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

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

Routing Suggestions :

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



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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 website <http://www.floridamedicare.com>.

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

Who Receives the Bulletin?

Anyone may view, print or 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 Registration department. Please remember that address changes must be done using the appropriate Form CMS-855.

What Is in the Bulletin?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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Sign up to our eNews electronic mailing list

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

GENERAL INFORMATION

Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], durable medical equipment administrative contractors [DMACs], and fiscal intermediaries (FIs) including regional home health intermediaries [RHHIs]).

What Providers Need to Know

Change request (CR) 5643, from which this article is taken, reminds the Medicare contractors and providers that the annual International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) update will be effective for dates of service **on and after October 1, 2007. (For institutional providers, effective for discharges on or after October 1, 2007.)**

You may see the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) Web site at <http://www.cdc.gov/nchs/icd9.htm> in June of each year.

Background

ICD-9-CM codes, became mandatory as follows:

- In 1979 for use in reporting provider services on Form CMS-1450.
- On April 1, 1989, for use by all physician services submitted on Form CMS-1500.
- On October 1, 2003 for all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59).

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2, (Relationship of ICD-9-CM Codes and Date of Service).

The Centers for Medicare & Medicaid Services (CMS) issued CR 5643 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2007 (for institutional providers, effective for discharges on or after October 1, 2007).

You should remember that an ICD-9-CM code is required for all professional claims (including those from physicians, nonphysician practitioners, independent clinical

diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers [ASCs]), and for all institutional claims; but is not required for ambulance supplier claims.

Additional Information

You may find the official instruction, CR 5643, issued to your Medicare contractor by visiting the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1269CP.pdf>.

As mentioned, you may find the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) Web site at <http://www.cdc.gov/nchs/icd9.htm>, in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for \$25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided on the CMS Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DMAC 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: MM5643
Related Change Request (CR) Number: 5643
Related CR Release Date: June 15, 2007
Related CR Transmittal Number: R1269CP
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1260, CR 5643

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July 2007 Quarterly Update to Medically Unlikely Edits

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

Provider Types Affected

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

Background

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as medically unlikely edits (MUEs). The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs. Key points of change request (CR) 5603 are as follows:

- CR 5603 announces the upcoming release of the next version of the MUEs, which is version 1.2.
- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPSC) code, date of service, and billing provider against a criteria number of units of service.
- CR 5603 states that Medicare carriers and A/B MACs will **deny** the entire claim line from providers with units of service that exceed MUE criteria and pay the other services on the claims, where the claims are processed by either Medicare DME system (VMS) or Medicare carrier system (MCS).
- FIs and A/B MACs will return to provider (RTP) claims from institutional providers with units of service that exceed MUE criteria and which are processed by Medicare fiscal intermediary shared system (FISS).

With regard to MUEs, providers are reminded of the following:

- An appeal process will not be allowed for RTP claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the national correct coding contractor.
- Excess **charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a “provider liability”)**, and this provision can neither be waived nor subject to an advanced beneficiary notice (ABN).

Additional Information

To see the official instruction (CR 5603) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1265CP.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: MM5603

Related Change Request (CR) Number: 5603

Related CR Release Date: June 12, 2007

Related CR Transmittal Number: R1265CP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1265, CR 5603

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Discontinuance of the Unique Physician Identification Number Registry

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment 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

STOP – Impact to You

This article is based on change request (CR) 5584 which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning unique physician identification numbers (UPINs) on June 29, 2007.

CAUTION – What You Need to Know

The national provider identifier (NPI) is a requirement of the Health Insurance Portability and Accountability (HIPAA) Act of 1996, and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare fee-for-service [FFS] contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.) Information on that contingency plan is on the CMS Web site at http://www.cms.hhs.gov/NationalProvIdentStand/downloads/NPI_Contingency.pdf.

Discontinuance of the Unique Physician Identification Number Registry (continued)

GO – What You Need to Do

If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) Web site at <https://nppes.cms.hhs.gov/>.

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

Background

CMS was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health & Human Services published a final rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the NPI. The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007, (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007, but see the note in the following box regarding the May 23, 2007, implementation by Medicare.

Note: Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the NPI. In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1,

2007. For more information on this contingency plan, please visit the NPI dedicated Web site at <http://www.cms.hhs.NationalProvIdentStand/>.

This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007, or to disable the UPIN “look-up” functionality as of September 30, 2007.

CMS will discontinue assigning on June 29, 2007, but CMS will maintain its UPIN public “look-up” functionality and registry Web site (<http://www.upinregistry.com/>) through September 30, 2007.

Additional Information

For additional information regarding NPI requirements and use, please see *MLN Matters* articles, MM4023 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf>) titled *Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms*, and MM4293 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf>) titled *Revised CMS-1500 Claim Form*, which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the NPI and renamed CMS-1500 (08-05).

The official instruction (CR 5584) issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R207PI.pdf>.

If you have any questions, please contact your Medicare carrier, intermediary, 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: MM5584

Related Change Request (CR) Number: 5584

Related CR Release Date: May 31, 2007

Related CR Transmittal Number: R207PI

Effective Date: May 29, 2007

Implementation Date: June 29, 2007

Source: CMS Pub. 100-08, Transmittal 207, CR 5584

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Update to the 2007 Medicare Physician Fee Schedule Database

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

Provider Types Affected

Physicians and 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.
- 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.
- 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.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5614) 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>.

Update to the 2007 Medicare Physician Fee Schedule Database (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: MM5614

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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Emergency Update to the 2007 Medicare Physician Fee Schedule Database

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

Note: CMS has revised this *MLN Matters* article on January 12, 2007, to reflect changes made to change request (CR) 5459. The CR release date and transmittal number have been changed and the Web address for accessing CR 5459 has been revised. All other information remains the same. The revised *MLN Matters* article was published in the May 2007 *Medicare A Bulletin* (page 5-6).

Provider Types Affected

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

Background

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

Key Points

You may wish to **review Attachment 1** of CR 5459, which is located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf>.

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

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

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

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

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

Q4083	Hyalgan/supartz inj per dose
Q4084	Synvisc inj per dose
Q4085	Euflexxa inj per dose
Q4086	Orthovisc inj per dose.
- Procedure status I is assigned to J7319, **effective January 1, 2007.**

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

Additional Information

For complete details regarding this CR please see the official instruction (CR 5459) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.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: MM5459 – Revised
Related Change Request (CR) Number: 5459
Related CR Release Date: January 11, 2007
Related CR Transmittal Number: R1152CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1152, CR 5459

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Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2006 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.

July 2007 Update and Previous Revisions to the Quarterly Average Sale Price Medicare Part B Drug Pricing File Updates

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5646, which informs Medicare providers of the availability of the July 2007 average sales price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 and April 2007 ASP files. Providers should make certain that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS), will be paid based on the ASP methodology.

July 2007 Update and Previous Revisions to the Quarterly ASP Medicare Part B Drug Pricing File Updates (continued)

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its Web site at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>.

As announced in late 2006, after carefully examining Section 1847A of the Social Security Act, as added by the Medicare Modernization Act of 2003, CMS has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A. As part of this effort, CMS reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” are operationalized in the context of payment under section 1847A. For the purposes of identifying “single source drugs” and “biological products” subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

- The FDA approval
- Therapeutic equivalents as determined by the FDA
- The date of first sale in the United States.

For a biological product (as evidenced by a new FDA biologic license application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under Section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may also be operationalized through use of existing specific HCPCS codes or “not otherwise classified” HCPCS codes.

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

Average Sales Price Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

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

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not

paid on a prospective payment basis are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPTS at the amount specified for the ambulatory payment classification to which the product is assigned.

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

July 2007 Update and Previous Revisions to the Quarterly ASP Medicare Part B Drug Pricing File Updates (continued)

methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after June 19, 2007, revised January 2007 and April 2007 ASP payment files and the July 2007 ASP file will be available for retrieval from the CMS ASP Web page. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP webpage is located on the CMS Web site at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>.

The revised files are applicable to claims based on dates of service as shown in the following table:

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

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner)

to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

Additional Information

The official instruction (CR 5646) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1270CP.pdf>.

If you have questions, please contact your Medicare carrier, FI or A/B MAC, DME MAC, DMERC 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: MM5646

Related Change Request (CR) Number: 5646

Related CR Release Date: June 15, 2007

Related CR Transmittal Number: R1270CP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1270, CR 5646

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Physician Quality Reporting Initiative—Education Resources

As a reminder, the Centers for Medicare & Medicaid Services (CMS) has several educational resources to promote and increase an understanding of the Physician Quality Reporting Initiative (PQRI). These resources will provide further guidance that will complement your upcoming Ask-the-Contractor (ACT) calls. Educational resources available on the Web site include:

2007 PQRI – New Educational Products

- Coding for Quality – A handbook for PQRI participation
- 2007 PQRI Code Master
- 2007 PQRI Fact Sheet

Frequently Asked Questions

CMS has posted frequently asked questions (FAQs). You may access these FAQs by visiting CMS Web site PQRI Web page at <http://www.cms.hhs.gov>.

Go to the overview section, scroll down to the "Related Links Inside CMS" section and click on the link titled "All PQRI FAQs." Continue to check the FAQ section regularly for updates.

PowerPoint Presentations

- 2007 PQRI Preparation and Participation Strategies for Successful Reporting – April 19, 2007
- 2007 PQRI Coding Guidance – Module III – May 24, 2007

Physician Quality Reporting Initiative—Education Resources (continued)

- 2007 “Coding for Quality: The Measures, Module 4” – June 13, 2007

You may access these presentations by visiting the PQRI Web page at, <http://www.cms.hhs.gov/PQRI>.

Go to the “Educational Resources” section and download the materials. ❖

Source: CMS Provider Education Resource 200706-18

2007 Physician Quality Reporting Initiative Tool Kit Is now Available

2007 PQRI Tool Kit – Five Steps for Success

The Centers for Medicare & Medicaid Services (CMS) has developed a tool kit for the 2007 Physician Quality Reporting Initiative (PQRI) that will assist eligible professionals with successful reporting. This tool kit consists of some existing educational resources plus new measure-specific worksheets designed to walk the user step-by-step through reporting for each measure.

The tool kit is now a featured section on the CMS PQRI Web page. To access the tool kit, visit, <http://www.cms.hhs.gov/PQRI>, and scroll down to the PQRI Tool Kit tab. The page serves as a “Read This First” guide to the resources that are available to download.

The tool kit consists of the following:

1. 2007 PQRI Physician Quality Measures
2. 2007 Coding for Quality Handbook
3. 2007 Code Master
4. *MLN Matters* Article 5640 – Coding & Reporting Principles
5. Data Collection Worksheets

The tool kit will be expanded as new educational resources become available.

Revisions to the Final 2007 PQRI Measure Specifications

The CMS announces revisions to the final 2007 PQRI Measure Specifications, version 1.1 to provide certain technical corrections.

Please visit the “Measures/Codes” page of the PQRI Web site at <http://www.cms.hhs.gov/pqri> for the updated measure specifications and release notes. ❖

Source: CMS Provider Education Resource 200706-24

Materials for May 24, 2007, PQRI National Provider Call

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the materials used during the May 24, 2007, national provider call have been posted to the CMS Web site.

Available Materials

- 2007 Physician Quality Reporting Initiative (PQRI) PowerPoint® presentation on coding guidance-module III, May 24, 2007
- Change request (CR) 5640 – Physician Quality Reporting Initiative (PQRI) Coding & Reporting Principles
- *MLN Matters* Article – MM5640

How to Access the Materials

To access the meeting materials, visit <http://www.cms.hhs.gov/PQRI> on the CMS Web site and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the “Downloads” section and click on the “**Materials for PQRI National Provider Call, May 24, 2007**” link. As an added benefit, the presentation is also available as an Adobe Acrobat® file.

Question of the Week

What are the financial benefits of participation in the PQRI?

PQRI participants who reports successfully will be eligible for a lump-sum bonus payment of up to 1.5 percent of the Medicare Physician Fee Schedule allowed charges, for services provided during the reporting period, subject to a cap, as established by the Tax Relief and Health Care Act of 2006 (TRHCA).

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

Source: CMS Provider Education Resource 200705-33

Financial Measures for Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) released the measures that will be used to evaluate the financial stability of suppliers that bid under the new Medicare DMEPOS competitive bidding program on Friday, May 25, 2007. All bids must include certain financial documentation in order for the supplier to be considered for a contract under the program. CMS and its competitive bidding implementation contractor (CBIC) will evaluate each bidder's financial documentation to determine whether the supplier will be able to participate in the program and maintain viability for the duration of the contract period.

The financial measures are standard accounting ratios commonly used to evaluate financial health. The following financial ratios will be used:

- Current ratio = current assets/current liabilities
- Collection period = (accounts receivable/sales) x 360
- Accounts payable to sales = accounts payable/net sales

- Quick ratio = (cash + accounts receivable)/current liabilities
- Current liabilities to net worth = current liabilities/net worth
- Return on sales = net sales/inventory
- Sales to inventory
- Working capital = current assets – current liabilities
- Quality of earnings = cash flow from operations/(net income + depreciation)
- Operating cash flow to sales = cash flow from operations/(revenue – adjustment to revenue)

CMS and the CBIC will calculate each bidder's financial ratios using the financial information submitted as part of the bid. CMS and the CBIC will also be utilizing the supplier's credit history in evaluating the financial health of the supplier. ❖

Source: CMS Provider Education Resource 200705-36

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

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

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME regional carriers [DMERCs], DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5641, which provides the July 2007 quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error or that may no longer be paid under the fee schedule. Be sure billing staff are aware of these changes.

Background

The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 60; on the CMS Web site <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>.

CR 5641 provides specific instructions regarding the July quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for DME, prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the *Code of Federal Regulations* (42 CFR 414.102).

Key Points

The following are key changes in the July 2007 quarterly update of the DMEPOS fee schedule including the Healthcare Common Procedure Coding System (HCPCS) codes:

- **HCPCS code E0762** (Transcutaneous electrical joint stimulation device system, includes all accessories) is:
 - **Added** to the fee schedule on **July 1, 2007**.
 - **Effective** for claims submitted with dates of service on or after **January 1, 2007**.
- HCPCS codes added July 1, 2007 with dates of service on or after July 1, 2007 are:
 - K0553** Combination oral/nasal mask, used with continuous positive airway pressure device, each
 - K0554** Oral cushion for combination oral/nasal mask, replacement only, each
 - K0555** Nasal pillows for combination oral/nasal mask, replacement only, pair
- Suppliers must use **modifier “KL”** on claims for all diabetic supplies that are **delivered via mail** with dates of service on or after **July 1, 2007**, with the following codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258 and A4259. Modifier KL must be used with diabetic supplies that are ordered remotely (i.e., by phone, email, internet, or mail) and delivered to the beneficiary's residence by common carriers (e.g., U.S. postal service, Federal Express, United Parcel Service) and not with items obtained by beneficiaries from local supplier storefronts.

July Quarterly Update for 2007 HCPCS Fee Schedule (continued)

- Fee schedule amounts for HCPCS code E2374 (Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only) are being revised to correct errors in the fee schedule calculation. Medicare contractors will adjust previously processed claims with dates of service on or after January 1, 2007, if resubmitted as adjustments.
- If suppliers re-submit previously processed claims for **code K0864 in Puerto Rico with dates of service from November 15, 2006 through March 31, 2007**, the DME MACs and DMERCs will adjust the claims for payment.

Also, after consulting with the Food and Drug Administration, the Centers for Medicare & Medicaid Services (CMS) determined that **ultraviolet light therapy** systems are classified as **class II devices** and are not class III devices. Thus, suppliers **should not submit the class III modifier “KF” with claims for HCPCS codes E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2005**. CMS is removing HCPCS codes E0691, E0692, E0693, and E0694, billed with modifier KF, from the fee schedule, effective July 1, 2007, and as of that date, Medicare contractors will reject claims for HCPCS codes E0691, E0692, E0693, and E0694, which contain modifier KF and a date of service on or after January 1, 2005. Medicare contractors will adjust previously processed claims for E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2007, if suppliers resubmit the claims as adjustments.

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.

The HCPCS quarterly update public use file, containing the long and short descriptors for all new codes, is available for downloading at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp.

Additional Information

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

For complete details regarding this Change Request (CR) please see the official instruction (CR5641) issued to your Medicare A/B MAC, FI, DMERC, DME MAC, RHHI or carrier. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1263CP.pdf>.

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

MLN Matters Number: MM5641

Related Change Request (CR) Number: 5641

Related CR Release Date: June 8, 2007

Related CR Transmittal Number: R1263CP

Effective Date: January 1, 2007 for implementation of fee schedule amounts for codes in effect on January 1, 2007, July 1, 2007, for all other changes

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1263, CR 5641

DMEPOS Competitive Bidding Reminder

The Centers for Medicare & Medicaid Services (CMS) is soliciting bids for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding program.

Time Is Running Out

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.

The registration deadline is June 30, 2007

To register, please visit the Competitive Bidding Implementation Contractor (CBIC) Web site at <http://www.dmecompetitivebid.com>.

Additional Information

- The contract period for mail order diabetic supplies is April 1, 2008 – December 31, 2009.

- The contract period for all other first round product categories is April 1, 2008 – March 31, 2011.

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.

Note: All bids are due by 9:00 p.m. prevailing Eastern Time on July 13, 2007.

For more information on the program as well as bidding and accreditation information, please visit <http://www.dmecompetitivebid.com>. ❖

Source: CMS Provider Education Resource 200706-22
CMS Provider Education Resource 200706-28
CMS Provider Education Resource 200706-36

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Home Health Agencies Providing Durable Medical Equipment in Competitive Bidding Areas

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 May 22, 2007, to reflect changes made to change request (CR) 5551. The effective date, implementation date, transmittal number CR release date and Web address for accessing CR 5551 were changed. All other information remains the same. The revised *MLN Matters* article was published in the June 2007 *Medicare A Bulletin* (page 13).

Provider Types Affected

All home health agencies (HHAs) billing Medicare contractors (fiscal intermediaries [FIs] or regional home health intermediaries [RHHIs]) for durable medical equipment (DME) provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

HHAs that furnish DME and are located in one of the competitive bidding areas for DME where the DME items are subject to the competitive bidding program, must be either awarded a contract to furnish the items in this area or use a DME supplier who does have a contract with Medicare for such DME items.

CAUTION – What You Need to Know

The competitive bidding items are identified by HCPCS codes and the competitive bidding areas are identified based on ZIP codes of the permanent residence of the beneficiary receiving the items. Further, the RHHIs will not process claims with affected HCPCS codes for competitive bid DME items. Such claims will be returned to the HHA for removal of the DME line items and appropriate submission of those items to DME Medicare administrative contractors (MACs).

GO – What You Need to Do

HHAs should read the remainder of this article for important information regarding the new competitive bidding program for DME under Medicare and take appropriate action based on the impact of this program on your DME billings.

Background

This article and related change request (CR) 5551 provides general guidelines for processing HHA claims. Beginning in 2007, in a competitive bidding area, a supplier must be awarded a contract by the Centers for Medicare & Medicaid Services (CMS) in order to bill Medicare for competitively bid DME. Therefore, HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program must either:

- Be awarded a contract to furnish the items in this area or
- Use a contract supplier in the community to furnish these items.

The competitive bidding items will be identified by HCPCS codes and the competitive bidding areas will be identified based on ZIP codes where beneficiaries receiving these items maintain their permanent residence. The DME MACs will have edits in place indicating which entities are

eligible to bill for competitive bid items and the appropriate competitive bid payment amount.

Important points to remember are:

- All suppliers of competitively bid DME **must bill the DME MAC** for these items and will no longer be allowed to bill the RHHIs for competitive bid items.
- Claims submitted to the RHHI for HCPCS codes subject to a competitive bidding program will be returned to the provider to remove the affected DME line items and the providers will be advised to submit those charges to the DME MACs who will have jurisdiction over all claims for competitively bid items.
- Claims for DME furnished by HHAs that are not subject to competitive bidding would still be submitted to the RHHIs.

Attached to CR5551 is a list of the HCPCS codes and ZIP codes applicable to the competitive bidding areas. (See *Additional Information* section of this article for the Web address of CR 5551)

Additional Information

For information on registering to compete for a DME contract in the competitive bidding areas, see the *MLN Matters* article titled “Initial Supplier Registration for Competitive Bidding Program is Now Open”, which is on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0717.pdf>.

For complete details regarding this CR please see the official instruction (CR 5551) issued to your Medicare RHHI, FI, or DME MAC. This instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1246CP.pdf>.

If you have questions, please contact your Medicare FI, RHHI 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: MM5551 – Revised
Related Change Request (CR) Number: 5551
Related CR Release Date: May 22, 2007
Related CR Transmittal Number: R1246CP
Effective Date: April 1, 2008
Implementation Date: April 1, 2008

Source: CMS Pub. 100-04, Transmittal 1246, CR 5551

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AMBULANCE SERVICES

Medicare Payments for Ambulance Transports

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

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MAC) for ambulance services or who initiate ambulance transports for their Medicare patients.

Provider Action Needed

STOP – Impact to You

According to a recent study conducted by the Office of the Inspector General (OIG), “Medicare Payments for Ambulance Transports,” during the calendar year 2002 twenty-five percent of ambulance transports did not meet Medicare’s program requirements. This resulted in an estimated \$402 million of improper payments. In two out of three cases, third-party providers (most likely not the patient) who requested transports may not have been aware of Medicare’s requirements for ambulance transports.

CAUTION – What You Need to Know

Liability for overpayment resulting from a denied ambulance transport claim depends on the type of denial. A denial due to coverage reasons (such as when other forms of transportation are not contraindicated) may result in a liability to the Medicare beneficiary unless he or she lacks constructive knowledge that the service is not covered. Claims denied due to level of service requirements are often down-coded to a lower level of ambulance service. In this case, the ambulance supplier is generally liable in the event of an overpayment.

GO – What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified. It is important to know whether Medicare would cover the use of an ambulance transport for your patient, and if so, what level of service would be covered. Please refer to the *Background* section of this special edition article for information about payment and level of service requirements for ambulance transports.

Background

Some key provisions of the OIG Report are as follows:

Medicare Coverage of Ambulance Transports

When evaluating coverage of ambulance transport services, two separate questions are considered:

1. Would the patient’s health at the time of the service be jeopardized if an ambulance service was not used? If so, Medicare will cover the ambulance service whether it is emergency or nonemergency use of the transport. If not, the Centers for Medicare & Medicaid Services (CMS) will deny the transport claim. Additionally, Medicare does not cover nonambulance transports.

2. Once coverage requirements are met, Medicare asks the following question: What level of service (determined by medical necessity) is appropriate with regard to the diagnosis and treatment of the patient’s illness or injury? If the incorrect level of service is billed and subsequently denied, Medicare will usually reimburse at a lower rate reflecting the lower level of services judged appropriate.

Levels of ambulance service are differentiated by the equipment and supplies carried in the transport and by the qualifications and training of the crew. They include:

- a) Basic life support
- b) Advanced life support
- c) Specialty care transport
- d) Air transport – fixed wing and rotary wing

Emergency Ambulance Transport

An emergency transport is one provided after the sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to:

- Place the patient’s health in serious jeopardy
- Result in serious impairment of bodily functions, or
- Result in serious dysfunction of any bodily organ.

Symptoms or conditions that may warrant an emergency ambulance transport include, but are not limited to:

- Severe pain or hemorrhage
- Unconsciousness or shock
- Injuries requiring immobilization of the patient
- Patient needs to be restrained to keep from hurting himself or others
- Patient requires oxygen or other skilled medical treatment during transportation
- Suspicion that the patient is experiencing a stroke or myocardial infarction. See chapter 15 of the *Medicare Claims Processing Manual* (Pub. 100-4) and chapter 10 of the *Medicare Benefit Policy Manual* (Pub. 100-2) at <http://www.cms.hhs.gov/Manuals/TOM/list.asp>.

Nonemergency Ambulance Transports

Nonemergency ambulance transportation is appropriate with a patient who is bed-confined **and** his/her condition is such that other methods of transportation are contraindicated; OR if the patient’s condition, regardless of bed-confinement, is such that transportation by ambulance is medically required (patient poses a danger to him or herself or to others). **Bed-confinement alone is neither sufficient nor necessary to determine the coverage for Medicare**

Medicare Payments for Ambulance Transports (continued)

benefits. To be considered bed-confined, **the patient must be unable to do all three of the following:**

- Get up from bed without assistance
- Ambulate
- Sit in a chair or wheelchair.

Documentation Requirements

Ambulance suppliers are not required to submit documentation in addition to the uniform Medicare billing form CMS-1500 submitted by independent ambulance suppliers to Medicare carriers or A/B MACs or the UB-04 (form CMS-1450) billed to FIs or A/B MACs by ambulance suppliers that are owned by or affiliated with a Medicare Part A provider such as a hospital.

However, ambulance suppliers are required to retain documentation that contains information about the personnel involved in the transport and the patient's condition and to be made available to Medicare FIs, carriers, and A/B MACs upon request. Ambulance suppliers are also required to obtain a physician certification statement (PCS) for nonemergency transports. The PCS states the reason(s) a patient requires nonemergency transportation by ambulance. It is effective for 60 days from the date it is signed. The PCS, or proof of the supplier's attempt to obtain it, is required within 48 hours after provision of the ambulance service. The "trip ticket" is documentation used in emergency transports and contains the date, mileage, crew, origin, destination, type and level of ambulance service provided, patient condition, the type of service, and supplies provided to the patient while in transport.

How to Avoid Improper Billing

- Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation. For guidance, you may wish to refer to change request (CR) 5422 "Ambulance Fee Schedule – Medical Conditions List – Manualization," which contains an educational guideline that was developed to assist ambulance providers and suppliers communicate the patient's condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided below.

- Maintain documentation that will help to determine whether ambulance transports meet program requirements when Medicare FIs, carriers, and A/B MACs conduct medical reviews. Be sure to send complete documentation when requested by your FI, carrier, or A/B MAC. Generally, coverage errors for emergency transports were due to documentation discrepancies between the ambulance supplier and the third-party provider (e.g., emergency room records).
- Note whether your FI, carrier, or A/B MAC has implemented origin or destination modifiers such as for a dialysis facility and for non-emergency transports to and from a hospital, nursing home, or physician's office. Be sure to include these modifiers (if available) when billing for ambulance services. They will help your FI, carrier, or A/B MAC to determine, through a prepayment edit process, whether the coverage and/or level of service for ambulance use is correct.

Additional Information

SE0724 is based on the January 2006 U.S. Department of Health and Human Services (HHS) OIG report, *Medicare Payments for Ambulance Transports*, which is located at <http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf> on the OIG HHS Web site.

CR 5422, dated February 23, 2007, "Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions," is located on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf>.

If you have 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: SE0724

Related Change Request (CR) Number: N/A

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Source: CMS Special Edition *MLN Matters* Article SE0724

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NATIONAL PROVIDER IDENTIFIER

Stage 3 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice

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

Provider Types Affected

Physicians, providers, and suppliers who conduct Health Insurance Portability and Accountability Act (HIPAA) standard transactions, such as claims and eligibility inquiries, with Medicare.

Provider Action Needed

STOP – Impact to You

Be aware that Stage 3 of the national provider identifier (NPI) implementation is nearing. This article discusses impact of the NPI Stage 3 implementation on remittance advice transactions.

CAUTION – What You Need to Know

Make sure you have your NPI, know how to use it, and are prepared to receive it back in your remittance advice processes.

GO – What You Need to Do

Read the remainder of this article and be sure your staff is aware of how the NPI implementation impacts the remittance advice transactions you receive.

Background

This article discusses Stage 3 of Medicare fee-for-service (FFS) processes for the NPI and reflects Medicare processing of claims submitted with NPIs. Submitted NPIs will be cross-walked to the Medicare legacy number(s) for processing. Medicare internal provider files will continue to be based upon records established in relation to the legacy identifiers. The cross-walk may result in:

Scenario I: Single NPI cross-walked to single legacy number

Scenario II: Multiple NPIs cross-walked to single Medicare legacy number

Scenario III: Single NPI cross-walked to multiple Medicare legacy numbers

CMS will adjudicate Medicare FFS claims based upon a unique NPI/legacy combination for scenarios II and III, but the remittance advice, both electronic and paper, and any output using PC Print or Medicare Remit Easy Print (MREP) will have only NPI as the primary provider identification. The tax identification number (TIN) will be used as the secondary identifier for the payee. The NPI regulation permits continued use of the TIN for tax purposes if the implementation guide allows it.

The companion documents and flat files for both Part A and B will be updated to reflect these changes and the updated documents will be posted on the CMS Web site at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage.

The following three scenarios refer to Medicare reporting of NPIs in remittance advice processes.

Note: Current requirements concerning the reporting of provider names and addresses still apply.

Scenario I – Single NPI cross-walked to single legacy number:

- **Electronic Remittance Advice (ERA)** – Under this scenario, Medicare will report the NPI at the payee level as the payee primary ID, and the TIN (employer identification number [EIN]) social security number [SSN] (EIN/SSN) in the REF segment as Payee Additional ID. Medicare will report any relevant rendering provider NPI at the claim level if different from the payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will also report relevant rendering NPI(s) at the service line level if different from the claim level, rendering provider NPI. Under this scenario, there will be one remittance advice, and one check/electronic fund transfer (EFT) per NPI.
- **Standard Paper Remittance (SPR)** – Medicare will insert the appropriate payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** – Medicare will show the payee NPI at the header level and add the relevant rendering provider NPI at the claim level if different from the payee NPI.
- **MREP Software** – Medicare will show the payee NPI at the header level and add any relevant rendering provider NPI at the claim level if different from the payee NPI, and any relevant rendering NPI(s) at the service line level if different from the claim level rendering provider NPI.

Scenario II: Multiple NPIs cross-walked to single Medicare legacy number:

- **ERA** – Under this scenario, Medicare will report the NPI at the Payee level as the payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then add any relevant rendering provider NPI at the claim level if different from the payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add any relevant Rendering NPI(s) at the service line level if different from the claim level rendering provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be

Stage 3 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice (continued)

multiple remittance advices, checks and/or EFTs based on that unique combination.

- **SPR** – Medicare will insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** – Same as Scenario I.
- **MREP Software** – Same as Scenario I.

Scenario III: Single NPI cross-walked to multiple Medicare legacy numbers:

- **ERA** – Under this scenario, Medicare will report the NPI at the payee level as the payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then, Medicare will add any relevant rendering provider NPI at the claim level if different from the payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add relevant rendering NPI(s) at the service line level if different from the claim level, rendering provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** – Insert appropriate NPI number at the header level. The ERA reporting requirements apply to corresponding SPR fields. See above for additional notes.
- **PC Print Software** – Same as Scenario I.
- **MREP Software** – Same as Scenario I.

Implementation

While these changes are effective for dates of service on or after July 2, 2007, the changes will be implemented as follows:

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- For claims submitted to DMERCs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur on October 2, 2007.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5452) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf>.

The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* are attached to CR 5452.

If you have questions, please contact your Medicare carrier, FI, Part A/B Medicare administrative contractors (A/B MAC), durable medical equipment regional carrier (DMERC), DME/MAC, and/or regional home health intermediary (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: MM5452

Related Change Request (CR) Number: 5452

Related CR Release Date: May 18, 2007

Related CR Transmittal Number: R1241CP

Effective Date: July 2, 2007

Implementation Date for DME suppliers: July 2, 2007

Implementation Date for other providers: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1241, CR 5452

The National Provider Identifier Compliance Deadline Is Here**NPI: Is Here. NPI Is Now. Are You Using It?**

At this point, any covered entity that is noncompliant, and has not implemented a contingency plan, is at risk for enforcement action. Please review the April 2, 2007, CMS *“Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule.”* As this guidance pertains to claims transactions, it means that:

1. Providers must have and use their NPI.
2. Clearinghouses must accept and use NPIs.
3. Health plans must accept and send NPIs in claims transactions.

Providers should be:

1. Aware of contingency plans for any health plans they bill. Contingency plans may differ by health plan.

2. Aware that health plans may lift their contingency plans (and require an NPI on claims or other HIPAA transactions) any time before May 23, 2008.
3. Working with vendors and clearinghouses with whom they contract, to make sure the NPI is being passed to health plans.
4. Paying close attention to how and when health plans will be testing implementation of the NPI.
5. Aware that, for those health plans that did not establish a contingency plan, providers are required to use their NPIs now. This means that if you are not using your NPI, your claim may be rejected or denied.

The National Provider Identifier Compliance Deadline Is Here (continued)

New Tip Sheet Available

A tip sheet entitled **What the “Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule” Means for Health Care Providers** is now available at <http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/ContingencyTipSheet.pdf>.

This product provides helpful steps for providers based on the contingency guidance released on April 2, 2007. This guidance does not mean that providers have an extra year to get an NPI, so please view the tip sheet for additional information.

Reminder – Sharing NPIs

Once providers have received their NPIs, they should share them with other providers with whom they do business, and with health plans that request them. In fact, as outlined in current regulation, providers who are covered entities under HIPAA must share their NPIs with any entities that request them for use in standard transactions – including those who need to identify ordering or referring physicians/providers. Providers should also consider letting health plans, or institutions for whom they work (e.g., a large hospital system), share their NPIs for them.

When to Contact the NPI Enumerator for Assistance

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

- Status of an NPI application, update, or deactivation
- Forgotten/lost NPI
- Lost NPI notification letter
- Trouble accessing NPPES
- Forgotten password/user ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

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

Resources for other kinds of questions may be found at the end of this document.

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

Important Information for Medicare Fee-for-Service Providers Testing Medicare Claims

To date, Medicare has encouraged providers to submit

both an NPI and a legacy identifier on claims. 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. If any claim is rejected, the NPI should be verified to make sure it was entered correctly. If the NPI is correct, then data in either NPPES or Medicare provider files should be corrected. The following fields in your NPPES and/or 855 provider enrollment record should be validated:

- EIN (for organization providers)
- Other provider identification numbers. This is where providers, when they apply for their NPIs, list the Medicare legacy identifier(s) that needs to be linked to the NPI.
- Practice location address
- Master address (from provider enrollment records)
- Other address (from provider enrollment records)
- Legal name or legal business name

Once this has been done, 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.

While Medicare FFS has announced its contingency plan, it is committed to ending the contingency plan as soon as possible.

Reminder – Medicare FFS Contingency Plan Announced on April 24th

View the associated change request on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R1227CP.pdf>, as well as the related MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

These materials were recently revised; please be sure to visit the links above for the latest information.

Reminder – NPI MLN Matters Articles

There are many *MLN Matters* articles dealing with various topics of NPI relative to the Medicare program. These *MLN Matters* articles are available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/MMArticles_npi.pdf.

Additional Information

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 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 200705-30

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Important NPI Announcement Regarding Data Dissemination and UPIN Registry

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

CMS Publishes National Plan and Provider Enumeration System Data Dissemination Notice

On May 30, 2007, the Centers for Medicare & Medicaid Services (CMS) published the data dissemination notice in the *Federal Register*. The final copy of the notice is posted on the CMS NPI Web site at <http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf>.

New Data Dissemination FAQs Available

CMS has posted new FAQs related to the recently published data dissemination notice. Questions include:

- Where is the national plan and Provider Enumeration System (NPPES) data dissemination policy conveyed?
- What national plan and Provider Enumeration System (NPPES) data will CMS disclose?
- How will CMS make the Freedom of Information Act (FOIA)-disclosable national plan and Provider Enumeration System (NPPES) data available?
- Is there a charge to obtain the Freedom of Information Act (FOIA)-disclosable national plan and Provider Enumeration System (NPPES) health care provider data?
- I want Freedom of Information Act (FOIA)-disclosable data for only the physicians in New York and I want the data on a CD. How do I go about having my request fulfilled?
- When will the Freedom of Information Act (FOIA)-disclosable national plan and Provider Enumeration System (NPPES) health care provider data be available?

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To view these FAQs, you should:

- 1) Go to the CMS dedicated NPI web page at <http://www.cms.hhs.gov/NationalProvIdentStand>.
- 2) Scroll down to the section that says "Related Links Inside CMS"
- 3) Click on NPI Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated". Look for the word "NEW" in red font to appear beside the most recent FAQs.

Important Information for Medicare Fee-for-Service Providers

CMS Discontinues the Unique Physician Identifier Number (UPIN) Registry

Effective June 29, 2007, CMS will discontinue assigning UPINs to Medicare providers. For further details, visit the change request on this subject at <http://www.cms.hhs.gov/transmittals/downloads/R207PI.pdf> and the associated *MLN Matters* article on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5584.pdf>.

As always, more information and education on the NPI may be found on the CMS NPI 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 200706-03

National Plan and Provider Enumeration System Data Dissemination Notice

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

The Centers for Medicare & Medicaid Services (CMS) will be publishing the National Plan and Provider Enumeration System (NPPES) Data Dissemination Notice in the *Federal Register*. The notice is now on display at the Office of the Federal Register. It was published on May 30, 2007.

The notice describes the policy by which CMS will make certain NPPES health care provider data available to covered entities under the Health Insurance Portability and Accountability Act (HIPAA) and to others.

- NPPES health care provider data that are required to be disclosed under the Freedom of Information Act (FOIA) will be made publicly available on June 28, 2007, 30 days after the publication date of the notice.
- 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 whereby users can query by national provider identifier (NPI) or provider name.

- The notice encourages health care providers who have been assigned NPIs to review their NPPES data at this time and make any necessary updates or corrections prior to the end of the 30-day period, to ensure that their information is accurate when disclosed by CMS. (Health care providers who are covered entities under HIPAA are required by regulation to update their NPPES data within 30 days of any change.)
- The notice states that health care providers who wish to delete any NPPES data that was not required to be

National Plan and Provider Enumeration System Data Dissemination Notice (continued)

furnished in order to obtain an NPI may do so prior to the end of the 30-day period if they prefer that those data not be disclosed by CMS.

An advance copy of the notice is available on the CMS NPI Web site at

<http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf>.

Important Information

The PDF version of the notice that is available from this Web page, and the document published in the *Federal Register* may vary slightly if the editor at the Office of the *Federal Register* makes minor revisions to it. The official version of the notice will be the one that is published in the *Federal Register*.

Additional Information

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 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 200705-35

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.

Stage 2 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22—Remittance Advice

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

Special note regarding remittance advice transactions:

Just as it is important to understand when and where to report national providers identifiers (NPIs) in claim transactions, it is crucial that providers understand and be ready to accept the provider identifiers as reported on remittance advice transactions. This article discusses what provider identifiers Medicare will report on remittances under Stage 2 of Medicare NPI implementation. However, the processes will change as Medicare moves to Stage 3 implementation of the NPI. **A key difference is that NPIs will be returned in many remittance transactions as the payee and the tax identification number (TIN) as the additional payee identifier rather than the current practice of reporting TIN and legacy number respectively, even though the provider may have included the legacy number and the NPI on their claim. Providers need to review, and understand the impact of, Stage 3 on remittances** as discussed in the *MLN Matters* article MM5452, which is on the CMS Web site at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf>.

Also, note that CMS revised this *MLN Matters* article on May 7, 2007, to add this statement that Medicare fee-for-service (FFS) has announced a contingency plan regarding the May 23, 2007, implementation of the national provider identifier (NPI). For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article MM5595 on the CMS Web site at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

The *MLN Matters* article MM5595 was published in the May 2007 *Medicare A Bulletin* (pages 17-18).

Provider Types Affected

All Medicare physicians, providers, suppliers, and billing staff who submit claims for services to Medicare contractors (fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], carriers, and durable medical equipment regional carriers [DMERCs] and durable medical equipment administrative contractors [ME MACs])

Background

This article instructs the shared system maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advice (ERA) – transaction 835, and standard paper remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR, national supplier clearinghouse (NSC), provider identification numbers (PIN), national council of prescription drug plans (NCPDP) pharmacy identifiers, and unique physician identification numbers (UPINs). CMS's definition of legacy numbers does not include TIN such as employer identification numbers (EINs) or social security numbers (SSNs).

Stage 2 NPI Changes for Transaction 835, and Standard Paper Remittance Advice, ... (continued)

Medicare has published CR 4320 (<http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf>) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via direct data entry screens, or on paper claim forms.

Providers need to be aware that these instructions that impact contractors will also impact the content of their SPR, ERA, and their PC print and MREP software.

The following dates outline the regulations from January 2006 forward and are as follows:

- **January 3, 2006 – October 1, 2006:** Medicare rejects claims with only NPIs and no legacy number.
- **October 2, 2006 – May 22, 2007:** Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction e.g., ERA
- **May 23, 2007 – Forward:** Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

Medicare providers may want to be aware of the following Stage 2 scenarios so that they are compliant with claims regulations and receive payments in a timely manner.

Key Points

During Stage 2, if an NPI is received on the claim, it will be cross-walked to the Medicare legacy number(s) for processing. The crosswalk may result in:

Scenario I: Single NPI – cross walked to single legacy number

Scenario II: Multiple NPIs – cross walked to single Medicare legacy number

Scenario III: Single NPI – cross walked to multiple Medicare legacy numbers

Note: The standard paper remittance for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level.

CMS will adjudicate claims based upon Medicare legacy number(s) even when NPIs are received and validated. The remittance advice (RA) may be generated for claims with the same legacy numbers but and different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or electronic funds transfer (EFT).

During Stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers.

The companion documents will be updated to reflect these changes and the updated documents will be posted on the CMS Web site at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage.

Note: The following scenarios will change under Stage 3 of Medicare NPI implementation. To see the changes, see *MLN Matters* article MM5452, which is available on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf>.

Scenario I – Single NPI Cross Walked to Single Legacy Number

1. **ERA:** Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
2. **SPR:** Insert the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. **PC Print Software:** Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. **MREP Software:** Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

Scenario II: Multiple NPIs Cross Walked to Single Medicare Legacy Number

1. **ERA:** Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPI at the claim and/or at the service level, if needed. The specific NPI associate with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.
2. **SPR:** Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.
3. **PC Print Software:** Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.
4. **MREP Software:** Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

Scenario III: Single NPI Cross Walked to Multiple Medicare Legacy Numbers

1. **ERA:** Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed. (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to five legacy numbers, we will issue five separate RAs and 5 separate checks/EFTs per each legacy number.
2. **SPR:** Insert the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. **PC Print Software:** Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

Stage 2 NPI Changes for Transaction 835, and Standard Paper Remittance Advice, ... (continued)

4. **MREP software:** Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

Implementation

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

Additional Information

The official instructions issued to your Medicare FI, Carrier, RHHI, DMERC, or DME MAC regarding this change may be found on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R996CP.pdf>.

The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* is attached to CR 5081.

The *MLN Matters* article that provides additional information about Stage 1 Use of NPI is available on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.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.

If you have questions, please contact your Medicare carrier, FI, RHHI, DMERC, 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: MM5081 – Revised
Related Change Request (CR) Number: 5081
Related CR Release Date: June 30, 2006
Related CR Transmittal Number: R996CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 996, CR 5081

Implementation of the National Provider Identifier

CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.

The Second in the Series of Special Edition Medlearn Matters Articles on National Provider Identifier-Related Activities

Note: CMS has revised this *MLN Matters* article on May 18, 2007, to add this statement that Medicare fee-for-service (FFS) has announced a contingency plan regarding the May 23, 2007, implementation of the national provider identifier (NPI). For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article MM5595 on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

The *MLN Matters* article MM5595 was published in the May 2007 *Medicare A Bulletin* (pages 17-18).

Provider Types Affected

Providers and suppliers who conduct Health Insurance Portability and Accountability Act (HIPAA) standard transactions, such as claims and eligibility inquiries. In addition, organizations or associations that represent providers and plan to obtain national provider identifiers (NPIs) for those providers should take note of this article.

Part 1: Information That Applies to All Providers Background

All health care providers are eligible to receive NPIs. All HIPAA covered health care providers, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider’s NPI will not change. The NPI remains with the provider regardless of job or location changes.

Note: HIPAA covered entities such as providers completing electronic transactions, health care clearinghouses, and large health plans, must use only the NPI to identify covered health care providers in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008.

Obtaining and Sharing Your NPI

Providers and suppliers may now apply for their NPI on the National Plan and Provider Enumeration System (NPPES) Web site, <https://nppes.cms.hhs.gov>.

NPPES is the only source for NPI assignment.

The NPI will replace health care provider identifiers in use today in standard health care transactions by the above dates. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

Health care providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment. Providers may apply for an NPI in one of three ways:

Implementation of the National Provider Identifier (continued)

- An easy Web-based application process is available at <https://nppes.cms.hhs.gov>.
- A paper application may be submitted to an entity that assigns the NPI (the enumerator). A copy of the application, including the enumerator's mailing address, is available at <https://nppes.cms.hhs.gov>.
A copy of the paper application may also be obtained by calling the enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

Knowing the NPI Schedule of Your Health Plans and Practice Management System Companies

Providers should be aware of the NPI readiness schedule for each of the health plans with which they do business, as well as any practice management system companies or billing companies (if used). They should determine when each health plan intends to implement the NPI in standard transactions and keep in mind that each health plan will have its own schedule for this implementation. Your other health plans may provide guidance to you regarding the need to submit both legacy numbers and NPIs.

Providers should submit their NPI(s) on standard transactions only when the health plan has indicated that the plan is ready to accept the NPI. Providers should also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date.

Sharing Your NPI

Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

- Any provider with which they do business (e.g., pharmacies)
- Health plans with which they conduct business
- Organizations where they have staff privileges.

We understand that providers have many questions related to electronic file interchange (EFI) or bulk enumeration, NPPES data dissemination, and the Medicare subparts policy. We have included information currently available on these key topics in this article and will continue to provide updates, as more information becomes available.

Electronic File Interchange – Formerly Known as Bulk Enumeration

The Centers for Medicare & Medicaid Services (CMS) is in the process of establishing a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many health care providers, with provider approval, to the NPPES within a single electronic file. For example, a large group practice may want to have its staff handle the NPI applications for all its members. If an organization/provider employs all or a majority of its physicians and is willing to be considered

an EFI submitter, EFI enumeration may be a good solution for that group of providers.

The Electronic File Interchange Steps

Once EFI is available, concerned entities will follow these steps:

- An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES Web site (<https://nppes.cms.hhs.gov>) and download a certification form.
- The organization will send the completed certification form to the enumerator to be considered for approval as an EFI organization (EFIO).
- Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.
- Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.
- Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
- The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s).

An EFIO may also be used for updates and deactivations, if the providers agree to do so.

National Plan and Provider Enrollment System (NPPES) Data Dissemination Policy

CMS expects to publish a notice regarding its approach to NPI data dissemination in the coming months.

The notice will propose the data dissemination strategy and processes. The approach will describe the data that CMS expects to be available from the NPPES, in compliance with the provisions of the Privacy Act, the Freedom of Information Act, the Electronic FOIA Amendments of 1996, the NPPES System of Records Notice, and other applicable regulations and authorities.

Crosswalks

Each health plan may create its own crosswalk, to cross check NPI and legacy identifiers. To that end, CMS stresses the importance of health care providers entering all of their current identification numbers onto their NPI application to facilitate the building of the crosswalks.

Subparts of a Covered Organization

Covered-organization health care providers (e.g., hospitals, suppliers of durable medical equipment, pharmacies, etc.) may be made up of components (e.g., an acute care hospital with an ESRD program) or have separate physical locations (e.g., chain pharmacies) that furnish health care, but are not themselves legal entities. The Final NPI rule calls these entities “*subparts*” to avoid confusion with the term health care “*components*” used in HIPAA privacy and security rules. Subparts cannot be individuals such as physicians, e.g., group practices may have more than one NPI, but individual members of that group practice by definition are not and cannot be “*subparts*.”

Implementation of the National Provider Identifier (continued)

The NPI was mandated to identify each health care provider, not each service address at which health care is furnished. Covered organization providers must designate as subparts (according to the guidance given in the NPI final rule) any component(s) of themselves or separate physical locations that are not legal entities and that conduct their own standard transactions. Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct.

The NPI final rule also gives covered organizations/providers the ability to designate subparts should there be other reasons for doing so. Federal regulations or statutes may require health care providers to have unique billing numbers in order to be identified in claims sent to federal health programs, such as Medicare.

In some cases, health care providers who need billing numbers for federal health programs are actually components of covered health care providers. They may be located at the same address as the covered organization provider or they may have a different address.

In situations where such federal regulations or statutes are applicable, the covered organization providers would designate the components as subparts and ensure that they obtain NPI(s) in order to use them in standard transactions. The NPI will eventually replace the billing numbers in use today.

What Providers Can Do to Prepare for NPI Implementation

- Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.
- Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.
- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.
- Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

Part 2: Information that Applies to Medicare Fee-for-Service (FFS) Providers Only

All Medicare providers are reminded that they will be required to use the NPI *in Medicare claims transactions*.

NPI Transition Plans for Medicare FFS Providers

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

May 23, 2005 – January 2, 2006:

Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS

claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.

January 3, 2006 – October 1, 2006:

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

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

October 2, 2006 – May 22, 2007:

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

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

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

May 23, 2007 – Forward:

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

Crosswalk

The Medicare health plan is preparing a crosswalk to link NPI and Medicare legacy identifiers exclusively for Medicare business, which should enable Medicare to continue claims processing activities without interruption. NPI(s) will be verified to make sure that they were actually issued to the providers for which reported. Medicare will use the check digit to ensure the NPI(s) are valid.

Subparts Policy

CMS is currently developing policy on how Medicare providers should identify Medicare subparts. Further details will be provided when this policy is finalized.

Resources for Additional Information

Coming Soon – CMS is developing a Medlearn Web page on NPI for Medicare FFS providers, which will house all Medicare fee-for-service educational resources on NPI, including links to all Medlearn Matters articles, frequently-asked questions, and other information. CMS will widely publicize the launch of this Web page in the coming weeks.

You may wish to visit <http://www.cms.hhs.gov/hipaa/hipaa2/> regularly for the latest information about the NPI, including frequently asked questions, announcements of roundtables, conferences, and guidance documents regarding the NPI.

Go to <http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf> to

Implementation of the National Provider Identifier (continued)

access a tool to help establish whether one is a covered entity under the administrative simplifications of HIPAA.

A helpful tool that provides an overview of the NPI and the application process for obtaining an NPI is available at <http://www.cms.hhs.gov/medlearn/npi/npiviewlet.asp>.

The *Federal Register* notice containing the NPI Final Rule is available at <http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf>.

There are some non-CMS Web sites that have information on NPI-related issues. While CMS does not necessarily endorse those materials, there may be information and tools available that might be of value to you.

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You may also find some industry implementation recommendations and white papers on the NPI at <http://www.wedi.org>, which is the site of the Workgroup for Electronic Data Interchange (WEDI).

MLN Matters Number: SE0555 – 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 Medlearn Article SE0555

Medicare Policy on Subpart Designation

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 May 18, 2007, to add this statement that Medicare fee-for-service (FFS) has announced a contingency plan regarding the May 23, 2007 implementation of the national provider identifier (NPI). For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article MM5595 on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

The *MLN Matters* article MM5595 was published in the May 2007 *Medicare A Bulletin* (pages 17-18).

Provider Types Affected

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

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

Key Points

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

These numbers are now considered legacy identifiers or legacy numbers. Medicare is

transitioning from these legacy identifiers to **national provider identifiers, or NPIs.**

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

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

Background

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

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

Medicare Policy on Subpart Designation (continued)

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

Subpart Designation Guidelines

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

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

Regarding all of the entities that could be considered subparts:

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

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

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.
- A subpart may or may not have a taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part. Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI final rule. If such statutes or regulations exist, the health care providers to whom they apply would need NPIs in order to ensure they can continue to be uniquely identified.
- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

Medicare Organization Subpart Examples Enrolled Certified Providers and Suppliers

An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN (tax identification number) of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, Medicare encourages that the hospital mirror its Medicare enrollment and obtain a total of 11 unique NPIs in order to help avoid claims processing delays (one NPI for the hospital, and one for each of the 10 home health agencies).

Enrolled Supplier Group or Supplier Organization

An enrolled independent diagnostic testing facility (IDTF) has four different locations, and the carrier must

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

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

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

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

Important Medicare NPI Implementation Dates January 3, 2006 – October 1, 2006

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

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

October 2, 2006 – May 22, 2007

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

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

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

May 23, 2007 – Forward

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

Final Notes About NPIs

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

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

Medicare Policy on Subpart Designation (continued)

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

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

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

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

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

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

NPI final rule, page 3441 says the following: “If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may

decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls.”

Additional Information**Medicare’s NPI Responsibilities**

Medicare will:

- Use NPIs to **identify** health care providers and subparts in HIPAA standard transactions.
- NPI final rule, page 3469: section 162.412(a): “A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider’s identifier is required.”
- Ensure that the NPIs it receives in HIPAA standard transactions are valid.
 - Reject HIPAA standard transactions that contain invalid NPIs.

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

Related Links

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

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

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

The NPI final rule may be found on the CMS Web site at <http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf>.

MLN Matters Number: SE0608 – 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 SE0608

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

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

Note: CMS has revised this *MLN Matters* article on May 18, 2007, to add this statement that Medicare fee-for-service (FFS) has announced a contingency plan regarding the May 23, 2007, implementation of the national provider identifier (NPI). For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article MM5595 on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

The *MLN Matters* article MM5595 was published in the May 2007 *Medicare A Bulletin* (pages 17-18).

Provider Types Affected

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

Impact on Providers

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

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

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

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

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

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Additional Information

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

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

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

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

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

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

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

GENERAL COVERAGE

Discarded Drugs and Biologicals and Submission of Claims with Modifier JW

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

Provider Types Affected

Physicians, hospitals, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries [RHHI], Part A/B Medicare administrative contractors [MACs], durable medical equipment Medicare administrative contractors [DME MACs]) for administering or supplying drugs and biologicals.

What You Need to Know

Change request (CR) 5520, from which this article is taken, revises the *Medicare Claims Processing Manual*, chapter 17, sections 40 and 100.2.9 to include language that references payment for administering (and discarding) both single use vials and single use packages. Specifically, the change is to clarify that Medicare will cover the amount of a single use vial or single use package of a drug or biological that was discarded along with the amount of that single use vial/package that was administered to the Medicare patient.

Background

CR 5520, from which this article is taken revises the *Medicare Claims Processing Manual*, chapter 17 (Drugs and Biologicals), sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) to ensure the proper billing of discarded drugs and biologicals in both single use vials and single use packages.

These revisions are summarized as follows:

- The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.
- Section 40 of chapter 17 is amended to address single use vials/packages of drugs and biologicals. If after administering a dose/quantity of the drug or biological to a Medicare patient, a physician, hospital or other provider must discard the remainder of a single use vial or other single use package, the program provides payment for the amount of drug or biological administered and the amount discarded, up to the total amount of the drug or biological as indicated on the vial or package label.

- Section 100.2.9 is amended to show that CMS will reimburse physicians, providers and suppliers for the amount of a drug or biological administered (and for the amount discarded) when:
 - ♦ The participating competitive acquisition program (CAP) physician has made a good faith effort to minimize the unused portion of the CAP drug or biological in scheduling patients and in ordering, accepting, storing, and using the drug or biological.
 - ♦ In its process of supplying the drug or biological to the participating CAP physician, the approved CAP vendor has made a good faith effort to minimize the unused portion of the drug or biological.

Note: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Additional Information

You can view CR 5520, the official instruction issued to your Medicare contractor, by visiting the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1248CP.pdf>.

You will find the revised *Medicare Claims Processing Manual*, chapter 17 (Drugs and Biologicals), sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) as an attachment to that CR.

If you have any questions, please contact your FI, RHHI, carrier, 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: MM5520

Related Change Request (CR) Number: 5520

Related CR Release Date: May 25, 2007

Related CR Transmittal Number: R1248CP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1248, CR 5520

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Revised HCPCS Codes Relating to Immune Globulin

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

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (carriers; fiscal intermediaries [FI], including regional home health intermediaries [RHHIs]; Medicare administrative contractors [A/B MACs]; and durable medical equipment Medicare administrative contractors [DME MACs]) for immune globulin.

What You Need to Know

Change request (CR) 5635, from which this article is taken, implements 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.**
- **In its place, the following HCPCS codes are payable: Q4087 (Octagam, injection), Q4088 (Gammagard, liquid injection), Q4091 (Flebogamma, injection), and Q4092 (Gamunex, injection).**
- **In addition, for services on or after July 1, 2007, two new codes are payable:**
 - ♦ **Q4089** (Rhophylac, injection). Note that currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the Food and Drug Administration (FDA) approval for Rhophylac® become available, code Q4089 would be used to bill for such products.
 - ♦ **Q4090** (HepaGam B, injection). Note that currently, HepaGam BTM, when given intramuscularly, is the only product that should be billed using code Q4090. If other products under the FDA approval for HepaGam BTM IM become available, code Q4090 would be used to bill for such products. HepaGam BTM when given intravenously should be billed using an appropriate not otherwise classified code in the absence of a specific HCPCS code.
- For institutional claims, revenue code 0636 should be used for billing codes Q4087, Q4088, Q4089, Q4090, Q4091, and Q4092.
- As described in CR 5428, Medicare contractors will pay for pre-administration-related services (G0332) associated with intravenous immune globulin administration when Q4087, Q4088, Q4091, or Q4092 is billed in lieu of J1567.

Make sure that your billing staffs are aware of these immune globulin HCPCS code changes.

Background

CR 5635, from which this article is taken, implements HCPCS coding changes for immune globulin, effective for services on or after July 1, 2007. See Table 1, below, for details.

Table 1 – HCPCS Code Changes for Immune Globulin Effective July 1, 2007

HCPCS Code	Short Description	Long Description
Status: Not Payable by Medicare on or after July 1, 2007		
J1567	Immune globulin, liquid	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg
Status: Payable for services on or after July 1, 2007		
Q4087	Octagam, injection	Injection, immune globulin (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4088	Gammagard, liquid injection	Injection, immune globulin (Gammagard Liquid), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4091	Flebogamma injection	Injection, immune globulin (Flebogamma), intravenous, non-lyophilized(e.g. liquid), 500 mg
Q4092	Gamunex injection	Injection, immune globulin (Gamunex), intravenous, non-lyophilized (e.g., liquid), 500 mg
Status: New/Payable for services on or after July 1, 2007		
Q4089*	Rhophylac injection	Injection, Rho (D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 iu
Q4090^	HepaGam B injection	Injection, hepatitis B immune globulin (HepaGam B), intramuscular, 0.5 ml

*Currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the FDA approval for Rhophylac® become available, code Q4089 would be used to bill for such products.

^Currently, HepaGam BTM, when given intramuscularly, is the only product that should be billed using code Q4090. If other products under the FDA approval for HepaGam BTM IM become available, code Q4090 would be used to bill for such products. HepaGam BTM when given intravenously should be billed using an appropriate not otherwise classified code in the absence of a specific HCPCS code.

*Revised HCPCS Codes Relating to Immune Globulin (continued)***Additional Information**

You can find the official instruction issued to your Medicare contractor about the revised HCPCS codes relating to Immune Globulin by going to CR5635, located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1261CP.pdf>.

Payment limits for the new Q codes will be included in the July 2007 quarterly average sales price payment file, which will be posted at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage.

In addition, more information regarding the outpatient prospective payment system (OPPS) and the new Q codes in the July update of OPPS Addendum A and Addendum B on the hospital outpatient Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage>.

You might also want to look at CR 5428 (Medicare Payment for Pre-administration-Related Services Associated

with IVIG Administration—Payment Extended through CY 2007). The *MLN Matters* article (MM5428) associated with that CR is available on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5428.pdf>.

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: MM5635

Related Change Request (CR) Number: 5635

Related CR Release Date: June 1, 2007

Related CR Transmittal Number: R1261CP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1261, CR 5635

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July, 2007 Quarterly Update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], including regional home health intermediaries [RHHI]), Medicare administrative contractors (A/B MAC) and durable medical equipment Medicare administrative contractors (DME MAC)) for providing albuterol, levalbuterol, Reclast®, and Zometa® to Medicare beneficiaries.

What Providers Need to Know

Change request (CR) 5645, from which this article is taken, implements the July 2007 quarterly update to the HCPCS codes for albuterol, levalbuterol, and Reclast®.

Effective for dates of service on or after July 1, 2007, the following HCPCS codes are no longer payable by Medicare: J7611, J7612, J7613, and J7614; and the following are payable by Medicare: Q4093, Q4094, and Q4095. Code J3487 continues in use for Zometa®.

You should make sure that your billing staffs are aware of these HCPCS code changes.

Background

CR 5645, from which this article is taken, implements the July, 2007 quarterly update to the HCPCS codes for albuterol, levalbuterol, and Reclast®.

Effective July 1, 2007, the Health Care Procedure Code System (HCPCS) codes in **table 1** will no longer be payable for Medicare.

Table 1 – HCPCS Codes not Payable for Dates of Service on or after July 1, 2007

HCPCS Code	Short Description	Long Description
J7611	Albuterol non-comp con	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg
J7612	Levalbuterol non-comp con	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613	Albuterol non-comp unit	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
J7614	Levalbuterol non-comp unit	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg

July, 2007 Quarterly Update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast® (continued)

In place of the Table 1 codes, the HCPCS codes displayed in Table 2 **will be payable, effective July 1, 2007.**

Table 2 – HCPCS Codes Payable for Services on or After July 1, 2007

HCPCS Code	Short Description	Long Description
Q4093	Albuterol inh non-comp con	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)
Q4094	Albuterol inh non-comp u d	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)

In addition, a new code, Q4095 (in Table 3) will be effective July 1, 2007, for Reclast®.

Table 3 – HCPCS Q4095 Payable for Services on or after July 1, 2007

HCPCS Code	Short Description	Long Description
Q4095	Reclast injection	Injection, zoledronic acid (Reclast), 1 mg

Also, please note the following:

- Currently, Reclast® 5 mg/100 ml bottle (NDC 0078-0435-61) is the only product that should be billed using code Q4095. If other products under the FDA's approval for Reclast® become available, code Q4095 would be used to bill for such products.
- HCPCS code J3487 (short description: Zoledronic acid; long description: Injection, zoledronic acid, 1 mg) is used to bill for products under the FDA's approval for Zometa® or such therapeutically equivalent products that may become available as identified in the FDA's Orange Book.
- Payment limits for the new Q codes will be included in the July 2007 quarterly average sales price payment file, when those files are posted at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage.
- Payment information for the new Q codes under the hospital outpatient prospective payment system (OPPS) may be found in the July 2007 update of OPPS Addendum A and Addendum B when those addendums are added to the hospital outpatient Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage/>.

Additional Information

You can find the official instruction, CR 5645, issued to your carrier, FI (including RHHI), A/B MAC or DME MAC by visiting the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1260CP.pdf>.

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

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

MLN Matters Number: MM5645

Related Change Request (CR) Number: 5645

Related CR Release Date: June 1, 2007

Related CR Transmittal Number: R1260CP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1260, CR 5645

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Bone Mass Measurements

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 June 4, 2007, to clarify the Medicare summary notices (MSNs). Essentially, MSN 16.10 will be issued with a denied claim as well as either MSN 36.1 or MSN 36.2, depending on if an advance beneficiary notice (ABN) was issued. All other information remains the same. The MLN Matters article MM5521 was published in the June 2007 *Medicare A Bulletin* (page 31-33).

Provider Types Affected

Physicians, practitioners and hospitals that bill Medicare contractors (carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [(A/B MACs)] for bone mass measurement (BMM) services.

Provider Action Needed

STOP – Impact to You

Effective for dates of service **on or after January 1, 2007**, Medicare will pay for BMM services for dual-energy X-ray absorptiometry (CPT code 77080) when this procedure is used to monitor osteoporosis drug therapy. In addition, new CPT codes were assigned to BMMs.

CAUTION – What You Need to Know

Medicare edits will deny claims that are not consistent with revised BMM policy and providers may be liable for noncovered BMMs unless they have issued an advanced beneficiary notice (ABN) as required. This article explains the changes as a result of the calendar year (CY) 2007 physician fee schedule final rule.

GO – What You Need to Do

See the remainder of this article for important information regarding billing Medicare for BMMs.

Background

This article and related change request (CR) 5521 wants providers to know that on June 24, 1998, the Centers for Medicare & Medicaid Services (CMS) published an interim final rule with comment period (IFC) in the *Federal Register* entitled “*Medicare Coverage of and Payment for Bone Mass Measurements*.” This IFC implemented section 4106 of the BBA by establishing 42 CFR 410.31, Bone Mass Measurement: Conditions for Coverage and Frequency Standards. This new regulation defined BMM and individuals qualified to receive a BMM, established conditions for coverage under the “reasonable and necessary” provisions of 1862(a)(1)(A) of the Act, and established frequency standards governing when qualified individuals would be eligible for a BMM.

On December 1, 2006, CMS published the CY 2007 physician fee schedule final rule which included changes to 42 CFR 410.31. These changes may be found in Chapter 15, Section 80.5 of the *Medicare Benefit Policy Manual*, and in Chapter 13, Section 140 of the *Medicare Claims Processing Manual*. The revised manual sections are attached to CR 5221. The Web address for viewing CR 5221 is available in the “*Additional Information*” section at the end of this article.

Key Points

Listed is a summary of the revisions and additions to Chapter 13 of the *Medicare Claims Processing Manual* and Chapter 15 of the *Medicare Benefit Policy Manual*.

Chapter 13

Effective for dates of service **on and after January 1, 2007**, the CY 2007 physician fee schedule final rule expanded the number of beneficiaries qualifying for BMM by reducing the dosage requirement for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg. It also changed the definition of BMM by removing coverage for a single-photon absorptiometry (SPA), as it is not considered reasonable and necessary under section 1862 (a)(1)(A) of the Act.

Effective for dates of services **on and after January 1, 2007**, the following changes apply to BMM:

- New 2007 CPT bone mass codes have been assigned for BMM. The following codes will replace current codes, however the CPT descriptors for the services remain the same:

77078	replaces	76070
77079	replaces	76071
77080	replaces	76075
77081	replaces	76076
77083	replaces	76078
- BMM is not covered when a procedure other than dual-energy X-ray absorptiometry is used to monitor osteoporosis drug therapy. Therefore, Medicare will not pay for CPT codes 76977, 77078, 77079, 77081, 77083 and **HCPCS G0130** when billed with the following ICD-9-CM diagnosis codes:

733.00	733.01	733.02	733.03	733.09
733.90	255.0			
- BMM is covered when dual-energy X-ray absorptiometry is used to monitor osteoporosis drug therapy. Therefore, Medicare will pay CPT code 77080 when billed with the following ICD-9-CM diagnosis codes or any of the other valid ICD-9-CM diagnoses that are recognized by Medicare contractors appropriate for bone mass measurements:

733.00	733.01	733.02	733.03	733.09
733.90	255.0			
- In informing beneficiaries about the denials of claims processed for BMMs, Medicare will use the following MSN messages, effective for services on or after January 1, 2007:

MSN# 16.10: “Medicare does not pay for this item or service.” (FIs should not include this MSN.)

- If an advance beneficiary notice (ABN) **was issued**, the following MSN will follow:

MSN# 36.1: “Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for

Bone Mass Measurements (continued)

this charge. If you do not agree with this statement, you may ask for a review.”

- ♦ If an ABN **was not issued** the following MSN will be included:

MSN # 36.2: “It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider’s bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.”

Note: Medicare will not cover single photon absorptiometry and CPT code 78350 will be denied (using MSN# 16.10) for services on or after January 1, 2007.

- Effective January 1, 2007 the following remittance advice (RA) messages will be issued when Medicare denies BMM claims:
 - ♦ Claim adjustment reason code 50: “These are noncovered services because this is not deemed a “medical necessity” by the payer”.
 - ♦ If an ABN was issued the RA issued is 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.”
 - ♦ If an ABN was **not** issued RA remark code is 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.”
- **Advance Beneficiary Notices** – Physicians, practitioners and hospitals are liable for payment unless they issue an appropriate ABN. **More information on ABNs may be found in Chapter 30, Sections 40-40.3.8 of the Medicare Claims Processing Manual, located on the CMS Web site at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopofPage>.**

Chapter 15

- **Definition of BMM:** a radiologic, radioisotopic, or other procedure that meets all of the following conditions:

- ♦ Is performed to identify bone mass, detect bone loss, or determine bone quality.
- ♦ Is performed with either a bone densitometer (other than single-photon or dual-photon absorptiometry) or a bone sonometer system that has been cleared for marketing for BMM by the Food and Drug Administration (FDA) under 21 CFR part 807, or approved for marketing under 21 CFR part 814.
- ♦ Includes a physician’s interpretation of the results.

• Conditions for Coverage

- ♦ Medicare covers BMM if it is ordered by a qualified physician or nonphysician practitioner, who is treating the beneficiary following an evaluation of the need for a BMM and the appropriate BMM to be used.
- ♦ The BMM must be performed under the appropriate level of supervision as defined in 42 CFR 410.32(b).
- ♦ The BMM must be reasonable and necessary for diagnosis and treatment of a beneficiary who meets at least one of the following conditions:
 - A woman who has been determined by the physician or qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

Note: Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an “adequate” dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating nonphysician practitioner from ordering a bone mass measurement for her. If a BMM is ordered for a woman following a careful evaluation of her medical need, however, it is expected that the ordering treating physician (or other qualified treating nonphysician practitioner) will document in her medical record why he or she believes that the woman is estrogen-deficient and at clinical risk for osteoporosis.

- An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture.
- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than three months.
- An individual with primary hyperparathyroidism.

Bone Mass Measurements (continued)

- An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.
- ♦ In the case of any individual who being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy, the BMM must be performed with a dual-energy X-ray absorptiometry system (axial skeleton).
- ♦ In the case of any individual who meets the above conditions and who has a confirmatory BMM, the BMM is performed by a dual-energy X-ray absorptiometry system (axial skeleton) if the initial BMM was not performed by a dual-energy X-ray absorptiometry system (axial skeleton). A confirmatory baseline BMM is not covered if the initial BMM was performed by a dual-energy X-ray absorptiometry system (axial skeleton).
- **Frequency Standards**
 - ♦ Medicare pays for a screening BMM once every two years.
 - ♦ Medicare may pay for more frequent screenings when medically necessary. Examples include, but are not limited to, the following medical circumstances:
 - Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than three months.
 - Confirming baseline BMMs to permit monitoring of beneficiaries in the future.
- **Noncovered BMMs occur** when they are not considered reasonable and necessary under section 1862 (a) (1) (A) of the Act.
 - ♦ Single photon absorptiometry (effective January 1, 2007).
 - ♦ Dual photon absorptiometry (established in 1983).

Additional Information

For complete details regarding this CR please see the official instruction (CR 5521) issued to your Medicare carrier, FI or A/B MAC. That instruction consists of three transmittals, i.e.:

- Transmittal 69, which contains the Medicare National Coverage Determination, which is on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R69NCD.pdf>.
- Transmittal 70, which contains the revised *Medicare Benefit Policy Manual* sections, is on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R70BP.pdf>.
- Transmittal 1236 contains the *Medicare Claims Processing Manual* revisions and is on the CMS site at <http://www.cms.hhs.gov/Transmittals/downloads/R1236CP.pdf>.

A brochure outlining 'Bone Mass Measurements' is available at http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass_06-08-05.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: MM5521 – Revised
 Related Change Request (CR) Number: 5521
 Related CR Release Date: May 11, 2007
 Related CR Transmittal Number: R1236CP, R70BP, R69NCD
 Effective Date: January 1, 2007
 Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1236, CR 5521

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Guidelines for Payment of Diabetes Self-Management Training

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 May 29, 2007, to reflect changes made to change request (CR) 5433, which was revised on May 25, 2007. The CR 5433 was revised to show that hospitals subject to the outpatient prospective payment system (OPPS) will be paid under the Medicare physician fee schedule when billing HCPCS G0108 and G0109 on a type of bill 12x or 13x. The article has been revised accordingly. Also, the CR transmittal numbers and release date and the Web address for accessing CR 5433 have been revised. All other information remains the same. The MLN Matters article MM5433 related to CR 5433 was published in the March 2007 *Medicare A Bulletin* (page 11-13).

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs) for diabetes self-management training (DSMT) services provided in institutional settings to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5433, which corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings.

CAUTION – What You Need to Know

Medicare Part B covers **10** hours of initial training for a beneficiary who has been diagnosed with diabetes, and beneficiaries are eligible to receive **two** hours of follow-up training each calendar year following the year in which they were certified as requiring initial training. **The physician or qualified nonphysician practitioner who is managing the beneficiary's diabetic condition must order the DSMT.**

GO – What You Need to Do

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

Background

The Balanced Budget Act of 1997 (Section 4105) permits Medicare coverage of DSMT services when these services are furnished by a certified provider who meets certain quality standards, and CR 5433 corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings. Note that no new codes are being created by CR 5433. Also, deductible and coinsurance apply to these services.

The DSMT program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

Initial Training

The initial year for DSMT is the 12-month period following the initial date, and Medicare will cover initial training that meets the following conditions:

- DSMT is furnished to a beneficiary who has not previously received initial or follow-up training under

Healthcare Common Procedure Coding System (HCPCS) code G0108 or G0109.

- DSMT is furnished within a continuous 12-month period.
- DSMT does not exceed a total of 10 hours (the 10 hours of training may be done in any combination of 1/2-hour increments).
- With the exception of one hour of individual training, the DSMT training is usually furnished in a group setting with the group consisting of individuals who need not all be Medicare beneficiaries.
- The one-hour of individual training may be used for any part of the training including insulin training.

Follow-Up Training

Medicare covers follow-up training under the following conditions:

- No more than two hours individual or group training is provided per beneficiary per year.
- Group training consists of two to 20 individuals who need not all be Medicare beneficiaries.
- Follow-up training for subsequent years is based on a 12-month calendar after completion of the full 10 hours of initial training.
- Follow-up training is furnished in increments of no less than one-half hour.
- The physician (or qualified nonphysician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

Note: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

Examples

Example #1: Beneficiary Exhausts 10 hours in the Initial Year (12 continuous months)

Beneficiary receives first service in April 2006.

Beneficiary completes initial 10 hours DSMT training in April 2007.

Beneficiary is eligible for follow-up training in May 2007 13th month begins the subsequent year).

Beneficiary completes follow-up training in December 2007.

Beneficiary is eligible for next year training in January 2008.

Guidelines for Payment of Diabetes Self-Management Training (continued)**Example #2: Beneficiary Exhausts 10 Hours Within the Initial Calendar Year**

Beneficiary receives first service in April 2006.

Beneficiary completes initial 10 hours of DSMT training in December 2006.

Beneficiary is eligible for follow-up training in January 2007.

Beneficiary completes follow-up training in July 2007.

Beneficiary is eligible for next year follow-up training in January 2008.

Coding and Payment of DSMT Services

The following HCPCS codes should be used for DSMT:

G0108 Diabetes outpatient self-management training services, individual, per 30 minutes

G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Payment to physicians and providers for outpatient DSMT is made as follows:

Type of Facility/Provider	Payment Method	Type of Bill
Physician/nonphysician practitioner (billing carrier/MAC)	Medicare physician fee schedule (MPFS)	N/A
Hospitals subject to outpatient prospective payment system (OPPS)	Medicare physician fee schedule (MPFS)	12x, 13x
Method I and method II critical access hospitals (CAHs) (technical services)	101 percent of reasonable cost	12x and 85x
Indian health service (IHS) providers billing hospital outpatient	Office of Management and Budget (OMB)-approved outpatient per visit all-inclusive rate (AIR)	13x and revenue code 051x
IHS providers billing inpatient Part B	All-inclusive inpatient ancillary per diem rate	12x and revenue code 024x
IHS CAHs billing outpatient	101 percent of the all-inclusive facility specific per visit rate	85x and revenue code 051x
IHS CAHs billing inpatient Part B	101 percent of the all-inclusive facility specific per diem rate	12x and revenue code 024x
Rural health clinics (RHCs)	All-inclusive encounter rate	71x with revenue code 0520, 0521, 0522, 0524, 05225, 0527, 0528, or 0900
Federally qualified health centers (FQHCs)*	All-inclusive encounter rate	73x with revenue code 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900
Skilled nursing facilities (SNFs) **	Medicare physician fee schedule (MPFS) nonfacility rate	22x, 23x
Maryland hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	Payment in accordance with the terms of the Maryland waiver	12x, 13x
Home health agencies (can be billed if service is outside of the treatment plan)	MPFS nonfacility rate	34x

* Effective January 1, 2006, payment for DSMT provided in an FQHC, that meets all the requirements as above, may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB 73x, with HCPCS code G0108 or G0109, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.

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

Note: An end-stage renal disease (ESRD) facility is a reasonable site for this DSMT service, however, because it is required to provide dietician and nutritional services as part of the care covered in the composite rate, ESRD facilities are not allowed to bill for it separately and do not receive separate reimbursement.

Guidelines for Payment of Diabetes Self-Management Training (continued)

Advanced Beneficiary Notices (ABNs)

Providers should also be aware that the beneficiary is liable for services denied over the limited number of hours with referrals for DSMT. An ABN should be issued in these situations and absent evidence of a valid ABN, the provider would be held liable.

However, an ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their state, but who have not obtained Medicare provider numbers.

Additional Information

For complete details, please see the official instruction, CR 5433, issued to your FI, RHHI, and A/B MAC regarding this change. There are two transmittals related to CR 5433, one that revises the *Medicare Benefit Policy Manual* and one that modifies the *Medicare Claims Processing Manual*. These transmittals are at <http://www.cms.hhs.gov/Transmittals/downloads/R72BP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R1255CP.pdf>, respectively.

If you have any questions, please contact your FI, RHHI or A/B MAC at their toll-free number, which may be found on the CMS 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: MM5433 – Revised

Related Change Request (CR) Number: 5433

Related CR Release Date: May 25, 2007

Related CR Transmittal Number: R1255CP & R72BP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1255, CR 5433

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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 website <http://www.floridamedicare.com>. Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part A section under the Part A Medical Coverage section.

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

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

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

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ADDITIONS/REVISIONS TO LCDs

A91110: Wireless Capsule Endoscopy—Revision to the LCD

The local coverage determination (LCD) for wireless capsule endoscopy was last revised on January 1, 2007. Since that time, the LCD was revised to include the addition of ICD-9-CM codes 280.0 (*iron deficiency anemias, secondary to blood loss [(chronic)]*) and 280.9 (*iron deficiency anemia, unspecified*) in the “ICD-9 Codes that Support Medical Necessity” section of the LCD for CPT code 91110.

Coverage guidelines for wireless capsule endoscopy of the small bowel and esophagus remain the same. The ICD-9-CM codes are only surrogate for the indication of documented continuous blood loss and anemia secondary to obscure bleeding of the small bowel.

Effective Dates

This revision to the LCD is effective for services **provided on or after July 19, 2007.**

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

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AEPO: Epoetin alfa—Revision to the LCD

The local coverage determination (LCD) for epoetin alfa was last revised on May 3, 2007. Since that time, the LCD has been revised. Under the list of medically necessary ICD-9-CM diagnosis codes, the following ICD-9-CM diagnosis codes were deleted: 571.40, 571.41 and 571.49. These were replaced with ICD-9-CM codes 070.54 and 070.70. In addition, the following ICD-9-CM codes were also added to the list of medically necessary ICD-9-CM codes: 205.10 and 205.11. These codes allow for appropriate billing of the covered off-label indication for chronic myelomonocytic leukemia, which may be considered a form of myelodysplastic syndrome (MDS). The coding guideline was also revised as appropriate.

Effective Date

This revision to the LCD is effective for services **provided on or after August 10, 2007.**

The full text for this LCD (L895) is available through the provider education Web site <http://www.floridamedicare.com> on or after this effective date. ❖

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HOSPITAL SERVICES

Update to the Inpatient Psychiatric Facility Prospective Payment System for Rate Year 2008

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5619, which provides changes required as part of the annual inpatient psychiatric facility prospective payment system (IPF PPS) update for rate year (RY) 2008.

CAUTION – What You Need to Know

These changes include the market basket update, federal per diem base rate update, electroconvulsive therapy update, and PRICER update for the 2008 RY.

GO – What You Need to Do

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

Background

On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (http://www.access.gpo.gov/su_docs/fedreg/a041115c.html) a final rule that established the PPS for IPF under the Medicare program in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balance Budget Refinement Act of 1999 (BBRA).

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that:

- Includes both inpatient operating and capital-related costs (including routine and ancillary services), but
- Excludes certain pass-through costs (i.e., bad debts, and graduate medical education).

CMS is required to make updates to this IPF PPS annually. In addition, the RY update is effective July 1-June 30 of each year, while the diagnosis related groups (DRGs) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes are updated on October 1 of each year.

CR5619 identifies changes that are required as part of the annual IPF PPS update from the RY 2008 IPF PPS update notice, published on May 4, 2007. These changes are applicable to IPF discharges occurring during the RY beginning on July 1, 2007, through June 30, 2008, and the changes are as follows:

1. Market Basket Update:

CMS uses the **Rehabilitation/Psychiatric/Long-Term Care (RPL)** market basket to update the IPF PPS portion of the blended payment rate (that is the Federal per diem base rate). The 2002 excluded hospital market basket is used to update the cost-based portion (Tax Equity and Fiscal Responsibility Act of 1982- (TEFRA)), effective for cost reports periods beginning on or after October 1 of each year and is applied to the TEFRA target amount.

2. PRICER Updates:

The PRICER updates are as follows:

- The federal per diem base rate is **\$614.99**.
- The fixed dollar loss threshold amount is **\$6,488.00**.
- The IPF PPS transition blend percentage for cost reporting periods beginning on or after January 1, 2007, but before January 1, 2008, is **75 percent PPS and 25 percent TEFRA**. The transition blend percentage for cost reporting periods beginning on or after January 1, 2008 is 100 percent PPS.
- The IPF PPS will use the FY 2007 unadjusted pre-floor, pre-reclassified hospital wage index.
- The labor-related share is **75.788 percent**.
- The non-labor related share is **24.212 percent**.
- The electroconvulsive therapy (ECT) rate is **\$264.77**.

3. Payment Rate:

These rates for RY 2008 were published in the final rule and may also be found on the IPF PPS Web site at <http://www.cms.hhs.gov/InpatientPsychFacilPPS>.

Federal Per Diem Rate

Federal per diem base rate	\$614.99
Labor share (0.75788)	\$466.09
Non-labor share (0.24212)	\$148.90

4. ECT Update:

The update methodology for the ECT rate is to update the previous rate year's amount by the market basket increase and wage index budget neutrality factor. The ECT adjustment per treatment is **\$264.77** for RY 2008.

5. DRG Adjustment and Comorbidity Updates:

There are **no changes** to the DRG adjustment factors or the comorbidity adjustment factors for RY 2008.

Update to the Inpatient Psychiatric Facility Prospective Payment System for Rate Year 2008 (continued)

6. The National Urban and Rural Cost to Charge Ratios for the IPF PPS RY 2008:

National Urban and Rural Cost to Charge Ratios (CCRs)

Cost to Charge Ratio	Median	Ceiling
Urban	0.55	1.7947
Rural	0.71	1.7255

CMS is applying the national median CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the FI or A/B MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

7. Updated Methodology for computing CCRs for the IPF PPS RY 2008:

For IPFs that are distinct part psychiatric units, total Medicare inpatient routine and ancillary charges will be obtained from Worksheet D-4, column 2, line 31 (or appropriate subscript), plus line 103. To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101). All references to worksheet and specific line numbers should correspond with the subprovider identified as the IPF unit that is the letter "S" or "M" in the third position of the Medicare provider number. Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

For IPFs that are psychiatric hospitals, Medicare charges will be obtained from Worksheet D-4, column 2, lines 25 through 30, plus line 103 from the cost report. Medicare costs will be obtained from worksheet D-1, Part II, line 49, minus (Worksheet D, Part III, column 8, lines 25 through 30, plus Worksheet D, Part IV, column 7, line 101). Divide the Medicare costs by the Medicare charges to compute the CCR.

8. Cost of Living Adjustment (COLA) Updates:

The IPF PPS will apply a COLA to the non-labor related portion of the federal per diem base rate and ECT rate for IPFs in Alaska and Hawaii. The RY 2008 values for these COLAs is as follows:

- Alaska:
 - For the cities of Anchorage, Fairbanks, and Juneau, including an 80-kilometer (50-mile) radius by road for each of these cities, the COLA factor is 1.24.
 - For the rest of Alaska, the COLA factor is 1.25.
- Hawaii:
 - For the city and county of Honolulu and the counties of, Kalawao, Kauai, and Maui, the COLA factor is 1.25.
 - For the rest of Hawaii, the factor is 1.17.

Medicare Inpatient Psychiatric Facility Prospective Payment System Fact Sheet Available

The downloadable version of the IPF PPS Fact Sheet, which has been revised to include information about the rate year 2008 updates, is now available at <http://www.cms.hhs.gov/MLNProducts/downloads/InpatientPsychFac.pdf>.

The fact sheet also provides general information about the IPF PPS and how payment rates are set.

Additional Information

The official instruction, CR 5619, 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/R1256CP.pdf>.

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: MM5619

Related Change Request (CR) Number: 5619

Related CR Release Date: May 25, 2007

Related CR Transmittal Number: R1256CP

Effective Date: July 1, 2007 and later discharges

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1256, CR 5619

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.

Long-Term Care Hospital Prospective Payment System Rate Year 2008 Update

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

Provider Types Affected

Long-term care hospitals paid under the LTCH prospective payment system (PPS) by Medicare fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs).

Provider Action Needed

This article is based on change request (CR) 5652 which updates the changes to LTCH PPS for rate year (RY) 2008 (July 1, 2007 – June 30, 2008) including PRICER updates, short stay outlier (SSO) updates, and cost of living adjustment [COLA] updates).

Background

On October 1, 2002, the Centers for Medicare & Medicaid Services (CMS) implemented, through the *Federal Register* (August 30, 2002; http://www.access.gpo.gov/su_docs/fedreg/a020830c.html), a PPS for LTCHs under the Medicare program in accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

Payments under this system are made on a per discharge basis, using long-term care diagnosis-related groups (LTC-DRGs) that take into account differences in resource use of long-term care patients and the most recently available hospital discharge data. CMS is required to update the payments made under this PPS annually. There are two significant updates for LTCH PPS:

- The rate year update (July of each year)
- The DRGs update (October of each year).

PRICER Updates

For LTCH PPS rate year 2008 (applies to discharges on or after July 1, 2007 through June 30, 2008),

- The standard federal rate is \$38,356.45
- The fixed-loss amount is \$20,738
- The budget neutrality adjustment is 0 percent. (The PRICER payment amount will include the adjustment factor as 1.00.)
- The wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2006 is 5/5ths (100 percent). The wage index table within the PRICER will include two columns:
 - ♦ A 4/5ths column for discharges occurring in LTCH cost report periods beginning during fiscal year 2006
 - ♦ A 5/5ths column for discharges occurring in LTCH cost report periods beginning during fiscal year 2007
- The labor-related share is 75.788 percent
- The non-labor related share is 24.212 percent.

Short Stay Outlier (SSO) Updates

The existing payment adjustment formula for short-stay outlier cases was revised for those cases where the patient's LTCH covered length of stay (LOS) is less than, or equal to an "IPPS-comparable" threshold for the DRG to which the case is assigned. For cases falling within this "IPPS-comparable" threshold, Medicare payments under the SSO policy will be subject to an additional payment option that for these cases, will substitute for the blend of an amount calculated from a blend of 120 percent of the LTC-DRG specific per diem amount and an amount comparable to a per diem payment under the IPPS that was finalized for RY 2007.

The IPPS-comparable threshold is defined as a length of stay at the LTCH that is less than, or equal to, the geometric average length of stay for the same DRG under the IPPS plus one standard deviation (refer to Table 3 in the LTCH PPS RY http://www.access.gpo.gov/su_docs/fedreg/a070511c.html).

If the covered LOS at the LTCH is within the IPPS-comparable threshold, Medicare payment will be based on an IPPS comparable per diem amount, capped at the full IPPS comparable amount. This option would replace the "blend" option and become part of the adjusted LTCH PPS payment formula.

Effective for discharges occurring **on or after July 1, 2007**, therefore, the adjusted Medicare payment for a case where the covered LOS at the LTCH is within the IPPS-comparable threshold will equal the least of:

- Hundred percent of estimated cost of the case
- Hundred and twenty percent of the LTC-DRG per diem amount
- The full LTC-DRG payment, or
- The "IPPS comparable" per diem amount, capped at the full IPPS comparable amount.

For SSO cases with lengths of stay exceeding the "IPPS comparable" threshold, the fourth payment option will continue to be the blend, described above.

Some good examples of computations for SSOs are provided in tables in Chapter 3, Section 150.9.1.1 of the *Medicare Claims Processing Manual*. That section is among the sections attached to CR 5652, which is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1268CP.pdf>.

Cost of Living Adjustment Updates

LTCH PPS incorporates a cost of living adjustment (COLA) as part of the operating and capital payments in LTCH PPS. New COLAs for Alaska were implemented as part of the LTCH final rule for RY 2008. Those COLAs, which are effective for LTCH discharges occurring on or after July 1, 2007, are as follows:

Long-Term Care Hospital Prospective Payment System Rate Year 2008 Update (continued)

Alaska Area	Cost of Living Adjustment Factor
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25

Other Medicare Claims Processing Manual Revisions of Note

Also, note that effective for cost reporting periods beginning **on or after July 1, 2007**, the payment adjustment that governs LTCH HwHs (hospitals within hospitals) and satellites of HwHs discharging patients from their host hospital was extended to govern the discharges from all LTCHs (not already addressed by the existing policy) that are admitted from any referring hospital. This policy adjustment includes:

- Discharges from “grandfathered” LTCH HwHs and LTCH satellites that were admitted from their host hospitals.
- LTCH and LTCH satellite discharges admitted from referring hospitals that are not co-located with the discharging facility
- Discharges from “free-standing” LTCHs that were admitted from any referring hospital.

In addition, the basic payment formula under the 25 percent threshold payment adjustment for Medicare discharges from referring hospitals is amended, effective for rate year 2008, as follows:

For those admitted to grandfathered LTCH HwHs and LTCH satellites from the host hospitals:

- If a grandfathered LTCH HwH’s admission from its host hospital exceed 25 percent or the applicable percentage of its discharges for the HwHs cost reporting period, an adjusted payment will be made in the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise pay under the Inpatient PPS (IPPS) for cases in excess of the 25 percent threshold.
- In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host’s allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

For those admitted to all LTCHs and LTCH satellites from referring hospitals other than those with which they are co-located

- If a LTCH HwH’s admissions from its host hospital exceed 25 percent or the applicable percentage of its discharges for the HwH’s cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS for cases in excess of the 25 percent threshold.
- In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host’s allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

As in the case of the policy for co-located LTCHs and LTCH satellites, an additional adjustment is provided for patients admitted a LTCH and satellite LTCH located in rural areas or where the referring hospital is an metropolitan statistical area (MSA) dominant or sole urban hospital. In such situations, instead of the 25 percent threshold, Medicare provides for a threshold of up to 50 percent for patients from any referring hospital in these categories.

Complete details on these manual revisions, including a discussion of the transition period for all LTCHs affected by these provisions, are available in an attachment to CR 5652 at the Web site mentioned previously.

Additional Information

The official instruction, CR 5652, 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/R1268CP.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: MM5652

Related Change Request (CR) Number: 5652

Related CR Release Date: June 15, 2007

Related CR Transmittal Number: R1268CP

Effective Date: Discharges on or after July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1268, CR 5652

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Hospital Discharge Appeal Notices

CMS has posted two notices and form instructions associated with CMS-4105-F, "Notification of Hospital Discharge Appeal Rights." The "Important Message from Medicare" (CMS-R-193) is final and hospitals must use this version starting July 2, 2007. An **unofficial** version of the detailed notice of discharge has also been posted and providers may use this for programming and training purposes, **only**. The notices are posted at <http://www.cms.hhs.gov/bni>, click on "Hospital Discharge Appeal Notices." Check this page frequently for updates.

Manual instructions should be posted on this page within the next week. These instructions will be located in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 30, Section 200. ❖

Source: CMS Provider Education Resource 200705-34

Important Message from Medicare and Expedited Determination Procedures for Hospital Discharges

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5622 which implements new discharge notice requirements for hospital inpatients with Medicare, including the procedures for delivery of the "Important Message from Medicare" (a statutorily required notice), which were revised with publication of CMS-4105-F. **Hospitals need to be aware of these revised notice requirements and begin using the new notices on July 2, 2007.**

Background

Currently, at or about the time of admission, **hospitals must deliver the "Important Message from Medicare" (IM)**, to all hospital inpatients with Medicare to explain their rights as a hospital inpatient. These rights include the right to have a quality improvement organization (QIO) conduct an expedited review of a discharge decision as required by the Social Security Act (Section 1866(a)(1)(M); http://www.ssa.gov/OP_Home/ssact/title18/1866.htm).

In addition, **a hospital must provide a Hospital-Issued Notice of Non-coverage (HINN)** to any beneficiary in original Medicare who expresses dissatisfaction with an impending hospital discharge as required by the Social Security Act ((Section 1154); http://www.ssa.gov/OP_Home/ssact/title11/1154.htm).

Similarly, **Medicare Advantage (MA) organizations are required to provide their** enrollees with a notice of non-coverage, known as **the Notice of Discharge and Medicare Appeal Rights (NODMAR)**, whenever an enrollee disagrees with a discharge decision (or when the enrollee is not being discharged, but the organization no longer intends to cover the inpatient stay).

The settlement reached in the *Weichardt v. Leavitt* lawsuit, which contested the legitimacy of the current hospital notice procedures, required the Centers for Medicare & Medicaid Services (CMS) to publish a new rule setting forth revised discharge notice requirements for hospital inpatients who have Medicare.

The final rule, CMS-4105-F: *Notification of Hospital Discharge Appeal Rights* was published on November 27, 2006 (http://www.access.gpo.gov/su_docs/fedreg/a061127c.html).

The new notice requirements contained in the final rule must be implemented beginning July 2, 2007.

More information about the final rule and the notices can be found on the CMS Web site at http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

In addition, CMS established a questions and answers (Q & As) document on its BNI Web page regarding the final rule (Notification of Hospital Discharge Appeal Rights [CMS- 4105-F]), and this Web page may be found at: <https://www.cms.hhs.gov/BNI/Downloads/CMS-4105-FINAL%20RULE%20Qs%20and%20As%2004%2003%2007.pdf>.

Beginning July 2, 2007, hospitals must deliver the revised version of the "Important Message from Medicare (IM) CMS-R-193" (an existing statutorily required notice) to explain discharge appeal rights.

Within two calendar days of the day of admission, hospitals must issue the IM and obtain the signature of the Medicare beneficiary or his or her representative to indicate that he/she received and understood the notice.

As soon as possible prior to discharge, **but no more than two days before discharge**, the IM, or a follow-up copy of the signed IM, must also be provided to each Medicare beneficiary.

Thus, in cases where the delivery of the initial IM occurs more than 2 days before discharge, hospitals will deliver a follow-up copy of the signed notice to the Medicare beneficiary as soon as possible prior to discharge, **but no more than two days before discharge**.

For Medicare beneficiaries who request an appeal, the hospital (or health plan if applicable) will deliver a detailed notice.

CR 5622 also revises the *Medicare Claims Processing Manual*, Chapter 30 (Financial Liability Protections) by deleting Sections 80.0 - 80.3 from Chapter 2 (Admission and Registration Requirements) and by adding Sections 200.0 - 200.3 to Chapter 30 (Financial Liability Protection), and this is included as an attachment to CR5622. These additional sections of the manual include examples of the IM and the Detailed Notice, along with detailed specifica-

Important Message from Medicare and Expedited Determination Procedures for Hospital Discharges (continued)

tions regarding the contents of these notices and when the notices should be given to Medicare inpatients.

Additional Information

The official instruction, CR5622, 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/R1257CP.pdf>.

Providers should ensure that appropriate clinical and administrative staff members, including physicians, are aware of these new notice requirements.

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>.

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

MLN Matters Number: MM5622

Related Change Request (CR) Number: 5622

Related CR Release Date: May 25, 2007

Related CR Transmittal Number: R1257CP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1257, CR 5622

Organ Transplant Application Update

On March 30, 2007, the Department of Health & Human Services (DHHS) issued regulations authorizing the survey and certification of transplant programs. The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for monitoring compliance with the Medicare conditions of participation. Prior to this new regulation, organ transplant programs were approved for Medicare participation either through end-stage renal disease conditions of coverage (renal programs) or national coverage decisions (nonrenal). The new regulation established conditions of participation for all covered organ transplant programs.

All hospital transplant programs, approved for Medicare participation as of June 28, 2007, (approved either under the ESRD conditions of coverage or the national coverage decisions), must submit a request for new approval under the conditions of participation established by the new regulation. This request must be submitted to CMS by **December 26, 2007**, (180 days from the effective date of the regulation.) Requests may be:

Mailed to:

Centers for Medicare & Medicaid Services
Attention: Sherry Clark
7500 Security Blvd.
Mailstop: S2-12-25 – Baltimore, MD 21244

Faxed To:

(410) 786-0194
Attention: Sherry Clark

There is no official application form. Each approved program should prepare a letter to CMS formally requesting Medicare approval for their program(s) under the new Hospital Conditions of Participation: Requirements for Approval and Re-approval of Transplant Centers to Perform Organ Transplants. A hospital may submit one request for approval of all their transplant programs within one letter. However, the approval request must include all the essential information about **each** program.

Please visit the CMS/Survey and Certification Web site at http://www.cms.hhs.gov/CertificationandCompliance/20_Transplant.asp for the specific information that must be included in an approval request. CMS is deleting the requirement that each program must submit a signed statement from the Organ Procurement Transplant Network (OPTN) verifying that the program is in compliance with all the data submission requirements of that organization. CMS will not require that this statement be submitted with provider letters requesting approval under the new conditions of participation. CMS has been working with the Health Resources and Services Administration (HRSA) and the United Network for Organ Sharing (UNOS, HRSA's contractor to operate the OPTN) to develop a report that would provide CMS with the percentage of required forms programs have submitted to the OPTN within the timeframe outlined in the regulation.

CMS will notify each applicant upon receipt of the approval request, will review the information submitted, and will schedule an on-site review of the program(s).

Please be advised that CMS will not launch the approval process until the program has entered a formal request for approval under new the conditions of participation and the necessary information concerning the program(s) has been received. If a program does not submit a request for approval under the new conditions of participation by December 28, 2007, CMS will conclude that the program no longer desires Medicare participation and will begin the process to withdraw Medicare approval.

If you have any questions concerning the approval requests, timelines for the regulation, the information that must be submitted with the approval request, or the survey and certification process, please direct your inquiries to Sherry Clark in the Survey and Certification Group at CMS at (410) 786-8476. ❖

Source: CMS Provider Education Resource 200706-21

Countdown Begins for Current Medicare Approved Centers To Request Certification Under the New Rule—Organ Transplant Centers

As of **June 28, 2007**, all hospital transplant centers currently approved for Medicare participation (approved either under the end-stage renal disease (ESRD) conditions of coverage or the national coverage decisions) **must** submit a request for **new** approval under the conditions of participation established by the new regulation that was issued by the Centers for Medicare & Medicaid Services (CMS) on March 30, 2007. **Submit your request to CMS by December 26, 2007**, (180 days from the effective date of the regulation).

Note: If an organ transplant center does not submit a request for approval under the new conditions of participation by December 28, 2007, CMS will conclude that the center no longer desires Medicare participation and will begin the process to withdraw Medicare approval.

There is no application form. Transplant centers must send a request (e.g. a letter) to CMS with specific information. For a list of all transplant centers covered by the regulation and a listing of the minimum information that must be included in all requests to CMS for approval of your transplant center, please visit our transplant Web page at:

http://www.cms.hhs.gov/CertificationandCompliance/20_Transplant.asp.

After June 28, 2007, transplant centers desiring first time Medicare certification must send a request to CMS with the same information. This can be done any time the center is ready for initial Medicare certification.

If you have any questions concerning the approval requests, timelines for the regulation, the information that must be submitted with the approval request, or the survey and certification process, please direct your inquiries to Sherry Clark in the Survey and Certification Group at CMS at (410) 786-8476. ❖

Source: CMS Provider Education Resource 200706-30

Sign up to our eNews electronic mailing list

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

SKILLED NURSING FACILITY SERVICES

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.

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 non-covered 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 non-covered level of care) that overlap previously paid SNF TOB 22x (SNF inpatient stay, Part B only services [Part A exhausted]).

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 following SNF Spell of Illness Quick Reference chart:**

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
Medicare Skilled	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

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
Not Medicare Skilled	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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October 2007 Annual Update to Skilled Nursing Facility Consolidated Billing

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

Provider Types Affected

Skilled nursing facilities (SNFs) and other providers submitting claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries in SNFs.

What Providers Need to Know

- The 2007 FI annual update Major Category IV. A. Mammography Screening – CPT codes **77055** and **77056**, that are subject to the consolidated billing provision of the SNF prospective payment system (PPS) **are removed** with a retroactive effective date of **January 1, 2007**. CR 5636, on which this article is based, removes these two codes from the FI file.
- Healthcare Common Procedure Coding System (HCPCS) codes **Q1001** and **Q1002** **are added** to the file 1 coding file and are effective for dates of service **prior to June 30, 2005**. Please refer to the *Background* and *Additional Information* sections for more information.

Background

Periodically, the Centers for Medicaid & Medicare Services (CMS) updates the lists of HCPCS codes (for FIs carriers and DME/MACs) that are subject to the consolidated billing provision of the SNF PPS. This particular update, however, applies to providers who bill for new technology intraocular lenses (NTIOLs) furnished in ambulatory surgical centers (ASCs) as well as providers billing Medicare FIs for Major Category IV. A. Mammography Screening. The mammography codes for screening and diagnostic mammography services that are **no longer valid as of January 1, 2007** are:

- CPT code 77055 – *Diagnostic mammography, unilateral*
- CPT code 77056 – *Diagnostic mammography, bilateral*

NTIOLs that are now reimbursable separately by the carrier/MAC for dates of service prior to June 30, 2005 are:

- **Q1001** (Category 1, AMO array multifocal lens: model # SA40N)
- **Q1002** (Category 2, elastic ultraviolet-absorbing silicone posterior chamber lens).

In addition, Medicare edits allow the payment of the \$50 additional fee for Category 3 NTIOLs for dates of service prior to January 1, 2007, when billed with HCPCS code **Q1003**. (See MM4361 for additional information about NTIOLs and **Q1003** and the article may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4361.pdf>.)

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Remember that:

- With the exception of SNFs, Medicare will not pay providers for services appearing on the list of services included in SNF CB.
- Conversely, Medicare will pay non-SNF providers for beneficiary services **excluded** from SNF PPS and CB, even when in a SNF stay.
- SNF CB applies to nontherapy services only when furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.
- FIs, carriers and A/B MACs will not search their files for claims affected by this change to either retract payment for claims already paid or to retroactively pay claims, but will adjust such claims that you bring to their attention.

Additional Information

To see the official instruction (CR 5636) issued to your Medicare carrier, FI or A/B MAC, go to the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1266CP.pdf>.

Also, MM3901 is the article that announced the cessation of the additional \$50 payment for NTIOLs for codes Q1001 and Q1002 and that article may be viewed on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3901.pdf>.

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

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

If you have 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: MM5636

Related Change Request (CR) Number: 5636

Related CR Release Date: June 15, 2007

Related CR Transmittal Number: R1266CP

Effective Date: April 1, 2002

Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1266, CR 5636

RURAL HEALTH CLINIC SERVICES

Rural Health Clinic Fact Sheets now Available

The following rural health products are now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- Federally Qualified Health Center Fact Sheet, located at <http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf>.
Provides information about:
 - ♦ Federally Qualified Health Center (FQHC) designation
 - ♦ Covered FQHC services
 - ♦ FQHC preventive primary services that are not covered
 - ♦ FQHC payments
 - ♦ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- Rural Health Clinic Fact Sheet, located at <http://www.cms.hhs.gov/MLNProducts/downloads/rhcfactsheet.pdf>.
Provides information about:
 - ♦ Rural Health Clinic (RHC) services
 - ♦ RHC designation; RHC payments
 - ♦ Annual reconciliation
 - ♦ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- Rural Referral Center Fact Sheet, located at <http://www.cms.hhs.gov/MLNProducts/downloads/RuralRefCtrfctsh2007.pdf>.
Provides information about Rural Referral Center program requirements. ❖

Source: CMS Provider Education Resource 200706-17

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HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

July 2007 Integrated Outpatient Code Editor Specifications

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

Provider Types Affected

Providers who submit claims to Medicare contractors (fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for outpatient services rendered to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5617, which informs Medicare contractors that effective July 1, 2007, there will be an **integration of the non-outpatient prospective payment system (Non-OPPS) outpatient code editor (OCE) into the OPPS OCE**. This integration has resulted in the routing of all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. As a result of these changes specifications have been updated to ensure correct billing and payment of claims. Be sure your billing staff **is aware of the code changes in CR 5617**.

Background

This notification provides the integrated OCE instructions and specifications that will be used under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers of outpatient services, and for limited services when provided in a home health agency (HHA) not under the home health PPS or to a hospice patient for the treatment of a non-terminal illness.

The I/OCE has been updated with numerous additions, changes, and deletions to Healthcare Common Procedure Coding System/*Current Procedural Terminology* (HCPCS/CPT) codes and the ambulatory payment codes (APCs) effective July 1, 2007. Rather than duplicate all the additions, deletions and changes in this article, the Centers for Medicare & Medicaid Services (CMS) directs you to CR 5617, which contains two lengthy lists of these items. CR5617 is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1264CP.pdf>.

In addition to the HCPCS/CPT and APC changes, the key changes for the July 2007 update are in the following table:

Summary of Modifications

Effective Date	Modification
July 1, 2007	Modify the software program to add the processing of claims from hospitals that are not subject to OPPS (bill types 12x, 13x, 14x, 83x and 85x), for dates of service beginning 7/1/07 (in addition to all other institutional outpatient providers).
July 1, 2007	Activate the OPPS/Non-OPPS flag in the OCE control block.
July 1, 2007	Assign ASC group number and apply specified edits (appendix F(b)) to claims from Non-OPPS hospitals (OPPS flag = 2).
July 1, 2007	Interface change – New, 1-byte field added to the claim return buffer for the Non-OPPS bill type flag. Flag to be assigned by the OCE based on the presence/absence of ASC procedures on Non-OPPS hospital claims. Values: 1 = Bill type should be 83x 2 = Bill type should not be 83x
July 1, 2007	Make HCPCS/APC/SI changes as specified by CMS
	Implement version 13.1 of the NCCI file, removing all code pairs, which include anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911).
	Add specified modifiers to the valid modifier list (KG, KK, KL, KT, KU, 1P, 2P, 3P, 8P)
	Update procedure/device edit requirements
July 1, 2007	Change the name of the software program from outpatient code editor with ambulatory payment classification (OCE/APC) to integrated outpatient code editor (IOCE). No change to version numbering or date ranges.
July 1, 2007	Merge the Installation and User Manuals for the OPPS OCE and the Non-OPPS OCE into a single set of manuals for the Integrated OCE.

July 2007 Integrated Outpatient Code Editor Specifications (continued)

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5617) issued to your Medicare carrier, FI, A/B MAC, or RHHI. That instruction may be viewed by going to the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1264CP.pdf>.

For questions directly related to the I/OCE, you may send questions to the CMS OCE Integration email address at CMSOCEIntegration@ees.hhs.gov, or the OCE Web page at <http://www.cms.hhs.gov/OutpatientCodeEdit/>.

For policy related questions, please contact the Division of Outpatient Care at OutpatientPPS@cms.hhs.gov.

If you have questions, please contact your Medicare carrier, FI or A/B 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: MM5617

Related Change Request (CR) Number: 5617

Related CR Release Date: June 8, 2007

Related CR Transmittal Number: R1264CP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1264, CR 5617

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July 2007 Update of the Hospital Outpatient Prospective Payment System— Summary of Payment Policy Changes

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5623, which describes changes to, and billing instructions for various payment policies implemented in the July 2007 outpatient prospective payment system (OPPS) update.

CAUTION – What You Need to Know

The July 2007 update to the integrated/ outpatient code editor (I/OCE) and OPPS PRICER reflects Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions.

GO – What You Need to Do

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

Background

Change request (CR) 5623 provides changes to, and billing instructions for various payment policies implemented in the July 2007 OPPS update. Key changes for July 2007 are as follows:

1. Changes to Device Edits

The Medicare OPPS procedure to device edits and device to procedure edits are posted on the CMS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> under “downloads”. There is no new device to procedure edits for the July 2007 OCE. Therefore, the April 2007 file of device to procedure edits remains unchanged for the July 2007 OCE quarter.

The following new procedure to device edits are being implemented in the July 2007 OCE with the effective dates shown. Although the device edits for G0392 and G0393, new HCPCS codes for 2007, are effective for services furnished **on or after January 1, 2007**, no action is required on claims for these services that were processed before the implementation of the July 2007 OCE.

July 2007 Update of the Hospital OPPTS—Summary of Payment Policy Changes (continued)

Table 1 – New Procedure to Device Edits for Implementation in the July 2007 OCE

CPT/HCPCS	SI	Description	2007 APC	Device A	Device A Description	Effective Date of Edit (DOS)	Reason
G0392	T	AV fistula or graft arterial	0081	C1725	Cath, translumin non-laser	1/1/2007	New code for 2007
G0392	T	AV fistula or graft arterial	0081	C1874	Stent, coated/cov w/del sys	1/1/2007	New code for 2007
G0392	T	AV fistula or graft arterial	0081	C1876	Stent, non-coa/non-cov w/del	1/1/2007	New code for 2007
G0392	T	AV fistula or graft arterial	0081	C1885	Cath, translumin angio laser	1/1/2007	New code for 2007
G0392	T	AV fistula or graft arterial	0081	C2625	Stent, non-cor, tem w/del sy	1/1/2007	New code for 2007
G0393	T	AV fistula or graft venous	0081	C1725	Cath, translumin non-laser	1/1/2007	New code for 2007
G0393	T	AV fistula or graft venous	0081	C1874	Stent, coated/cov w/del sys	1/1/2007	New code for 2007
G0393	T	AV fistula or graft venous	0081	C1876	Stent, non-coa/non-cov w/del	1/1/2007	New code for 2007
G0393	T	AV fistula or graft venous	0081	C1885	Cath, translumin angio laser	1/1/2007	New code for 2007
G0393	T	AV fistula or graft venous	0081	C2625	Stent, non-cor, tem w/del sy	1/1/2007	New code for 2007
50688	T	Change of ureter tube	0122	C2625	Stent, non-cor, tem w/ del	10/1/2005	Device added

2. New Services

The following new service is assigned for payment under the OPPTS:

Table 2 – New Service Payable as of July 1, 2007

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
C9728	7/1/2007	T	0156	Place device/marker, non pros	Placement of interstitial device(s) for radiation therapy/surgery guidance (eg, fiducial markers, dosimeter), other than prostate (any approach), single or multiple	\$209.48	\$41.90

3. Category III CPT Codes

AMA releases category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to calendar year (CY) 2006, CMS implemented new category III CPT codes once a year in January of the following year.

As discussed in the CY 2006 OPPTS final rule with comment period (70 FR 68567), CMS modified the process for implementing the category III codes that AMA releases each January for implementation in July. CMS does this:

- To ensure timely collection of data pertinent to the services described by the codes
- To ensure patient access to the services the codes describe
- To eliminate potential redundancy between category III CPT codes and some of the C-codes that are payable under the OPPTS and were created by CMS in response to applications for new technology services.

Therefore, on July 1, 2007, CMS implements five category III CPT codes in the OPPTS that AMA released in January 2007 for implementation in July 2007. The codes, along with their status indicators and APCs, are shown in table 3 below.

July 2007 Update of the Hospital OPPI—Summary of Payment Policy Changes (continued)

Table 3 – Category III CPT Codes Implemented as of July 1, 2007

CPT Code	Long Descriptor	SI	APC	Payment Rate	Minimum Unadjusted Copayment
0178T	<i>Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report</i>	B	Not applicable	Not applicable	Not applicable
0179T	<i>Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report</i>	X	0100	\$155.74	\$31.15
0180T	<i>Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; interpretation and report only</i>	B	Not applicable	Not applicable	Not applicable
0181T	<i>Corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report</i>	S	0230	\$48.55	\$9.71
0182T*	<i>High dose rate electronic brachytherapy, per fraction</i>	S	1519	\$1,750.00	\$350.00

* As indicated by CPT, do not report CPT code 0182T in conjunction with CPT codes 77761-77763, 77776-77778, 77781-77784, 77789. Additionally, when a high dose rate electronic brachytherapy service described by CPT code 0182T is provided, along with a procedure to place and remove (if performed) an applicator into the breast for radiation therapy described by HCPCS code C9726, both services are separately reportable.

4. Payment for Brachytherapy Sources

The Medicare Modernization Act of 2003 (MMA) requires Medicare to pay for brachytherapy sources in separately paid APCs, and for the period of January 1, 2004 through December 31, 2006, to pay for brachytherapy sources at hospitals' charges adjusted to their cost. Effective January 1, 2007, CMS continued to pay for specified brachytherapy sources separately, pursuant to MMA, and at hospitals' charges adjusted to their cost pursuant to the Tax Relief and Health Care Act of 2006 (TRHCA), which extends the charges adjusted to cost payment for brachytherapy sources until January 1, 2008. The TRHCA also requires that CMS create separate APC groups for stranded and non-stranded sources furnished on or after July 1, 2007.

CMS is currently aware of three sources that come in stranded and non-stranded forms: iodine, palladium and cesium. Therefore, CMS created six new codes to reflect these three sources in stranded and non-stranded versions. At the same time, CMS is deleting the three non-specific brachytherapy source codes for iodine, palladium and cesium. The deleted brachytherapy source codes, effective July 1, 2007, are listed in Table 5 below.

a. Billing for Stranded and Non-stranded Brachytherapy Sources

The new codes for these separately paid sources, long descriptors and APCs are listed in Table 4, the comprehensive brachytherapy source table below, payable as of July 1, 2007. Please note that when billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should **not** bill as one unit per strand. If a hospital applies both stranded and non-stranded sources to a patient in a single treatment, the hospital should bill the stranded and non-stranded sources separately, according to the differentiated HCPCS codes listed in Table 4 below.

b. Comprehensive List of Brachytherapy Sources Payable as of July 1, 2007

Below is coding information for all brachytherapy sources payable as of July 1, 2007. Please note that CMS has added the term "non-stranded" to the descriptors for all sources that are described as "per source," other than iodine-125, palladium-103 and cesium-131, for which CMS has separate stranded or non-stranded codes. All changes, i.e., new codes and descriptors and changes to existing code descriptors are noted in bold.

Table 4 – Comprehensive List of Brachytherapy Sources Payable as of July 1, 2007

CPT/ HCPCS	Long Descriptor	SI	APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	H	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	H	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	H	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	H	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	H	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	H	2635

July 2007 Update of the Hospital OPPI—Summary of Payment Policy Changes (continued)

CPT/ HCPCS	Long Descriptor	SI	APC
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	H	2636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	H	2637
C2638	Brachytherapy source, stranded, Iodine-125, per source	H	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	H	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	H	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	H	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	H	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	H	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	H	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	H	2699

c. Coding for Not Otherwise Specified Brachytherapy Sources and New Sources

If CMS receives information that any of the sources listed above now designated as non-stranded (i.e., other than iodine, palladium and cesium sources) are also FDA-approved and marketed as a stranded source, CMS will create coding information for the stranded source. CMS has also established two not otherwise specified (NOC) codes for stranded and non-stranded sources that are not yet known to us and for which CMS does not have source-specific codes. If a hospital purchases a new FDA-approved and marketed radioactive source consisting of a radioactive isotope, (consistent with our definition of a brachytherapy source eligible for separate payment, discussed in the November 24, 2006 final rule, 71 FR 68113), for which CMS does not yet have a separate source code established, the hospital should bill such sources using the appropriate NOS codes found in Table 4 above, i.e., C2698 for stranded NOS sources, and C2699 for non-stranded NOS sources. For example, if a new FDA-approved stranded source comes onto the market and there is currently only a billing code for the non-stranded source, the hospital should bill the stranded source under C2698 (stranded NOS source) until a specific stranded billing code for the source is established.

Hospitals and other parties are invited to submit recommendations to CMS for new HCPCS codes to describe new sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources. CMS will continue to endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis. Please direct such recommendations to:

The Division of Outpatient Care
Mail Stop C4-05-17
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

d. Brachytherapy Source Codes Deleted as of July 1, 2007

CMS is deleting the following codes for iodine, palladium and cesium sources, effective July 1, 2007, which do not specify whether sources are stranded or non-stranded.

Table 5 – Brachytherapy Source Codes Deleted as of July 1, 2007

CPT/HCPCS	Long Descriptor
C1718	Brachytherapy source, Iodine 125, per source
C1720	Brachytherapy source, Palladium 103, per source
C2633	Brachytherapy source, Cesium-131, per source

5. Billing for Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

a. Drugs and Biologicals with Payments Based on Average Sales Price Effective July 1, 2007

In the CY 2007 OPPI final rule, it was stated that payments for separately payable drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submission, CMS will incorporate changes to the payment rates in the July 2007 release of the OPPI PRICER. The updated payment rates effective July 1, 2007, will be included in the July 2007 update of the OPPI Addendum A and Addendum B, which will be posted on the CMS Web site at the end of June at

<http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage>.

July 2007 Update of the Hospital OPPTS—Summary of Payment Policy Changes (continued)
b. Updated Payment Rates for Certain Drugs and Biologicals Effective January 1, 2007 through March 31, 2007

The payment rates for the drugs and biologicals listed below were incorrect in the April 2007 OPPTS PRICER. The corrected payment rates will be installed in the July 2007 OPPTS PRICER effective for services furnished on January 1, 2007, through March 31, 2007. Your Medicare contractor will adjust claims processed at the incorrect rates if you bring such claims to their attention.

Table 6 – Updated Payment Rates for Certain Drugs and Biologicals Effective January 1, 2007 through March 31, 2007

HCPCS	APC	Long Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9350	9350	Microporous collagen tube of non-human origin, per centimeter length	\$485.91	\$97.18
J0152	0917	Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds; instead use A9270)	\$69.20	\$13.84
J0215	1633	Injection, alefacept, 0.5 mg	\$26.28	\$5.26
J0289	0736	Injection, amphotericin b liposome, 10 mg	\$16.66	\$3.33
J7342	9054	Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter	\$31.66	\$6.33
J8560	0802	Etoposide; oral, 50 mg	\$30.53	\$6.11
J9268	0844	Pentostatin, per 10 mg	\$1,828.98	\$365.80

c. Updated Payment Rates for Certain Drugs and Biologicals Effective April 1, 2007 through June 30, 2007

The payment rates for the drugs and biologicals listed below were incorrect in the April 2007 OPPTS PRICER. The corrected payment rates will be installed in the July 2007 OPPTS PRICER effective for services furnished on April 1, 2007 through June 30, 2007. Your Medicare contractor will adjust claims processed at the incorrect rates if you bring such claims to their attention.

Table 7 – Updated Payment Rates for Certain Drugs and Biologicals Effective April 1, 2007 through June 30, 2007

HCPCS	APC	Long Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q2017	7035	Injection, teniposide, 50 mg	\$264.43	\$52.89
J2503	1697	Injection, pegaptanib sodium, 0.3 mg	\$1107.54	\$221.51

d. Newly-Approved Drug Eligible for Pass-Through Status as of July 1, 2007

The following drug has been designated as eligible for pass-through status under the OPPTS effective July 1, 2007.

Table 8 – Newly-Approved Drug Eligible for Pass-Through Status as of July 1, 2007

HCPCS Code	APC	SI	Long Description
J9261	0825	G	Injection, nelarabine, 50 mg

The payment rate for this drug can be found in the July 2007 update of OPPTS Addendum A and Addendum B which will be posted at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage> on the CMS Web site at the end of June. While this drug code was made effective January 1, 2007, its pass-through status does not become effective until July 1, 2007. J9261 has been assigned to status indicator “K” under the OPPTS effective January 1, 2007. However, the status indicator for J9261 will change from “K” to “G” effective July 1, 2007.

e. New HCPCS Drug Codes Separately Payable Under OPPTS as of July 1, 2007

The following seven HCPCS drug codes will be made effective July 1, 2007. These HCPCS codes will be separately payable under the hospital OPPTS. The payment rates for these drugs can be found in the July 2007 update of OPPTS Addendum A and Addendum B which will be posted on the CMS Web site at the end of June.

July 2007 Update of the Hospital OPPTS—Summary of Payment Policy Changes (continued)

Table 9 – New Drug Codes Separately Payable under OPPTS as of July 1, 2007

HCPSC Code	APC	SI	Long Descriptor
Q4087	0943	K	Injection, immune globulin, (Octagam), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4088	0944	K	Injection, immune globulin, (Gammagard liquid), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4089	0945	K	Injection, rho(d) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 iu
Q4090	0946	K	Injection, hepatitis b immune globulin (Hepagam B), intramuscular, 0.5 ml
Q4091	0947	K	Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4092	0948	K	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg
Q4095	0951	K	Injection, zoledronic acid (Reclast), 1 mg

f. Billing for Zometa and Reclast under the OPPTS as of July 1, 2007

Effective July 1, 2007, hospitals should report one of two HCXPCS codes for zoledronic acid, i.e., J3487 for Zometa and Q4095 for Reclast.

Table 10 – Drug Codes for Zometa and Reclast under the OPPTS as of July 1, 2007

HCPSC Code	APC	SI	Long Descriptor	Drug Name
J3487	9115	K	Injection, zoledronic acid, 1 mg	Zometa
Q4095	0951	K	Injection, zoledronic acid (Reclast), 1 mg	Reclast

g. Drug HCPCS Code J1567 Not Reportable Under the Hospital OPPTS as of July 1, 2007

HCPCS code J1567 will no longer be recognized by Medicare effective July 1, 2007. Therefore, HCPCS code J1567 will no longer be reportable under the hospital OPPTS. To report those drugs previously reported under HCPCS code J1567, refer to HCPCS codes Q4087, Q4088, Q4091, or Q4092.

Table 11 – Drug Code Not Reportable Under the Hospital OPPTS as of July 1, 2007

HCPSC Code	Long Descriptor
J1567	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg

h. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

6. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPTS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. FIs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, fiscal intermediaries determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR 5623, issued to your Medicare FI, RHHI, or A/B MAC regarding this change may be viewed on the CMS web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1259CP.pdf>.

If you have any questions, please contact your Medicare FI, RHHI, 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>.

July 2007 Update of the Hospital OPPTS—Summary of Payment Policy Changes (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: MM5623

Related Change Request (CR) Number: 5623

Related CR Release Date: June 1, 2007

Related CR Transmittal Number: R1259CP

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1259, CR 5623

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

ELECTRONIC DATA INTERCHANGE

Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or Paper Claim Forms

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

Note: CMS has revised this *MLN Matters* article on May 18, 2007, to add this statement that Medicare fee-for-service (FFS) has announced a contingency plan regarding the May 23, 2007, implementation of the national provider identifier (NPI). For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article MM5595 on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

The *MLN Matters* article MM5595 was published in the May 2007 *Medicare A Bulletin* (pages 17-18).

Provider Types Affected

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

Provider Action Needed

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

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began accepting applications for and issuing NPIs on May 23, 2005. Applications may be made by mail, and online on the CMS Web site at <https://nppes.cms.hhs.gov>.

CMS has endorsed the Workgroup for Electronic Data Interchange (WEDI) Dual NPI-Legacy Identifier strategy for cross-health care industry implementation of the NPI.

The *Dual Use of NPI & Legacy Identifiers* paper is available at: <http://www.wedi.org/snip/public/articles/>. (Once at the site, scroll down and look for the paper issued on January 22, 2006.)

The remainder of this article describes CMS' current plans for a staged process leading to full implementation of the adoption of the NPI in Medicare transactions involving providers.

Background

Implementation involves acceptance and processing of transactions that use the NPI in lieu of the previously used OSCAR, UPIN, PIN, and national supplier clearinghouse (NSC) numbers. The WEDI strategy provides for four stages during which system change schedules of trading partners will occur independently of each other.

Medicare fee-for-service (FFS) transaction implementation for NPI will occur in the following stages:

Stage 1 (January 1, 2006 – October 1, 2006)

During this stage, the NPI will be accepted on inbound claims, other than NCPDP claims, and other transactions but will not be used for Medicare processing.

CR 4320 focuses primarily on Stage 1 of the NPI implementation process. During stage 1:

- The “legacy identifier” (pre-NPI provider identifiers) will be used to identify providers while Medicare carriers, DMERCs, and intermediaries make sure that X12 837 version 4010A1 claims and other X12 HIPAA adopted transactions are not rejected due to the presence of an NPI. (Transactions may be submitted with or without an NPI during stage 1, as long as the Medicare legacy identifier is still reported.)
- Additionally, NPIs will be edited to verify that they meet basic structure requirements established for NPIs.
- Medicare will allow NPIs on the X12 270 version 4010A1 eligibility inquiry and the 276 claim status inquiry and return them in the respective X12 271 or 277 response, as long as the legacy identifier is also reported in the 270 or the 276.
- NPIs, as well as legacy identifiers, will be reported in coordination of benefit claims sent to trading partners when submitted on claims submitted to Medicare.
- NPIs will NOT be reported in the following outbound transactions during Stage 1, even if an NPI was submitted on related claims:
 - ♦ X12 835 claims; or
 - ♦ SPRs (standard paper remittance) formats.
- Medicare carriers, DMERCs, and intermediaries must **reject the following transactions if submitted with NPIs**, since it is not possible to report both NPIs and legacy identifiers for providers in these transactions:
 - ♦ **NCPDP claims**
 - ♦ **DDE claims, claim status and eligibility inquiries**
 - ♦ **UB-92 (CMS-1450) paper claims** (the National Uniform Billing Committee [NUBC] announced that the use of the UB-04, which is able to report the NPI and a legacy identifier for each provider

Stage 1 Use and Editing of NPI Numbers Received in EDI Transactions... (continued)

involved with a claim, will begin March 1, 2007, and that May 22, 2007, is the last day that a payer should accept a UB-92 form). Since it is not possible to report both a legacy identifier and an NPI on the UB-92, submitters of the UB-92 will be limited to reporting of their legacy identifier on those claims.

- ♦ **CMS-1500 paper** claims until the National Uniform Claim Committee implements a revised 1500 and CMS announces its implementation of that revised form.

The NUCC has approved a revised CMS-1500 form and has announced that payers should begin to accept the revised form effective October 1, 2006. Between October 1, 2006, and January 31, 2007, payers should accept either the current or the revised CMS-1500 form. Effective February 1, 2007, and later, payers should accept only the revised CMS-1500 form. Both the NPI and the legacy identifier can be reported on the revised CMS-1500 form, but not on the form currently in use. Until a provider begins to use the revised form, that provider will be limited to submission of legacy identifiers on the non-revised CMS-1500 form.

Stage 2: (October 2, 2006 – May 22, 2007)

During this stage:

- Providers, clearinghouses, and billing services will be directed to provide a Medicare legacy identifier as a secondary identifier when NPIs are submitted as the primary provider identifiers in their X12 837 claims.
- The legacy identifier alone can still be used to identify those providers that have not yet obtained an NPI.
- The transitional Dual NPI-Legacy Identifier strategy includes the development of a crosswalk between Medicare legacy numbers and their associated NPIs. The crosswalk should help Medicare validate most NPIs to ascertain that they were actually issued to the providers for which reported, and will help to identify transcription errors in a reported NPI. The Crosswalk will begin operating at the onset of stage 2.
- If you use free billing software supplied by your carrier, DMERC, or intermediary/RHHI, it will be modified for stage 2 to permit reporting of your NPI, once received, and your legacy Medicare provider identifier. You will need to download the new version of the software when notified it is available.

The 835 PC-Print and Easy Print software for printing of remittances will also be updated for stage 2 to permit reporting of NPIs as well as legacy numbers when both are reported in an 835 transaction. Be sure to download the new version of that software when notified it is available.

- DDE screens will be modified for this stage to accept and return both NPIs, when available, and legacy identifiers.
- NPIs, when available in Medicare provider files, as well as legacy identifiers will be returned in 835 transactions and SPRs during stage 2.

Stage 3 (May 23, 2007 – and Later)

Stage 3 involves the transition to full use of the NPI for acceptance and processing of transactions, **except** for coordination of benefits (COB) claims that Medicare sends to small trading partners.

- HIPAA prohibits the reporting of any provider legacy identifiers to other than small health plans during this period (e.g., plans with less than \$5 million in annual receipts).
- All claims, including NCPDP claims, and 270, 276, and 277 attachment transactions sent to Medicare, must contain the NPI in lieu of the legacy identifier (please see Stage 4 below regarding claims). Those that do not are to be rejected.
- Legacy identifiers will no longer be sent to coordination of benefits (COB) trading partners or on outbound electronic or paper Medicare transactions or correspondence.

Stage 4 (May 23, 2007 – May 22, 2008)

Stage 4 involves completion of transition to the full use of NPI by all small trading partners. NPIs, rather than legacy identifiers, will be reported in all 837 version 4010A COB and NCPDP claims sent to small trading partners.

Additional Information

CR 4320 is the official instruction issued to your FI, including RHHI, or carrier, including DMERC, regarding changes mentioned in this article. CR 4320 may be found on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf>.

You may also want to review *MLN Matters* Special Edition SE0555, concerning the NPI. That article is available on the CMS Web site at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0555.pdf>.

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

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

MLN Matters Number: MM4320 – Revised
Related Change Request (CR) Number: 4320
Related CR Release Date: February 1, 2006
Related CR Transmittal Number: R204OTN
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Source: CMS Pub. 100-20, Transmittal 204, CR 4320

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FRAUD AND ABUSE

Strike Force Formed to Target Fraudulent Billing of Medicare Program By Health Care Companies

Thirty-eight people have been arrested in the first phase of a targeted criminal, civil and administrative effort against individuals and health care companies that fraudulently bill the Medicare program, Attorney General Alberto R. Gonzales and Secretary Michael Leavitt of the U.S. Department of Health & Human Services have announced today.

The arrests in the Southern District of Florida are the result of the establishment of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing data. Since the first phase of strike force operations began on March 1, 2007 in southern Florida, the strike force has obtained indictments of individuals and organizations that have collectively billed the Medicare program for \$142,061,059. Charges brought against the defendants in these indictments include conspiracy to defraud the Medicare program, criminal false claims, and violations of the anti-kickback statutes. If convicted, many of the defendants face up to 20 years in prison on these charges.

The strike force is able to identify potential fraud cases for investigation and prosecution quickly through real-time analysis of billing data from Medicare program safeguard contractors (PSCs) and claims data extracted from the Health Care Information System. In phase one operations in Miami, teams have identified two primary schemes that defrauded the Medicare program – infusion therapy and durable medical equipment (DME) suppliers. All of the strike force cases to date target these two areas.

The work of the strike force is just one step in a multi-phase enforcement and regulatory project designed to improve the quality of the industry and reduce the potential for fraud in the durable medical equipment and infusion areas. The Centers for Medicare & Medicaid Services (CMS) is taking steps to increase accountability and decrease the presence of fraudulent providers. The end result will be better service to beneficiaries and savings of billions of dollars that might otherwise go to fraudulent businesses.

“This initiative targets those who steal taxpayer funds intended to provide health care to the elderly,” stated Attorney General Gonzales. “Protecting the financial integrity of the Medicare program for generations to come is important to the millions of seniors who rely on this program. Through the collaborative efforts of federal, state and local law enforcement and other agencies, we will concentrate our efforts. The Medicare Fraud Strike Force will allow us to have real-time access to Medicare billing data and provide authority to move quickly to make arrests and bring prosecutions as quickly as possible. With better tools and information sharing, we can expect greater levels of enforcement.”

“The Medicare Fraud Strike Force is just one weapon in our arsenal to protect Medicare beneficiaries and taxpayers from fraud. I will be working closely with the Administration and Congress to put processes in place that will improve the industry and eliminate the likelihood for deception,” Secretary Leavitt said. “We will be announcing the second step in this multi-year process within the next month. We expect industry leaders will embrace the changes that will improve the quality of the durable medical equipment industry and others who serve our Medicare beneficiaries.”

On the morning of May 8, 2007, federal agents arrested 24 people to conclude a sweep in southern Florida of DME supply company owners who were engaged in various schemes to defraud Medicare based on fraudulent prescriptions. The arrests bring the total number of arrests to date to 38.

The indictments outline various types of fraudulent schemes. Those schemes included compounded aerosol medications – a process where a pharmacist makes medicine to meet a special medical need for a patient, rather than dispensing less expensive commercial pharmaceuticals. The indictments allege that the homemade medications were not necessary and that they were only prescribed to defraud Medicare.

In one example, Eduardo Moreno, the owner of multiple DME companies, was arrested on April 7 after being named in a six-count indictment on fraud charges. Two of Moreno’s companies – Brenda Medical Supply Inc., and Faster Medical Equipment Inc. – allegedly billed Medicare for more than \$1.9 million for services that were not medically necessary. The FBI has seized some of Moreno’s assets, including a new Rolls Royce Phantom worth approximately \$200,000.

In a five-count indictment out of the Southern District of Florida, Barbara Diaz and Jose Prieto were charged with conspiring to defraud Medicare, submitting false claims to Medicare and money laundering. The indictment alleges that Diaz and Prieto engaged in an “infusion therapy scheme” where patients did not need the drugs that were purportedly used. From March 9 through Dec. 31, 2006, the defendants billed Medicare more than \$900,000 for infusion.

Seizure warrants have been used to take money back from bank accounts associated with the activity alleged in the indictment. In one case, HHS-Inspector General agents recovered more than \$1.2 million from a corporate bank account after arresting Leider Alexis Munoz, the president and chief executive officer of RTC of Miami, Inc., an infusion clinic located in Hialeah, Fla.

“History has shown that health care fraud is best investigated jointly. The FBI, as part of the Medicare Fraud Strike Force, worked closely with its law enforcement

Strike Force Formed to Target Fraudulent Billing of Medicare Program By Health Care Companies (continued)

partners and oversight authorities to assist investigations of fraud, waste and abuse across Southern Florida,” said Assistant Director Kenneth W. Kaiser, FBI Criminal Investigative Division. “Health care fraud increases the cost of health care for everyone and the FBI remains committed to pursuing any company or individual that attempts to take advantage of the system for personal gain.”

“The landscape for fraud in south Florida has changed dramatically over the past two years. CMS has taken aggressive action to curb infusion therapy fraud and other organized fraud actions,” said Leslie Norwalk, acting administrator of CMS. We have opened two satellite offices that are dedicated to combating fraud in high-risk areas and we will soon be opening a third. We are sending a strong message to those who seek to defraud the programs that if they engage in fraudulent activity, they will be caught and no longer able to take advantage of the programs to their own gain.”

The strike force teams are led by a federal prosecutor supervised by both the Criminal Division’s Fraud Section in Washington and the office of U.S. Attorney R. Alexander Acosta of the Southern District of Florida. Each team has four to six agents, at least one agent from the FBI and HHS Office of Inspector General, as well as representatives of local law enforcement. The teams operate out of the federal Health Care Fraud Facility in Miramar, Fla.

The operation is being prosecuted by attorneys from the Criminal Division’s Fraud Section and the Major Crimes Section of the U.S. Attorney’s Office for the Southern District of Florida, and supervised by Fraud Section Deputy Chief Kirk Ogrosky and Chief of the Criminal Division in Miami, Matthew Menchel. In addition to federal agents, the teams have officers and detectives from the Florida Medicaid Fraud Control Unit and Hialeah Police Department.

An indictment is merely an allegation and defendants are presumed innocent until and unless proven guilty. ❖

Frequently Asked Questions About the Office of Inspector General Advisory Opinion

What is an advisory opinion?

An OIG advisory opinion is a legal opinion issued by the Office of Inspector General (“OIG”) to one or more requesting parties about the application of the OIG’s fraud and abuse authorities to the party’s existing or proposed business arrangement. An OIG advisory opinion is legally binding on the Department of Health & Human Services (the “Department”) and the requesting party or parties. It is not binding on any other governmental department or agency. A party that receives a favorable advisory opinion is protected from OIG administrative sanctions, so long as the arrangement at issue is conducted in accordance with the facts submitted to the OIG. However, no person or entity can rely on an advisory opinion issued to someone else.

What law applies to the OIG advisory opinion process?

Congress established the OIG advisory opinion process as part of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Information about the process may be found by reviewing the following law and regulations:

Statute

The statute is section 1128D(b) of the Social Security Act (the “Act”), 42 U.S.C. Section 1320a-7d(b) (see <http://www4.law.cornell.edu/uscode/42/1320a-7d.html>).

Regulations

Regulations implementing the process may be found at the following locations:

- (a) in the *Code of Federal Regulations* at 42 C.F.R. Part 1008 (see http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr1008_99.html); or
- (b) in the *Federal Register* by reviewing both the interim final rule at 62 Fed. Reg. 7,350 (1997) and the revised final rule at 63 Fed. Reg. 38,311 (1998) (see our Web page).

Do I have to get an advisory opinion?

No, the advisory opinion process is voluntary. A party’s failure to seek an advisory opinion about a transaction or business arrangement may not be introduced into evidence to prove that the party intended to violate the law.

What are appropriate subject matters for advisory opinion requests?

Most advisory opinion requests seek guidance regarding the anti-kickback statute, section 1128B(b) of the Act, or the anti-kickback “safe harbor” regulations at 42 C.F.R. section 1001.952. However, the OIG may also issue advisory opinions regarding the exclusion authorities in section 1128 of the Act, the civil monetary penalty authorities in section 1128A of the Act, and the criminal penalties in section 1128B of the Act. A party seeking an advisory opinion can help us process its request more quickly by identifying the specific subsections of 1128, 1128A, or 1128B of the Act about which the party is seeking an opinion and by providing facts relevant to the specific subsections.

What topics are NOT appropriate for the advisory opinion process?

We cannot address the following topics in an advisory opinion:

- hypothetical situations
- “model” arrangements
- general questions of interpretation
- activities in which the party requesting the advisory opinion is not, and does not plan to be, involved (for example, we cannot issue an opinion to Company A about the business practice of Company B, unless Company A is a current or prospective party to Company B’s business practice)

Frequently Asked Questions About the Office of Inspector General Advisory Opinion (continued)

- the fair market value of goods, services, or property
- whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986
- the application of statutes not contained in sections 1128, 1128A, or 1128B of the Act
- the application of section 1877 of the Act (also known as the “Stark” law or “physician self-referral law”) (see question below).

How do I request an advisory opinion?

To request an advisory opinion, you must submit a written request that contains certain specified information (see the following question). You should send the original and two copies of the request, via U.S. mail, overnight courier, or hand delivery, to the following address:

Chief, Industry Guidance Branch
U. S. Department of Health and Human Services
Office of Inspector General
Office of Counsel to the Inspector General
Room 5527, Cohen Building
330 Independence Avenue, S.W.
Washington, DC 20201

We cannot accept faxed or emailed requests.

What information should an advisory opinion request include?

We have prepared a checklist of the information to submit. In addition, there are “preliminary questions” intended to give requestors an idea of the type of information that the OIG may need to do the analysis. In general, the request must specifically identify the requesting parties (and any other actual or potential parties, to the extent known) and must provide a detailed factual description of the arrangement at issue and copies of any operative documents. For proposed arrangements, we recognize that actual documents may not be available. In such cases, the requesting party can submit draft documents or detailed narrative descriptions of the material terms to be contained in the documents. However, material differences between the drafts or descriptions submitted and the final operative documents may affect the enforceability of the opinion.

Each requesting party must certify the truthfulness of the information submitted (see question below). We cannot issue an opinion to an anonymous requestor. You must designate a contact person who will be available to discuss your request. You must include a non-refundable deposit of \$250 (see question below). You may ask for an estimate of the cost for processing your advisory opinion (see question below) and/or designate a “triggering” dollar amount (see question below).

If your request contains trade secrets or confidential commercial or financial information that you believe should be protected from public disclosure, you should identify this information in the manner described in the

Department’s Freedom of Information Act regulations at 45 C.F.R. section 5.65 (see link). The identification may be more effective if you designate trade secrets or confidential information contained in your request with specificity, instead of generally telling us that the request contains that kind of information.

What certifications are required?

Our regulations (42 C.F.R. section 1008.38) provide that every advisory opinion request must include a signed certification from each requesting party using the following language, as appropriate:

For an existing arrangement

With knowledge of the penalties for false statements provided by 18 U.S.C. 1001 and with knowledge that this request for an advisory opinion is being submitted to the Department of Health and Human Services, I certify that all of the information provided is true and correct, and constitutes a complete description of the facts regarding which an advisory opinion is sought, to the best of my knowledge and belief.

For a proposed arrangement

With knowledge of the penalties for false statements provided by 18 U.S.C. 1001 and with knowledge that this request for an advisory opinion is being submitted to the Department of Health & Human Services, I certify that all of the information provided is true and correct, and constitutes a complete description of the facts regarding which an advisory opinion is sought, to the best of my knowledge and belief. The arrangement described in this request for an advisory opinion is one that [the requestor(s)] in good faith plan(s) to undertake. [This certification may be made contingent on a favorable advisory opinion by adding the phrase “if the OIG issues a favorable advisory opinion.”]

The signatory of the certification must be a person with authority to bind the requesting party. In particular, the signatory should be:

- The requesting party, if the requesting party is an individual
- The chief executive officer or comparable officer, if the requesting party is a corporation
- The managing partner, if the requestor is a partnership, or
- The managing member or comparable person, if the requestor is a limited liability company.

How long does it take to get an opinion?

The statute provides that advisory opinions should be issued within 60 days. In addition, the regulations establish a 10-day period for the initial review and processing of the incoming request. The length of time that it takes for the OIG to issue an opinion varies based upon a number of factors, including the complexity of the arrangement, the completeness of the submission, and how promptly the requestor responds to requests for additional information. The time frame for issuing the opinion may be extended to account for the time during which we are waiting for additional

Frequently Asked Questions About the Office of Inspector General Advisory Opinion (continued)

information and in certain other circumstances. We may request additional information, as needed, at any time during the processing of an advisory opinion request.

Can I withdraw my request after I've submitted it?

Yes, our regulations permit the requesting party to withdraw its request at any time before the opinion is issued. The requesting party remains liable for any fees incurred up to that point.

How much does an advisory opinion cost? Can I set a cap?

We are required by statute to collect a fee for preparing an advisory opinion. The statute provides no exceptions to the fee requirement. We currently charge \$86 per hour for the preparation of an opinion. The actual cost of an opinion will vary based upon the amount of work required to prepare the opinion. There is a \$250 non-refundable deposit required at the time a request is submitted. We deduct the \$250 deposit from the total cost of the opinion, and this balance must be paid in full before the opinion is issued. Both the \$250 deposit and the balance due upon completion of the opinion should be made payable to the Treasury of the United States. You can set a cap by designating a "triggering" dollar amount. A "triggering" dollar amount is the maximum amount that you are willing to spend on an advisory opinion. If you designate a "triggering" dollar amount, we will stop processing your request and notify you if the costs have reached, or are likely to exceed, the amount you designate. At that point, you can withdraw the request (you remain liable for the fees incurred) or notify us that you would like us to continue processing the request. If you tell us to proceed, you will be agreeing to pay the fee even though it may exceed your "triggering" amount.

Can I get an estimate of the fee?

Yes, in your request you may ask for a written estimate of the cost involved in processing the advisory opinion. After our initial, 10-day review of the request, we will notify you of our estimate in writing and stop processing your request until you confirm in writing that you want us to continue. A fee estimate is not binding, and the actual cost of the opinion may be higher or lower than the estimate. Your written confirmation may include a new or revised "triggering" dollar amount (see question above).

Will my advisory opinion be released to the public?

Yes, we are required to make opinions available to the public. Advisory opinions are posted on our Website. We remove identifying information, such as the names of the parties, before posting opinions on the Web. In addition, information submitted in connection with an advisory opinion request may be subject to disclosure under the Freedom of Information Act ("FOIA") (see question above). Additional information about FOIA may be found on the OIG Web page.

Will I have an opportunity to discuss my opinion request with OIG staff before it is issued?

Our goal is to render meaningful and informed opinions based on a complete and comprehensive understanding of the facts and circumstances of a given arrangement. We generally find that informal consultation with the requesting parties helps us with our review and analysis of requests. We will initiate discussions with a requesting party's designated contact person at the point at which we would find such discussions useful. We generally conduct these discussions by telephone; in-person meetings are not necessary.

Can I make changes to my proposed arrangement during the advisory opinion process?

Minor revisions to a proposed arrangement generally are not a problem, although they may delay issuance of the opinion. You will be required to submit information about the changes in writing and to certify the supplemental submission. If you need to make major changes, we may suggest that you withdraw the opinion request and submit a new one.

Does the OIG issue opinions about the "Stark" law?

Opinions about the "Stark" law (section 1877 of the Act, also known as the "physician self-referral law") come within the jurisdiction of the Centers for Medicare & Medicaid Services ("CMS"), which operates the Medicare and Medicaid programs. Information about the Stark advisory opinion process is available at 42 C.F.R. sections 411.370-.389 (see http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr411_02.html).

The Stark law and the anti-kickback statute are separate statutes, and, depending on the facts, a particular arrangement might implicate one or both statutes. The Stark law applies in the case of direct and indirect financial relationships with referring physicians (as further described in that law). Although the OIG is not authorized to issue opinions about the Stark law, our regulations require that a party requesting an OIG advisory opinion notify us if the party will be separately requesting a Stark opinion from CMS about the same arrangement.

I still have questions about the advisory opinion process. Whom do I call for further information?

If, after reviewing these [Frequently Asked Questions](#) and the other materials on our Web page, you still have questions about the advisory opinion process, you may call 202-619-0335 and ask to speak to a member of the Industry Guidance Branch. ♦

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.

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

August 2007 – September 2007

Ask the Contractor (Topics To Be Determined)

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

Keep checking our website at <http://www.floridamedicare.com>, or listening to information on the FCSO Provider Education and Outreach Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

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

Online Registration

To participate in the above educational events, access <http://www.floridamedicare.com>. Select “Calendar” or “Event List” on the left navigation menu. Providers with Internet barriers may complete and fax this form to 1-904-791-6035.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Source: Julie Stiles, Medicare Provider Outreach & Education

Sign up to our eNews electronic mailing list

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

PREVENTIVE SERVICES

National Men's Health Week

June 11-17 is National Men's Health Week. The goal of this annual week-long observance is to heighten the awareness of preventable health problems and encourage early detection and treatment of disease among men and boys. In keeping with the goal of National Men's Health Week, the Centers for Medicare & Medicaid Services (CMS) continues its initiative focused on motivating seniors and others with Medicare to make the most of Medicare's preventive services and maintaining healthy lifestyles by asking health care providers to use this week as an opportunity to encourage patients with Medicare to take advantage of preventive services and screenings for which they may be eligible. Medicare pays for a full range of preventive services and screenings such as colorectal and prostate cancer screenings and diabetes and cardiovascular screenings. These screenings can help men with Medicare stay healthy and detect conditions like cancer, diabetes, and cardiovascular disease early when treatment works best. CMS hopes that you will join with us in spreading the word to Medicare beneficiaries and their caregivers.

How Can You Help?

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about potentially life saving preventive services and screenings. While Medicare pays for more preventive benefits, many men with Medicare don't fully realize that utilizing preventive services and screenings covered by Medicare can help them live longer, better, healthier lives. As a health care professional you can help your patients with Medicare understand the importance of disease prevention, early detection and lifestyle modifications that support a healthier life.

- Talk with your patients with Medicare about their risk for disease and lifestyle modifications that can help reduce risk of disease and complications.
- Educate your patients about the benefits of using preventive services and screenings.

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.

- Discuss with them which Medicare-covered preventive services and screenings are right for them and encourage utilization by providing referrals for appropriate services for which they may be eligible.

Working together we can ensure that men with Medicare receive the preventive services and screenings that are right for them.

For More Information

For more information about Medicare-covered preventive services and screenings, including coverage, coding and billing guidelines, please visit the following CMS Web site:

- The MLN Preventive Services Educational Products Web page – This Web page is a one-stop shop for provider educational information on coverage, coding, and billing of Medicare-covered preventive benefits. The Web page contains a descriptive listing of the products, which include: articles, a guide, brochures, quick reference charts, Web-based training courses, a video program, a slide presentation, seasonal flu information, and a bookmark, as well as product ordering information and links to other related CMS and non-CMS prevention resources and Web sites.

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage.

For products to share with your Medicare patients go to <http://www.medicare.gov>.

To learn more about National Men's Health Week, please visit <http://www.menshealthweek.org/>.

Thank you for joining with CMS in spreading the message about prevention and early detection and ensuring that men and all people with Medicare take full advantage of their preventive benefits. ❖

Source: CMS Provider Education Resources 200706-07

OTHER EDUCATIONAL RESOURCES

New Products Available from CMS Medicare Learning Network

The following products are now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network:

- The *Medicare Disproportionate Share Hospital Fact Sheet*, which provides information about methods to qualify for the Medicare disproportionate share hospital (DSH) adjustment and Medicare DSH payment adjustment formulas.
- The *Critical Access Hospital Fact Sheet*, which provides general information about critical access hospitals.
- The *Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians* which contains rural health information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization

Act of 2003 and the Deficit Reduction Act of 2005 (also now available in CD-ROM format).

- The *Inpatient Psychiatric Facility Prospective Payment System Fact Sheet*, which provides general information about the inpatient psychiatric facility prospective payment system (IPF PPS), how payment rates are set, and the rate year 2008 update to the IPF PPS.
- The *Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet*, which provides information about inpatient rehabilitation facility prospective payment system rates and classification criterion.

To place your order for these products, visit <http://www.cms.hhs.gov/mlngeninfo>, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.” ❖

Source: CMS Provider Education Resource 200706-02

Medicare Learning Network Products now Available

The following products are now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network:

- The Rural Health Clinic Fact Sheet, which provides the following information about rural health clinic (RHC) services:
 - ♦ RHC Services
 - ♦ RHC Designation
 - ♦ RHC Payments
 - ♦ Annual Reconciliation
 - ♦ Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- The *Federally Qualified Health Center Fact Sheet*, which provides the following information about federally qualified health center (FQHC) designation covered FQHC services:
 - ♦ FQHC preventive primary services that are not covered

- ♦ FQHC payments
- ♦ Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

To place your order for the above products, visit <http://www.cms.hhs.gov/mlngeninfo>, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

The following products are now available in downloadable format from the *Medicare Learning Network*:

- The *Sole Community Hospital Fact Sheet*, which provides information about sole community hospital classification and payments, is located at <http://www.cms.hhs.gov/MLNProducts/downloads/2007sch.pdf>.

The Rural Health Clinic Fact Sheet has been revised as of June 2007 and is located at <http://www.cms.hhs.gov/MLNProducts/downloads/rhcfactsheet.pdf>. ❖

Source: CMS Provider Education Resource 200706-26

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>Medicare A Bulletin Subscriptions – The <i>Medicare A Bulletin</i> is available free of charge online at http://www.floridamedicare.com. 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>Beginning with publications issued after June 1, 2003, 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.</p> <p>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:</p> <p><input type="checkbox"/> Subscription Renewal or <input type="checkbox"/> New Subscription</p>	700284	<p>\$250.00 (Hardcopy)</p> <p>\$20.00 (CD-ROM)</p>

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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-92 (MSP Related)****Conditional Payment**

Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Automobile Accident Cases**Settlements/Lawsuits****Other Liabilities**

Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

PROVIDER EDUCATION

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

Seminar Registration Hotline

1-904-791-8103

ELECTRONIC CLAIM FILING**“DDE Startup”**

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION**Claims Denied at the Redetermination Level**

MAXIMUS
QIC Part A East Project
Eastgate Square
50 Square Drive
Victor, NY 14564-1099

OVERPAYMENT COLLECTIONS**Repayment Plans for Part A****Participating Providers****Cost Reports (original and amended)****Receipts and Acceptances****Tentative Settlement Determinations****Provider Statistical and Reimbursement****(PS&R) Reports****Cost Report Settlement (payments due to provider or program)****Interim Rate Determinations****TEFRA Target Limit and Skilled****Nursing Facility Routine Cost Limit****Exceptions****Freedom of Information Act Requests (relative to cost reports and audits)**

Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

MEDICARE REGISTRATION**American Diabetes Association****Certificates**

Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

Telephone Numbers**PROVIDERS**

Customer Service Center Toll-Free
1-888-664-4112
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 Websites**PROVIDERS**

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

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

Palmetto 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



MEDICARE A BULLETIN

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

*** ATTENTION BILLING MANAGER ***