers and providers billing MSP claims to Medicare carriers, fiscal intermediaries (FI), durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs)

**Key Points for Providers**

Change request (CR) 4261 makes two key changes to Medicare claims processing as follows:

- **First,** CR 4261 states that inbound MSP claims will be rejected if the paid amounts and the adjusted amounts paid by the primary payer do not equal the billed amounts at the line level and if the claim lacks standard claim adjustment reason codes to identify adjustments performed. While Medicare may be able to handle such a discrepancy because it does not always use this information, it may pass such claims to other payers. Such other payers may then reject the claims because they do not comply with the 837 version 4010A1 institutional and professional implementation guides. As a result, Medicare will not accept such claims in order to be fully compliant with HIPAA.

- **Second,** if a provider’s paper claims have been denied due to Administrative Simplification Compliance Act (ASCA) electronic claims provision enforcement by Medicare contractors (carriers, FIs, RHHIs, and DMERCs), the provider may resubmit the paper claims if they submit appropriate documentation that establishes that they meet the criteria for submitting paper claims. Providers have until the 91st day after the initial ASCA letter to submit documentation that proves eligibility for submission of paper claims. If a provider establishes eligibility later than the 91st day of

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find their toll free phone number, go to the CMS website at [http://www.cms.hhs.gov/apps/contacts/](http://www.cms.hhs.gov/apps/contacts/).

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

MLN Matters Number: MM4320
Related Change Request (CR) Number: 4320
Related CR Release Date: February 1, 2006
Related CR Transmittal Number: R204OTN
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Source: CMS Pub. 100-20, Transmittal 204, CR 4320

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**Implementation**

The implementation date for the instruction is July 3, 2006

**Additional Information**


If you have questions, please contact your contractors at their toll-free number, which may be found on the CMS website at [http://www.cms.hhs.gov/apps/contacts/](http://www.cms.hhs.gov/apps/contacts/).

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

MLN Matters Number: MM4261
Related Change Request (CR) Number: 4261
Related CR Release Date: February 2, 2006
Related CR Transmittal Number: R831CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 831, CR 4261

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Website URL References Update to Chapter 24—EDI Support Requirements
CMS has issued the following “MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider Types Affected
Physicians, providers, and suppliers who submit claims for services to the Centers for Medicare & Medicaid Services (CMS) Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and durable medical equipment regional carriers [DMERCs])

Background
This article, based on CR 4398, highlights the fact that the http://www.cms.hhs.gov website has been completely redesigned. Currently, Chapter 24 of the Medicare Claims Processing Manual contains URLs that no longer direct the user to the new CMS website. If used, the following message will appear. ‘We’re sorry. The page you requested cannot be found. CMS has recently launched a website redesign and many addresses have changed.’

This instruction updates the URLs that are currently in Chapter 24, removes the URLs that no longer apply, and replaces them with the new URLs.

Key Points
The key new Web addresses are as follows:

• The new address for accessing and downloading the CMS EDI instructions is http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp.

• The X12N 837 implementation guide (IG) version 4010A1 for Institutional (I) and Professional (P) claims is now on the CMS website at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp.

• The implementation guide for coordination of benefits (COB) with other payers is on the CMS website at http://www.cms.hhs.gov/ElectronicBillingEDITrans/12_COB.asp.

• The NCPDP Telecommunications Standard Specifications and IG version 5.1 and Batch Standard 1.1 for retail prescription drug claims (Billed to Medicare DMERCs only) and COB are on the CMS website at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp.

• The X12 835 IG version 4010A1 for Remittance Advice is on the CMS website at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp.

• The X12 276/277 IG version 4010A1 for Claim Status Inquiry and Response is located on the CMS website at http://www.cms.hhs.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp.


Once at that site, select the specific transaction desired from the left side of the screen and you will then get a link to the companion document at the bottom of the page for that transaction.

Additional Information
The official instructions issued to your carrier or intermediary regarding this change may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R900CF.pdf.

If you have questions, please contact your contractor at the toll-free number, which may be found on the CMS website at http://www.cms.hhs.gov/apps/contacts/.

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

MLN Matters Number: MM4398
Related Change Request (CR) Number: 4398
Related CR Release Date: April 7, 2006
Related CR Transmittal Number: R900CP
Effective Date: May 8, 2006
Implementation Date: July 7, 2006
Source: CMS Pub. 100-04, Transmittal 900, CR 4398

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.

Understanding the Remittance Advice

This comprehensive publication provides practical information on the types, uses, components of and standardized codes sets used on the remittance advice (RA) as well as how to read the standard paper remittance advice and the electronic remittance advice using PC-Print software (for institutional providers who receive RAs from fiscal intermediaries or regional home health intermediaries) and Medicare Remit Easy Print software (for professional providers who receive RAs from carriers or DMERCs). It also includes a number of helpful resources including field indexes (for institutional RAs and professional RAs), an acronym list, and a glossary. In addition to the online version of “The RA Guide”, it will also be available in print and on CD ROM later this spring. CMS will announce the availability of these products as they become accessible.

Source: CMS Provider Education Resources Listserv, Message 200603-15
Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

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

Key Points

- Effective December 29, 2005, Remark Code MA02 was updated to reflect the following narrative:
   “If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a quality improvement organization (QIO) must be appealed to that QIO within 60 days.”

- Within 30 days of release of CR 4326, Remark Code MA03 will not be used for Medicare fee-for-service (FFS) and Medicare will update the current narrative of remark code CA02 in the same timeframe.

- Contractors will use the text posted on the Washington Publishing Company (WPC) website if there are discrepancies between any code text included in this article and the corresponding text on the WPC website: http://www.wpcedi.com/codes.

Background

There are two code sets that must be used to report payment adjustments, appeal rights, and related information for transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice. These code sets, updated on a regular basis, include:

- Claim Adjustment Reason Code (CARC)
- Remittance Advice Remark Code (RARC)

Additionally, for transaction 837 COB, CARC must be used.

Additional Information

CR 4326 is the official instruction issued to your FI/RHII or your carrier/DMERC regarding changes mentioned in this article, MM4326. CR 4326 may be found by going to the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R860CP.pdf.

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

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

MLN Matters Number: MM4326
Related Change Request (CR) Number: 4326
Related CR Release Date: February 17, 2006
Related CR Transmittal Number: R860CP
Effective Date: May 17, 2006
Implementation Date: May 17, 2006
Source: CMS Pub. 100-04, Transmittal 860, CR 4326

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.

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Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs)) for services.

Provider Action Needed

STOP – Impact to You

The complete list, including changes made from July 1, 2005, through October 30, 2005, of X12N 835 Remittance Advice Remark Codes (RARC) and X12N 835 Claim Adjustment Reason Codes (CARC) have been posted. The most current and complete code list will be found at http://www.wpc-edi.com/codes.

CAUTION – What You Need to Know

Please refer to the Additional Information section of this article for remark and reason code changes approved between July 1, 2005, to October 30, 2005, and in September 2005, respectively. By April 3, 2006, all applicable code text changes and new codes should be in use and the deactivated codes terminated.

GO – What You Need to Do

The above codes are updated three times a year. Be sure your staff is aware of these changes in order to ensure correct interpretation of the electronic or paper remittance advice notices sent by Medicare.
Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

Background

Two code sets—the claim adjustment reason code set and the remittance advice remark code set—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination of benefits transactions.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers. Additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities. This list is updated three times a year, and posted at http://wpc-edi.com/codes.

The RARC database has expanded rapidly in the last couple of years. CMS has developed a new website to help navigate the database more easily. A tool is provided to help search if you are looking for a specific category of code. You can also find at this site some other information that is available from the WPC website. The new website address is: http://www.cmsremarkcodes.info/.

Note: This website is not replacing the WPC website as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC website.

Implementation

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

Additional Information

The following list summarizes changes made from July 1, 2005, through October 30, 2005:

Remittance Advice Remark Code Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>Status</th>
<th>Current Narrative</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>N357</td>
<td>New</td>
<td>Time frame requirements between this service procedure/supply and a related service procedure/supply have not been met</td>
<td>Medicare Initiated</td>
</tr>
<tr>
<td>N358</td>
<td>New</td>
<td>This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.</td>
<td>Not Medicare Initiated</td>
</tr>
<tr>
<td>N359</td>
<td>New</td>
<td>Missing/incomplete/invalid height.</td>
<td>Not Medicare Initiated</td>
</tr>
<tr>
<td>N360</td>
<td>New</td>
<td>Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.</td>
<td>Not Medicare Initiated</td>
</tr>
<tr>
<td>N361</td>
<td>New</td>
<td>Charges are adjusted based on multiple diagnostic imaging procedure rules.</td>
<td>Not Medicare Initiated</td>
</tr>
<tr>
<td>N362</td>
<td>New</td>
<td>The number of Days or Units of Service exceeds our acceptable maximum.</td>
<td>Not Medicare Initiated</td>
</tr>
<tr>
<td>N363</td>
<td>New</td>
<td>Alert: in the near future we are implementing new policies/procedures that would affect this determination.</td>
<td>Not Medicare Initiated</td>
</tr>
<tr>
<td>N364</td>
<td>New</td>
<td>According to our agreement, you must waive the deductible and/or coinsurance amounts.</td>
<td>Medicare Initiated</td>
</tr>
<tr>
<td>M16</td>
<td>Modified</td>
<td>Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.</td>
<td>Modified effective 11/18/05</td>
</tr>
<tr>
<td>MA02</td>
<td>Modified</td>
<td>If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.</td>
<td>Modified effective 12/29/05 (1)</td>
</tr>
<tr>
<td>MA03</td>
<td>Modified</td>
<td>If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.</td>
<td>Modified effective 11/18/05 (2)</td>
</tr>
<tr>
<td>N9</td>
<td>Modified</td>
<td>Adjustment represents the estimated amount a previous payer may pay.</td>
<td>Modified effective 11/18/05</td>
</tr>
<tr>
<td>N34</td>
<td>Modified</td>
<td>Incorrect claim form/format for this service.</td>
<td>Modified effective 11/18/05</td>
</tr>
<tr>
<td>N207</td>
<td>Modified</td>
<td>Missing/incomplete/invalid weight.</td>
<td>Modified effective 11/18/05</td>
</tr>
</tbody>
</table>
Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Status</th>
<th>Current Narrative</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>N355</td>
<td>Modified</td>
<td>The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at anytime within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.</td>
<td>Modified effective 11/18/05</td>
</tr>
</tbody>
</table>

Claim Adjustment Reason Code Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>Status</th>
<th>Current Narrative</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>190</td>
<td>New</td>
<td>Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.</td>
<td>New as of 10/05</td>
</tr>
<tr>
<td>191</td>
<td>New</td>
<td>Claim denied because this is not a work related injury/illness and thus not the liability of the workers’ compensation carrier.</td>
<td>New as of 10/05</td>
</tr>
<tr>
<td>192</td>
<td>New</td>
<td>Non-standard adjustment code from paper remittance advice.</td>
<td>New as of 10/05</td>
</tr>
<tr>
<td>182</td>
<td>Modified</td>
<td>Payment adjusted because the procedure modifier was invalid on the date of service.</td>
<td>Modified 8/8/05</td>
</tr>
<tr>
<td>B18</td>
<td>Modified</td>
<td>Payment adjusted because this procedure code and modifier were invalid on the date of service.</td>
<td>Modified 8/8/05</td>
</tr>
<tr>
<td>52</td>
<td>Retired</td>
<td>The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.</td>
<td>Inactive as of 2/1/06</td>
</tr>
<tr>
<td>B17</td>
<td>Retired</td>
<td>Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.</td>
<td>Inactive as of 2/1/06</td>
</tr>
</tbody>
</table>

1 This modification is effective January 1, 2006, and has been communicated in a separate instruction (CR 4326).
2 Medicare will not use MA03 effective from January 1, 2006, and that has been communicated in CR4326.
3 This new code was created at the request of Medicare because:
   - Providers who do not qualify for Administrative Simplification Compliance Act (ASCA) exemption must submit claims electronically.
   - If Medicare is secondary, and the primary payer has sent a paper RA with proprietary code(s), the provider could not send a compliant electronic claim unless a crosswalk between the payer proprietary codes and the standard CARC is available.

In CR 4123, Medicare contractors were instructed to complete entry of 192 as a valid code, and accept claims containing this code for adjudication. CMS encourages providers to utilize this code, and submit COB claims electronically.

Reason Codes 1 and 2

In September, CMS requested two new codes to be used in lieu of current reason codes 1 (“Deductible”) and 2 (“Coinsurance Amount”) when a provider is not allowed to collect any deductible and/or any coinsurance.

Section 630 of the Medicare Modernization Act (MMA) permits Indian Health Service (IHS) facilities to directly bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Federal government agencies do not permit providers to collect coinsurance or deductible payments from IHS patients.

The committee did not approve the CMS request for new codes, but suggested that reason codes 1 and 2 should be used with group code CO (contractual obligation) instead of PR (patient responsibility). Currently, in most situations group code
Medicare on a Real-Time Basis)

Health Insurance Portability and Accountability Act

infrastructure needed to provide a real-time, centralized
beneficiary eligibility inquiries, and creates the database and
Other than Claims or Remittance).

Processing Manual

Medicare providers to the revision in the
Background

GO – What You Need to Do

Additional Information

CAUTION – What You Need to Know

Provider Action Needed

STOP – Impact to You

Provider Types Affected

Note:

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Attestation Form for Conducting Real Time Eligibility Inquiries with Medicare

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

MLN Matters Number: MM4314
Related Change Request (CR) Number: 4314
Related CR Release Date: February 17, 2006
Related CR Transmittal Number: R859CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Source: CMS Pub. 100-04, Transmittal 859, CR 4314

PR is used with reason codes 1 and 2. Medicare contractors must use group code CO under this special situation with codes 1 and 2. (See related CR 3845 and the MLN Matters article on the CMS website at http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3845.pdf.)

The official instructions (CR 4314) issued to your Medicare carrier, intermediary, DMERC, or RHII regarding this change may be found on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R859CP.pdf.

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

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

Note: CMS has revised this MLN Matters article on January 31, 2006, to change the effective date from October 1, 2006, to October 1, 2005. All other information remains the same. This article was originally published in the Second Quarter 2006 Medicare A Bulletin (page 95).

Provider Types Affected

Providers who access the 270/271 health care eligibility inquiry and response application in real time

Provider Action Needed

STOP – Impact to You

Beginning September 1, 2005, an on-line attestation form (Trading Partner Agreement for Submission of 270s to Medicare on a Real-Time Basis) must be completed by submitters authenticated by the Centers for Medicare & Medicaid Services (CMS) to conduct 270/271 transactions with CMS before providers may access the real-time 270/271 health care eligibility inquiry and response application.

CAUTION – What You Need to Know

Submitters requesting access to the Medicare beneficiary database must follow the procedure outlined in the Additional Information section below.

GO – What You Need to Do

Please be sure to fill out this new agreement form located at http://www.cms.hhs.gov/it so you can conduct 270/271 transactions with Medicare.

Background

The purpose of change request (CR) 4093 is to alert Medicare providers to the revision in the Medicare Claims Processing Manual, Chapter 31 (ANSI X12N Formats Other than Claims or Remittance).

This revision addresses the standards for Medicare beneficiary eligibility inquiries, and creates the database and infrastructure needed to provide a real-time, centralized Health Insurance Portability and Accountability Act (HIPAA) compliant Health Care Eligibility Benefit Inquiry and Response Transaction (270/271).

Additional Information

Access Process for Clearinghouses/Provider

Beginning September 1, 2005:

• The Medicare eligibility integration contractor (MEIC) will e-mail the on-line attestation form outlining security and privacy procedures for submitters already submitting authenticated 270 transactions on a real time basis.

• Each Submitter should complete the form in its entirety and transmit it back via e-mail to MCAREHD@emdeon.com.

Beginning October 1, 2005:

• Submitters will be able to access the appropriate forms for the CMS 270/271 Medicare Eligibility transaction at: http://www.cms.hhs.gov/AccessToDataApplication.

• The submitter must provide the information requested on the form electronically and click on the appropriate assurances. If the submitter does not consent to the terms of the agreement, by appropriately completing the form, the access process will be terminated.

• A copy of the appropriately completed form must be electronically submitted to CMS. Once CMS has the completed form, it will be authenticated, at which time the submitter will then be directed to complete a Medicare Data Communications Network (MDCN) connectivity form and submit it electronically in order to be connected to the 270/271 eligibility database.
CMS staff will make sure that all of the necessary
information is provided on the form, and will ensure the
complete connectivity to the 270/271 application.
A CMS contractor known as the Medicare eligibility
integration contractor (MEIC) will contact the submitter in
order to authenticate the accessing entity’s identity.

Once authentication has been completed, the MEIC will
provide the clearinghouses, providers, and trading partners
with a submitter identification (ID) that must be used on all
270/271 transactions.

The MDCN extranet application is suitable for many
providers that can create, send, and receive complete X12
eligibility transactions. CMS will soon offer a second
solution for providers that desire to conduct the transaction
using the direct data entry (DDE) version. The DDE
version will allow all approved providers to conduct
eligibility transactions over the public Internet at no cost to
the provider.

Please note that in order to access the MDCN, an entity
must obtain the necessary telecommunication software from
the AT&T reseller on its own. AT&T Resellers and contact
cumbers include the following:

- IVANS: http://www.ivans.com; telephone: 1-800-548-2675
- McKesson: http://www.mckesson.com; telephone: 1-
  800-782-7426; key option 5, then key option 8

MEIC Helpdesk Support

You may also contact the MEIC help desk for connec-
tivity issues on Monday through Friday, 7:00 a.m. - 9:00
p.m. EST; Telephone: 1-866-324-7315; E-mail address:
MCARE@cms.hhs.gov.

Related Links

The official instruction issued to your fiscal intermedi-
ary (FI), regional home health intermediary (RHHI), carrier,
or durable medical equipment regional carrier (DMERC)
regarding this change may be found by going to the CMS
website http://www.cms.hhs.gov/Transmittals/downloads/
R700CP.pdf.

Please refer to your local FI, RHHI, Carrier or DMERC
for more information about this issue. To find the toll free
phone number, go to on the CMS website http://
www.cms.hhs.gov/apps/contacts/.

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

MLN Matters Number: MM4093 – Revised
Related Change Request (CR) Number: 4093
Related CR Release Date: October 7, 2005
Related CR Transmittal Number: R700CP
Effective Date: October 1, 2005
Implementation Date: November 7, 2005
Source: CMS Pub. 100-04, Transmittal 700, CR 4093

Providers Must Send Medicare Secondary Payer Claims Electronically

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically,
with few exceptions. **MSP claims are not an exception unless the provider submits the claim for Medicare payment
after receiving payment from more than one other payer and at least one of those payers reduced their payment due
to an obligated to accept as payment in full (OTAF) adjustment.** The 837-4010A1 Implementation Guides, section
1.4.2.1, contain detailed information on how to submit MSP claims electronically. In the near future MSP paper claims will
not be processed for electronic submitters.

We ask that you contact your vendor, billing service, clearinghouse or internal IT staff to ensure that your software is
correctly set up to capture the data required and begin submission of your MSP claims electronically.

For assistance from Medicare EDI, please contact the Medicare Part A support group at 1-904-791-8131, option 2.  

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Third Quarter 2006 The Florida Medicare A Bulletin 131
Welcome to the World of Medicare Electronic Data Interchange

Whether you are already a provider who submits electronic claims data to First Coast Service Options (FCSO), a provider who submits paper claims, or a new provider, the information below may be of benefit to you. Please read further.

ASCA (Administrative Simplification and Compliance Act) Provision – This mandate dictates that all claims submitted to Medicare should be submitted electronically (with few exceptions). The enforcement of this provision will entail identifying providers who are currently submitting paper claims and contacting them directly to ensure they meet the exception criteria. Providers not meeting the exception criteria will be given a specific period of time to come into compliance, after which time any paper claims received for that provider will be denied. Providers not meeting the criteria should do the following:

- If you are a new provider, or a provider who submits only paper claims – Contact our office at 1-904-791-8767, option 1. We will discuss available options for submitting your claims electronically. Medicare can also provide free software to you that will allow claims to be submitted electronically.
- If you are a provider who submits claims electronically – Many providers have processes in place that do generate some paper claims. Check to ensure that all claims are being submitted electronically.

HIPAA (Health Insurance Portability and Accountability Act) – This law requires that claims submitted electronically be submitted in a standardized/compliant electronic format, currently the ANSI x12 837 4010A1 format. Claims submitted by providers in a noncompliant format are being held for payment as if they were paper claims (29 days versus 14 days for electronic claims).

The compliant format requirement also applies to ERA (electronic remittance advice), which is the ability to receive payment information electronically for auto posting into your practice management system (see electronic applications below for more information).

To all Providers – Ensure that your electronic software (or your clearinghouse software, if using a clearinghouse) is sending claims (or receiving remittance) in a HIPAA compliant format. Work with your vendor to obtain a compliant format if you are not in compliance.

Other Electronic Applications

Electronic Funds Transfer – Have your Medicare payments deposited directly into your bank account. No waiting for a paper check in the mail, or last minute trips to the bank to make deposits. Combine this with ERA for a paperless environment.

Electronic Remittance Advice – This is a valuable tool for provider offices, allowing individual claim payment information (identical to the paper remittance form) to be electronically retrieved and automatically posted into your account management system. This eliminates both clerical entry errors and entry time in posting this data and allows your staff to concentrate on other office functions.

Important: Contact your vendor or Medicare EDI for additional information regarding this application.

- We also offer free software that enables you to read and print a remittance advice from the HIPAA compliant electronic remittance in a format similar to the standard paper remittance.
- Medicare Part B - Medicare Remit Easy Print (MREP) and Medicare Part A – PC-Print Software

Free Software (PC-ACE Pro32) – This is a claims submission software, not a practice management system. It creates HIPAA format compliant claims to be transmitted electronically.

Electronic Reject Reports – This is an important report that provides details about your claim transmissions. It contains information reflecting the volume of claims that were submitted during the transmission, the number of claims successfully received, and the number of claims that rejected based on edit criteria. It also provides specific information on the claims that rejected. Your software vendor would need to make this capability available to you.

Electronic Claim Status Request and Verification – Instead of manually researching the status of your outstanding claims via the interactive voice response (IVR) unit, you can obtain your claim status information electronically.

For additional information, please contact our EDI department at 1-904-791-8767, option 1, or visit our provider education website, at http://www.floridamedicare.com.
An Open Letter to Health Care Providers from the Inspector General

This open letter discusses certain of my perspectives on compliance, the resolution of health care fraud cases, corporate integrity agreements (CIAs), and the OIG’s provider self-disclosure protocol (SDP). I am also announcing an initiative that promotes the use of the SDP to resolve civil monetary penalty (CMP) liability under the physician self-referral and anti-kickback statutes for financial arrangements between hospitals and physicians.

In addition to working with our law enforcement partners to sanction companies and individuals who violate the law, OIG also commits substantial resources to promote voluntary compliance by the health care industry. Our guidance to the industry, in the form of advisory opinions, special fraud alerts, special advisory bulletins, and compliance program guidance, offers substantive assistance to program participants committed to promoting ethical and lawful conduct in their organizations. Examples of recent guidance include a special advisory bulletin in concerning patient assistance programs for Medicare Part D enrollees, and a supplemental compliance program guidance for hospitals. All of our compliance materials may be found at OIG’s website, http://www.oig.hhs.gov.

When a health care provider is alleged to have violated the law, OIG’s first priority is to protect the Department’s programs and their beneficiaries. OIG has several tools available for pursuing this goal, including program exclusion, CMPs, and integrity agreements. We will continue to seek the exclusion of providers that demonstrate a lack of integrity, or that provide substandard care to beneficiaries. For those providers that demonstrate the requisite level of trustworthiness and that also have in place, or are willing to develop, an effective compliance program, OIG will waive its exclusion authority concurrent with resolution of monetary liability under the False Claims Act and the CMP Law. Typically, these settlements include an integrity agreement between OIG and the provider.

Effective compliance systems are key to strengthening the integrity of the health care system. OIG integrity agreements have been a catalyst for change in corporate culture, and can result in the development of comprehensive internal control systems. Our communications with providers during the course of our compliance monitoring efforts have also enhanced compliance within their organizations.

While we are committed to working collaboratively with providers operating under integrity agreements, some providers fail to demonstrate a commitment to compliance even while operating under such agreements. Integrity agreements typically include contractual remedies for breach of the agreement, including stipulated penalties and exclusion from federal health care programs. Since 1999, OIG has imposed stipulated penalties totaling about $300,000 in 21 cases where providers have failed to meet explicit requirements of their integrity agreements. In a recent case involving repeated and flagrant violations of a CIA, we excluded a hospital.

The OIG’s November 2001 “Open Letter to Health Care Providers” continues to guide decisions about whether to require an integrity agreement and the specific terms of these agreements. Many providers have independently developed robust and effective compliance programs, which include internal auditing mechanisms. In appropriate cases, we have agreed to reduce the obligation on providers settling health care fraud matters by entering into certification of compliance agreements (CCAs), rather than more extensive CIAs. CCAs require providers to certify that they will continue to operate their existing compliance programs for a fixed term, typically three years, rather than enter into a more extensive CIA with a five-year term. CCAs do not require independent review organizations to conduct or verify audits or claims reviews.

A provider’s self-disclosure of conduct continues to be an important factor in determining whether a CCA is appropriate, because detection and prompt disclosure of potential fraud are evidence of an effective compliance program. The OIG’s 1998 SDP (available on OIG website) sets forth a mechanism for providers to investigate, quantify, and resolve potential fraud matters. Consistent with the 2001 open letter, we have required CIAs in only 27 of the 136 self-disclosures resolved with a monetary payment.

OIG has heard from hospitals that, through their compliance programs, they are discovering improper arrangements under the physician self-referral law (42 U.S.C. section 1395nn) and are seeking a way to resolve violations. The SDP is one vehicle to resolve this type of administrative liability. OIG has the authority to impose CMPs of up to $15,000 for each service billed in knowing violation of the physician self-referral law, and assessments of up to three times the amount claimed for such services (see 42 U.S.C. section 1395nn(g)(3)). Hospitals and physicians also have potential liability for these arrangements under OIG’s anti-kickback CMP (see 42 U.S.C. section 1320a-7a(a)(7)), which authorizes a penalty of $50,000 for each kickback, plus an assessment of not more than three times the total amount of remuneration offered, paid, solicited, or received. In addition to CMPs, OIG may also seek exclusion under these authorities.

We are now seeking to increase awareness in the hospital and physician communities of a way to resolve conduct that may result in liability under the OIG’s CMP authorities for physician self-referral and anti-kickback violations. This new initiative supplements the SDP by providing guidance on how these types of disclosures will be resolved. The initiative
incorporates the SDP process, whereby OIG confers with the Department of Justice (DOJ) to ensure that it is aware of each disclosure and has an opportunity to opine before OIG accepts a provider into the Protocol and is presented with the results of OIG’s review of the SDP matter before it is resolved under OIG’s CMP authorities. It is important to stress that OIG’s agreement to resolve an SDP matter is not binding upon DOJ.

The initiative is limited to matters that, in the provider’s reasonable assessment, involve conduct that subjects the provider to CMP liability under the OIG’s physician self-referral and anti-kickback authorities—in particular, situations involving a financial benefit knowingly conferred by a hospital upon one or more physicians. The financial benefit conferred upon a physician may take various forms, for example, an arrangement under which the physician pays the hospital below fair market value for a good or service (e.g., lease of office space).

Because multiple OIG authorities are implicated, a provider’s liability in these cases typically falls along a continuum—the CMP damages calculation for physician self-referral violations is based on the number and dollar value of improper claims, while the CMP damages calculation for kickbacks is based on the number and dollar value of improper payments or remuneration. Subject to the facts and circumstances of the case, OIG will generally settle SDP matters for an amount near the lower end of this continuum, i.e., a multiplier of the value of the financial benefit conferred by the hospital upon the physician(s).

A provider’s participation in the SDP is contingent upon full cooperation and complete disclosure of the facts and circumstances surrounding the violation. Providers will be removed from participation in the initiative unless they disclose in good faith and timely perform the required self-assessment, including quantifying the financial benefits conferred upon the physician(s) and quantify the full amount of the overpayment. The degree of the provider’s cooperation is considered when determining the appropriate terms of an administrative settlement. OIG will also consider the provider’s existing compliance program when evaluating whether a CIA, CCA, or no additional compliance measures will be required.

This new self-disclosure initiative will serve as an additional opportunity for providers to work collaboratively with OIG and to take responsibility for further strengthening the integrity of our health care system. I look forward to continuing our joint efforts to promote compliance in the federal health care programs.

Source: Mr. Daniel L. Levinson, Inspector General, April 24, 2006
Announcing a New Name for Medicare Provider Education Articles—MLN Matters

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

Provider Types Affected
All Medicare physicians, providers, and suppliers

Background
The Medicare Learning Network is pleased to announce a new name for our very popular provider education articles. To more closely associate these articles with the Medicare Learning Network, i.e., the official educational information source for Medicare fee-for-service (FFS) providers, the articles previously known as “Medlearn Matters” articles will now be known as “MLN Matters” articles (the MLN standing for “Medicare Learning Network”).

You will also notice a new logo at the top of the articles indicating the name change. The Centers for Medicare & Medicaid Services (CMS) knows that you have come to rely on these articles to help you more easily understand new or changed Medicare policy and to help you gain quick access to accurate Medicare program information.

The articles can now be accessed from the CMS website at http://www.cms.hhs.gov/MLNMattersArticles.

If you have previously bookmarked the “Medlearn Matters” page, please update your bookmark to the new URL.

We hope that you will continue to utilize these articles that are always prepared with the affected provider audience in mind.

In conjunction with the above referenced change, the URLs for the Medicare Learning Network (MLN) Web pages have also been changed. You can reach our MLN Web pages from the cms.hhs.gov main page – just click on “Outreach and Education.” The full URLs to access the various MLN sections on the CMS website are:

MLN Products – http://www.cms.hhs.gov/MLNProducts

Additional Information
Also, note that if you know the specific number of an article you are after, such as SE0620, you can go directly to the specific URL for an article by using the format below. For example, the web site for SE0620 is http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0620.pdf.

For any other article, just substitute its number for the SE0620 in this URL to go directly to the PDF version of the article on the CMS website.

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Announcing a New Name for Educational Articles—MLN Matters

The Medicare Learning Network is pleased to announce a new name for its very popular Medicare fee-for-service provider education articles. Formerly known as “Medlearn Matters,” these national articles are now called “MLN Matters.” CMS has changed the name to more closely associate these articles with the Medicare Learning Network, which is the official educational information source for Medicare fee-for-service providers. Please see the attached Special Edition article SE0620 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0620.pdf) for details on this and other changes to the Medicare Learning Network’s Web pages.

Source: Provider Education Resources Listserv, Message 200604-05

Evaluation & Management Service Guide


Source: Provider Education Resources Listserv, Message 200604-10

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Creating AV Fistulas in All Eligible Hemodialysis Patients Training Module

The training module titled “Creating AV Fistulas in All Eligible Hemodialysis Patients” is now available free of charge from the Medicare Learning Network located on the CMS website at [http://www.cms.hhs.gov/MLNGenInfo](http://www.cms.hhs.gov/MLNGenInfo).

Scroll down and select “MLN Product Ordering Page” to request the training module.

**Primary Affected Providers:** Vascular access surgeons, interventional radiologists/nephrologists, nephrologists, physicians, and hospital health care professionals.

Source: Provider Education Resources Listserv, Message 200604-09

New eLearning Course Now Available

First Coast Service Option (FCSO) is pleased to announce the posting of a new online course for Part A providers, titled “Verifying Beneficiary Eligibility in DDE.” We continue to receive many inquiries about verifying beneficiary eligibility. We created this course to address your needs. This course describes the benefits of researching the eligibility for Part A, or ELGA, screens in direct data entry (DDE) to determine the current eligibility, entitlement, and utilization information for a Medicare beneficiary. The course also includes a demonstration of accessing these screens for a sample beneficiary and allows you to practice hands-on application of the skills in a risk-free, simulated environment.

This is just one of the many online courses that are available 24 hours a day, seven days a week, at no charge, through our provider education website. Click “Education” on the top navigation menu and “eLearning” on the left navigation menu. Courses currently available include:

- Beneficiary Name and Medicare Number Mismatch
- Coding Inpatient Cost Outlier Claims
- Comprehensive Error Rate Testing (CERT)
- Determining Medicare Part A Benefit Period
- Medical Documentation Requests
- Progressive Corrective Action

Check regularly our provider education website for an upcoming online course on Medicare as secondary payer.

Medicare Provides Coverage for Many Preventive Services and Screenings

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

**Provider Types Affected**

All Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who provide and bill for preventive services and screenings provided to Medicare beneficiaries.

**Provider Action Needed**

This article serves as a reminder that we need your help to ensure that Medicare beneficiaries receive the preventive services they need. Become familiar with the preventive services and screenings covered by Medicare. Help the Centers for Medicare & Medicaid Services (CMS) spread the news about the many preventive services and screenings covered by Medicare.

Talk with your Medicare patients about preventive services and screenings and encourage use of those services, where appropriate. Order and use the educational products developed by CMS to educate your staff about these benefits. The information found in these products will also help you communicate with your patients about Medicare preventive benefits.

**Introduction**

Medicare provides coverage for many diseases that are preventable through immunization or amendable through early detection, treatment, and lifestyle changes. This special edition MLN Matters article informs health care professionals about the preventive services and screenings covered by Medicare and highlights the educational and informational products developed by CMS for health care professionals to promote awareness and increase appropriate utilization of these services.

**Medicare provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):**

- Adult Immunizations
  - Influenza (flu)
  - Pneumococcal polysaccharide vaccine (PPV)
  - Hepatitis B virus (HBV)
- Bone Mass Measurements
- Cancer Screenings
  - Breast (mammography)
Medicare Provides Coverage for Many Preventive Services and Screenings (continued)

- Cervical & vaginal (Pap test & pelvic exam)
- Colorectal
- Prostate
- Cardiovascular Disease Screening
- Diabetes Screening
  - Self-Management Training
  - Medical Nutrition Therapy
  - Supplies
- Glaucoma Screening
- Initial preventive physical exam (IPPE) (“Welcome to Medicare” Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling Services

CMS needs your help to get the word out about the many preventive services and screenings covered by Medicare. Each of these benefits presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing certain diseases.

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about preventive services and screenings. As a trusted source, your recommendation is the most important factor in increasing the use of appropriate preventive services.

Talk to your Medicare patients about the benefits of preventive medicine, detecting disease earlier when outcomes are best, reducing infectious disease, and improving the quality of their lives.

Educational Products and Informational Resources for Health Care Professionals

CMS has developed a variety of educational products to:

- Help increase your awareness of Medicare’s coverage of disease prevention and early detection
- Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible
- Give you resources to help you effectively file claims.

Print products may be ordered, free of charge, from the Medicare Learning Network (MLN). All print products are available to download and view on line and may be reprinted or redistributed as needed. Some print products are only available as a download and will be notated as such.

Product Ordering Instructions

To order a product, free of charge, access this link: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.

You may click on the title of the publications below to view them online.

Brochures

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals – This series of tri-fold brochures provides an overview of Medicare’s coverage for preventive services and screenings including the new benefits: diabetes and cardiovascular disease screenings and the initial preventive physical examination (IPPE). (See Expanded Benefits brochure.)

- Adult Immunizations [PDF 279KB]
- Bone Mass Measurements [PDF 269KB]
- Cancer Screenings [PDF 295KB]
- Expanded Benefits [PDF 255KB]
- Glaucoma Screening [PDF 242KB]
- Smoking and Tobacco-Use Cessation Counseling Services [PDF, 562KB] (available in download only at this time)

Guides

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals [PDF 2MB] – This guide provides information on Medicare’s preventive benefits including coverage, frequency, risk factors, billing and reimbursement. (May 2005. See the errata sheet for corrections identified since May 2005 printing.)

Determining a Medicare Beneficiary’s Eligibility for Medicare Preventive Services [PDF 304KB] – This guide provides information on interpreting the Medicare beneficiary preventive services “next eligible date” data and is intended to supplement the educational materials already available for the HIQA, HIQH, HUQA, ELGA, ELGB and ELGH eligibility inquiry screens used to access common working file (CWF) records. (September 2005; Available in download only)

Medicare Preventive Services CD ROM

Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals – This CD ROM contains The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals; six brochures: 1) Expanded Benefits, 2) Glaucoma Screenings, 3) Cancer Screenings, 4) Bone Mass Measurements, 5) Adult Immunizations, and 6) Smoking and Tobacco-Use Cessation Counseling Services; and a Quick Reference Information: Medicare Preventive Services chart.

These resources are useful for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals that bill Medicare for preventive services. (See errata sheets for corrections identified since May 2005 printing of these products. See product ordering instructions above.)

Quick Reference Information Chart

Quick Reference Information: Medicare Preventive Services [PDF 74KB] – This two-sided laminated chart gives a quick reference to Medicare’s preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. (May 2005. See errata sheet for corrections identified since May 2005 printing.)
Medicare Provides Coverage for Many Preventive Services and Screenings (continued)

Video Programs

Flu Billing Made Easy – This video explains the process of billing for flu and pneumonia vaccinations. (January 2004) (English and Spanish) Ordering and other relevant information can be found at the following Web pages:

- Flu Billing Made Easier – Order (English and Spanish video)
- Flu Billing Made Easier – Video Transcript [PDF 91KB]
- Flu Billing Made Easier – Video Errata [PDF 13KB]
- Flu Billing Made Easier Recommended Dial-Up
- Flu Billing Made Easier Recommended DSL/Cable
- Flu Billing Made Easier Recommended T1/DS3

Web-Based Training Courses

Web-Based Training Modules (WBTs) – Three Web-based training courses covering coding, billing, overage and reimbursement for Medicare preventive services and screenings. (To access these WBT courses, go to the MLN Products Web page at http://www.cms.hhs.gov/MLNProducts/. scroll to the bottom of the page to “Links Inside CMS” and click on Web-based training modules.

Web Page

MLN Preventive Services Web Page – This Medicare Learning Network (MLN) Web page, for Medicare fee-for-services health care professionals, provides links to all of the provider/supplier specific preventive services educational and informational products mentioned in this article.

Other Useful Provider Resources

Other useful provider resources include the following:

Prevention Toolkit – This online toolkit contains resources that you may find useful when talking to your patients about Medicare preventive benefits.

Immunizations Toolkit – This online toolkit contains printable resources that nursing home providers can use to help improve the influenza and pneumococcal immunization rates among their residents, staff, and volunteers.

CMS Prevention Web Pages

CMS has created individual web pages for each of the preventive services and screenings covered by Medicare. For additional information visit http://www.cms.hhs.gov/home/medicare.asp and scroll down to the Prevention section.

Medicare Learning Network (MLN)

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network’s Web page on the CMS website at http://www.cms.hhs.gov/MLNGenInfo.

We encourage you to order and use these provider-specific products to:

- Increase your awareness of preventive services covered by Medicare
- Equip you to talk with your patients about Medicare-covered preventive services and encourage utilization of these potentially life saving benefits
- Help you file preventive services claims more effectively.

Note: These products have been developed for you, the health care professional.

Provider-specific products are not meant for distribution to Medicare beneficiaries. See below for where to obtain beneficiary specific information.

Preventive Benefit Information for Medicare Beneficiaries

Medicare beneficiaries may obtain information about Medicare preventive benefits by going to http://www.medicare.gov/ and clicking on “Preventive Services.”

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

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March is National Kidney Month

As you know, chronic kidney disease (CKD) is a growing problem in the United States. CKD can lead to cardiovascular disease, among other serious health conditions, and left unchecked can eventually lead to kidney failure. Over 400,000 Americans suffer from kidney failure (end stage renal disease, or ESRD) and require either kidney dialysis or transplantation to live. Additionally, 8 to 20 million Americans have reduced kidney function, due primarily to diabetes and hypertension, which can lead to kidney failure. ESRD is Medicare’s only disease-specific program that entitles people of all ages to Medicare coverage on the basis of their diagnosis. Your patients may be at risk for chronic kidney disease if they:

- Have Diabetes
- Have High Blood Pressure
- Have a Family History of Chronic Kidney Disease
- Are 60 Years of Age or Older
March is National Kidney Month (continued)

- Are from the following ethnic groups (African American, Hispanic, Asian or Pacific Islander)

The Medicare Program provides coverage of kidney dialysis and kidney transplant services for eligible Medicare patients. Your Medicare patients may also be eligible for coverage of cardiovascular disease and diabetes screenings, diseases that may increase the risk of kidney damage.

**What can you do?**

*Prevention is possible! Talk with your patients about their risk for kidney disease and encourage them to take advantage of the appropriate Medicare benefits, such as cardiovascular disease and diabetes screenings and medical nutrition therapy services. Early treatment can slow progression of kidney disease and reduce cardiovascular risk.*

**Resources**

To learn more about Medicare’s coverage of and payment for kidney related services, please refer to the following publications, developed by the Medicare Learning Network (MLN) for health care professionals:

  http://www.cms.hhs.gov/MedlearnProducts/downloads/Book_Kidney_Dialysis-Final.pdf (Available in print or download)

**Other Helpful Education Resources**

- National Kidney Disease Education Program
  www.nkdep.nih.gov/ to learn more about kidney disease and how you can help your patients.

Source: Provider Education Resources Listserv, Message 200603-07

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.

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**PRESCRIPTION DRUG COVERAGE**

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**2006 Standard Medicare Prescription Drug Coverage—Understanding Costs to Beneficiaries**

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

*The twelfth article in a series of: Information for Providers, Physicians, Pharmacies and their Staff About Medicare Prescription Drug Coverage*

**Provider Types Affected**

Physicians, providers, and suppliers, and their staff who provide service to people with Medicare

**Important Points to Remember**

Key points to remember about the new Medicare prescription drug coverage include the following:

- **Beneficiaries can join a Medicare prescription drug plan that covers prescription drugs only and keep their original Medicare coverage.** Or, they can join a Medicare Advantage plan or other Medicare health plan that covers doctor and hospital care as well as prescriptions.

- **Medicare prescription drug coverage is NOT automatic—people must join a plan to get coverage**

- **Your patients have an initial opportunity to join a Medicare drug plan now through May 15, 2006.**

- Most people will have to pay a higher premium that includes a penalty if they wait to join a Medicare drug plan until after May 15, 2006, unless they have other coverage that, on average, is at least as good as Medicare prescription drug coverage.

  This penalty consists of an additional one percent of the base premium for every month the person went without coverage, and is levied as long as the person is enrolled in a Medicare drug plan.

- **People who do not join a Medicare drug plan by May 15, 2006, may also have to wait until November 15, 2006 for their next opportunity to join.**

  If your Medicare patients ask you questions about the new coverage, you can refer them to http://www.medicare.gov and 1-800-MEDICARE for additional information and assistance.
2006 Standard Medicare Prescription Drug Coverage—Understanding Costs to Beneficiaries (continued)

General Information

One of the issues that may be most important for your patients involves what Medicare prescription drug coverage means to them in terms of cost. This article focuses on the out-of-pocket expenses that your patients will incur under this new program and highlights the costs covered by a standard plan.

Actual costs of the specific Medicare prescription drug plans and the Medicare Advantage plans or other Medicare health plans in each area are available in the “Medicare & You 2006” handbook and on the Web at http://www.medicare.gov.

Costs Covered by a Standard Plan

Costs for your patients who join a Medicare drug plan will vary depending on their financial situation and which Medicare drug plan they join. All Medicare drug plans will offer at least the standard level of coverage described below.

Medicare drug plans may design their plans differently as long as what their plan offers is, on average, at least as good as the standard coverage. Some plans may offer more coverage for higher premiums.

Patient costs under standard Medicare drug coverage as defined by the MMA for 2006 will include the following:

- A monthly premium (average of $32 in 2006).
- A $250 deductible.
- Person pays, on average, 25 percent of allowable drug expenses up to a coverage limit of $2,250 (plan pays the other 75 percent).
- After $2,250 in covered drug costs, person pays 100 percent of covered drug costs until $3,600 limit in true out-of-pocket spending is reached.
- About 5 percent coinsurance for covered drug costs after $3,600 out-of-pocket limit is reached.

Individuals with standard coverage will pay the full cost of their prescriptions for drug spending between $2,250 and up to their true out-of-pocket limit of $3,600.

However, plan enrollees will still be able to obtain their plan’s discounted price for prescription drugs in this coverage gap.

Alternate Coverage

Plans are able to offer alternative coverage structures. For example, a plan can offer a deductible lower than $250, or use tiered copayments rather than coinsurance – provided that the alternative coverage structure meets certain tests of actuarial equivalence.

Also, plans may offer additional drug coverage that supplements the standard coverage. Medicare payments to plans do not subsidize such supplemental coverage.

Costs for Patients With Medicare and Full Medicaid Benefits

Under Part D, starting in 2006, Medicare will provide primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals who earn incomes up to 100 percent of the federal poverty level will have Medicare prescription drug coverage with no deductibles, no premiums, nominal copays, and no coverage gap.

Beneficiaries who do not qualify for Medicaid, but whose incomes are below 150 percent of poverty and who meet an asset test, will qualify for extra help paying for Medicare prescription drug coverage. Beneficiaries who qualify for extra help can join a Medicare drug plan with full or partial coverage for premiums and cost sharing and no coverage gap.

Specific Information on Out-of-Pocket Expenses Medicare Drug Plan Premiums

Medicare drug plan monthly premiums vary, depending on the plan; however:

- All regions of the country have multiple plan options with premiums significantly below $30.
- There will be at least one prescription drug plan with a premium below $20 per month in every region of the country except Alaska.
- The average monthly beneficiary premium is $32.20, about $384 per year.

True Out-Of-Pocket Costs

The cost to beneficiaries with Medicare for Medicare prescription drug coverage over and above the monthly premium is often referred to as “true out-of-pocket expenses” or TrOOP.

The TrOOP represents the amount a beneficiary must spend on Part D covered drugs until catastrophic coverage begins. That catastrophic coverage begins when the beneficiary’s out-of-pocket expenses reach $3,600 in a year.

In addition to paying the base premium for their plan, Medicare beneficiaries will also pay TrOOP costs including the following:

- A deductible amount ($250) and coinsurance (25 percent of covered drug costs during the plan payment plus coinsurance stage).
- All costs during the coverage gap stage.
- Five percent of covered drug costs during the catastrophic coverage stage.

These additional TrOOP expenses are explained as follows:

Deductible (From $0 to $250: A net value of $250)

Under standard coverage, plan enrollees pay a $250 deductible each calendar year out of their own pockets for Part D covered drugs.

Plan Payments Plus Coinsurance (From $251 to $2,250)

Once the annual ($250) deductible is met, standard coverage pays 75 percent of the next $2,000 (or up to $1,500) for covered (allowable) drugs and biologicals. The remaining 25 percent (a maximum of $500) of the cost is covered by the beneficiary via coinsurance/copayments.

Coverage Gap (From $2,251 to $3,600 TROOP limit)

Once covered drug costs have reached the plan payment plus coinsurance plus deductible limit of $2,250, the plan does not pay again until the plan enrollee has reached the $3,600 limit in out-of-pocket spending. The beneficiary pays all covered drug costs incurred in this “gap.” The total out of pocket cost (not including premiums) to this point (deductible plus plan payments plus coinsurance plus...
coverage gap) is $3,600 for coverage through the full “gap” (see TrOOP discussion below.)

**Catastrophic Coverage (Costs over $3,600 TROOP limit)**

Once the individual’s true out-of-pocket spending reaches $3,600, costs for necessary covered drugs are covered as follows:

- **Reinsurance** – 80 percent of covered drug-related costs are covered by Medicare.
- **Plan payments** – 15 percent of covered drug-related costs are covered by the drug plan.
- **Coinsurance** – Five percent of covered drug-related costs are covered by the individual.

**What Counts Toward True Out-of-Pocket (TrOOP) Costs?**

Beneficiaries must adhere to their plan’s formulary, prior authorization, and formulary exceptions processes in order for their out-of-pocket spending to count toward the $3,600 limit.

The following types of spending count toward the $3,600 threshold:

- The beneficiary’s own out-of-pocket spending
- Spending by a family member or official charity, on behalf of the beneficiary
- Supplemental drug coverage provided through qualifying state pharmacy assistance programs (SPAP) or Medicare’s extra help
- Under the Centers for Medicare & Medicaid Services’ (CMS’) demonstration authority, supplemental drug coverage paid for with MA rebate dollars.

In summary, the amount that a beneficiary must spend on part D-covered drugs until catastrophic coverage is reached, based on the 2006 standard coverage, is as follows:

- $250 deductible
- + $500 plan enrollee coinsurance during initial coverage
- + $2,850 coverage gap
- = $3,600 (plus the monthly premium, which averages $384/year)

Once this cost has been reached for covered drugs, catastrophic coverage begins.

**Related Links**

HHS Secretary Mike Leavitt recently released a two-month progress report on Medicare Prescription Drug Coverage that takes a hard look at what is working and what needs to improve. To view the report, visit on the Web: [http://www.hhs.gov/medicare2final.pdf](http://www.hhs.gov/medicare2final.pdf).

For more information about Medicare Prescription Drug Coverage for Providers, visit the CMS website [http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage](http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage).

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Source: Special Edition MLN Matters Article SE0618

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**Streamlined Drug Coverage Materials for Health Care Professionals—New Fact Sheet and Script for Recent Audio Conference**

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

**Provider Types Affected**

Providers, physicians, and suppliers and their staff who prescribe medications for Medicare patients

**Key Points**

The Centers for Medicare & Medicaid Services (CMS) has developed three new products as part of the Medicare Prescription Drug Coverage (Part D) campaign for health care professionals:

**Consolidated List of Links**

A consolidated list of links to resources for prescribers is located on the CMS website at [http://www.cms.hhs.gov/center/provider.asp](http://www.cms.hhs.gov/center/provider.asp).

At this Web page, offices can get access to direct telephone numbers to a Medicare drug plan’s coverage determination staff, as well as to obtain model forms that will help speed this process.

Educational information for fee-for-service (FFS) providers is always available through our Medicare Learning Network drug coverage page on the CMS website at [http://www.cms.hhs.gov/MLNProducts/23_DrugCoverage.asp](http://www.cms.hhs.gov/MLNProducts/23_DrugCoverage.asp).

**Transition Policy Fact Sheet**

A new fact sheet regarding the new transition policy, as well as the exceptions and appeals process for Medicare Prescription Drug Coverage, is available for use in prescriber offices. This resource fact sheet provides ready links to tools that will streamline the prescribing process under the new coverage.

CMS continues to work with groups representing physicians, pharmacists, patients, and Part D plans to simplify and standardize the information that physicians need to provide to plans.
Streamlined Drug Coverage Materials for Health Care Professionals (continued)


An Important Message for Providers Regarding Medicare Part D from CMS Administrator Dr. Mark McClellan

Dr. McClellan’s message to providers describes the steps CMS is taking to implement the new Medicare prescription drug coverage. Dr. McClellan also discusses helpful resources for providers. Streaming video of this message is available on the CMS website at http://media.cms.hhs.gov/cms/McClellanPartDProvider.wmv.

Phone Conference Training Session

A PowerPoint presentation and audio replay of a recent phone conference training session is available, entitled “Working with Plan Formularies: Transition Supplies, Prior Authorization, Quantity Limits, Step Therapy, and Exceptions.” This training session is geared towards guiding office staff through the exceptions process. These materials are located on the CMS website at http://media.cms.hhs.gov/cms/partner03022006.wma.

Other Special Edition Articles

Other special edition articles regarding the prescription drug program include, but are not limited to, the following:


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Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: March 3, 2006
Implementation Date: N/A
Source: Special Edition MLN Matters Article SE0619

Streamlined Drug Coverage Materials for Health Care Professionals

New! Visit http://www.cms.hhs.gov/center/provider.asp and scroll down to “Part D Tools for Health Care Professionals” for a comprehensive list of links to agency-wide resources for providers on Medicare prescription coverage. These resources can help providers and office staff access direct phone numbers to a Medicare drug plan’s coverage determination staff, as well as obtain model forms that will help speed the process.

Additionally, a new fact sheet, as well as other educational products for the Medicare fee-for-service community, is now available on the CMS website at http://www.cms.hhs.gov/MLNProducts/23_drugcoverage.asp.

Source: CMS Joint Signature Memorandum 06312, March 3, 2006

An Important Message for Providers Regarding Medicare Part D from the CMS Administrator, Dr. Mark McClellan

Prescribers are vital to the well being of their patients and the Centers for Medicare & Medicaid Services is doing everything we can to streamline the new Part D coverage to make it easier for you to help your patients, while not infringing on the scarce clinical time you have with them.

The following link will take you to a video that we hope explains what we are doing during the transition to help prescribers and their office staff smooth the process of prior authorizations, exceptions and appeals. Go to our provider center at http://www.cms.hhs.gov/center/provider.asp (go to Part D tools) and select the video.

There are a number of other useful lists that CMS has assembled there to help ease the process of helping your patients with their new drug coverage.

CMS has a dedicated e-mail for prescriber’s questions at PRIT@cms.hhs.gov, as well as a standing teleconference every Tuesday at 2:00 p.m. by calling 1-800-619-2457 – passcode: RBMDL.

Source: Provider Education Resources Listserv, Message 200603-10

Extension of Transitional Drug Coverage

A new fact sheet, describing the recent extension of transitional drug coverage to 90 days, may be found on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11193.pdf.

On February 1, 2006, HHS Secretary Mike Leavitt announced that plans would be extending the 30-day transitional drug coverage period, extending it from the 30-day period to an additional sixty more days. That means that the plans are providing a full ninety days of drug coverage (through March 31, 2006).

Source: Provider Education Resources Listserv, Message 200602-05
Essential Information and Resources for Prescribing Health Care Professionals

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this article on February 6, 2006, to reflect revised CMS policy that now provides for a 90-day supply of transitional prescription medicine. Also, to conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same. This article was previously published in the Second Quarter 2006 Medicare A Bulletin (pages 99-100).

The eleventh article in a series of: Information for Providers, Physicians, Pharmacies and their Staff About Medicare Prescription Drug Coverage

Provider Types Affected
All health care professionals who prescribe prescription medications for Medicare beneficiaries.

Impact on Providers
The new Medicare prescription drug coverage began on January 1st. Already, pharmacists have filled millions of prescriptions for people with Medicare. During this important transition period to the new prescription drug coverage, the Centers for Medicare & Medicaid Services (CMS) understands that there is much that prescribing health care professionals need to know about this new coverage in order to help their Medicare patients.

Essential Information for Prescribing Health Care Professionals
CMS has compiled a list of information, resources, and tools that will allow health care professionals and their support staff to help their Medicare patients during this transition period.

Finding formulary Information
CMS has a formulary finder that provides direct access to all plan websites at http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp.

In addition, we have worked with Epocrates to provide free software which makes the formulary selection process very simple. You can load this program into your PDA or run the software on a desktop. This tool is available on the Web at http://www2.epocrates.com/index.html.

Coverage Determination
CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, an enrollee can request an off-formulary drug, an exception to the plan’s tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

CMS does not have the authority to mandate a standard exception process for each Medicare drug plan or MA-PD; however, the Agency is working to simplify the exceptions process. Like typical commercial payers, health care professionals may occasionally need to help a patient file a prior authorization for a medication or appeal a medication’s tier. CMS is working with medical specialty societies to address these issues.

A form has been created by a coalition of medical societies and advocacy groups that can be faxed to your office by a pharmacist when he or she is given a prescription that is either not on the formulary or on a higher tier.

This form streamlines communication between the pharmacist and the physician and reduces the need for time consuming telephone calls to the doctor’s office.

The form is located at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartDPharmacyFaxForm.pdf, on CMS website as well as at several medical society websites.

Expedited Review Process
There is an expedited review process that CMS has outlined to ensure that drug plans can move an appeal quickly, i.e., within a 24-hour turnaround time, to provide medicines to patients with an immediate need. Beyond this expedited review process, the standard appeals process to challenge a plan’s coverage determination has five levels:

• Redetermination by the plan
• Reconsideration by a Medicare drug coverage qualified independent contractor (QIC)
• An administrative law judge (ALJ) hearing
• Review by the Medicare Appeals Council
• Review by federal district court.

Visit http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp for a list of plan contacts you can use to query your patient’s plan should you need to pursue an appeal or require clarification on an issue.

Part B Drugs vs. Drugs Covered under Medicare Prescription Drug Coverage (Part D)
A previous MLN Matters article explains the difference between drugs covered under Part B versus those covered under Part D.

This article may be found on the CMS website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf.

Additionally, a chart explaining specific drugs may be found on the CMS website at http://www.cms.hhs.gov/Pharmacy/downloads/partsbdcovissues.pdf.

Verifying Beneficiary Enrollment in a Medicare Drug Plan
Office staff can use the Medicare Prescription Drug Plan Finder, located at http://www.medicare.gov, to verify
a beneficiary’s enrollment in a Medicare drug plan. By entering all information provided on a beneficiary’s Medicare card, the Plan Finder will identify the plan in which the beneficiary is enrolled.

Pharmacists have access to a new computer tool called “E1” that provides real time enrollment and eligibility information. This tool provides both eligibility and billing information at the point of sale and is constantly updated by CMS.

Obtaining Prior Authorizations

A prior authorization can only be obtained by calling the drug plan directly. 1-800-MEDICARE cannot process a prior authorization.

Ensuring Coverage for a Dual Eligible Beneficiary Who Needs To Be Enrolled in a Plan

CMS has ensured that people with Medicare and full Medicaid benefits (full dual) will have drug coverage by enabling customer service representatives at 1-800-MEDICARE to enroll these beneficiaries in WellPoint, a national plan.

If these beneficiaries have immediate prescription needs, they should visit their local pharmacies. The pharmacist can enroll them in WellPoint at the pharmacy.

To find out more about what happens with Medicare prescription drug coverage in certain situations, visit on CMS website http://www.cms.hhs.gov/Pharmacy/Downloads/whatisf.pdf;

Providing a 90-day Supply of Transitional Prescription Medication

CMS has instructed all Medicare-approved plans to extend the original 30-day transitional coverage period by an additional 60 days. This means that a Part D beneficiary will be able to get a 90-day supply of all of his or her medications when they enroll in Part D, even if some of the medications are not on formulary. This 90-day period will give the patient’s doctor and pharmacist time to adjust the patient’s drug regimen, or request exceptions to the plan’s formulary, so that the next refill of medications will be consistent with the plan’s coverage rules. Beneficiaries who enroll after March 31st will get a 30-day transitional fill so that they have time to adjust their medication regimen to the plan formulary.

Important Contact Information to Report Problems with Medicare Prescription Drug Coverage

Health Care Professionals: E-mail prit@cms.hhs.gov

with problems and issues encountered. Please take advantage of CMS’ regular conference call at 2:00 p.m. EST every Tuesday. This call gives health care professionals an opportunity to ask questions of CMS staff. Call 1-800-619-2457; Passcode: RBDMCL.

Pharmacists: Call 1-866-835-7595, a CMS dedicated line designed to help answer questions regarding billing and beneficiary enrollment information.

Additional Information

Health care professionals may visit on CMS website http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage.

The redesigned Web page contains all the latest information on Medicare prescription drug coverage.

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

Source: Special Edition MLN Matters Article SE0603

Provider Part D Fact Sheet

The Centers for Medicare & Medicaid Services has assembled a fact sheet for use in prescriber’s offices regarding the new transition policy, as well as the exceptions and appeals process for the Medicare Prescription Drug Benefit. This resource fact sheet is designed to provide ready-links to tools that will streamline the prescribing process under the new benefit. We continue to work with groups representing physicians, pharmacists, patients and Part D plans to simplify and standardize the information that physicians need to provide to plans.


We have consolidated most of the resources for prescribers into the provider website at www.cms.hhs.gov/center/provider.asp where offices can get access to direct phone numbers to the plan’s coverage determination people, as well as copies of model forms that will help speed the process. Of course, information is always available through our Medicare Learning Network at www.cms.hhs.gov/medlearn/drugcoverage.asp.

We are hopeful that you will share this fact sheet with your members and feature it in your electronic and print outlets so that as many prescriber’s offices know about the processes and tools we have designed to make it easier for them and their patients.

Source: Provider Education Resources Listserv, Message 200602-07
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