

# Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers



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**T**he 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](http://www.floridamedicare.com).

#### Routing Suggestions :

- Medicare Manager
- Reimbursement Director
- Chief Financial Officer
- Compliance Officer
- DRG Coordinator
- \_\_\_\_\_
- \_\_\_\_\_
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**Medicare A Bulletin**

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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 publication developed 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 between publications will be posted to the FCSO Medicare provider education Web site <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 download 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 Enrollment department. Please remember that address changes must be done using the appropriate 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 Web site information, and reproducible forms.
- Important addresses and phone numbers are in the back of every issue.

**The Medicare A Bulletin Represents Formal Notice of Coverage Policies**

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

**Do You Have Comments?**

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

Editor, *Medicare A Bulletin*  
 Medicare Publications – 4C  
 P.O. Box 45270  
 Jacksonville, FL 32232-5270

**Sign up to our eNews electronic mailing list**

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

# PROVIDER ENROLLMENT

## Tips to Expedite your Medicare Enrollment Process

Medicare Enrollment Applications/Forms (**CMS-855A, CMS-855B, CMS-855I, CMS-855R and CMS-855S, 06/06 versions**) submitted to First Coast Service Options, Inc. (FCSO) must be completed with accurate information and must have all supporting documentation attached. FCSO Provider Enrollment staff will review all submitted applications, and as necessary, will send a letter asking for additional information and/or documentation. The following tips regard the most common reasons for which FCSO **must** request additional information and/or documentation.

**1. Ensure the name reflected on your National Provider Identifier (NPI) application form identically matches your legal business name.**

Access the following Web site address or phone number to validate that the legal business name the Internal Revenue Service (IRS) has for you (CP-575) matches the business name registered with the National Plan & Provider Enumeration System (NPES): <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, 1-800-465-3203 or 1-800-692-2326 for TTY services.

Applying for an NPI is a separate process from requesting provider enrollment in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) **requires** that providers and suppliers obtain their NPI prior to enrolling for, or updating, their Medicare enrollment information. Based on this regulation, **each** enrollment application form (initial applications and changes/updates) **must** include your NPI and a copy of the NPI notification from the NPI contractor. If your NPI and the NPI notification letter are not submitted, your enrollment into the Medicare program will be delayed.

FCSO will send a letter to the **contact person** you named in Section 13 of the enrollment application, **or** if there is no contact person listed, the letter will be sent to your **correspondence address**.

**2. Attach a copy of your Internal Revenue Service (IRS) CP-575 form.**

The IRS CP-575 is a letter you receive from the IRS granting your employer identification number (EIN). This IRS form reflects your legal business name. It also provides proof of your employer tax identification number (TIN), which is required for FCSO's Medicare records.

Medicare records **must** have a written confirmation from the IRS validating your TIN with your legal business name. Acceptable tax documents **must be generated or pre-printed by the IRS**. Examples of acceptable documentation are IRS CP-575, IRS Form

8109 and IRS substitute letter 147C. A W-9 is **not** acceptable documentation.

- 3. Attach a copy of your Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588 – not to be confused with CMS-855 enrollment forms).** FCSO requires this form if you are submitting an initial Provider Enrollment Application **or** a change to an existing Medicare provider number that has not previously been set up for EFT. Remember to **also include** a copy of a voided check and/or a deposit slip. Be aware that with the EFT authorization, Medicare can send payments directly to your financial institution whether claims are filed electronically or on paper.

**Note:** FCSO has determined that some banks may not use the routing number located at the bottom of your pre-printed check or deposit ticket for direct deposits but may use the automated clearing house (ACH) number located elsewhere on the check or deposit ticket. Please check with your bank for the proper number to report as the routing number on your EFT form.

- 4. Read each section of the application form(s)** For each section of the Provider Enrollment forms, CMS has provided detailed instructions. Ensure that, where applicable, boxes are checked, signatures (in ink) are provided and all required fields have been completed.

**5. Include copies of all professional and business licenses.**

Examples include, but are not limited to:

- Occupational licenses – Check with your city and county for applicable licensure requirements
- Licenses, certifications and registrations required by your state, city and/or county boards (e.g., State of Florida Professional License, CRNA Recertification, Health Care Clinic Licenses, Radiation Control License, FDA Mammography Certification, CLIA, Diabetes Education Certificate)
- Certifications and/or registrations required to operate a health care facility
- Health care clinic licenses ([http://www.fdhc.state.fl.us/MCHQ/Health\\_Facility\\_Regulation/HealthCareClinic/index.shtml](http://www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/HealthCareClinic/index.shtml))
- Certified registered nurse anesthetists licenses (<http://www.aana.com>)
- Provisional licenses



*Tips to Expedite your Medicare Enrollment Process (continued)***6. Obtain other helpful information**

- Within the instructions in the “Medicare Enrollment Application” itself. See “Tips,” and Section 17 “Supporting Documents.”
- From your Medical Association or Medical Society.
- At the CMS Web site (<http://www.cms.hhs.gov/>).
- At the Florida State Requirements Web site (<http://www.doh-mqaservices.com/>).
- At the Florida Department of Business and Professional Regulations Web site (<http://www.myflorida.com/>)

**7. Send all Provider Enrollment Applications to the following address:**

First Coast Service Options, Inc.  
P.O. Box 44021  
Jacksonville, Florida 32231-4021

**Ask the Contractor Teleconference (ACT)**

**Tuesday, August 14, 2007**

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

**D**o you have questions on the changes the Centers for Medicare & Medicaid Services (CMS) has implemented for Provider Enrollment?

- Should you or shouldn't you complete the CMS-855 enrollment application?
- What is required to start submitting claims with the National Provider Identifier (NPI)?

If you have questions, this conference call is for you. Get answers to your questions by Medicare subject matter experts.

*Don't miss out on this opportunity to interact directly with your Medicare contractor.*

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# GENERAL INFORMATION

## Appeals Transition—BIPA Section 521 Appeals

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, 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) 5460, which notifies Medicare contractors about their need to comply with changes to provisions in Chapter 29 of the *Medicare Claims Processing Manual* (Publication 100-04) that address the appointment of representatives, fraud and abuse, guidelines for writing appeals correspondence, and the disclosure of information.

### Background

The Medicare claims appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) and the Medicare Prescription Drug Improvement and Modernization Act (MMA). The Social Security Act (Section 1869(c)), as amended by BIPA and MMA, requires changes to the *Code of Federal Regulations* (CFR; Title 42) regarding:

- Appointment of representatives
- Fraud and abuse
- Guidelines for writing appeals correspondence
- The disclosure of information.

Therefore, the Centers for Medicare & Medicaid Services (CMS) is revising provisions in Chapter 29 of the *Medicare Claims Processing Manual* that address these changes.

The purpose of CR 5460 is to notify Medicare contractors about their need to comply with these revised *Medicare Claims Processing Manual* provisions, which are included as an attachment to CR 5460.

Some of the key changes to the manual direct Medicare contractors to:

- Follow the procedures that define who may be a representative and how a representative is appointed via the Appointment of Representative (AOR) form (CMS-1696).
  - Do not accept an appointment if the contractor has evidence that the appointment should not be honored.
  - Send notice only to the representative when the contractor takes action or issues a redetermination (if there is an appointed representative).
  - Provide assistance in completing the CMS-1696 form, as needed.

- Do not release beneficiary-specific information to a representative before the beneficiary or appellant and the prospective representative have completed and signed the CMS-1696 or other conforming written instrument.

**Note:** The AOR applies to all services, claims and appeals submitted on behalf of the beneficiary for the duration of the AOR.

- Follow the procedures that describe the process a beneficiary must use to assign their appeal rights to a provider via the Transfer of Appeal Rights form (CMS-20031).
    - For each new appeal request, a form needs to be submitted, this form is valid for all levels of the appeal process including judicial review, even in the event of the death of the beneficiary.
    - If a provider furnishes the service, he/she would be a party to the initial determinations, only providers or suppliers who are not a party may accept assignment of appeal rights from a beneficiary. That is assignment of appeal rights applies only to providers and suppliers who are never a party to an appeal because they do not participate in Medicare and have not taken the claim on assignment.
    - The provider or supplier who accepts the appeal rights to collect payment from the beneficiary for the item or service that is the subject of the appeal. The provider or supplier may collect any applicable deductible or coinsurance. The provider or supplier agrees to this waiver by completing and signing section II of the Transfer of Appeal Rights form.
  - Provide redetermination letters that are understandable to beneficiaries.
- Note:** An **Assignment of Appeal Rights** is valid for the duration of an appeal unless the beneficiary revokes it.

### Additional Information

The official instruction, CR 5460, issued to your Medicare contractor regarding this change may be viewed on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R1274CP.pdf>.

The revised portions of the *Medicare Claims Processing Manual* are attached to that CR.

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

*Appeals Transition—BIPA Section 521 Appeals (continued)*

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-888-664-4112.

MLN Matters Number: MM5460

Related Change Request (CR) Number: 5460

Related CR Release Date: June 29, 2007

Related CR Transmittal Number: R1274CP

Effective Date: July 1, 2007

Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1274, CR 5460

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

## Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D

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

### Provider Types Affected

Physicians, pharmacists, health care professionals, suppliers, and their staff.

### Provider Action Needed

This special edition *MLN Matters* article describes the Centers for Medicare & Medicaid Services (CMS) policy regarding provider reimbursement for Part D vaccines and vaccine administration in 2007 and 2008 under the Medicare Prescription Drug Benefit (Part D). In addition, the article outlines various approaches that Part D plans may implement to ensure beneficiaries have adequate access to Part D vaccines.

### Background

With the advent of the Medicare Part D program, there is now broader reimbursement available to providers for vaccines administered to Medicare beneficiaries. Some vaccines are covered under Medicare Part B and others under Part D. The Part B program covers most of the vaccines indicated for the Medicare population, with the immunizer administering the vaccine and billing the Part B contractor (Medicare carrier or Part A/B Medicare administrative contractor or A/B MAC) for both the vaccine and its associated administration. The Part D program generally covers those vaccines not available under Part B; however, unlike Part B, the immunizer may or may not be able to directly bill the Part D sponsor for the vaccine and its administration, but instead may need to work with the beneficiary and his/her Part D plan to facilitate reimbursement. The first step is for the provider to understand which vaccines are available under the two different programs so he/she can assist the beneficiary in obtaining the vaccines needed to maintain and improve his/her health.

### Coverage of Vaccines Under the Part B Program

Medicare Part B currently covers the following immunizations:

- Pneumococcal pneumonia vaccine
- Influenza virus vaccine
- Hepatitis B vaccine for individuals at high or intermediate risk
- Other vaccines (e.g. tetanus toxoid) when directly

related to the treatment of an injury or direct exposure to a disease or condition.

**If a vaccine is covered under Part B, it will continue to be covered under Part B regardless of the changes to Part D vaccine administration reimbursement in 2007 and 2008 discussed later in this article.**

### Coverage of Vaccines Under the Part D Program

The Part D program will generally cover those vaccines not available for reimbursement under Medicare Parts A or B when administration is reasonable and necessary for the prevention of illness.

Part D plans identify covered drugs and vaccines through the use of formularies. However, a new preventative vaccine may not be specifically listed on the Part D plan's formulary. This does not mean the vaccine is not available for reimbursement. The provider can contact the Part D plan about coverage and any supporting information that might be necessary to facilitate vaccine coverage for the beneficiary (Part D plan contact information is located at the end of this article).

To facilitate greater access to Part D vaccines, CMS has directed that starting in 2008 all Part D plans' formularies must contain all commercially available vaccines (unless excluded due to available reimbursement under Part B, e.g., influenza or pneumococcal vaccines as discussed above).

### Example of Identifying Vaccines Covered Under Part B or Part D

Hepatitis B vaccine provides a useful illustration of how a provider could approach vaccine reimbursement under Medicare Part B or D. **Part B covers hepatitis B vaccine for intermediate and high-risk patients.** A beneficiary meeting the intermediate or high-risk coverage criteria could obtain the hepatitis B vaccination series from their physician and the physician would submit a claim to the Medicare Part B contractor. For the beneficiary who did not satisfy the appropriate Part B risk criteria, he or she could still obtain the hepatitis B vaccine from their physician; however, any potential reimbursement would be available from the beneficiary's Part D plan instead of the Part B contractor. Facilitation of Part D vaccine reimbursement is discussed later in this article.

**Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D (continued)****Coverage of Vaccine Administration Under the Part B Program**

The Tax Relief and Health Care Act (TRHCA), effective January 1, 2007, provided for reimbursement of vaccine administration associated with Part D vaccines. Pharmacies and physicians can use a newly instituted G code (G0377) to bill Part D vaccine administration to local Medicare Part B contractors. Normal Part B beneficiary deductible and coinsurance requirements apply and **reimbursement for this code is only effective for calendar year 2007.**

**Payment for the actual Part D covered vaccine is the responsibility of the beneficiary's Part D plan. In other words, in 2007 Medicare Part B will not pay for the Part D vaccine (i.e. low-risk hepatitis B vaccine), just the Part D vaccine administration.**

For additional information on Part B reimbursement of Part D vaccine administration in 2007, see the *MLN Matters* articles MM5443 and MM5459, published in December 2006:

- MM5443 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5443.pdf>
- MM5459 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf>.

**Coverage of Vaccine Administration Under the Part D Program**

TRHCA modified the definition of a Part D drug to include "for [Part D] vaccines administered on or after January 1, 2008, its administration." Consequently, beginning on January 1, 2008, the Part D program will cover vaccine administration costs associated with Part D vaccines. **Thus, the coverage available in 2007 under Part B will cease and reimbursement will be available solely under Part D.** CMS interprets this new statutory requirement to mean that the Part D vaccine administration costs are a component of the negotiated price for a Part D-covered vaccine. In other words, the negotiated price for a Part D vaccine will be comprised of the vaccine ingredient cost, a dispensing fee (if applicable), sales tax (if applicable) and a vaccine administration fee. This interpretation recognizes the intrinsic linkage that exists between the vaccine and its corresponding administration, since a beneficiary would never purchase a vaccine without the expectation that it would be administered.

In general, CMS believes that Part D vaccines, including the associated administration costs, should be billed on one claim for both in- and out-of-network situations. For example, if an in-network pharmacy dispenses and administers the vaccine in accordance with state law, the pharmacy would process a single claim to the Part D sponsor and collect from the enrollee any applicable cost sharing on the vaccine and its administration.

Alternatively, if a vaccine is administered out-of-network in a physician's office, the physician would administer the vaccine and then bill the beneficiary for the entire charge, including both components. The beneficiary would, in turn, submit a paper claim to the Part D sponsor for reimbursement of plan allowable costs for both the vaccine cost and the administration fee.

**Cost-Sharing Considerations**

In general, a Part D plan should not charge separate copays for the vaccine and its administration since CMS views the vaccine and its administration as intrinsically linked. If a Part D plan charges coinsurance, it should be applied relative to the entire price of both components. Low income subsidy eligible individuals with copays set by statute (see section 1860D-14(a)(1)(D) of the Social Security Act) will always pay only one copay for a vaccine and all related charges. Thus, for example, a low income subsidy eligible individual entitled to \$1.05/\$3.10 copays in 2008 would pay only \$3.10 for both the vaccine and its administration (and any applicable dispensing fee) even if the components are billed separately.

**Elements of Vaccine Administration**

CMS expects that Part D plans will take into consideration the elements reflected in existing 2007 Part B vaccine administration fees when establishing their own vaccine administration fees for 2008. Part D plans will have the discretion to implement either a single vaccine administration fee for all vaccines or multiple administration fees based on type of vaccine, variance in provider type, and product administration complexity. Providers should contact Part D plans regarding specific vaccine administration fees for 2008. (Part D plan contact information is listed at the end of this article.)

**Part D Reimbursement for Vaccines in Provider Settings**

As stated earlier, Part D plans are required to provide access to vaccines not covered under Parts A or B. During initial Part D rulemaking, CMS described use of standard out-of-network requirements to ensure adequate access to the small number of vaccines covered under Part D that are administered in a physician's office. CMS approach was based on the fact that most vaccines of interest for the Medicare population (influenza, pneumococcal, and hepatitis B for intermediate and high-risk patients) were covered and remain covered under Part B. For those that are not covered under Part B, the beneficiary would pay the physician and then submit a paper claim to his or her Part D plan for reimbursement up to the plan's allowable charge. In the absence of communication with the plan prior to vaccine administration, the amount the physician charges may be different from the plan's allowable charge, and a differential may remain that the beneficiary will be responsible for paying.

As newer vaccines have entered the market with indications for use in the Medicare population, Part D vaccine in-network access has become more imperative. Requiring the beneficiary to pay the physician's full charge for a vaccine out of pocket first and be reimbursed by the plan later is not an optimal solution, and CMS has urged Part D plans to implement cost-effective, real-time billing options at the time of administration. CMS issued guidance to Part D plans to investigate alternative approaches to improve access to vaccines under the drug benefit without requiring up-front beneficiary payment and to ensure adequate access to Part D vaccines.

CMS outlined the following options to Part D plans for their consideration. Physicians should expect to see various models develop and should be aware of both their potential existence and use by Medicare beneficiaries.



*Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D (continued)***Options to Ensure Adequate Access Under Part D to Covered Vaccines****In-Network Distribution Approaches**

- **In-Network Access to Retail Pharmacies:** Enrollees could obtain a prescription from the physician and bring it to their local network retail pharmacy for filling. In some states, it will already be possible for the vaccine to be administered by the pharmacist. Forty-six states currently allow pharmacists to provide some type of vaccinations. When it is safe to dispense and administer these vaccines in the pharmacy, plans will be exploring utilization of their network pharmacists as a provider of adult Medicare Part D vaccines.
- **In-Network Pharmacy Distribution:** A Part D plan's local pharmacy or specialty pharmacy could provide vaccines directly to physician offices. Under this scenario, the physician could call in a prescription, or the beneficiary could deliver or mail a prescription for the vaccine to the pharmacy. The pharmacy would fill the prescription for the vaccine, ship or deliver to the physician's office, and bill the Part D plan for the vaccine. (This model resembles the competitive acquisition program (CAP) for Medicare Part B drugs in that the drug is shipped to the physician, but the physician never purchases or gets reimbursed for the drug.)

**Out-of-Network Approaches: Facilitated Out-of-Network Access Approaches**

- **Web-Assisted Out-of-Network Billing:** Under this approach, physicians would electronically submit beneficiary out-of-network claims to Part D plans for vaccines dispensed and administered in the physician's office through a web-assisted portal (vendor). This approach would allow the beneficiary to pay out of pocket only the appropriate deductible and copay or cost sharing directly to the physician, thus avoiding any up-front payment and repayment for the full cost of the vaccine. The physician would assume responsibility for submitting the claim on behalf of the beneficiary and would agree to accept Part D plan payment as payment in full.
- **Model Vaccine Notice for Physicians (Paper Claim Enhancement):** Part D plans would provide all enrollees with a vaccine-specific notice that the enrollees could bring to their physicians. This notice would provide information necessary for a physician to contact the enrollee's Part D plan to receive authorization of coverage for a particular vaccine, reimbursement rates, enrollee cost-sharing to be collected by the physician, and instructions on how to submit the out-of-network claim on the beneficiary's behalf.

**It is important to emphasize for either out-of-network approach, the physician does not become a network provider, but is assisting the beneficiary in the submission of his or her out-of-network claim.**

CMS is working with Part D sponsors to facilitate these various approaches. CMS encourages additional exploration of other possible means to coordinate the billing of vaccines in the real-time environment of the Part D benefit. CMS expects significant development in this area over the next year.

**Frequently Asked Questions****If I Need To Immunize a Beneficiary with a Part D Vaccine, what Do I Need To Do?**

The beneficiary or physician may call the Part D plan to discuss what the cost sharing and allowable charges would be for the vaccine as part of the Part D plan's out-of-network access or inquire as to the availability of any alternative vaccine access options. Plan contact information is available at the following Web site: <http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/MPDPFIntro.asp> and then follow the directions on the section "Learn More About Plans in Your Area." You may also obtain plan contact information by calling 1-800-MEDICARE.

**Do I Need To Provide Advanced Beneficiary Notice?**

No. Unlike traditional Medicare, Part D does not require ABNs.

**Can I Charge an Administration Fee?**

Yes. Administration fees for vaccines could be handled in the following manner:

- Before January 1, 2008: When a physician administers a Part D vaccine, the physician should use HCPCS code G0377 (linked to CPT code 90471) to bill the Part B local carrier for the administration fee of the vaccine.
- January 1, 2008 and after: Part D vaccines, including the associated administration costs could be billed on one claim to the beneficiary or to the Part D plan, as stated in the preceding examples.

**Is the Herpes Zoster Vaccine (trade name Zostavax) Covered Under Medicare Part B or D?**

Since the herpes zoster vaccine is a preventive vaccine, it will be available for reimbursement under Part D. Beneficiaries and providers should contact the Part D plans for more information about costs and reimbursement for this and other preventive vaccines.

**Additional Information**

More information about Part D for physicians is available on the CMS prescription drug Web page for physicians, which is at [http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04\\_Formulary.asp#TopOfPage](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp#TopOfPage).

MLN Matters Number: SE0727

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Related CR Transmittal Number: N/A

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Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0727

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## Charges for Missed Appointments

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], or Part A/B Medicare administrative contractors [A/B MACs]).

### Provider Action Needed

#### STOP – Impact to You

The Centers for Medicaid & Medicare Services (CMS) policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments. However, Medicare itself does not pay for missed appointments, so such charges should not be billed to Medicare.

#### CAUTION – What You Need to Know

Providers may **not charge ONLY** Medicare beneficiaries for missed appointments; they must **also charge non-Medicare patients**. The amount the physician/supplier charges Medicare beneficiaries for missed appointments must be the same as the amount that they charge non-Medicare patients.

#### GO – What You Need to Do

Make certain that your billing staff is aware that you may bill the beneficiary directly, that Medicare itself does **not** make any payments for missed appointments, and that Medicare should not be billed for these charges.

### Background

According to Chapter 12, section 30.3.13 of the *Medicare Claims Processing Manual*, which is attached to change request (CR) 5613, CMS policy allows physicians, providers, and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments and the charges for Medicare and non-Medicare patient are the same. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

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The other key points of CR 5613 are:

- The provider may bill the Medicare beneficiary directly.
- Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers.
- Claims for missed appointments sent to Medicare will be denied with the reason code 204 (This service/equipment/drug is not covered under the patient's current benefit plan.).
- In most instances, a hospital outpatient department can charge a beneficiary a missed appointment charge.
- In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

### Additional Information

For complete details regarding this CR please see the official instruction (CR5613) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1279CP.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 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 1-888-664-4112.

MLN Matters Number: MM5613  
 Related Change Request (CR) Number: 5613  
 Related CR Release Date: June 29, 2007  
 Related CR Transmittal Number: R1279CP  
 Effective Date: October 1, 2007  
 Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1279, CR 5613

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

## Provider Customer Service Program Updates

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

### Provider Types Affected

All physicians, suppliers, and providers who submit written inquiries to, or contact the toll-free lines at, their Medicare contractors [fiscal intermediaries (FIs), carriers, Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment (DME/MACs), and/or regional home health intermediaries (RHHIs)].

### Provider Action Needed

Change request (CR) 5597 contains a number of revisions to the *Medicare Contractor Beneficiary and Provider Communications Manual*, including changes for authenticating providers who make inquiries of Medicare contractors. Due to the Medicare fee-for-service contingency plan for the national provider identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare fee-for-service provider contact centers (PCCs), will be the required authentication element for all inquiries to interactive voice response (IVR) systems, customer service representatives (CSRs), and written inquiry units. **While the authentication rules are part of CR 5597, for complete details about these rules under the Medicare NPI contingency plan, see MLN Matters article SE0721**, which you will find on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf>.

**The remainder of this article provides information on the highlights of changes announced in CR 5597.**

### Background

CR 5597 modifies *Medicare Contractor Beneficiary and Provider Communications Manual*, Publication 100-09. These changes are summarized as follows:

#### Overlapping Claims—New Rules

- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.
- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, health insurance claim number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.

- Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.
- For specific information regarding the resolution of claims rejected by Medicare's common working file (CWF) system, refer to the *Medicare Claims Processing Manual, Chapter 27, Section 50* on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf>.

#### Information Available on the IVR

- **USE THE IVR whenever possible.** Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage you to use the self-service options that are available.
- If at any time during a telephone inquiry, you request information that can be found on the IVR the CSR will most likely refer you back to the IVR.

#### Information Available on the Remittance Advice (RA)

- **THE RA whenever possible.** If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available on the CMS Web site at: [http://www.cms.hhs.gov/AccessstoDataApplication/02\\_MedicareRemitEasyPrint.asp](http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp).
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* which is available on the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf).
- Also available is a Web site that serves as a resource allowing providers to check the definitions of *Claim Adjustment Reason Codes* and *Remittance Advice Remark Codes*. This information is available on the Washington Publishing Company Web site at <http://www.wpc-edi.com/products/codelists/alertservice>.

## Provider Customer Service Program Updates (continued)

- There is a Web-based training course, Understanding the Remittance Advice for Professional Providers, which is available on the CMS Web site at: [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5).

The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading electronic remittance advices (ERAs) and standard paper remittance advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

## Authentication of Beneficiary Elements—Additions to Current Rules

CR 5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR 5597 is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf>.

## Additional Key Points of CR 5597

- Medicare's CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the report of contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the

discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.

- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, **you must notify the contractor before the event.**

## Additional Information

For complete details regarding this CR please see the official instruction (CR 5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to the CMS Web site to <http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf>.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-888-664-4112.

MLN Matters Number: MM5597

Related Change Request (CR) Number: 5597

Related CR Release Date: July 13, 2007

Related CR Transmittal Number: R20COM

Effective Date: May 23, 2007

Implementation Date: July 30, 2007

Source: CMS Pub. 100-09, Transmittal 20, CR 5597

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## Requests for Information Available on the Remittance Advice

New federal regulations and guidelines require Medicare contractors to advise providers to refer to the remittance advice (RA) whenever the contractor receives written or telephone inquiries/questions for which the answers are available on the RA. Providers are also advised that any billing staff or representatives that make inquiries on the provider's behalf will need a copy of the remittance advice in question.

In accordance with this CMS mandate, the provider/representative's needs to refer and research the appropriate RA for any inquiry or question relative to information that can be found on the RA. The Centers for Medicare & Medicaid Services (CMS) is encouraging Medicare providers to use the self-service tools and products available to facilitate and understand the Medicare program.

To educate themselves and their representatives about reading and understanding the RA, providers may take advantage of the training material entitled "Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers" available on CMS Web site [http://www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf). ❖

Source: CMS Pub. 100-09, Transmittal 19, CR 5597



## Problem with Certain Claims Looping and not Finalizing

First Coast Service Options, Inc. (FCSO) is aware that certain claims are continually “looping” and will not finalize. It appears that this problem is occurring on adjustment claims that contain therapy services. Adjustment claims have a type of bill ending in a ‘7’. FCSO is diligently working on resolving this problem and hope to have a resolution in the near future.

### No Action Required by Providers

Please **do not contact** the provider call center on this issue as FCSO will identify all impacted claims and will adjudicate them once the issue has been identified and resolved.

### Important Reminder to Providers

When submitting an adjustment claim, please remember to **completely delete and re-key your claim** and **not** re-image the original claim.

We apologize for any inconvenience this may have caused. ❖

## 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.*

**Note:** CMS has revised this *MLN Matters* article on July 9, 2007, to reference MM5635. *MLN Matters* article MM5635 implemented HCPCS coding changes for immune globulin. On and after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg) will no longer be payable by Medicare. There is a reference to HCPCS code J1567 in this article. To view the new HCPCS codes for immune globulin, please go to the CMS Web site <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5635.pdf>.

The *MLN Matters* article MM5614 was published in the July 2007 *Medicare A Bulletin* (pages 7-8).

### Provider Types Affected

Physicians and providers who submit claims to Medicare contractors (fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], carriers) for services provided to Medicare beneficiaries that are paid based on the Medicare physician fee schedule (MPFS).

### Provider Action Needed

#### STOP – Impact to You

Payment files for the MPFS were issued based on the December 1, 2006 MPFS final rule. Change request (CR) 5614, amends those files and includes new/revised codes for the Physician Quality Reporting Initiative (PQRI).

#### CAUTION – What You Need to Know

Physicians and providers may want to pay particular attention to **Attachment 1** of CR 5614 that identifies the changes included in the July update to the 2007 MPFS database. The **highlights of attachment 1 are:**

- Effective for dates of service **on or after July 1, 2007**, category II **modifier 8P** will be recognized in addition to category II modifiers 1P, 2P and 3P.
- **Note:** **Modifier 8P** is intended to be used as a “reporting modifier” to allow the reporting of circumstances when an action described in a measure numerator is not performed and the reason is not otherwise specified.
- Effective for dates of service **on or after January 1, 2007**, Medicare contractors will update their systems to reflect 11 base units for *CPT* code 00797.
- This CR 5614 lists the new category II HCPCS codes that will be added to the MPFSDB with a status indicator of “M” for the PQRI.

#### GO – What You Need To Do

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

### Background

Section 1848 (c)(4) of the Social Security Act provides for the establishment of the policies needed in order to implement relative values for physician services. CR 5614 is the official document that announces these changes in the Medicare schedule. Rather than duplicate all the additions, deletions and changes in this article, the Centers for Medicare & Medicaid Services (CMS) directs you to **CR 5614, which contains lengthy lists of these items**. CR 5614 is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1258CP.pdf>.

As mentioned above, the key portion of CR 5614 is attachment 1, which includes the following information:

- Several changes retroactive to January 1, 2007. The changes are for the following *CPT/HCPCS* codes:
  - 00797 (base units set to 11)
  - 0115T, 0116T, and 0117T (procedure status is now N)
  - 19301 (short descriptor is partial mastectomy)
  - 33208 (work RVUs set to 8.72)
  - 75365-TC (diagnostic indicator set to 02)
  - 77422, 77423, G9041, G9042, G9043, G9044 (PE RVU changes).
- *CPT* codes 0024T and 0133T are assigned a procedure status of I, effective for dates of service on or after July 1, 2007.
- As previously mentioned, modifier 8P is added for the PQRI program.
- The list of G codes that are no longer used for the PQRI program as of July 1, 2007.

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

- The list of new CPT category II codes, new HCPCS G codes and the new/revised descriptors for the codes that will be used for the PQRI, effective for dates of service on or after July 1, 2007.
- Information on category III codes (0178T through 0180T (all of which deal with electrocardiograms), 0181T (corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report), and 0182T (High dose rate electronic brachytherapy, per fraction), which are effective for dates of service on or after July 1, 2007.
- Effective July 1, 2007, HCPCS codes J1567, J7611, J7612, J7613, and J7614 will be assigned a procedure status of I. (See note regarding J1567.)
- Information related to HCPCS codes Q4087 through Q4095, which are added to the MPFSDB as of July 1, 2007 with a status indicator of E.

Also, attachment 3 (which is informational only) states that the performance payment indicator has been changed to '1' for the extensive list of carrier priced codes identified in attachment 3.

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**Additional Information**

For complete details regarding this CR please see the official instruction (CR 5614) issued to your Medicare carrier, FI, or A/B MAC. That instruction may be viewed by going to the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1258CP.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 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 1-888-664-4112.

MLN Matters Number: MM5614 – Revised  
 Related Change Request (CR) Number: 5614  
 Related CR Release Date: May 29, 2007  
 Related CR Transmittal Number: R1258CP  
 Effective Date: January 1, 2007  
 Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1258, CR 5614

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**Update to the Hospice Payment Rates, Wage Index and PRICER for Fiscal Year 2008**

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

**Provider Types Affected**

Hospices billing Medicare regional home health intermediaries (RHHIs) for hospice services.

**Provider Action Needed**

Be sure billing staff are aware of this information.

**Background**

The law governing the payment for hospice care requires annual updates to the hospice payment rates. Section 1814(i)(1)(C)(ii) of the Social Security Act (the Act) stipulates that the payments for hospice care for fiscal years after 2002 will increase by the market basket percentage increase for the fiscal year (FY). This payment methodology has been codified in regulations found at 42 CFR §418.306(a)(b).

**Hospice Payment Rates**

The FY 2008 payment rates will be the FY 2007 payment rates, increased by 3.3 percentage points, which is the total market basket percentage increase forecasted for FY 2008. The FY 2008 hospice payment rates are effective for care and services furnished **on or after October 1, 2007, through September 30, 2008.**

The national payment rates for revenue codes 651, 652, 655, and 656 for October 1, 2007, through September 30, 2008, are listed in the following table:

Code	Description	Rate	Wage Component Subject to Index	Non-Weighted Amount
651	Routine home care	\$135.11	\$92.83	\$42.28
652	Continuous home care full rate = 24 hours of care \$32.86 hourly rate	\$788.55	\$541.81	\$246.74
655	Inpatient respite care	\$139.76	\$75.65	\$64.11
656	General inpatient care	\$601.02	\$384.71	\$216.31

*Update to the Hospice Payment Rates, Wage Index and PRICER for Fiscal Year 2008 (continued)***Hospice Cap**

The hospice cap is updated annually in accordance with section 1814(i)(2)(B) of the Act and provides for an increase (or decrease) in the hospice cap amount. Specifically, the cap amount is increased or decreased, for accounting years after 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the consumer price index for all urban consumers.

The latest hospice cap amount for the cap year ending October 31, 2007, is \$21,410.04. The hospice cap is discussed further in the *Medicare Claims Processing Manual*, Chapter 11, Processing Hospice Claims, Section 80.2. (See *Additional Information* section for the Web address)

**Hospice-Wage Index**

The hospice-wage index is used to adjust payment rates to reflect local differences in wages according to the revised wage index. The hospice-wage index is updated annually in accordance with recommendations made by a negotiated rulemaking advisory committee as published in the *Federal Register* on August 8, 1997. 42 CFR section 418.306(C) requires that the updated hospice-wage index be published annually as a notice in the *Federal Register*.

The hospice-wage index notice will be effective October 1, 2007, and published in the *Federal Register* before that date. The revised wage index and payment rates will be incorporated in the hospice PRICER and forwarded to your intermediary following publication of the notice.

**Additional Billing Instructions**

Hospices are also advised to refer to CR 5685 for claims processing information. Some key points of CR 5685 are:

- Hospices should split claims if dates of service span fiscal years, e.g., if services span September and October of 2007 so the services can be paid using the correct fiscal year rates.

- If a hospice does not split such claims, the entire claim will be paid at the lower FY 2007 rate and your RHHI will make no subsequent adjustment to the claim.
- Hospices should include the core based statistical area (CBSA) corresponding to the state and county of the beneficiary's home in value code 61 – on claims that include routine home care or continuous home care. Use the *Federal Register* table associating states and counties to CBSA codes (codes in the range of 10180-49740 and 01-65 rural state codes) to determine the code to report in value code 61.
- Medicare systems will use CBSA codes for purposes of wage index adjustment of hospice claims.
- Medicare systems will also use a table of wage index values associated with CBSA codes for FY 2008 hospice payment calculations.

**Additional Information**

For complete details, please see the official instruction issued to your RHHI regarding this change. That instruction may be viewed by going to the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1280CP.pdf>.

The hospice payment rate and cap are discussed further in the *Medicare Claims Processing Manual*, Chapter 11, Processing Hospice Claims, Section 30.2. and Section 80.2. This information may be reviewed on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf>.

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

MLN Matters Number: MM5685

Related Change Request (CR) Number: 5685

Related CR Release Date: June 29, 2007

Related CR Transmittal Number: R1280CP

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1280, CR 5685

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## Deadlines Extended for the DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) is extending the registration and bid submission deadlines for the first round of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) Competitive Bidding Program.

All bids were due by 9:00 p.m. prevailing Eastern Time on July 20, 2007, and the registration deadline was July 7, 2007.

On May 15, 2007, CMS issued a request for bids for the first round of the Medicare DMEPOS competitive bidding program. The original due date was 9:00 p.m. prevailing Eastern Time on July 13, 2007. *All bids were due by 9:00 p.m. prevailing Eastern Time on July 20, 2007.*

Suppliers interested in bidding must first register and receive a user ID and password before they can access the Internet-based bid submission system. Suppliers should register immediately to avoid a delay in being able to submit bids. Registration opened on April 9, 2007. The original registration deadline was June 30, 2007. The registration deadline was extended to July 7, 2007.

Suppliers must be accredited or be pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. For a list of the CMS-approved deemed accreditation organizations, visit <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/>.

For more information on the program, please visit <http://www.dmecompetitivebid.com>. ❖

Source: CMS Provider Education Resource 200706-40

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## Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program

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 July 9, 2007, to add a link to the special edition article SE0717 related to DMEPOS competitive bidding program. All other information remains the same. The *MLN Matters* article SE0714 was published in the June 2007 *Medicare A Bulletin* (pages 14-15).

### Provider Types Affected

All suppliers of durable medical equipment (DME) that wish to participate in the Medicare DME prosthetic and orthotics devices (POS) competitive bidding program.

### Provider Action Needed

This *MLN Matters* special edition (SE) article, SE0714, outlines the pre-bidding activities that DME suppliers need to follow in order to participate in the Medicare DMEPOS competitive bidding program.

### Background

Providers and suppliers that furnish certain DMEPOS to Medicare beneficiaries under Medicare Part B will have an opportunity to participate in a competitive acquisition program (the “Medicare DMEPOS Competitive Bidding Program”). This program will improve the accuracy of Medicare’s payments for certain DMEPOS, reduce beneficiary out-of-pocket expenses, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services.

To assist with the DMEPOS competitive bidding program, CMS awarded a contract to Palmetto GBA to serve as the competitive bidding implementation contractor (CBIC) for program implementation and monitoring.

As the DMEPOS progresses, suppliers may want to view the final rule governing the program, which is available on the CMS Web site at <http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1270f.pdf>.

In addition, you may want to visit <http://www.cms.hhs.gov/competitiveacqfordmepos> for more complete information on the program and the process whereby suppliers can bid and participate.

There are other *MLN Matters* articles on the program. These articles are discussed briefly in the “*Additional Information*” section of this article.

### Basic Instructions

#### All suppliers submitting a bid must:

- Be in good standing and have an active national supplier clearinghouse (NSC) number.
- Meet any local or state licensure requirements, if any, for the item being bid.
- Be accredited or be pending accreditation. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. (For a listing of CMS-approved accrediting organizations, please visit the CMS Web site at [http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS\\_Accreditation\\_Organizations.pdf](http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf).)

*MLN Matters* article SE0713 provides additional information on accreditation and is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf>.



*Pre-Bidding Activities for the Medicare DMEPOS Competitive Bidding Program (continued)*

- Complete initial registration in the Internet application (Individuals Authorized Access CMS computer Services, IACS) to get a USER ID and password. Suppliers need to complete this initial registration process early to avoid delays in being able to submit bids. The initial registration process requires the **authorized official**, as identified in Section 15 of the CMS-855S, to complete the information required in the Internet application. The authorized official's information **must** match the information on file at the national supplier clearinghouse. To complete this initial registration and obtain a USER ID and password, please go to <https://applications.cms.hhs.gov>.
- CMS encourages you to register to receive updates on the competitive bidding program. You may do so by going to the CMS Web site at <http://www.cms.hhs.gov/apps/maillinglists/>.

**Additional Information**

The CMS complete listing of all DME resources is available on the CMS Web site at <http://www.cms.hhs.gov/center/dme.asp>.

A background review of the rationale for this program is on the CMS Web site at [http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME\\_sum.pdf](http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME_sum.pdf).

MLN Matters article SE0713, *Accreditation Information for Suppliers of Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS)*, **relates to** this article and provides an overview of the Medicare Modernization Act legislation and how it impacts this competitive bidding program. It also outlines the quality standards for suppliers, describes the status of accreditation, and provides the Web addresses of the ten accrediting organizations. SE0713 may be viewed on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf>.

Another article, MM5574, provides more overview information regarding the DMEPOS competitive bidding program and that article is on the CMS site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf>.

MLN Matters Number: SE0714 – Revised  
 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 SE0714

**All suppliers submitting a bid should:**

- Review *MLN Matters* article SE0717, “Initial Supplier Registration for Competitive Bidding Program Is Now Open,” which provides important information about the registration process. *MLN Matters* article SE0717 may be viewed on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0717.pdf>.
- Review the information in the bid application tool kit to facilitate a better understanding of the bidding process and rules. This information is located on the CBIC Web site at [http://www.dmecompetitivebid.com/cbic/cbic.nsf/\(subpages\)/CBICSuppliersBid%20Application%20Tool%20Kit](http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersBid%20Application%20Tool%20Kit).
- View the educational Webcast to learn more about the Medicare DMEPOS competitive bidding program and detailed information on the bid application process. This information is located on the CBIC Web site at [http://www.dmecompetitivebid.com/cbic/cbic.nsf/\(subpages\)/CBICSuppliersEducational%20Tools](http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersEducational%20Tools).

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

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## Reporting on the 2007 Physician Quality Reporting Initiative Begins

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that reporting for the 2007 Physician Quality Reporting Initiative (PQRI) on claims for dates of service as of July 1, 2007, has begun. Eligible professionals may now start participating in the PQRI by simply reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor.

Remember, all your informational needs can be met by visiting the PQRI Web site at <http://www.cms.hhs.gov/PQRI>.

Here you will find educational resources, including the PQRI Tool Kit, and links to our most frequently asked questions (FAQs).

CMS also announced the proposed rule that would establish new policies and payment rates for physicians and other providers who are paid under the Medicare physician fee schedule. Included in the proposed rule is important information directly related to 2008 PQRI. To view or download the proposed rule, visit <http://www.cms.hhs.gov/center/physician.asp>, click on CMS-1385-P, then go to page 402 of the document. ❖

Source: CMS Provider Education Resource 200707-05

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## 2007 Physician Quality Reporting Initiative Update

### The Testing Opportunity for the 2007 Physician Quality Reporting Initiative Has Ended

Effective June 30, 2007, Physician Quality Reporting Initiative (PQRI) testing with the G8300 test code ended. Carriers and A/B MACs will no longer accept the test code G8300 on claims.

**Reminder:** For dates of service beginning July 1, 2007, when 2007 PQRI line items are included on claims, the PQRI line item will be denied and remittance advice (RA) remark code message N365, “This procedure code is not payable. It is for reporting/information purposes only” will appear on the RA.

### Updated 2007 Physician Quality Reporting Initiative Educational Resource

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the updated version of The Measure Finder Tool (version 1.1) and user guide are now available as part of the 2007 PQRI Tool Kit – Six Steps to Success.

The Measure Finder Tool (version 1.1) is a slightly modified version of the tool to address a technical problem in Measure Finder Tool (version 1.0). Please delete the previous version of the tool from your computer.

The Measure Finder Tool (version 1.1) is designed to help eligible professionals and their coding/billing staff to quickly search for applicable measures and their detailed specifications. This tool will allow users to search for applicable measures based on a single code or a combination of codes.

The user guide provides instruction on how to use the PQRI Measure Finder Tool (version 1.1).

To access the Tool Kit, visit, <http://www.cms.hhs.gov/PQRI>, on the CMS Web site in the PQRI Tool Kit section. Once on the PQRI Tool Kit page, scroll down to the “Downloads” section. ❖

Source: CMS Provider Education Resource 200706-39  
CMS Provider Education Resource 200706-40

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## New 2007 Physician Quality Reporting Initiative Educational Resource Expands the PQRI Tool Kit

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Measure Finder Tool (version 1.0) is now available as part of the *2007 PQRI Tool Kit – Six Steps to Success*.

The Measure Finder Tool (version 1.0) is designed to help eligible professionals and their coding/billing staff to quickly search for applicable measures and their detailed specifications. This tool will allow users to search for applicable measures based on a single code or a combination of codes.

The addition of this new product expands the tool kit to six new and existing educational resources that will assist eligible professionals with successful reporting.

To access the tool kit, visit, <http://www.cms.hhs.gov/PQRI>, on the CMS Web site in the PQRI Tool Kit section. Once on the PQRI Tool Kit page, scroll down to the “Downloads” section.

### PQRI Question of the Week

**Question:** The 1.5 percent bonus is subject to a cap. How and when will CMS calculate the cap for an individual eligible professional?

**Answer:** The bonus cap calculation is defined as follows: (the individual’s instances of reporting quality data) multiplied by (300 percent) multiplied by (the national average per measure payment). The third factor, the “national average per measure payment amount” can only be calculated after the reporting period ends because it is equal to (the total amount of allowed charges under the physician fee schedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program) divided by (the total number of instances where data were reported by all participants in the program for all measures during the reporting period).

### Example

Because the “national average per measure payment amount” is not yet available, the following is a hypothetical example:

Dr. Smith had \$400,000 in allowed charges during the PQRI reporting period. The 1.5 percent potential bonus is \$6000. Dr. Smith reported quality data codes in 500 instances. The national average per measure payment amount for 2007 was calculated in calendar year (CY) 2008 and turned out to be \$100 (\$100 M total national allowed charges claims submitted from July through December, divided by, one million instances of PQRI quality data codes being reported in the same time period).

The cap for Dr. Smith is \$150,000 (500 x 3 x \$100). The bonus paid to Dr. Smith in early CY 2008 is \$6,000.

Reference: <http://www.cms.hhs.gov/PQRI>. ❖

Source: CMS Provider Education Resource 200706-31

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## Physician Quality Reporting Initiative Letter to Medicare Beneficiaries

The Centers for Medicare & Medicaid Services has posted a letter to Medicare beneficiaries with important information about the Physician Quality Reporting Initiative (PQRI) on the CMS Web site at <http://www.cms.hhs.gov/PQRI>.

The letter is from Medicare to the patient explaining what the program is, and the implications for the patient. Physicians may choose to provide a copy to their patients in support of their PQRI participation. To access the letter, visit the CMS Web site at <http://www.cms.hhs.gov/PQRI>. Once on the *Overview page*, scroll down to the “**Downloads**” section.

### PQRI Questions of the Week

**Q:** If a PQRI quality-data code is not listed on a line adjacent to the correct *Current Procedural Terminology (CPT)* category I code, will the quality data code be accepted?

**A:** Yes, the PQRI analyses will match PQRI quality-data codes to the CPT category I codes that appear on any nondenied service line on the claim, regardless of the order in which the various line items appear.

**Q:** If I report a modifier to a PQRI quality-data code on a claim, when use of that modifier is not specifically allowed per the PQRI measure specifications document, will I get credit for reporting?

**A:** No. In order to be considered an instance of appropriate quality data submission, PQRI quality-data codes should be accurate and reflect valid modifiers as in the measure specifications. Invalid codes will not be included in reporting or performance rate calculations.

**Q:** I have questions about which PQRI measures are most applicable to my specialty and practice, and how best to implement PQRI in my practice. Where can I get more information and advice on these topics?

**A:** For specialty or practice-specific questions, please contact your professional organization or specialty association for guidance. In many cases, these organizations have information and tools to enable successful reporting of PQRI measures available on their Web sites.

**Q:** The 1.5 percent bonus is subject to a cap. How and when will CMS calculate the cap for an individual eligible professional?

**A:** The bonus cap calculation is defined as follows: (the individual’s instances of reporting quality data) multiplied by (300 percent) multiplied by (the national average per measure payment).

The third factor, the “national average per measure payment amount” may only be calculated after the reporting period ends because it is equal to (the total amount of allowed charges under the physician fee schedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program) divided by (the total number of instances where data were reported by all participants in the program for all measures during the reporting period.)

Because the “national average per measure payment amount” is not yet available, the following is a hypothetical example:

#### Example:

Dr. Smith had \$400,000 in allowed charges during the PQRI reporting period.

The 1.5 percent potential bonus is \$6000.

Dr. Smith reported quality data codes in 500 instances.

The national average per measure payment amount for 2007 was calculated in calendar year 2008 and turned out to be \$100 (\$100 M total national allowed charges claims submitted from July through December, divided by, 1 million instances of PQRI quality data codes being reported in the same time period).

The cap for Dr. Smith is \$150,000 (500 x 3 x \$100).

The bonus paid to Dr. Smith in early CY 2008 is \$6,000.

For a complete listing of all questions and answers about the 2007 PQRI, visit the CMS Web site at <http://www.cms.hhs.gov/PQRI>, and click on “All PQRI FAQs” available on any page. ❖

Source: CMS Provider Education Resource 200707-10

## 2007 Physician Quality Reporting Initiative Alert

It has come to the attention of Centers for Medicare & Medicaid Services (CMS) that some clearinghouses are stripping the national provider identifier (NPI) prior to submission of the claim to Medicare. This will adversely affect eligible professionals in that these claims will not count toward Physician Quality Reporting Initiative (PQRI) participation. CMS urges eligible professionals that use clearinghouses to check with their clearinghouse to assure NPIs are not being stripped from claims. If the eligible professional determines that their clearinghouse is stripping NPIs from the claim, the eligible professional may want to consider other billing options.

A recent special edition *MLN Matters* article contains important information for Medicare providers and suppliers, including how to use the NPI correctly on Part A and Part B claims. You may view this article by visiting the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf>. ❖

Source: CMS Provider Education Resource 200707-12

# NATIONAL PROVIDER IDENTIFIER

## Deadline for NPI Updates/Changes/Deletions

**NPI Is Here. NPI Is Now. Are You Using It?**

### CMS Announces the Date by which Updates/Changes/Deletions Must Be Submitted to NPPES in Order to be Reflected in Initial Downloadable File

The Centers for Medicare & Medicaid Services (CMS) will be disseminating provider information contained in the National Plan and Provider Enumeration System (NPPES) that is required to be disclosed under the Freedom of Information Act (FOIA), in accordance with the NPPES Data Dissemination Notice (CMS-6060-N) that was published in the *Federal Register* on May 30, 2007. The notice encouraged providers who have been assigned national provider identifiers (NPIs) to view their NPPES data and to update, change, or delete (where permitted) the data that will be disclosed under the FOIA.

NPPES FOIA-disclosable data will be made available in an initial file that may be downloaded from the Internet, as well as in a query-only database known as the NPI Registry. There will be monthly update files that will also be downloadable from the Internet. CMS will begin disseminating data on August 1, 2007.

CMS has made available a document that will assist providers in making updates, changes, and deletions to the FOIA-disclosable NPPES provider data. The document is entitled, "National Plan and Provider Enumeration System (NPPES) Data Elements – Data Dissemination – Information for Providers" available on the NPI Web site at [http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES\\_FOIA\\_Data%20Elements\\_062007.pdf](http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf).

We strongly recommend that providers read this document as soon as possible.

The initial downloadable file will be created using a "snapshot" of the NPPES FOIA-disclosable provider data as of a specific date. Because the initial downloadable file will be the foundation containing the FOIA-disclosable data for more than 2.2 million providers, it is important that the information in that file be as accurate as possible.

In order for providers' updates, changes, and deletions to be reflected in the initial downloadable file, providers must ensure that their updates, changes, and deletions are submitted to NPPES **no later than July 16, 2007**. To ensure the inclusion of updates, changes, and deletions in the initial downloadable file, July 16 is the last date on which they may be submitted via the Web-based process, and is the last date by which the NPI Enumerator can receive them on the paper NPI Application/Update form (CMS-10114).\*\*

There will undoubtedly be some updates, changes, and deletions that will require action on the part of the NPI Enumerator. For example, a change may be missing some required data. As a result, the change cannot be made until the NPI Enumerator has contacted the provider and

obtained the missing data, enabling the change to be successfully processed and reflected in NPPES and then in the initial downloadable file. The July 16 date allows a period of time for this type of NPI Enumerator intervention, if necessary.

Updates, changes, and deletions that are submitted after July 16 will be reflected in the appropriate monthly update file, also downloadable from the Internet. For example, an update submitted on July 26 would be effective after the creation of the initial downloadable file and thus would be reflected in the first update file (to be created 1 month after the creation of the initial downloadable file); an update submitted on August 30 would be effective after the creation of the first update file and thus would be reflected in the second update file (to be created one month after the creation of the first monthly update file).

After the initial downloadable file is made available, an update file will be available each month thereafter at the same Internet location. All of the files (the initial file and the update files) will remain available for download at that Internet location.

The NPI Registry will operate in a real-time environment. Updates, changes, and deletions will be reflected in the NPI Registry at the same time they are reflected in NPPES. Therefore, the July 16 date is insignificant with respect to the data in the NPI Registry.

### 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 Web page <http://www.cms.hhs.gov/NationalProvIdentStand>.

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

### Getting an NPI Is Free – Not Having One May Be Costly

**\*\*Note:** If submitting the paper NPI Application/Update form, you may use the old version until July 10, 2007. Do not submit old versions of the CMS-10114 to the NPI Enumerator after that date. Submit the revised CMS-10114. The revised CMS-10114 is available from the NPI Enumerator (1-800-465-3203) or from the CMS forms page <http://www.cms.hhs.gov/cmsforms>. ❖

Source: CMS Provider Education Resource 200706-40

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## New National Provider Identifier Educational Products Available

### NPI Is Here. NPI Is Now. Are You Using It?

Approximately 98 percent of the estimated 2.3 million covered health care providers now have national provider identifiers (NPIs). Health plans, health care clearinghouses and health care providers are now transitioning to the implementation phase for NPI compliance.

### CMS Delays Dissemination of National Plan and Provider Enumeration System Data

The National Plan and Provider Enumeration System (NPPES) Data Dissemination Notice (CMS-6060-N) was published on May 30, 2007. NPPES health care provider data that are required to be disclosed under the Freedom of Information Act (FOIA) will be made publicly available. The FOIA-disclosable data will be made available in an initial file downloadable from the Internet, with monthly update files also downloadable from the Internet, and in a query-only database (the NPI registry) whereby users can query by NPI or provider name. The notice stated that these data will be available 30 days after the publication date, and the Centers for Medicare & Medicaid Services (CMS) had previously stated that they would be available on June 28, 2007.

CMS believes that health care providers need additional time, beyond what was afforded in the Data Dissemination Notice, in which to view their FOIA-disclosable NPPES data and make any updates or deletions (where permitted) that they feel are necessary. **Therefore, CMS has decided to delay the dissemination of FOIA-disclosable NPPES health care provider data until August 1, 2007, 60 days after the publication date of the notice.**

CMS will provide additional information in the near future with respect to the date by which changes would have to be submitted in order to be reflected in the initial downloadable file. CMS understands that the health care industry is in urgent need of the FOIA-disclosable NPPES health care provider data; however, CMS believes it is in the best interests of the industry, and the health care providers in particular, that the NPPES data we will be disclosing be as accurate as possible.

For the latest information on data dissemination, as well as a list of the FOIA-disclosable data elements, visit the NPI Web site [http://www.cms.hhs.gov/NationalProvIdentStand/06a\\_DataDissemination.asp](http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp).

### Revised NPI Application/Update Form

The NPI Application/Update form (CMS-10114, 05-07) has been revised and is now available for download on the CMS Web site. More information on the revisions to the form, as well as a link to the revised form, is available on the CMS NPI Web site at [http://www.cms.hhs.gov/NationalProvIdentStand/03\\_apply.asp](http://www.cms.hhs.gov/NationalProvIdentStand/03_apply.asp).

### The Importance of Up-to-Date Billing Software

Providers that use billing software should make sure they are using the most current version. Software vendors have made changes to accommodate the NPI. Running an outdated software version could contribute to claim rejections or the inability to send your NPI.

### National Uniform Billing Committee Response Regarding Printing Problems with the UB-04 Form

It has come to the attention of the National Uniform Billing Committee (NUBC) that some laser printers are having difficulty meeting the print specification of the UB-04 form. The UB-04 form and the UB-92 contain identical margin specifications. Both forms are 82 characters across. To accommodate the 80-character limitation of some laser printers, many users of the UB-92 form developed workarounds that basically “cheated” on the printing layout. This was commonly accomplished by starting in the second position and ending in the 80th position; basically ignoring the first column on the left and the last column on the right. The UB-92 had no critical data elements in these fields. In order to meet the UB-04 print specifications, users should utilize laser printers that have “edge-to-edge” print capability (four mm margins on the left and right) or wide carriage impact printers (dot-matrix or line printers).

More information may be found on the NUBC Web site at [http://www.nubc.org/UB-04\\_Printing\\_Requirements.pdf](http://www.nubc.org/UB-04_Printing_Requirements.pdf).

### Important Information for Medicare Providers Testing Your NPI on Medicare Claims

To date, Medicare has encouraged providers to submit both an NPI and a legacy identifier on claims.

At this time, only fiscal intermediaries and the CIGNA Idaho and Tennessee carrier are editing the NPI against the Medicare NPI crosswalk file when the NPI/legacy identifier is submitted. If you are billing these contractors and claims are not rejecting, your reporting of the NPI is successful.

Other carriers (including CIGNA North Carolina) and durable medical equipment Medicare administrative contractors (DME MACs) are not validating the NPI/legacy pair against the Medicare crosswalk. If a provider is submitting claims to these contractors your claims have not, and will not reject because the system is bypassing the NPI crosswalk validation and simply processing on the legacy provider number. Although carrier submitters may be receiving informational edits when the problem occurs, DME MAC submitters are not.

To fully understand if your provider information is valid on both the crosswalk and the contractors provider file, Medicare is now asking providers who submit claims to the other carriers and DME MACs to send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume. If any claim is rejected due to provider identifier issues, first verify your NPI to make sure it was entered correctly. If the NPI is correct, then data in either NPPES or Medicare provider files is incorrect. You must check the accuracy of the following fields in your NPPES record and/or 855 provider enrollment record:

- Employee identification number (EIN) (for organization providers), social security number (SSN) (for individual providers)

## *New National Provider Identifier Educational Products Available (continued)*

- Other provider identification numbers (in NPES where type = Medicare. This is where providers, when they apply for their NPIs, may, as an option, list the Medicare legacy identifier(s) that needs to be linked to the NPI.)
- Business location (practice location) address (from NPES and provider enrollment records)
- Master address (from provider enrollment records)
- Other address (from provider enrollment records)
- Legal name or legal business name

Once data is corrected, please wait a few days for the systems to update, and test again with a small number of claims. This process will help establish confidence that your claims will be paid. It is critical that you start testing with your NPI now.

Note that for claims submitted with the NPI only (no legacy identifier) to any contractor (carrier, FI, DME MAC); the NPI has been and will be edited against the NPI crosswalk.

While Medicare fee-for-schedule (FFS) has announced its contingency plan, it is committed to ending the contingency plan as soon as possible.

### **Common Errors that May Result in Claim Rejections**

- Errors in the EIN, or Tax ID (TIN). As a reminder, providers that are organizations are required to report the EIN when they apply for an NPI (on-line, paper, and EFI). That EIN might or might not also be the TIN. With the revised CMS-10114 (to be used beginning July 10, for on-line, paper, and EFI), organizations that are subparts will be required to report the LBN of their “parent” and the “parent’s” TIN. The applicant will continue to be required to report its EIN. If the EIN error is on the Medicare record, the provider should submit a CMS-855 to correct.
- Invalid or incomplete data within the ‘Other Provider Identifiers’ section of the NPES online application, such as
  - The absence of the Medicare identification number/provider number.
  - Not having the ‘Type’ listed as Medicare for a Medicare identification number/provider number, and or
  - Having extra Medicare identification numbers/provider numbers that shouldn’t be linked to the NPI of the applicant.
- Delays in reporting change of ownership. Whenever there is a change of ownership, the provider is responsible for reporting that change to the appropriate Medicare contractor within 30 days. Providers are supposed to report that change on the CMS-855.

CMS is currently working on a special edition *MLN Matters* article regarding verifying NPES data and correct

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

billing for Medicare claims. This article will be announced as soon as it is available.

### **835 Electronic Remittance Advice Changes Effective on July 2, 2007**

A recent *MLN Matters* article discusses the changes currently scheduled for the implementation into the Medicare DMERC processing system July 2, 2007. Visit the CMS Web site <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf>.

### **How do I Share my NPI with Medicare?**

Please share your NPI with Medicare by submitting it on Medicare claims. Unlike some health plans, there is no fax number, phone number or special Web site you need to use to communicate your NPI to Medicare. As stated previously, Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume.

### **NPIs and the Physician Quality Reporting Initiative**

Please note that individual NPIs will be required on claims from those providers who will be participating in the 2007 Physician Quality Reporting Initiative (PQRI). For more details, please visit <http://www.cms.hhs.gov/pqri>.

### **CMS Discontinues the Assignment of Unique Physician Identification Numbers**

Effective June 29, 2007, CMS will discontinue assigning unique physician identification numbers (UPINs) to Medicare providers. CMS is considering extending access to the UPIN Registry until May 23, 2008. For further details, visit the change request (CR 5584) on this subject on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R207PI.pdf> and the associated *MLN Matters* article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5584.pdf>.

### **Upcoming WEDI NPI Industry Forum**

The Workgroup for Electronic Data Interchange (WEDI) will host its 7th NPI Industry Forum July 18-19, 2007, in Fairfax, VA. For more details and to register, please visit <http://www.wedi.org/npioi/index.shtml>.

Please note that there is a charge to participate in WEDI events.

### **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 Web page <http://www.cms.hhs.gov/NationalProvIdentStand>.

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

### **Getting an NPI Is Free – Not Having One May Be Costly**

Source: CMS Provider Education Resource 200706-33

## Information Regarding National Plan and Provider Enumeration System Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes

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 fee-for-service contractors (carriers, fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], Part A/B Medicare administrative contractors [A/B MACs], and durable medical equipment Medicare administrative contractors [DME MACs]).

### Provider Action Needed STOP – Impact to You

Certain information you enter into the National Plan and Provider Enumeration System (NPPES) in order to obtain and maintain your national provider identifier (NPI) is used by Medicare in processing claims.

### CAUTION – What You Need to Know

If the information you entered in NPPES is not correct, your claims may reject. It is important to verify that information was entered correctly. Other guidance in this article will also help assure your claims are processed timely and correctly.

### GO – What You Need to Do

The Centers for Medicare & Medicaid Services (CMS) recommends that physicians, providers, and suppliers validate their NPPES data and be sure their staff are aware of the key elements that need to be correct as explained in this article. Also, you may want to be sure your staff are aware of the important billing tips in this article.

### Background

As Medicare begins to implement the NPI into its systems, several enumeration and billing errors have been identified that may result in claim rejections.

### Common Enumeration Errors in NPPES

Below are some of the more frequent errors providers have been making when applying for NPIs:

- **Errors in employer identification number (EIN):** As a reminder, providers that are organizations are required to report the EIN when they apply for an NPI (on-line, paper, and electronic file interchange (EFI)). That EIN may also be the taxpayer identification number (TIN). With the revised NPI application/update form (CMS-10114) (to be used beginning July 10, 2007, for online, paper, and EFI), organizations that are subparts will be required to report the legal business name (LBN) of their “parent” and the “parent’s” TIN. The applicant will continue to be required to report its EIN. **If the EIN error is on the Medicare provider enrollment record, the provider should submit a CMS-855 to the Medicare contractor to correct it.**
- **Invalid or incomplete data within the ‘Other Provider Identifiers’ section of the NPPES online application, such as:**

- The absence of the Medicare legacy number
- Not having the ‘Type’ listed as Medicare for a Medicare provider number, and/or
- Reporting Medicare provider numbers that do not belong to the provider applying for the NPI and, therefore, should not be linked to the assigned NPI.
- **Reporting an incomplete identifier:** Medicare providers/suppliers need to ensure that, if reporting their Medicare legacy identifiers to NPPES, they report the full identifier. This means that suffixes to the OSCAR/certification numbers are to be reported. If the full identifier is not reported, it will be impossible for Medicare to establish the linkage from the NPI to that particular Medicare legacy identifier when using NPPES data and the NPI crosswalk.
- **Having more than the allowable number of legacy numbers:** At the present time, the NPPES can capture a grand total of 20 “Other Provider Identification Numbers.” While this adequately accommodates the majority of providers/suppliers, it does not accommodate all of them. NPPES will be expanded to capture more than 20 “Other Provider Identification Numbers” at a future date. Medicare providers/suppliers who have more than 20 Medicare legacy identifiers that need to be linked directly to the NPI to be assigned should contact their Medicare fee-for-service contractors to determine how best to inform those contractors of all of the Medicare legacy identifiers.
- **Listing legacy numbers that do not belong to the applicant:** The provider/supplier should make sure that any Medicare legacy identifier(s) (OSCAR/certification number, provider identification number (PIN), unique physician identification number (UPIN), and national supplier clearinghouse (NSC) number) entered in that field in NPPES are those that will need to be linked directly to the NPI to be assigned. That is, do not list in the “Other Provider Identification Numbers” section identifiers that belong to providers other than the one that is applying for the NPI. Specific examples follow in the “Do and Don’t” section below.

### Do and Don’t When Reporting “Other Provider Identification Numbers” in NPPES

- **For a Medicare physician or other practitioner applying for an NPI:**  
**Do include** your UPIN (if one was assigned) and your PIN when applying for an NPI.  
**Do not include** the PIN of your group practice or clinic if you are affiliated with a group practice or clinic.



*Information Regarding National Plan and Provider Enumeration System Errors, ... (continued)*

- **For a Medicare group practice or clinic applying for an NPI:**

**Do include** your PIN.

**Do not include** the PINs or UPINs of any of the members of the group practice or clinic.

- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy/DME supplier:**

**Do include** both NSC numbers (pharmacy and DME supplier).

- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy:**

**Do include** the NSC number assigned to the pharmacy.

**Do not include** the NSC number assigned to the DME supplier.

- **For a Medicare pharmacy that is applying for an NPI as a DME supplier:**

**Do include** the NSC number assigned to the DME supplier.

**Do not include** the NSC number assigned to the pharmacy.

- **For a Medicare hospital swing bed unit that is applying for an NPI as a swing bed unit:**

**Do include** the OSCAR/certification number assigned to the swing bed unit.

**Do not include** the OSCAR/certification number assigned to the hospital.

- **For a Medicare hospital that is applying for an NPI but does not want swing bed units or rehabilitation units (if they have these units) to have their own NPIs:**

**Do include** the OSCAR/certification number assigned to the hospital **and** the OSCAR/certification numbers assigned to both the swing bed unit and the rehabilitation unit.

If Medicare providers/suppliers determine that they should make changes to their NPPES records, they may do so by going to NPPES at <https://nppes.cms.hhs.gov/> at any time and updating their information. Or, if they prefer, they may send updates on the paper NPI Application/Update Form (CMS-10114). Forms may be requested by calling the NPI enumerator at their toll-free number, which is 1-800-465-3203, TTY 1-800-692-2326.

**The revised CMS-10114 is to be used beginning July 10, 2007.**

These forms may be obtained from the enumerator, as outlined above, or you may download the form from the CMS Web site forms page at <http://www.cms.hhs.gov/cmsforms>.

CMS recommends that Medicare providers/suppliers make a copy of their NPPES information by doing a “print screen” of their NPPES record or make a photocopy of the completed paper NPI Application/Update form and keep it on hand for reference if they encounter problems.

**Common Error in Reporting Change of Ownership to Medicare**

**Delays in reporting Change of Ownership**

Whenever there is a change of ownership, the provider is responsible for reporting that change to the appropriate Medicare contractor within 30 days. Providers are supposed to report that change on the CMS-855.

**How To Use Your NPI when Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary or A/B MAC**

For providers who submit electronic Part A institutional claims to Medicare FIs or A/B MACs, a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Failure to properly submit the NPI in the correct loops may cause the claim to reject. Organization providers should utilize their NPI in the 2010AA or 2010AB loop. The attending, operating or other physicians should be identified in the 2310A, B and C loops respectively. If 2420A loop is used, the Attending Physician NPI must be submitted.

**Below is a guide to use when submitting primary NPIs:**

<b>Name/Loop</b>	<b>Legacy Information</b>	<b>NPI Information</b>
Billing provider 2010AA loop	OSCAR	Provider NPI
Pay to provider 2010AB loop	OSCAR	Provider NPI
Attending physician 2310A loop	PIN, UPIN	Physician NPI
Operating physician 2310B loop	PIN, UPIN	Physician NPI
Other physician 2310C	PIN, UPIN	Physician NPI
Attending physician 2420A	PIN, UPIN	Physician NPI

Some Medicare FIs and A/B MACs have developed front-end reason codes that will return claims to the providers when the NPI and Legacy combination submitted does not match the NPI crosswalk.

If a reject or RTP (Return to Provider) is received, providers are encouraged to verify that their NPI/Legacy combination is valid in NPPES first at <https://nppes.cms.hhs.gov>.

The following is a listing of front-end processing reason codes:

<b>Code</b>	<b>Description</b>
<b>32000</b>	This claim has been rejected because the intermediary has no record of the Medicare provider number submitted.



*Information Regarding National Plan and Provider Enumeration System Errors, ... (continued)*

- 32102** The claim contains an NPI but the first digit of the NPI is not equal to “1”, “2”, “3”, “4” or the 10th digit of the NPI does not follow the check digit validation routine. Please verify billing and, if appropriate, correct.  
 \*\*\*Online providers – press PF9 to store the claim.  
 \*\*\*Other providers – return to the intermediary.
- 32103** NPI/OSCAR pair on the claim is not present in the Medicare NPI crosswalk file.  
 This edit applies to the NPI associated with the OSCAR number. Please verify provider-billing number and, if appropriate, please correct either NPPES or your CMS-855 information. Please verify all of your information in NPPES. You should validate that the NPI/OSCAR pair you are using on the claim reflects the OSCAR number that you reported to NPPES. You may view/correct your NPPES information by going to <https://nppes.cms.hhs.gov>.  
 If your NPPES information is correct, and you have included all Medicare legacy identifiers (OSCARs) in NPPES, but you are still experiencing problems with your claims that contain a valid NPI, you may need to submit a Medicare enrollment application (i.e., the CMS 855). Please contact your contractor prior to submitting a CMS-855 form.  
 The NPI and the legacy (OSCAR) number are present on the claim and the NPI is present in the crosswalk file, but the associated legacy (OSCAR) number in the crosswalk file does not match the legacy (OSCAR) number on the claim. Please verify billing number and, if appropriate, correct.  
 \*\*\*Online providers – Press PF9 to store the claim.  
 \*\*\*Other Providers – Return to the intermediary.
- 32105** The NPI is present in the Crosswalk file but the NPI corresponds to more than one legacy (OSCAR) number.  
 Enter the OSCAR number associated with the NPI submitted. Please verify billing number and, if appropriate, correct.  
 \*\*\*Online providers – Press PF9 to store the claim.  
 \*\*\*Other providers – Return to the intermediary.
- 32107** The NPI for the attending physician on the claim is not present in the crosswalk file.  
 Please verify billing number and, if appropriate, correct.  
 \*\*\*Online providers – Press PF9 to store the claim.  
 \*\*\*Other providers – Return to the intermediary.
- 32108** The attending physician’s NPI and UPIN are present on the claim and the attending physician’s NPI is present in the Crosswalk file, but the attending physician’s UPIN in the crosswalk file does not match the attending physician’s UPIN on the claim.
- Please verify the UPIN and, if appropriate, correct.  
 \*\*\*Online providers – Press PF9 to store the claim.  
 \*\*\*Other providers – Return to the intermediary.
- 32109** The operating physician’s NPI on the claim is not present in the crosswalk file.  
 Please verify billing number and, if appropriate, correct.  
 \*\*\*Online providers – Press PF9 to store the claim.  
 \*\*\*Other providers – Return to the intermediary.
- 32110** The operating physician’s NPI and UPIN are present on the claim and the operating physician’s NPI is present in the crosswalk file, but the operating physician’s UPIN in the crosswalk file does not match the operating physician’s UPIN on the claim.  
 Please verify the UPIN and, if appropriate, correct.  
 \*\*\*Online providers – Press PF9 to store the claim.  
 \*\*\*Other providers – Return to the intermediary.
- 32111** The other physician NPI on the claim is not present in the crosswalk file.  
 Please verify the billing number and, if appropriate, correct.  
 \*\*\*Online providers – Press PF9 to store the claim.  
 \*\*\*Other providers – Return to the intermediary.
- 32112** The other physician’s NPI and UPIN are present on the claim and the other physician’s NPI is present in the crosswalk file, but the other physician’s UPIN in the crosswalk file does not match the other physician’s UPIN on the claim.  
 Please verify the UPIN and, if appropriate, correct.  
 \*\*\*Online providers – Press PF9 to store the claim.  
 \*\*\*Other providers – Return to the intermediary.
- 32113** The taxonomy code entered is invalid.  
 Or, a taxonomy code is required when the NPI is present in the crosswalk file and the NPI corresponds to more than one legacy (OSCAR) number.  
 Please verify the billing number and, if appropriate, correct.  
 \*\*\*Online providers – Press PF9 to store the claim.  
 \*\*\*Other providers – Return to the intermediary.

If your FI or A/B MAC is using the MEDATRAN claims translator, below is a list of EDI Inbound Reject codes you may receive:

*Information Regarding National Plan and Provider Enumeration System Errors, ... (continued)*

<b>Edit Number</b>	<b>Loop</b>	<b>Edit Description</b>
99	2010AA	The NPI/legacy combination does not match the NPI crosswalk.
99	2010AB	The NPI/legacy combination does not match the NPI crosswalk.
99	2310A,B,C	The NPI/legacy combination does not match the NPI crosswalk.
99	2420A	The NPI/legacy combination does not match the NPI crosswalk.

**How To Use Your NPI when Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs**

For providers who submit electronic professional claims to Medicare Part B carriers and A/B MACs, CMS test data indicates that a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Even if you have validated your NPPES data, failure to properly submit the NPI in the correct loops may cause the claim to reject. Group providers should utilize the GROUP NPI in the 2010AA or 2010AB loop. The INDIVIDUAL or MEMBER OF GROUP NPI should only be submitted in the 2310B or 2420A loops.

Below is a guide to use when submitting primary NPIs:

<b>Name/Loop</b>	<b>Legacy Information</b>	<b>NPI Information</b>
Billing provider 2010AA loop	Group PIN individual PIN	Group NPI
Individual NPI pay to provider 2010AB loop (this should only be submitted if different from billing provider)	Group PIN individual PIN	Group NPI individual NPI
Rendering provider 2310B loop (this should only be submitted if a group practice)	Individual/ member of group PIN	Individual/ member of group NPI
Rendering provider 2420A loop (this should only be submitted if a group practice)	Individual/ member of group PIN	Individual/ member of group NPI

Some carriers and A/B MACs will return the informational messages or edits below when the NPI and legacy identifier combination submitted does not match the NPI crosswalk. As of the date of this article, claims with NPI/legacy identifiers are not rejecting because Part B contractors (except CIGNA Tennessee and Idaho), have “crosswalk

bypass” logic in their system that will allow invalid pairs to process on the legacy number. The informational edits you are receiving are a warning that your claims will reject when the logic is removed. Providers are encouraged to verify that the NPI/legacy identifier combination is valid on NPPES prior to submission of Medicare claims at <https://nppes.cms.hhs.gov>.

Following is a listing of the edits you may receive when billing professional Part B claims:

<b>Edit Number</b>	<b>Loop</b>	<b>Edit Description</b>
M340	2010AA	The NPI/legacy combination does not match the NPI crosswalk.
M341	2010AB	The NPI/legacy combination does not match the NPI crosswalk.
M343	2310B	The NPI/legacy combination does not match the NPI crosswalk.
M347	2420A	The NPI/legacy combination does not match the NPI crosswalk.

**Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007, for DME Suppliers Submitting Claims to DME MACS Only**

DME suppliers are reminded that important changes will occur on your electronic remittance advice and your standard paper remittance actions, effective July 2, 2007. As of that date when you have submitted an NPI on your claim, your DME MAC will report on the 835 (or via the Medicare remit easy print [MREP]) software) as follows:

- The billing/pay-to NPI will be reported at the payee level (loop 1000B in N104 with qualifier XX in N103 of the 835).
- The TIN (EIN/SSN) will be reported in the REF segment (loop 1000B, data field REF 02 with qualifier TJ in REF 01 of the 835) as payee additional ID.
- Any relevant rendering provider NPI will be reported at the claim level (loop 2100, data field NM 109 with qualifier XX in NM 108 on the 835) if different from the payee NPI.
- Any relevant rendering NPI(s) will be reported at the service line level (loop 2110, data field REF 02 with qualifier HPI in REF 01 on the 835) when different from the claim level rendering NPI.

When you do not report your NPI, but report your legacy national supplier clearinghouse (NSC) number on a claim, Medicare will continue to report legacy numbers in generating your remittance advice. Further information regarding the remittance changes may be found in CR 5452, which is on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf> or in the related *MLN Matters* article, MM5452, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf>.

*Information Regarding National Plan and Provider Enumeration System Errors, ... (continued)*

**Note:** The 835 remittance advice changes listed above will be effective for other providers submitting Part A institutional claims and Part B professional claims, at a later date. Medicare will notify submitters when a date is determined.

**Additional Information**

You may also want to review *MLN Matters* article SE0679, which has additional information on the overall NPI activity. This article is on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf>.

Important information regarding current NPI implementation contingency plan is in article MM5595, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

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

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If you have any questions, please contact your Medicare contractor 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 1-888-664-4112.

*MLN Matters* Number: SE0725

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 SE0725

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## Date to Submit Changes to NPES for the Initial Downloadable File

### NPI Is Here. NPI Is Now. Are You Using It?

The Centers for Medicare & Medicaid Services (CMS) will be disseminating provider information contained in the National Plan and Provider Enumeration System (NPES) that is required to be disclosed under the Freedom of Information Act (FOIA), in accordance with the NPES Data Dissemination Notice (CMS-6060-N) that was published in the *Federal Register* on May 30, 2007. The notice encouraged providers who have been assigned national provider identifiers (NPIs) to view their NPES data and to update, change, or delete (where permitted) the data that will be disclosed under the FOIA.

NPES FOIA-disclosable data will be made available in an initial file that may be downloaded from the Internet, as well as in a query-only database known as the NPI registry. There will be monthly update files that will also be downloadable from the Internet. CMS will begin disseminating data on August 1, 2007.

CMS has made available a document that will assist providers in making updates, changes, and deletions to the FOIA-disclosable NPES provider data. The document is entitled, "National Plan and Provider Enumeration System (NPES) Data Elements – Data Dissemination – Information for Providers" available on the NPI Web site at [http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPES\\_FOIA\\_Data%20Elements\\_062007.pdf](http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPES_FOIA_Data%20Elements_062007.pdf).

We strongly recommend that providers read this document as soon as possible.

The initial downloadable file will be created using a "snapshot" of the NPES FOIA-disclosable provider data as of a specific date. Because the initial downloadable file will be the foundation containing the FOIA-disclosable data for more than 2.2 million providers, it is important that the information in that file be as accurate as possible. **In order for providers' updates, changes, and deletions to be**

**reflected in the initial downloadable file, providers must ensure that their updates, changes, and deletions are submitted to NPES no later than July 16, 2007. To ensure the inclusion of updates, changes, and deletions in the initial downloadable file, July 16 is the last date on which they may be submitted via the web-based process, and is the last date by which the NPI Enumerator can receive them on the paper NPI Application/Update form (CMS-10114).[1]**

There will undoubtedly be some updates, changes, and deletions that will require action on the part of the NPI Enumerator. For example, a change may be missing some required data. As a result, the change cannot be made until the NPI enumerator has contacted the provider and obtained the missing data, enabling the change to be successfully processed and reflected in NPES and then in the initial downloadable file. The July 16 date allows a period of time for this type of NPI enumerator intervention, if necessary.

Updates, changes, and deletions that are submitted after July 16 will be reflected in the appropriate monthly update file, also downloadable from the Internet. For example, an update submitted on July 26 would be effective after the creation of the initial downloadable file and thus would be reflected in the first update file (to be created one month after the creation of the initial downloadable file); an update submitted on August 30 would be effective after the creation of the first update file and thus would be reflected in the second update file (to be created one month after the creation of the first monthly update file).

After the initial downloadable file is made available, an update file will be available each month thereafter at the same Internet location. All of the files (the initial file and the update files) will remain available for download at that Internet location.

### *Date to Submit Changes to NPPES for the Initial Downloadable File (continued)*

The NPI registry will operate in a real-time environment. Updates, changes, and deletions will be reflected in the NPI registry at the same time they are reflected in NPPES. Therefore, the July 16 date is insignificant with respect to the data in the NPI registry.

### **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 Web page <http://www.cms.hhs.gov/NationalProvIdentStand>.

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

### **Getting an NPI Is Free – Not Having One May Be Costly**

Source: CMS Provider Education Resource 200706-37

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## **New National Provider Identifier Educational Products Available**

### **NPI Is Here. NPI Is Now. Are You Using It?**

#### **New MLN Matters Article Available**

A new special edition *MLN Matters* article is now posted on the CMS Web site with important information for Medicare providers and suppliers. Some of the topics include:

- Common Enumeration Errors in NPPES.
- Dos and Don'ts when Reporting "Other Provider Identification Numbers" in NPPES.
- How To Use your NPI when Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary (FI) or A/B MAC.
- How To Use Your NPI When Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs.
- Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007, for DME Suppliers Submitting Claims to DME MACS Only.

You can view this article by visiting the CMS Web site at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf>.

#### **June 14, 2007 NPI Data Dissemination Roundtable Transcript Available Now**

The transcript for the June 14, 2007, NPI data dissemination roundtable may be found on the CMS Web site at <http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/6-14NPITranscript.pdf>.

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 Web page <http://www.cms.hhs.gov/NationalProvIdentStand>.

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

### **Getting an NPI Is Free – Not Having One May Be Costly**

Source: CMS Provider Education Resource 200707-08

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### **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 Web site <http://www.floridamedicare.com>. It's very easy to do. Simply go to the Web site, click on the "eNews" link on the navigational menu and follow the prompts.



# GENERAL COVERAGE

## Percutaneous Transluminal Angioplasty

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

### Provider Types Affected

Physicians and hospitals that submit claims to Medicare contractors (Part A/B Medicare administrative contractors [A/B MACs], fiscal intermediaries [FI] or carriers) for PTA services provided to Medicare beneficiaries.

### Provider Action Needed

#### STOP – Impact to You

On August 02, 2006, a request to reconsider the national coverage determination (NCD) for PTA and stenting of the carotid arteries initiated a national coverage analysis. Change request (CR) 5660 communicates the findings resulting from that analysis.

#### CAUTION – What You Need to Know

Effective for dates of service performed on and after April 30, 2007, be aware of:

- Clarifications regarding the use of PTA and stenting of the carotid arteries for patients at high risk for carotid endarterectomy (CEA)
- **Note the process that facilities must follow for certification and recertification** that is specified in section 20.7 of Publication 100-03, the *Medicare National Coverage Determinations Manual*.

#### GO – What You Need to Do

If you are a provider of PTA and stenting of the carotid arteries services be aware that CMS has reviewed the evidence and determined that **coverage for this NCD is unchanged** and that **facilities should follow the certification/recertification guidelines in CR 5660**. See the *Background and Additional Information* sections of this Medicare Modernization Act (MMA) update.

### Background

On April 22, 2005, the Centers for Medicare & Medicaid Services (CMS) issued CR 3811 providing Medicare coverage for PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent when beneficiaries are at high risk for carotid endarterectomy (CEA). This national coverage determination (NCD) is contained in section 20.7 of the *Medicare National Coverage Determinations Manual* and the **changes in the NCD are listed below**. To read more about this NCD, click on the article issued with this change request that may be found in the *Additional Information* section of this article.

**PTA is covered when used under the following conditions:**

- Treatment of atherosclerotic obstructive lesions
  - ♦ In the lower extremities, i.e., the iliac, femoral, and popliteal arteries.
  - ♦ In the upper extremities, i.e., the innominate, subclavian, axillary, and brachial arteries, but not head or neck vessels.

- Of a single coronary artery
- Concurrent with carotid stent placement.
- Food and Drug Administration (FDA)-approved category B investigational device exemption (IDE) clinical trials, effective July 1, 2001.
- FDA-approved post approval studies, effective October 12, 2004.
- Patients at high risk for carotid endarterectomy (CEA), effective March 17, 2005.

**Notes:** Coverage is limited to procedures performed using FDA approved carotid artery stents and embolic protection devices.

The use of a distal embolic protection device is required. If deployment of the distal embolic protection device is not technically possible, then the procedure should be aborted given the risks of carotid artery stenting (CAS) without distal embolic protection.

- Concurrent with intracranial stent placement
- FDA-approved category B IDE clinical trials, effective November 6, 2006.

CAS for patients who are not at high risk for CEA remains covered only in FDA-approved category B IDE clinical trials under 42 CFR 405.201.

CMS has determined that PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent is not reasonable and necessary for all other patients.

### Facilities Certification

Facilities must be certified for Medicare to cover the CAS procedures and must recertify every two (2) years in order to maintain Medicare coverage of CAS procedures. Recertification will occur when the facility documents that and describes how it continues to meet the CMS standards. The new recertification guidelines are as follows:

#### At 23 months after initial certification:

- Submission of a letter to CMS stating how the facility continues to meet the minimum facility standards as listed in Section 20.7 of the *Medicare National Coverage Determinations Manual*. (See the *Additional Information* section of this article for the Web link to the NCD within CR5660)

#### At 27 months after initial certification:

- Submission of required data elements for all CAS procedures performed on patients during the previous two (2) years of certification.
- Required data elements:
  - Patients' Medicare identification number if a Medicare beneficiary

## *Percutaneous Transluminal Angioplasty (continued)*

Patients' date of birth

Date of procedure

Does the patient meet high surgical risk criteria (defined below)?

- Age =80
- Recent (< 30 days) myocardial infarction (MI)
- Left ventricle ejection fraction (LVEF) < 30%
- Contralateral carotid occlusion
- New York Heart Association (NYHA) class III or IV congestive heart failure
- Unstable angina: canadian cardiovascular society (CCS) class III/IV
- Renal failure: end stage renal disease on dialysis
- Common carotid artery (CCA) lesion(s) below clavicle
- Severe chronic lung disease
- Previous neck radiation
- High cervical internal carotid artery (ICA) lesion(s)
- Restenosis of prior carotid endarterectomy (CEA)
- Tracheostomy
- Contralateral laryngeal nerve palsy.

### **Is the patient symptomatic (defined below)?**

- Carotid transient ischemic attack (TIA) persisting less than 24 hours
- Non-disabling stroke: modified Rankin scale <3 with symptoms for 24 hours or more
- Transient monocular blindness:amaurosis fugax

Modified Rankin Scale score if the patient experienced a stroke

Percent stenosis of stented lesion(s) by angiography

Was embolic protection used?

Were there any complications during hospitalization (defined below)?

- Stroke: an ischemic neurologic deficit that persisted more than 24 hours
- MI
- Death

Recertification is effective for two (2) additional years during which facilities will be required to submit the requested data every April 1 and October 1.

CMS will consider the approval of national carotid artery stenting registries that provide CMS with a comprehensive overview of the registry and its capabilities, and the manner in which the registry meets CMS data collection and evaluation requirements. Specific standards for CMS approval are listed below. Facilities enrolled in a CMS

approved national CAS registry will automatically meet the data collection standards required for initial and continued facility certification. Hospitals' contracts with an approved registry may include authority for the registry to submit required data to CMS for the hospital. A list of approved registries will be made available on the CMS coverage website. In addition, CMS will publish a list of approved facilities in the *Federal Register*.

### **National Registries**

As noted above, CMS will approve national registries developed by professional societies and other organizations and allow these entities to collect and submit data to CMS on behalf of participating facilities to meet facility certification and recertification requirements. To be eligible to perform these functions and become a CMS approved registry, the national registry, at a minimum, must be able to:

1. Enroll facilities in every US state and territory
2. Assure data confidentiality and compliance with HIPAA
3. Collect the required CMS data elements as listed above
4. Assure data quality and data completeness
5. Address deficiencies in the facility data collection, quality, and submission
6. Validate the data submitted by facilities, as needed
7. Track long term outcomes such as stroke and death
8. Conduct data analyses and produce facility specific data reports and summaries
9. Submit data to CMS on behalf of the individual facilities
10. Provide quarterly reports to CMS on facilities that do not meet or no longer meet the CMS facility certification and recertification requirements pertaining to data collection and analysis.

Registries wishing to receive this designation from CMS must submit evidence that they meet or exceed these 10 requirements. Though the registry requirements pertain to CAS, CMS strongly encourages all national registries to establish a similar mechanism to collect comparable data on CEA. Having both CAS and CEA data will help answer questions about carotid revascularization, in general, in the Medicare population.

### **Additional Information**

For complete details regarding this CR please see the official instruction (CR 5660) issued to your Medicare carrier, or A/B MAC. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R71NCD.pdf>.

The *MLN Matters* article related to CR3811, which is referenced in the *Background Section* of this article may be reviewed by clicking on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf>.

**Percutaneous Transluminal Angioplasty (continued)**

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 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 1-888-664-4112.

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MLN Matters Number: MM5660

Related Change Request (CR) Number: 5660

Related CR Release Date: June 29, 2007

Related CR Transmittal Number: R71NCD

Effective Date: April 30, 2007

Implementation Date: July 30, 2007

Source: CMS Pub. 100-03, Transmittal 71, CR 5660

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## Vagus Nerve Stimulation for Resistant Depression

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

### Provider Types Affected

Physicians, hospitals, and other providers who bill Medicare carriers, fiscal intermediaries (FI), and Medicare administrative contractors (A/B MAC) for vagus nerve stimulation (VNS) procedures.

### Provider Action Needed

Change request (CR) 5612, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) is issuing a national noncoverage determination (NCD) stating that vagus nerve stimulation (VNS) is not reasonable and necessary for the treatment of resistant depression.

Therefore, **effective May 4, 2007**, CMS will deny VNS claims when resistant depression is the indication for the procedure.

### Background

VNS uses a battery-powered pulse generator (similar to a pacemaker), that is surgically implanted under the skin of the left chest and an electrical lead (wire) connected from the generator to the left vagus nerve; through which electrical signals are sent to the brain.

In 1999, CMS issued a national coverage determination (NCD) that (effective for services performed on or after July 1, 1999) VNS is reasonable and necessary for patients with medically refractory partial onset seizures when surgery is not recommended or has failed.

On August 7, 2006, a formal request to reconsider resistant depression as an additional indication initiated a national coverage analysis, and CR 5612, from which this article is taken, communicates the findings of that analysis. Specifically in CR 5612, CMS announces that it has reviewed the evidence and has concluded that vagus nerve stimulation (VNS) is not reasonable and necessary for the treatment of resistant depression under section 1862(a)(1)(A) of the Social Security Act, and has issued a national noncoverage determination for this indication.

Therefore, effective May 4, 2007, CMS will deny or reject, as appropriate, VNS claims for resistant depression, as specified in the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 2 (Sections 90 – 160.25 (Coverage Determinations)), Section 160.18 (Vagus Nerve Stimulation (VNS), Subsection C (Nationally Non-Covered Indications)).

CR 5612 contains some specifics about VNS coverage that you should be aware of:

- Carriers, FIs, and A/B MACs will continue to pay VNS claims for medically refractory partial onset seizures as specified in section 160.18.B of the *Medicare National Coverage Determination Manual*, identified when any of the following ICD-9-CM diagnosis codes appear on the claim:

41.41	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures with intractable epilepsy
51.51	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures with intractable epilepsy

- Carriers, FIs, and A/B MACs will continue to deny/reject VNS claims for all other types of seizures as specified in section 160.18.C of the *Medicare National Coverage Determination Manual*.
- Physicians and hospitals will be liable for noncovered VNS procedures unless they issue an appropriate advance beneficiary notice (ABN), which should include the following language:

**Items or Service Section:** “Vagus Nerve Stimulation”

**Because Section:** “As specified in section 160.18 of Pub.100-03, *Medicare National Coverage Determination Manual*, Medicare will not pay for this procedure as it is not a reasonable and necessary treatment for (select either “your type of seizure disorder” or “resistant depression.”)”

- When denying noncovered VNS services carriers, FIs, and A/B MACs will use the following messages:

Medicare summary notice (MSN) **16.10** “Medicare does not pay for this item or service”

**CARC 50:** “These are noncovered services because this is not deemed a “medical necessity” by the payer”

One of the following RARC messages, depending on liability:

*Vagus Nerve Stimulation for Resistant Depression (continued)*

**M27** “The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient’s waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office”

or

**M38** “The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.”

- Medicare carriers, FIs, and A/B MACs will also include group code CO (contractual obligation) or PR (patient responsibility) depending on liability.
- Carrier, FIs, and A/B MACs will not search their files to retract payment for claims already paid, but will adjust claims brought to their attention.

Finally, you should remember that this addition/revision of section 160.18 of the *Medicare National Coverage Determination Manual* is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR

section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

**Additional Information**

You can find the official instruction issued to your carrier, FI, or A/B MAC about the VNS NCD by looking at the two transmittals for CR 5612. The first transmittal is on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R70NCD.pdf>.

That transmittal contains the amended *Medicare National Coverage Determinations Manual*, Chapter 1, Part 2 (Sections 90 – 160.25 – Coverage

Determinations), Section 160.18 (Vagus Nerve Stimulation (VNS), Subsection C (Nationally Non-Covered Indications). The second transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R1271CP.pdf> and it contains the amended *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 200 (Billing Requirements for Vagus Nerve Stimulation (VNS).

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 1-888-664-4112.

MLN Matters Number: MM5612  
 Related Change Request (CR) Number: 5612  
 Related CR Release Date: June 22, 2007  
 Related CR Transmittal Number: R1271CP and R70NCD  
 Effective Date: May 4, 2007  
 Implementation Date: July 23, 2007

Source: CMS Pub. 100-04, Transmittal 1271, CR 5612

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**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.*

**Note:** CMS has revised this *MLN Matters* article on July 9, 2007, to reference MM5635. *MLN Matters* article MM5635 implemented HCPCS coding changes for immune globulin. On and after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg) will no longer be payable by Medicare. To view the new HCPCS codes for immune globulin, please go to the CMS Web site <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5635.pdf>.

The *MLN Matters* article MM5428 was published in the January 2007 *Medicare A Bulletin* (page 31).

**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.



*Medicare Payment for Preadministration-Related Services Associated with IVIG Administration... (continued)***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 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 preadministration 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. **(See note regarding J1567.)**
- 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 Web site 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 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: MM5428 – Revised  
 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

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## Astigmatism-Correcting Intraocular Lens Implementation

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 July 18, 2007, to correct a typo and to provide new Web addresses for accessing the Notices of Exclusion from Medicare Benefits. All other information remains the same. The MLN Matters article MM5527 was published in the June 2007 *Medicare A Bulletin* (pages 34-37).

### Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on change request (CR) 5527, which discusses a recent administrator, ruling from the Centers for Medicare & Medicaid Services (CMS) regarding astigmatism-correcting intraocular lenses (A-C IOLs) following cataract surgery (CMS-1536-R). **The new policy is effective for dates of service on and after January 22, 2007. Physicians and providers need to be aware that effective January 22, 2007:**

- Medicare will pay the same amount for cataract extraction with A-C IOL insertion that it pays for cataract extraction with conventional IOL insertion.
- **The beneficiary is responsible for payment of that portion of the hospital or ambulatory surgery center (ASC) charge for the procedure that exceeds the facility's usual charge for cataract extraction and insertion of a conventional IOL following cataract surgery, as well as any fees that exceed the physician's usual charge to perform a cataract extraction with insertion of a conventional IOL.**

In addition, CMS reminds physicians that they can be reimbursed for the conventional or A-C IOL (V2632) only when the service is performed in a physician's office. Also, when physicians perform cataract surgery in an ASC or hospital outpatient setting, the physician may only bill for the professional service because payment for the lens is bundled into the facility payment for the cataract extraction.

### Background

CMS administrator rulings serve as 1) precedent final opinions and orders and 2) statements of policy and interpretation. The administrator rulings provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, utilization and peer review by quality improvement organizations, private health insurance, and related matters. These rulings also promote consistency in interpretation of policy and adjudication of disputes, and they are binding on all CMS components, Medicare contractors, the Provider

Reimbursement Review Board, the Medicare Geographic Classification Review Board, and administrative law judges who hear Medicare appeals.

CR 5527 discusses a recent CMS administrator ruling concerning requirements for determining payment for insertion of IOLs that replace beneficiaries' natural lenses and correct preexisting astigmatism following cataract surgery under the Social Security Act:

**Note:** CR 5527 basically restates CMS policy provided in CR 3927 (MLN Matters article MM3927), except that CR 3927 focused on presbyopia-correcting IOLs and this article focuses on A-C IOLs.

### Coverage Policy

In general, an item or service covered by Medicare must satisfy the following three basic requirements:

- Fall within a statutorily-defined benefit category.
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.
- Not be excluded from coverage.

The Social Security Act specifically excludes eyeglasses and contact lenses from coverage, with an exception for one pair of eyeglasses or contact lenses covered as a prosthetic device furnished after each cataract surgery with insertion of an IOL. In addition, there is no Medicare benefit category to allow payment for the surgical correction of cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for the imperfect curvature of the cornea (astigmatism).

An A-C IOL is intended to provide what is otherwise achieved by two separate items:

- An implantable conventional IOL (one that is not astigmatism-correcting) that is covered by Medicare, and
- The surgical correction, eyeglasses, or contact lenses that are not covered by Medicare.

Although A-C IOLs may serve the same function as eyeglasses or contact lenses furnished following removal of a cataract, A-C IOLs are neither eyeglasses nor contact lenses. The following table is a summary of benefits for which Medicare **makes** payment, and services for which Medicare does **not** pay (no benefit category):

*Astigmatism-Correcting Intraocular Lens Implementation (continued)*

<b>Benefits for Which Medicare Makes Payment</b>	<b>Services for Which Medicare Does <i>not</i> Pay – No Benefit Category</b>
A conventional intraocular lens (IOL) implanted following cataract surgery.	The astigmatism-correcting functionality of an IOL implanted following cataract surgery.
Facility or physician services and supplies required inserting a conventional IOL following cataract surgery.	Facility or physician services and resources required to insert and adjust an AC-IOL following cataract surgery that exceeds the services and resources furnished for insertion of a conventional IOL.
One pair of eyeglasses or contact lenses as a prosthetic device furnished after each cataract surgery with insertion of an IOL.	The surgical correction of cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for imperfect curvature of the cornea (astigmatism).  Eye examinations performed to determine the refractive state of the eyes specifically associated with insertion of an AC-IOL (including subsequent monitoring services), that exceed the one-time eye examination following cataract surgery with insertion of a conventional IOL.

Currently, there is one NTIOL class approved for special payment when furnished by an ASC, and this currently active NTIOL category for “Reduced Spherical Aberration” was established on February 27, 2006 and expires on February 26, 2011.

Effective for services furnished on or after January 22, 2007, CMS now recognizes the following as A-C IOLs:

- Acrysof® Toric IOL (models: SN60T3, SN60T4, and SN60T5), manufactured by Alcon Laboratories, Inc; and
- Silicon 1P Toric IOL (models: AA4203TF and AA4203TL), manufactured by STAAR Surgical.

**Payment Policy for Facility Services and Supplies**

The following applies to an IOL inserted following removal of a cataract in a hospital (on either an outpatient or inpatient basis) that is paid under 1) the hospital outpatient prospective payment system (OPPS) or 2) the inpatient prospective payment system (IPPS), respectively (or in a Medicare-approved ASC that is paid under the ASC fee schedule):

- Medicare does not make separate payment to the hospital or the ASC for an IOL inserted subsequent to extraction of a cataract. Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure; and
- Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted during or subsequent to cataract surgery for which payment is made under the ASC fee schedule, is subject to a civil money penalty.

For an A-C IOL inserted subsequent to removal of a cataract in a hospital (on either an outpatient or inpatient basis) that is paid under the OPPS or the IPPS, respectively (or in a Medicare-approved ASC that is paid under the ASC fee schedule):

- The facility should bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or A-C IOL is inserted. When a beneficiary receives an A-C IOL following removal of a cataract, hospitals and ASCs should report the same

CPT code that is used to report removal of a cataract with insertion of a conventional IOL (see “Coding” below).

- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL.
- There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives an AC-IOL following removal of a cataract that exceed the facility charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary after cataract surgery followed by insertion of a conventional IOL.

**Payment Policy for Physician Services and Supplies**

For an IOL inserted following removal of a cataract in a physician’s office Medicare makes separate payment, based on reasonable charges, for an IOL inserted subsequent to extraction of a cataract that is performed at a physician’s office.

For an A-C IOL inserted following removal of a cataract in a physician’s office:

- A physician should bill for a conventional IOL, regardless of whether a conventional or A-C IOL is inserted (see “Coding,” below).
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL.
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an AC-IOL that exceed the physician charges for services and supplies to examine

## *Astigmatism-Correcting Intraocular Lens Implementation (continued)*

and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.

For an A-C IOL inserted following removal of a cataract in a hospital or ASC:

- A physician may not bill Medicare for the A-C IOL inserted during a cataract procedure performed in those settings because payment for the lens is included in the payment made to the facility for the entire procedure.
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed physician charges for services and supplies required for the insertion of a conventional IOL.
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an A-C IOL that exceed the physician charges for services and supplies required to examine and monitor a beneficiary following cataract surgery with insertion of a conventional IOL.

### **Coding**

No new codes are being established at this time to identify an A-C IOL or procedures and services related to an A-C IOL, and hospitals, ASCs, and physicians should report one of the following *CPT* codes to bill Medicare for removal of a cataract with IOL insertion:

- *CPT* code 66982 – *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage*
- *CPT* code 66983 – *Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)*
- *CPT* Code 66984 – *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)*

Physicians inserting an IOL or an A-C IOL in an office setting may bill code V2632 (posterior chamber intraocular lens) for the IOL or the A-C IOL, which is paid on a reasonable charge basis.

If appropriate, hospitals and physicians may use the proper *CPT* code(s) to bill Medicare for evaluation and management services usually associated with services following cataract extraction surgery, if appropriate.

### **Beneficiary Liability**

When a beneficiary requests insertion of an A-C IOL instead of a conventional IOL following removal of a cataract and that procedure is performed, the beneficiary is responsible for payment of facility charges for services and supplies attributable to the astigmatism-correcting functionality of the A-C IOL:

- In determining the beneficiary's liability, the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the AC-IOL that exceeds the work and resources attributable to insertion of a conventional IOL.
- The physician and the facility may not charge for cataract extraction with insertion of an A-C IOL unless the beneficiary requests this service.
- The physician and the facility may not require the beneficiary to request an A-C IOL as a condition of performing a cataract extraction with IOL insertion.

### **Provider Notification Requirements**

When a beneficiary requests insertion of an A-C IOL instead of a conventional IOL following removal of a cataract:

- Prior to the procedure to remove a cataractous lens and insert an A-C IOL, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment, or other subsequent treatments related to the astigmatism-correcting functionality of the IOL.
- The correcting functionality of an A-C IOL does not fall into a Medicare benefit category and, therefore, is not covered. Therefore, the facility and physician are not required to provide an advanced beneficiary notice to beneficiaries who request an A-C IOL.
- Although not required, CMS strongly encourages facilities and physicians to issue a **Notice of Exclusion from Medicare Benefits** to beneficiaries in order to identify clearly the non-payable aspects of an A-C IOL insertion. This notice may be found on the CMS Web site at:
  - For the English language version, <http://www.cms.hhs.gov/BNI/downloads/CMS20007English.pdf>.
  - For the Spanish language version, <http://www.cms.hhs.gov/BNI/downloads/CMS20007Spanish.pdf>.

### **Additional Information**

The official instruction, CR 5527, issued to your Medicare carrier, intermediary, and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1228CP.pdf>.



***Astigmatism-Correcting Intraocular Lens Implementation (continued)***

If you have any questions, please contact your Medicare carrier, intermediary, 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 1-888-664-4112.

MLN Matters Number: MM5527 – Revised  
Related Change Request (CR) Number: 5527  
Related CR Release Date: April 27, 2007  
Related CR Transmittal Number: R1228CP  
Effective Date: January 22, 2007  
Implementation Date: May 29, 2007

Source: CMS Pub. 100-04, Transmittal 1228, CR 5527

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

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# LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by LCMS, 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 Web site <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 Web site 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 Web site, <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

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### Advance Beneficiary Notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ**.

**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 Web site at <http://www.floridamedicare.com>.**

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## NEW LCD IMPLEMENTATION

### A64702: Surgical Decompression for Peripheral Polyneuropathy of Diabetes—New LCD

Surgical decompression of multiple lower extremity peripheral nerves is being used as an alternative approach for the treatment of symptomatic diabetic polyneuropathy. Currently, the preponderance of clinical evidence as noted in various publications in the peer reviewed literature is not sufficient to support the efficacy of surgical decompression of peripheral nerves for the treatment of symptomatic diabetic metabolic, inflammatory or toxic polyneuropathy.

This local coverage determination (LCD) was developed to provide noncoverage of this procedure specifically when used for treating peripheral polyneuropathy of diabetes.

#### Effective Dates

This new LCD will be effective for services provided **on or after September 30, 2007**.

The full text for this new LCD (L25269) is available through the provider education Web site

<http://www.floridamedicare.com> on or after this effective date. ❖

### A0171T: Interspinous Process Decompression—New LCD

Interspinous process decompression (IPD<sup>®</sup>) system also known as X-Stop<sup>®</sup> is an emerging technology that is intended for the treatment of patients who have failed to respond to conservative treatment of lumbar spinal stenosis. It is indicated for patients 50 years and older who have moderately impaired physical function from back and leg pain caused by spinal stenosis and who have obtained little or no pain relief after at least six months of non-surgical treatments such as pain medications, physical therapy, injections and/or manipulations.

This local coverage determination (LCD) was developed to provide indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines for the IPD<sup>®</sup> procedure.

#### Effective Dates

This new LCD will be effective for services provided **on or after September 30, 2007**.

The full text for this new LCD (L25265) is available through the provider education Web site

<http://www.floridamedicare.com> on or after this effective date. ❖

### AJ9055: Cetuximab (Erbitux<sup>®</sup>)—New LCD

Cetuximab (Erbitux<sup>®</sup>) is a recombinant, human/mouse chimeric monoclonal antibody that binds specifically to the extracellular domain of the human epidermal growth factor receptor (EGFR). The Food and Drug Administration (FDA) has approved cetuximab for the following indications:

- When used in combination with irinotecan for the treatment of EGFR-expressing metastatic colorectal carcinoma in patients who are refractory to irinotecan-based chemotherapy;
- When administered as a single agent for the treatment of EGFR-expressing metastatic colorectal carcinoma in patients who are intolerant to irinotecan-based chemotherapy;
- When used in combination with radiation therapy for the treatment of locally or regionally advanced squamous cell carcinoma of the head and neck; and
- When used as a single agent for the treatment of patients with recurrent or metastatic squamous cell carcinoma of the head and neck where platinum-based therapy has failed.

An evaluation was completed to determine if current documentation justified the administration of this drug for the treatment of all metastatic colorectal malignancies without a required demonstration of EGFR positivity, and based on the submitted documentation, a decision to allow this off-label indication was made.

This new local coverage determination (LCD) was developed to include indications and limitations of coverage (including the off-label indication mentioned above), documentation requirements, utilization guidelines, ICD-9-CM codes that support medical necessity, and coding guidelines.

#### Effective Dates

This new LCD will be effective for services provided **on or after September 30, 2007**.

The full text for this new LCD (L25277) is available through the provider education Web site

<http://www.floridamedicare.com> on or after this effective date. ❖

## **ADDITIONS/REVISIONS TO EXISTING LCDs**

### **A77078: Bone Mineral Density Studies—Revision to the LCD**

The local coverage determination (LCD) for bone mineral density studies was last revised on January 1, 2007. Since that time, the LCD has been revised based on change request 5521, dated May 11, 2007. The following sections have been revised: Indications and Limitations of Coverage and/or Medical Necessity, CPT/HCPCS Codes, ICD-9 Codes that Support Medical Necessity, Documentation Requirements, and Utilization Guidelines.

Revisions made to the LCD include:

- A reduction of dosage requirements for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg.
- Deletion of type of bill code 14x.
- Addition of type of bill code 71x.
- Deletion of CPT code 78350 as a covered procedure code.
- Language to indicate only dual-energy X-ray absorptiometry will be allowed to monitor osteoporosis drug therapy.
- Addition of ICD-9-CM codes 255.0 and 733.03 to the ‘ICD-Codes that Support Medical Necessity’ section of the LCD for CPT code 77080.
- Addition of statement to indicate that, effective for dates of service on or after January 1, 2007, procedure codes G0130, 77078, 77079, 77081, 77083 and 76977 will be denied when billed with ICD-9-CM codes 255.0, 733.00, 733.01, 733.02, 733.03, 733.09 or 733.90.
- The language which recommended ICD-9-CM codes for the indications was deleted from the ‘Indications’ section under the ‘Indications and Limitations of Coverage and/or Medical Necessity’ section of the LCD.

#### **Effective Dates**

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

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

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### **A95860: Electromyography and Nerve Conduction Studies—Revision to the Coding Guidelines**

The local coverage determination (LCD) coding guideline attachment for electromyography and nerve conduction studies (A95860) was effective on June 30, 2007. Since that time, the “Coding Guidelines” section has been revised to include coding information regarding H-Reflex studies for CPT codes 95934 and 95936. This information is based on the recommendations from the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) and includes information related to performing H-Reflex studies bilaterally, assessment of the gastrocnemius/soleus muscle, and testing in other muscles.

#### **Effective Dates**

This revision to the LCD coding guidelines is effective for services provided **on or after June 30, 2007**.

The full text for this LCD (L885) is available through the provider education Web site <http://www.floridamedicare.com> on or after this effective date. ❖

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## AG0108: Diabetes Outpatient Self-Management Training—Revision to the LCD

The local coverage determination (LCD) for diabetes outpatient self-management training was last revised on January 1, 2005. Since that time, the LCD has been revised based on change request (CR) 5433, dated May 25, 2007. In this regard, the LCD has been revised in the Coding Information/Bill Type Codes' section of the LCD to add type of bill codes 23x and 71x and to delete type of bill codes 72x, 74x and 75x. Also, the following revenue codes were added: 520, 521, 524, 525, 527 and 528. In addition, the language in the 'Other Comments' section of the 'Coding Guidelines' attachment has been replaced.

Also, the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD has been revised to delete the 'Medical Eligibility for Coverage' language in the latter part of this section, as CMS change request 3185, dated May 28, 2004, replaced this language **effective for services provided on or after January 1, 2004**.

### Effective Dates

These revisions to the LCD based on CR 5433 are effective for services provided **on or after July 1, 2007**.

The full text for this LCD (L1055) is available through the provider education Web site <http://www.floridamedicare.com> on or after this effective date. ❖

## AJ0129: Abatacept—Revision to the LCD

The local coverage determination (LCD) for abatacept became effective June 30, 2007. The type of bill (TOB) for billing claims for the administration of abatacept was inadvertently left out of the final version of the LCD. Therefore, the LCD is being revised to include TOB 12x, 13x, and 85x for billing the administration of abatacept.

### Effective Dates

This revision to the LCD is effective for services provided **on or after June 30, 2007**.

The full text for this LCD (L24536) is available through the provider education Web site <http://www.floridamedicare.com> on or after this effective date. ❖

## AJ1566: Intravenous Immune Globulin—Revision to the LCD

The local coverage determination (LCD) for intravenous immune globulin was last revised on October 30, 2006. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5635, transmittal 1261, dated June 1, 2007, to implement Health Care Procedure Code System (HCPCS) coding changes for intravenous immune globulin.

HCPCS code J1567 (Injection, immune globulin, intravenous, non-lyophilized [e.g., liquid], 500 mg) will no longer be payable by Medicare. The following HCPCS codes will replace HCPCS code J1567:

Q4087 Injection, immune globulin (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg

Q4088 Injection, immune globulin (Gammagard liquid), intravenous, non-lyophilized (e.g. liquid), 500mg

Q4091 Injection, immune globulin (Flebogamma), intravenous, non-lyophilized (e.g. liquid), 500mg

Q4092 Injection, immune globulin (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg

### Effective Dates

This revision to the LCD is effective for services provided **on or after July 1, 2007**.

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

## AJ2792: Rho (D) Immune Globulin Intravenous—Revision to the LCD

The local coverage determination (LCD) for Rho (D) immune globulin intravenous was last revised on October 1, 2005. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5635, transmittal 1261, dated June 1, 2007, to implement Health Care Procedure Code System (HCPCS) coding changes for Rho (D) immune globulin intravenous.

A new HCPCS code, Q4089 (Injection, Rho (D) immune globulin (human), (Rhophylac<sup>®</sup>), intramuscular or intravenous, 100 IU), has been established. Currently, Rhophylac<sup>®</sup> is the only product that should be billed using HCPCS code Q4089. If other products under the Food and Drug Administration (FDA) approval for Rhophylac<sup>®</sup> become available, HCPCS code Q4089 would be used to bill for such products.

### Effective Dates

This revision to the LCD is effective for services provided **on or after July 1, 2007**.

The full text for this LCD (L1339) is available through the provider education Web site <http://www.floridamedicare.com> on or after this effective date. ❖

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**AJ9000: Doxorubicin HCl—Revision to the LCD**

The local coverage determination (LCD) for doxorubicin HCl was last updated on April 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Association (FDA) drug label, and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI) for doxorubicin HCl – J9000.

Revisions for FDA approved indications and off-label indications were made under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.

**Effective Dates**

This revision to the LCD will be effective for services provided **on or after September 30, 2007**.

The full text for this LCD (L25108) is available through the provider education Web site <http://www.floridamedicare.com> on or after this effective date. ❖

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**AJ9206: Irinotecan (Camptosar®)—Revision to the LCD**

The local coverage determination (LCD) for irinotecan (Camptosar®) was last updated on April 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Association (FDA) drug label, and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI) for irinotecan – J9206.

Revisions for FDA approved indications and off-label indications were made under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.

**Effective Dates**

This revision to the LCD will be effective for services provided **on or after September 30, 2007**.

The full text for this LCD (L25120) is available through the provider education Web site <http://www.floridamedicare.com> on or after this effective date. ❖

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**ANCSVCS: The List of Medicare Noncovered Services—Revision to the LCD**

The local coverage determination (LCD) for the list of Medicare noncovered services became effective February 28, 2007. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5530, transmittal 67, dated April 6, 2007, which determined that the use of osmotic blood brain barrier disruption is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors. Therefore, this LCD is revised to add CPT code 64999 when used to bill for blood brain barrier osmotic disruption for the treatment of brain tumors to the “National Noncoverage Decisions” section of the LCD.

**Effective Dates**

This revision to the LCD is effective for services provided **on or after March 20, 2007**.

The full text for this LCD (L24028) is available through the provider education Web site <http://www.floridamedicare.com> on or after this effective date. ❖

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**AVISCO: Viscosupplementation Therapy For Knee—Revision to the LCD**

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised February 27, 2007. Since that time, a provider specific probe, prompted by data analysis for knee arthrography, revealed that providers were using imaging for the purpose of needle guidance when performing viscosupplementation. This LCD has been revised to clarify the indications and limitations, documentation requirements, and utilization guidelines. The “indications” and “limitations” have been separated and revised under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD to reflect additional requirements. The “Documentation Requirements” section of the LCD was revised to include the requirement of an X-ray report to support the diagnosis of osteoarthritis; and the requirement that the height and weight must be recorded in the medical record has been removed. Revisions under the “Utilization Guidelines” section of the LCD include a listing of the hyaluronic preparations, the weekly dosages and the total dosages per course of treatment. Additionally, there is a statement regarding the use of imaging procedures when performing viscosupplementation.

**Effective Dates**

This revision to the LCD will be effective for services provided **on or after September 30, 2007**.

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

# HOSPITAL SERVICES

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## American Medical Group Association Survey Data

In the May 11, 2007, *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) stated the posting on the CMS Web site of the American Medical Group Association (AMGA) survey data to be used in determining the teaching physician portion of costs for “all or substantially all of the costs for the training program in the non-hospital setting.” Since publication of the final rule, CMS have revised their Web posting of the AMGA survey data to include the salary data for both dentists and podiatrists. The AMGA data may be found at [http://www.cms.hhs.gov/AcuteInpatientPPS/06\\_dgme.asp](http://www.cms.hhs.gov/AcuteInpatientPPS/06_dgme.asp). ❖

Source: CMS Provider Education Resource 200707-04

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# CRITICAL ACCESS HOSPITAL SERVICES

## Health Professional Shortage Area Listing

The following are counties (all census tracts) designated as geographic health professional shortage areas (HPSAs) and therefore eligible for the bonus payment, as of May 11, 2007.

### Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Clay/Keystone Heights		Rural
Collier/Imokalee/Everglades		Rural
Columbia		Rural
Dixie		Rural
Escambia/Atmore (AL/FL)	0038.00, 0039.00, 0040.00	Rural
Franklin		Rural
Gadsden		Urban
Glades		Rural
Hamilton		Rural
Hardee		Rural
Hendry		Rural
Jefferson		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown		Rural
Okeechobee		Rural
Palm Beach	0080.01, 0080.02, 0081.01, 0081.02, 0082.01, 0082.02, 0082.03, 0083.01, 0083.02	Rural
Sumter		Rural
Suwannee		Rural
Wakulla		Rural

### Mental Health

County	Type
Bradford	Rural
Calhoun	Rural
Columbia	Rural
Dixie	Rural
Franklin	Rural
Gilchrist	Rural
Glades//Hendry CA	Rural
Gulf	Rural
Hamilton	Rural
Hendry CA/Glades	Rural
Hillsborough/Ruskin CCD/Wimauma-Lithia CCD	Urban
Holmes	Rural
Indian River/Fellsmere	Rural
Jackson	Rural
Jefferson	Rural
Lafayette	Rural
Lake	Rural
Liberty	Rural

County	Type
Madison	Rural
Martin/Indiantown Service area/Indiantown	Rural
Monroe/Upper Keys	Rural
Putnam	Rural
St Johns	Urban
Sumter	Rural
Suwannee	Rural
Taylor	Rural
Union	Rural
Wakulla	Rural
Walton	Rural
Washington	Rural

Source: CMS Atlanta Regional Office Memorandum, June 29, 2007



# ESRD SERVICES

## Line Item Billing Requirement for Epoetin Alfa Submitted on End-Stage Renal Disease Claims

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

### Provider Types Affected

Renal dialysis facilities (RDFs) submitting claims to Medicare fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for EPO provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on change request (CR) 5545, which completes the implementation of end-stage renal disease (ESRD) line item billing for renal dialysis facilities (RDFs) by providing instructions required to submit line item billing for EPO on ESRD claims with dates of service on or after January 1, 2008. Be sure your billing staff is aware of these requirements.

### Background

The first stage of the ESRD line item billing requirement was implemented by CR 5039 beginning on April 1, 2007. Now, CR 5545 completes the implementation of ESRD line item billing by providing instructions required to submit line item billing for EPO on ESRD claims with dates of service on or after January 1, 2008.

You may find an *MLN Matters* article related to CR 5039 on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5039.pdf>.

Line item billing allows for EPO to be billed the same way as all other separately payable drugs. For claims with dates of service on or after January 1, 2008, RDFs will bill for each administration of EPO on a separate line of the 72x type of bill indicating the line item date of service for the administration. The units reported on the claim line for EPO are multiplied by the total units defined by the Healthcare Common Procedure Coding System (HCPCS) to reflect the dosage per administration. Medicare will then calculate the EPO payment based on the units reported on the line for 72x claims with dates of service on or after January 1, 2008.

RDFs are no longer required to report value code 68 with the total monthly dosage with dates of service on or after January 1, 2008.

The total number of administrations of EPO will be determined by the total number of lines on the claim billing for EPO.

When RDFs report modifier GS, it is not required to be reported on every EPO line item. Modifier GS should be reported on the line item(s) that represent an administration of EPO at the reduced dosage following existing instruc-

tions in the *Medicare Claims Processing Manual* (Chapter 8, Section 60.4; <http://www.cms.hhs.gov/manuals/downloads/clm104c08.pdf>).

No payment reduction is made when modifier GS is present on the claim.

Supplies of EPO and Aranesp® for self-administration should be billed according to the pre-determined schedule in the plan-of-care provided to the beneficiary. RDFs should submit a separate line item **for each date an administration is expected to be performed** with the expected dosage. In the event that the schedule was changed, the provider should note the changes in the medical record and bill according to the revised schedule. For patients beginning to self-administer EPO or Aranesp at home who are receiving an extra month supply of the drug, RDFs should:

- Bill the one-month reserve supply on one claim line.
- Include modifier EM – Emergency Reserve Supply (for ESRD benefit only).

**Note:** Medicare will return claims to the provider containing more than one EPO or Aranesp line with the EM modifier for claims with dates of service on or after January 1, 2008.

RDFs should include condition code 70 on claims billing for home dialysis patients that self-administer anemia management drugs, including EPO and Aranesp.

**Note:** The electronic form required for billing ESRD claims is the ANSI X12 837 Institutional claim transaction. The data structure of that transaction is difficult to express in narrative form. In addition, small providers who are excepted from the requirement to submit electronic claims, CMS provides instructions in CR 5545 relative to the UB-04 (form CMS-1450) hardcopy form. Those instructions are in the form of a revision to the *Medicare Claims Processing Manual* and that revision is attached to CR 5545.

### Additional Information

The official instruction, CR 5545, issued to your Medicare FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1285CP.pdf>.

### *Line Item Billing Requirement for Epoetin Alfa Submitted on End-Stage Renal Disease Claims (continued)*

If you have any questions, please contact your Medicare FI 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 1-888-664-4112.

*MLN Matters* Number: MM5545

Related Change Request (CR) Number: 5545

Related CR Release Date: July 13, 2007

Related CR Transmittal Number: R1285CP

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1285, CR 5545

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# SKILLED NURSING FACILITY SERVICES

## Clarification of Skilled Nursing Facility Billing Requirements for Medicare Advantage Plans

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

### Provider Types Affected

Skilled nursing facilities (SNFs) billing either a Medicare administrative contractor (A/B MAC) or fiscal intermediary (FI) for SNF services provided to Medicare beneficiaries enrolled in a Medicare Advantage (MA) plan.

### Provider Action Needed

This article is based on change request (CR) 5653, which clarifies the Medicare billing requirements for beneficiaries enrolled in MA plans. CR 5653 reminds SNFs (and swing bed [SB] units) providers of the need to submit claims for such beneficiaries enrolled in MA plans and receiving skilled care in order to take benefit days from the beneficiary and/or update the beneficiary's spell of illness information in Medicare systems.

### Background

This instruction incorporates SNF billing requirements for beneficiaries that are enrolled in MA plans into the *Medicare Claims Processing Manual*. SNF providers must submit bills for beneficiaries enrolled in MA plans and receiving skilled care in order to take benefit days from the beneficiary and/or update the beneficiary's spell of illness in the Medicare's common working file (CWF) system.

In addition, Medicare is making system changes to allow hospital-qualifying stay edits to be overridden by contractors. This change is necessary in case of a disaster or emergency-related situation, or some other circumstance indicated by the Centers for Medicare & Medicaid Services (CMS), which requires special processing of claims.

### Key Points of Change Request 5653

Be aware that if a Medicare beneficiary chooses an MA plan as their form of Medicare, he/she cannot look to traditional "fee for service" Medicare to pay the claim if the MA plan denies coverage. SNF providers will apply the following policies to MA beneficiaries who are admitted to a SNF:

- If the SNF is non-participating with the plan, the beneficiary must be notified of their status because they are private pay in this circumstance.
- If the SNF is participating with the plan, pre-approve the SNF stay with the plan.
- If the plan denies coverage, appeal to the plan, not to the "fee for service" FI or A/B MAC.

- Count the number of days paid by the plan as Part A days used. (This counts as part of the beneficiary's 100 days of Medicare SNF benefits.)

- Submit a claim to the "fee for service" FI or A/B MAC to take benefit days from the CWF records.

**Note:** The MA plans do not send claims to Medicare for SNF stays). Failure to send a claim to the FI or A/B MAC will inaccurately show days available.

- Submit the claim using bill type 18x or 21x and include a HIPPS code (use default code AAA00 if no assessment was done), room and board charges and condition code 04 (informational only bill).

**Note:** If the beneficiary drops their MA plan participation, beneficiaries have the balance of their 100 SNF days available to use under Medicare fee-for-service.

### Additional Information

For complete details regarding this CR please see the official instruction (CR 5653) issued to your Medicare FI or A/B MAC. That instruction may be viewed by going to the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1290CP.pdf>.

If you have questions, please contact your Medicare FI or A/B MAC at their toll-free number, which may be found on the CMS 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 1-888-664-4112.

MLN Matters Number: MM5653

Related Change Request (CR) Number: 5653

Related CR Release Date: July 13, 2007

Related CR Transmittal Number: R1290CP

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1290, CR 5653

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## **CFW Edit C7251 Assigning Incorrectly on Skilled Nursing Facility Ancillary Type of Bills 22x**

First Coast Service Options, Inc. (FCSO) has discovered providers are receiving reject C7251 incorrectly on therapy services billed during a skilled nursing facility (SNF) inpatient stay when the SNF benefits are exhausted. It appears this problem began in October 2006.

This system problem was corrected on April 16, 2007; however, FCSO is working closely with the common working file and the Florida data center systems to identify the impacted claims.

### **Provider Action Needed**

**Providers do not need to take action at this time. Please do not resubmit your claims.**

FCSO will post updated information as needed to the provider educational Web site (<http://www.floridamedicare.com>) and providers will be notified of its availability via the eNews electronic mail.

We apologize for any inconvenience this may have caused. ❖

## **Clarification of Skilled Nursing Facility No Payment Billing**

*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 July 11, 2007, to delete a reference to “Part A exhausted” in the “No Pay Billings” section of this article. All other information remains the same. The *MLN Matters* article MM5583 was published in the July 2007 *Medicare A Bulletin* (pages 50-51).

### **Provider Types Affected**

Skilled nursing facilities (SNFs) submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for SNF services provided to Medicare beneficiaries.

### **Provider Action Needed**

#### **STOP – Impact to You**

This article is based on change request (CR) 5583, which clarifies SNF no-payment billing when the no-pay services overlap periods covered by a previously paid SNF type of bill (TOB) 22x.

#### **CAUTION – What You Need to Know**

Providers must include occurrence span code 74 with the ‘statement covers period’ of the TOB 210 being submitted in order to bypass Medicare edits that do not allow SNF TOB 210 (SNF noncovered level of care) to process when overlapping with previously paid TOB 22x (SNF inpatient stay, Part B only services [Part A exhausted]). CR 5583 also clarifies provider-billing requirements for beneficiaries who have disenrolled from Medicare Advantage (MA) plans, and it updates various sections of Chapter 6 (SNF Inpatient Part A Billing) of the *Medicare Claims Processing Manual* (Publication 100-04). **However, there are no policy changes made by CR 5583.**

#### **GO – What You Need to Do**

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

### **Background**

#### **No Pay Billings**

CR 5583 clarifies no pay billing instructions for SNF TOB 210 (SNF noncovered level of care) that overlap previously paid SNF TOB 22x (SNF inpatient stay, Part B only services).

In order to bypass Medicare edits that do not allow SNF TOB 210 to process when overlapping with previously

paid TOBs 22x, providers must include occurrence span code 74 with the ‘statement covers period’ of the 210 bill being submitted.

### **Beneficiaries Disenrolled from Medicare Advantage (MA) Plans**

Medicare covers SNF inpatient services for beneficiaries disenrolling from risk MA plans **when the beneficiary has not met the three-day prior hospital stay requirement.** (Where a beneficiary disenrolls from a risk MA, is discharged from the SNF, and then is re-admitted to the SNF under the 30-day rule, all requirements of original Medicare will apply, including the three-day prior hospital stay.)

Your FI or A/B MAC will begin counting 100 days of SNF care with the SNF admission date regardless of whether the beneficiary met the skilled level of care requirements on that date. All other Medicare rules apply, including:

- The requirement that beneficiaries meet the skilled level of care requirement (for the period for which the original Medicare fee-for-service program is billed).
- The rules regarding cost sharing apply to these cases.

In other words, providers may only charge beneficiaries for SNF coinsurance amounts.

SNFs submit the first fee-for-service inpatient claim with **condition code ‘58’** to indicate:

- A patient was disenrolled from an MA plan.
- The three-day prior stay requirement was not met.

Claims with condition code ‘58’ will not require the three-day prior inpatient hospital stay.

CR 5583 updates various sections of Chapter 6 of the *Medicare Claims Processing Manual* and these updates are provided as enclosures to CR 5583 including **the SNF Spell of Illness Quick Reference chart:**



*Clarification of Skilled Nursing Facility No Payment Billing (continued)*

Level of Care	Patient's Medicare SNF Part A Benefits Exhausted	Patient Is In Medicare Certified Area of Facility*	If in non-Medicare Area, Facility Meets Definition of SNF **	Is Inpatient Spell of Illness Continued?	Billing Action
<b>Medicare Skilled</b>	YES	YES	N/A	YES	Submit monthly covered claim
	NO	YES	N/A	YES	Submit monthly covered claim
	YES	NO	YES	YES	Submit monthly covered claim
	NO	NO	YES	Patient should be returned to certified area for Medicare to be billed	N/A
	NO	NO	NO	Patient should be returned to certified area for Medicare to be billed	N/A
<b>Not Medicare Skilled</b>	YES	NO	NO	NO	Do not submit claim if patient came in nonskilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	YES	YES	N/A	NO	Do not submit claim if patient came in nonskilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	NO	YES	N/A	NO	Do not submit claim if patient came in nonskilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	NO	NO	YES	NO	Do not submit claim if patient came in nonskilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	YES	NO	YES	NO	Do not submit claim if patient came in nonskilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.

\* Whether the facility considers a patient's bed in the certified area to be a Medicare bed or not has no effect on whether the spell of illness continues.

\*\* In some states, licensing laws for all nursing homes have incorporated requirements of the basic SNF definition (Social Security Act §1819(a)(1)). When this is the case, any nursing home in such a state would be considered to meet this definition (see *CMS Internet-Only Manual*, Pub. 100-7, Chapter 2, section 2164 on the CMS Web site at <http://www.cms.hhs.gov/manuals/>).

**Additional Information**

The official instruction, CR 5583, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1252CP.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 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 1-888-664-4112.

MLN Matters Number: MM5583  
 Related Change Request (CR) Number: 5583  
 Related CR Release Date: May 25, 2007  
 Related CR Transmittal #: R1252CP  
 Effective Date: October 1, 2006  
 Implementation Date: August 27, 2007

Source: CMS Pub. 100-04, Transmittal 1252, CR 5583

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# HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## New Outpatient Code Editor Resources Available

The outpatient code editor (OCE) processes outpatient Medicare claims from/for all institutional providers. Understanding the OCE is important to institutional providers because the OCE performs three major functions:

- Edits the outpatient claim data to identify coding errors
- Assigns an ambulatory payment classification (APC) number for each service covered under the outpatient prospective payment system (OPPS), and return information to be used as input to a pricer program.
- Assigns an ambulatory surgical center (ASC) payment group for services on claims from certain non-OPPS hospitals.

Effective for claims with dates of service July 1, 2007, and later, the non-outpatient prospective payment system (non-OPPS) OCE will be integrated into the OPPS OCE. The resulting integrated OCE will be used by fiscal intermediaries to process outpatient claims from both OPPS and non-OPPS hospitals.

Claims from non-OPPS hospitals with dates of service prior to July 1, 2007, will be routed through the last non-integrated update of the non-OPPS OCE software (OCE v22.2) and will process with the versions in effect for the date of service on the claim.

Editing that was only applied to OPPS hospitals (e.g., blood, drug, partial hospitalization logic) in the past will not be applied to non-OPPS hospitals at this time. However, with the integrated OCE, non-OPPS hospitals will be assigned specific edit numbers and dispositions, where in the past, this type of detail was not provided.

To understand the OCE and to stay up-to-date with changes, providers are encouraged to:

- Visit the OCE Web page at <http://www.cms.hhs.gov/OutpatientCodeEdit/> on the CMS Web site and review the various sections
- Review the OCE transmittal that is issued quarterly in order to identify any changes (OCE is updated generally at the beginning of January, April, July, and October)
- Take the OCE Web-based training course on the CMS Web site at [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=1](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1).

A July 2007 version of this course is under development. ❖

Source: CMS Provider Education Resource 200707-03  
CMS Provider Education Resource 200707-04

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# ELECTRONIC DATA INTERCHANGE

## Update of Claim Adjustment Reason Codes and Remittance Advice Remark Codes and Enhancement of Medicare Remit Easy Print

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

This article is based on change request (CR) 5634, which instructs Medicare contractors that a remittance advice remark code (RARC) must be used with claim adjustment reason codes (CARCs) 16, 17, 96, 125, and A1. CR 5634 also instructs that updated Medicare remit easy print (MREP) software will be provided which incorporates enhancements approved by the Centers for Medicare & Medicaid Services (CMS) and the currently valid claim adjustment reason and remittance advice remark codes.

### Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions (submission of claims, claims inquiries, electronic remittance advice, etc.) adopted under HIPAA using valid standard codes. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 transactions are part of the transactions and code sets rule selected by HIPAA, and the ANSI X12 subcommittee 'N' covers standards in the insurance industry, including health insurance (hence these are X12N standards). The ANSI ASC X12N transaction number 835 (ANSI ASC X12N-835) is the ANSI standard electronic remittance advice (ERA) transaction that provides payment information on a submitted claim.

### Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) Update

As a reminder, Medicare policy states that:

- Claim adjustment reason codes are required in the remittance advice and coordination of benefits transactions
- Remittance advice remark codes are **required in the remittance advice for both paper and electronic formats.**

When the payment differs from the amount being billed, payers communicate the reason for any adjustment using:

- **Group Codes** (which identify who is financially responsible for the amount that the payer is not reimbursing)

- **CARCs** (which provide an explanation why an amount is being adjusted)
- **RARCs** (which provide a supplemental explanation about the adjustment) Any RARC that has the word "Alert" is an informational remark code that does not provide any supplemental explanation for a specific adjustment but provides general information related to adjudication.

The following table includes Group Codes currently being used by CMS:

#### Group Code Definition

- CO** Contractual Obligation (Provider is financially responsible)
- PR** Patient responsibility (Provider can collect the amount from patient)
- OA** Other Adjustment (Generally used to report bundling/unbundling situation, predetermination of benefits, and secondary payments)
- CR** Correction (Used with reversal and correction)

The ANSI ASC X12N-835 Implementation Guide (version 004010A1) requires CARCs (if needed) but does not require use of RARCs. A HIPAA compliant version of the Implementation Guide for transaction 835 (Health Care Claim Payment & Remittance Advice) is available at <http://www.wpc-edi.com/HIPAA>.

The code committee that maintains the CARC code set recently modified five CARCs (16, 17, 96, 125, and A1). These CARCs were selected for modification because they were very generic, and they were used most frequently. Of these five CARCs, the following four now require the use of at least one appropriate RARC, and they are **effective April 1, 2007**:

#### CARC Definition

- 16** Claim/service lacks information, which 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.)
- 17** 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.)

## Update of Claim Adjustment Reason Codes and Remittance Advice Remark Codes ... (continued)

- 96** 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.)
- 125** 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.)

The remaining one CARC (which follows) also requires at least one RARC, but it is **effective June 1, 2007**.

### CARC Definition

**A1** Claim denied charges

CMS instructed your Medicare contractor(s) to analyze their current use of RARCs with CARCs 16, 17, 96, and 125, and determine if any existing RARCs (that are not currently being used) may be appropriate to explain an adjustment. Your Medicare contractor(s) may start using any of the currently existing RARCs with CARCs 16, 17, 96, 125, and A1.

**Note:** The most current list of RARCs may be found at <http://www.wpc-edi.com/codes>.

In addition, the committee that maintains reason codes approved the following CARC effective February 28, 2007:

### CARC Definition

**204** This service/equipment/drug is not covered under the patient's current benefit plan

Your Medicare contractor(s) may use CARC 204 instead of CARC 96 and an appropriate remark code, e.g., N130.

### RARC Definition

**N130** Consult plan benefit documents for information about restrictions for this service

RARC N130 will be used with CARC 96 as a default combination to be reported on all DME claims if:

- No code has been assigned by your Medicare contractor
- The service is not covered by Medicare.

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### Medicare Remit Easy Print Enhancement

CMS developed Medicare remit easy print (MREP) software that gives providers a tool to read and print an electronic remittance advice (RA) in a readable format. Providers who use the MREP software have the ability to print paper documentation that may be used to reconcile accounts receivable, as well as create document(s) that can be included with claims submissions to secondary/tertiary payers for coordination of benefits. Information regarding MREP and instructions on obtaining MREP are available through your Medicare contractor.

In a continuing effort to improve MREP, CMS established a process to receive suggestions to enhance the functionality and effectiveness of MREP from providers, contractors, and CMS staff. The next updated version of MREP that incorporates improvements approved by CMS will be available in July 2007. Note that the timeline for the annual MREP enhancement update has changed from October to July.

### Additional Information

The official instruction, CR 5634, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1267CP.pdf>.

If you have any questions, please contact your Medicare carrier, FI, RHHI, A/B MAC, or DME 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 1-888-664-4112.

MLN Matters Number: MM5634

Related Change Request (CR) Number: 5634

Related CR Release Date: June 15, 2007

Related CR Transmittal Number: R1267CP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1267, CR 5634



## National Provider Identifier Required to Enroll in Electronic Data Interchange and Update of Telecommunication and Transmission Protocols

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 [FI], including regional home health intermediaries [RHHI], Medicare administrative contractors (A/B MAC), or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

### Provider Action Needed

#### STOP – Impact to You

If not already enrolled for use of electronic billing and other electronic data interchange (EDI) transactions, you will not be able to enroll to begin use if you have not yet obtained a national provider identifier (NPI).

#### CAUTION – What You Need to Know

Change Request (CR) 5637, from which this article is taken, announces that providers must obtain an NPI, as a condition for initial enrollment, for the use of EDI. Your Medicare contractor will not issue you an EDI access number and password until you obtain an NPI.

#### GO – What You Need to Do

If you have not already obtained your NPI, you should apply now. You can apply online by going to <https://nppes.cms.hhs.gov/>.

### Background

Since May 2006, providers have been required to obtain an NPI prior to initial Medicare enrollment, or before updating their enrollment records, but were not required to have an NPI, as a condition for enrollment, in order to begin using EDI transactions.

CR 5637, from which this article is taken, announces that effective October 1, 2007 providers will need to obtain an NPI, as a condition for initial enrollment, for the use of EDI.

This is being implemented to further support efforts by the Centers for Medicare & Medicaid Services (CMS) to have all providers obtain NPIs as soon as possible. Moreover, as indicated in *MLN Matters* article MM5595 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>), Medicare is monitoring claims to determine the level of NPI reporting. This is being done to determine when it will be reasonable for Medicare to begin rejecting claims that lack an NPI for billing, pay-to or rendering providers.

CR 5637 also updates EDI connectivity information in the *Medicare Claims Processing Manual*, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and

Transmission Protocols) because some of the information in the manual is obsolete due to technology changes.

In summary, these changes are:

- Medicare contractors will use V.90 56K modems for EDI transactions submitted via dial-in connections.
- Medicare contractors will offer data compression in a means that an EDI transaction sender/receiver requests, using the V.90 56 K modem, PK ZIP version 2.04x or higher, WinZIP or V.42 bis data compression.
- DME MACs will reject standard National Council for Prescription Drug Programs (NCPDP) transactions that do not use the standard NCPDP electronic envelope.
- Medicare contractors may, but are not required to, accommodate other types of data compression that an EDI submitter/receiver requests.

### Additional Information

You can find more information about the requirement for an NPI in order to be able to use EDI transactions, by going to CR 5637, located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1283CP.pdf>.

As an attachment to CR 5637, you will find updated *Medicare Claims Processing Manual*, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols). You can find more information about EDI on the CMS Web site at

<http://www.cms.hhs.gov/ElectronicBillingEDITrans/>, and more information about the NPI at on the CMS Web site <http://www.cms.hhs.gov/NationalProvIdentstand/>.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME 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 1-888-664-4112.

*MLN Matters* Number: MM5637

Related Change Request (CR) Number: 5637

Related CR Release Date: July 6, 2007

Related CR Transmittal Number: R1283CP

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1283, CR 5637

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# **FRAUD AND ABUSE**

## **Health & Human Services Fights Durable Medical Equipment Fraud**

The Health & Human Services (HHS) Secretary Mike Leavitt announced a two-year effort designed to further protect Medicare beneficiaries from fraudulent suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). This initiative is focused on preventing deceptive companies from operating in south Florida and southern California.

This new initiative will have an immediate effect in two regions of the country where there are high concentration of suppliers, south Florida and southern California. Based on the results, it could be expanded nationwide.

Miami and Los Angeles have been identified as high-risk areas when it comes to fraudulent billing by DMEPOS suppliers. HHS, working with the Department of Justice (DOJ), formed a Medicare fraud strike force to combat fraud through the use of real-time analysis of Medicare billing data. In just three months, 56 individuals have been charged in the southern district of Florida with fraudulently billing Medicare for more than \$258 million. The strike force is made up of federal, state and local investigators.

For your convenience, copies of the HHS press release and fact sheet on this topic are available on the HHS Web site at <http://www.hhs.gov/news>. ❖

Source: CMS Provider Education Resource 200707-04

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

# EDUCATIONAL EVENTS

## Upcoming Provider Outreach and Education Events

*August 2007 – September 2007*

### Medicare 101 Seminar

**When:** Thursday, August 9, 2007  
**Time:** 8:00 a.m. – 5:00 p.m. Eastern Standard Time  
**Where:** Marriot Orlando Airport  
 7499 Augusta National Drive  
 Orlando Florida  
**Type of Event:** In-Person Seminar

### Ask the Contractor – Provider Enrollment Topics

**When:** Tuesday, August 14, 2007  
**Time:** 11:30 a.m. – 1:00 p.m. Eastern Standard Time  
**Type of Event:** Teleconference

### Hot Topics (Topics To Be Determined)

**When:** Tuesday, September 11, 2007  
**Time:** 11:30 a.m. – 12:30 p.m. Eastern Standard Time  
**Type of Event:** Teleconference

### Two Easy Ways To Register

**Online** – To register for this seminar, please visit our new training Web site at [www.fcsomedicaretraining.com](http://www.fcsomedicaretraining.com).

- If you are already a registered user of FCSO's Learning Management System (LMS), simply log on, select the specific session you are interested in, and click the "Register" button.
- If you are a **first-time user** of the LMS, you will need to set up an account. To do so, follow these steps:
  - From the welcome page, click on "I need to request an account" just above the log on button.
  - Complete the Request User Account form. (**Note:** Providers who do not yet have an NPI may use 9999.) You will receive your log on information within 72 hours of requesting an account.
  - Once your registration is complete, log on and select "Course Catalog," then select "Catalog." Select the specific session you are interested in, and then click the "Register" button.

**Fax** – Providers without Internet access can leave a message on our FCSO Provider Education and Outreach Registration Hotline 1-904-791-8103 requesting a fax registration form.

### 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.

Registrant's Name: \_\_\_\_\_

Registrant's Title: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

## OTHER EDUCATIONAL RESOURCES

### Rural Referral Center Fact Sheet

The *Rural Referral Center Fact Sheet*, which provides information about rural referral center program requirements, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order for the fact sheet, visit <http://www.cms.hhs.gov/mlngeninfo>, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.” ❖

Sources: CMS Provider Education Resource 200706-32  
CMS Provider Education Resource 200706-40

### News from the Medicare Learning Network

Want to know when the latest *Medicare Learning Network (MLN)* products are available? By subscribing to the *MLN\_EDUCATION\_PRODUCTS-L listserv* you will receive e-mail notifications of new and updated *MLN* products. To subscribe to the *MLN\_EDUCATION\_PRODUCTS-L listserv* or to any of the many other CMS listservs, go to the CMS Mailing Lists Web page at <http://www.cms.hhs.gov/apps/maillinglists/> and sign up today. ❖

Source: CMS Provider Education Resource 200706-40

### Updated 2007 Physician Quality Reporting Initiative Educational Resource

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the updated version of The Measure Finder Tool (Version 1.1) and *User Guide* is now available as part of the 2007 PQRI Tool Kit – Six Steps to Success.

The Measure Finder Tool (Version 1.1) is a slightly modified version of the tool to address a technical problem in Measure Finder Tool (Version 1.0). Please delete the previous version of the tool from your computer.

The Measure Finder Tool (Version 1.1) is designed to help eligible professionals and their coding/billing staff to quickly search for applicable measures and their detailed specifications. This tool will allow users to search for applicable measures based on a single code or a combination of codes. The *User Guide* provides instruction on how to use the PQRI Measure Finder Tool (Version 1.1).

To access the tool kit, visit, <http://www.cms.hhs.gov/PQRI>, on the CMS Web site in the *PQRI Tool Kit* section. Once on the *PQRI Tool Kit* page, scroll down to the “Downloads” section. ❖

Source: CMS Provider Education Resource 200706-38

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**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
_____	<p><b>Medicare A Bulletin Subscriptions</b> – The <i>Medicare A Bulletin</i> is available free of charge online at <a href="http://www.floridamedicare.com">http://www.floridamedicare.com</a>. Hardcopy or CD-ROM distribution is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida for processing during the twelve months prior to the release of each issue.</p> <p><b>Beginning with publications issued after June 1, 2003</b>, providers that meet the above criteria must register with our office (see Third Quarter 2006 <i>Medicare A Bulletin</i> page 8-9) to receive the <i>Bulletin</i> in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason is giving indicating why the electronic publication available free-of-charge on the Internet cannot be used. Non-Medicare providers (e.g., billing agencies, consultants, software vendors, etc.) or providers that need additional copies at other office-facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published during October 2006 through September 2007 (back issues sent upon receipt of the order). Please check here if this will be a:  <input type="checkbox"/> Subscription Renewal or  <input type="checkbox"/> New Subscription</p>	700284	<p>\$250.00 (Hardcopy)</p> <p>\$20.00 (CD-ROM)</p>

Subtotal \$ \_\_\_\_\_

Tax (add % for your area) \$ \_\_\_\_\_

Total \$ \_\_\_\_\_

**Mail this form with payment to:**  
**First Coast Service Options, Inc.**  
**Medicare Publications**  
**P.O. Box 406443**  
**Atlanta, GA 30384-6443**

Facility Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Attention: \_\_\_\_\_ Area Code/Telephone Number: \_\_\_\_\_

**Please make check/money order payable to: FCSO Account #700284**  
**(CHECKS MADE TO “PURCHASE ORDERS” NOT ACCEPTED)**

**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](http://www.floridamedicare.com).*

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**Addresses****CLAIMS STATUS****Coverage Guidelines****Billing Issues Regarding****Outpatient Services, CORE, ORF, PHP**

Medicare Part A Customer Service  
P. O. Box 2711  
Jacksonville, FL 32231-0021

**PART A REDETERMINATION**

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

**MEDICARE SECONDARY PAYER (MSP)****Information on Hospital Protocols****Admission Questionnaires****Audits**

Medicare Secondary Payer  
Hospital Review  
P. O. Box 45267  
Jacksonville, FL 32232-5267

**General MSP Information****Completion of UB-04 (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  
1-888-664-4112  
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 Web sites****PROVIDERS**

Florida Medicare Contractor  
[www.floridamedicare.com](http://www.floridamedicare.com)  
Centers for Medicare & Medicaid  
Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)

**BENEFICIARIES**

Centers for Medicare & Medicaid  
Services  
[www.medicare.gov](http://www.medicare.gov)

**Other Important Addresses****REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY****Home Health Agency Claims Hospice Claims**

Palmetto Government Benefit Administrators – Gulf Coast  
34650 US Highway 19 North, Suite 202  
Palm Harbour, FL 34684-2156

**RAILROAD MEDICARE****Railroad Retiree Medical Claims**

Palmetto Government Benefit Administrators  
P. O. Box 10066  
Augusta, GA 30999-0001

**DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)****Durable Medical Equipment Claims Orthotic and Prosthetic Device Claims Take Home Supplies****Oral Anti-Cancer Drugs**

CIGNA Government Services  
P. O. Box 20010  
Nashville, Tennessee 37202



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***MEDICARE A BULLETIN***

*FIRST COAST SERVICE OPTIONS, INC. ✦ P.O. Box 2078 ✦ JACKSONVILLE, FL 32231-0048*

**\* ATTENTION BILLING MANAGER \***

