Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Medically Unlikely Edits

Implementation of Medically Unlikely Edits Based on Anatomical Considerations 8

Medicare Contractor Provider Satisfaction Survey

CMS tool to Measure Medicare Providers Satisfaction Levels. Randomly Selected Providers Will Have Opportunity To Rate FCSO' Performance 23

National Provider Identification

Reminder of the Steps Needed for the Fast Approaching Date of the National Provider Identifier Initiative Implementation Date 26

Infrared Therapy Devices

National Coverage Determination Guidelines for this Service 32

Inpatient Rehabilitation Facility Teaching Adjustment

Clarification on the guidelines for Medicare Providers that Have Been Training Residents and Are Currently Converting to Inpatient Rehabilitation Facilities 36

Local Coverage Determinations

Notification of New, Additions/Revisions to Local Coverage Determinations 39

Edit to Bypass Hospital Emergency Room Services

Guidelines To Identify Emergency Services Provided to Part A SNF Stay Beneficiaries.... 29

2007 Outpatient Service Fee Schedules

Payment Amounts Established for these Services Provided During 2007 53

Features

About This Bulletin 3
General Information 4
General Coverage 30
Hospital Services 36
Local Coverage Determinations 39
Critical Access Hospital 45
End-Stage Renal Disease Services 47
Skilled Nursing Facilities 48
CORF Services 49
Rural Health Clinic Services 52
Outpatient Prospective Payment System 53
2007 Outpatient Service Fee Schedules 55
Electronic Data Interchange 69
Educational Resources 74

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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
- ☐ _____
- ☐ _____
- ☐ _____

Table of Contents

In This Issue 1

About the *Medicare A Bulletin* 3

General Information

2007 Physician Fee Schedule Payment Policies . 4
Legislative Change to the Update Factor for the 2007 Medicare Physician Fee Schedule and Extension of the Participation Enrollment Period .. 6
Emergency Update to the 2007 Medicare Physician Fee Schedule Database 7
Medically Unlikely Edits 8
Flu Shot Reminder 9
Payments Allowance for the Influenza Virus Vaccine and the Pneumoccocal Vaccine 9
January 2007 Quarterly Average Sales Price Medicare Part B Drug Pricing File, and Revisions to 2006 Quarterly Drug Pricing Files 10
2007 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment 12
Laboratory Competitive Bidding Demonstration .. 14
2007 Fee Schedule Update for DME, Prosthetics, Orthotics, and Supplies 17
Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses 18
Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement 20
Medicare Home Health Prospective Payment System Rate Update for Calendar Year 2007 .. 21
2007 Medicare Contractor Provider Satisfaction Survey 23
Revisions to Procedure to Establish Good Cause and Qualified Independent Contractor Jurisdiction 24
Medicare Fee-for-Service and Medicare Advantage Eligibility System Issues 25
Optical Character Recognition Interface in the Fiscal Intermediary Standard System 26
Just Five Months Remaining—National Provider Identifier Reminder 26
Claims Submitted With Only a National Provider Identifier During Stage 2 NPI Transition Period .. 28

General Coverage

New 2007 Current Procedure Terminology Mammography Codes 30
Medicare Payment for Preadministration-Related Services Associated with IVIG Administration—Payment Extended Through 2007 31
Infrared Therapy Devices 32
Cavernous Nerves Electrical Stimulation with Penile Plethysmograph 33
Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms 34

Hospital Services

Inpatient Rehabilitation Facility Teaching Adjustment 36
Correction of Instructions for Calculating Inpatient Rehabilitation Facility Compliance Percentage Threshold 37
Inpatient Psychiatric Facility Prospective Payment System Fact Sheet now Available .. 38

Local Coverage Determinations

LCD Table of Contents 39

Critical Access Hospital Services

2007 Update of HCPCS Codes and Payments for Ambulatory Surgical Centers 45
January 2007 Non-Outpatient Prospective Payment System Outpatient Code Editor Specifications Version 22.1 46
List of Procedures Approved in Ambulatory Surgical Centers 46

End-Stage Renal Disease Services

Implementation of Changes in End-Stage Renal Disease Payment for 2007 47

Skilled Nursing Facility Services

Skilled Nursing Facility Consolidated Billing Common Working File Edit To Bypass Hospital Emergency Room Services Spanning Multiple Service Dates 48

CORF Services

Outpatient Therapy Cap Exceptions Clarifications 49
Revision to the ICD-9-CM Diagnostic List To Qualify for Therapy Cap Exception 51

Rural Health Clinic Services

Announcement of Medicare Rural Health Clinics and Federally Qualified Health Care Payment Rate Increases 52

Outpatient Prospective Payment System

January 2007 Outpatient Prospective Payment System Outpatient Code Editor Specifications Version 8.0 53

2007 Outpatient Service Fee Schedules

Ambulance Services 55
Mammography Services 55
Outpatient Rehabilitation Services 56
Surgical Dressing Services 57
Orthotic/Prosthetic Devices 58
Clinical Laboratory Services 62

Electronic Data Interchange

Remittance Advice Remark Code and Claim Adjustment Reason Code Update 69
Revised American National Standards Institute (ANSI) X12N 837 Institutional Health Care Claim Companion Document ... 71
Reporting of Taxonomy Codes To Identify Provider Subparts on Institutional Claims 72

Educational Resources

Upcoming Provider Outreach and Educational Events 74
Medicare Immunization Billing Chart now Available 75
Understanding the Remittance Advice for Professional Providers Web-based Training now Available 75
Hospital Outpatient Prospective Payment System Fact Sheet now Available 75
Hospice Payment System Fact Sheet now Available 75
Order Form - Part A Materials 76
Important Addresses, Telephone Numbers and Websites 77

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

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

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About the *Medicare A Bulletin*

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

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

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

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

Who Receives the *Bulletin*?

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

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

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

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

What Is in the *Bulletin*?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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Medicare Publications – 10T
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Jacksonville, FL 32232-5270

Sign up to our *eNews* electronic mailing list

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

GENERAL INFORMATION

2007 Physician Fee Schedule Payment Policies

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

Provider Types Affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI) and A/B MACs for services, including ambulance and telehealth services.

What you Need to Know

CR 5443, from which this article was taken: 1) Summarizes significant issues contained in the Medicare physician fee schedule regulation for 2007 (including publishing the ambulance inflation factor (AIF) for CY 2007); and 2) Announces the telehealth originating site facility fee for 2007. CR5443 also discusses several provisions of the recently-enacted Tax Relief and Health Care Act of 2006. You should refer to the **Background** and **Additional Information** sections, below, for more details and information on how to find the background/reference documents.

Background

Tax Relief and Health Care Act of 2006

The Tax Relief and Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same level as in 2006 ($37.8975), reversing the statutorily mandated 5.0 percent negative update. However, it does not maintain 2007 physician payments at 2006 levels. There are a number of other factors that affect payment rates for 2007 and this article discusses several of those factors. The legislation also extends the 1.0 floor on work geographic practice cost indices (GPCIs) through December 31, 2007. Practice expense GPCIs and malpractice GPCIs are not affected by this provision.

Section 202 of this act mandates that Medicare Part B will cover, for 2007 only, the administration of vaccines that are covered under Part D of Medicare. A new G code (G0377) has been created for the administration of Part D vaccines and payment for G0377 will be crosswalked to *CPT* code *90471* for one year. When a physician administers a Part D vaccine, the physician should use G0377 to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to the administration. Payment for Part D covered vaccines is made solely by the participating prescription drug plan. Medicare Part B will not pay for the vaccine itself.

Medicare Physician Fee Schedule Regulation for 2007

Section 1848(b)(1) of the Social Security Act requires the Centers for Medicare and Medicaid Services (CMS) to establish (by regulation, before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year.

Accordingly, on November 1, 2006, the Centers for Medicare & Medicaid Services (CMS) released the Medicare physician fee schedule (MPFS) final rule for calendar year 2007. In this rule (effective January 1, 2007) Medicare:

- Will increase physician payment for the time spent talking with Medicare beneficiaries about their health care. The 2007 final rule significantly increases the relative value unit (RVU) work component for the face-to-face visits (evaluation and management or "E&M services"), during which the physician and patient discuss the patient's health status and the steps that can be taken to maintain or improve the patient's health.
- Adopts work values for *CPT* codes *97802*, *97803*, *97804*, G0270, and G0271.
- Expands its preventive services benefits to include:
  - Adding a one-time preventive ultrasound screening for abdominal aortic aneurysms (AAA), for at risk beneficiaries, **only available** as part of the initial preventive physical examination (also referred to as the welcome to Medicare physical).
  - Insuring more accurate and reliable bone mass measurements are performed for Medicare beneficiaries.
  - Exempting the colorectal cancer screening benefit from the Part B deductible.
- Adjusts the methodology for determining practice expense (such as office overhead) RVUs. As part of the methodology, CMS will use a bottom-up methodology for direct costs, use supplementary survey data for indirect costs, and eliminate the nonphysician workpool. This methodology (to be phased over a four-year period), will be more transparent than the existing methodology, allowing specialties and other stakeholders to predict the effects of proposals to improve accuracy of practice expense payments.
- Adds diabetes outpatient self-management training and medical nutrition therapy services to the list of covered and separately payable services included in the federally qualified health center benefit, making these services more available to beneficiaries in both rural and urban underserved areas.
- Caps payment rates for imaging services under the physician fee schedule at the amount paid for the same services when performed in hospital outpatient departments; includes a list of codes to which the outpatient prospective payment system (OPPS) cap would apply; and reduces the payment for certain multiple imaging procedures on contiguous body parts by 25 percent after full payment for the first procedure.

Note: *CMS will apply the multiple imaging reductions first, followed by the OPPS imaging cap, if applicable.*

The final rule also:

2007 Physician Fee Schedule Payment Policies (continued)

- Finalizes drug manufacturer reporting requirements and addresses a number of technical average sales price (ASP) issues such as the treatment of *bona fide* service fees in the context of the ASP calculation and the definition of nominal sales;
- Codifies the public consultation process for developing payment amounts for new clinical laboratory tests.
- Adopts supplier standards for independent diagnostic testing facilities (IDTFs).
- Continues the temporary intravenous immune globulin preadministration-related services fee into 2007.
- Addresses the final regulations affecting ambulance payment policy under the ambulance fee schedule, which will improve the accuracy of payments for ambulance services and incorporate changes in geographic adjustments based on the most recent census data.
- Announces an ambulance inflation factor (AIF) for CY 2007 of 4.3 percent, and further 1) Clarifies the designation of areas as urban or rural to incorporate changes made by the Office of Management and Budget to the Metropolitan Statistical Areas (MSAs); 2) Replaces the Goldsmith modification (identifying rural census tracts within MSAs) with the most recent version based on rural urban commuting areas; and 3) Discontinues formal annual reviews of "low billers" and air ambulances to determine whether adjustments are needed in the ambulance fee schedule conversion factors.
- Includes a discussion of exceptions to the therapy cap for CY2006 and 2007 and announces that the 2007 therapy cap is $1,780. (Note that Section 201 of the Tax Relief and Health Care Act of 2006 extended the exceptions process until December 31, 2007.)
- Amends the reassignment of payment regulations to state that an individual supplier furnishing a service has unrestricted access to the billings submitted by the entity receiving Medicare payment for services furnished by that supplier, irrespective of whether the supplier is an employee or independent contractor.
- Announces that the drug add-on adjustment to the end-stage renal diseased (ESRD) composite payment rate for 2007 will increase from 14.5 percent to 15.1 percent.

Lastly, the final rule addresses comments received on the separate notice published June 29, 2006 (Five Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology [CMS-1521-PN]), which is contained in an attachment to CR 5443. Further discussion of the above-summarized items is in that same attachment to CR 5443.

Telehealth originating site facility fee for 2007

Section 1834(m) of the Social Security Act established the Medicare telehealth originating site facility fee payment amount for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare economic index (MEI).

The MEI increase for 2007 is 2.1 percent. Thus for calendar year 2007, the payment amount for HCPCS code "Q3014, telehealth originating site facility fee" is 80 percent of the lesser of the actual charge, or $22.94.

Note: The beneficiary is responsible for any unmet deductible amount or coinsurance.

The Medicare telehealth originating site facility fee and MEI increase by applicable time period is shown in the table below.

Medicare Telehealth Originating site Facility Fee and MEI by Time Period

Facility Fee	MEI	Time Period
$20.00	N/A	October 01, 2001 – December 31, 2002
$20.60	3.0%	January 1, 2003 – December, 31, 2003
$21.20	2.9%	January 1, 2004 – December, 31, 2004
$21.86	3.1%	January 1, 2005 – December, 31, 2005
$22.47	2.8%	January 1, 2006 – December, 31, 2006
$22.94	2.1%	January 1, 2007 – December, 31, 2007

Additional Information

You can find more information about the 2007 Physician Fee Schedule Payment Policies by going to CR 5443, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R258OTN.pdf*.

Please see, as an attachment to that CR, a document entitled Revisions to Payment Policies and Five-Year Review of Work Relative Value Units Under the Physician Fee Schedules for CY 2007, and Other Changes to Payment Under Part B; Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; Ambulance Inflation Factor Update for CY 2007, for more details on the significant issues discussed in the final rule. You can find the November 1, 2006 CMS press release entitled MEDICARE ANNOUNCES FINAL RULE SETTING PHYSICIAN PAYMENT RATES AND POLICIES FOR 2007, by going to *http://cms.hhs.gov/apps/media/press/release.asp?Counter=2044*; and other information about the physician fee schedule by going to the CMS Physician Center Website at *http://cms.hhs.gov/center/physician.asp*.

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

2007 Physician Fee Schedule Payment Policies (continued)

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

MLN Matters Number: MM5443
Related Change Request (CR) Number: 5443
Related CR Release Date: December 22, 2006
Related CR Transmittal Number: R258OTN
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-20, Transmittal 258, CR 5443

Legislative Change to the Update Factor for the 2007 Medicare Physician Fee Schedule and Extension of the Participation Enrollment Period

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

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], and Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries, which are paid based on the Medicare physician fee schedule (MPFS).

What You Need to Know

This article is based on change request (CR) 5448. The Tax Relief and Health Care Act of 2006 changes the update to the 2007 conversion factor for services paid under the MPFS, and this change is effective for services provided on or after January 1, 2007.

The Tax Relief and Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same level as in 2006 ($37.8975), reversing the statutorily mandated 5.0 percent negative update. However, it does not maintain 2007 physician payments at 2006 levels. There are a number of other factors that affect payment rates for 2007.

Other changes adopted in the physician fee schedule final rule that affect 2007 payment rates include changes in the practice expense RVU-setting methodology, refinements to the practice expense RVUs, re-weighting of geographic adjustment factors, limits on payments for imaging services required by the Deficit Reduction Act, and other annual refinements including coding changes.

Both the Centers for Medicare & Medicaid Services (CMS) and your local Medicare contractor will display the resulting new fees on its Web site no later than December 31, 2006. (FCSO posted the 2007 outpatient service fee schedules to the provider educational website *http://www.floridamedicare.com* on December 28, 2006.) The revised fees under the 2007 MPFS will be effective for services provided on or after January 1, 2007.

The change to the 2007 MPFS will also result in an extension of the participation enrollment period to February 14, 2007. Therefore, the participation enrollment period runs from November 15, 2006, through February 14, 2007. The effective date for any participation change is January 1, 2007.

Physicians who wish to sign an agreement and become participating (Par) physicians can access the Par Agreement (CMS-460 form) from the CD, which was mailed to all physicians last November. Physicians can also request the CMS-460 form from their local Medicare contractor. Existing Par physicians who no longer wish to be Par must notify their Medicare contractor in writing of their decision to terminate their Par agreement. Physicians who change their Par status during the extension period should begin to submit claims based on their new Par status.

Background

Based on the new Tax Relief and Health Care Act of 2006, CR 5448 emphasizes the following:

1. Change to the 2007 MPFS rates.
2. Capability of Medicare contractors to begin processing claims for services paid under the MPFS with the new fees beginning January 2, 2007.
3. Extension of the participation enrollment period to February 14, 2007.

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

Note: Services not paid under the MPFS (e.g., durable medical equipment [DME], clinical lab, etc) **are not impacted by this instruction,** and claims containing those services will also be processed beginning January 2, 2007.

In addition, Medicare contractors will:

- Have hard copies of the new 2007 MPFS to mail to those physicians/practitioners that do not have ready Internet access and request a copy.
- Not charge providers requesting hard copy 2007 MPFS who do NOT have ready Internet access.

Legislative Change to the Update Factor for the 2007 MPFS ... (continued)

- Charge a reasonable fee for mailing hard copies of the 2007 MPFS to providers who do have ready Internet access but want a hard copy for convenience.
- Accept any participation changes made during the extended enrollment period that are received or postmarked by February 14, 2007. All participation changes are effective January 1, 2007.
- Load their updated local Medicare participating physician/supplier directories (MEDPARDs) to their websites within 30 days following the close of the extended enrollment period.

Additional Information

For complete details, please see the official instruction, CR 5448, issued to your carrier, FI, RHHI, or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1131CP.pdf*.

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

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

MLN Matters Number: MM5448
Related Change Request (CR) Number: 5448
Related CR Release Date: December 15, 2006
Related CR Transmittal Number: R1131CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1131, CR 5448

Emergency Update to the 2007 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 and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs)) for professional services paid under the Medicare physician fee schedule (MPFS).

Background

This article and related change request (CR) 5459 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS final rule. CR5459 amends those payment files.

Key Points

You may wish to **review Attachment 1** of the CR 5459, which is located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1143CP.pdf*.

The following key points summarize the specifics that are identified in the attachment to CR 5459.

- The physician fee schedule status indicators for oncology demonstration HCPCS codes G9050 to G9062 for 2007 are "I"; these codes are invalid for Medicare use in 2007, thus, payment will not be made for these codes in 2007. (For more details on the oncology demonstration, see the *MLN Matters* article on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf*.)
- Oncology demonstration HCPCS codes G9076, G9081, G9082, G9118, G9119, G9120, G9121, G9122, and G9127 are **deleted and will not be paid for services provided after December 31, 2006 in 2007.**
- Active oncology demonstration codes in the range G9063 to G9139 have status indicators of "M" on the Medicare physician fee schedule database. (Note: See requirement above for discontinued oncology demonstration codes within this range). Those filing claims may report these codes for oncology disease status in 2007, but payment will not be made for these codes for services provided after December 31, 2006.
- Category II codes *3047F* and *3076F* and category III code *0152T* have been deleted for 2007.
- HCPCS G codes G0377 and G8348 through G8368 will be added to the 2007 HCPCS file.
- HCPCS Q codes Q4083, Q 4084, Q4085, and Q4086 will be added, even though they are not on the 2007 HCPCS file. Note that corresponding ASP amounts will be reflected in updated 2007 ASP pricing files to be posted to the CMS web site.
- Incorrect diagnostic supervision indicators were assigned to some codes and these codes and correct indicators are listed in the attachment to CR 5459.
- Corrected multiple procedure codes of 0 and diagnostic family imaging indicators of 99 have been assigned to codes HCPCS codes G0389, G0389-TC, and *CPT* codes *70554*, *70554-TC*, *70555*, *70555-TC*, *76776*, and *76776-TC*.
- As identified in the attachment to CR 5459, correct work, practice expense, and/or malpractice relative value units (RVUs) have been assigned for *CPT* codes *44180*, *44186*, *73223*, *73223-26*, *76775*, *76775-TC*, *76775-26*, *93503*, *93539*, *93540*, *93541*, *93542*, *93543*, *93544*, *93545*, *95060*, *95065*, and HCPCS codes G0389, G0389-TC, and G0389-26.
- As a result of the Tax Relief and Health Care Act of 2006, effective January 1, 2007, HCPCS code G0377 (Administration of vaccine for Part D drug) is added to

Emergency Update to the 2007 Medicare Physician Fee Schedule Database (continued)

the MPFS with a status indicator of X. Payment for HCPCS code G0377 is linked to *CPT* code *90471* (just as payment is made for G0008, G0009, and G0010). For 2007 only, the legislation provides for Part B to pay for the administration of a covered Part D vaccine. When a physician administers a Part D vaccine, the physician should use HCPCS code G0377 to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to this administration. Payment for Part D covered vaccines is made solely by the participating prescription drug plan. Medicare will not pay for the vaccine itself.

- Effective January 1, 2007, the following HCPCS G codes are added to the MPFS database with a status indicator of M: G8348, G8349, G8350, G8351, G8352, G8353, G8354, G8355, G8356, G8357, G9358, G8359, G8360, G8361, G8362, G8363, G8364, G8365, G8366, G8367, and G8368.
- CMS has established separate payment for sodium hyaluronate products that have come on the market since October 2003. Four interim Q codes are in effect for these products as of January 1, 2007:

Q4083	Hyalgan/supartz inj per dose
Q4084	Synvisc inj per dose
Q4095	Euflexxa inj per does
Q4086	Orthovisc inj per dose.

- Procedure status I is assigned to J7319, effective January 1, 2007.
- Effective January 1, 2007, the HCPCS codes Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, and Q9964 will be assigned to procedure status indicator E.
- As a courtesy to the public, CMS has established RVUs for a number of codes, even though the codes are either bundled or not valid for Medicare purposes. These *CPT* codes are *38204, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, and 38215*. The RVUs are listed for these codes in the attachment to CR 5459.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5459) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1143CP.pdf*.

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

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

MLN Matters Number: MM5459
Related Change Request (CR) Number: 5459
Related CR Release Date: December 22, 2006
Related CR Transmittal Number: R1143CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1143, CR 5459

Medically Unlikely Edits

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare fiscal intermediaries (FIs), carriers, Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME/MACs), and/or regional home health intermediaries (RHHIs).

Background

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as medically unlikely edits (MUEs). The national correct coding initiative (NCCI) contractor develops and maintains MUEs.

- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- The MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria or return to provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points

- CR 5402 states that Medicare contractors will deny the claim line or RTP claims with units of service that exceed MUE criteria and pay the other services on the claim as part of initial claims processing activities.
- The MUEs that will be implemented by this notice are based on anatomic considerations. CMS believes that most MUEs based on anatomic considerations are not controversial, but CMS will allow and require an appeals process for those claim line items that are denied as a result of an MUE edit.

Medically Unlikely Edits (continued)

- An appeals process will not be allowed or required for claims that are RTPed as a result of an MUE edit. Instead, providers should resubmit corrected claims.
- This set of MUEs that is based on anatomical considerations addresses approximately 2,800 codes.
- Excess **charges due to units of service greater than the MUE** may not be billed to the beneficiary (this **is a "provider liability"**), and this provision can neither be waived nor subject to an advanced beneficiary notice (ABN).

Additional Information

For complete details regarding CR 5402 please see the official instruction issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to the CMS website to *http://www.cms.hhs.gov/Transmittals/downloads/R178PI.pdf*.

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

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

MLN Matters Number: MM5402
Related Change Request (CR) #: 5402
Related CR Release Date: December 8, 2006
Related CR Transmittal #: R178PI
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-08 Transmittal 178, CR 5402

Flu Shot Reminder

As a respected source of health care information, patients trust their doctors' recommendations. If you have Medicare patients who haven't yet received their flu shot, help protect them by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – **And don't forget to immunize yourself and your staff.**

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

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

Note: Influenza vaccine is not a Medicare Part D covered drug.

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

Source: CMS Provider Education Resource 200612-02

Payment Allowances for the Influenza Virus Vaccine and the Pneumoccocal Vaccine

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

Provider Types Affected

Physicians, nonphysician practitioners, providers and suppliers billing Medicare contractors (Part A/B Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs) and carriers for the influenza and pneumoccocal vaccines.

Background

This article and related change request (CR) 5365 provide the payment allowances for the following influenza virus vaccines: *CPT* codes *90655*, *90656*, *90657*, and *90658* as well as the pneumoccocal vaccine (*CPT* code *90732*) when payment is based on 95 percent of the average wholesale price (AWP).

Key Points

- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT* code *90655* is $15.377.
- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT* code *90656* is $16.574.
- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT* code *90657* is $6.312.
- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT* code *90658* is $12.624.
- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT* code *90732* is $27.028.
- Annual Part B deductible and coinsurance amounts do not apply to these services.
- All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumoccocal vaccination must take assignment on the claim for the vaccine.
- Note that your carrier or FI may also cover *CPT* code *90660* (FluMist, a nasal influenza vaccine) if they determine its use is medically reasonable and necessary for the beneficiary.

Payment Allowances for the Influenza Virus Vaccine and the Pneumoccocal Vaccine (continued)

- Please take note of this pricing information to ensure accurate claims processing. Your carrier or FI will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they will adjust claims brought to their attention.

Implementation

While the implementation of these rates will occur on January 22, 2007, the rates apply to dates of service on or after September 1, 2006.

Additional Information

To view CR 5365, the official instruction issued to your Medicare FI, Carrier or A/B MAC on this issue, visit the CMS web site *http://www.cms.hhs.gov/Transmittals/downloads/R256OTN.pdf*.

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

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

MLN Matters Number: MM5365
Related Change Request (CR) Number: 5365
Related CR Release Date: December 22, 2006
Related CR Transmittal Number: R256OTN
Effective Date: September 1, 2006
Implementation Date: January 22, 2007

Source: CMS Pub. 100-20, Transmittal 256, CR 5365

January 2007 Quarterly Average Sales Price Medicare Part B Drug Pricing File, and Revisions to 2006 Quarterly Drug Pricing Files

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5413, which informs Medicare contractors to download the January 2007 average sales price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2006, April 2006, July 2006, and October 2006 files.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all end-stage renal disease (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 OPPS, will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

For 2007, a separate fee of $0.152 per international unit (I.U.) of blood clotting factor furnished is payable when a separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

ASP Methodology

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 (106 %) of the ASP.

Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106 %) of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities).
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent (95 %) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under out

January 2007 Quarterly ASP Medicare Part B Drug Pricing File, and Revisions to 2006 ... (continued)

patient prospective payment system (OPPS) at the amount specified for the APC to which the product is assigned.

- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of DME that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95 %) of the first published AWP unless the drug is compounded.
- Payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent (95 %) of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for **drugs that are not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file**, other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 17, Drugs and Biologicals) for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent (100%) of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file.
- The payment allowance limits for **new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration (FDA)** and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent (106%) of the WAC or invoice pricing, if the WAC is not published. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after December 19, 2006, the revised April, July and October 2006 and January 2007 ASP file and ASP NOC files will be available for retrieval from the CMS ASP Web page, and the payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The revised files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2006	April 1, 2006 through June 30, 2006
July 2006	July 1, 2006 through September 30, 2006
October 2006	October 1, 2006 through December 31, 2006
January 2007	January 1, 2007 through March 31, 2007

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

Drugs Furnished During Filling or Refilling an Implantable Pumpor Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm*) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above.

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1129CP.pdf*.

January 2007 Quarterly ASP Medicare Part B Drug Pricing File, and Revisions to 2006 ... (continued)

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

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

MLN Matters Number: MM5413
Related Change Request (CR) Number: 5413
Related CR Release Date: December 15, 2006
Related CR Transmittal Number: R1129CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1129, CR 5413

2007 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

Provider Types Affected

Clinical laboratories billing Medicare carriers, intermediaries, or Part A/B Medicare administrative contractors (A/B MACs).

Provider Action Needed

This article and related change request (CR) 5362 contain important information regarding:

- The 2007 annual updates to the clinical laboratory fee schedule
- Mapping for new codes for clinical laboratory tests
- Laboratory costs related to services subject to reasonable charge payments.

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

Key Points

Update to Fees

In accordance with section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by section 628 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2007 is zero (0) percent.

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

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

National Minimum Payment Amounts

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

The 2007 national minimum payment amount is $14.76 ($14.76 plus zero percent update for 2007). The affected codes for the national minimum payment amount include the following *Current Procedure Terminology (CPT)* codes:

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

National Limitation Amounts (Maximum)

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

Access to 2007 Clinical Laboratory Fee Schedule

Internet access to the 2007 clinical laboratory fee schedule data file should be available after November 20, 2006, on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.hhs.gov/ClinicalLabFeeSched*.

Medicaid state agencies, the Indian Health Service, the United Mine Workers, Railroad Retirement Board, and other interested parties should use the Internet to retrieve the 2007 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 17, 2006, CMS hosted a public meeting to solicit input on the payment relationship between 2006 codes and new 2007 *CPT* codes. Notice of the meeting was published in the *Federal Register* on May 26, 2006 and on the CMS website on June 19, 2006.

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

Additional written comments from the public were accepted until September 26, 2006.

2007 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services ... (continued)

Additional Pricing Information

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

For dates of service January 1, 2007 through December 2007, the fee for clinical laboratory travel HCPCS code P9603 is $0.935 per mile and for HCPCS code P9604 is $9.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. The standard mileage rate for transportation costs was increased by the Federal Government's Treasury Department to 48.5 cents a mile and this amount is incorporated into the fees for travel codes P9603 and P9604.

The 2007 laboratory fee schedule also includes codes that have a 'QW' modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Based on comments and data submitted, *CPT* codes *83037* and *83037*QW are priced by crosswalking to *CPT* code *82985*.

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2006 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping Information

CMS advises the following:

New *CTP* code *80178QW* is priced at the same rate as *CTP* code *80178*.

New *CTP* code *82107* is priced at the same rate as *CTP* code *83950*.

New *CTP* code *83698* is priced at the same rate as *CTP* code *83880*.

New *CTP* code *83913* is priced at the same rate as *CTP* code *83907*.

New *CTP* code *84443QW* is priced at the same rate as *CTP* code *84443*.

New *CTP* code *86788* is priced at the same rate as *CTP* code *86645*.

New *CTP* code *86789* is priced at the same rate as *CTP* code *86644*.

New *CTP* code *86901* is priced at the same rate as *CTP* code *86900*.

New *CTP* code *87305* is priced at the same rate as *CTP* code *87327*.

New *CTP* code *87498* is priced at the same rate as *CTP* code *87496*.

New *CTP* code *87640* is priced at the same rate as *CTP* code *87651*.

New *CTP* code *87641* is priced at the same rate as *CTP* code *87651*.

New *CTP* code *87653* is priced at the same rate as *CTP* code *87651*.

New *CTP* code *87808* is priced at the same rate as *CTP* code *87802*.

New *CTP* code *87808QW* is priced at the same rate as *CTP* code *87808*.

New HCPCS code G0394 is priced at the same rate as *CTP* code *82270*.

Laboratory Costs Subject to Reasonable Charge Payment in 2006

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as prescribed by section 1842(b)(3) of the Act and 42 CFR 405.509(b)(1). The inflation-indexed update for year 2007 is 4.3 percent.

Manual instructions for determining the reasonable charge payment may be found in the *Medicare Claims Processing Manual*, Chapter 23, §80-80.8. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. The *Medicare Claims Processing Manual*, is located on the CMS website at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

When these services are performed for independent dialysis-facility patients, *Medicare Claims Processing Manual*, Chapter 8, section 60.3 instructs the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood Products

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

Also, the following codes should be applied to the blood deductible, as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, (also available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*) Chapter 3, Section 20.5-20.54:

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

Note: Biologic products not paid on a cost or prospective payment basis are paid based on section 1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes

2007 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services ... (continued)

P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion Medicine

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

Reproductive Medicine Procedures

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

Additional Information

For complete details regarding CR 5362, please see the official instruction issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1122CP.pdf*.

Instructions for calculating reasonable charges are located in the *Medicare Claims Processing Manual* (Pub. 100-04) Chapter 23, Sections 80-80.8 on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*.

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

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

MLN Matters Number: MM5362
Related Change Request (CR) Number: 5362
Related CR Release Date: December 8, 2006
Related CR Transmittal Number: R1122CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1122, CR 5362

Laboratory Competitive Bidding Demonstration

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 27, and December 19, 2006, to specify that the only hospital were those billing with type of bill (TOB) 14x, and to specify that to be terminated, the $100,000 annual ceiling for passive laboratories must be exceeded by $25,000 or more. All other information remains the same. The *MLN Matters* article MM5359 was published in the December 2006 *Medicare A Bulletin* (pages 9-11).

Provider Types Affected

Physicians and hospitals (TOB 14x only) who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites.

Background

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, Pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and CR 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this article and CR 5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the ZIP code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore **exempt** from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing **are not included in the demonstration**, **except** where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Laboratory Competitive Bidding Demonstration (continued)

Required Bidders

Laboratory firms with $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for "demonstration tests" provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as "required bidders."

Passive Laboratories

Small laboratories or laboratory firms with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will **not be required** to bid in the demonstration. These laboratories are considered "passive" laboratories." Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of $100,000.

Passive laboratory firms exceeding the annual ceiling of $100,000 by 25,000 or more will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- **Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end-stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considers "passive-ESRD" laboratories.** Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007 through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

Winners

Both required and non-required bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled "winners."

Nonwinners

Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled "nonwinners."

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Nonwinner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, nonwinner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although nonwinner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses metropolitan statistical areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's ZIP code of residence.

CMS will provide the contractors with a list of ZIP codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of Pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR 5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

Laboratory Competitive Bidding Demonstration (continued)

During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national ZIP code pricing file identifying the ZIP codes included in the first CBA. Also, in that same timeframe, CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by nonwinner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (noncovered charges)
- Remark code M114 (*This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor*.)
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Using these same reason and remark codes, Medicare will reject any laboratory claims with a date of service between April 1, 2007, and March 31, 2010 with a modifier of "90" submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA, regardless of the referring laboratory's participation status.

Medicare will pay claims during the demonstration period submitted by nondemonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., "snow birds") according to the laboratory competitive bidding demonstration.

Nonwinning laboratories should know that advance beneficiary notices (ABNs) and notices of beneficiary exclusion from Medicare benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at nonwinner laboratories.

Line items for demonstration services and for nondemonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember: Required and non-required bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R50DEMO.pdf*.

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

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

MLN Matters Number: MM5359 – Revised
Related Change Request (CR) Number: 5359
Related CR Release Date: November 1, 2006
Related CR Transmittal Number: R50DEMO
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-19, Transmittal 50, CR 5359

2007 Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), carriers, and/or regional home health intermediaries (RHHIs)), for services paid under the DMEPOS fee schedule.

Provider Action Needed

This article is based on change request (CR) 5417, and it provides specific information regarding the annual update for the 2007 DMEPOS fee schedule. Be sure billing staff are aware of this update.

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), and (i))
- Parenteral and enteral nutrition (PEN) by regulations contained in the *Code of Federal Regulations* (42 CFR 414.102).

Note: DMERCs and DME MACS will use the 2007 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2007 through December 31, 2007.

Deleted HCPCS Codes

The following codes are being **deleted** from the HCPCS **effective January 1, 2007,** and are therefore being removed from the DMEPOS and PEN fee schedule files.

A4348	A4359	A4462
A4632	E0164	E0166
E0180	E0701	E0977
E0997 thru E0999	E2320	K0090 thru K0097
K0099	L0100	L0110
L3902	L3914	L6700
L6705	L6710	L6715
L6720	L6725	L6730
L6735	L6740	L6745
L6750	L6755	L6765
L6770	L6775	L6780
L6790	L6795	L6800
L6806 thru L6809	L6825	L6830
L6835	L6840	L6845
L6850	L6855	L6860
L6865	L6867	L6868
L6870	L6872	L6873
L6875	L6880	L7010
L7015	L7020	L7025
L7030	L7035	

Added HCPCS

The HCPCS codes listed below are being **added** to the HCPCS **effective January 1, 2007:**

A4461	A4463	A4559
A4600	A4601	A8000
A8001	A8002	A8003
A8004	A9279	E0676
E0936	E2373 thru E2377	E2381 thru E2396
K0733 thru K0737	L6611	L6624
L6639	L1001	L3806
L3808	L3915	L5993
L5994	L8691	L8695
L6703	L6704	L6706
L6707 thru L6709	L7007 thru L7009	L8690

Payment Rates for Oxygen and Oxygen Equipment

As part of this fee schedule update, the Centers for Medicare & Medicaid Services (CMS) is implementing national monthly payment rates for oxygen and oxygen equipment effective for claims with dates of service on or after January 1, 2007. The 2007 national monthly payment rates are listed in the table below. As a result of these changes, CMS is revising the fee schedule amounts for codes E1405 and E1406. Since 1989, the fees for E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

As part of these changes, suppliers must submit claims with both the code for stationary oxygen contents (E0441 or E0442) and the code for portable oxygen contents (E0443 or E0444) when billing for payment for furnishing both stationary and portable oxygen contents for beneficiary-owned gaseous or liquid stationary and portable oxygen equipment.

HCPCS Codes	Amount	Class
E0424, E0439, E1390, and E1391	$198.40	Stationary oxygen equipment (including stationary concentrator, liquid and gaseous equipment) and oxygen contents (stationary and portable)
E0431 and E0434	$31.79	Portable equipment only (gaseous or liquid tanks)
E1392 and K0738	$51.63	Oxygen generating portable equipment (OGPE) only
E0441 and E0442	$77.45	Oxygen contents for beneficiary-owned stationary gaseous or liquid oxygen equipment
E0443 and E0444	$77.45	Oxygen contents for beneficiary-owned portable gaseous or liquid oxygen equipment

2007 Fee Schedule Update for DMEPOS (continued)

The fee schedules for HCPCS code E0461 (volume control ventilator, without pressure support mode, may include pressure control mode, used with noninvasive interface, e.g. mask) are being revised as part of this update to correct calculation errors and are effective for dates of service on or after January 1, 2007.

Gap-Fill Items

The Medicare DMERCS and DME MACs will gap-fill base fee schedule amounts for each state in their region for the following new and revised HCPCS codes that will be subject to the DMEPOS fee schedules in 2007:

- Inexpensive or routinely purchased DME for codes A8002, A8003, A8004, E2373, E2374, E2375, E2376, E2377, E2388, E2389, E2390, E2391, E2392, E2393, E2394, E2395
- Capped rental DME codes of E0639 and E0640
- Prosthetics and Orthotics codes of L1001, L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639
- Surgical Dressings codes of A4463
- DME supplies codes of A4559

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5417) issued to your Medicare A/B MAC, DMERC, DME MAC, FI, RHHI, or carrier. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1125CP.pdf*.

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

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

MLN Matters Number: MM5417
Related Change Request (CR) Number: 5417
Related CR Release Date: December 8, 2006
Related CR Transmittal Number: R1125CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1125, CR 5417

Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

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, durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME MACs), or Part A/B Medicare administrative contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Affected providers may want to be sure their billing staff knows of these changes.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses in calendar year 2007 as required by regulations contained in 42 CFR 405.501 (*http://www.gpoaccess.gov/cfr/retrieve.html*).

For splints and casts, Q-codes are to be used when supplies are indicated for cast and splint purposes. *Current Procedural Terminology (CPT)* codes should be used as indicated in the *CPT* section "Application of Casts and Strapping" for the specified *CPT* procedure codes in the 29XXX series. This payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.

For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. Change request (CR) 5282 instructs your carrier, DMERC, DME MAC, or A/B MAC to compute 2007 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular lenses implanted in a physician's office) using actual charge data from July 1, 2005, through June 30, 2006. Carriers, and A/B MACs will compute 2007 inflation-indexed charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2006.

DMERCs and DME MACs will compute 2007 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2005, through June 30, 2006. For these same codes, they will compute 2007 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2006. These tables are:

Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766

Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, ... (continued)

A4770 A4771 A4772 A4773 A4774 A4802
A4860 A4870 A4890 A4911 A4918 A4929 E1634

Dialysis Equipment Billed With AX Modifier
E0210NU E1632 E1637 E1639

Dialysis Equipment Billed Without AX Modifier
E1500 E1510 E1520 E1530 E1540 E1550 E1560
E1570 E1575 E1580 E1590 E1592 E1594 E1600
E1610 E1615 E1620 E1625 E1630 E1635 E1636

Carriers and A/B MACs will make payment for splints and casts furnished in 2007 based on the lower of the actual charge or the payment limits established for these codes. **Carriers, DMERCs and DME MACs** will use the 2007 reasonable charges or the same payment limits to pay claims for items furnished from January 1, 2007 through December 31, 2007. **Those 2007 payment limits are in the table at the end of this article.**

Additional Information

Instructions for calculating:

- Reasonable charges are located in chapter 23 (section 80) of the Medicare Claims Processing Manual (Pub. 100-04).
- Customary and prevailing charge are locate in section 80.2 and 80.4 of chapter 23 of the Medicare Claims Processing Manual (Pub 100-04)
- The IIC (inflation indexed charge) are located in section 80.6 of chapter 23 of the Medicare Claims Processing Manual (Pub. 100-04). The IIC update factor for 2007 is 4.3 percent.

You can find chapter 23 of the Medicare Claims Processing Manual (Pub. 100-04) at the following CMS website: *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*.

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC, or A/B MAC regarding this change. That instruction may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1118CP.pdf*.

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

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

2007 Payment Limits for Splints and Casts Disclaimer

Code	Payment Limit
A4565	$7.19
Q4001	$40.91
Q4002	$154.63
Q4003	$29.39
Q4004	$101.74
Q4005	$10.83
Q4006	$24.42
Q4007	$5.43
Q4008	$12.21
Q4009	$7.23
Q4010	$16.28
Q4011	$3.61
Q4012	$8.14
Q4013	$13.16
Q4014	$22.21
Q4015	$6.58
Q4016	$11.10
Q4017	$7.61
Q4018	$12.14
Q4019	$3.81
Q4020	$6.08
Q4021	$5.63
Q4022	$10.17
Q4023	$2.83
Q4024	$5.08
Q4025	$31.60
Q4026	$98.64
Q4027	$15.80
Q4028	$49.33
Q4029	$24.16
Q4030	$63.59
Q4031	$12.08
Q4032	$31.79
Q4033	$22.53
Q4034	$56.05
Q4035	$11.27
Q4036	$28.03
Q4037	$13.75
Q4038	$34.44
Q4039	$6.89
Q4040	$17.22
Q4041	$16.71
Q4042	$28.53
Q4043	$8.36
Q4044	$14.27
Q4045	$9.70
Q4046	$15.61
Q4047	$4.84
Q4048	$7.81
Q4049	$1.77

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

MLN Matters Number: MM5382
Related Change Request (CR) Number: 5382
Related CR Release Date: November 24, 2006
Related CR Transmittal Number: R1118CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1118, CR 5382

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

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (fiscal intermediaries [FIs], carriers, durable medical equipment regional carriers [DMERC], regional home health intermediaries [RHHIs], and DME Medicare administrative contractors [DME MACs] and Part A/B Medicare administrative contractors [A/B MACs]) for medical supply or therapy services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2007. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional information* section of this article.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA). As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

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

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

Key Points

CR 5356 provides the annual HH consolidated billing update effective January 1, 2007. The following tables describe the *CPT*/HCPCS codes and the specific changes to each that this notification is implementing on January 2, 2007.

Table 1: Non Routine Supplies

Code	Description	Action	Replacement Code or Code Being Replaced
A4213	Syringe, sterile, 20 CC or greater	Add	
A4215	Needle, sterile, any size, each	Add	
A4348	Male external catheter with integral collection compartment, extended wear, each (e.g., 2 per month)	Delete	
A4359	Urinary suspensory without leg bag	Delete	
A4244	Alcohol or peroxide, per pint	Add	
A4245	Alcohol wipes, per box	Add	
A4246	Betadine or phisohex solution, per pint	Add	
A4247	Betadine or iodine swabs/wipes, per box	Add	
A4461	Surgical dressing holder, non-reusable, each	Add	Replaces code: A4462
A4462	Abdominal dressing holder, each	Delete	Replacement code: A4461 and A4463
A4463	Surgical dressing holder, reusable, each	Add	Replaces code: A4462
A4932	Rectal thermometer, reusable, any type, each	Add	
A6412	Eye patch, occlusive, each	Add	

Table 2: Therapies

Code	Description	Action	Replacement Code or Code being Replaced
97020	Application microwave	Delete	Replacement Code: *97024*
97024	Application of a modality to one or more areas: diathermy (e.g., microwave)	Redefine	Replaces code: *97020*
97504	Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes	Delete	Replacement code: *97760*
97520	Prosthetic training, upper and/or lower extremity(ies), each 15 minutes	Delete	Replacement code: *97761*

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

Code	Description	Action	Replacement Code or Code being Replaced
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	Delete	Replacement code: *97762*
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	Add	Replaces code: *97504*
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	Add	Replaces code: *97520*
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	Add	Replaces code: *97703*

Additional Information

For complete details regarding this CR please see the official instruction issued to your Medicare FI, carrier, A/B MAC, DMERC, RHHI, or DME MAC. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1082CP.pdf*.

A complete historical listing of codes subject to HH consolidated billing can be found on the CMS website at *http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp*.

To review the Medicare regulations discussed in this article see the Medicare Claims Processing Manual Chapter 10, Section 10.1.25 on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf*.

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

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

MLN Matters Number: MM5356
Related Change Request (CR) Number: 5356
Related CR Release Date: October 27, 2006
Related CR Transmittal Number: R1082CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1082, CR 5356

Medicare Home Health Prospective Payment System Rate Update for Calendar Year 2007

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

Provider Types Affected

Home health agencies submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MAC s), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5423, which announces the Medicare home health agency (HHA) prospective payment system (PPS) update for calendar year (CY) 2007.

CAUTION – What You Need to Know

HHAs that report the quality data will receive a 3.3 percent increase in payments for CY 2007, while HHAs that do not report the quality data will receive a two percent reduction to the 3.3 percent increase in payments for CY 2007.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details, including 2007 payment rates.

The Deficit Reduction Act (DRA; Section 5201) provides that Medicare home health payments be updated by the applicable home health market basket percentage

Medicare Home Health Prospective Payment System Rate Update for Calendar Year 2007 (continued)

increase for CY 2007, and the DRA requires that home health agencies (HHAs) report such quality data as determined by the Secretary. HHAs that do not report the required quality data receive a 2 percent reduction to the home health market basket percentage increase. For CY 2007, the applicable home health market basket percentage increase is 3.3 percent.

The one-year transition policy of using 50 percent of the metropolitan statistical area (MSA) based and 50 percent of the CBSA-based wage index expires at the end of CY 2006. For CY 2007, the Centers for Medicare & Medicaid Services (CMS) is using the core based statistical area (CBSA) wage index only. CMS is also revising the fixed dollar loss ratio, which is used in the calculation of outlier payments, from 0.65 in CY 2006 to 0.67 for CY 2007.

The labor adjustment to the prospective payment system (PPS) rates will continue to be based on the site of service of the beneficiary as set forth in the 42 CFR at 484.220 and 484.230 (*http://www.gpoaccess.gov/cfr/retrieve.html*).

The case mix adjustment is applied to 60-day episode payments, and the labor adjustment is applied to both 60-day episode and per-visit payments.

The CY 2007 payment rates apply to episodes that end on or after January 1, 2007, and before January 1, 2008.

The following four tables show the payment to HHAS that *do report* the required quality data.

CY 2006 national 60-day episode payment	3.3 percent update	CY 2007 national 60-day episode payment
$2,264.28	x 1.033	$2,339.00

The national standardized per-visit amounts are used to calculate low utilization payment adjustments (LUPAs**)** and outlier payments. The national per-visit amounts are as follows:

Home Health Discipline	CY 2006 per-visit payments	3.3 percent update	CY 2007 per-visit payments
Home Health Aide	$ 44.76	x 1.033	$ 46.24
Medical Social Services	$158.45	x 1.033	$163.68
Occupational Therapy	$108.81	x 1.033	$112.40
Physical Therapy	$108.08	x 1.033	$111.65
Skilled Nursing	$ 98.85	x 1.033	$102.11
Speech-Pathology	$117.44	x 1.033	$121.32

Section 5201 of the DRA provides for a 5 percent payment increase for home health services furnished in a rural (non-CBSA) area for episodes and visits that begin on or **after January 1, 2006 and before January 1, 2007**. While the rural add-on primarily affects those episodes paid based on CY 2006 rates, it also affects a number of CY 2007 episodes.

CY 2007 national 60 day episode payment	Rural add-on	CY 2007 60-day episode payment for rural areas
$ 2,339.00	x 1.05	$2,455.95

The per-visit amounts applied to LUPA and outlier payments for services furnished in rural areas are as follows:

Home Health Discipline	CY 2007 per-visit amounts	Rural add-on	CY 2007 per-visit amounts for rural areas
Home Health Aide	$ 46.24	x 1.05	$ 48.55
Medical Social Services	$163.68	x 1.05	$171.86
Occupational Therapy	$112.40	x 1.05	$118.02
Physical Therapy	$111.65	x 1.05	$117.23
Skilled Nursing	$102.11	x 1.05	$107.22
Speech-Pathology	$121.32	x 1.05	$127.39

The following tables show the payments to HHAs that *do not report* the required quality data.

The DRA provides that if the required quality data is not submitted by an HHA, then the home health market basket percentage increase applicable to that provider's payments will be reduced by 2 percent. Therefore, the increase that is applied to CY 2007 payments to HHAs that do not report the report the required quality data is 1.3 percent (CY 2007 market basket update of 3.3 percent minus 2 percent). The rural add-on also applies to payments for services furnished in rural (non-CBSA) areas to HHAs that do not report the quality data. Again, the rural add-on applies to episodes that **begin** on or after January 1, 2006 and before January 1, 2007.

Medicare Home Health Prospective Payment System Rate Update for Calendar Year 2007 (continued)

CY 2006 national 60-day episode payment	1.3 percent update	CY 2007 60-day episode payment	Rural add-on	CY 2007 60-day episode payment for rural areas
$ 2,264.28	x 1.013	$2,293.72	x 1.05	$2,408.41

The per-visit amounts applied to LUPA and outlier payments to HHAs that **do not report** the quality data are as follows:

Home Health Discipline	CY 2006 per-visit amounts	Updated by 1.3 percent	CY 2007 per-visit amounts	Rural add-on	CY 2007 per-visit amounts for rural areas
Home Health Aide	$ 44.76	x 1.013	$ 45.34	x 1.05	$ 47.61
Medical Social Services	$158.45	x 1.013	$160.51	x 1.05	$168.54
Occupational Therapy	$108.81	x 1.013	$110.22	x 1.05	$115.73
Physical Therapy	$108.08	x 1.013	$109.49	x 1.05	$114.96
Skilled Nursing	$ 98.85	x 1.013	$100.14	x 1.05	$105.15
Speech-Pathology	$117.44	x 1.013	$118.97	x 1.05	$124.92

Additional Information

For complete details, please see the official instruction, CR 5423, issued to your FI, RHHI, or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R253OTN.pdf*.

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

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

MLN Matters Number: MM5423
Related Change Request (CR) Number: 5423
Related CR Release Date: December 15, 2006
Related CR Transmittal Number: R253OTN
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-20, Transmittal 253, CR 5423

2007 Medicare Contractor Provider Satisfaction Survey

The Medicare Contractor Provider Satisfaction Survey (MCPSS) is one of the tools CMS will use to measure satisfaction levels with the services provided by Medicare fee-for-service contractors. This annual survey was first implemented in 2006, and Westat, a survey research firm contracted by the Centers for Medicare & Medicaid Services (CMS), administers it.

What's New…

The 2007 MCPSS will be distributed to a new sample of Medicare providers beginning in January. Randomly selected providers will have an opportunity to rate FCSO's performance and tell us how we are doing in our interactions with you.

FCSO urges all Medicare providers who are selected to participate to complete and return their surveys according to the instructions provided. We know your time is valuable and appreciate your willingness to participate. The information you provide will remain confidential.

Remember, Your Feedback Is Very Important…

FCSO takes your feedback very seriously. Verbatim comments from the 2006 survey have been carefully reviewed and we are already making improvements to our processes and services based on your feedback.

Where Can I Get More Information?

If you have questions about the MCPSS and would like to speak to a representative from Westat, please contact: The **MCPSS Provider Helpline at 1-888-863-3561** or visit Westat MCPSS home study Web page at *https://www.mcpsstudy.org/default.asp*.

Additional information about the MCPSS is available on the CMS website at *http://www.cms.hhs.gov/MCPSS/*. ❖

Source: CMS Joint Signature Memorandum 07009, October 16, 2006

Revisions to Procedures to Establish Good Cause and Qualified Independent Contractor Jurisdictions

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 bill Medicare contractors (A/B Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], carriers, regional home health intermediaries [RHHIs], durable medical equipment regional carriers [DMERCs] or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

Background

The purpose of change request (CR) 5386 is to notify providers and suppliers of the restructured **Part B/DME QIC** jurisdictions. Under the new jurisdictions, three QICs will process reconsiderations as follows:

- Two qualified independent contractors (QICs) will process reconsiderations of carrier and A/B MAC re-determinations effective November 15, 2006 for contractors that process claims in the North jurisdiction and January 1, 2007 for contractors that process claims in the South jurisdiction. Your contractor will reference the appropriate QIC in the Medicare redetermination notice (MRN). In order to expedite your request for appeal, please make sure you follow the instructions on your MRN regarding where to submit your request for reconsideration. If you have already submitted a reconsideration request with the incumbent QIC, please do not submit a duplicate request.
- The third QIC will process all reconsiderations of DMERC and DME MAC redeterminations effective December 1, 2006.

Key Points

- Your contractor will reference the appropriate QIC with jurisdiction in the redetermination letter.
- One QIC will process all reconsiderations of DME claims.
- There are two QIC jurisdictions for Part B claims: a North jurisdiction and a South jurisdiction.
    - The North QIC jurisdiction includes the following states: Alaska, Arizona, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, District of Columbia, New York, Pennsylvania, New Jersey, Delaware, Maryland, Ohio, Kentucky, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Missouri, Iowa, Washington, Oregon, Nevada, Idaho, Wyoming, Montana, California, Utah, Kansas, Nebraska, North Dakota, South Dakota, Hawaii, American Samoa, Guam, and the Northern Marianas Islands.
    - The South QIC jurisdiction is comprised of the following states: Colorado, Connecticut, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, Florida, North Carolina, South Carolina, Virginia, West Virginia, Puerto Rico, and Virgin Islands.

Additional Information

For complete details regarding this CR, please see the official instruction (CR 5386) issued to your Medicare A/B MAC, FI, carrier, RHHI, DMERC or DME MAC. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1136CP.pdf*.

For additional supporting information that details the general appeals process in initial determinations please see *MLN Matters* article MM4019 on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4019.pdf*.

MLN Matters article MM3530, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3530.pdf*, provides a detailed explanation of the term *'vacate a dismissal'* as well as more background information about the second level of appeals process for Medicare Part A and Part B claims called 'reconsiderations.'

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

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

MLN Matters Number: MM5386
Related Change Request (CR) Number: 5386
Related CR Release Date: December 22, 2006
Related CR Transmittal MM5386: R1136CP
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1136, CR 5386

Medicare Fee-for-Service and Medicare Advantage Eligibility System Issues

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

Provider Types Affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Provider Action Needed

Be aware that Medicare reverses fee-for-service (FFS) payments when Medicare Advantage (MA) enrollments with retroactive dates are processed by CMS systems. Also know what action to take when there are conflicts in CMS eligibility data.

Background

In some cases, MA enrollments with retroactive dates are processed by CMS systems. The result is that Medicare may pay for the services rendered twice, once under fee-for-service and second by the MA payment systems in the monthly capitation rate to the plan.

The FFS contractor reverses the FFS payment, recovers from the provider, and the provider then bills the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the Medicare FFS rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

FFS Claims Paid in Error

Due to CMS beneficiary eligibility system updates, beneficiaries enrolled in MA organizations may be identified as having been inappropriately paid on a FFS basis. FIs, carriers, and A/B MACs will adjust these claims and seek overpayments. Where such an overpayment is recovered from a provider, the related remittance advice for the claim adjustment will indicate reason code 24, which states: 'Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan'.

Whenever CMS reverses FFS payments as a result of confirmed retroactive enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the FFS rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

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

The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations.

Eligibility Data Discrepancies: Provider Action

Despite system corrections, there remains a small number (under 1000) of beneficiary eligibility records that have not been updated. CMS is working to correct this. In the interim, if a provider has information from the MA plan that conflicts with information received from an FI, carrier, or A/B MAC in reply to an eligibility inquiry, the provider should call the FI/carrier/MAC provider call center.

The call center representative will check Medicare's common working file system and if the conflict is confirmed the provider will be referred to the CMS regional office for resolution.

Additional Information

Your call to the FI, carrier, or A/B Mac is a toll free call and if you do not have their number, you may obtain it on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: SE0681
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 SE0681

Optical Character Recognition Interface in the Fiscal Intermediary Standard System

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

Provider Types Affected

Providers submitting paper claims to Medicare fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5374 which instructs that the Fiscal Intermediary Standard System (FISS) is required to provide the capability for Medicare administrative contractors (MACs) to process optical character recognition (OCR) claims. The article is for informational purposes for those providers wishing to submit paper claims.

Background

Using certain systems, known within The Centers for Medicare & Medicaid Services (CMS) as "Shared Systems," Medicare FIs and A/B MACs perform traditional claims processing services. FISS is the system used by FIs and A/B MACs to process many claims.

CR 5374 notifies all interested parties that the FISS system will process OCR claims effective January 1, 2007. CR 5374 further instructs that the A/B MAC or FI will recognize, process, and report these claims as paper claims and they will apply the appropriate payment floor criterion will be applied when processing these claims. Applying the payment floor for paper claims means the claims will not be paid until 29 days after receipt (at the earliest) as opposed to 14 days for electronic claims.

Additional Information

For complete details, please see the official instruction issued to your FI or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R248OTN.pdf*.

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

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

MLN Matters Number: MM5374
Related Change Request (CR) Number: 5374
Related CR Release Date: November 3, 2006
Related CR Transmittal #: R248OTN
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-20, Transmittal 248, CR 5374

NATIONAL PROVIDER IDENTIFICATION

Just Five Months Remaining—National Provider Identifier Reminder

NPI: Get It. Share It. Use It.

Only five months remain until the NPI compliance date – are you ready to use your NPI? A recent survey of the health care industry, conducted by the Workgroup for Electronic Data Interchange (WEDI), indicates that providers should be moving from the enumeration stage into the implementation stage to ensure NPI readiness by the compliance date. Remember, it is estimated that it may take up to 120 days to complete the work needed in order to implement the NPI into your current business practices. The following steps will assist you in your preparation:

Enumerate: Have you applied for your NPI(s)?
Not only should individual providers (type 1) have enumerated, but organizations and subparts (type 2) should have enumerated also.

Update: Have you received your software application updates, upgrades and/or changes relevant to NPI?
Be sure that the updates not only addresses the HIPAA transactions, but includes the CMS-1500, UB-04 and/or dental claim form changes.

Communicate: Have you communicated your NPI(s) to your health plans and other organizations you work with? Keep in mind, as outlined in current regulation, all covered providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes – including designation of ordering or referring physician.

Collaborate: Do you know the readiness of your trading partners (such as health plans, TPAs, clearinghouses, etc...)? It's important to work with your trading partners to know their readiness with NPI and how it impacts you.

Test: Have you started testing the NPI, both internally and externally?
Not only do you need to test the HIPAA transactions such as 837 laims, but if you process 835 remittance advice, be sure to test that your system can process the NPI appropriately. Also, if you submit paper claims, be sure that you've tested the data being printed in the correct fields.

Just Five Months Remaining—National Provider Identifier Reminder (continued)

Educate: Have you educated your staff on what the NPI is and the use of it?
It's important that staff that may be using the NPI in day-to-day work, such as verification of eligibility, or other tasks that may need the NPI, be aware of the NPI and the provider identifiers that it replaces. The staff may have to change policies and procedures.

Implement: Have you implemented the NPI into your business practices?
Once testing is complete, changes will go into production. Prior to doing this, you'll need to make sure your trading partners are ready to process with the NPI only.

Given all the steps above, will you be ready by May 23, 2007?

Enumeration Advice for Incorporated Individual Providers

Health care providers who are individuals are eligible for an entity type 1 (individual) NPI. If these individuals incorporate themselves (i.e., if they form corporations) and the corporations are health care providers, the corporations are organization providers that are eligible for an entity type 2 (organization) NPI. If either of these health care providers (the individual or the corporation) are covered providers (i.e. providers that send electronic transactions) under HIPAA, the NPI final rule requires them to obtain NPIs.

Reminder to Supply Legacy Identifiers on NPI Application

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

Common Testing Error Identified

Given recent testing experience, one common testing error found is that claims submitters check that they are submitting an NPI in the 2010AA Billing Provider REF02 segment instead of NM109. The REF segment is situational, but required if it is necessary to report a secondary ID, such as a legacy identifier and a taxpayer identification number. NM109 is where the NPI is to be submitted, but the claim submitter incorrectly submits a legacy identifier instead. Remember to make sure you correctly designate the type of identifier you are submitting to aid in crosswalk development during this testing phase.

NPI Questions

CMS continues to update our Frequently Asked Questions (FAQs) to answer many of the NPI questions we receive on a daily basis. Visit the following link to view all NPI FAQs:
http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=Qir3YRYh&p_lva=&p_li=&p_page=l&p_cv=&p_pv=&p_prods=0&p_cats=&p_hidden hidden_prodsa=&prod_lvll=)&p_s

Providers should remember that the NPI enumerator can only answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter (i.e., for those providers enumerated via paper or web-based applications)
- Trouble accessing NPPES
- Forgotten password/user ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at CustomerService@NPIenumerator.com.

Note: The NPI Enumerator's operation is closed on federal holidays. The federal holidays observed are: New Year's Day, Independence Day, Veteran's Day, Christmas Day, Martin Luther King's Birthday, Washington's Birthday, Memorial Day, Labor Day, Columbus Day, and Thanksgiving

Important Information for Medicare Providers Requirement of Taxonomy Codes on Institutional Provider Claims

Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a **taxonomy code** on all claims submitted to their FI. Taxonomy codes shall be reported by these facilities whether or not the facility has applied for NPIs for each of their subparts. Institutional providers that do not currently bill Medicare for subparts are not required to use taxonomy codes on their claims to Medicare.

A recent *MLN Matters* article discusses this requirement in more detail and may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5243.pdf*.

Reminder to Submit Claims with Your NPI and your Legacy Number

From October 1, 2006 through May 22, 2007 or until further notice, CMS recommends that Medicare providers submit claims using both the provider's NPI and legacy number or just the provider's legacy number.

If claims are submitted with only an NPI:

- Claims for which Medicare systems are unable to properly match the incoming NPI with a legacy number may be rejected/returned as unprocessable to the provider.

The provider will then need to resubmit the claim with the appropriate legacy number.

Just Five Months Remaining—National Provider Identifier Reminder (continued)

Reminder of DME Supplier Enumeration Requirement

As mentioned in the paper entitled, *"Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA,"* **Medicare DME suppliers are required to obtain an NPI for every location**. The only exception to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the supplier may have.

Communicating NPIs to Medicare

Medicare providers should know that there is no "special process" or need to call to communicate NPIs to the Medicare program. NPIs can be shared with the Medicare program by using them on your claims along with your legacy identifier. Secondly, for providers applying for Medicare enrollment, an NPI must be reported on the CMS-855 enrollment application (along with a photocopy of the NPI notification received by the provider from the NPPES or from an EFIO). Existing Medicare providers must provide their NPIs when making any changes to their Medicare enrollment information.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it?

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

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

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

Source: CMS Provider Education Resource 200612-08

Claims Submitted With Only a National Provider Identifier During the Stage 2 NPI Transition Period

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

Beginning October 1, 2006, and until further notice, claims that you submit containing only an NPI will be returned you as unprocessable if a properly matching legacy number cannot be found.

CAUTION – What You Need to Know

From the beginning of Medicare's stage 2 NPI transition period on October 1, 2006, and until further notice, you should submit both NPIs and legacy provider numbers on your Medicare claims to ensure that they are properly processed. During this period, claims submitted with only an NPI that Medicare systems are unable to properly match with a legacy number (e.g., PIN, OSCAR number), **may** be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

GO – What You Need to Do

You should make sure that when submitting Medicare claims with dates of service on or after October 1, 2006, your billing staff submit both your NPI and legacy provider numbers until further notice from CMS.

Background

As previously announced, the Centers for Medicare & Medicaid Services (CMS) plans to begin testing new software it has been developed to use the NPI in the existing Medicare fee-for-service claims processing systems. (Remember that you will be required to submit claims and other HIPAA transactions with only an NPI beginning on May 23, 2007).

During the stage 2 NPI transition period of October 1, 2006, through May 22, 2007, Medicare will accept claims having only NPIs (as well as those having only legacy provider numbers); however in CR 5378, from which this article is taken, CMS recommends that during this period you submit claims using:

- **The provider's legacy number**, such as a provider identification number (PIN), NSC number, OSCAR number or UPIN; or
- **Both** the provider's NPI **and** legacy number.

Note: Until January 2, 2007, NPIs are not to be submitted on paper claims via CMS 1500 forms. Institutional providers are advised that FIs or A/B MACs will not accept the NPI on paper claims until implementation of the UB-04 on May 23, 2007.

Until testing of Medicare's new software is complete, if you submit Medicare claims with only your NPI:

1. They may be processed and paid, or

Claims Submitted With Only a NPI During the Stage 2 NPI Transition Period (continued)

2. If the Medicare systems are unable to properly match the incoming NPI with a legacy number (e.g., PIN, OSCAR number), they **may** be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

Additional Information

The official instruction issued to your Medicare contractor on this issue, CR 5378, is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R249OTN.pdf*.

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

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

MLN Matters Number: MM5378
Related Change Request (CR) Number: 5378
Related CR Release Date: November 13, 2006
Related CR Transmittal Number: R249OTN
Effective Date: October 1, 2006
Implementation Date: November 20, 2006

Source: CMS Pub. 100-20, Transmittal 249, CR 5378

GENERAL COVERAGE

New 2007 Current Procedural Terminology Mammography Codes

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

Provider Types Affected

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FI), or Part A/B Medicare administrative contractors (A/B MACs) for providing mammography services.

Provider Action Needed

STOP – Impact to You

As part of the annual HCPCS update, CMS has assigned new 2007 *Current Procedural Terminology (CPT)* mammography codes for screening and diagnostic mammography services. Effective January 1, 2007, these codes (*77051*, *77052*, *77055*, *77056*, and *77057*) will replace the current *CPT* codes; however the *CPT* code descriptors for the services are unchanged.

CAUTION – What You Need to Know

Failure to submit the correct codes will cause your claims to be returned and not processed.

GO – What You Need to Do

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

Background

CR 5327 announces the assignment of new *CPT* codes for screening and diagnostic mammography services. As part of the annual HCPCS update, CMS has assigned new 2007 *CPT* mammography codes for screening and diagnostic mammography services. Effective January 1, 2007, *CPT* codes *77051*, *77052*, *77055*, *77056*, and *77057* will replace the current *CPT* codes; however the *CPT* code descriptors for the services are unchanged. The following table displays the new and old *CPT* codes and their description.

2007 Screening and Diagnostic Mammography *CPT* Codes

New Code	Old Code	Description
77051	*76082*	*Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography. (List separately in addition to code for primary procedure.)*
77052	*76083*	*Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography. (List separately in addition to code for primary procedure.)*
77055	*76090*	*Diagnostic mammography, unilateral*
77056	*76091*	*Diagnostic mammography, bilateral*
77057	*76092*	*Screening mammography, bilateral (two view film study of each breast)*

Be advised that your carriers and FIs will return claims (with dates of service on or after January 1, 2007) that contain the old screening and diagnostic mammography codes. And also effective January 1, 2007, frequency standards for screening mammography will be applied to the new screening *CPT* codes (*77052* and *77057*).

Additional Information

You can find more information about the new 2007 mammography *CPT* codes by going to CR 5327, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1070CP.pdf*.

There, as an attachment to that CR, you will find revised Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services) of the Medicare Claims Processing Manual (100-04).

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

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

MLN Matters Number: MM5327
Related Change Request (CR) Number: 5327
Related CR Release Date: September 29, 2006
Related CR Transmittal Number: R1070CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1070, CR 5327

Medicare Payment for Preadministration-Related Services Associated with IVIG Administration—Payment Extended Through Calendar Year 2007

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

Provider Types Affected

Physicians and hospitals that bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for intravenous immune globulin (IVIG) administration.

Provider Action Needed

STOP – Impact to You

You may bill for preadministration-related services associated with intravenous immune globulin (IVIG) administration (HCPCS code G0332) during calendar year 2007. The preadministration-related service must be billed on the same claim and have the same date of service, as the claim for the IVIG itself (codes J1566 and/or J1567) and the drug administration service.

CAUTION – What You Need to Know

CR 5428, from which this article was taken, extends payment of the preadministration-related service for IVIG through calendar year (CY) 2007 **but only when submitted on the same claim as the IVIG and its administration**.

GO – What You Need to Do

Make sure that your billing staff is aware that they must include your claim for the IVIG preadministration-related services on the same claim (and with the same date of service) as the IVIG and its administration.

Background

Under Section 1861(s)(1) and 1861(s)(2), Medicare Part B covers intravenous immune globulin (IVIG) administered by physicians in physician offices and by hospital outpatient departments. More specifically, when you administer IVIG to a Medicare beneficiary in the physician office or hospital outpatient department, Medicare makes separate payments to the physician or hospital for both the IVIG product itself and for its administration via intravenous infusion.

In addition, for 2006, CMS established a temporary preadministration-related service payment, for physicians and hospital outpatient departments that administer IVIG to Medicare beneficiaries, to cover the effort required to locate and acquire adequate IVIG product and to prepare for an infusion of IVIG during this current period where there may be potential market issues. **CR 5428, from which this article was taken, announces the extension of this temporary payment for the IVIG preadministration-related service through CY 2007.**

As a reminder, here are some important details that you should know:

- The policy and billing requirements concerning the IVIG preadministration-related services payment are the same in 2007 as they were in 2006.
- This IVIG pre-administration service payment is in addition to Medicare's payments to the physician or hospital for the IVIG product itself and for its administration by intravenous infusion.
- Medicare carriers, FIs, or A/B MACs will pay for these services, that are provided in a physician office, under the physician fee schedule; and FIs or A/B MACs will pay for them under the outpatient prospective payment system (OPPS), for hospitals subject to OPPS (bill types: 12x, 13x) or under current payment methodologies for all non-OPPS hospitals (bill types: 12x, 13x, 85x).
- You need to use HCPCS code G0332 - Preadministration-Related Services for intravenous infusion of immunoglobulin, (this service is to be billed in conjunction with administration of immunoglobulin) to bill for this service.
- You can bill for this only one IVIG preadministration per patient per day of IVIG administration.
- The service must be billed on the same claim form as the IVIG product (HCPCS codes J1566 (Injection, immune globulin, intravenous, lyophilized (E.G. powder), 500 mg) and/or J1567 (Injection, immune globulin, intravenous, non-lyophilized (E.G. liquid), 500 mg), and have the same date of service as the IVIG product and a drug administration service.
- Your claims for preadministration-related services will be returned/rejected by your FI, carrier, or A/B MAC if more than one unit of service of G0332 is indicated on the same claim for the same date of service. They will use the appropriate reason/remark code such as:
  - M80 - "Not covered when performed during the same session/date as a previously processed service for the patient;"
  - B5 - "Payment adjusted because coverage/program guidelines were not met or were exceeded;"
  - M67 - "Missing other procedure codes;" and/or
  - 16 - "Claim/service lacks information which is needed for adjudication."

Additional Information

You can find the official instruction, CR 5428, issued to your FI, carrier, or A/B MAC by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1140CP.pdf*.

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

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

MLN Matters Number: MM5428
Related Change Request (CR) Number: 5428
Related CR Release Date: December 22, 2006
Related CR Transmittal Number: R1140CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1140, CR 5428

Infrared Therapy Devices

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

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare carriers, Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME/MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs), for the use of infrared therapy devices for treatment of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5421. Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services (CMS) has made a national coverage determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), **is noncovered for the treatment,** including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Background

The use of infrared therapy devices has been proposed for a variety of disorders, including treatment of diabetic neuropathy, other peripheral neuropathy, skin ulcers and wounds, and similar related conditions, including symptoms such as pain arising from these conditions. A wide variety of devices are currently available. Previously there was no NCD concerning the use of infrared therapy devices, leaving the decision to cover or not cover up to local Medicare contractors.

The following requirements are in effect as of October 24, 2006:

- **Effective for services performed on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) **are noncovered** as DME or PT/OT services when used for the treatment of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.
- Claims will be denied with *CPT 97026* (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9-CM codes:

  250.60-250.63
  354.4, 354.5, 354.9
  355.1-355.4
  355.6-355.9
  356.0, 356.2-356.4, 356.8-356.9
  357.0-357.7
  674.10, 674.12, 674.14, 674.20, 674.22, 674.24
  707.00-707.07, 707.09-707.15, 707.19
  870.0-879.9
  880.00-887.79
  890.0-897.7
  998.31-998.32.

- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects type of bills (TOBs) 12x, 13x, 22x, 23x, 34x, 74x, 75x and 85x.
- If you submit a claim for one of the noncovered services, your patient will receive the Medicare summary notice (MSN) message stating "This service was not covered by Medicare at the time you received it". The Spanish translation is: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."
- If you submit a claim for one of the noncovered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, "These are noncovered services because this is not deemed a 'medical necessity' by the payer."
- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that **you are liable** if the service is performed, unless the beneficiary signs an advanced beneficiary notice (ABN).
- DME suppliers and HHA be aware that **you are liable** for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR 5421. The first is the national coverage determination transmittal, located at on the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf*.

In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1127CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.
MLN Matters Number: MM5421
Related Change Request (CR) Number: 5421
Related CR Release Date: December 15, 2006
Related CR Transmittal Number: R1127CP and R62NCD
Effective Date: October 24, 2006
Implementation Date: January 16, 2007

Source: CMS Pub. 100-04, Transmittal 1129, CR 5413

Cavernous Nerves Electrical Stimulation with Penile Plethysmograph

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

Provider Types Affected

Physicians and hospitals who bill Medicare fiscal intermediaries (FI) and carriers for performing cavernous nerves electrical stimulation with penile plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

Provider Action Needed

STOP – Impact to You

Effective for claims with dates of service on or after August 24, 2006, Medicare will not pay for performing cavernous nerves electrical stimulation with penile plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

CAUTION – What You Need to Know

Change Request (CR) 5294, from which this article is taken, announces' the results of a national coverage determination (NCD) addressing cavernous nerves electrical stimulation with penile plethysmography performed for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures. It states that CMS, after reviewing the evidence, has determined that this test is not reasonable and necessary for Medicare beneficiaries undergoing these procedures.

GO – What You Need to Do

Make sure that your billing staffs are aware of this NCD.

Background

The direct application of electrical stimulation with penile plethysmography (also referred to as cavernosal nerve mapping) may be performed, in nerve-sparing prostatic and colorectal surgical procedures, to assess the integrity and function of the cavernous nerves.

Through either an open or laparoscopic approach, the surgeon can assess the function of the cavernous nerves by stimulating, with an electrical nerve stimulator, the most distal end of the nerve that can be located. A functioning and stimulated nerve will trigger blood flow either into or out of the penis, which can be detected via a penile plethysmography sensor fitted around the penis and connected to a nerve stimulator control unit. If the nerves are intact, cavernous blood flow will cause slight changes in penile girth, which the sensor can detect. The presence (and degree) of a response may be used to provide the surgeon with a more realistic assessment of the chance of the patient regaining potency and assist in choosing appropriate therapy.

Heretofore, local Medicare carriers/FIs had the discretion to cover this test whenever it was determined to be medically necessary for the individual patient, because a national coverage determination (NCD) or national Medicare coverage policy had not been issued. However, on December 9, 2005, a request for review of this test initiated a national coverage analysis.

CR 5294, from which this article is taken, announces the results of this NCD. It provides that CMS has reviewed the evidence and determined that:

1) Cavernous nerves electrical stimulation with penile plethysmography is not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.
2) This test is **noncovered** under Medicare (as specified the Medicare National Coverage Manual (100-03, Section 160.26 (Cavernous Nerves Electrical Stimulation with Penile Plethysmography).

Effective with claims with dates of service on or after August 24, 2006, your FIs and carriers will not pay for these services.

Physicians should use HCPCS code 55899 to bill this for test. Your FIs and carriers will suspend claims containing this code to determine whether this test is the service being billed, and will deny the line item associated with it, using Medicare Summary Notice 21.11 (This test was not covered by Medicare at the time you received it).

You should be aware that your FIs, A/B MACs and carriers will not search for, and adjust, claims for tests that have been paid prior to January 8, 2007, but they will adjust claims brought to their attention. Further, physicians and hospitals should, as appropriate:

1. Issue the appropriate liability notice for Medicare beneficiaries having this test.
2. Include the following language when issuing an advanced beneficiary notice (ABN):
   - ***Under "Items or Service" Section:*** *Cavernous Nerves Electrical Stimulation with Penile Plethysmography.*
   - ***Under "Because" Section:*** *As specified in section 160.26 of Medicare NCD Manual, Medicare will not pay for this test as it is not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.* and/or
3. Issue a hospital issued notice of noncoverage (HINN).

If a physician does not issue an ABN, the physician is liable for the service.

Additional Information

You can find more information about payment for cavernous nerves electrical stimulation with penile plethysmography by going to CR5294, which is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R61NCD.pdf*.

You will find revised section 160.26 (Cavernous Nerves Electrical Stimulation with Penile Plethysmography) of the *Medicare National Coverage Manual* (Publication 100-03) as an attachment to this CR.

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

Cavernous Nerves Electrical Stimulation with Penile Plethysmograph (continued)

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

MLN Matters Number: MM5294
Related Change Request (CR) Number: 5294
Related CR Release Date: November 24, 2006
Related CR Transmittal Number: R61NCD
Effective Date: August 24, 2006
Implementation Date: January 8, 2007

Source: CMS Pub. 100-03, Transmittal 61, CR 5294

Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms

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 December 8, 2006, to emphasize that this coverage is for a one-time only service and it must also be as a result of a referral from an initial preventive physical exam and is also subject to other limitation as discussed in this article and in change request 5235. The original MLN Matters article was published in the December 2006 *Medicare A Bulletin* (pages 18-19).

Provider Types Affected

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (MACs) for subject services.

Background

This article and related CR 5235 highlight the fact that section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for abdominal aortic aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007, as a result of a referral from an initial preventive physical examination (IPPE) and subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test.

Key Points

Effective for dates of services on or after January 1, 2007, Medicare will pay for a one-time ultrasound screening for AAA, for beneficiaries who meet the following criteria:

- Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (IPPE). For more details on the IPPE, see *MLN Matters* article MM3638 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf*.
- Receives such ultrasound screening from a provider or supplier who is authorized to provide covered diagnostic services.
- Has not been previously furnished such an ultrasound screening under the Medicare program
- Is included in at least one of the following risk categories:
  1. Has a family history of abdominal aortic aneurysm.
  2. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime
  3. Is a beneficiary, who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health & Human Services, through the national coverage determinations process.

Payment

The Part B deductible for screening AAA is waived effective January 1, 2007, but coinsurance is applicable.

If the screening is provided in a physician office, the service is billed to the carrier using the HCPCS code G0389: Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening.

- Short Descriptor: Ultrasound exam AAA screen
- Modifiers: TC, 26 (modifiers are optional)
- Payment is under the Medicare physician fee schedule (MPFS).

FIs will pay for the AAA screening only when the services are performed in a hospital, including a **CAH, IHS facility, an SNF, RHC, or FQHC** and submitted on one of the following types of bills (TOBs): **12x, 13x, 22x, 23x, 71x, 73x, 85x.**

Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms (continued)

The following table describes the payment methodology Medicare will use for AAA screening:

Facility	Type of Bill	Payment
Hospitals subject to OPPS	12x, 13x	OPPS
Method I and method II critical access hospitals (CAHs)	12x and 85x	101 percent of reasonable cost
IHS providers	13x, revenue code 051x	OMB-approved outpatient per visit all inclusive rate (AIR)
IHS providers	12x, revenue code 024x	All-inclusive inpatient ancillary per diem rate
IHS CAHs	85x, revenue code 051x	101 percent of the all-inclusive facility specific per visit rate
IHS CAHs	12x, revenue code 024x	101 percent of the all-inclusive facility specific per diem rate
SNFs **	22x, 23x	Nonfacility rate on the MPFS
RHCs*	71x, revenue code 052x	All-inclusive encounter rate
FQHCs*	73x, revenue code 052x	All-inclusive encounter rate
Maryland hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12x, 13x	94 percent of provider submitted charges or according to the terms of the Maryland waiver

*****If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI using TOBs 71x and 73x, respectively, and the appropriate site of service revenue code in the 052x revenue code series. If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier under the practitioner's ID following instructions for submitting practitioner claims to the Medicare carrier. If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI under the base provider's ID, following instructions for submitting claims to the FI from the base provider.

****** The SNF consolidated billing provision allows separate Part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a TOB 22x. Screening services provided by other provider types must be reimbursed by the SNF.

Implementation

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

Information Regarding Advanced Beneficiary Notices

Medicare contractors will deny an AAA screening service billed more than one in a beneficiary's lifetime.

If a second G0389 is billed for AAA for the same beneficiary or if any of the other statutory criteria for coverage listed in Section 1861(s)(2)(AA) of the Social Security Act are not met, the service would be denied as a statutory (technical) denial under Section 1861(s)(2)(AA), not a medical necessity denial.

If a provider cannot determine whether or not the beneficiary has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN-G. Likewise, if all of the statutory requirements for coverage have been met, but a question of medical necessity still exists, the provider should issue the ABN-G.

Additional Information

The official instructions for CR 5235, issued to your Medicare carrier, FI, MAC, FQHC, RHC, SNF, or CAH regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1113CP.pdf*.

The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 18, has been updated to include the requirements to implement section 5112 of the DRA of 2005. The new sections of this chapter address the payment and allowable settings for AAA and the sections are attached to CR 5235.

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

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

MLN Matters Number: MM5235
Related Change Request (CR) Number: 5235
Related CR Release Date: November 17, 2006
Related CR Transmittal Number: R1113CP
Effective Date: January 2, 2007
Implementation Date: January 1, 2007

Source: CMS Pub. 100-04, Transmittal 1113, CR 5235

HOSPITAL SERVICES

Inpatient Rehabilitation Facility Teaching Adjustment

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) for inpatient rehabilitation facility (IRF) services provided to Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5325, which provides clarification of the IRF teaching adjustment for other types of Medicare providers, including long-term care hospitals (LTCHs), that have been training residents and are currently converting to IRFs.

Background

Beginning October 1, 2005, the Centers for Medicare & Medicaid Services (CMS) implemented an adjustment for teaching facilities that operate an IRF in order to compensate them for the higher costs incurred in providing care to Medicare beneficiaries. CMS implemented the teaching adjustment based on the ratio of residents and interns to the average daily census, raised to some power as described in the final rule.

The details of the adjustment are included as an attachment to the official instructions (CR 4099) issued to your FI. That instruction and the revised portions of Chapter 3 of *the Medicare Claims Processing Manual* may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R693CP.pdf*.

The *MLN Matters* article corresponding to CR 4099 can be found at the following CMS website: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4099.pdf*.

For Medicare providers (including LTCHs) that have been training residents and are currently converting to IRFs, the provider's FI will:

- Determine a full-time equivalent (FTE) resident cap (for purposes of the IRF teaching status adjustment) that is:
  - Applicable beginning with the new IRF's payments under the IRF prospective payment system (PPS).
  - Based on the FTE count of residents during the predecessor facility's cost reporting period ending on or before November 15, 2004.

Similar to the existing CMS policy for IRFs, if the predecessor facility did not begin training residents until after November 15, 2004, then the facility would initially receive an FTE cap of "0."

Once established, the FTE resident cap for the teaching status adjustment for the new IRF will be subject to the same rules and adjustments as any IRF's FTE resident cap.

CR5325 instructs your FI to:

- Identify all Medicare providers that are converting to IRFs for cost reporting periods beginning on and after October 1, 2006.
- Determine an FTE resident cap for purposes of the IRF teaching adjustment based upon the FTE count of residents during the predecessor facility's cost reporting period ending on or before November 15, 2004.
- Assign an FTE cap of zero if the predecessor facility did not begin training residents until after November 15, 2004.
- Make adjustments to the cap in accordance with the polices that are being applied in the IPF PPS and IPPS.

Implementation

The implementation date for CR 5325 is January 22, 2007.

Additional Information

For more information, you may also visit the IRF PPS web site on the CMS website at *http://www.cms.hhs.gov/InpatientRehabFacPPS/01_Overview.asp#TopOfPage*.

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1137CP.pdf*.

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

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

MLN Matters Number: MM5325
Related Change Request (CR) Number: CR5325
Related CR Release Date: December 22, 2006
Related CR Transmittal Number: R1137CP
Effective Date: October 1, 2005
Implementation Date: January 22, 2007

Source: CMS Pub. 100-04, Transmittal 1137, CR 5325

LOCAL COVERAGE DETERMINATIONS

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

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

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

Local Coverage Determination Table of Contents

New LCD Implementation
A90802: Interactive Psychiatric Services 40
ANCSVCS: The List of Medicare Noncovered Services 40

Additions/Revisions to Existing LCDs
A76070 Bone Mineral Density Studies 41
ABotulinum Toxins 41
AEPO: Epoetin alfa 41
ANESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) 41
AJ9000: Antineoplastic Drugs 42
ATHERSVCS: Therapy and Rehabilitation Services 42

Additional Medical Information
2007 HCPCS Local Coverage Determination Changes 43
Self-Administered Drug (SAD) List 44

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*.

Correction of Instructions for Calculating Inpatient Rehabilitation Facility Compliance Percentage Threshold

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

Provider Types Affected

Inpatient rehabilitation facilities (IRFs) billing Medicare fiscal intermediaries (FIs) or Medicare Part A and Part B administrative contractors (A/B MACs) for services paid under the IRF prospective payment system (IRF PPS).

Background

This article and related CR 5303 highlights the regulations at 42 CFR 412.23(b), 412.25, 412.29, and 412.30, that specify the criteria for a provider to be classified as an IRF. (You may search for CFR sections at *http://www.gpoaccess.gov/cfr/index.html*.)

Hospitals and units meeting these and other criteria are eligible to be paid on a PPS basis as an IRF under the IRF PPS. Further interpretation and instructions for implementing these regulations are found in the revised sections of Chapter 3, Section 140 of the *Medicare Claims Processing Manual* and the Web address for that manual is listed in the *Additional Information* section of this article.

Key Points

An IRF is excluded from the acute care hospital PPS or the critical access hospital payment system, if the FI (or A/B MAC) calculations determine that a percentage, or percentages, of a currently certified IRF's total inpatient population during a most recent, consecutive, and appropriate 12-month time period (as defined by the Centers for Medicare & Medicaid [CMS] or the FI) met a specified list of medical condition.

For cost reporting periods that start on or after July 1, 2005, but not later than June 30, 2009, where the compliance review period spans two cost reporting periods, and the compliance review period is divided into two portions of time, the **compliance percentage is calculated by your FI or A/B MAC using either of the following two methods:**

- When the compliance review period spans two cost reporting periods, and the compliance review period is divided into two portions of time, the FI determines that each portion of the compliance review period met the compliance threshold of the cost reporting period that includes that portion of time of the compliance review period.
- When the compliance review period spans two cost reporting periods, and the compliance review period is divided into two portions of time, the FI calculates a weighted average compliance percentage for the entire compliance review period. The FI then determines if the weighted average compliance percentage at least met the greater of the two compliance thresholds when each portion of the compliance review period is linked to its associated cost reporting period.

For cost reporting periods starting after July 1, 2009, the compliance threshold that must be met is 75 percent, and the compliance review period will be a 12-month time period that is not divided into two portions of time.

Note that the table titled "Table of Compliance Review Periods" illustrates the time spans associated with an IRF's compliance review period and the compliance percentage threshold that must be met during each compliance review period.

Depending on the specific compliance review period, a compliance review period may include a span of time from only one cost reporting period, or a compliance review period may span periods of time from two cost reporting periods. This table is available by viewing the official instruction issued to your Medicare FI or A/B MAC and that Web address is listed in the *Additional Information* section of this article.

Implementation

The implementation date for the instruction is March 22, 2007.

Additional Information

For complete details, please see the official instruction issued to your Medicare FI or A/B MAC regarding this change. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1135CP.pdf*.

The following CMS website lists IRF federal regulations as well as a complete listing of federal regulations related to the PPS for IRFs. The website provides links to the rules that gradually increase the compliance percentage threshold that IRFs must meet. The website is located on the CMS website at *http://www.cms.hhs.gov/InpatientRehabFacPPS/LIRFF/list.asp*.

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

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

MLN Matters Number: MM5303
Related Change Request (CR) Number: 5303
Related CR Release Date: December 22, 2006
Related CR Transmittal Number: R1135CP
Effective Date: July 1, 2005
Implementation Date: March 22, 2007

Source: CMS Pub. 100-04, Transmittal 1135, CR 5303

Inpatient Psychiatric Facility Prospective Payment System Fact Sheet now Available

The *Inpatient Psychiatric Facility Prospective Payment System Fact Sheet*, which provides general information about the inpatient psychiatric facility prospective payment system (IPF PPS), how payment rates are set, and the rate year 2007 update to the IPF PPS, is now available in downloadable format from the Centers for Medicare & Medicaid Services MLN Publications Page located at *http://www.cms.hhs.gov/MLNProducts/downloads/InpatientPsychFac.pdf*.

Print versions of the fact sheet will be available in the summer 2007. ❖

Source: CMS Provider Education Resource 200612-04

NEW LCD IMPLEMENTATIONION

A90802: Interactive Psychiatric Services—New LCD

The interactive psychiatric techniques are utilized primarily to evaluate children and/or adults who do not have the ability to interact through ordinary verbal communication. It involves the use of physical aids and nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication. An interactive technique may include the use of inanimate objects such as toys and dolls for a child, physical aids and non-verbal communication to overcome barriers to therapeutic interaction, or an interpreter for a person who is deaf or in situations where the patient does not speak the same language as the provider of care. If a patient is unable to communicate by any means, the interactive codes should not be billed.

This new local coverage determination (LCD) has been developed to provide indications and limitations of coverage and/or medical necessity and documentation requirements for *CPT* codes *90802, 90810, 90811, 90812, 90813, 90814, 90815, 90823, 90824, 90826, 90827, 90828, 90829* and *90857*.

In addition, "Interactive Individual Psychotherapy" (A90810) and "Interactive Group Psychotherapy" (A90857) LCDs are being retired as they have been incorporated in this new LCD.

Effective Dates

This new LCD and the retired LCDs are effective for services provided **on or after February 28, 2007.**

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

ANCSVCS: The List of Medicare Noncovered Services—New LCD

The purpose of these coding guidelines is to create a working list of medical services and procedures that are never covered by the Medicare program. Such services and procedures are always denied either because:

- A national decision to noncover the service/procedure exists, or
- The service/procedure is included on the list of services determined by this contractor to be excluded from coverage:
  - The coding guidelines are developed under an iterative process and will be updated as national and local coverage decisions change.

This local coverage determination (LCD) will evolve as new services are identified as noncovered. Currently, procedure codes on this list include only noncovered services or procedures that have been identified since July 1, 2006, and will allow for tracking and automation going forward.

The following procedure codes are included in the LCD:

*0155T** *Laparoscopy, surgical; implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*

*0156T** *revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*

*0157T** *Laparotomy, implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*

*0158T** *Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*

*0159T** *Computer aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure)*

*0160T** *Therapeutic repetitive transcranial magnetic stimulation treatment planning*

*0161T** *Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session*

53899+* RENESSA™ (system for stress urinary incontinence)

***Services which are noncovered due to their being investigational/experimental.**

+Claims for these services will always be reviewed, as they must currently be billed with an unlisted procedure code.

When billing as a fiscal intermediary for an unlisted procedure, the drescription of the service should be entered in form locator 84 of claim form CMS-1450 (UB-92) or the electronic equivalent.

Effective Dates

This LCD is effective for services provided **on or after February 28, 2007.**

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

ADDITIONS/REVISIONS TO LCDS

A76070 Bone Mineral Density Studies—Revision to the LCD

The local coverage determination (LCD) for bone mineral density studies was last revised on April 11, 2006. Since that time, the LCD has been revised to delete reference to ICD-9-CM code E932.0 (Adrenal cortical steroids causing adverse effects in therapeutic use) in the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-9 Codes that Support Medical Necessity" sections of the LCD, as this code is intended to provide supplementary classification and is not mandatory for billing purposes.

Effective Dates

This revision is effective for services **provided on or after January 1, 2007.**

The full text for this LCD (L1375) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ABotulinum Toxins—Revision to the LCD

The local coverage determination (LCD) for botulinum toxins was last revised on November 1, 2006. Since that time, the LCD has been revised in regard to the annual 2007 ICD-9-CM update. The "ICD-9 Codes that Support Medical Necessity" section of the LCD for HCPCS code J0585 has been revised to add ICD-9-CM code 333.79 (Other acquired torsion dystonia).

Effective Dates

This revision is effective for claims processed **on or after December 21, 2006,** for services provided **on or after October 1, 2006.**

The full text for this LCD (L1382) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AEPO: Epoetin alfa—Revision to the Coding Guideline

The local coverage determination (LCD) for epoetin alfa was last updated on October 19, 2006. Since that time, the coding guideline has been revised. Based on instructions communicated through change request (CR) 5251, language was revised to clarify instructions originally published in CR 4135. The revised language states that for providers submitting type of bill (TOB) 72x claims for patients who have opted to receive home dialysis under method I and are self-administering the EPO in their home, are exempt from the policy outlined in CR 4135. Therefore, they are not subject to automatic monitoring or the automatic 25 percent reduction as described in CR 4135.

Providers should report condition code 70 on claims to identify home dialysis patients who self-administer EPO and condition code 76 for the home dialysis patient who received back-up services in the facility.

Effective Date

This revision to the LCD is effective for claims **processed on or after January 2, 2007,** for services **provided on or after April 1, 2006.**

The full text for this LCD (L895) is available 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 Coding Guideline

The local coverage determination (LCD) for darbepoetin alfa (Aranesp) (novel erythropoiesis stimulating protein [NESP]) was last updated on October 1, 2006. Since that time, the coding guideline has been revised. Based on instructions communicated through change request (CR) 5251, language was revised to clarify instructions originally published in CR 4135. The revised language states that for providers submitting type of bill (TOB) 72x claims for patients who have opted to receive home dialysis under method I and are self-administering the Aranesp in their home, are exempt from the policy outlined in CR 4135. Therefore, they are not subject to automatic monitoring or the automatic 25 percent reduction as described in CR 4135.

Providers should report condition code 70 on claims to identify home dialysis patients who self-administer Aranesp and condition code 76 for the home dialysis patient who received back-up services in the facility.

Effective Date

This revision to the LCD is effective for claims **processed on or after January 2, 2007,** for services **provided on or after April 1, 2006.**

The full text for this LCD (L13796) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ9000: Antineoplastic Drugs—Addition to the LCD

The local coverage determination (LCD) for antineoplastic drugs was last updated on November 9, 2006. Since that time, revisions were made to add additional ICD-9-CM codes and indications, as well as update verbiage based on the Food and Drug Administration (FDA) label where applicable for the following drugs:

Docetaxel (J9170)

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following FDA approved indication was added:

- Docetaxel in combination with cisplatin and fluorouracil is indicated for the induction treatment of patients with inoperable locally advanced squamous cell carcinoma of the head and neck.

Under the "ICD-9 Codes that Support Medical Necessity" section, the following diagnoses were added:

173.0 Other malignant neoplasm of skin of lip
173.1 Other malignant neoplasm of skin, eyelid, including canthus
173.2 Other malignant neoplasm of skin of ear and external auditory canal
173.3 Other malignant neoplasm of skin of other and unspecified parts of face
173.4 Other malignant neoplasm of skin, scalp and skin of neck

Rituximab (J9310)

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following off-label indication was added:

- For the treatment of refractory thrombotic thrombocytopenic purpura (TTP) for patients who do not respond to plasmapheresis.

Under the "ICD-9 Codes that Support Medical Necessity" section, the following diagnosis was added:

446.6 Thrombotic microangiopathy [use this code for refractory thrombotic thrombocytopenic purpura (TTP)]

Trastuzumab (J9355)

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following FDA approved indication was added:

- Trastuzumab, as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel, is indicated for the adjuvant treatment of patients with HER2-overexpressing, node-positive breast cancer.

Effective Dates

For HCPCS code J9170, this addition is effective for claims processed **on or after January 18, 2007,** for services provided **on or after October 17, 2006.**

For HCPCS code J9310, this addition is effective for services provided **on or after January 18, 2007.**

For HCPCS code J9355, this addition is effective for services provided **on or after November 16, 2006.**

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

ATHERSVCS: Therapy and Rehabilitation Services—Revision to the LCD and Coding Guideline

The local coverage determination (LCD) for therapy and rehabilitation services was last updated on May 10, 2006, for services provided on or after January 1, 2006. Since that time, the LCD has been revised. Revisions were made to the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of this LCD based on instructions communicated through change request (CR) 5271, transmittals 60, 171 and 1106 dated November 9, 2006. These revisions clarify language pertaining to outpatient therapy CAPS. The coding guideline was revised accordingly, also based on CR 5271.

This revision is effective for services provided **on or after December 9, 2006**.

In addition to the above revisions to the LCD and coding guideline, the coding guideline was also modified to include revised language communicated through CR 5253. The revised language encompasses instructions for billing timed and untimed codes, counting minutes for timed codes in 15-minute units and specific limits for HCPCS.

This revision is effective for services **provided on or after January 1, 2007,** for claims **processed on or after January 2, 2007.**

The full text for this LCD (L1125) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

Sign up to our *eNews* electronic mailing list

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

ADDITIONAL MEDICAL INFORMATION

2007 HCPCS Local Coverage Determination Changes

Florida Medicare has revised local coverage determinations (LCDs) impacted by the 2007 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

LCD Title	2007 Changes
AAPBI – Accelerated Partial Breast Irradiation **(Coding Guidelines only)**	• Deleted *CPT* code *76370* • Added *CPT* code *77014*
AEPO – Epoetin alfa	• Added HCPCS code Q4081 • Added statement that HCPCS code Q4081 is to only be billed by type of bills (TOBs) 12x, 13x, 72x, and 85x
ADYSPHRT – Dysphagia/Swallowing Diagnosis and Therapy	• Descriptor change for *CPT* code *76536*
AG0104 – Colorectal Cancer Screening	• Deleted HCPCS code G0107 • Added *CPT* code *82270*
AJ7188 – Hemophilia Clotting Factors	• Deleted HCPCS code J7188 • Added HCPCS code J7187 • Changed contractor's determination number to AJ7187
APULMDIAGSVCS – Pulmonary Diagnostic Services	• Descriptor change for *CPT* code *94620*
ASKINSUB – Skin Substitutes	• Deleted *CPT* codes *15000* and *15001* • Added *CPT* codes *15002*, *15003*, *15004*, and *15005*
AVISCO – Viscosupplementation Therapy For Knee	• Deleted HCPCS codes C9220, J7317 and J7320 • Added HCPCS code J7319
A0145T – Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries	• Descriptor change for *CPT* code *71275*
A11000 – Debridement Services **(Coding Guidelines only)**	• Deleted *CPT* codes *15000* and *15001* • Added *CPT* codes *15002*, *15003*, *15004*, and *15005*
A17304 – Mohs Micrographic Surgery (MMS)	• Deleted *CPT* codes *17304*, *17305*, *17306*, *17307*, and *17310* • Added *CPT* code *17311*, *17312*, *17313*, *17314*, and *17315* • Changed contractor's determination number to A17311
A70540 – Magnetic Resonance Imaging of the Orbit, Face, and Neck	• Descriptor change for *CPT* code *70540*
A76070 – Bone Mineral Density Studies	• Deleted *CPT* codes *76070*, *76071*, *76075*, *76076*, *76077*, *and 76078* • Added *CPT* codes *77078*, *77079*, *77080*, *77081*, *77082*, *and 77083* • Changed contractor's determination number to A77078
A76536 – Ultrasound, Soft Tissues of Head and Neck	• Descriptor change for *CPT* code *76536*
A91110 – Wireless Capsule Endoscopy	• Added *CPT* code *91111*

Final LCDs are available on the Florida Medicare provider education website *http://www.floridamedicare.com*. ❖

Self-Administered Drug (SAD) List

The Center for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Providers may read the instructions in their entirety in the CMS *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services provided **on or after January 19, 2007,** the following drug has been be added to the self-administered drug (SAD) list:

J3490 exenatide injection (Byetta®) 5 mcg, 10 mcg

When billing as a fiscal intermediary for an unlisted procedure, the drug and dosage should be entered in form locator 84 of the claim form CMS-1450 (UB-92) or the electronic equivalent.

The evaluation of drugs for addition to the SAD list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The SAD list may be viewed in its entirety at the provider education website *http://www.floridamedicare.com*. ❖

Sign up to our *eNews* electronic mailing list

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

CRITICAL ACCESS HOSPITAL SERVICES

2007 Update of HCPCS Codes and Payments for Ambulatory Surgical Centers

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

Provider Types Affected

Ambulatory surgical centers (ASCs) submitting claims to Medicare carriers or fiscal intermediaries (FIs) for ASC services provided to Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5211, which updates the 2007 HCPCS codes and ASC payment rates, effective for services furnished on or after January 1, 2007.

Background

Section 5103 of the Deficit Reduction Act of 2005 (DRA) limits ASC payments to:

- The lesser of the Medicare hospital outpatient prospective payment system (OPPS) payment amount; or
- The ASC payment amount for services furnished on or after January 1, 2007.

Also, section 1833(i)(1) of the Social Security Act requires that the list of payable ASC procedures be updated as least every two years.

CR 5211, from which this article is taken, implements the required biennial ASC update, which includes changes made by the American Medical Association for the CY 2007 Common Procedural Terminology (CPT). These changes include replacing the ASC 2-digit payment group code designation next to the ASC-approved Healthcare Common Procedure Coding System (HCPCS) codes with a "yy" designation for these codes, which will be defined as "the procedure is approved to be performed in an ambulatory surgical center."

CR 5211 also revises the manner in which ASC payment groups are defined. The number of ASC payment groups that carriers and fiscal intermediaries (FI) currently use to identify ASC payment amounts for individual HCPCS codes is being expanded in order to accommodate the new payment amounts that will be assigned to certain ASC services in calendar year (CY) 2007 under the DRA requirement. The ASC payment groups will now be called ASC PRICER groups.

The additional ASC PRICER groups reflect the DRA-driven payment amounts, which will be included in the ASC PRICER files that carriers, and certain FIs, use to process ASC facility claims.

And lastly, CR 5211 includes payment file retrieval instructions that your carriers and FIs will use to access the final payment files on, or after, the specified retrieval date provided in CMS's notification.

You should be aware that final ASC payment rates are established after publication of the OPPS final rule and the code change update will be published as part of the OPPS final rule in the *Federal Register*. This publication usually occurs in late October. Shortly after publication, you can reach this rule through a link on the CMS website at *http://www.cms.hhs.gov/center/asc.asp*.

Also note that your carriers and FIs will continue to use the wage index values contained in Transmittal 51, dated February 4, 2004, to calculate payment amounts for all type of service F Healthcare Common Procedural Coding System (HCPCS) codes until further notice. This transmittal is available on the CMS site at *http://www.cms.hhs.gov/Transmittals/downloads/R51OTN.pdf*.

Additional Information

For complete details, please see CR 5211, the official instruction issued to your carrier/intermediary regarding this change, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1134CP.pdf*.

The "2007 ASC Approved HCPCS Codes and Payment Rates" changes are available on the CMS site at *http://www.cms.hhs.gov/ASCPayment/01_Overview.asp*.

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

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

MLN Matters Number: MM5211
Related Change Request (CR) Number: 5211
Related CR Release Date: December 20, 2006
Related CR Transmittal Number: R1134CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1134, CR 5211

January 2007 Non-Outpatient Prospective Payment System Outpatient Code Editor Specifications Version 22.1

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) for services rendered to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5437, which informs fiscal intermediaries (FIs) that the January 2007 non-outpatient prospective payment system (non-OPPS) outpatient code editor (OCE) specifications have been updated to ensure correct billing and payment of claims. Be sure your billing staff are aware of the code changes in CR 5437.

Background

The non-OPPS OCE has been updated with numerous new additions, changes, and deletions to Healthcare Common Procedure Coding System/*Current Procedural Terminology* (HCPCS/*CPT*) codes. Rather than duplicate all the additions, deletions and changes in this article, the Centers for Medicare & Medicaid Services directs you to CR 5437, which contains the lengthy lists of these items. CR 5437 is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1128CP.pdf*.

Additional Information

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

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

MLN Matters Number: MM5437
Related Change Request (CR) Number: 5437
Related CR Release Date: December 15, 2006
Related CR Transmittal Number: R1128CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1128, CR 5437

List of Procedures Approved in an Ambulatory Surgical Center

An inclusive list of surgical procedures that may be reimbursed when billed by an ASC, effective for services rendered on or after January 1, 2007 is available on the Centers for Medicare & Medicaid Services website at *http://www.cms.hhs.gov/ascpayment/01_overview.asp*. From that page, click the link entitled "2007 ASC Approved HCPCS Codes and Payment Rates [ZIP 143KB] – updated 12/22/06," and open the file provided. An ASC facility charge for a procedure *other than* one on this list is not a benefit of Medicare, although the physician's fee may be covered.

Calculating Payment

ASC payment rates are calculated as follows. The calculations are rounded to the fourth decimal place at each step. The payment rates may be accessed at *http://www.cms.hhs.gov/ascpayment/01_overview.asp*.

1. Separate each group's payment rate into its labor (.3445) and nonlabor (.6555) components.
   - To determine the payment rate that is subject to the labor adjustment for procedure codes in PRICER groups 6 and 8, first subtract the $150 IOL allowance from each group's composite payment rate. (This is because IOLs are not subject to adjustment for labor costs, therefore the IOL allowance must be subtracted from the composite payment rate before applying the wage index adjustment, and then added back in the calculation as described in step 5).
2. Identify the appropriate wage-index value for the ASC's location. The wage-index values may be accessed at *http://www.cms.hhs.gov/Transmittals/Downloads/AB03116.pdf*. Locate the wage-index value for your county listed under the appropriate metropolitan statistical area (MSA).
3. Multiply the labor component (payment rate multiplied by .3445 – Step 1) by the wage-index value.
4. Add the adjusted labor component (Step 3) to the nonlabor component (payment rate multiplied by .6555 – Step 1) to determine the total adjusted payment rate.
   - For procedure codes in PRICER groups *other than* 6 and 8, stop here.
5. For PRICER groups 6 and 8, add the $150 IOL allowance to the total adjusted payment rate (Step 4) to determine the total adjusted composite rate for the procedures in these groups.

This provides the ASC payment rate for the ASC. Round the final amount to the nearest dollar. Note that coinsurance (and deductible if applicable) is deducted from the payment amount. ❖

Source: CMS Pub. 100-04, Transmittal 1134, CR 5211
CMS Internet Only Manual, Publication 100-04, Chapter 14, Section 40.2

ESRD SERVICES

Implementation of Changes in End Stage Renal Disease Payment for Calendar Year 2007

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

Provider Types Affected

Medicare certified end-stage renal disease (ESRD) facilities billing Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for ESRD dialysis services.

What You Need to Know

Change request (CR) 5407, from which this article is taken, notes that for calendar year (CY) 2007, there are no significant changes to the ESRD composite-rate payment methodology; but announces that the Centers for Medicare & Medicaid Services (CMS) made two updates: 1) To the drug add-on adjustment to the composite rate; and 2) To the wage index and transition.

Background

Section 1881(b) of the Social Security Act as amended by section 623 of the Medicare Modernization Act (MMA) directed CMS to make a number of revisions to the ESRD composite rate payment system, as well as to the payment for separately billable drugs furnished by ESRD facilities.

For calendar year (CY) 2007 CMS did not propose any significant changes to the composite rate payment methodology, but did make the following updates:

1. An update to the drug add-on adjustment to the composite rate
2. An update to the wage index and transition.

Drug Add-on Adjustment

MMA Section 623 established the ESRD composite-payment rate drug add-on adjustment to account for the difference between 1) Payment amounts for separately billable drugs under pre-MMA payments, and 2) The new payment methodology established under Section 623.

The current add-on adjustment is 14.5 percent and includes a 1.4 percent update for 2006. CR 5407 announces that for CY 2007, the drug add-on adjustment to the composite payment rate is 0.5 percent. As a result, the drug add-on adjustment for 2007 will increase from 14.5 percent to 15.1 percent (1.145 x 1.005).

Also, note that there are no changes to the current CMS policy for payment of separately billed ESRD drugs. Therefore, for CY 2007, payment for separately billable drugs furnished by ESRD facilities will continue at average sales price (ASP) plus six percent.

Wage index and transition

CR 5407 also announces an update to the wage index adjustment to reflect the latest hospital wage data, including a budget neutrality adjustment to the wage index for CY 2007 (the second year of the four-year transition period). Consistent with the transition blends, CMS is implementing a 50/50 blend between an ESRD facility's metropolitan statistical area (MSA) based composite rate, and its CY 2007 core based statistical area (CBSA) based rate reflecting its revised wage index values.

Also, for CY 2007, CMS is reducing the wage index floor from 0.85 to 0.80, so after applying a budget neutrality adjustment of 1.052818, the wage index floor is 0.8423.

Additional Information

You can find more information about the ESRD payment for CY 2007 by going to CR 5407, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R61BP.pdf*.

You will find the updated *Medicare Benefit Policy Manual*, Chapter 11 (End Stage Renal Disease [(ESRD]), Section 30.5.1 (New ESRD Composite Payment Rates) as an attachment to that CR.

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

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

MLN Matters Number: MM5407
Related Change Request (CR) Number: 5407
Related CR Release Date: November 24, 2006
Related CR Transmittal Number: R61BP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 61, CR 5407

SKILLED NURSING FACILITY SERVICES

Skilled Nursing Facility Consolidated Billing Common Working File Edit To Bypass Hospital Emergency Room Services Spanning Multiple Service Dates

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

Provider Types Affected

Providers who submit hospital emergency room claims paid under the OPPS to Medicare fiscal intermediaries (FIs) or Part A/B Medicare Administrative Contractors.

Provider Action Needed

STOP – Impact to You

The common working file (CWF), a portion of Medicare's claim processing system, will reject hospital claims (including those from critical access hospitals [CAHs]) for emergency services that you provide to beneficiaries who are in Part A skilled nursing facility (SNF) stays, if these services span more than one day; unless the hospital identifies them by appending modifier ET (emergency services) to those line items.

CAUTION – What You Need to Know

Emergency room services that hospitals (including CAH) provide to beneficiaries in skilled Part A SNF stays are excluded from SNF consolidated billing (CB). When these emergency room services span more than one service date, the CWF rejects the services that are provided on the subsequent service dates, because the line item date of service (LIDOS) for these services does not match the LIDOS reported under 045x revenue code.

GO – What You Need to Do

Make sure that your billing staffs identify claims for emergency services that 1) you provide to beneficiaries in Part A SNF stays, 2) that span more than one day; by appending modifier ET (emergency services) to line item date of service on outpatient bill types 13x and 85x when revenue code 045x (emergency room) is present on the claim.

Background

Change request (CR) 5389, from which this article is taken, clarifies instructions in CR 4252 (Transmittal 881) entitled "Outpatient Prospective Payment System Emergency Room Services Exceeding 24 Hours" that was released March 3, 2006. CR 4252 provided that hospital OPPS claims submitted for emergency room services should be identified with revenue code 045x; using as the service date, the date that the emergency service was provided. It further provided that if the patient were in the emergency room after midnight, only the one service date should be used.

This guidance, however, requires clarification when related to emergency room (ER) services that a hospital provides to beneficiaries in skilled Part A SNF stays. Specifically, ER services (and all services related to that ER encounter) that hospitals (including CAHs) provide to beneficiaries in skilled Part A SNF stays are excluded from SNF consolidated billing (CB).

Further, current common working file (CWF) SNF CB edits contain bypasses that allow ER related services with LIDOS that match the reported LIDOS on the 045x revenue code to bypass SNF CB edits. However, when services related to the ER encounter (for beneficiaries in type A SNF stays) span more than one service date, the encounter-related services that are performed on subsequent service dates are currently being rejected by the CWF because the LIDOS for these services does not match the LIDOS reported under 045x ER revenue code.

Therefore, in order to bypass the ER encounter-related services that hospitals provide on a subsequent service date to beneficiaries in type A SNF stays, CR 5389 **instructs hospitals to identify those services by appending the modifier ET (emergency services) to line item date of service on their outpatient bill types 13x and 85x when revenue code 045x (Emergency Room) is present on the claim.** The reporting of the ET modifier will alert CWF that these are related ER services performed on subsequent dates so that it will bypass the SNF CB edits.

Additional Information

You can find the official instruction, CR 5389, issued to your FI or A/B MAC by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1109CP.pdf*.

Attached to that CR, you fill find updated *Medicare Claims Processing Manual* (Publication 100-04), Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 180.6 (Emergency Room Services That Span Multiple Service Dates), and Chapter 6 (SNF Inpatient Part A Billing), Section 20.1.2.2 (Emergency Services).

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

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

MLN Matters Number: MM5389
Related Change Request (CR) Number: 5389
Related CR Release Date: November 9,2006
Related CR Transmittal Number: R1109CP
Effective Date: October 1, 2005
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1109, CR 5389

CORF SERVICES

Outpatient Therapy Cap Exceptions 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 December 4, 2006, to reflect the correct effective and implementation dates as described in CR 5271, which CMS recently revised. While CR 5271 also reflects effective and implementation dates in January 2007 for Medicare system changes, the information in this article clarifies existing processes. Also, this revision reminds providers that the exception to therapy caps ends December 31, 2006. The revision to this article was published in the December 2006 *Medicare A Bulletin* (pages 32-33).

Provider Types Affected

Providers, physicians, and nonphysician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries [RHHIs], Part A/B Medicare administrative contractors [A/B MACs], and carriers) under the Part B benefit for therapy services.

Provider Action Needed

CR 4364, released February 15, 2006, described the exception process to the caps set on outpatient therapy services (physical therapy and occupational therapy). CR 5271, upon which this article is based, clarifies questions (below) that have arisen about this exception process. Thus, the article is meant primarily for informational purposes. It also reminds you that the exception process stops after December 31, 2006.

Background

A brief history may be beneficial at this point. The Balanced Budget Act of 1997 placed financial limitations on Medicare covered therapy services (therapy caps), which were implemented in 1999 and again for a short time in 2003. Congress placed moratoria on these caps for 2004 and 2005, but the moratoria are no longer in place, and the caps were reimplemented on January 1, 2006. However, Congress, through the Deficit Reduction Act has provided that (only for calendar year 2006) exceptions to caps may be made when provision of additional therapy services is determined to be medically necessary. **This process ends on December 31, 2006.**

Review of This Exception Process

Section 1833(g)(5) of the Social Security Act provides that, **for services provided during calendar year 2006**, FIs, RHHIs, and carriers can, in certain circumstances, grant an exception to the therapy cap when requested by the individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).

Exception Processes fall into two categories:

1. **Automatic** process exceptions
   Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if they meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 5, (as revised by CR 5271) for exception from the therapy cap for 2006.
2. **Manual** process exceptions
   Medicare beneficiaries may be request an exception using the manual process for exception 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 criteria for automatic exceptions.

Clarifications to Questions Generated from CR 4364

Your FI, RHHI, or carrier:

1. Will grant exceptions for any number of medically necessary services for 2006 that meet the automatic process exception criteria, if the beneficiary meets the conditions described in *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 4364).
2. Will grant an exception to the therapy cap, by approving any number of additional therapy treatment days, when these additional treatment days are deemed medically necessary based on documentation that you have submitted for services provided in 2006.
3. Will utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance in which you do not submit all required documentation with the exception request in 2006.
4. Must reply as soon as practicable to a request for exception for services provided in 2006. They will grant an exception to the therapy cap, approving the number of treatment days that you or the beneficiary request (not to exceed 15 future treatment days), if they do not make a decision within 10 business days of receipt of any request and appropriate documentation.
5. Will allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.
6. Will follow the manual description for allowing exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process in 2006.
7. Will allow automatic process exceptions when complexities occur in combination with other conditions that **may or may not be on the list** in the *Medicare Claims Processing Manual* in 2006.

Outpatient Therapy Cap Exceptions Clarifications (continued)

8. Will, when a patient is being treated under the care of two physicians for separate conditions, accept as appropriate documentation either 1) A combined plan of care certified by one of the physicians/NPPs, or 2) Two separate plans of care certified by separate physicians/NPPs.
9. Will update the list of exceptions in 2006 according to the changes provided in this transmittal. You should be aware that they may expand (but not contract) this list if their manual process exception decisions lead them to believe further exceptions should be allowed.
10. Will not require the additional documentation that is encouraged but not required in the manuals.
11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.
12. Will not deny payment for reevaluation **only** because an evaluation or reevaluation was recently done, as long as documentation supports the need for re-evaluation. A reevaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.
13. Will require clinicians to write progress reports at least during each progress report period. Note that required elements of the progress report that are written into the treatment notes or in a plan of care, acceptably fulfill the requirement for a progress report. In these instances, a separate progress report is not required.
14. Will require, on pre or postpay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each progress report period and sign the progress report.
15. Will continue to use Medicare summary notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: "ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are $1,740 for PT and SLP combined and $1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE."
16. Will continue to enforce local coverage determinations (LCDs).

Final Note: You should keep in mind that claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable.

Additional Information

You can find more information about outpatient therapy cap exceptions by going to CR 5271, issued in three transmittals. As attachments to those transmittals, you will find updated manual sections for:

- The *Medicare Claims Processing Manual*, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services, section 10.2, The Financial Limitation. This is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1106Cp.pdf*.
- The *Medicare Program Integrity Manual*, Chapter 3, Verifying Potential Errors and Taking Corrective Actions, Section 3.4.1.1.1, Exception from the Uniform Dollar Limitation ("Therapy Cap"). This is available at *http://www.cms.hhs.gov/Transmittals/downloads/R171PI.pdf*.
- The *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3, Documentation Requirements for Therapy Services. This is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R60BP.pdf*.

These manual revisions include numerous additional changes clarifications.

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

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

MLN Matters Number: MM5271 – Revised
Related Change Request (CR) Number: 5271
Related CR Release Date: November 9, 2006
Related CR Transmittal Number: R60BP, R171PI, R1106CP
Effective Date: December 9, 2006
Implementation Date: December 9, 2006

Source: CMS Pub. 100-04, Transmittal 1106, CR 5271

Revision to the ICD-9-CM Diagnosis List To Qualify for Therapy Cap Exception

The Centers for Medicare & Medicaid Services (CMS) has revised and correct some of the ICD-9-CM diagnosis ranges on the list of conditions and complexities for which exceptions to the outpatient therapy cap may be allowed. This list was previously published in the Third Quarter 2006 *Medicare A Bulletin* (pages 106-108) as part of the guidelines for therapy cap exception process.

The changes have been bolded and italicized in the following table for easy identification.

250.*00* – 250.93*	**353.*0* – 357.*7***	486*	724.3*	828.0 – 828.1
278.01 – 278.02*	359.0 – 359.9	490 – 496*	724.4*	852.00 – 852.59
290.0 – 290.*43**	386.0 – 386.9*	**707.*00* – 707.9***	726.10 – 726.19	853.00 – 853.19
294.0 – 294.9*	401.0 – 401.9*	710.0 – 710.9	727.61 – 727.62	854.00 – 854.19
311*	402.00 – 402.91*	711.00 – 711.99*	733.00	881.0 – 881.2
323.0 – 323.*09**	414.00 – 414.9*	713.0 – 713.8*	780.93	882.0 – 882.2
331.0 – 331.9	415.0 – 415.19*	714.0 – 714.9*	781.2	884.0 – 884.2
332.0 – 332.1	416.0 – 416.9*	715.09	781.3	887.0 – 887.7
333.0 – 333.99	**427.0 – 427.9***	715.11	781.8	897.0 – 897.7
334.0 – 334.9	428.0 – 428.9*	715.15	781.92*	**941.00 – *949.5***
335.0 – 335.9	430 – 432.9	715.16	**784.3 – 784.*9***	***950.00 – 952.9***
336.0 – 336.9	**433.*00* – 434.*91***	715.91	787.2	959.01
337.20 – 337.29	436	715.96	**806.00 – 806.*9***	V43.64
340	437.0 – 437.9	718.44	810.00 – 810.13	V43.65
342.00 – 342.*92*	438.0 – 438.9	718.49	811.00 – 811.19	V43.61
343.0 – 343.9	443.0 – 443.9*	719.7*	812.00 – 812.59	V49.63 – 49.67
344.00 – 344.9	453.0 – 453.9*	721.91	813.00 – 813.93	V49.73 – 49.77
348.9 – 348.9	457.0 – 457.1	723.4	820.00 – 820.9	
349.0 – 349.9	478.30 – 478.5	724.02	**821.*00* – 821.39**	

***** Complexities

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 1106, CR 5271

RURAL HEALTH CLINIC SERVICES

Announcement of Medicare Rural Health Clinics and Federally Qualified Health Centers Payment Rate Increases

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) and/or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on change request (CR) 5435 which provides instructions for the calendar year (CY) 2007 payment rate increases for rural health clinic (RHC) and federally qualified health center (FQHC) services. The RHC upper payment limit increase per visit is $74.29 and reflects a CY 2007 rate increase of 2.1 percent. The FQHC upper payment limit per visit also reflects a CY 2007 rate increase of 2.1 percent for urban ($115.33) and rural ($99.17) areas.

Background

The following provides instructions for the CY2007 payment rate increases for RHC and FQHC services.

Rural Health Clinics:

The RHC upper payment limit per visit **is increased**

- From $72.76 **to $74.29** effective January 1, 2007, through December 31, 2007 (i.e., CY 2007).

The 2007 rate reflects **a 2.1 percent increase** over the 2006 payment limit in accordance with the rate of increase in the Medicare economic index (MEI) as authorized by the Social Security Act (section 1833(f); *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*).

Federally Qualified Health Centers:

The FQHC upper payment limit per visit for **urban FQHCs is increased**:

- From $112.96 **to $115.33** effective January 1, 2007, through December 31, 2007 (i.e., CY 2007).

The maximum Medicare payment limit per visit for **rural FQHCs is increased**:

- From $97.13 **to $99.17** effective January 1, 2007, through December 31, 2007 (i.e. CY 2007).

The 2007 FQHC rates reflect **a 2.1 percent increase** over the 2006 rates, in accordance with the rate of increase in the MEI.

Additional Information

The official instruction, CR 5435, issued to your FI and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1126Cp.pdf*.

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

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

MLN Matters Number: MM5435
Related Change Request (CR) Number: 5435
Related CR Release Date: December 8, 2006
Related CR Transmittal Number: R1126CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1126, CR 5435,

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 2007 Outpatient Prospective Payment System Outpatient Code Editor Specifications Version 8.0

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

Provider Types Affected

All providers billing outpatient services to Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) that are paid under the outpatient prospective payment system (OPPS).

Provider Action Needed

This article is based on information contained in change request (CR) 5425 informs FIs that the April 2005 OPPS OCE specifications have been updated with new additions, changes, and deletions, and it instructs FIs to install the updated January 2007 OPPS OCE specifications (version 8.0) into their systems.

Background

Full details of version 8.0 of the OPPS OCE are contained in CR 5425 and will not be repeated in this article; especially since many of the details are not changing, and providers paid under the OPPS are likely to be familiar with these details. The modifications of the outpatient code editor/ambulatory patient classification (OCE/APC) for the January 2007 release (V8.0) are summarized in the following table:

	Mod. Type	**Effective Date**	**Edit**	
1.	Logic	1/1/07		Add new payment adjustment flag (PAF) 7; assign to procedures subject to offset, when modifier FB is present. Reduce APC payment rate by offset amount before application of discounting logic.
2.	Logic	1/1/07	75	New edit 75 – Incorrect billing of modifier FB (RTP). If modifier FB is present and SI is not S, T, V or X.
3.	Logic	1/1/07		Special packaged codes with SI = Q. Change SI and assign APC if no other code subject to APC payment is present on the same day. Change SI to N if another code that is subject to APC payment is present on the same day. Pay the highest APC if more than one special packaged code qualify for payment on the same day.
4.	Logic	1/1/07		Add G0104, G0105, G0106, G0120, G0121 and G0389 to the 'Deductible Not Applicable' list.
5.	Logic	1/1/07		Deactivate special drug administration logic (appendix I). Deactivate packaging flag 4 (Packaged as part of drug administration APC payment).
6.	Logic	1/1/07	71	Expand edit 71 to trigger if some specified devices are present on a claim without the required procedure (reverse device edit).
7.	Logic	1/1/07	76	New edit 76 – Trauma response critical care code without revenue code 068x and *CPT 99291* (LIR). – If the trauma response critical care code is present without revenue code 068x and *CPT* code *99291* on the same date of service (DOS).
8.	Logic	1/1/07	15	Assign unit of service = 1 for code G0390
9.	Logic	**7/1/02**		Remove bill type 74x from the box in appendix E that assigns only payment method flags 1 & 2
10.	Logic	1/1/07		Update medical visit APC numbers in appendix H.
11.	Content			Make HCPCS/APC/SI changes, as specified by CMS.

January 2007 Outpatient PPS Outpatient Code Editor Specifications Version 8.0 (continued)

	Mod. Type	Effective Date	Edit	
12.	Content		19,20, 39,40	Implement version 12.3 of the NCCI file, removing all code pairs which include anesthesia (*CPT* code range *00100-01999*), E&M (*CPT* code range *92002-92014*, *99201-99499*), or MH (*CPT* code range *90804-90911*); and the following drug admin code pairs: C8950-C8952, C8953-C8950, C8953-C8952, C8954-C8950, C8954-C8952, C8954-C8953. Change modifier indicator from 0 to 1, effective 4/1/06, for the following code pairs: G0245 – 97597 G0245 – 97598 G0246 – 97597 G0246 – 97598 G0247 – 97597 G0247 – 97598 *67221* – C8950 *67221 – 90760* *67221 – 90765*
13.	Content	**1/1/06**	22	Correct the effective date of new *CPT* modifiers (genetic testing category) added to global 'valid modifier' list.
14.	Content			Add and delete modifiers as specified by CMS and/or as found on the HCPCS master tape.
15.	Doc		71	Modify description for edit 71: Claim lacks required device or procedure code
16.	Doc	1/1/07		Modify description for SI 'H': Pass-through device categories and radiopharmaceutical agents
17.	Doc	1/1/07		Modify description for SI 'K': Non-pass-through drugs and biologicals, brachytherapy sources and blood and blood products.
18.	Doc		10	Modify description for edit 10: Service submitted for denial (condition code 21)
19.	Doc			UB-04 form locators for claim input values added to tables #1 and #2
20.	Doc			Appendix C – Revise text of PH payment APC assignment footnote to clarify that AT, OT and ET are not assigned to HCPCS APCs.

You should also read through the specifications in the official instruction (CR 5425) issued to your intermediary, and note the highlighted sections, which also indicate changes from the prior release of the software. Some OCE/APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date appears in the "Effective Date" column in the above table.

Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1130CP.pdf*.

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

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

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Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1130, CR 5425

AMBULANCE SERVICES

2006 Ambulance Fee Schedule

The following ambulance fee schedule (AFS) rates for 2007 based on localities are effective for services provided **on or after January 1, 2007.**

Medicare Part B coinsurance and deductible requirements apply to these services.

2007 Revised Ambulance Fee Schedule Rates

HCPCS Code	Loc 01/02	Loc 03	Loc 04
A0425	$6.25	$6.25	$6.25
A0426	$222.85	$231.67	$241.14
A0427	$352.85	$366.81	$381.81
A0428	$185.71	$193.06	$200.95
A0429	$297.14	$308.89	$321.52
A0430	$2,553.99	$2,625.23	$2,701.74
A0430*	$3,830.99	$3,937.84	$4,052.61
A0431	$2,969.39	$3,052.21	$3,141.17
A0431*	$4,454.08	$4,578.32	$4,711.76
A0432	$324.99	$337.85	$351.67
A0433	$510.70	$530.91	$552.62
A0434	$603.56	$627.44	$653.10

* Rural Rate

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

Source: CMS Pub. 100-04, Transmittal 1102, CR 5358

MAMMOGRAPHY SERVICES

The following fee schedules are effective for mammography services furnished **on or after January 1, 2007.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that services.

Code/MOD	Loc 01/02	Loc 03	Loc 04
G0202 TC	$92.71	$98.99	$106.01
G0204 TC	$95.55	$101.99	$109.19
G0206 TC	$76.98	$82.22	$88.09
77051 TC	$13.24	$14.14	$15.14
77052 TC	$13.24	$14.14	$15.14
77055 TC	$42.57	$45.83	$49.56
77056 TC	$53.33	$57.34	$61.92
77057 TC	$46.24	$49.84	$53.98

CMS Pub. 100-04, Transmittal 1131, CR 5448

OUPATIENT REHABILITATION SERVICES

The following fee schedules are effective for outpatient rehabilitation services furnished **on or after January 1, 2007.** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Code/MD	Loc. 01/02	Loc. 03	Loc. 04
G0101	$34.20	$35.56	$37.11
G0102	$19.28	$20.20	$21.23
G0128	$4.19	$4.41	$4.69
G0281	$10.79	$11.20	$11.68
G0283	$10.79	$11.20	$11.68
G0329	$7.34	$7.78	$8.30
64550	$15.76	$16.45	$17.24
90804	$60.82	$62.35	$64.10
90805	$66.84	$68.40	$70.20
90806	$88.60	$90.59	$92.89
90807	$96.17	$98.41	$101.01
90808	$131.31	$134.20	$137.53
90809	$138.15	$141.26	$144.88
90810	$65.09	$66.77	$68.74
90811	$73.94	$75.83	$78.02
90812	$95.58	$97.76	$100.25
90813	$103.16	$105.58	$108.37
90814	$137.94	$140.99	$144.50
90815	$144.43	$147.68	$151.45
90845	$81.71	$83.44	$85.45
90846	$86.42	$88.33	$90.54
90847	$106.16	$108.60	$111.42
90849	$30.97	$31.86	$32.90
90853	$29.78	$30.48	$31.26
90857	$33.07	$33.87	$34.76
90901	$36.61	$38.18	$39.94
92506	$128.51	$134.64	$141.34
92507	$58.84	$61.48	$64.38
92508	$27.28	$28.49	$29.82
92526	$78.05	$81.74	$85.79
92552	$18.57	$20.17	$22.05
92553	$26.61	$28.95	$31.69
92555	$15.38	$16.80	$18.48
92556	$22.71	$24.82	$27.32
92557	$48.61	$53.01	$58.21
92561	$28.03	$30.45	$33.28
92562	$18.92	$20.55	$22.45
92563	$16.44	$17.92	$19.67
92564	$18.69	$20.43	$22.50
92565	$14.67	$16.05	$17.68
92567	$20.94	$22.94	$25.33
92568	$13.25	$14.55	$16.09
92569	$14.31	$15.67	$17.29
92571	$15.73	$17.17	$18.87
92572	$8.28	$8.89	$9.58
92575	$18.68	$20.03	$21.55
92576	$19.04	$20.81	$22.90
92577	$24.60	$26.95	$29.75
92579	$29.80	$32.32	$35.26
92582	$31.93	$34.57	$37.65
92583	$33.59	$36.59	$40.13
92584	$85.87	$93.62	$102.76
92587	$52.45	$56.81	$61.97
92587 TC	$45.30	$49.38	$54.19
92587 26	$7.15	$7.43	$7.78
92588	$71.26	$76.54	$82.76
92588 TC	$53.34	$58.15	$63.82
92588 26	$17.92	$18.39	$18.93
92596	$26.97	$29.32	$32.08
92597	$90.55	$94.49	$98.84
92607	$122.27	$129.99	$138.47
92608	24.72	$26.81	$29.25
92609	$64.68	$68.95	$73.68
92610	$109.50	$116.88	$125.13
92611	$111.63	$119.13	$127.51
92612	$142.29	$148.54	$155.41
92614	$131.65	$137.29	$143.50
92616	$182.88	$190.54	$199.00
94664	$13.60	$14.92	$16.49
94667	$21.17	$23.06	$25.28
94668	$17.27	$18.53	$19.96
95831	$25.56	$26.62	$27.80
95832	$22.86	$23.88	$25.05
95833	$36.37	$37.82	$39.45
95834	$43.52	$45.26	$47.23
95851	$17.84	$18.70	$19.66
95852	$13.13	$13.80	$14.57
96105	$73.45	$80.08	$87.91
97001	$69.19	$71.49	$74.15
97002	$36.67	$37.87	$39.24
97003	$74.28	$77.00	$80.16
97004	$44.11	$45.75	$47.58
97012	$13.42	$13.85	$14.35
97016	$13.63	$14.20	$14.85
97018	$6.63	$7.03	$7.51
97022	$14.67	$15.32	$16.06
97024	$4.85	$5.16	$5.52
97026	$4.50	$4.78	$5.12
97028	$5.61	$5.91	$6.28
97032	$14.84	$15.35	$15.94
97033	$20.19	$20.98	$21.87
97034	$13.35	$13.84	$14.40
97035	$11.22	$11.59	$12.02
97036	$22.36	$23.24	$24.22
97110	$26.04	$26.93	$27.97
97112	$26.98	$27.80	$28.71
97113	$30.89	$31.93	$33.08
97116	$22.99	$23.66	$24.42
97124	$20.74	$21.39	$22.13
97140	$24.48	$25.17	$25.95
97150	$16.31	$16.86	$17.49
97530	$27.69	$28.55	$29.51
97532	$23.08	$23.67	$24.35
97533	$24.50	$25.17	$25.93
97535	$27.69	$28.55	$29.51
97537	$25.21	$25.92	$26.73

Outpatient Rehabilitation Services (continued)

Code/MD	Loc. 01/02	Loc. 03	Loc. 04	Code/MD	Loc. 01/02	Loc. 03	Loc. 04
97542	$25.57	$26.30	$27.13	*97750*	$27.46	$28.43	$29.56
97597	$49.39	$51.77	$54.52	*97755*	$32.10	$33.00	$34.04
97598	$61.94	$64.60	$67.66	*97760*	$29.35	$30.57	$32.00
97605	$32.29	$33.35	$34.56	*97761*	$26.39	$27.31	$28.37
97606	$35.01	$36.25	$37.70	*97762*	$27.02	$28.37	$29.89

Source: CMS Pub. 100-04, Transmittal 1121, CR 5448

SURGICAL DRESSING SERVICES

The following fee schedules are effective for surgical dressing items furnished **on or after January 1, 2007.** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Code/MD	Fee	Code/MD	Fee	Code/MD	Fee	Code/MD	Fee	Code/MD	Fee
A4461	$3.29	A6210	$19.92	A6238	$22.79	A6402	$0.12	A6454	$0.77
A4463	$0.00	A6211	$29.37	A6240	$12.24	A6403	$0.43	A6455	$1.39
A6010	$30.96	A6212	$9.70	A6241	$2.57	A6407	$1.88	A6456	$1.28
A6011	$2.28	A6214	$10.29	A6242	$6.07	A6410	$0.39	A6457	$1.14
A6021	$21.02	A6216	$0.05	A6243	$12.31	A6411	$0.00	A6501	$0.00
A6022	$21.02	A6217	$0.00	A6244	$39.28	A6441	$0.67	A6502	$0.00
A6023	$190.30	A6219	$0.95	A6245	$7.27	A6442	$0.17	A6503	$0.00
A6024	$6.19	A6220	$2.58	A6246	$9.92	A6443	$0.29	A6504	$0.00
A6154	$13.93	A6222	$2.13	A6247	$23.78	A6444	$0.56	A6505	$0.00
A6196	$7.35	A6223	$2.42	A6248	$16.24	A6445	$0.32	A6506	$0.00
A6197	$16.44	A6224	$3.61	A6251	$1.99	A6446	$0.41	A6507	$0.00
A6199	$5.29	A6229	$3.61	A6252	$3.25	A6447	$0.67	A6508	$0.00
A6200	$9.50	A6231	$4.66	A6253	$6.34	A6448	$1.16	A6509	$0.00
A6201	$20.80	A6232	$6.88	A6254	$1.21	A6449	$1.75	A6510	$0.00
A6202	$34.88	A6233	$19.19	A6255	$3.03	A6450	$0.00	A6511	$0.00
A6203	$3.35	A6234	$6.54	A6257	$1.53	A6451	$0.00	A6513	$0.00
A6204	$6.23	A6235	$16.82	A6258	$4.30	A6452	$5.91	A6531 AW	$43.27
A6207	$7.34	A6236	$27.25	A6259	$10.94	A6453	$0.61	A6532 AW	$60.96
A6209	$7.48	A6237	$7.91	A6266	$1.92				

Source: CMS Pub. 100-04, Transmittal 1125, CR 5417

ORTHOTIC/PROSTHETIC DEVICES

The following fee schedules are effective for orthotic and prosthetic devices furnished **on or after January 1, 2007.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that services.

Code/MD	Fee	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees
A4216	$0.43	A4382	$24.62	A4452 AV	$0.36	A7524	$77.40	L0635	$897.72
A4217 AU	$3.13	A4383	$28.19	A4452 AW	$0.40	A7525	$2.07	L0636	$1,324.63
A4280	$5.19	A4384	$9.62	A4455	$1.22	A7526	$3.37	L0637	$1,149.30
A4310	$6.56	A4385	$5.10	A4481	$0.37	A7527	$3.58	L0638	$1,113.45
A4311	$12.61	A4387	$0.00	A4483	$0.00	L0112	$1,181.59	L0639	$1,149.30
A4312	$18.04	A4388	$4.36	A4561	$20.05	L0120	$23.62	L0640	$883.40
A4313	$15.74	A4389	$6.22	A4562	$49.83	L0130	$170.79	L0700	$1,817.63
A4314	$21.50	A4390	$9.61	A4623	$6.55	L0140	$58.93	L0710	$1,984.07
A4315	$22.43	A4391	$7.07	A4625	$6.93	L0150	$98.28	L0810	$2,107.77
A4316	$24.14	A4392	$8.18	A4626	$2.71	L0160	$139.92	L0820	$1,705.10
A4320	$5.33	A4393	$9.04	A4629	$4.63	L0170	$592.12	L0830	$2,461.98
A4321	$0.00	A4394	$2.58	A5051	$2.07	L0172	$120.06	L0859	$956.46
A4322	$2.82	A4395	$0.05	A5052	$1.49	L0174	$215.68	L0861	$181.97
A4326	$10.79	A4396	$40.48	A5053	$1.68	L0180	$293.33	L0960	$72.31
A4327	$42.27	A4397	$4.13	A5054	$1.79	L0190	$441.55	L0970	$89.73
A4328	$9.86	A4398	$13.81	A5055	$1.44	L0200	$405.44	L0972	$91.72
A4330	$7.15	A4399	$12.26	A5061	$3.52	L0210	$42.09	L0974	$187.42
A4331	$3.18	A4400	$41.54	A5062	$2.09	L0220	$96.16	L0976	$167.38
A4332	$0.12	A4402	$1.42	A5063	$2.70	L0430	$1,174.29	L0978	$151.13
A4333	$2.20	A4404	$1.69	A5071	$6.01	L0450	$158.74	L0980	$13.71
A4334	$4.93	A4405	$3.40	A5072	$2.99	L0452	$0.00	L0982	$14.94
A4338	$12.26	A4406	$5.74	A5073	$2.74	L0454	$292.79	L0984	$47.67
A4340	$31.75	A4407	$8.76	A5081	$3.30	L0456	$839.65	L1000	$1,593.99
A4344	$16.02	A4408	$9.87	A5082	$10.11	L0458	$752.91	L1001	$0.00
A4346	$19.59	A4409	$6.22	A5093	$1.95	L0460	$847.46	L1005	$2,702.06
A4349	$2.02	A4410	$9.04	A5102	$22.58	L0462	$1,054.10	L1010	$64.19
A4351	$1.81	A4411	$5.10	A5105	$34.65	L0464	$1,254.89	L1020	$87.70
A4352	$5.46	A4412	$2.70	A5112	$34.62	L0466	$322.68	L1025	$99.68
A4353	$6.99	A4413	$5.50	A5113	$4.70	L0468	$404.56	L1030	$66.60
A4354	$10.03	A4414	$4.93	A5114	$8.06	L0470	$575.99	L1040	$80.16
A4355	$7.57	A4415	$6.00	A5120 AU	$0.25	L0472	$361.54	L1050	$69.41
A4356	$45.63	A4416	$2.75	A5120 AV	$0.23	L0480	$1,117.97	L1060	$78.29
A4357	$9.70	A4417	$3.72	A5121	$6.34	L0482	$1,281.60	L1070	$80.03
A4358	$6.63	A4418	$1.81	A5122	$12.85	L0484	$1,494.32	L1080	$55.46
A4361	$18.37	A4419	$1.74	A5126	$1.12	L0486	$1,480.30	L1085	$154.07
A4362	$3.39	A4420	$0.00	A5131	$13.48	L0488	$847.46	L1090	$71.97
A4363	$2.36	A4422	$0.12	A5200	$11.29	L0490	$238.81	L1100	$127.05
A4364	$2.62	A4423	$1.86	A7040	$39.61	L0491	$648.35	L1110	$215.18
A4365	$11.32	A4424	$4.75	A7041	$74.42	L0492	$420.19	L1120	$34.28
A4366	$1.30	A4425	$3.58	A7042	$176.81	L0621	$75.27	L1200	$1,364.45
A4367	$7.35	A4426	$2.73	A7043	$28.16	L0622	$204.12	L1210	$205.44
A4368	$0.26	A4427	$2.78	A7501	$105.03	L0623	$0.00	L1220	$173.94
A4369	$2.42	A4428	$6.51	A7502	$49.91	L0624	$0.00	L1230	$446.31
A4371	$3.65	A4429	$8.25	A7503	$11.33	L0625	$46.52	L1240	$76.81
A4372	$4.18	A4430	$8.52	A7504	$0.67	L0626	$65.81	L1250	$75.63
A4373	$6.28	A4431	$6.22	A7505	$4.68	L0627	$347.03	L1260	$77.71
A4375	$17.18	A4432	$3.59	A7506	$0.33	L0628	$70.81	L1270	$77.61
A4376	$47.58	A4433	$3.34	A7507	$2.49	L0629	$0.00	L1280	$69.19
A4377	$4.29	A4434	$3.76	A7508	$2.87	L0630	$136.71	L1290	$78.45
A4378	$30.75	A4450 AU	$0.09	A7509	$1.41	L0631	$866.65	L1300	$1,311.50
A4379	$15.02	A4450 AV	$0.09	A7520	$47.48	L0632	$0.00	L1310	$1,349.53
A4380	$37.33	A4450 AW	$0.11	A7521	$47.05	L0633	$242.08	L1500	$1,491.32
A4381	$4.61	A4452 AU	$0.36	A7522	$45.16	L0634	$0.00	L1510	$943.47

Orthotic/Prosthetic Devices (continued)

Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees
L1520	$2,240.91	L2005	$3,459.40	L2405	$73.61	L3224	$46.17	L3765	$985.17
L1600	$101.17	L2010	$725.94	L2415	$102.55	L3225	$53.11	L3766	$1,043.23
L1610	$34.47	L2020	$916.75	L2425	$121.00	L3300	$44.01	L3800	$153.63
L1620	$113.51	L2030	$795.36	L2430	$121.00	L3310	$68.71	L3805	$245.81
L1630	$135.44	L2034	$1,733.45	L2492	$80.06	L3330	$477.78	L3806	$0.00
L1640	$362.28	L2035	$146.25	L2500	$247.69	L3332	$62.27	L3807	$192.11
L1650	$192.11	L2036	$1,456.66	L2510	$663.16	L3334	$32.21	L3808	$0.00
L1652	$300.94	L2037	$1,342.40	L2520	$361.69	L3340	$71.96	L3810	$49.79
L1660	$134.36	L2038	$1,122.52	L2525	$1,240.89	L3350	$19.31	L3815	$46.22
L1680	$1,104.66	L2040	$143.38	L2526	$668.84	L3360	$30.06	L3820	$79.39
L1685	$1,165.60	L2050	$381.85	L2530	$184.47	L3370	$41.88	L3825	$56.37
L1686	$781.97	L2060	$490.08	L2540	$331.94	L3380	$41.88	L3830	$65.04
L1690	$1,632.52	L2070	$140.78	L2550	$225.49	L3390	$41.88	L3835	$70.51
L1700	$1,358.15	L2080	$300.22	L2570	$498.62	L3400	$34.37	L3840	$48.29
L1710	$1,596.43	L2090	$370.07	L2580	$472.66	L3410	$78.39	L3845	$62.37
L1720	$1,179.28	L2106	$533.82	L2600	$161.24	L3420	$46.15	L3850	$89.09
L1730	$889.75	L2108	$838.87	L2610	$190.67	L3430	$135.29	L3855	$96.28
L1755	$1,295.03	L2112	$398.31	L2620	$209.92	L3440	$64.42	L3860	$130.92
L1800	$69.64	L2114	$455.71	L2622	$240.77	L3450	$89.09	L3900	$1,200.24
L1810	$102.21	L2116	$600.42	L2624	$327.31	L3455	$34.37	L3901	$1,345.79
L1815	$93.67	L2126	$1,068.28	L2627	$1,348.51	L3460	$28.97	L3904	$2,739.66
L1820	$101.80	L2128	$1,346.28	L2628	$1,584.08	L3465	$49.38	L3905	$761.93
L1825	$45.38	L2132	$633.34	L2630	$194.41	L3470	$52.60	L3906	$324.12
L1830	$85.16	L2134	$759.35	L2640	$263.85	L3480	$52.60	L3907	$436.19
L1831	$248.46	L2136	$928.49	L2650	$94.22	L3500	$24.71	L3908	$46.03
L1832	$636.44	L2180	$91.94	L2660	$146.33	L3510	$24.71	L3909	$10.87
L1834	$748.75	L2182	$71.96	L2670	$133.93	L3520	$26.85	L3910	$340.07
L1836	$112.64	L2184	$129.68	L2680	$122.86	L3530	$26.85	L3911	$19.06
L1840	$787.07	L2186	$143.69	L2750	$65.63	L3540	$42.96	L3912	$73.85
L1843	$757.49	L2188	$313.52	L2755	$110.33	L3550	$7.53	L3913	$208.09
L1844	$1,312.55	L2190	$81.43	L2760	$47.70	L3560	$19.31	L3915	$0.00
L1845	$790.75	L2192	$279.94	L2768	$110.02	L3570	$71.96	L3916	$97.58
L1846	$991.08	L2200	$37.33	L2770	$48.48	L3580	$54.75	L3917	$81.16
L1847	$485.58	L2210	$60.58	L2780	$56.43	L3590	$45.09	L3918	$65.98
L1850	$225.99	L2220	$69.55	L2785	$33.18	L3595	$35.42	L3919	$208.09
L1855	$967.04	L2230	$60.24	L2795	$66.71	L3600	$64.42	L3920	$78.67
L1858	$1,062.80	L2232	$81.56	L2800	$83.74	L3610	$84.82	L3921	$246.78
L1860	$876.53	L2240	$65.66	L2810	$61.32	L3620	$64.42	L3922	$90.24
L1870	$900.82	L2250	$278.98	L2820	$68.18	L3630	$84.82	L3923	$29.90
L1880	$555.71	L2260	$157.39	L2830	$76.67	L3640	$36.49	L3924	$96.46
L1900	$237.46	L2265	$92.46	L2840	$42.78	L3650	$45.99	L3926	$79.31
L1901	$14.94	L2270	$42.16	L2850	$48.61	L3651	$50.58	L3928	$46.84
L1902	$64.49	L2275	$102.59	L3000	$265.20	L3652	$152.47	L3930	$48.36
L1904	$369.21	L2280	$381.14	L3001	$111.65	L3660	$78.97	L3932	$41.95
L1906	$107.89	L2300	$215.14	L3002	$136.35	L3670	$110.07	L3933	$163.94
L1907	$475.04	L2310	$96.59	L3003	$147.09	L3671	$692.29	L3934	$37.02
L1910	$209.96	L2320	$161.54	L3010	$147.09	L3672	$860.93	L3935	$169.75
L1920	$274.48	L2330	$308.29	L3020	$167.50	L3673	$938.33	L3936	$68.44
L1930	$185.73	L2335	$181.36	L3030	$64.42	L3675	$134.84	L3938	$71.99
L1932	$753.34	L2340	$427.96	L3031	$0.00	L3700	$53.63	L3940	$82.59
L1940	$419.73	L2350	$699.58	L3040	$39.73	L3701	$15.65	L3942	$57.12
L1945	$770.80	L2360	$40.62	L3050	$39.73	L3702	$221.85	L3944	$94.07
L1950	$584.80	L2370	$201.55	L3060	$62.27	L3710	$111.39	L3946	$77.20
L1951	$709.00	L2375	$88.71	L3070	$26.85	L3720	$555.75	L3948	$51.69
L1960	$435.19	L2380	$96.66	L3080	$26.85	L3730	$731.59	L3950	$121.71
L1970	$643.66	L2385	$105.16	L3090	$34.37	L3740	$822.18	L3952	$134.89
L1971	$395.71	L2387	$142.72	L3100	$36.49	L3760	$384.23	L3954	$84.85
L1980	$288.15	L2390	$85.94	L3140	$75.16	L3762	$82.62	L3956	$0.00
L1990	$370.22	L2395	$131.22	L3150	$68.71	L3763	$985.17	L3960	$633.31
L2000	$796.34	L2397	$92.02	L3170	$42.96	L3764	$1,043.23	L3961	$1,290.87

Orthotic/Prosthetic Devices (continued)

Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees
L3962	$659.42	L5400	$1,139.11	L5666	$58.55	L5830	$1,587.20	L6382	$1,537.09
L3967	$1,524.07	L5410	$349.48	L5668	$94.44	L5840	$2,934.73	L6384	$2,126.38
L3971	$1,446.67	L5420	$1,395.95	L5670	$226.97	L5845	$1,516.12	L6386	$335.91
L3973	$1,524.07	L5430	$420.91	L5671	$480.97	L5848	$909.56	L6388	$367.72
L3975	$1,290.87	L5450	$342.43	L5672	$249.42	L5850	$107.00	L6400	$1,940.90
L3976	$1,290.87	L5460	$456.21	L5673	$594.76	L5855	$287.53	L6450	$2,593.00
L3977	$1,446.67	L5500	$1,074.28	L5676	$303.11	L5856	$20,305.85	L6500	$2,712.81
L3978	$1,524.07	L5505	$1,485.76	L5677	$412.42	L5857	$7,205.25	L6550	$3,260.85
L3980	$237.51	L5510	$1,217.77	L5678	$33.21	L5858	$15,720.67	L6570	$3,661.05
L3982	$293.45	L5520	$1,202.86	L5679	$495.62	L5910	$302.94	L6580	$1,397.71
L3984	$313.23	L5530	$1,444.75	L5680	$277.23	L5920	$443.81	L6582	$1,265.95
L3985	$464.85	L5535	$1,418.46	L5681	$1,112.66	L5925	$374.74	L6584	$1,985.33
L3986	$537.62	L5540	$1,513.95	L5682	$523.11	L5930	$2,847.10	L6586	$1,857.95
L3995	$26.29	L5560	$1,625.72	L5683	$1,112.66	L5940	$419.57	L6588	$2,441.31
L4000	$1,024.23	L5570	$1,690.17	L5684	$40.26	L5950	$656.04	L6590	$2,318.88
L4002	$0.00	L5580	$1,973.15	L5685	$108.34	L5960	$806.38	L6600	$156.90
L4010	$576.37	L5585	$2,428.29	L5686	$42.73	L5962	$530.68	L6605	$154.92
L4020	$719.94	L5590	$2,010.78	L5688	$51.09	L5964	$783.36	L6610	$148.77
L4030	$396.40	L5595	$3,552.32	L5690	$81.85	L5966	$998.19	L6611	$0.00
L4040	$320.49	L5600	$3,818.57	L5692	$111.14	L5968	$3,073.84	L6615	$160.31
L4045	$257.54	L5610	$1,731.78	L5694	$151.74	L5970	$169.88	L6616	$59.40
L4050	$324.14	L5611	$1,347.67	L5695	$140.09	L5971	$169.88	L6620	$256.48
L4055	$209.89	L5613	$2,107.03	L5696	$154.76	L5972	$317.31	L6621	$1,934.74
L4060	$249.51	L5614	$1,427.37	L5697	$67.15	L5974	$194.92	L6623	$715.41
L4070	$238.06	L5616	$1,138.63	L5698	$109.81	L5975	$392.15	L6624	$0.00
L4080	$83.92	L5617	$473.27	L5699	$197.80	L5976	$468.43	L6625	$508.32
L4090	$74.28	L5618	$250.37	L5700	$2,396.59	L5978	$244.10	L6628	$400.70
L4100	$83.78	L5620	$232.55	L5701	$2,878.13	L5979	$1,908.58	L6629	$122.38
L4110	$66.58	L5622	$303.23	L5702	$3,641.27	L5980	$3,101.33	L6630	$180.27
L4130	$458.24	L5624	$304.10	L5703	$1,884.39	L5981	$2,505.44	L6632	$62.61
L4350	$82.56	L5626	$398.81	L5704	$448.34	L5982	$483.56	L6635	$147.32
L4360	$230.97	L5628	$426.43	L5705	$801.11	L5984	$476.51	L6637	$314.25
L4370	$148.22	L5629	$265.83	L5706	$785.31	L5985	$238.85	L6638	$2,115.30
L4380	$90.88	L5630	$375.39	L5707	$1,035.31	L5986	$530.05	L6639	$0.00
L4386	$133.86	L5631	$367.52	L5710	$312.82	L5987	$6,084.99	L6640	$279.16
L4392	$19.88	L5632	$205.12	L5711	$437.20	L5988	$1,689.79	L6641	$134.19
L4394	$14.51	L5634	$254.44	L5712	$366.34	L5990	$1,534.59	L6642	$181.88
L4396	$141.69	L5636	$213.13	L5714	$376.29	L5993	$0.00	L6645	$335.73
L4398	$65.20	L5637	$241.64	L5716	$609.64	L5994	$0.00	L6646	$2,667.87
L5000	$442.67	L5638	$420.93	L5718	$761.98	L5995	$0.00	L6647	$439.20
L5010	$1,069.13	L5639	$937.81	L5722	$805.01	L6000	$1,111.39	L6648	$2,751.52
L5020	$1,815.66	L5640	$534.86	L5724	$1,262.55	L6010	$1,236.79	L6650	$348.57
L5050	$2,008.45	L5642	$518.24	L5726	$1,455.07	L6020	$1,153.11	L6655	$68.51
L5060	$2,310.29	L5643	$1,301.89	L5728	$1,990.33	L6025	$6,768.97	L6660	$76.78
L5100	$2,012.88	L5644	$494.04	L5780	$957.66	L6050	$1,588.94	L6665	$38.53
L5105	$2,905.80	L5645	$667.40	L5781	$3,384.48	L6055	$2,214.58	L6670	$42.59
L5150	$2,937.36	L5646	$458.30	L5782	$3,568.01	L6100	$1,609.84	L6672	$169.03
L5160	$3,194.91	L5647	$665.36	L5785	$538.32	L6110	$1,707.51	L6675	$100.45
L5200	$3,059.58	L5648	$550.70	L5790	$601.43	L6120	$1,989.86	L6676	$116.12
L5210	$2,029.72	L5649	$1,995.49	L5795	$1,197.46	L6130	$2,165.34	L6677	$250.95
L5220	$2,307.14	L5650	$408.34	L5810	$407.24	L6200	$2,281.91	L6680	$194.07
L5230	$3,182.01	L5651	$1,004.51	L5811	$610.04	L6205	$3,046.00	L6682	$214.56
L5250	$4,339.98	L5652	$364.68	L5812	$472.84	L6250	$2,390.92	L6684	$291.56
L5270	$4,320.72	L5653	$486.81	L5814	$3,141.46	L6300	$3,116.31	L6686	$658.41
L5280	$4,287.63	L5654	$277.40	L5816	$715.63	L6310	$2,690.79	L6687	$482.48
L5301	$2,300.84	L5655	$235.08	L5818	$803.27	L6320	01,469.93	L6688	$479.57
L5311	$3,293.50	L5656	$315.37	L5822	$1,424.39	L6350	$3,276.32	L6689	$574.58
L5321	$3,335.13	L5658	$304.13	L5824	$1,282.75	L6360	$2,946.54	L6690	$626.12
L5331	$4,249.63	L5661	$509.02	L5826	$2,641.56	L6370	$1,763.12	L6691	$289.81
L5341	$4,423.88	L5665	$428.28	L5828	$2,362.09	L6380	$1,021.68	L6692	$467.77

Orthotic/Prosthetic Devices (continued)

Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees
L6693	$2,401.41	L7366	$448.98	L8485	$9.30	Q0490	$594.73	V2303	$58.61
L6694	$594.76	L7367	$329.31	L8500	$552.02	Q0491	$934.97	V2304	$61.34
L6695	$495.62	L7368	$426.90	L8501	$122.60	Q0492	$75.35	V2305	$75.22
L6696	$1,112.66	L7400	$259.26	L8507	$35.43	Q0493	$214.47	V2306	$70.15
L6697	$1,112.66	L7401	$290.23	L8509	$92.39	Q0494	$181.49	V2307	$69.55
L6698	$480.97	L7402	$313.41	L8510	$213.75	Q0495	$3,533.29	V2308	$74.22
L6703	$304.09	L7403	$311.52	L8511	$61.53	Q0496	$1,268.16	V2309	$86.82
L6704	$489.86	L7404	$470.13	L8512	$1.85	Q0497	$395.99	V2310	$95.49
L6706	$291.86	L7405	$614.86	L8513	$4.40	Q0498	$434.49	V2311	$90.95
L6707	$1,075.73	L7900	$457.79	L8514	$79.78	Q0499	$141.16	V2312	$80.18
L6708	$703.24	L8000	$36.80	L8515	$53.39	Q0500	$25.82	V2313	$109.43
L6709	$1,013.39	L8001	$106.09	L8600	$522.32	Q0501	$431.99	V2314	$119.87
L6805	$284.59	L8002	$139.56	L8603	$366.83	Q0502	$549.96	V2315	$133.08
L6810	$161.31	L8015	$50.70	L8606	$192.56	Q0503	$1,099.95	V2318	$122.70
L6881	$3,458.11	L8020	$190.70	L8609	$5,511.23	Q0504	$580.41	V2319	$41.54
L6882	$2,623.16	L8030	$275.84	L8610	$535.77	V2020	$67.42	V2320	$43.82
L6883	$1,327.35	L8035	$3,098.95	L8612	$565.08	V2100	$32.76	V2321	$131.17
L6884	$1,970.06	L8040	$2,044.62	L8613	$253.00	V2101	$34.52	V2410	$75.00
L6885	$2,946.54	L8040 KM	$1,942.39	L8614	$16,013.67	V2102	$48.97	V2430	$97.65
L6890	$142.27	L8040 KN	$817.85	L8615	$381.50	V2103	$28.45	V2500	$67.99
L6895	$523.37	L8041	$2,464.39	L8616	$88.86	V2104	$31.51	V2501	$103.56
L6900	$1,493.57	L8041 KM	$2,341.16	L8617	$77.61	V2105	$38.57	V2502	$127.57
L6905	$1,485.08	L8041 KN	$985.75	L8618	$22.16	V2106	$39.14	V2503	$122.05
L6910	$1,269.90	L8042	$2,768.97	L8619	$6,869.27	V2107	$41.15	V2510	$92.81
L6915	$640.26	L8042 KM	$2,630.53	L8621	$0.52	V2108	$39.91	V2511	$133.35
L6920	$5,582.26	L8042 KN	$1,107.58	L8622	$0.28	V2109	$45.87	V2512	$157.57
L6925	$7,514.68	L8043	$3,101.26	L8623	$54.72	V2110	$53.54	V2513	$132.29
L6930	$5,616.88	L8043 KM	$2,946.17	L8624	$136.38	V2111	$47.20	V2520	$87.24
L6935	$7,631.30	L8043 KN	$1,240.50	L8630	$281.81	V2112	$46.57	V2521	$151.88
L6940	$7,338.81	L8044	$3,433.52	L8631	$1,891.22	V2113	$64.34	V2522	$147.80
L6945	$8,967.16	L8044 KM	$3,261.86	L8641	$305.85	V2114	$56.91	V2523	$125.95
L6950	$8,341.59	L8044 KN	$1,373.42	L8642	$251.06	V2115	$61.88	V2530	$186.55
L6955	$9,990.20	L8045	$2,150.17	L8658	$262.39	V2118	$61.34	V2531	$457.99
L6960	$11,316.40	L8045 KM	$2,042.65	L8659	$1,632.25	V2121	$63.33	V2623	$750.83
L6965	$12,069.35	L8045 KN	$860.07	L8670	$465.61	V2200	$42.88	V2624	$50.92
L6970	$12,576.47	L8046	$2,215.18	L8680	$388.54	V2201	$46.74	V2625	$329.82
L6975	$13,754.61	L8046 KM	$2,104.42	L8681	$955.39	V2202	$55.00	V2626	$209.25
L7007	$2,878.29	L8046 KN	$886.06	L8682	$5,042.80	V2203	$43.26	V2627	$1,198.02
L7008	$4,530.13	L8047	$1,135.27	L8683	$4,438.80	V2204	$46.91	V2628	$273.91
L7009	$2,936.77	L8047 KM	$1,078.51	L8684	$582.91	V2205	$51.47	V2700	$36.64
L7040	$2,358.11	L8047 KN	$454.11	L8685	$11,061.27	V2206	$62.66	V2710	$53.63
L7045	$1,351.99	L8300	$81.46	L8686	$7,057.99	V2207	$52.31	V2715	$9.72
L7170	$6,225.03	L8310	$125.26	L8687	$14,395.13	V2208	$52.94	V2718	$23.88
L7180	$27,324.50	L8320	$54.72	L8688	$9,185.27	V2209	$58.24	V2730	$17.64
L7181	$33,892.38	L8330	$54.24	L8689	$1,459.07	V2210	$74.93	V2744	$18.30
L7185	$6,147.31	L8400	$15.85	L8690	$0.00	V2211	$63.89	V2745	$10.38
L7186	$7,398.89	L8410	$18.03	L8691	$0.00	V2212	$69.53	V2750	$21.29
L7190	$6,456.77	L8415	$17.93	L8695	$14.10	V2213	$71.30	V2755	$15.38
L7191	$7,731.40	L8417	$63.60	Q0480	$76,182.94	V2214	$76.43	V2760	$13.40
L7260	$1,646.16	L8420	$20.96	Q0481	$12,291.24	V2215	$82.70	V2762	$50.43
L7261	$2,996.64	L8430	$23.05	Q0482	$3,849.84	V2218	$84.61	V2770	$17.30
L7266	$1,104.20	L8435	$20.69	Q0483	$15,859.63	V2219	$37.24	V2780	$13.97
L7272	01,912.16	L8440	$43.86	Q0484	$3,079.89	V2220	$30.20	V2782	$54.44
L7274	04,804.24	L8460	$61.03	Q0485	$297.36	V2221	$80.70	V2783	$61.41
L7360	$199.59	L8465	$54.40	Q0486	$247.49	V2300	$55.69	V2784	$39.93
L7362	$209.57	L8470	$5.58	Q0487	$288.74	V2301	$64.58	V2786	$0.00
L7364	$333.31	L8480	$7.70	Q0489	$13,749.44	V2302	$70.76		

Source: CMS Pub. 100-04, Transmittal 1125, CR 5417

CLINICAL LABORATORY SERVICES

The following fee schedules are effective for clinical laboratory services furnished **on or after January 1, 2007.** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Code/MD	60%	62%	Code/MD	60%	62%	Code/MD	60%	62%
ATP02	$7.28	$7.52	*80101* QW	$19.24	$19.88	*80435*	$143.85	$148.65
ATP03	$9.29	$9.60	*80102*	$18.51	$19.13	*80436*	$127.36	$131.61
ATP04	$9.80	$10.13	*80150*	$21.06	$21.76	*80438*	$70.41	$72.76
ATP05	$10.93	$11.29	*80152*	$25.01	$25.84	*80439*	$93.88	$97.01
ATP06	$10.96	$11.33	*80154*	$25.84	$26.70	*80440*	$81.24	$83.95
ATP07	$11.42	$11.80	*80156*	$20.34	$21.02	*81000*	$4.43	$4.58
ATP08	$11.83	$12.22	*80157*	$18.52	$19.14	*81001*	$4.43	$4.58
ATP09	$12.13	$12.53	*80158*	$24.31	$25.12	*81002*	$3.57	$3.69
ATP10	$12.13	$12.53	*80160*	$24.05	$24.85	*81003*	$3.14	$3.24
ATP11	$12.34	$12.75	*80162*	$18.55	$19.17	*81003* QW	$3.14	$3.24
ATP12	$12.62	$13.04	*80164*	$18.93	$19.56	*81005*	$3.03	$3.13
ATP16	$14.77	$15.26	*80166*	$21.66	$22.38	*81007*	$3.59	$3.71
ATP18	$14.87	$15.37	*80168*	$22.83	$23.59	*81007* QW	$3.59	$3.71
ATP19	$15.45	$15.97	*80170*	$22.90	$23.66	*81015*	$4.02	$4.15
ATP20	$15.95	$16.48	*80172*	$22.76	$23.52	*81020*	$5.15	$5.32
ATP21	$16.45	$17.00	*80173*	$20.34	$21.02	*81025*	$8.84	$9.13
ATP22	$16.95	$17.52	*80174*	$24.05	$24.85	*81050*	$4.19	$4.33
G0027	$9.09	$9.39	*80176*	$16.26	$16.80	*82000*	$17.31	$17.89
G0103	$25.70	$26.56	*80178*	$9.24	$9.55	*82003*	$28.28	$29.22
G0123	$28.21	$29.15	*80182*	$18.93	$19.56	*82009*	$6.31	$6.52
G0143	$28.21	$29.15	*80184*	$16.01	$16.54	*82010*	$9.99	$10.32
G0144	$29.39	$30.37	*80185*	$18.52	$19.14	*82010* QW	$9.99	$10.32
G0145	$34.70	$35.86	*80186*	$19.23	$19.87	*82013*	$15.61	$16.13
G0147	$14.76	$14.76	*80188*	$23.18	$23.95	*82016*	$19.37	$20.02
G0148	$14.76	$14.76	*80190*	$23.41	$24.19	*82017*	$23.57	$24.36
G0265	$14.11	$14.58	*80192*	$23.41	$24.19	*82024*	$53.97	$55.77
G0266	$14.11	$14.58	*80194*	$20.39	$21.07	*82030*	$18.08	$18.68
G0306	$10.86	$11.22	*80195*	$19.17	$19.81	*82040*	$5.73	$5.92
G0307	$9.04	$9.34	*80196*	$9.92	$10.25	*82042*	$2.46	$2.54
G0328	$22.22	$22.96	*80197*	$19.17	$19.81	*82043*	$2.46	$2.54
G0328QW	$22.22	$22.96	*80198*	$19.77	$20.43	*82044*	$6.39	$6.60
G0394	$4.54	$4.69	*80200*	$22.52	$23.27	*82044* QW	$6.39	$6.60
P2038	$7.02	$7.25	*80201*	$16.66	$17.22	*82045*	$47.43	$49.01
P3000	$14.76	$14.76	*80202*	$18.93	$19.56	*82055*	$15.10	$15.60
P9612	$3.00	$3.00	*80299*	$19.13	$19.77	*82055* QW	$15.10	$15.60
P9615	$3.00	$3.00	*80400*	$45.56	$47.08	*82075*	$16.84	$17.40
Q0111	$5.96	$6.16	*80402*	$121.46	$125.51	*82085*	$13.56	$14.01
Q0112	$5.96	$6.16	*80406*	$109.34	$112.98	*82088*	$56.94	$58.84
Q0113	$7.56	$7.81	*80408*	$175.34	$181.18	*82101*	$41.94	$43.34
Q0114	$9.99	$10.32	*80410*	$112.23	$115.97	*82103*	$18.77	$19.40
Q0115	$13.83	$14.29	*80412*	$460.50	$475.85	*82104*	$20.20	$20.87
36415	$3.00	$3.00	*80414*	$72.16	$74.57	*82105*	$23.44	$24.22
78267	$10.98	$11.35	*80415*	$78.08	$80.68	*82106*	$23.44	$24.22
78268	$94.11	$97.25	*80416*	$184.38	$190.53	*82107*	$89.99	$92.99
80048	$11.83	$12.22	*80417*	$61.46	$63.51	*82108*	$35.60	$36.79
80051	$9.80	$10.13	*80418*	$809.76	$836.75	*82120*	$4.02	$4.15
80053	$14.77	$15.26	*80420*	$100.64	$103.99	*82120* QW	$4.02	$4.15
80061	$18.72	$19.34	*80422*	$64.38	$66.53	*82127*	$19.37	$20.02
80061 QW	$18.72	$19.34	*80424*	$66.56	$68.78	*82128*	$19.37	$20.02
80069	$12.13	$12.53	*80426*	$207.40	$214.31	*82131*	$23.57	$24.36
80074	$66.54	$68.76	*80428*	$93.16	$96.27	*82135*	$23.00	$23.77
80076	$11.42	$11.80	*80430*	$109.60	$113.25	*82136*	$23.57	$24.36
80100	$20.32	$21.00	*80432*	$177.43	$183.34	*82139*	$23.57	$24.36
80101	$19.24	$19.88	*80434*	$141.30	$146.01	*82140*	$20.36	$21.04

Clinical Laboratory Services (continued)

Code/MD	60%	62%	Code/MD	60%	62%	Code/MD	60%	62%
82143	$9.61	$9.93	*82480*	$9.93	$10.26	*82693*	$13.75	$14.21
82145	$21.72	$22.44	*82482*	$8.31	$8.59	*82696*	$32.95	$34.05
82150	$9.06	$9.36	*82485*	$20.02	$20.69	*82705*	$7.11	$7.35
82154	$40.29	$41.63	*82486*	$24.35	$25.16	*82710*	$22.12	$22.86
82157	$40.90	$42.26	*82487*	$20.02	$20.69	*82715*	$24.05	$24.85
82160	$34.94	$36.10	*82488*	$20.02	$20.69	*82725*	$12.08	$12.48
82163	$28.68	$29.64	*82489*	$20.02	$20.69	*82726*	$24.35	$25.16
82164	$20.39	$21.07	*82491*	$24.35	$25.16	*82728*	$19.03	$19.66
82172	$19.80	$20.46	*82492*	$24.35	$25.16	*82731*	$89.99	$92.99
82175	$26.51	$27.39	*82495*	$28.34	$29.28	*82735*	$12.62	$13.04
82180	$13.81	$14.27	*82507*	$38.85	$40.15	*82742*	$27.66	$28.58
82190	$17.08	$17.65	*82520*	$21.17	$21.88	*82746*	$20.54	$21.22
82205	$16.01	$16.54	*82523*	$26.11	$26.98	*82747*	$4.30	$4.44
82232	$22.61	$23.36	*82523* QW	$26.11	$26.98	*82757*	$16.89	$17.45
82239	$23.94	$24.74	*82525*	$17.34	$17.92	*82759*	$30.01	$31.01
82240	$24.31	$25.12	*82528*	$31.45	$32.50	*82760*	$15.64	$16.16
82247	$7.02	$7.25	*82530*	$23.35	$24.13	*82775*	$29.43	$30.41
82248	$7.02	$7.25	*82533*	$22.78	$23.54	*82776*	$11.71	$12.10
82252	$2.73	$2.82	*82540*	$6.48	$6.70	*82784*	$12.99	$13.42
82261	$23.57	$24.36	*82541*	$24.35	$25.16	*82785*	$23.01	$23.78
82270	$4.54	$4.69	*82542*	$24.35	$25.16	*82787*	$4.36	$4.51
82271	$4.54	$4.69	*82543*	$24.35	$25.16	*82800*	$4.88	$5.04
82271 QW	$4.54	$4.69	*82544*	$24.35	$25.16	*82803*	$27.04	$27.94
82272	$4.54	$4.69	*82550*	$9.10	$9.40	*82805*	$39.65	$40.97
82272 QW	$4.54	$4.69	*82552*	$18.71	$19.33	*82810*	$12.20	$12.61
82274	$22.22	$22.96	*82553*	$13.00	$13.43	*82820*	$13.96	$14.43
82274 QW	$22.22	$22.96	*82554*	$13.00	$13.43	*82926*	$7.61	$7.86
82286	$9.62	$9.94	*82565*	$7.16	$7.40	*82928*	$7.32	$7.56
82300	$13.25	$13.69	*82570*	$7.23	$7.47	*82938*	$24.72	$25.54
82306	$41.36	$42.74	*82570* QW	$7.23	$7.47	*82941*	$24.64	$25.46
82307	$45.02	$46.52	*82575*	$13.20	$13.64	*82943*	$19.97	$20.64
82308	$37.41	$38.66	*82585*	$11.98	$12.38	*82945*	$5.48	$5.66
82310	$7.20	$7.44	*82595*	$9.04	$9.34	*82946*	$21.06	$21.76
82330	$19.09	$19.73	*82600*	$27.11	$28.01	*82947*	$5.48	$5.66
82331	$7.23	$7.47	*82607*	$21.06	$21.76	*82947* QW	$5.48	$5.66
82340	$8.43	$8.71	*82608*	$20.01	$20.68	*82948*	$4.43	$4.58
82355	$16.17	$16.71	*82615*	$11.41	$11.79	*82950*	$6.64	$6.86
82360	$12.22	$12.63	*82626*	$35.31	$36.49	*82950* QW	$6.64	$6.86
82365	$17.30	$17.88	*82627*	$31.07	$32.11	*82951*	$17.99	$18.59
82370	$17.51	$18.09	*82633*	$43.28	$44.72	*82951* QW	$17.99	$18.59
82373	$24.35	$25.16	*82634*	$40.90	$42.26	*82952*	$5.48	$5.66
82374	$6.83	$7.06	*82638*	$17.11	$17.68	*82952* QW	$5.48	$5.66
82375	$17.22	$17.79	*82646*	$27.81	$28.74	*82953*	$6.63	$6.85
82376	$7.94	$8.20	*82649*	$35.91	$37.11	*82955*	$13.55	$14.00
82378	$26.51	$27.39	*82651*	$36.07	$37.27	*82960*	$8.12	$8.39
82379	$23.57	$24.36	*82652*	$53.78	$55.57	*82962*	$3.27	$3.38
82380	$12.89	$13.32	*82654*	$19.11	$19.75	*82963*	$30.01	$31.01
82382	$24.02	$24.82	*82656*	$16.12	$16.66	*82965*	$7.28	$7.52
82383	$35.01	$36.18	*82657*	$24.35	$25.16	*82975*	$22.13	$22.87
82384	$33.28	$34.39	*82658*	$24.35	$25.16	*82977*	$10.06	$10.40
82387	$29.07	$30.04	*82664*	$48.00	$49.60	*82978*	$19.91	$20.57
82390	$15.01	$15.51	*82666*	$30.01	$31.01	*82979*	$9.62	$9.94
82397	$19.74	$20.40	*82668*	$26.26	$27.14	*82980*	$24.31	$25.12
82415	$17.70	$18.29	*82670*	$39.04	$40.34	*82985*	$21.06	$21.76
82435	$6.42	$6.63	*82671*	$45.13	$46.63	*82985* QW	$21.06	$21.76
82436	$4.55	$4.70	*82672*	$30.30	$31.31	*83001*	$25.97	$26.84
82438	$6.83	$7.06	*82677*	$33.79	$34.92	*83001* QW	$25.97	$26.84
82441	$8.38	$8.66	*82679*	$34.88	$36.04	*83002*	$25.88	$26.74
82465	$6.08	$6.28	*82679* QW	$34.88	$36.04	*83002* QW	$25.88	$26.74
82465 QW	$6.08	$6.28	*82690*	$21.99	$22.72	*83003*	$23.29	$24.07

Clinical Laboratory Services (continued)

Code/MD	60%	62%	Code/MD	60%	62%	Code/MD	60%	62%
83008	$23.45	$24.23	*83655*	$16.91	$17.47	*83915*	$15.58	$16.10
83009	$94.11	$97.25	*83661*	$27.56	$28.48	*83916*	$27.42	$28.33
83010	$17.58	$18.17	*83662*	$26.43	$27.31	*83918*	$21.19	$21.90
83012	$24.02	$24.82	*83663*	$26.43	$27.31	*83919*	$21.19	$21.90
83013	$94.11	$97.25	*83664*	$26.43	$27.31	*83921*	$21.19	$21.90
83014	$10.98	$11.35	*83670*	$12.80	$13.23	*83925*	$27.19	$28.10
83015	$26.31	$27.19	*83690*	$9.62	$9.94	*83930*	$9.24	$9.55
83018	$30.68	$31.70	*83695*	$18.09	$18.69	*83935*	$9.52	$9.84
83020	$17.99	$18.59	*83698*	$47.43	$49.01	*83937*	$28.73	$29.69
83021	$24.35	$25.16	*83700*	$15.73	$16.25	*83945*	$17.99	$18.59
83026	$3.30	$3.41	*83701*	$17.30	$17.88	*83950*	$89.99	$92.99
83030	$11.56	$11.95	*83704*	$29.52	$30.50	*83970*	$57.67	$59.59
83033	$6.50	$6.72	*83718*	$11.44	$11.82	*83986*	$5.00	$5.17
83036	$13.56	$14.01	*83718* QW	$11.44	$11.82	*83986* QW	$5.00	$5.17
83036 QW	$13.56	$14.01	*83719*	$16.26	$16.80	*83992*	$20.54	$21.22
83037	$21.06	$21.76	*83721*	$13.33	$13.77	*84022*	$21.76	$22.49
*8303 7*QW	$21.06	$21.76	*83721* QW	$13.33	$13.77	*84030*	$7.69	$7.95
83045	$4.88	$5.04	*83727*	$24.02	$24.82	*84035*	$5.11	$5.28
83050	$5.86	$6.06	*83735*	$9.36	$9.67	*84060*	$10.32	$10.66
83051	$10.21	$10.55	*83775*	$10.30	$10.64	*84061*	$11.06	$11.43
83055	$6.87	$7.10	*83785*	$34.36	$35.51	*84066*	$13.50	$13.95
83060	$8.12	$8.39	*83788*	$24.35	$25.16	*84075*	$7.23	$7.47
83065	$6.00	$6.20	*83789*	$24.35	$25.16	*84078*	$10.20	$10.54
83068	$11.83	$12.22	*83805*	$24.63	$25.45	*84080*	$20.66	$21.35
83069	$5.51	$5.69	*83825*	$22.72	$23.48	*84081*	$23.09	$23.86
83070	$6.64	$6.86	*83835*	$23.67	$24.46	*84085*	$9.42	$9.73
83071	$9.61	$9.93	*83840*	$22.81	$23.57	*84087*	$11.31	$11.69
83080	$23.57	$24.36	*83857*	$15.01	$15.51	*84100*	$6.63	$6.85
83088	$41.26	$42.64	*83858*	$18.72	$19.34	*84105*	$6.50	$6.72
83090	$23.57	$24.36	*83864*	$27.82	$28.75	*84106*	$5.99	$6.19
83150	$17.30	$17.88	*83866*	$13.76	$14.22	*84110*	$11.80	$12.19
83491	$24.47	$25.29	*83872*	$8.19	$8.46	*84119*	$12.03	$12.43
83497	$18.01	$18.61	*83873*	$24.04	$24.84	*84120*	$20.55	$21.24
83498	$37.95	$39.22	*83874*	$18.04	$18.64	*84126*	$35.59	$36.78
83499	$35.22	$36.39	*83880*	$47.43	$49.01	*84127*	$16.28	$16.82
83500	$31.65	$32.71	*83880* QW	$47.43	$49.01	*84132*	$6.42	$6.63
83505	$33.96	$35.09	*83883*	$19.00	$19.63	*84133*	$6.01	$6.21
83516	$16.12	$16.66	*83885*	$7.94	$8.20	*84134*	$20.38	$21.06
83518	$11.85	$12.25	*83887*	$33.09	$34.19	*84135*	$26.73	$27.62
83518 QW	$11.85	$12.25	*83890*	$3.56	$3.68	*84138*	$26.46	$27.34
83519	$18.88	$19.51	*83891*	$3.56	$3.68	*84140*	$23.53	$24.31
83520	$18.09	$18.69	*83892*	$3.56	$3.68	*84143*	$31.89	$32.95
83525	$15.98	$16.51	*83893*	$3.56	$3.68	*84144*	$29.15	$30.12
83527	$18.09	$18.69	*83894*	$3.56	$3.68	*84146*	$27.08	$27.98
83528	$22.22	$22.96	*83896*	$3.56	$3.68	*84150*	$34.88	$36.04
83540	$9.05	$9.35	*83897*	$3.56	$3.68	*84152*	$25.70	$26.56
83550	$12.21	$12.62	*83898*	$23.42	$24.20	*84153*	$25.70	$26.56
83570	$12.36	$12.77	*83900*	$46.84	$48.40	*84154*	$25.70	$26.56
83582	$19.80	$20.46	*83901*	$23.42	$24.20	*84155*	$5.12	$5.29
83586	$17.89	$18.49	*83902*	$15.17	$15.68	*84156*	$5.12	$5.29
83593	$36.75	$37.98	*83903*	$23.42	$24.20	*84157*	$5.12	$5.29
83605	$14.92	$15.42	*83904*	$23.42	$24.20	*84160*	$7.23	$7.47
83605 QW	$14.92	$15.42	*83905*	$23.42	$24.20	*84163*	$21.03	$21.73
83615	$8.44	$8.72	*83906*	$23.42	$24.20	*84165*	$15.01	$15.51
83625	$17.88	$18.48	*83907*	$18.66	$19.28	*84166*	$24.92	$25.75
83630	$27.42	$28.33	*83908*	$23.42	$24.20	*84181*	$23.80	$24.59
83631	$27.42	$28.33	*83909*	$23.42	$24.20	*84182*	$25.15	$25.99
83632	$28.24	$29.18	*83912*	$3.56	$3.68	*84202*	$10.67	$11.03
83633	$7.69	$7.95	*83913*	$18.66	$19.28	*84203*	$10.67	$11.03
83634	$11.17	$11.54	*83914*	$23.42	$24.20	*84206*	$18.72	$19.34

Clinical Laboratory Services (continued)

Code/MD	60%	62%	Code/MD	60%	62%	Code/MD	60%	62%
84207	$26.00	$26.87	*84525*	$4.02	$4.15	*85292*	$7.28	$7.52
84210	$15.17	$15.68	*84540*	$6.64	$6.86	*85293*	$7.28	$7.52
84220	$7.28	$7.52	*84545*	$9.23	$9.54	*85300*	$8.12	$8.39
84228	$7.94	$8.20	*84550*	$6.31	$6.52	*85301*	$15.11	$15.61
84233	$89.99	$92.99	*84560*	$6.64	$6.86	*85302*	$16.80	$17.36
84234	$90.64	$93.66	*84577*	$17.43	$18.01	*85303*	$19.32	$19.96
84235	$73.12	$75.56	*84578*	$4.54	$4.69	*85305*	$16.20	$16.74
84238	$51.09	$52.79	*84580*	$9.92	$10.25	*85306*	$21.41	$22.12
84244	$30.73	$31.75	*84583*	$7.02	$7.25	*85307*	$21.41	$22.12
84252	$17.81	$18.40	*84585*	$21.66	$22.38	*85335*	$17.99	$18.59
84255	$35.67	$36.86	*84586*	$26.81	$27.70	*85337*	$14.56	$15.05
84260	$21.19	$21.90	*84588*	$47.43	$49.01	*85345*	$6.01	$6.21
84270	$11.17	$11.54	*84590*	$16.20	$16.74	*85347*	$5.95	$6.15
84275	$10.28	$10.62	*84591*	$16.20	$16.74	*85348*	$5.20	$5.37
84285	$32.90	$34.00	*84597*	$9.77	$10.10	*85360*	$11.17	$11.54
84295	$6.72	$6.94	*84600*	$22.45	$23.20	*85362*	$9.62	$9.94
84300	$6.79	$7.02	*84620*	$16.55	$17.10	*85366*	$12.03	$12.43
84302	$6.79	$7.02	*84630*	$15.91	$16.44	*85370*	$14.83	$15.32
84305	$27.55	$28.47	*84681*	$26.81	$27.70	*85378*	$9.97	$10.30
84307	$21.61	$22.33	*84702*	$21.03	$21.73	*85379*	$14.22	$14.69
84311	$9.77	$10.10	*84703*	$10.49	$10.84	*85380*	$14.22	$14.69
84315	$3.50	$3.62	*84703* QW	$10.49	$10.84	*85384*	$11.87	$12.27
84375	$12.22	$12.63	*84830*	$14.02	$14.49	*85385*	$11.87	$12.27
84376	$7.69	$7.95	*85002*	$6.29	$6.50	*85390*	$6.63	$6.85
84377	$7.69	$7.95	*85004*	$9.04	$9.34	*85400*	$12.36	$12.77
84378	$11.17	$11.54	*85007*	$4.81	$4.97	*85410*	$10.77	$11.13
84379	$11.17	$11.54	*85008*	$4.81	$4.97	*85415*	$13.25	$13.69
84392	$6.64	$6.86	*85009*	$5.19	$5.36	*85420*	$9.13	$9.43
84402	$35.57	$36.76	*85013*	$3.31	$3.42	*85421*	$14.23	$14.70
84403	$36.08	$37.28	*85014*	$3.31	$3.42	*85441*	$5.88	$6.08
84425	$12.22	$12.63	*85014* QW	$3.31	$3.42	*85445*	$9.52	$9.84
84430	$16.26	$16.80	*85018*	$3.31	$3.42	*85460*	$10.81	$11.17
84432	$22.44	$23.19	*85018* QW	$3.31	$3.42	*85461*	$9.26	$9.57
84436	$9.61	$9.93	*85025*	$10.86	$11.22	*85475*	$12.40	$12.81
84437	$7.94	$8.20	*85027*	$9.04	$9.34	*85520*	$13.25	$13.69
84439	$12.60	$13.02	*85032*	$6.01	$6.21	*85525*	$13.25	$13.69
84442	$20.66	$21.35	*85041*	$4.20	$4.34	*85530*	$13.25	$13.69
84443	$23.47	$24.25	*85044*	$6.01	$6.21	*85536*	$9.04	$9.34
84443 QW	$23.47	$24.25	*85045*	$5.59	$5.78	*85540*	$12.02	$12.42
84445	$24.31	$25.12	*85046*	$7.80	$8.06	*85547*	$12.02	$12.42
84446	$19.81	$20.47	*85048*	$3.55	$3.67	*85549*	$26.21	$27.08
84449	$21.05	$21.75	*85049*	$6.25	$6.46	*85555*	$9.34	$9.65
84450	$7.22	$7.46	*85055*	$5.86	$6.06	*85557*	$18.66	$19.28
84450 QW	$7.22	$7.46	*85130*	$16.62	$17.17	*85576*	$30.01	$31.01
84460	$7.40	$7.65	*85170*	$5.05	$5.22	*85576* QW	$30.01	$31.01
84460 QW	$7.40	$7.65	*85175*	$6.35	$6.56	*85597*	$25.12	$25.96
84466	$17.84	$18.43	*85210*	$8.12	$8.39	*85610*	$5.49	$5.67
84478	$8.04	$8.31	*85220*	$24.66	$25.48	*85610* QW	$5.49	$5.67
84478 QW	$8.04	$8.31	*85230*	$25.02	$25.85	*85611*	$5.51	$5.69
84479	$9.04	$9.34	*85240*	$25.02	$25.85	*85612*	$13.37	$13.82
84480	$19.81	$20.47	*85244*	$28.53	$29.48	*85613*	$13.37	$13.82
84481	$21.97	$22.70	*85245*	$32.06	$33.13	*85635*	$13.76	$14.22
84482	$21.97	$22.70	*85246*	$32.06	$33.13	*85651*	$4.96	$5.13
84484	$13.75	$14.21	*85247*	$32.06	$33.13	*85652*	$3.77	$3.90
84485	$10.01	$10.34	*85250*	$26.60	$27.49	*85660*	$7.71	$7.97
84488	$10.01	$10.34	*85260*	$25.02	$25.85	*85670*	$8.07	$8.34
84490	$10.01	$10.34	*85270*	$25.02	$25.85	*85675*	$6.50	$6.72
84510	$12.22	$12.63	*85280*	$27.04	$27.94	*85705*	$11.17	$11.54
84512	$7.58	$7.83	*85290*	$22.83	$23.59	*85730*	$8.38	$8.66
84520	$5.51	$5.69	*85291*	$12.42	$12.83	*85732*	$9.04	$9.34

Clinical Laboratory Services (continued)

Code/MD	60%	62%	Code/MD	60%	62%	Code/MD	60%	62%
85810	$16.32	$16.86	*86343*	$17.41	$17.99	*86688*	$19.57	$20.22
86000	$9.75	$10.08	*86344*	$11.16	$11.53	*86689*	$27.05	$27.95
86001	$7.30	$7.54	*86353*	$68.49	$70.77	*86692*	$23.98	$24.78
86003	$7.30	$7.54	*86355*	$52.70	$54.46	*86694*	$20.11	$20.78
86005	$11.14	$11.51	*86357*	$52.70	$54.46	*86695*	$18.43	$19.04
86021	$21.03	$21.73	*86359*	$52.70	$54.46	*86696*	$27.05	$27.95
86022	$25.66	$26.52	*86360*	$9.77	$10.10	*86698*	$17.46	$18.04
86023	$17.40	$17.98	*86361*	$5.86	$6.06	*86701*	$12.41	$12.82
86038	$16.89	$17.45	*86367*	$52.70	$54.46	*86701* QW	$12.41	$12.82
86039	$15.60	$16.12	*86376*	$20.33	$21.01	*86702*	$18.88	$19.51
86060	$10.20	$10.54	*86378*	$27.51	$28.43	*86703*	$19.17	$19.81
86063	$8.07	$8.34	*86382*	$23.62	$24.41	*86704*	$16.84	$17.40
86140	$7.23	$7.47	*86384*	$15.91	$16.44	*86705*	$16.44	$16.99
86141	$18.09	$18.69	*86403*	$14.24	$14.71	*86706*	$15.01	$15.51
86146	$23.12	$23.89	*86406*	$14.87	$15.37	*86707*	$16.16	$16.70
86147	$23.12	$23.89	*86430*	$7.93	$8.19	*86708*	$17.31	$17.89
86148	$22.44	$23.19	*86431*	$7.93	$8.19	*86709*	$15.73	$16.25
86155	$22.33	$23.07	*86480*	$86.59	$89.48	*86710*	$18.94	$19.57
86156	$9.36	$9.67	*86586*	$4.47	$4.62	*86713*	$21.39	$22.10
86157	$11.27	$11.65	*86590*	$12.22	$12.63	*86717*	$17.12	$17.69
86160	$16.78	$17.34	*86592*	$5.96	$6.16	*86720*	$18.43	$19.04
86161	$16.78	$17.34	*86593*	$6.16	$6.37	*86723*	$18.43	$19.04
86162	$28.39	$29.34	*86602*	$8.11	$8.38	*86727*	$17.98	$18.58
86171	$14.00	$14.47	*86603*	$17.98	$18.58	*86729*	$16.69	$17.25
86185	$12.50	$12.92	*86606*	$21.03	$21.73	*86732*	$18.43	$19.04
86200	$18.09	$18.69	*86609*	$18.00	$18.60	*86735*	$18.23	$18.84
86215	$18.51	$19.13	*86611*	$8.11	$8.38	*86738*	$18.51	$19.13
86225	$19.20	$19.84	*86612*	$18.03	$18.63	*86741*	$18.43	$19.04
86226	$16.92	$17.48	*86615*	$18.43	$19.04	*86744*	$18.43	$19.04
86235	$25.06	$25.90	*86617*	$21.64	$22.36	*86747*	$21.00	$21.70
86243	$28.68	$29.64	*86618*	$21.05	$21.75	*86750*	$13.00	$13.43
86255	$16.84	$17.40	*86618* QW	$21.05	$21.75	*86753*	$17.32	$17.90
86256	$16.84	$17.40	*86619*	$18.69	$19.31	*86756*	$18.01	$18.61
86277	$21.99	$22.72	*86622*	$12.48	$12.90	*86757*	$27.05	$27.95
86280	$11.44	$11.82	*86625*	$18.33	$18.94	*86759*	$18.43	$19.04
86294	$27.41	$28.32	*86628*	$11.31	$11.69	*86762*	$20.11	$20.78
86294 QW	$27.41	$28.32	*86631*	$16.52	$17.07	*86765*	$18.00	$18.60
86300	$28.50	$29.45	*86632*	$17.74	$18.33	*86768*	$16.26	$16.80
86301	$28.50	$29.45	*86635*	$16.03	$16.56	*86771*	$18.33	$18.94
86304	$28.50	$29.45	*86638*	$16.94	$17.50	*86774*	$20.68	$21.37
86308	$7.23	$7.47	*86641*	$15.86	$16.39	*86777*	$20.11	$20.78
86308 QW	$7.23	$7.47	*86644*	$20.11	$20.78	*86778*	$20.12	$20.79
86309	$9.04	$9.34	*86645*	$23.54	$24.32	*86781*	$18.50	$19.12
86310	$10.30	$10.64	*86648*	$21.25	$21.96	*86784*	$11.31	$11.69
86316	$28.50	$29.45	*86651*	$18.43	$19.04	*86787*	$18.00	$18.60
86317	$20.95	$21.65	*86652*	$18.43	$19.04	*86788*	$23.54	$24.32
86318	$18.09	$18.69	*86653*	$18.43	$19.04	*86789*	$20.11	$20.78
86318 QW	$18.09	$18.69	*86654*	$18.43	$19.04	*86790*	$18.00	$18.60
86320	$31.32	$32.36	*86658*	$18.20	$18.81	*86793*	$18.33	$18.94
86325	$31.24	$32.28	*86663*	$18.33	$18.94	*86800*	$22.22	$22.96
86327	$31.70	$32.76	*86664*	$21.38	$22.09	*86803*	$19.94	$20.60
86329	$19.62	$20.27	*86665*	$25.35	$26.20	*86804*	$21.64	$22.36
86331	$16.75	$17.31	*86666*	$8.11	$8.38	*86805*	$73.05	$75.49
86332	$34.05	$35.19	*86668*	$14.53	$15.01	*86806*	$66.49	$68.71
86334	$31.21	$32.25	*86671*	$17.13	$17.70	*86807*	$55.29	$57.13
86335	$41.00	$42.37	*86674*	$19.64	$20.29	*86808*	$41.47	$42.85
86336	$21.77	$22.50	*86677*	$20.28	$20.96	*86812*	$36.06	$37.26
86337	$29.92	$30.92	*86682*	$18.17	$18.78	*86813*	$81.02	$83.72
86340	$21.06	$21.76	*86684*	$22.14	$22.88	*86816*	$38.92	$40.22
86341	$27.65	$28.57	*86687*	$11.72	$12.11	*86817*	$89.95	$92.95

Clinical Laboratory Services (continued)

Code/MD	60%	62%	Code/MD	60%	62%	Code/MD	60%	62%
86821	$78.88	$81.51	*87205*	$5.96	$6.16	*87449* QW	$16.76	$17.32
86822	$51.07	$52.77	*87206*	$7.50	$7.75	*87450*	$13.39	$13.84
86880	$7.50	$7.75	*87207*	$8.37	$8.65	*87451*	$13.39	$13.84
86885	$7.99	$8.26	*87209*	$25.11	$25.95	*87470*	$17.79	$18.38
86886	$7.23	$7.47	*87210*	$5.96	$6.16	*87471*	$41.65	$43.04
86900	$4.17	$4.31	*87210* QW	$5.96	$6.16	*87472*	$59.85	$61.85
86901	$4.17	$4.31	*87220*	$5.96	$6.16	*87475*	$17.79	$18.38
86903	$8.46	$8.74	*87230*	$27.59	$28.51	*87476*	$41.65	$43.04
86904	$13.28	$13.72	*87250*	$27.32	$28.23	*87477*	$59.85	$61.85
86905	$5.34	$5.52	*87252*	$36.42	$37.63	*87480*	$17.79	$18.38
86906	$10.83	$11.19	*87253*	$28.22	$29.16	*87481*	$41.65	$43.04
86940	$11.46	$11.84	*87254*	$27.32	$28.23	*87482*	$58.33	$60.27
86941	$13.27	$13.71	*87255*	$47.31	$48.89	*87485*	$17.79	$18.38
87001	$18.47	$19.09	*87260*	$16.76	$17.32	*87486*	$41.65	$43.04
87003	$23.52	$24.30	*87265*	$16.76	$17.32	*87487*	$59.85	$61.85
87015	$9.33	$9.64	*87267*	$16.76	$17.32	*87490*	$17.79	$18.38
87040	$14.42	$14.90	*87269*	$16.76	$17.32	*87491*	$41.65	$43.04
87045	$13.18	$13.62	*87270*	$16.76	$17.32	*87492*	$48.84	$50.47
87046	$13.18	$13.62	*87271*	$16.76	$17.32	*87495*	$17.79	$18.38
87070	$12.03	$12.43	*87272*	$16.76	$17.32	*87496*	$41.65	$43.04
87071	$13.18	$13.62	*87273*	$16.76	$17.32	*87497*	$59.85	$61.85
87073	$13.18	$13.62	*87274*	$16.76	$17.32	*87498*	$41.65	$43.04
87075	$13.22	$13.66	*87275*	$16.76	$17.32	*87510*	$17.79	$18.38
87076	$11.29	$11.67	*87276*	$16.76	$17.32	*87511*	$41.65	$43.04
87077	$11.29	$11.67	*87277*	$16.76	$17.32	*87512*	$58.33	$60.27
87077 QW	$11.29	$11.67	*87278*	$16.76	$17.32	*87515*	$17.79	$18.38
87081	$9.26	$9.57	*87279*	$16.76	$17.32	*87516*	$41.65	$43.04
87084	$12.03	$12.43	*87280*	$16.76	$17.32	*87517*	$59.85	$61.85
87086	$11.28	$11.66	*87281*	$16.76	$17.32	*87520*	$17.79	$18.38
87088	$11.31	$11.69	*87283*	$16.76	$17.32	*87521*	$41.65	$43.04
87101	$10.77	$11.13	*87285*	$16.76	$17.32	*87522*	$59.85	$61.85
87102	$11.74	$12.13	*87290*	$16.76	$17.32	*87525*	$17.79	$18.38
87103	$12.60	$13.02	*87299*	$16.76	$17.32	*87526*	$41.65	$43.04
87106	$14.42	$14.90	*87300*	$16.76	$17.32	*87527*	$58.33	$60.27
87107	$14.42	$14.90	*87301*	$16.76	$17.32	*87528*	$17.79	$18.38
87109	$21.50	$22.22	*87305*	$16.76	$17.32	*87529*	$41.65	$43.04
87110	$23.73	$24.52	*87320*	$16.76	$17.32	*87530*	$59.85	$61.85
87116	$15.10	$15.60	*87324*	$16.76	$17.32	*87531*	$17.79	$18.38
87118	$15.29	$15.80	*87327*	$16.76	$17.32	*87532*	$41.65	$43.04
87140	$7.79	$8.05	*87328*	$16.76	$17.32	*87533*	$58.33	$60.27
87143	$17.51	$18.09	*87329*	$16.76	$17.32	*87534*	$17.79	$18.38
87147	$7.23	$7.47	*87332*	$16.76	$17.32	*87535*	$41.65	$43.04
87149	$17.79	$18.38	*87335*	$16.76	$17.32	*87536*	$98.47	$101.75
87152	$7.31	$7.55	*87336*	$16.76	$17.32	*87537*	$17.79	$18.38
87158	$7.31	$7.55	*87337*	$16.76	$17.32	*87538*	$41.65	$43.04
87164	$15.01	$15.51	*87338*	$17.19	$17.76	*87539*	$59.85	$61.85
87166	$15.78	$16.31	*87339*	$16.76	$17.32	*87540*	$17.79	$18.38
87168	$5.96	$6.16	*87340*	$14.43	$14.91	*87541*	$41.65	$43.04
87169	$5.96	$6.16	*87341*	$14.43	$14.91	*87542*	$58.33	$60.27
87172	$5.96	$6.16	*87350*	$16.10	$16.64	*87550*	$17.79	$18.38
87176	$8.22	$8.49	*87380*	$22.94	$23.70	*87551*	$41.65	$43.04
87177	$12.43	$12.84	*87385*	$16.76	$17.32	*87552*	$59.85	$61.85
87181	$1.17	$1.21	*87390*	$15.61	$16.13	*87555*	$17.79	$18.38
87184	$9.63	$9.95	*87391*	$15.61	$16.13	*87556*	$41.65	$43.04
87185	$1.17	$1.21	*87400*	$16.76	$17.32	*87557*	$59.85	$61.85
87186	$12.08	$12.48	*87420*	$16.76	$17.32	*87560*	$17.79	$18.38
87187	$14.48	$14.96	*87425*	$16.76	$17.32	*87561*	$41.65	$43.04
87188	$8.12	$8.39	*87427*	$16.76	$17.32	*87562*	$59.85	$61.85
87190	$7.90	$8.16	*87430*	$16.76	$17.32	*87580*	$17.79	$18.38
87197	$20.99	$21.69	*87449*	$16.76	$17.32	*87581*	$41.65	$43.04

Clinical Laboratory Services (continued)

Code/MD	60%	62%	Code/MD	60%	62%	Code/MD	60%	62%
87582	$58.33	$60.27	*87901*	$359.69	$371.68	*88263*	$190.23	$196.57
87590	$17.79	$18.38	*87902*	$359.69	$371.68	*88264*	$174.14	$179.94
87591	$41.65	$43.04	*87903*	$682.72	$705.48	*88267*	$251.17	$259.54
87592	$59.85	$61.85	*87904*	$36.42	$37.63	*88269*	$190.23	$196.57
87620	$17.79	$18.38	*88130*	$21.02	$21.72	*88271*	$20.22	$20.89
87621	$41.65	$43.04	*88140*	$11.17	$11.54	*88272*	$35.39	$36.57
87622	$58.33	$60.27	*88142*	$28.21	$29.15	*88273*	$44.89	$46.39
87640	$41.65	$43.04	*88143*	$28.21	$29.15	*88274*	$48.63	$50.25
87641	$41.65	$43.04	*88147*	$14.76	$14.76	*88275*	$56.11	$57.98
87650	$17.79	$18.38	*88148*	$14.76	$14.76	*88280*	$35.07	$36.24
87651	$41.65	$43.04	*88150*	$14.76	$14.76	*88283*	$95.84	$99.03
87652	$58.33	$60.27	*88152*	$14.76	$14.76	*88285*	$26.54	$27.42
87640	$41.65	$43.04	*88153*	$14.76	$14.76	*88289*	$40.56	$41.91
87660	$17.79	$18.38	*88154*	$14.76	$14.76	*88371*	$31.05	$32.09
87797	$17.79	$18.38	*88155*	$8.37	$8.65	*88372*	$31.79	$32.85
87798	$41.65	$43.04	*88164*	$14.76	$14.76	*88400*	$7.02	$7.25
87799	$59.85	$61.85	*88165*	$14.76	$14.76	*89050*	$6.61	$6.83
87800	$35.58	$36.77	*88166*	$14.76	$14.76	*89051*	$7.70	$7.96
87801	$83.30	$86.08	*88167*	$14.76	$14.76	*89055*	$5.96	$6.16
87802	$16.76	$17.32	*88174*	$29.39	$30.37	*89060*	$9.99	$10.32
87803	$16.76	$17.32	*88175*	$34.70	$35.86	*89125*	$6.03	$6.23
87804	$16.76	$17.32	*88230*	$162.77	$168.20	*89160*	$5.15	$5.32
87804 QW	$16.76	$17.32	*88233*	$196.63	$203.18	*89190*	$6.64	$6.86
87807	$16.76	$17.32	*88235*	$205.74	$212.60	*89225*	$4.67	$4.83
87807 QW	$16.76	$17.32	*88237*	$176.47	$182.35	*89235*	$7.69	$7.95
87808	$16.76	$17.32	*88239*	$206.12	$212.99	*89300*	$12.45	$12.87
87810	$16.76	$17.32	*88240*	$14.11	$14.58	*89300* QW	$12.45	$12.87
87850	$16.76	$17.32	*88241*	$14.11	$14.58	*89310*	$12.03	$12.43
87880	$16.76	$17.32	*88245*	$190.23	$196.57	*89320*	$16.84	$17.40
87880 QW	$16.76	$17.32	*88248*	$241.96	$250.03	*89321*	$16.84	$17.40
87899	$16.76	$17.32	*88249*	$241.96	$250.03	*89325*	$14.91	$15.41
87899 QW	$16.76	$17.32	*88261*	$246.93	$255.16	*89329*	$29.30	$30.28
87900	$182.11	$188.18	*88262*	$174.14	$179.94	*89330*	$13.83	$14.29

Source: CMS Pub. 100-04, Transmittal 1122, CR 5362

ELECTRONIC DATA INTERCHANGE

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), Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs)) for services.

Provider Action Needed

Change request 5346, from which this article is taken, announces the latest update of X12N 835 health care remittance advice remark codes and X12N 835 and 837 health care claim adjustment reason codes, effective January 2, 2007. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at *http://wpc-edi.com/codes*. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5346, effective on and after January 1, 2007.

CMS has also developed a new tool to help you search for a specific category of code and that tool is at *http://www.cmsremarkcodes.info*. Note that this website does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest remittance advice remark code and claim adjustment reason code updates by going to CR 5346, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1087CP.pdf*.

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

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

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

Remittance Advice Remark Code Changes

Code	New/Modified/ Deactivated/ Retired	Current Narrative	Comment
N370	New	Billing exceeds the rental months covered/approved by the payer.	Medicare initiated
N371	New	Alert: title of this equipment must be transferred to the patient. *	Medicare initiated
N372	New	Only reasonable and necessary maintenance/service charges are covered.	Medicare initiated
MA02	Modified	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.	Modified effective 8/1/06
M114	Modified	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, contact your local contractor.	Modified effective 8/1/06
N199	Modified	Additional payment/recoupment approved based on payer-initiated review/audit.	Modified effective 8/1/06

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

There are no deactivated remittance advice remark code changes.

***Note:** Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

These informational codes will be used only if specific information needs to be communicated but not as default codes.

Reason Code Changes

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
196	New	Claim/service denied based on prior payer's coverage determination	New as of June, 2006
16	Modified	Claim/service lacks information that is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
17	Modified	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
96	Modified	Noncovered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
125	Modified	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
43	Retired	Gramm-Rudman reduction.	Modified as of June, 2006, and deactivated on July 1, 2006

MLN Matters Number: MM5346
Related Change Request (CR) Number: 5346
Related CR Release Date: October 27, 2006
Related CR Transmittal Number: R1087CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1087, CR 5346

Revised American National Standards Institute (ANSI) 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 submitting claims to Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5334, which informs your FI, RHHI, or A/B MAC that changes (including national provider identifier (NPI) and taxonomy code reporting information changes) are being made to the ANSI X12 837 Institutional Companion Document, which is included with CR 5334 as an attachment.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires that the Centers for Medicare & Medicaid Services (CMS), and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health & Human Services.

The American National Standards Institute (ANSI) X12N 837 implementation guides have been 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. Implementation guides for each ANSI X12N transaction adopted as a HIPAA standard may be found at the following website: *http://www.wpc-edi.com*.

The ANSI X12 837 Institutional Companion Document includes a set of statements, which supplements the requirements (but does not contradict) the X12N 837 Institutional Implementation Guide, and it clarifies Medicare contractor (FI/RHHI/A/B MAC) expectations regarding data submission, processing, and adjudication.

Change Request (CR) 5334:

- Provides your FI, RHHI, or A/B MAC with changes needed to the ANSI X12 837 Institutional Companion Document as an attachment.
- Instructs your FI, RHHI, or A/B MAC to use these changes (which include adding a requirement to report, as of May 23, 2007, the national provider identifier (NPI) and taxonomy code reporting information) to revise/update your ANSI X12 837 Institutional Companion document.

The revised/updated ANSI X12N 837 Institutional Companion Document will be available through your Medicare FI, A/B MAC, or RHHI.

Implementation

The implementation date for CR 5334 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your FI, RHHI, or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1116CP.pdf*.

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

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

MLN Matters Number: MM5334
Related Change Request (CR) Number: 5334
Related CR Release Date: November 24, 2006
Related CR Transmittal Number: R1116CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1116, CR 5334

Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims

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

Note: CMS has revised for the third and fourth time this *MLN Matters* article on November 24, and December 20, 2006, to reflect changes made to CR 5243. CR 5243 had erroneously restored a portion of the taxonomy code definition and this restored portion has now been deleted. In addition, some billing instructions have been revised to provider additional clarity. The article was also revised to reflect the new CR transmittal number, CR release date, and the Web address for accessing CR 5243. All other information remains the same. The second revision to this article was published in the December 2006 *Medicare A Bulletin* (pages 40-42).

Provider Types Affected

Institutional providers who bill Medicare fiscal intermediaries (FIs) for their services.

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

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

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

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Short-term (general and specialty) hospitals	0001-0879 *positions 3-6 of the OSCAR number	282N00000X
Critical access hospitals	1300-1399*	282NC0060X
Long-term care hospitals (LTCH swing beds submitting with type of bill [TOB] 18x must use the LTCH taxonomy code)	2000-2299*	282E00000X
Hospital-based renal dialysis facilities	2300-2499*	261QE0700X
Independent-renal dialysis facilities	2500-2899*	261QE0700X
Rehabilitation hospitals	3025-3099*	283X00000X
Children's hospitals	3300-3399*	282NC2000X
Hospital-based satellite renal dialysis facilities	3500-3699	TOB 72x and taxonomy code of 261QE0700X and a ZIP code different than any renal dialysis facility issued an OSCAR number that is located on that hospital's campus
Psychiatric hospitals	4000-4499*	283Q00000X

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Organ procurement organization (OPO)	P in third position of the OSCAR number	335U00000X
Psychiatric unit	M or S in third Position	273R00000X
Rehabilitation unit	R or T in third Position	273Y00000X
Swing-bed unit/facility	U, W, Y, or Z in third position	TOB X8X with one of the following to show type of facility in which the swing-bed is located: 275N00000X short term hospital (U); 282E00000X long-term care hospital (W); 283X00000X rehabilitation facility (Y); or 282NC0060X critical access hospital (Z)

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

- Report the service facility locator loop (2310E) in an 837-I claim whenever the service was furnished at an address other than the address reported on the claim for the billing or pay-to-provider.
- Input the taxonomy code in the 837-I provider loop 2000A (billing or pay-to-provider taxonomy code).
- Submit separate batches of claims for each subpart identified by a different taxonomy code.
- Providers submitting claims for their primary facility and its subparts must submit a nine-digit ZIP code on their claims.
- Submitters of institutional claims (X12 837-I version 4010A1) that bill and are to be paid for services furnished by a subpart, **and** that **subpart does** not have a unique NPI separate from that of the main entity or another subpart, the subpart that furnished the billed care must be identified in the billing provider loop (2010AA) of the claim and the entity to be paid in the pay-to provider loop (2010AB). The taxonomy code of the subpart must also be reported in the PRV segment in the 2000A loop.
- CMS recommends submitting both the OSCAR number and the NPI on claims submitted through May 22, 2007. (Note that failure to report an OSCAR number that corresponds to your NPI could result in a payment delay.)

Implementation Date

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

Additional Information

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

CR 5243 is the official instruction issued to your Medicare FI regarding changes mentioned in this article. CR 5243 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1133CP.pdf*.

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

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

MLN Matters Number: MM5243 – Revised
Related Change Request (CR) Number: 5243
Related CR Release Date: December 19, 2006
Related CR Transmittal Number: R1133CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1133, CR 5243

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

January 2007 – March 2007

NPI CMS Module-4 & 5

When: **Thursday, January 18, 2007**

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

Type of Event: **Educational Webcast**

Ask the Contractor (Topics To Be Determined)

When: **Tuesday, February 13, 2007**

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

Type of Event: **Teleconference**

2007 Medifest Symposium (Medicare Part A and B)

When: **Tuesday-Thursday, March 13-15, 2007**

Where: **Jacksonville Marriott**
4670 Salisbury Road
Jacksonville, FL 32256

Type of Event: **Educational Seminar**

Hot Topics (Topics To Be Determined)

When: **Tuesday, March 20, 2007**

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

Type of Event: **Teleconference**

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

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

What Is a Webcast?

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

Online Registration

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Provider Address: _____

City, State, ZIP Code: _____

PREVENTIVE SERVICES

Medicare Immunization Billing Chart Available to Order

The *Quick Reference Information: Medicare Immunization Billing* chart is now available in hardcopy or as a download from the *Medicare Learning Network*. This two-sided laminated chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals quick information to assist with filing claims for influenza, pneumococcal polysaccharide (PPV), and hepatitis B (HBV) vaccines and their administration.

To download, view and print the chart go to *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf* or a hardcopy of the chart may be ordered through the Medicare Learning Network Product Ordering Page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*. ❖

Source: CMS Provider Education Resource 200612-07

***Third-party Websites**. 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.*

EDUCATIONAL RESOURCES

Understanding the Remittance Advice for Professional Providers Web-based Training now Available

Understanding the Remittance Advice for Professional Providers Web-based training (WBT) course is now available through the *Medicare Learning Network*. This WBT course is designed to provide professional providers and their billing staff with general remittance advice (RA) information. This course provides instructions to help professional providers interpret the RA received from Medicare and reconcile it against submitted claims. Course participants will receive guidance on how to read electronic remittance advices (ERAs) and standard paper remittance advices (SPRs). The course also provides an overview of software that Medicare provides free to providers for viewing ERAs.

The course takes approximately 90 minutes to complete and participants may receive .2 CEUs for successful completion. To register to take this WBT course participants may go to the *Medicare Learning Network's* Product Ordering Page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* and click on the course title. ❖

Source: CMS Provider Education Resource 200612-06

***Third-party Websites**. 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.*

Hospital Outpatient Prospective Payment System Fact Sheet now Available

The *Hospital Outpatient Prospective Payment System Fact Sheet*, which provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment rates are set, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network (MLN). To place your order, visit *http://www.cms.hhs.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page." ❖

Source: CMS Provider Education Resource 200612-09

Hospice Payment System Fact Sheet now Available

The *Hospice Payment System Fact Sheet*, which provides general information about the Medicare hospice benefit, certification requirements, election periods, and payment rates, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network.

To place your order, visit *http://www.cms.hhs.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page." ❖

Source: CMS Provider Education Resource 200612-03

ORDER FORM - PART A MATERIALS

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

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
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Medicare Publications – ROC 10T

P.O. Box 45280

Jacksonville, FL 32232-5280

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Attention:_____ Area Code/Telephone Number:_____

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ALL ORDERS MUST BE PREPAID –

DO NOT FAX - PLEASE PRINT

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

IMPORTANT ADDRESSES, TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

PROVIDER EDUCATION

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

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION

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

OVERPAYMENT COLLECTIONS

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

MEDICARE REGISTRATION

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

Telephone Numbers

PROVIDERS

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

BENEFICIARY

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

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Websites

PROVIDERS

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

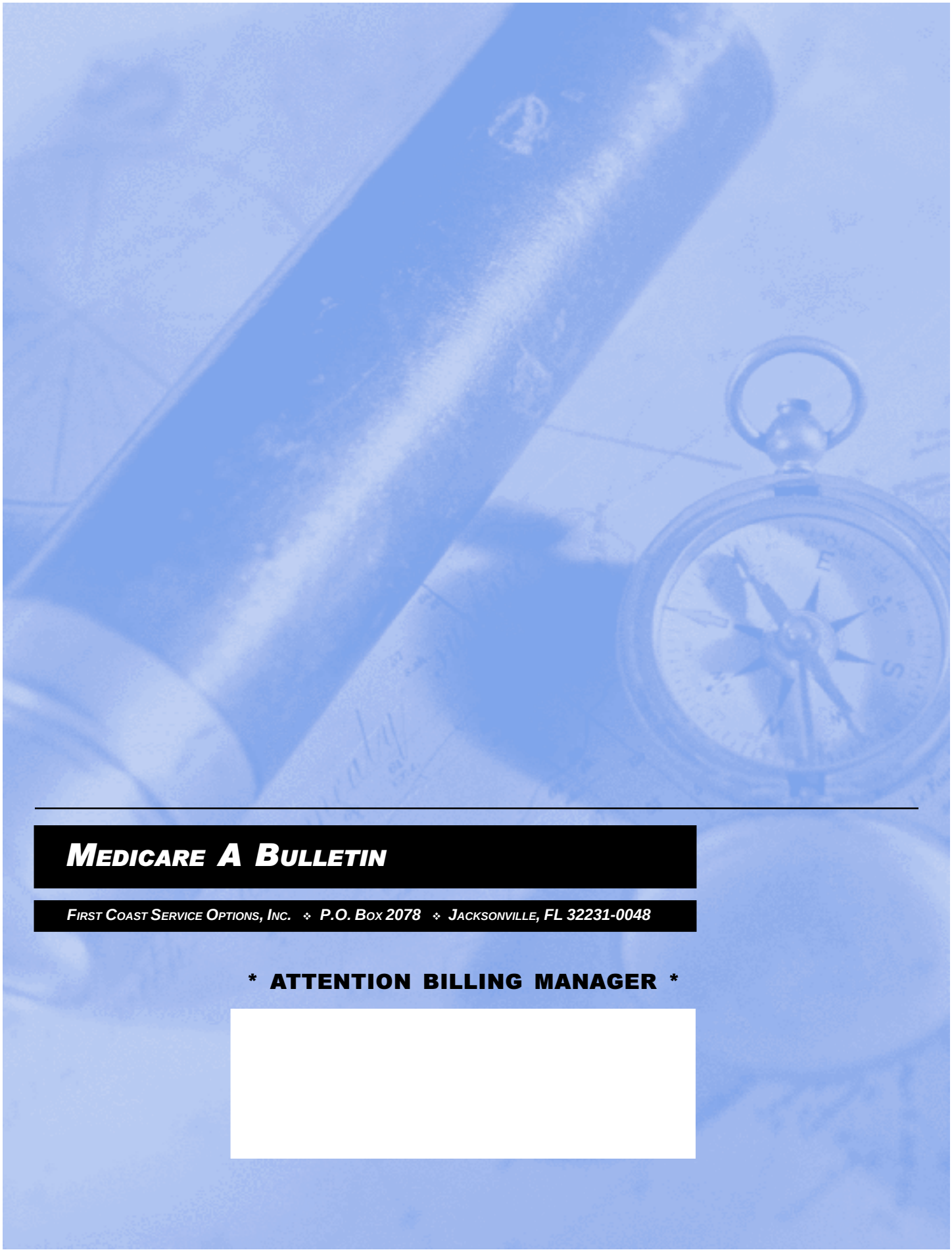
Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators – Gulf Coast
34650 US Highway 19 North, Suite 202
Palm Harbour, FL 34684-2156

RAILROAD MEDICARE

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

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



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*** ATTENTION BILLING MANAGER ***