Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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
- ☐ _____
- ☐ _____
- ☐ _____

CMS CENTERS for MEDICARE & MEDICAID SERVICES

FIRST COAST SERVICE OPTIONS, INC.
A CMS Contracted Intermediary & Carrier

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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:

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

About the *Medicare A Bulletin*

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

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

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

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

Who Receives the *Bulletin*?

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

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

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

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

What Is in the *Bulletin*?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education 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.

Annual *Medicare A Bulletin* Hardcopy/CD-ROM Registration Form

To receive the *Medicare A Bulletin* in hardcopy, CD-ROM, or email format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. **To receive a hardcopy, CD-ROM or email of future issues of the *Medicare A Bulletin* your form must be faxed or postmarked on or before August 1, 2007.** Providers currently receiving hardcopy publications that do not return this form by August 1, 2007, will not receive hardcopy versions after that date.

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

Provider/Facility Name:

Medicare Provider Identification Number (PIN):

Address:

City, State, ZIP Code:

Contact Person/Title:

Telephone Number: **Fax Number:** **Email Address:**

Rationale for needing a hardcopy:

Does your office have Internet access? YES ❑ NO ❑

Do you have a PC with a CD-ROM drive? YES ❑ NO ❑

Will you accept publications via email? YES ❑ NO ❑

Other technical barrier or reason for needing publications hardcopy or on CD-ROM:

Mail your completed form to:

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

or fax to 1-904-791-6292

Please share your questions and/or concerns regarding this initiative with us.

Additional questions or concerns may be submitted via the Medicare provider education website *http://www.floridamedicare.com* using the *Contacts* feature, or sent via fax to 1-904-791-6292. **Our Provider Contact Center will not be able to respond to inquiries about this form.**

GENERAL INFORMATION

Provider Transaction Access Number (PTAN)—A Term You Need To Know

Effective May 23, 2007, First Coast Service Options, Inc. will make changes to the interactive voice response (IVR) system. Providers using the IVR will be prompted to enter their provider transaction access number (PTAN) when requesting certain information.

The PTAN is a new term that refers to your Medicare provider number. Therefore, when calling the IVR system, remember that your PTAN is your Medicare provider number.

In addition, when calling to speak with our customer service representatives, providers will be asked to provide their PTAN.

As a reminder, **beginning May 23, 2007,** the PTAN will be required by the IVR system as well as with any other communications to Florida Medicare. ❖

CMS Joint Signature Memorandum 07386, May 7, 2007

Provider Authentication Requirements for Telephone and Written Inquires During the National Provider Identifier Contingency Plan

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

Provider Types Affected

All physicians, suppliers, and providers who call or write their Medicare fee-for-service (FFS) contractors (fiscal intermediaries [FIs], carriers, Part A/B Medicare administrative contractors[A/B MACs], DME Medicare administrative contractors [DME/MACs], DME regional carriers [MERCs] and/or regional home health intermediaries [HHIs] with general inquiries.

Provider Action Needed

STOP – Impact to You

Due to the Medicare FFS national provider identifier (NPI) contingency plan, the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare FFS provider contact centers (PCCs), will be the required authentication element for all inquiries to interactive voice response (IVR) systems, customer service representatives (CSRs), and the written inquiries units.

CAUTION – What You Need to Know

Medicare FFS will give sufficient notice to providers of the contingency plan end date. Until the date, you will need to provide the following:

- **For inquiries to the IVR:**
  - **PTAN / legacy number, depending upon the contractor**
- **For inquiries to a CSR and written inquiries:**
  - **PTAN/legacy number, depending upon the contractor**
  - **Provider name.**

Remember, if you make inquiries to more than one contractor, you may hear the provider identification number referred to as either the legacy number or PTAN. On the date that the NPI is required to be on all claim transactions, the provider authentication elements required by **all** contractors will be both the NPI **and** PTAN.

GO – What You Need to Do

If you have not yet done so, **you should obtain your NPI now**. You can apply online on the CMS website at *https://nppes.cms.hhs.gov/*.

Once CMS ends the contingency plans, your claims and inquiries will not be processed without NPIs.

Background

In order to give providers and other trading partners more time to obtain and use the NPI, Medicare FFS invoked a contingency plan that allows continued use of legacy numbers beyond the May 23, 2007, implementation for the NPI. As reported in *MLN Matters* article MM5595, for some period after May 23, 2007, Medicare FFS will:

- Allow continued use of legacy numbers on transactions
- Accept transactions with only NPIs
- Accept transactions with both legacy numbers and NPIs.

After May 23, 2008, legacy numbers will NOT be permitted on ANY inbound or outbound transactions.

As part of this plan, Medicare FFS is assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (billing, pay-to and rendering providers) is determined to be sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers. Beginning May 23, 2007, Medicare FFS contractors will require that providers provide their PTAN as a required authentication element for all general telephone or written inquiries.

In this contingency environment, the PTAN is the provider legacy number. Some contractors may continue to use the provider legacy number as the required authentication element. Other contractors will begin to refer to the legacy number as the PTAN.

Provider enrollment letters may also continue to refer to the provider legacy number. Newly enrolled or re-enrolled providers will receive either a legacy number or PTAN in

Provider Authentication Requirements for Inquires During the NPI Contingency Plan (continued)

their provider enrollment letters depending on which is used for authentication.

Remember:

CMS may end the contingency plan once it appears that the level of claims containing NPIs is sufficient to do so. CMS encourages you to get and use your NPI now. Also, remember to ready your other processes to use the NPI as soon as possible to avoid a situation where your claims are not processed when the contingency ends.

Additional Information

The CMS complete listing of all NPI resources is available on the CMS website at *http://www.cms.hhs.gov/NationalProvIdentStand/*.

More details regarding the CMS NPI contingency plan are in the *MLN Matters* article MM5595 on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf*.

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

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

Source: CMS Special Edition *MLN Matters* Article SE0721

Method of Payment for Extended Stay Services Under the Frontier Extended Stay Clinic Demonstration

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

Provider Types Affected

Clinics billing (or that wish to bill) Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for care provided to Medicare beneficiaries under the Frontier Extended Stay Clinic demonstration.

Provider Action Needed

Change request (CR) 5454, from which this article is taken, provides Medicare FI and A/B MACs the billing and system instructions they need to pay clinics that provide authorized extended stays under the Frontier Extended Stay Clinic demonstration. The Centers for Medicare & Medicaid Services (CMS) will select no more than six clinics initially and that selection will occur during calendar year 2007.

Please refer to the *Background* section, below, for more information.

Background

Section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established the Frontier Extended Stay Clinic (FESC) demonstration project to test the feasibility of providing extended stay services to remote, frontier areas under Medicare payment and regulations. In fulfilling this requirement, CMS announced, in an August 29, 2006, news release, that it will provide, in the three-year FESC demonstration, added financial support to designated small health clinics that serve highly remote areas in Alaska and other states. (CMS news releases are available on the CMS website at *http://www.cms.hhs.gov/apps/media/*.)

These frontier extended stay clinics (FESCs) are designed to address the needs of 1) seriously or critically ill (or injured) patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care hospitals; or 2) patients who do not meet CMS inpatient hospital admission criteria and who need monitoring and observation for a limited period of time. Further, in order to qualify, FESCs must be located in communities which are 1) at least 75 miles away from the nearest acute care hospital or critical access hospital, or 2) inaccessible by public road.

As mentioned, under the FESC demonstration, participating clinics will be allowed to keep patients for extended stays in situations where weather or other circumstances prevent transfer, including extended stays up to 48 hours for patients who do not meet CMS inpatient hospital admission criteria but who need monitoring and observation. You should be aware, however, that there may be no more than **four** patients under this criterion at any one time at any single facility.

CMS will select no more than **six** clinics initially and that selection will occur during calendar year 2007. Clinics will be identified by rural health clinic and federally qualified health center provider numbers.

CR 5454, from which this article is taken, provides your Medicare fiscal intermediaries and A/B MACs with the billing and systems instructions they need to pay clinics participating under the FESC demonstration for the authorized extended stays.

These instructions follow:

- As mentioned above, clinics can provide services to:
  - Patients with emergency medical conditions who require an extended stay due to weather or other conditions that preclude transport to an acute care hospital.
  - Ill or injured patients who need an extended stay because a physician, nurse practitioner or physician assistant 1) determines that they do not meet Medicare inpatient hospital admission criteria, but do need monitoring and observation, and 2) determines that they can be discharged within 48 hours.

Method of Payment for Extended Stay Services under the Frontier Extended Stay Clinic Demonstration (continued)

- Clinics will be paid for extended stays in four-hour increments after an initial four-hour stay. Subject to a screening for medical necessity, Medicare payment will only occur for stays that equal or exceed four hours.
- It is important to note that the Medicare FI and/or A/B MAC will conduct a medical necessity screening and make Medicare payment under the demonstration only if the patient meets the following medical necessity requirements:
  - The patient's stay equals or exceeds four hours.
  - The FI and/or A/B MAC determines under its medical review that the patient's condition has been evaluated by a physician, physician assistant, or nurse practitioner and is of sufficient risk to warrant continued observation in the clinic.
- The FI or A/B MAC will use an adaptation of the Section 290.4.3 of Chapter 4 of the *Medicare Claims Processing Manual* in conducting its medical necessity screening. These instructions are summarized as follows:
  - All medical conditions are eligible.
  - Observation time begins when the clinic staff sees the patient and observation time must be documented on the medical record.
  - The beneficiary must be in the care of a physician, physician assistant, or nurse practitioner during the observation period, as determined in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician, physician assistant, or nurse practitioner.
  - The medical record must include documentation that the physician, physician assistant, or nurse practitioner explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.
- Code Gxxxx will be used to indicate length of stay for each Medicare patient from when he/she is admitted to the clinic, measured in four-hour units of time. If the indicated length of stay is between four and eight hours, the clinic receives payment for two units. If code Gxxxx indicates a stay between eight and 12 hours, the clinic would receive payment for three units, etc.
- Providers should bill for services using type of bill 71x, 73x, or 13x with revenue codes 516, 519, 0529, or 0510.
- When code Gxxxx indicates less than 1 time unit, i.e., less than four hours, clinics will not receive any additional payment for the extended stay. However, in this situation, particular clinics (listed below) can bill and receive the customary encounter-based payment for a clinic visit:
  - Federally certified rural health clinics will bill for the rural health clinic encounter-based payment for a Medicare visit.
  - Federally qualified health centers will bill the federally qualified health center encounter-based clinic visit for Medicare.
  - Indian health service owned and operated clinics will bill the Indian health service encounter-based clinic visit for Medicare.
  - Tribally owned and operated clinics electing to bill as Indian health service, tribally operated Indian health service facilities, and tribally owned and operated facilities will bill the customary encounter based clinic rate for Medicare.

CMS will identify a payment rate for a four-hour stay unit and the rate may vary by type of provider. Total payment will be the payment rate multiplied by the number of extended stay units. Except for Indian health service and tribally owned and operated clinics, Medicare will impose a 20 percent coinsurance on the beneficiary for the extended stay services. However, there will be no deductible for extended stay services.

CMS will design a form, which each participating clinic will use to document weather conditions or other circumstances that prevent a transfer. Clinics will complete the form for each patient held for 48 hours or more, store it onsite at the clinic, and make it available to the FI, A/B MAC, and/or CMS for audit when requested. Either CMS, the FI, or the A/B MAC will audit these records at least once every six months and determine whether the clinic is in compliance with the 48 hour rule. If CMS determines that the clinic is not maintaining this rule, it has the right to suspend payments of greater than 48 hours to the clinic.

The clinic will report to CMS, the FI, or A/B MAC any time there are more than **four** Medicare patients in the clinic for more than **four** hours, and complete the form documenting weather or other conditions that prevent transfer. Either CMS, the FI, or A/B MAC will audit these records at least once every quarter and determine whether the clinic is in compliance with the rule.

Additional Information

You can find the official instruction, CR 5454, issued to your FI or A/B MAC by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R53DEMO.pdf*.

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

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

MLN Matters Number: MM5454
Related Change Request (CR) Number: 5454
Related CR Release Date: April 27, 2007
Effective Date: October 1, 2007
Related CR Transmittal Number: R53DEMO
Implementation Date: October 2, 2007

Source: CMS Pub. 100-19, Transmittal 43, CR 5454

Modification to the Redetermination Notice and Administrative Law Judge Filing Locations

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]).

Provider Action Needed

STOP – Impact to You

The Centers for Medicaid & Medicare Services (CMS) issued change request (CR) 5554 in order to modify the Reconsideration Request Form and to amend the administrative law judge (ALJ) filing locations.

CAUTION – What You Need to Know

Providers and suppliers do not need to resubmit documentation when requesting a qualified independent contractor (QIC) reconsideration if the documentation was previously submitted as part of the redetermination process. This documentation is forwarded to the QIC as part of the case file utilized in the reconsideration process. Make certain that any additional evidence is submitted prior to the reconsideration decision. If all additional evidence is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the ALJ or further appeal unless you can demonstrate good cause for withholding the evidence from the QIC.

Be aware that when the service was rendered in **Delaware, Kentucky, Virginia, Puerto Rico, and/or the US Virgin Islands,** the filing locations for ALJ requests **are modified** to identify the appropriate Office of Medicare Hearings and Appeals (OMHA) field office. All other jurisdictions remain unchanged.

GO – What You Need to Do

Make certain that your billing staff or other staff that handle reconsideration requests for you are aware of these changes.

Background

CR 5554 is the official document that announces these changes in Medicare processes. Attached to this CR are three documents that assist with the appeals process:

- A sample form letter titled: Medicare Appeal Decision.
- A paper outlining Important Information About Your Appeal Rights.
- A modified **Reconsideration Request Form** containing revised introductory instructions, as follows: "At a minimum, you must complete/include information for items 1, 2a, 6, and 7 but to help us serve you better, please include a copy of the redetermination notice you received with your reconsideration request."

The revised filing locations for sending documentation for requesting ALJ hearings are as follows:

- **Cleveland, Ohio** is the filing location for services rendered in **Delaware and Kentucky.**
- **Arlington, Virginia** for services in **Virginia.**
- **Miami, Florida** for services in **Puerto Rico and the US Virgin Islands.**

The following table lists the addresses of all filing locations along with the place of service.

HHS OMHA Field Office & Mailing Address	**Jurisdiction (Based on the place of service)**			
Cleveland, OH BP Tower & Garage 200 Public Square, Suite 1300 Cleveland, OH 44114-2316	Connecticut Rhode Island Puerto Rico West Virginia Ohio	Maine Vermont Virgin Islands *Kentucky* Michigan	Massachusetts New York Pennsylvania Illinois Minnesota	New Hampshire New Jersey *Delaware* Indiana Wisconsin
Miami, FL 100 SE 2nd Street, Suite 1700 Miami, FL 33131-2100	Alabama North Carolina Louisiana *Puerto Rico*	Florida South Carolina New Mexico *US Virgin Islands*	Georgia Tennessee Oklahoma	Mississippi Arkansas Texas
Irvine, CA 27 Technology Drive, Suite 100 Irvine, CA 92618-2364	Iowa Colorado Utah Hawaii Idaho Trust Territory of the Pacific Islands	Kansas Montana Wyoming Nevada Oregon	Missouri North Dakota Arizona Guam Washington	Nebraska South Dakota California Alaska American Samoa
Arlington, VA 1700 N. Moore St., Suite 1600 Arlington, VA 22209	*Virginia* Maryland District of Columbia			

Modification to the Redetermination Notice and Administrative Law Judge Filing Locations (continued)

Additional Information

For complete details regarding this CR please see the official instruction (CR 5554) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1229CP.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 at on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: MM5554
Related Change Request (CR) Number: 5554
Related CR Release Date: April 27, 2007
Related CR Transmittal Number: R1229CP
Effective Date: July 2, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1229, CR 5554

Therapy Services Rendered by Massage Therapists and Billed "Incident To"

It has come to the attention of First Coast Service Options, Inc. that physical therapy services performed by massage therapists are being billed to Medicare by physical therapists and physicians under the "incident to" provision.

The coverage criteria and required qualifications of personnel included in the therapy services benefit are detailed in the *Benefit Policy Manual*, CMS Pub. 100-02, Chapter 15, sections 220 and 230. Specifically, for therapy services to be billed to Medicare, they must be provided by either a licensed therapist or by a therapy assistant under the licensed therapist's supervision. Regardless of any state licensing that allows other health professionals to provide therapy services, Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy, or speech-language pathology. This means services of athletic trainers, massage therapists, and any other professionals who are not trained and licensed in therapy according to the requirements of the state in which they practice may **not** be billed to Medicare as therapy services.

The *Benefit Policy Manual*, Chapter 15, section 230.1 C specifies there is no Medicare coverage for therapy assistant services billed "incident to" a physician or nonphysician practitioner's service, because the therapy assistant does not meet the qualifications of a therapist. When a therapy assistant provides services under the supervision of a licensed therapist, such services are included as part of the covered service and are billed by the supervising therapist.

Massage therapists do not meet the required qualifications of personnel included in the therapy services benefit, and as such, their services are not covered. Furthermore, therapy services provided by massage therapists cannot be billed "incident to" the physician or nonphysician practitioner's service, because the massage therapist does not meet the qualifications of a therapist.

First Coast Service Options, Inc. will continue to monitor this issue via the progressive corrective action process, which may result in prepayment reviews, requests for overpayments, and statistical sample reviews. ❖

Uniform Billing (UB-04) Implementation—UB-92 Replacement

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 3, 2007, to reference the national provider identifier (NPI) contingency plan, which extends the May 23, 2007, required date for the NPI usage on claims. In addition, a reference to Attachment C of CR 5072 was deleted. All other information remains the same. The *MLN Matters* MM5072 was published in the December 2006 *Medicare A Bulletin* (pages 4-5).

Provider Types Affected

All providers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), using the UB-92 (universal billing-92)

Provider Action Needed
STOP – Impact to You

The UB-04 is replacing the UB-92. You may begin using it **on March 1, 2007,** during an initial transitional period. **Starting May 23, 2007, all of your paper claims must use the UB-04** since the UB-92 will no longer be acceptable.

Uniform Billing (UB-04) Implementation—UB-92 Replacement (continued)

CAUTION – What You Need to Know

CR 5072 announces the replacement of the UB-92 by the UB-04, **effective March 1, 2007.** The UB-04, which is only accepted from institutional providers that are excluded from the mandatory electronic claim submission requirements, incorporates the NPI, taxonomy, and additional codes.

GO – What You Need to Do

Make sure that your billing staffs are aware of this new uniform institutional provider bill form for paper claims.

Background

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. **Effective March 1, 2007,** institutional claim filers such as hospitals, skilled nursing facilities, hospices, and others can begin using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007, during which time either the UB-92 or the UB-04 may be used.

Starting May 23, 2007, all institutional paper claims must be submitted on the UB-04. The UB-92 will no longer be acceptable, even as an adjustment claim, after May 22, 2007.

Claim Form UB-04

The UB-04 is the basic form that CMS prescribes for the Medicare program. It is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

It incorporates the NPI, taxonomy, and additional codes. (Please refer to the crosswalk file attached to CR 5072 to show how data elements crosswalk from the UB-92 to the UB-04.)

Note: While most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change.

There are a few details that you should be aware of:

- The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.
- When filing, you should retain the copy designated "Institution Copy" and submit the remaining copies to your FI, managed care plan, or other insurer.
- Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.
- If you omit any required data, your FI will either ask you for them or obtain them from other sources and will maintain them on its history record. It will not obtain data that are not needed to process the claim.
- Data elements in the CMS uniform electronic billing specifications are consistent with the Form CMS-1450 (another name for the UB-04) data set to the extent that one processing system can handle both. The definitions are identical, although in some situations, the electronic record contains characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.
- Also note that CMS is accepting valid NPIs on the UB-04 between March 1, 2007, and May 22, 2007, and the NPI is required as of May 23, 2007.

Note: Medicare fee-for-service (FFS) has instituted a contingency plan for the NPI implementation that delays the requirement for the NPI beyond May 23, 2007. For details regarding this delay, please see *MLN Matters* article MM5595 on the CMS website 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).

Additional Information

You may find more information about the UB-04 (Form CMS-1450) by going to CR 5072, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1104CP.pdf*.

Included with this CR are the following:

- A copy of the UB-04 form (front and back) in PDF format (Attachment E)
- The UB-92-to-UB-04 crosswalk (Attachment B)
- The revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill – Form CMS-1450 [UB-04]) and 71 (General Instructions for Completion of Form CMS-1450 [UB-04]) (Attachment A). These sections contain very detailed instructions for completing the form.

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

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

MLN Matters Number: MM5072 – Revised
Related Change Request (CR) Number: 5072
Related CR Release Date: November 3, 2006
Related CR Transmittal Number: R1104CP
Effective Date: March 1, 2007
Implementation Date: March 1, 2007

Source: CMS Pub. 100-04, Transmittal 1104, CR 5072

Disclosure Desk Reference for Provider Contact Centers

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 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 website 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 physicians, providers, and suppliers billing Medicare

Provider Action Needed

STOP – Impact to You

When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

CAUTION – What You Need to Know

CR 5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

GO – What You Need to Do

Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

Background

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare PCCs must first authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

CR 5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request beneficiary protected health information.
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

Following is the authentication guidance that the PCCs will be using:

Telephone Inquiries
Provider Authentication
CSR Telephone Inquiries – Through May 22, 2007, customer service representatives (CSR) will authenticate providers using provider number and provider name.

Interactive Voice Response Telephone Inquiries – Through May 22, 2007, IVRs will authenticate providers using only the provider number.

Note: See *"Final Note"* to learn more about provider authentication after May 22, 2007.

Written Inquiries
Provider Authentication

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider name and number.

Note: See *"Final Note"* to learn more about provider authentication after May 22, 2007.

At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider's official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider's name and address are included in the letterhead and clearly establish the provider's identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you. Rather, they will send you the requested information by regular mail, or respond to these requests by telephone.

In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

Disclosure Desk Reference for Provider Contact Centers (continued)

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on remittance advice (RAs) or Medicare summary notices (MSNs), will be authenticated the same as written inquiries,(explained above) using provider name and the provider number.

Insufficient or Inaccurate Requests

You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information will be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms, will be returned in their entirety by regular mail, with a note stating that the requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record.

Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

Beneficiary Authentication

Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

1) Last name
2) First name or initial
3) Health insurance claim number
4) Either date of birth (eligibility, next eligible date, certificate of medical necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) [pre-claim]) **or** date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR 5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR 5089 is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf*.

Special Instances

Below are three special instances that you should know.

Overlapping Claims

Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

Sometimes this happens when the provider is seeking to avoid have a claim be rejected, for example:

- When some ESRD facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or
- Skilled nursing facility and inpatient hospital stays.

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

Pending Claims

A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including internal control number (ICN), pay date/amount or denial, as long as all authentication requirements are met.

Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

Deceased Beneficiaries

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

Final Note: More information will be provided in a future *MLN Matters* article about authentication on and after May 23, 2007, the implementation date for the national provider identifier or NPI.

Additional Information

You can find more information about provider contact center guidelines concerning authentication by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf*.

Attached to that CR, you will find the updated *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100.09), Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information); and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information).

If you have any questions, please contact your carrier, durable medical equipment (DME) regional carrier, DME Medicare administrative contractor (DME MAC), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: MM5089 – Revised
Related Change Request (CR) Number: 5089
Related CR Release Date: July 21, 2006
Related CR Transmittal Number: R16COM
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-09, Transmittal 16, CR 5089

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.

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 CR 5551 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 Biding Program is Now Open", which is on the CMS website 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 website *http://www.cms.hhs.gov/Transmittals/downloads/R1224CP.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 website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: MM5551
Related Change Request (CR) Number: 5551
Related CR Release Date: MM5551
Related CR Transmittal Number: R1224CP
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1224, CR 5551

CMS Proposes Payment Changes For Medicare Home Health Services

Centers for Medicare & Medicaid Services (CMS) announced proposed changes to the Medicare home health prospective payment system (HH PPS) that will improve the accuracy of payments to home health agencies for services they furnish to Medicare beneficiaries. The display copy of the proposed rule is posted on the CMS website at *http://www.cms.hhs.gov/HomeHealthPPS/downloads/CMS-1541-P.pdf*.

This rule includes a number of refinement proposals that will update the case-mix model to better reflect the current mix of home health patients, better reflect resources associated with certain type of episodes, and adjust for case mix creep.

In addition, this rule proposes routine annual updates to the market basket, the fixed dollar loss ratio, and pay for reporting requirements. This update reflects the proposed home health market basket of 2.9 percent for Medicare payment rates for calendar year 2008 as well as a 2.75 percent reduction in the rates to account for nominal change in case-mix. The overall impact of the proposed refinements of this rule is estimated to increase total payments to home health agencies by approximately $140 million in CY 2008. For more detailed information on the provisions of this proposed rule, refer to the HHA fact sheet *http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2134*. ❖

Source: CMS Provider Education Resource 200704-39

New Contractor Workload Number for Cahaba Part A Iowa Data

The Centers for Medicare & Medicaid Services (CMS) has assigned a new contractor workload number for the Cahaba Part A Iowa workload. This change is a result of a scheduling conflict in the HIGLAS (healthcare integrated general ledge accounting system) and Medicare administrative contractor (MAC) implementations as they relate to the Cahaba Part A Iowa workload. Therefore, CMS has decided to create a separate contractor workload number for the Cahaba Iowa Part A workload and separate the Cahaba regional home health intermediary (RHHI) and Iowa Part A workloads into separate CICS regions in the data center.

Currently, the contractor number 00011 identifies all of the Cahaba Part A and RHHI workload. The Iowa Part A workload shall now be identified separately by contractor number 00012.

The following systems shall reflect the new contractor number: BESS, CAFM, CASR, CERT, CMIS, COBA, CROWD, CSAMS, CWF, DCS, ECRS, FISS, HCIS, HIGLAS, IRIS, LOLA, MPaRTS, NGD, OSCAR, PECOS, PIMR, PORS, PS&R, PSOR, PULSE, REMAS, REMIS, STAR, VMS, and all free billing software.

All interested parties need to take note of this change. ❖

Source: CMS Pub. 100-20, Transmittal 275, CR 5566

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

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

Basic Instructions

All suppliers submitting a bid must:

- Be in good standing and have an active national supplier clearinghouse number (NSC#).
- Meet any local or state licensure requirements, if any, for the item being bid.
- Be accredited or be pending accreditation. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for

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

accreditation immediately to allow adequate time to process their applications. (For a listing of CMS-approved accrediting organizations, please the CMS website visit *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf*. *MLN Matters* article SE0713 provides additional information on accreditation and is located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf*.

- Complete initial registration in the Internet application (Individuals Authorized Access CMS computer Services, IACS) to get a USER ID and password. Suppliers need to complete this initial registration process early to avoid delays in being able to submit bids. The initial registration process requires the **authorized official**, as identified in Section 15 of the CMS 855S, to complete the information required in the Internet application. The authorized official's information must match the information on file at the national supplier clearinghouse. To complete this initial registration and obtain a USER ID and password, please go to *https://applications.cms.hhs.gov*.

All suppliers submitting a bid should:

- Review *MLN Matters* article SE0717, "Initial Supplier Registration for Competitive Bidding Program Is Now Open," which provides important information about the registration process.
- Review the information in the bid application tool kit to facilitate a better understanding of the bidding process and rules. This information is located on the CBIC website at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersBid%20Application%20Tool%20Kit*.
- View the educational Webcast to learn more about the Medicare DMEPOS Competitive Bidding program and detailed information on the bid application process. This information is located on the CBIC website at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersEducational%20Tools*.
- CMS encourages you to register to receive updates on the Competitive Bidding program. You may do so by going on the Web to *http://www.cms.hhs.gov/apps/mailinglists/*.

Additional Information

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

A background review of the rationale for this program is on the CMS website at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME_sum.pdf*.

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

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

MLN Matters Number: SE0714
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0714

Webcast Available for DMEPOS Competitive Bidding Program Suppliers

An educational Webcast is now available at the Competitive Bidding website at *http://www.dmecompetitivebid.com*. The presentation is designed to help suppliers that intend to participate in the Medicare DMEPOS Competitive Bidding program being implemented in ten metropolitan areas throughout the United States.

The Webcast highlights key bidding dates, provides an overview of the Competitive Bidding program, and guides bidders through required application forms. Suppliers may view it at any time and submit questions at the conclusion of the presentation.

The Competitive Bidding website contains other helpful educational materials for suppliers, including a supplier tool kit, fact sheets, frequently asked questions, and more. For more information, call the Competitive Bidding Helpline at (877) 577-5331. ❖

Source: CMS Provider Education Resource 200704-37

NATIONAL PROVIDER IDENTIFIER

The Latest News About the National Provider Identifier Implementation

NPI: Get It. Share It. Use It.

Over two million providers have their national provider identifier (NPIs) – do you have your NPI yet? Covered entities (including health plans, covered health care providers and clearinghouses) across the country are making decisions regarding their need for contingency plans for NPI implementation. It is more important than ever to obtain an NPI as soon as possible and begin testing it on claims, as directed by your health plan.

Medicare providers should pay special attention to the Medicare information section below for important news on the Medicare fee-for-service (FFS) contingency plan.

New Compliance Contingency Guidance Frequently Asked Questions

The Centers for Medicare & Medicaid Services (CMS) has posted new frequently asked questions (FAQs) related to the previously posted NPI compliance contingency guidance.

Questions include:

- What are the exact dates for the NPI contingency plan?
- If a complaint is filed against me for not being in compliance with the NPI after May 23, 2007, what will happen?
- What happens if a complaint for not being in compliance with the NPI is filed against me after May 23, 2008?
- Is it acceptable for a health plan to announce their NPI contingency now?
- Is the NPI contingency plan voluntary?
- Am I allowed to give my NPI to other providers as well as to the health plans with whom I exchange transactions?

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.

Obtain Information on Contingency Plans

CMS strongly urges providers to pay attention to information from the health plans they bill so that they are aware if, and when, a specific health plan announces its own contingency plan.

Reminder – Sharing NPIs

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that request their NPIs. In fact, as outlined in current regulation, providers who are covered entities under HIPAA must share their NPIs with any entities that need them for billing purposes – including those who need them for designation of ordering or referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their NPIs for them.

Reminder – Enumerating a Group Practice

A group practice that conducts any of the HIPAA standard transactions is a covered healthcare provider (a covered entity under HIPAA) and, as such, must obtain an NPI. The physicians employed by the group practice, on the other hand, are furnishing services at the group office(s) but they are not conducting any of the HIPAA standard transactions (such as submitting claims, checking eligibility and claim status). As such, the physicians would not be covered health care providers and are not required by the NPI final rule to obtain NPIs.

However, as the employer, the group could require these physicians to obtain NPIs and use the NPIs to identify them as the rendering providers in the claims that the group submits. If these physicians prescribe medication, the pharmacies may require their NPIs in the claims that the pharmacies submit to health plans. Additionally, health plans can require enrolled physicians to obtain NPIs in order to participate in that plan. Medicare is an example of a health plan with this requirement.

Reminder – Applying for an NPI Does Not Enroll a Health Care Provider in a Health Plan

Applying for an NPI and enrolling in a health plan are two completely separate activities. Having an NPI does not guarantee payment by any health plan.

When to Contact the NPI Enumerator for Assistance

Providers should remember that the NPI enumerator *only* answers/addresses the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter (i.e., for those providers enumerated via paper or Web-based applications)
- Trouble accessing NPPES
- Forgotten password/User ID

The Latest News About the National Provider Identifier Implementation (continued)

- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application.

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

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

Important Information for Medicare Providers

Medicare Fee-for-Service Contingency Plan Announced!

Medicare FFS announced its contingency plan. View the associated change request at *http://www.cms.hhs.gov/transmittals/downloads/R1227CP.pdf*, as well as the related *MLN Matters* article on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf*.

Please note that these materials were recently revised; please be sure to visit the links above for the latest information. This information will also be available shortly on CMS dedicated NPI Web page.

Reporting a Group Practice NPI on Claims

Medicare has identified instances where the multi-carrier system (MCS) is correcting billing or pay-to provider data on Part B claims submitted by group practices. As of May 18, 2007, the MCS Part B claim processing systems will no longer correct claims submitted by group practices that are reporting the individual rendering provider identification number (PIN) or individual rendering NPI in either the billing or pay-to provider identifier fields. Groups should enter either their group NPI or group NPI and legacy PIN number pair in either of these fields.

Reminder – Medicare Extending Date for Accepting Form CMS-1500 (12-90)

While Medicare began to accept the revised Form CMS-1500 (08-05) on January 1, 2007, and was positioned to completely cutover to the new form on April 1, 2007, it has recently come to CMS attention that there are incorrectly formatted versions of the revised form being sold by the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. The error resulted in the sale of both printed forms and negatives that do not comply with the form specifications. **However, not all of the new forms are in error.**

Given the circumstances, CMS is extending the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007, deadline while this situation is resolved. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007, as that date.

During the interim, contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received that are not printed to specification. By returning the incorrectly formatted claim forms back to providers, we are able to make them aware of the situation so they can begin communications with their form suppliers.

For more details, and to learn how to identify the proper version of the new form, visit a recent *MLN Matters* article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5568.pdf* on the CMS website.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? More information and education on the NPI may be found at the CMS NPI Web page *http://www.cms.hhs.gov/NationalProvIdentStand*.

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

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

Source: CMS Provider Education Resource 200704-33

Florida Part A National Provider Identifier Validation

When the national provider identification (NPI) stage 2 was implemented on October 2, 2006, providers were encouraged to submit both the NPI and Medicare legacy identifier (OSCAR) on their claims. However, during this timeframe providers were not penalized for invalid NPI/legacy ID combinations.

Effective May 7, 2007, First Coast Service Options, Inc. Florida Part A began editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims are being returned to the provider (RTP).

When the claim is returned, verify that the correct NPI was submitted. If correct, you will need to verify that your legacy identifier (OSCAR) number corresponds with the NPI on file with National Plan and Provider Enumeration System (NPPES). NPPES may be contacted online at *https://nppes.cms.hhs.gov*.

If your NPPES information is correct, and you have included **all** Medicare legacy identifiers (OSCAR) in NPPES, but you are experiencing problems with your claims that contain a valid NPI, you may need to submit a Medicare enrollment application (i.e., Form CMS-855).

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*. ❖

Source: CMS Joint Signature Memorandum 07368, April 27, 2007

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.

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

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

Note: CMS has revised this *MLN Matters* article on May 4, 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 website 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 conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare.

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

Modification of National Provider Identifier Editing Requirements in CR 4023 and an Attachment to CR 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 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 website 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, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Medicare carriers including durable medical equipment regional carriers (DMERCs) (or durable medical equipment Medicare administrative contractors (DME MACs) if appropriate)

Provider Action Needed

STOP – Impact to You

This article is based on CR 5229, which corrects certain business requirements from CR 4023 that relate to edits for NPIs and provider legacy identifiers when reported on claims, particularly for **referring/ordering or other secondary providers**, effective October 1, 2006, and later. Additionally, CR 5229 revises Attachment 1 to CR 4320.

CAUTION – What You Need to Know

Some of those business requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare provider identifier crosswalk. This is not always the case. CR 5229 modifies those business requirements.

GO – What You Need to Do

These modifications will enable correct processing of affected claims in October 2006 and later, and will avoid the unnecessary rejection of many claims that involve a referring/ordering or other secondary provider. Please refer to the *Background* section of this article and to CR 5229 for additional important information regarding these modifications.

Background

MLN Matters articles, MM4023 and MM4320, which are based on CR 4023 and CR 4320 respectively, contain important information about the stages of the NPI implementation process. Some of this information is updated in the current article. The links to these articles are located in the *Additional Information* section of this article.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique NPI to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414). To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs on May 23, 2005. Applications may be made by mail and online at *https://nppes.cms.hhs.gov*.

Modification of NPI Editing Requirements in CR 4023 and an Attachment to CR 4320 (continued)

During stage 2 of the NPI implementation process (October 2, 2006 – May 22, 2007), Medicare will utilize a Medicare provider identifier crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions.

Primary and Secondary Providers

Providers, for NPI editing purposes, are categorized as either "primary" or "secondary" providers. Primary providers include billing, pay-to, and rendering providers. Primary providers are required to be enrolled in Medicare for the claim to qualify for payment.

Secondary providers are all other providers for which data could be reported on an institutional (837-I) or professional (837-P), free billing software or direct data entry (DDE) claim, or on a revised CMS-1500 or a UB-04 (once those paper claims are accepted by Medicare). Since the UB-92, the currently used CMS-1500, and the HIPAA NCPDP format do not allow reporting of both NPIs and legacy identifiers, information on secondary providers in those claims is not included in the following requirements. **Secondary providers may be enrolled, but are not required to be enrolled in Medicare** (unless they plan to bill or be paid by Medicare for care rendered to Medicare beneficiaries).

Secondary Provider Claims
Claims Submitted with NPI and Medicare Legacy Identifier:

During stage 2, claim submitters should submit a provider's Medicare legacy identifier whenever reporting an NPI for a provider. Failure to report a Medicare legacy number for a provider enrolled in Medicare could result in a delay in processing of the claim. When an NPI and a legacy identifier are reported for a provider, Medicare contractors will apply the same edits to those numbers that would have been applied if that provider was a primary provider. (See MM4023.)

There are two exceptions:

1. A Medicare contractor cannot edit a surrogate unique provider identification number (sometimes called a dummy UPIN, such as OTN000). Despite its name, a surrogate is not actually unique for a specific provider.
2. Only a national supplier clearinghouse (NSC) identification number or a UPIN should ever be reported as the legacy numbers on a claim sent to a DMERC/DME MAC. If a carrier provider identification number (PIN) is reported as a legacy identifier with an NPI, DMERCs/DME MACs will edit as if the NPI was the only provider identifier reported for that provider.

Claims Submitted with NPI Only

The NPI is edited to determine if it meets with the physical requirements of the NPI (10 digits, begins with a 1, 2, 3, or 4, and the check digit in 10th position is correct), and whether there is a Medicare provider identifier crosswalk entry for that NPI.

If the NPI is located in the crosswalk:

- The taxpayer identification number (TIN) (employer identification number (EIN) or social security number (SSN) and legacy identifier will be sent to the trading partner in addition to the NPI if coordination of benefits (COB) applies.
- However, only the TIN will be forwarded to the COB payer if there is more than one legacy identifier associated with the same NPI in the Medicare provider identifier crosswalk because it may be difficult to know which Medicare legacy identifier applies to that claim.

If the NPI is not located in the crosswalk:

- No supplemental identifier can be reported to a COB payer.
- However, the claim **will not be rejected** if the NPI for a referring/ordering provider or another secondary provider cannot be located in the Medicare provider identifier crosswalk, with one exception. Reporting of a Medicare legacy identifier other than a surrogate UPIN signifies a provider is enrolled in Medicare. If a Medicare legacy identifier is reported and cannot be located in the crosswalk, the claim will be rejected, regardless of whether an NPI was reported for that provider.

Claims (including UB-92 or the current CMS-1500 paper claims) submitted with Medicare legacy identifier only

- A Medicare contractor may, but is not required to check a legacy number against the Medicare provider identifier crosswalk.
- As at present, claims will be rejected if any Medicare legacy identifier reported on a claim does not meet the physical requirements (length, if numeric or alphanumeric as applicable) for that type of Medicare provider identifier.

COB and Medigap Trading Partners

Legacy identifiers will not be reported to these trading partners for secondary providers if they are not submitted on the claim sent to Medicare, are surrogate UPINs or if the provider is not enrolled in Medicare. If not enrolled, a legacy identifier or a TIN cannot be sent for a "secondary" provider because Medicare would not have issued a legacy identifier to or collected a TIN from that provider.

837-I or 837-P version 4010A1 Claims

Attachment 1 to CR 4320 which is being revised as part of CR 5229 addresses (among other issues), the identification of secondary providers for which the 837-I or 837-P version 4010A1 implementation guides only require reporting of an NPI or other identifier "if known." Unless there is a pre-existing Medicare instruction that mandates the reporting of a specific identifier for those "if known" types of providers, there is no requirement for entry of any identifier for those entities/individuals. If there is no such requirement, claims received that lack an identifier for those types of providers will not be denied.

Note that "secondary" providers such as a referring/ordering physician are not required to be enrolled in Medicare as a **condition for payment** of the services or

Modification of NPI Editing Requirements in CR 4023 and an Attachment to CR 4320 (continued)

supplies they order, furnish, supervise delivery of, etc. for beneficiaries **when those services are billed, paid-to or rendered by "primary" providers**. For example, Medicare could pay:

- A hospital for services ordered for a patient for inpatient hospital care when the admitting or attending physician is not enrolled in Medicare;
- Hospital surgery costs when the surgeon is not enrolled in Medicare; or
- A hospital when services are purchased from another provider "under arrangements" even if that other provider is not enrolled in Medicare.

Implementation Date

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

Additional Information

CR 4320, issued February 1, 2006, "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" is located on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf*.

The associated MLN article (with the same title) MM4320, may be found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf*.

CR 4023, dated November 3, 2005, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms" is located on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf*.

MM4023, the associated MLN article, is located on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf*.

CR 5229 is the official instruction issued to your Medicare carrier/DMERC (DME MAC if appropriate), FI/RHHI regarding changes mentioned in this article. CR 5229 may be found on the CMS website at *http://ww.cms.hhs.gov/Transmittals/downloads/R234OTN.pdf*.

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

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

MLN Matters Number: MM5229 – Revised
Related Change Request (CR) Number: 5229
Related CR Release Date: August 18, 2006
Related CR Transmittal Number: R234OTN
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-20, Transmittal 234, CR 5229

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.

Note: CMS has 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 website 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.

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

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 taxpayer identifier numbers (TIN) such as employer identification numbers (EINs) or social security numbers (SSNs).

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 website at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage*.

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 NPIs 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 5 legacy numbers, we will issue 5 separate RAs and 5 separate checks/EFTs per each legacy number.
2. **SPR:** Insert the appropriate legacy number at the header level and theNPI 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 website 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 website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf*.

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

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

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

Note: CMS revised this *MLN Matters* article on August 25, 2006, by adding this statement directing readers to view article MM5060 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf* for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR 5060, which is available at *http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf*.

In addition, CMS has revised this *MLN Matters* article on May 8, 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 website 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 for services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), to include regional home health intermediaries (RHHIs)

Provider Action Needed

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

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

Background

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

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

Applications may be made by mail and also online at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.

NPI and Legacy Identifiers

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

Legacy provider identifiers include:

- Online survey certification and reporting (OSCAR) system numbers

Stage 2 Requirements—Requirements for Use and Editing of National Provider Identifier Numbers (continued)

- National supplier clearinghouse (NSC) numbers
- Provider identification numbers (PINs)
- Unique physician identification numbers (UPINs) used by Medicare.

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

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

Primary and Secondary Providers

Providers are categorized as either "primary" or "secondary" providers:

- ***Primary providers*** include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- ***Secondary providers*** include supervising physicians, operating physicians, referring providers, and so on.

Crosswalk

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

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

NPI Transition Plans for Medicare FFS Providers

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

Stage	Medicare Implementation
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 (*This is stage 2, the subject of CR4023)*	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.
May 23, 2007 – Forward	CMS systems will **only** accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

Stage 2 Requirements—Requirements for Use and Editing of National Provider Identifier Numbers (continued)

Claim Rejection

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
  - X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only)
  - National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only)
  - Claims submitted using Medicare's free billing software
  - Electronic claim status request received via X12 276 or DDE screen
  - Non-X12 electronic claim status queries
- An NPI reported cannot be located in Medicare files.
- The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI.
- Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare's free billing software.

Note: If only provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.

Additional Information

X12 837 Incoming Claims and COB

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

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

National Council of Prescription Drug Plans (NCPDP) Claims

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

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

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

Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006 and end February 28, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

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

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

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

Standard Paper Remits (SPRs)

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

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

Remit Print Software

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

Free Billing Software

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

In-Depth Information

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

- Crosswalk
- X12 837 Incoming Claims and COB
- Non-HIPAA COB Claims
- NCPDP Claims

Stage 2 Requirements—Requirements for Use and Editing of National Provider Identifier Numbers (continued)

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

CR 4023, the official instruction issued to your FI/regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to CMS website *http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf*.

You may also wish to review *Medlearn Matters* article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *Medlearn Matters* Articles on NPI-Related Activities," which is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0555.pdf*.

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

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

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

CMS Announces the National Provider Identifier Enumerator Contractor

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 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 website 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 health care providers – Medicare and non-Medicare

Provider Action Needed

Learn about the National Provider Identifier NPI and how and when to apply for one.

Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health & Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a final rule that adopted the NPI as this identifier.

The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions.

Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23,

CMS Announces the National Provider Identifier Enumerator Contractor (continued)

2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

Note: While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

NPI Enumerator Contract Awarded

Recently, CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project.

Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

Who may apply for the NPI?

All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI.

Note: All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI final rule to obtain NPIs. This is true even if they use business associates such as billing agencies to prepare the transactions.

The NPI Application Process

Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, **it will be important to apply for your NPI** before the compliance date of May 2007 because health plans could require you to use your NPI before that date.

You will be able to apply for your NPI in one of three ways:

1. You may apply through an easy-to-use Web-based application process, beginning May 23, 2005.

   The Web address will be *https://nppes.cms.hhs.gov*, but please note – the website was available on May 23, 2005.

2. Beginning July 1, 2005, you may complete a paper application and send it to the Enumerator. A copy of the application, including the Enumerator's mailing address (where you will send it) will be available on *https://nppes.cms.hhs.gov* or you can call the Enumerator to receive a copy. The phone number is 1-800-465-3203 or TTY 1-800-692-2326. **But remember, paper applications may not be submitted until July 1, 2005.**

3. With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. **This process will be available in the fall of 2005.**

You may apply for an NPI using only one of these methods. When gathering information for your application, be sure that all of your information, such as your social security number and the federal employer identification number, are correct. Once you receive your NPI, safeguard its use.

If all information is complete and accurate, the Web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer. The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years.

Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions like claims. You can expect to hear about the importance of applying for an NPI from a variety of sources. Be clear that you only have to apply for, and acquire, one NPI. Your unique NPI will be used for all standard transactions, Medicare and non-Medicare.

Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

Additional Information

For additional information on NPIs:

- Visit *http://www.cms.hhs.gov/hipaa/hipaa2* on the Web.
- Beginning May 23, 2005, visit *https://nppes.cms.hhs.gov* or call the enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- For HIPAA information, you may call the HIPAA hotline: 1-866-282-0659, or write to *AskHIPAA@cms.hhs.gov* on the Web.

MLN Matters Number: SE0528 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0528

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims

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 8, 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 website 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 conduct HIPAA standard transactions, such as claims and eligibility inquiries

Provider Action Needed

STOP – Impact to You

You must report your NPI correctly on all electronic data interchange (EDI) transactions that you submit, as well as on paper claims you send to Medicare and telephone interactive voice response (IVR) queries **by no later than May 23, 2007, or your transactions will be rejected.**

CAUTION – What You Need to Know

Carriers have reported errors on claims (see *Background*, below) that will impact your payment when you begin to submit NPIs. Although not mandated until May 23, 2007, providers are currently allowed to submit NPIs in Medicare transactions other than paper claims. NPI will be accepted on the revised paper claim CMS-1500 (0805) and UB-04 forms early in 2007.

GO – What You Need to Do

Make sure that your billing staffs are using your NPI correctly when they submit your claims for services provided to Medicare beneficiaries or submit electronic beneficiary or claim status queries to Medicare.

Background

All HIPAA covered health care providers who would either bill Medicare; render care to Medicare beneficiaries; order durable medical equipment, supplies, or services for beneficiaries; refer beneficiaries for other health care services; act as an attending physician when a beneficiary is hospitalized; prescribe covered retail prescription drugs for beneficiaries; operate on beneficiaries; or could otherwise be identified on a claim submitted to Medicare for payment **must** obtain an NPI. This applies whether providers 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, managed care organizations, suppliers of durable medical equipment, pharmacies, etc.) **must** obtain an NPI for use to identify themselves in HIPAA standard transactions.

Although the NPI requirement applies by law to covered entities such as health care providers, health care clearinghouses, and health plans in the U.S. when exchanging electronic transactions for which a national standard has been adopted under HIPAA, HIPAA permits health care plans to elect to require reporting of NPIs in paper claims and for non-HIPAA transaction purposes.

Medicare will also require NPIs for identification of all providers listed on the UB-04 institutional paper claim form and of physicians and suppliers listed on the revised CMS-1500 (08-05) professional paper claim form by May 23, 2007.

Medicare will reject paper claims received after May 22, 2007, that do not identify each provider, physician or supplier listed on a paper or electronic claim with an NPI. Medicare will also begin to require an NPI in interactive voice response (IVR) queries effective May 23, 2007.

Retail pharmacies are required to use the NCPDP format adopted as a HIPAA standard for submission of prescription drug claims to Medicare. Since that format permits entry of only one provider identifier each for a pharmacy and the physician who prescribed the medication, retail pharmacies that use the NCPDP HIPAA format can use either their national supplier clearinghouse (NSC) number or their NPI to identify themselves, and either the unique provider identification number (UPIN) or the NPI to identify the prescribing physician prior to May 23, 2007.

May 23, 2007, and later, only an NPI may be reported for identification of pharmacies and prescribing physicians. NCPDP claims received by Medicare after May 22, 2007, that lack an NPI for either the pharmacy or the prescribing physician will be rejected.

This being said, Medicare carriers and fiscal intermediaries (FIs) have reported receiving X12 837-P (professional) and X12-837–I (institutional) claims containing errors that will result in claim rejection, and/or processing delays, if they continue to occur once NPI reporting begins.

Some of the errors seen by Medicare carriers include the following:

Incorrect Information in the 2010A/A Billing Provider Loop in X12 837-P Claims

Prior to May 23, 2007, carriers will reject claims when the NPI in a loop does not belong to the owner of the PIN or UPIN that should also be reported in REF02 of the same loop, or if the name and address of the provider in that loop do not correlate with either the NPI, PIN or UPIN in the same loop. The same edits will also be applied to NPIs when received on paper claims prior to May 23, 2007.

Carriers have also detected claims where the rendering physician's or supplier's NPI is reported in the 2010A/A NM1 segment when the claim was submitted by a group to which the physician belongs or the home office of a chain to which a supplier belongs. The 2010A/A loop of an 837-P claim must contain the identifier that applies to the groups/

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims (continued)

chains (NPI entity 2) that submitted the claims. This rule also applies to identification of the billing provider on a paper claim. Information concerning a billing agent or a health care clearinghouse may never be reported in the billing provider loop for a Medicare claim.

To prevent this error, you must report the rendering physician's or supplier's NPI in the NM109 data element in the rendering provider claim level loop (2310B), unless multiple services were furnished by different members of the group/chain.

If multiple rendering providers were involved, the information for each must be reported in the service level 2420A loop along with the service(s) each of them rendered.

To facilitate claim processing prior to May 23, 2007, you should also report the rendering provider(s) PIN(s) as the REF02 data element with 1C in REF01 in that same rendering provider loop (2310B for the claim or 2420A for individual services, as applicable).

Reporting of the Pay-to-Address in the Billing Provider (2010A/A) Loop

Once NPI reporting begins, carriers will reject claims when the pay-to-address, if different than the actual practice location address, is in the 2010A/A (billing provider) loop, rather than in the 2010A/B (pay-to-provider) loop.

> **When groups or organizations submit claims, and the billing and the pay-to providers are different individuals or entities, the pay-to information must always be reported in the 2010A/B loop and the billing provider information in the 2010A/A loop.**

Reporting of the Name and Address of a Billing Provider in the 2010A/A Loop of an X12 837-I (Institutional) Electronic Claim

FIs will reject claims in which the billing provider and the rendering provider are different entities, and you report the billing provider's name and address in the 2010A/A loop of an X12 837-I (institutional) electronic claim, and the OSCAR number of the rendering provider in that same loop.

If the home office of a chain has obtained one NPI for all facilities it owns, or one of a chain's facilities bills for all (or other) facilities owned by that chain, or a hospital bills for its special units, the home office, hospital or other facility submitting those claims is considered a form of billing agent for Medicare purposes.

In this instance, you must identify the specific provider, for whom the claim is being submitted, as the billing provider for that claim. If a provider that furnished the care had a separate OSCAR (online survey certification and reporting) system number than the entity submitting its claims, the provider that furnished the care must be identified in the billing provider loop. You must also report the name of the facility for whom the claim is being submitted, that facility's address, and should report applicable NPI (when obtained prior to May 23, 2007), as well as the Medicare OSCAR number assigned to that provider in the 2010A/A (billing provider) loop of the claim.

If the home office, hospital or other entity that prepared the claim is to be sent payment for the claim, you must report the name and address, and should report the NPI if issued, and the applicable OSCAR number associated with that entity in the 2010A/B (pay-to-provider) loop prior to May 23, 2007.

However, you should note that Medicare will not issue payment to a third party for a provider solely as result of completion of the 2010A/B loop of an electronic claim.

The facility that furnished the care, or the established owner of that facility, must have indicated on their CMS-855 provider enrollment form filed when that facility enrolled in Medicare (or via a subsequent CMS-855 used to update enrollment information) that payments for that facility are to be issued to that home office, hospital, other facility or an alternate third party.

For those providers still permitted to submit any paper claims under the restrictions imposed by the Administrative Simplification Compliance Act, Medicare plans to begin accepting paper claims on the revised CMS-1500 (08-05 version) beginning January 2, 2007 (allowing you to report a provider's NPI as well as the applicable PIN or UPIN); and on the revised UB-04 (CMS-1450) form beginning March 1, 2007 (allowing you to report a provider's NPI as well as the applicable OSCAR or UPIN). Medicare carriers plan to reject "old" CMS-1500 forms received after March 31, 2007, and FIs plan to reject UB-92 forms received after April 30, 2007.

Note: Medicare does not accept NPIs on the "old" versions of the CMS-1500 or UB-92 forms. There are no fields on those forms designed for NPI reporting.

CMS highly recommends that for electronic or paper Medicare claims that you submit during the transition period to full NPI implementation on May 23, 2007, you include both the NPI and the Medicare legacy identifier of each provider for whom you report information.

- When you report an NPI on a claim sent to a carrier for a referring, ordering, purchased service or supervising physician, or for a provider listed in the service facility locator loop, use a UPIN as the Medicare legacy identifier.
  Furthermore, if any of those physicians are not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007, you should report OTH000 as the UPIN.
- When you report an NPI on a claim sent to an FI for an attending, operating or other physician, or in the service facility locator loop (when those loops apply), you should also report the provider's UPIN. And as above, you may report OTH000 as the surrogate UPIN if any of those providers is not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007.
- Finally, when you report an NPI for a billing, pay-to, or rendering provider identified on a claim sent to a carrier, you should also report the valid Medicare PIN that applies to that physician or supplier. Additionally, you should always report an OSCAR number for each

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims (continued)

billing, pay-to, or possibly a service facility locator loop provider identified on a claim sent to an FI, as well as the NPI if issued to each of those providers, prior to May 23, 2007.

Remember that failure to report information as described here may result in delayed processing or rejection of your claims.

You may find more information about NPI by going to the NPI page on the CMS website at *http://www.cms.hhs.gov/apps/npi/01_overview.asp*.

In addition, if you have any questions on the NPI, you may call your carrier or FI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

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Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
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Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0659

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GENERAL COVERAGE

Bone Mass Measurements

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

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

- Medicare will not cover single photon absorptiometry and *CPT* code *78350* will be **denied** for services **on or after January 1, 2007.**

- In informing beneficiaries about the denials of claims processed for BMMs, Medicare will use the following Medicare summary notice (MSN) messages, effective for services on or after January 1, 2007:

  - *CPT* code *78350*:

    MSN# 16.10: "Medicare does not pay for this item or service."

Bone Mass Measurements (continued)

- *CPT* codes *77078*, *77079*, *77081*, *77083*, *76977* and G0131 when billed with ICD-9-CM diagnosis codes 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0

  MSN #15.4: "The information provided does not support the need for this service or item."

- 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 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 six months of the date of this notice. Future services of this type provided to you will be your responsibility."

- 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 non-covered 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 website at** *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopofPage*.

Chapter15

- **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

Bone Mass Measurements (continued)

prednisone, or greater, per day, for more than three months.

- An individual with primary hyperparathyroidism.
- 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 website 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 website 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 website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: MM5521
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

Information Update Regarding Payment and Coding for Drugs and Biologicals

As announced in late 2006, after carefully examining Section 1847A of the Social Security Act, as added by the Medicare Modernization Act of 2003, the Centers for Medicare & Medicaid Services (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, Medicare has also reviewed how to operationalize the terms "single source drug," "multiple source drug," and "biological product" 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. Medicare will consider:

- The Food and Drug Administration (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 Health Care Procedure Code System (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. Examples of how Medicare is operationalizing this approach using unique HCPCS codes include:

- Q codes for Euflexxa™, Orthovisc®, and Synvisc® effective January 1, 2007.
- Q codes for immune globulin and the new Q code for Reclast® effective July 1, 2007

Section 1847A requires single source drugs or biologicals that were within the same billing and payment code as of October 1, 2003, be treated as multiple source drugs, so the payment under Section 1847A for these drugs and biologicals is based on the volume weighted average of the pricing information for all of the products within the billing and payment code. Medicare is working to ensure that payments accurately reflect this "grandfathering" provision. Examples of how Medicare is operationalizing this provision include:

- Q4083 for Hyalgan and Supartz effective January 1, 2007
- Q4094 for albuterol and levalbuterol and Q4093 for concentrated forms of albuterol and levalbuterol effective July 1, 2007

In addition, appropriate modifications of the national drug code (NDC) to HCPCS crosswalk used to calculate the payment limits for purposes of Section 1847A will be made to ensure that payment will be based on the pricing information for all products produced or distributed under an FDA-approval for the drug or biological.

One result is the same payment limit for J0885 (injection, epoetin alfa, [for non-ESRD use]) and J0886 (injection, epoetin alfa, [for ESRD on dialysis]).

CMS will continue to work to identify and implement payment and coding changes as necessary to ensure more accurate payments under Section 1847A. So that CMS can implement any further necessary changes during 2007, CMS will continue to use the internal process for modifying the HCPCS code set and for adjusting the NDC to HCPCS crosswalk.

A full list of the July 2007 quarterly updates to the HCPCS is available at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage*.

Pricing information for Part B drugs and biologicals for the third quarter of 2007 (July 1 – September 30) will be posted on or after June 15th at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage*.

The announcement for the Q codes for Euflexxa™, Orthovisc®, and Synvisc® effective January 1, 2007, and Q4083 for Hyalgan and Supartz also effective January 1, 2007, was posted on December 22, 2006, and is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf*. ❖

Source: CMS Provider Education Resource 200705-23

Astigmatism-Correcting Intraocular Lens (A-C IOLs)—CMS 1536-Ruling Implementation

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, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs] for services provided to Medicare beneficiaries.

Provider Action Needed

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

Astigmatism-Correcting Intraocular Lens (A-C IOLs)—CMS 1536-Ruling Implementation (continued)

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

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

Background

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

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

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

Coverage Policy

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

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

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

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

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

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

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

Astigmatism-Correcting Intraocular Lens (A-C IOLs)—CMS 1536-Ruling Implementation (continued)

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

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

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

Payment Policy for Facility Services and Supplies

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

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

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

- The facility should bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or A-C IOL is inserted. When a beneficiary receives an A-C IOL following removal of a cataract, hospitals and ASCs should report the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL (see "*Coding*" section).
- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL.
- There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives an AC-IOL following removal of a cataract that exceed the facility charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary after cataract surgery followed by insertion of a conventional IOL.

Payment Policy for Physician Services and Supplies

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

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

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

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

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

Coding

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

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion

Astigmatism-Correcting Intraocular Lens (A-C IOLs)—CMS 1536-Ruling Implementation (continued)

device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage

66983 I*ntracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)*

66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)*

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

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

Beneficiary Liability

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

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

Provider Notification Requirements

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

- Prior to the procedure to remove a cataractous lens and insert an A-C IOL, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment, or other subsequent treatments related to the astigmatism-correcting functionality of the IOL.
- The correcting functionality of an A-C IOL does not fall into a Medicare benefit category and, therefore, is not covered. Therefore, the facility and physician are not required to provide an advanced beneficiary notice to beneficiaries who request an A-C IOL.
- Although not required, CMS strongly encourages facilities and physicians to issue a **Notice of Exclusion from Medicare Benefits** to beneficiaries in order to identify clearly the non-payable aspects of an A-C IOL insertion. This notice may be found on the CMS website at:
  - *http://cms.hhs.gov/medicare/bni/20007_English.pdf* for the English language version.
  - *http://cms.hhs.gov/medicare/bni/20007_Spanish.pdf* for the Spanish language version.

Additional Information

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

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

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

MLN Matters Number: MM5527
Related Change Request (CR) Number: 5527
Related CR Release Date: April 27, 2007
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Implementation Date: May 29, 2007

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

Clarification of Bariatric Surgery Billing Requirements

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5477, which clarifies the claims processing instructions contained in CR 5013 (Transmittals R931CP and R54NCD; titled *Bariatric Surgery for Morbid Obesity*).

CAUTION – What You Need to Know

On April 28, 2006, the Centers for Medicare & Medicaid Services (CMS) issued CR 5013 providing coverage for certain bariatric surgical procedures. CMS found that some claims not involving bariatric surgery are being denied in error while some covered bariatric surgery claims are being held rather than paid.

GO – What You Need to Do

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

Background

On April 28, 2006, CMS issued change request (CR) 5013 (Transmittals R931CP and R54NCD, dated April 28, 2006) providing coverage for certain bariatric surgical procedures. This national coverage determination (NCD) is contained in section 100.1 of the *Medicare National Coverage Determination Manual*.

It came to the attention of the CMS that this NCD is not being implemented uniformly, and CMS found that:

- Some claims not involving bariatric surgery are being denied in error, and
- Some covered bariatric surgery claims are being held rather than paid.

Therefore, CMS is issuing CR 5477 to clarify the claims processing instructions contained in CR 5013.

Certain bariatric surgery procedures for treatment of co-morbidities associated with morbid obesity are considered reasonable and necessary under the Social Security Act (Section 1862(a)(1)(A)) if the following conditions are satisfied:

1. The Medicare beneficiary:
   - Has a body-mass index (BMI) $\geq$ 35,
   - Has at least one co-morbidity related to obesity (such as diabetes or hypertension), and
   - Has been previously unsuccessful with medical treatment for obesity.
2. The procedure is performed in an approved facility listed on the CMS website at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp*.

Note: The NCD itself has not changed and treatments for obesity alone are noncovered.

The following revisions to the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 32) provide guidance for bariatric surgery claims payment:

ICD-9 Diagnosis Codes for BMI $\geq$ 35

V85.35	Body Mass Index 35.0-35.9, adult
V85.36	Body Mass Index 36.0-36.9, adult
V85.37	Body Mass Index 37.0-37.9, adult
V85.38	Body Mass Index 38.0-38.9, adult
V85.39	Body Mass Index 39.0-39.9, adult
V85.4	Body Mass Index 40 and over, adult

Claims must be submitted to carriers or A/B MACs with the ICD-9-CM diagnosis code of 278.01 for morbid obesity and one of the appropriate Healthcare Common Procedure Coding System (HCPCS) codes as follows:

43770 *Laparoscopy, surgical, gastric restrictive procedure: placement of adjustable gastric band (gastric band and subcutaneous port components)*

43644 *Laparoscopy, surgical, gastric restrictive procedure with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)*

43645 *Laparoscopy, surgical, gastric restrictive procedure with gastric bypass and small intestine reconstruction to limit absorption*

43845 *Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileolieostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)*

43846 *Gastric restrictive procedure, with gastric bypass, for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy*

43847 *Gastric restrictive procedure with small intestine reconstruction to limit absorption*

Medicare FIs and A/B MACS will accept bariatric surgery claims billed by institutional providers with and ICD-9-CM diagnosis code of 278.01 for morbid obesity and one of the following ICD-9-CM procedure codes:

38.38 Laparoscopic gastroenterostomy; bypass: gastroduodenostomy, gastroenterostomy, gastrogastrostomy; laparoscopic gastrojejunostomy without gastrectomy NEC.

38.39 Other gastroenterostomy; bypass: gastroduodenostomy, gastroenterostomy, gastrogastrostomy; gastrojejunostomy without gastrectomy NOS.

44.95 Laparoscopic gastric restrictive procedure; adjustable gastric band and port insertion.

Clarification of Bariatric Surgery Billing Requirements (continued)

Note: If ICD-9-CM diagnosis code 278.01 is present, but one of the listed ICD-9-CM procedure codes or HCPCS codes is not present, then the Medicare contractor will determine the claim is not for bariatric surgery and will process the claim accordingly. Also, if one of the ICD-9-CM procedure codes is present without ICD-9-CM diagnosis code 278.01, then the claim is not for bariatric surgery, and the contractor will process the claim accordingly.

Also, to describe either laparoscopic or open biliopancreatic diversion with duodenal switch (BPD/DS), **claims must contain all three of the following codes**:

89.89 Other; partial gastrectomy with bypass gastrogastrostomy; sleeve resection of stomach.

51.51 Isolation of segment of small intestine; isolation of ileal loop; resection of small intestine for interposition.

45.91 Small-to-small intestinal anastomosis.

Claims submitted to FIs or A/B MACs must contain International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure code reported as specified according to the following conditions:

- The Medicare contractor will pay the bariatric surgery claim if ICD-9-CM diagnosis code 278.01 (Morbid obesity; severe obesity) is present **and all of the following are present:**
  - At least one of the specified ICD-9-CM diagnosis codes for BMI ≥35.
  - An appropriate procedure code(s) as listed in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 32, Sections 150.2 and 150.3.
  - An appropriate obesity-related co-morbid diagnosis code(s).
  - The procedure was performed in an approved facility.
- The Medicare contractor will **deny the bariatric surgery claim** if ICD-9-CM diagnosis code 278.01 is present, but any of the following are not present:
  - At least one of the specified ICD-9-CM diagnosis codes for BMI ≥ 35.
  - An appropriate procedure code(s) as listed in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 32, Sections 150.2 and 150.3.
  - An appropriate obesity-related co-morbid diagnosis code(s).
  - The procedure was performed in an approved facility.

Note: The term, "deny", rather than "reject" is used because beneficiaries and providers are entitled to appeal rights.

- If ICD-9-CM diagnosis code 278.01 is not present, the contractor will adjudicate the non-bariatric surgery claim based on the ICD-9-CM procedure codes listed on the claim.

Noncovered HCPCS/ICD-9-CM Procedure Codes

Contractors (carriers and B MACs) will **deny** bariatric surgery claims when:

- Billed with *CPT* code *43842 (Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty*) when used for open vertical banded gastroplasty.

  Note: This code was included in the April 2006 update of the Medicare physician fee schedule database and the July update of the Medicare outpatient code editor.
- Billed with *CPT* code *43999* not otherwise classified (NOC) when used for the following noncovered procedures: (When this NOC coded is used, the procedure should be described.)
  - Laparoscopic vertical banded gastroplasty
  - Open sleeve gastrectomy
  - Laparoscopic sleeve gastrectomy
  - Open adjustable gastric banding

Contractors (FIs and A MACs) will **reject** bariatric surgery claims when:

- Billed with principal ICD-9-CM diagnosis code 278.01 and ICD-9 procedure code 44.68 when used for the following noncovered procedures:
  - Open adjustable gastric banding
  - Laparoscopic vertical banded gastroplasty.
- Billed with principal ICD-9-CM diagnosis code 278.01 and ICD-9 procedure code 44.69 when used for the noncovered procedure, open vertical banded gastroplasty.
- Billed with principal ICD-9 CM diagnosis code 278.01 and ICD-9 procedure code 43.89 when used for the following noncovered procedures:
  - Open sleeve gastrectomy
  - Laparoscopic sleeve gastrectomy.

Note: Carriers, FIs, or A/B MACs will use claim adjustment reason code 50 when denying/rejecting claims for noncovered bariatric surgery procedures, reason code 58 when payment is denied due to performing the surgery at an unapproved facility, and reason code 167 when denying the claim because the patient did not meet the conditions for coverage. Appeal rights will be afforded to all parties.

Clarification of Bariatric Surgery Billing Requirements (continued)

Additional Information

The official instruction, CR 5477, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1233CP.pdf*.

The manual revisions to the *Medicare Claims Processing Manual* (Pub. 100-04; Chapter 32) included as an attachment to CR5477: CR 5013, Transmittal R931CP and R54NCD, dated April 28, 2006, may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R931CP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R54NCD.pdf*).

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

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

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LOCAL COVERAGE DETERMINATIONS

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

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

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

Local Coverage Determination Table of Contents

Additions/Revisions to Existing LCDs

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*.

ADDITIONS/REVISIONS TO LCDS

AJ0740: Ganciclovir and Cidofovir—Revision to the LCD

The local coverage determination (LCD) for ganciclovir and cidofovir was effective October 30, 2006. Since that time, the LCD has been revised. Under the list of medically necessary ICD-9-CM diagnosis codes, the note about diagnosis requirements for HCPCS codes J0740 and J7310 was revised to clarify that a diagnosis code from one of the following groups is also required when billing for these drugs: 363.00-363.08 or 363.10-363.15.

The coding guidelines were also revised to include the revised billing instructions for HCPCS codes J0740 and J7310.

Effective Date

This revision to the LCD is effective for services **provided on or after October 30, 2006.**

The full text for this LCD (L23097) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ1440: G-CSF (Filgrastim, Neupogen®)—Revision to the LCD

The local coverage determination (LCD) for G-CSF (filgrastim, Neupogen®) was last revised on October 1, 2006. Since that time, the LCD has been revised. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis codes V42.81 and V42.82 were added as appropriate diagnosis codes. In addition, a note was added to the ICD-9-CM code list indicating that diagnosis codes V42.81 and V42.82 are secondary diagnosis codes and that the underlying condition should be billed as the primary diagnosis code.

Effective Date

This revision to the LCD is effective for services **provided on or after May 9, 2007.**

The full text for this LCD (L1269) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AJ9000: Antineoplastic Drugs—*Retired* LCD and Individual Revised LCDs

The local coverage determination (LCD) for antineoplastic drugs was last updated on February 8, 2007. Since that time, this LCD is being retired as individual revised LCDs were developed for all drugs included in the Antineoplastic Drugs LCD. The following is a list of the drugs for which individual revised LCDs were developed:

J9000 – Doxorubicin HCl, 10mg
J9001 – Doxorubicin HCl, all lipid formulations, 10mg
J9010 – Alemtuzumab, 10mg
J9015 – Aldesleukin, per single use vial
J9045 – Carboplatin, 50mg
J9160 – Denileukin diftitox, 300mcg
J9170 – Docetaxel, 20mg
J9178 – Injection, epirubicin HCl, 2mg
J9181 & J9182 Etoposide 10mg & 100mg (combined in one LCD)
J9185 – Fludarabine phosphate, 50mg
J9200 – Floxuridine, 500mg
J9201 – Gemcitabine HCl, 200mg
J9206 – Irinotecan, 20mg
J9263 – Injection, oxaliplatin, 0.5mg
J9265 – Paclitaxel, 30mg
J9280, J9290, & J9291 Mitomycin 5mg, 20mg, & 40mg (combined in one LCD)
J9300 – Gemtuzumab ozogamicin, 5mg
J9310 – Rituximab, 100mg
J9350 – Topotecan, 4mg
J9355 – Trastuzumab, 10mg
J9390 – Vinorelbine tartrate, per 10mg
J9395 – Injection, fulvestrant, 25mg
J9600 – Porfimer sodium, 75mg

AJ9000: Antineoplastic Drugs (continued)

Effective Dates

The LCD retirement for AJ9000 – Antineoplastic Drugs will be effective for services provided **on or after May 24, 2007**.

The individual revised LCDs for the above drugs will be effective for services provided **on or after May 24, 2007**.

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

The full text for the individual retired LCDs (L25108-L25130) are available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

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HOSPITAL SERVICES

Implementation of Present on Admission Indicator

Section 5001(c) of the Deficit Reduction Act of 2005 requires hospitals to begin reporting the secondary diagnoses that are present on the admission (POA) of patients effective for **discharges on or after October 1, 2007.**

By October 1, 2007, the Secretary must select at least two conditions that are: 1) high cost or high volume or both; 2) assigned to a higher paying DRG when present as a secondary diagnosis; and 3) reasonably preventable through application of evidence based guidelines.

Effective for acute care inpatient PPS discharges on or after October 1, 2008, the Secretary cannot assign cases with these conditions to a higher paying diagnosis related group (DRG) unless they were present on admission.

This instruction will require hospitals to begin reporting the POA code on claims with discharges beginning on or after October 1, 2007.

Although hospitals must report the POA code on the claim, the information will not be used by claim processing systems until January 1, 2008.

Beginning with claims with discharges **on or after January 1, 2008,** if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will continue to process. However, hospitals will be provided with a remark code on their remittance advice advising them that they did not correctly submit the POA code on the claim.

Beginning April 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will be returned to the hospital for correct submission of POA information. Direct data entry (DDE) screens cannot be updated to include a space for entering POA information until January 1, 2008. Therefore, hospitals that submit claims via DDE will be unable to submit the POA indicator on October 1, 2007. These hospitals must begin submitting the POA indicator on January 1, 2008.

In order to group diagnoses into the proper DRG, CMS needs to capture a POA indicator for all claims involving inpatient admissions to general acute care hospitals. Use the *UB-04 Data Specifications Manual* and the I*CD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim forms UB-04 and 837 Institutional.

The law requires that these POA indicators be reported on all claims for inpatient admissions to general acute care hospitals with discharge dates on or after October 1, 2007. Critical access hospitals, Maryland waiver hospitals, LTCH, cancer hospitals and children's inpatient facilities are exempt from this requirement.

These guidelines are not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting.* The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the *Introduction* to the I*CD-9-CM Official Guidelines for Coding and Reporting*, a joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term "provider" means a physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

Note: The provider, their billing office, third party billing agents and anyone else involved in the transmission of this data shall insure that any resequencing of diagnoses codes prior to their transmission to the Centers for Medicare & Medicaid Services (CMS), also includes a resequencing of the POA indicators as well.

The following information is an excerpt from the *UB-04 Data Specifications Manual* and is provided to assist hospitals in understanding how and when to code POA indicators. See the complete instructions in the *UB-04 Data Specifications Manual* when more specific instructions or examples are necessary.

General Reporting Requirements

- All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.
- Present on admission is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.
- POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*) and the external cause of injury codes.
- Issues related to inconsistent, the provider must still resolve missing, conflicting or unclear documentation.
- If a condition would not be coded and reported based on the uniform hospital discharge data set definitions and current official coding guidelines, then the POA indicator would not be reported.

Implementation of Present on Admission Indicator (continued)

- CMS does not require a POA indicator for the external cause of injury code unless it is being reported as an "other diagnosis".

CMS Reporting Options and Definitions

Y Yes – present at the time of inpatient admission

N No – not present at the time of inpatient admission

U Unknown – the documentation is insufficient to determine if the condition was present at the time of inpatient admission

W Clinically Undetermined – the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not

1 Unreported/Not used – Exempt from POA reporting. This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks were undesirable when submitting this data via the 4010A1. ❖

Source: CMS Pub. 100-04, Transmittal 1240, CR 5499

Present on Admission Indicator

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

Provider Types Affected

Hospitals who submit claims to fiscal intermediaries (FI) or Part A/B Medicare administrative contractors (A/B MACs) for Medicare beneficiary inpatient services.

Provider Action Needed

STOP – Impact to You

Effective October 1, 2007, Medicare will begin to accept a present on admission (POA) indicator for every diagnosis on your inpatient acute care hospital claims. **However, providers must submit the POA indicator on hospital claims beginning with discharges on or after January 1, 2008**. Critical access hospitals, Maryland waiver hospitals, long-term care hospitals, cancer hospitals, and children's inpatient facilities are exempt from this requirement.

CAUTION – What You Need to Know

CR 5499, from which this article is taken, announces the requirement for completing a POA indicator for every diagnosis on an inpatient acute care hospital claim beginning with discharges **on or after January 1, 2008,** and provides your FI and A/B MACs with the coding and editing requirements, and software modifications needed to successfully implement this indicator. (Providers can begin to submit POA indicators as of October 1, 2007.)

GO – What You Need to Do

You should make sure that your billing staffs are aware of this requirement, and that your physicians and other practitioners and coders are collaborating to ensure complete and accurate documentation, code assignment and reporting of diagnoses and procedures. Please refer to the *Background* section for more details.

Background

Section 5001(c) of the Deficit Reduction Act of 2005 requires hospitals to begin reporting the secondary diagnoses that are present on the admission of patients **effective for discharges on or after October 1, 2007.** Effective for acute care inpatient prospective payment system (PPS) discharges on or after October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) will have selected at least two high cost or high volume (or both) diagnosis codes that:

- Represent conditions (including certain hospital acquired infections) that could reasonably have been prevented through the application of evidence-based guidelines; and
- When present on a claim along with other (secondary) diagnoses, have a diagnosis related group (DRG) assignment with a higher payment weight.

Then, for acute care inpatient PPS discharges on or after October 1, 2008, while the presence of these diagnosis codes on claims **could** allow the assignment of a higher paying DRG, when they are present at the time of discharge, but not at the time of admission, the DRG that must be assigned to the claim will be the one that does **not** result in the higher payment.

Beginning for discharges on or after October 1, 2007, hospitals should begin reporting the POA indicator for acute care inpatient PPS discharges. **There is one exception, i.e., claims submitted via direct data entry (DDE) should not report the POA indicators until January 1, 2008, as the DDE screens will not be able to accommodate the codes until that date.**

Hospitals that fail to provide the POA indicator **for discharges on or after January 1, 2008** will receive a remittance advice remark code informing them that they failed to report a valid POA indicator. However, **beginning with discharges on or after April 1, 2008,** Medicare will return claims to the hospital if the POA indicator is not reported and the hospital will have to supply the correct POA code and resubmit the claim.

In order to be able to group these diagnoses into the proper DRG, CMS needs to capture a POA indicator for all claims involving inpatient admissions to general acute care hospitals. CR 5499, from which this article is taken, announces this requirement (effective January 1, 2008); and provides your FI and A/B MACs with the coding and editing requirements, and software modifications needed to successfully implement this indicator.

Note: Adjustments to the relative weight that occur because of this action are not budget neutral. Specifically, aggregate payments for discharges in a fiscal year could be changed as a result of these adjustments.

Present on Admission Indicator (continued)

These POA guidelines are not intended to replace any found in the ICD-9-CM *Official Guidelines for Coding And Reporting*, nor are they intended to provide guidance on when a condition should be coded. Rather, you should use them in conjunction with the UB-04 data specifications manual and the ICD-9-CM *Official Guidelines For Coding And Reporting* to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim Form CMS 1450 (UB-04 and 837 Institutional). Information regarding the UB-04 data specifications may be found at *http://www.nubc.org/become.html*.

Note: Critical access hospitals, Maryland waiver hospitals, long-term care hospitals, cancer hospitals, and children's inpatient facilities are exempt from this requirement.

The following information, from the *UB-04 Data Specifications Manual*, is provided to help you understand how and when to code POA indicators:

1. General Reporting Requirements

- Pertain to all claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.
- Present on admission is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.
- POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting)* and the external cause of injury codes.
- The provider must still resolved issues related to inconsistent, missing, conflicting, or unclear documentation.
- If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.
- CMS does not require a POA indicator for the external cause of injury code unless it is being reported as an "other diagnosis."

2. Reporting Options and Definitions

Y – Yes (present at the time of inpatient admission)

N – No (not present at the time of inpatient admission)

U – Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)

W – Clinically undetermined (provider is unable to clinically determine whether condition was present at time of inpatient admission or not)

1 – Unreported/Not used – Exempt from POA reporting (This code is the equivalent of a blank on the UB-04, but blanks are not desir4eable when submitting data via the 4010A1.

The POA data element on your electronic claims must contain the letters "POA", followed by a single POA indicator for every diagnosis that you report. The POA indicator for the principal diagnosis should be the first indicator after "POA," and (when applicable) the POA indicators for secondary diagnoses would follow. The last POA indicator must be followed by the letter "Z" to indicate the end of the data element (or FIs and A/B MACs will allow the letter "X" which CMS may use to identify special data processing situations in the future).

Note that on paper claims the POA indicator is the eighth digit of the principal diagnosis field (FL 67), and the eighth digit of each of the secondary diagnosis fields (FL 67 A-Q); and on claims submitted electronically via 837, 4010 format, you must use segment K3 in the 2300 loop, data element K301.

Below is an example of what this coding should look like on an electronic claim:

If segment K3 read as follows: "POAYNUW1YZ," it would represent the POA indicators for a claim with 1 principal and 5 secondary diagnoses. The principal diagnosis was POA (Y), the first secondary diagnosis was not POA (N), it was unknown if the second secondary diagnosis was POA (U), it is clinically undetermined if the third secondary diagnosis was POA (W), the fourth secondary diagnosis was exempt from reporting for POA (1), and the fifth secondary diagnosis was POA (Y).

As of January 1, 2008, all direct data entry (DDE) screens will allow for the entry of POA data and POA data will also be included with any secondary claims sent by Medicare for coordination of benefits purposes.

See the complete instructions in the *UB-04 Data Specifications Manual* for more specific instructions and examples.

Note: CMS, in consultation with the Centers for Disease Control and Prevention and other appropriate entities, may revise the list of selected diagnose from time to time, but there will always be at least two conditions selected for discharges occurring during any fiscal year. Further, this list of diagnosis codes and DRGs is not subject to judicial review.

Finally, you should keep in mind that achieving complete and accurate documentation, code assignment, and reporting of diagnoses and procedures requires a joint effort between the health care provider and the coder. Medical record documentation from any provider (a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis) involved in the patient's care and treatment may be used to support the determination of whether a condition was present on admission or not; and the importance of consistent, complete documentation in the medical record cannot be overemphasized.

Present on Admission Indicator (continued)

Note: You, your billing office, third party billing agents and anyone else involved in the transmission of this data must insure that any resequencing of diagnoses codes prior to their transmission to CMS, also includes a resequencing of the POA indicators.

Additional Information

You can find the official instruction, CR 5499, issued to your FI or A/B MAC by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1240CP.pdf*.

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

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

MLN Matters Number: MM5499
Related Change Request (CR) Number: 5499
Related CR Release Date: May 11, 2007
Related CR Transmittal #: R1240CP
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1240, CR 5499

Medicare Graduate Medical Education Payments to Teaching Hospitals

On May 1, 2007, the Centers for Medicare & Medicaid Services (CMS) finalized a change concerning Medicare graduate medical education (GME) payments to teaching hospitals. The change is included in a final rule titled "Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Final Annual Payment Rate Updates, and Policy Changes; and Final Hospital Direct and Indirect Graduate Medical Education Policy Changes."

The final rule modifies the rules concerning GME payments to teaching hospitals with respect to the time that residents spend training in nonhospital settings. To view the display copy of the final rule and the section on GME payments, click on the following link: *http://www.cms.hhs.gov/LongTermCareHospitalPPS/downloads/cms-1529-f.pdf*. ❖

Source: CMS Provider Education Resource 200705-03

CMS Proposes Payment Reform for Inpatient Hospital Services in 2008

On April 13, 2007, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2008 hospital inpatient prospective payment system (IPPS) proposed rule (CMS-1533-P). The FY 2008 IPPS proposed rule appeared in the May 3, 2007, issue of the *Federal Register*. CMS recently discovered an error that was made in the calculation of the diagnosis related group (DRG) relative weights in the FY 2008 IPPS proposed rule.

CMS revised the relative weights to correct the error and recalculated the IPPS standardized amounts.

The changes will increase the IPPS standardized amounts by $0.18. Other information in the IPPS proposed rule will also be affected. The proposed FY 2008 outlier threshold will decrease by $85 to $22,940. There will also be some minor changes to the wage index in the 4th decimal place for some hospitals. CMS has posted new tables (Tables 1A-1D, Table 2 and Table 4J, Table 5, new payment impact files, new DRG cost and charge weights file) on the CMS website.

CMS also expects to publish a correction notice with the revised information in the *Federal Register* shortly. Please go to the following Web pages for revised FY 2008 IPPS rule information (click to sort the fiscal year column in descending order):

http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage

http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage. ❖

Source: CMS Provider Education Resource 200705-22

Update of HCPCS Codes for Hemophilia Clotting Factors

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

Provider Types Affected

Providers who submit claims to Medicare fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for hemophilia clotting factors.

Provider Action Needed

STOP – Impact to You

Discontinue the use of HCPCS code J7188, injection, von Willebrand factor complex, human, ristocetin cofactor, per IU, effective for discharges after December 31, 2006.

CAUTION – What You Need to Know

Providers are to use the new HCPCS code J7187, injection, von Willebrand factor complex, human, ristocetin cofactor, per IU, **effective with dates of discharge January 1, 2007.** However, Medicare systems will not be ready to process J7187 until October 1, 2007. Claims submitted with J1787 prior to the October 1, 2007 implementation date will be returned to the provider (RTP).

GO – What You Need to Do

Be sure billing staff are aware of this change and of how to handle related claims until Medicare systems are updated on October 1, 2007. The background section of this article provides instructions for handling this issue until October 1, 2007.

Background

Effective for dates of discharge on or after January 1, 2007, providers should use the new HCPCS code of J7187 for appropriate hemophilia clotting factors. However, as mentioned, Medicare systems will not be ready to process HCPCS code J7187 until October 1, 2007. Thus, for claims submitted from January 1, 2007 through September 30, 2007, (and for dates of discharge on or after January 1, 2007), hospitals should take the following steps:

- For claims for hospital inpatient care, omit HCPCS code J7187 from the claim.
- Once payment has been received for the inpatient claim, immediately submit an adjustment request (type of bill 117), including HCPCS code J7187 in the adjustment.
- Once Medicare systems are ready to process HCPCS code J7187, the adjustment will process automatically.

With the exception of the adjustment requests just mentioned, Medicare will return claims containing HCPCS code J7187 with dates of discharge on or after January 1, 2007, which are received prior to the October 1, 2007 implementation date.

Providers should note that this does not impact payment of outpatient claims, or skilled nursing facility claims. However, claims paid under the inpatient psychiatric facility (IPF) prospective payment system will also need to omit HCPCS code J7187 as noted above and IPF providers should follow the above instructions.

Additional Information

CR 5466 is the official instruction issued to your Medicare A/B MAC or FI on this issue. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1234CP.pdf*.

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

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

MLN Matters Number: MM5466
Related Change Request (CR) Number: 5466
Related CR Release Date: April 27, 2007
Related CR Transmittal Number: R1234CP
Effective Date: January 1, 2007
Implementation Date: October 2, 2007

Source: CMS Pub. 100-04, Transmittal 1234, CR 5466

CMS Proposes Payment Policy Changes for Inpatient Rehabilitation Facilities in Fiscal Year 2008

Inpatient rehabilitation facilities (IRFs) are projected to receive approximately $6.3 billion in payments from the Medicare program in fiscal year (FY) 2008, under a proposed rule announced today by the Centers for Medicare & Medicaid Services (CMS).

The proposed rule would update payment rates and modify payment policies for services furnished to Medicare beneficiaries for discharges occurring **on or after October 1, 2007, through September 30, 2008.**

The rule provisions are estimated to increase Medicare payments to approximately 1,234 IRFs in FY 2008 by approximately $150 million.

To view the press release, please click here: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

To view the display copy, please click here: *http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551P.pdf*. ❖

Source: CMS Provider Education Resource 200705-08

Inpatient Psychiatric Facility Claims Incorrectly Receiving Infectious Disease Comorbidity Adjustment

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries that some inpatient psychiatric facility (IPF) claims with discharges **on and after October 1, 2006,** but before **March 31, 2007,** were erroneously reimbursing the infectious disease comorbidity. The comorbidity codes were identified and corrected in the IPF PRICER released in April 2007. Contactors shall adjust previously processed IPF claims for discharges on and after October 1, 2006, but before March 31, 2007, that incorrectly received the infectious disease comorbidity adjustment.

The following ICD-9-CM diagnosis codes may have resulted in overpayments:

04111	04119	0412	0413	0414	0415	0416	0417	04181
04182	04183	04184	04185	04186	04189	0419	05320	05321
05322	05329	05371	05379	05410	05411	05412	05413	05419
05471	05472	05473	05474	05479	0771	0772	0773	0774
0778	07798	07799	0780	07810	07811	07819		

No Action Required by Providers

IPF claims for discharge dates **on and after October 1, 2006, but before March 31, 2007,** which have received reimbursement for the infectious disease comorbidity adjustment, will be adjusted by June 19, 2007. ❖

Source: CMS Joint Signature Memorandum 07355, May 3, 2007

Inpatient Psychiatric Facility Prospective Payment System Fact Sheet

The downloadable version of the *Inpatient Psychiatric Facility Prospective Payment System Fact Sheet*, which has been revised to include information about the rate year 2008 updates, is now available on the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/InpatientPsychFac.pdf*.

The fact sheet also provides general information about the inpatient psychiatric facility prospective payment system and how payment rates are set. The print version of the fact sheet will be available in approximately six weeks. ❖

Source: CMS Provider Education Resource 200705-16 – CMS Provider Education Resource 200705-24

Use of Benefit Exhaust Day as Discharge Date for Payment Purposes for Inpatient Psychiatric Facility Prospective Payment System

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs), and/or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries in long-term care hospitals (LTCHs) or in inpatient psychiatric facilities (IPFs) subject to the IPF prospective payment system (PPS).

Provider Action Needed

This article is based on change request (CR) 5474, which clarifies that the benefit exhaust date is considered a discharge for payment purposes under the LTCH PPS, redefines policy to benefit exhaust date in IPFs should show as the discharge date and allows both IPFs and LTCHs to bill no-pay claims (type of bill [TOB] 110) once benefits exhaust, **effective December 3, 2007.**

Background

In the IPF PPS, claims are currently paid based on the date the beneficiary is physically discharged rather than on the date benefits are exhausted. In accordance with the Social Security Act (Section1812), benefits exhaust when:

- No benefit days remain in the beneficiary's applicable benefit period, or
- The beneficiary has exhausted the 190-day lifetime limit in a psychiatric hospital.

Some psychiatric patients may have longer lengths of stays than the median length of stay of nine days, and their associated claims may cross a rate year change and would be paid at the higher rate (i.e., higher electro-convulsive therapy [ECT] rate or outlier). Final bills are not submitted until the patient is officially discharged (i.e., patient physically leaves the hospital or dies).

When benefits exhaust, TOB 117 with a patient status code of 30 (still an inpatient) are submitted. These are also known as continuation bills. Because they have not yet been discharged, psychiatric patients with long lengths of stays may not be captured on the applicable provider statistical and reimbursement (PS&R) report.

In the LTCH PPS, discharge is defined as when:

- The patient is formally released,
- The patient stops receiving Medicare covered long term care services, or
- The patient dies.

Much like IPF PPS, Medicare has been paying LTCH claims on the actual discharge date, not the benefit exhaust date (if present). Medicare will apply this policy of using the benefit exhaust date for LTCH discharge/benefit exhaust dates as of October 1, 2002.

Effective for IPF discharge/benefit exhaust date on or after December 3, 2007, (for payment purposes) an IPF discharge occurs when benefits exhaust. The claim is paid based on the benefit exhaust date rather than the discharge date.

Use of Benefit Exhaust Day as Discharge Date for Payment Purposes for IPF PPS (continued)

Note: As of the implementation date of December 3, 2007, Medicare will return claims to providers that submit claims that meet the benefit exhaust criteria without showing the correct discharge date. The providers will then have to split those claims and resubmit, adding the appropriate diagnosis and/or procedure codes based on the date of service.

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the PS&R report used the benefit exhaust date as the discharge date. This changed when the IPF PPS and LTCH PPS were implemented, and the 'actual' discharge date was used. CR 5474 redefines this policy (consistent with the previous methodology), and now **the PS&R report shall use the benefit exhaust date as the discharge date for cost reporting purposes for IPF PPS and LTCH PPS**.

This will make it easier for the PS&R report (especially during the blend period) to settle the cost report as the days stay with the year in which they occurred. This change in policy means:

- Claims will now be settled on the appropriate cost report.
- The appropriate PPS-TEFRA blend percentage will be paid.
- Patients with long lengths of stay will be counted on the correct PS&R report.
- The PRICER version used will be the one in effect at the time the services were provided.

In summary, CR 5474 instructs your FI and/or A/B MAC to:

- Use the benefit exhaust date to substitute for the discharge date on both IPF and LTCH PPS claims when present.
- Use the IPF or LTCH PPS PRICER version in effect at the time the services occurred to price claims.
- **Effective December 3, 2007,** accept and process no-pay claims (TOB 110) for IPF PPS and LTCH PPS, once benefits exhaust, instead of requiring the adjustment of claims (TOB 117) until actual discharge occurs.
- Note that TOB 117 adjustments are still required when the beneficiary has benefits and when the patient is in a noncovered level of care.

Additional Information

The official instruction, CR 5474, issued to your FI or A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1231CP.pdf*.

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

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

Source: CMS Pub. 100-04, Transmittal 1231, CR 5474

Policy and Payment Rate Changes for Long-Term Care Hospitals for 2008

On May 1, 2007, the Centers for Medicare & Medicaid Services (CMS) issued the final rule titled "Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Final Annual Payment Rate Updates, and Policy Changes; and Final Hospital Direct and Indirect Graduate Medical Education Policy Changes" (CMS-1529-F). This final rule includes proposed payment rates and policy changes for hospitals paid under the long-term care hospital (LTCH) prospective payment system (PPS) for the year 2008.

This final rule also includes a change concerning Medicare graduate medical education (GME) payments to teaching hospitals. The final rule modifies the rules concerning GME payments to teaching hospitals with respect to the time that residents spend training in nonhospital settings.

The display copy of the final rule may be viewed at *http://www.cms.hhs.gov/LongTermCareHospitalPPS/downloads/cms-1529-f.pdf*.

To view the CMS press release, click on *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2154*.

To view the CMS fact sheet, click on *http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2155*. ❖

Source: CMS Provider Education Resource 200705-04

Revision to Year 2008 Payment Rate for Long-Term Care Hospitals

On May 1, 2007, the Centers for Medicare & Medicaid Services (CMS) posted the 2008 annual payment rates for long-term care hospital prospective payment system (LTCH PPS) final rule (CMS-1529-F). This information was issued in the May 11, 2007 of the *Federal Register*.

CMS recently discovered an error in the calculation of the high cost outlier fixed-loss amount in the 2008 payment rate for LTCH PPS final rule. The high cost outlier fixed-loss amount should have been **$20,738**. CMS will publish a correction notice with the revised information in the *Federal Register* shortly. ❖

Source: CMS Provider Education Resource 200705-21

ESRD SERVICES

Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents

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, including durable medical equipment regional carriers [DMERCs] and DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], and Medicare administrative contractors [MACs]) for providing ESA administration services to Medicare end-stage renal disease (ESRD) beneficiaries.

What You Need to Know

CR 5480, from which this article is taken, instructs all providers and suppliers on the voluntary reporting of route of administration modifiers on claims for erythropoiesis stimulating agents (ESAs) for ESRD beneficiaries. Route of administration modifiers were published and effective January 1, 2007, for reporting on Medicare claims submitted **on or after February 1, 2007**, for dates of service **on or after January 1, 2007**. Please see the *Background* section for details.

Background

Current claims processing requirements do not allow you to report the method of administering ESA – such as epoetin alfa (EPO) and darbepoetin alfa (Aranesp®) – to treat your ESRD patients who are anemic. However, in order to study the efficacy of both intravenous administration and subcutaneous administration methods of ESA administration, the Centers for Medicare & Medicaid Services (CMS) will begin requesting you to voluntarily report modifiers, which will indicate the method of ESA administration.

Specifically, CR 5480, from which this article is taken, announces that, effective for claims submitted **on or after February 1, 2007,** with dates of services **on or after January 1, 2007**, all providers and suppliers who bill for administering ESA to ESRD beneficiaries (Healthcare Common Procedure Coding System (HCPCS) codes Q4081, J0882, or J0886) are encouraged to include:

- Modifier JA on the claim to indicate an intravenous administration or
- Modifier JB to indicate a subcutaneous administration.

You should be aware that in the future, this reporting of the route of ESA administration will be a requirement, and additional instructions will be issued at that time. But until then, a claim for an ESA that does not report the route of administration will not be returned to the provider, and will be paid the same as a claim that does report the route of administration. Also, be aware that renal dialysis facilities whose claims include charges for ESA administration by both methods should report them in separate lines in order to identify the number of administrations provided by each method.

Additional Information

You can find more information about route of administration codes for ESAs by going to CR 5480, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1212CP.pdf*.

As attachments to this CR, you will find updated *Medicare Claims Processing Manual* , Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 60.2.3.1 (Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents (ESAs)); and Chapter 17 (Drugs and Biologicals), Section 80.11(Requirements for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents (ESAs)).

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

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

MLN Matters Number: MM5480
Related Change Request (CR) Number: 5480
Related CR Release Date: March 30, 2007
Related CR Transmittal Number: R1212CP
Effective Date: January 1, 2007
Implementation Date: June 29, 2007

Source: CMS Pub. 100-04, Transmittal 1212, CR 5480

SKILLED NURSING FACILITY SERVICES

Invalid Skilled Nursing Facility Informational Unsolicited Responses from Medicare Common Working File System

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 [Fs] carriers, Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment regional carriers [DMERCs], DME Medicare administrative contractors [DME/MACs], and/or regional home health intermediaries [RHHIs]).

Provider Action Needed

STOP – Impact to You

Medicare systems may have inadvertently rejected outpatient, Part B, and DME claims that overlapped periods of a skilled nursing facility (SNF) stay by a beneficiary, whose Medicare SNF benefits were exhausted and for whom a nonpay SNF claim was submitted to Medicare.

CAUTION – What You Need to Know

This problem may have affected some of your claims processed by Medicare **from October 2, 2006, until January 29, 2007,** when Medicare systems were fixed.

GO – What You Need to Do

You need not take any action as your Medicare contractor will take steps to adjust any claims affected and to reverse or stop any payment recovery actions. See the *Background* section for more details.

Background

Providers need to be aware that the Centers for Medicare & Medicaid Services (CMS) has identified an issue with processing outpatient, Part B, and DME claims for beneficiaries who are in an SNF, but whose Medicare coverage for the SNF stay has ended. In October of 2006 change request (CR) 4292 (Benefits Exhaust and No-Payment for Medicare FIs and SNFs) was implemented. CR 4292 (see *Additional Information* section for the CMS website address of CR 4292) mandated that providers submit **all** SNF nonpay claims after benefits were exhausted to allow CMS to track the beneficiary's benefit period.

Medicare system changes relating to CR 4292 caused outpatient, Part B, and DME paid claims that overlap nonpay SNF claims to be rejected. **This is an error and your Medicare contractor will adjust claims or payment recovery actions resulting from this problem.** The common working file (CWF) coding change to fix this problem was effective and in production on January 29, 2007 and CWF will provide a list of claims to the applicable contractors to allow for corrections and payment to be made to providers.

Key Points

CMS has directed Medicare contractors to correct any claims that were adjusted as a result of the problem with implementation of CR 4292.

- Any providers whose claims were impacted will be paid any payment recovered to include any interest charged.
- Where the payment recovery has not occurred, the Medicare contractor will stop such action.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5587) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R274OTN.pdf*.

The *MLN Matters* article for CR 4292, *Benefits Exhaust and No-Payment for Medicare FIs and SNFs*, may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4292.pdf*.

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

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

MLN Matters Number: MM5587
Related Change Request (CR) Number: 5587
Related CR Release Date: April 27, 2007
Related CR Transmittal Number: R274OTN
Effective Date: April 27, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-20 Transmittal 274 CR 5587

Part B Paid Claims Overlapping Nonpay Skilled Nursing Facility Claims

On April 27, 2007, CMS released change request (CR) 5587 addressing the issue of Part B paid claims that overlap nonpay skilled nursing facility (SNF) claims rejecting in error. CR 5587, transmittal R274OTN, "Invalid Skilled Nursing Facility (SNF) Information Unsolicited Responses (IURs) from CWF" may be found on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R274OTN.pdf* and is being published in this publication.

CMS has commissioned the common working file (CWF) maintainer to create a program that will automatically identify the Part B claims that were erroneously rejected for the FIs, Part A MACs, MCS carriers, and DME MACs. The FISS (fiscal intermediary share system) maintainer has created an additional utility that will automatically adjust the Part B claims and reinstate the payment that was erroneously recouped. The FIs will utilize this program during the weekend of May 26 and May 27, 2007. The applicable providers will be able to view the corrected claims during the week of May 28, 2007, through June 1, 2007, and should expect payment shortly thereafter.

Regarding the Part B MCS carriers and DME MACs, these contractors will be manually adjusting these claims now that CR 5587 has been released. The applicable providers will begin seeing these claims online and should expect to receive payment immediately thereafter. Part B providers are encouraged to allow the Medicare contractors to reprocess these claims and to not resubmit or adjust them in the meantime. If there are any questions or concerns relating to the timeframes in which these claims will be reprocessed, please contact the appropriate FI, carrier, or DME MAC. ❖

Source: CMS Provider Education Resource 200705-02

CMS Proposes Increase in Medicare Payments to Nursing Homes for 2008

Medicare payments to nursing homes would increase by approximately $690 million in fiscal year 2008 under new rates proposed by the Centers for Medicare & Medicaid Services (CMS). This 3.3 percent increase would affect payment rates to nursing facilities that furnish certain skilled nursing and rehabilitation care to Medicare beneficiaries recovering from serious health problems. The proposed rule for the skilled nursing facility prospective payment system (SNF PPS) was placed on display at the *Federal Register* on April 30, 2007.

To see the CMS press release, please click on *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

To view the proposed rule, click on *http://www.cms.hhs.gov/SNFPPS/downloads/cms-1545-pdisplay.pdf*.

For further information about the SNF PPS, please click on *http://www.cms.hhs.gov/snfpps/*. ❖

Source: CMS Provider Education Resource 200705-01

Claim Submission Instructions for Institutional Providers Billing Vaccine Claims Where a National Provider Identifier Is not Available

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 8, 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 website 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

Institutional providers submiting affected claims to Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs).

Background

Regulations implementing the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require the use of national provider identifiers (NPIs) by covered health care providers and health plans (other than small plans), **effective May 23, 2007.** This article provides information about Medicare claim submissions for immunizations where the NPI of the attending physician may not be available.

Key Point

For claims received **on or after May 23, 2007,** where an NPI is not available for use in claim processing, institutions submitting vaccine roster bills to FIs or RHHIs must duplicate their own NPI in the attending physician NPI field on the claims.

Additional Information

Institutional Roster Billing – Institutions that provide covered vaccinations to groups of Medicare beneficiaries may use simplified roster billing procedures to submit a single claim form to Medicare, attaching a roster of all the beneficiaries vaccinated on a given day. Since the provider identifiers of the attending physicians of these beneficiaries are not available to the institution providing the

Claim Submission Instructions for Institutional Providers Billing Vaccine Claims Where a NPI Is not Available (continued)

immunizations, longstanding Medicare instructions require the use of the surrogate unique physician identification number (UPIN) "SLF000" in the UPIN field on the institutional claim.

For claims submitted on or after May 23, 2007, the provider's own NPI is to be reported in the NPI field for the attending physician.

The official instruction issued to your FI/RHHI regarding this change may be found by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1051CP.pdf*.

Please contact your local FI/RHHI if you have questions about this issue. To find their toll free phone number, go to the CMS website at *http://www.cms.hhs.gov/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: MM4239 – Revised
Related Change Request (CR) Number: 4239
Related CR Release Date: September 8, 2006
Related CR Transmittal Number: R1051CP
Effective Date: May 23, 2007
Implementation Date: May 23, 2007

Source: CMS Pub. 100-04, Transmittal 1051, CR 4239

ELECTRONIC DATA INTERCHANGE

Revised American National Standards Institute X12N 837 Institutional Health Care Claim Companion Document

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

Note: CMS has revised this *MLN Matters* article on May 8, 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 website 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 submitting claims to Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Impact on Providers

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

Background

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

The American National Standards Institute (ANSI) X12N 837 implementation guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. Implementation guides for each ANSI X12N transaction adopted as a HIPAA standard may be found at the following website: *http://www.wpc-edi.com*.

The ANSI X12 837 institutional companion document includes a set of statements, which supplements the requirements (but does not contradict) the X12N 837 institutional implementation guide, and it clarifies Medicare contractor (FI/RHHI/A/B MAC) expectations regarding data submission, processing, and adjudication.

Change request (CR) 5334:

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

The revised/updated ANSI X12N 837 institutional companion document will be available through your Medicare FI, A/B MAC, or RHHI.

Implementation

The implementation date for CR 5334 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your FI, RHHI, or A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1116CP.pdf*.

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

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

MLN Matters Number: MM5334 – Revised
Related Change Request (CR) Number: 5334
Related CR Release Date: November 24, 2006
Related CR Transmittal Number: R1116CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1116, CR 5334

Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims

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

Note: CMS has revised this *MLN Matters* article on May 8, 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 website 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

Institutional providers who bill Medicare fiscal intermediaries (FIs) for their services.

Provider Action Needed

STOP – Impact to You

Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a **taxonomy code** on all claims submitted to their FI.

CAUTION – What You Need to Know

Please use the attachment to CR 5243 (supplied in the *Background* section of this article) to crosswalk the OSCAR (online survey certification and reporting) system number to the appropriate taxonomy code for your type of facility. The taxonomy code will assist Medicare in crosswalking from the NPI of the provider to each of its subparts in the event that the provider chooses not to apply for a unique NPI for each of its subparts individually.

GO – What You Need to Do

Refer to the *Background* section of this article for additional crosswalk information.

Background

Regulations implementing the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 require the use of NPIs by covered health care providers and health plans (other than small plans) **effective May 23, 2007.** (45 CFR Part 162, Subpart D (162.402-162.414)

The Centers for Medicare & Medicaid Services (CMS) will use a Medicare provider identifier crosswalk between NPIs and legacy identifiers (such as OSCAR numbers) to validate NPIs received in transactions, assist with the population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. (See MM4023 at the link provided below for more information on CMS' implementation of the NPI.) The crosswalk detailed in CR 5243 between the provider's OSCAR number and the appropriate taxonomy code will assist in this process.

Attachment to CR 5243: Reporting of Taxonomy Codes (Institutional Providers)

The following chart supplies the crosswalk from the OSCAR number to the appropriate taxonomy code based on the provider's facility type.

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Short-term (general and specialty) hospitals	0001-0879 *positions 3-6 of the OSCAR number	282N00000X
Critical access hospitals	1300-1399*	282NC0060X
Long-term care hospitals (LTCH swing beds submitting with type of bill [TOB] 18x must use the LTCH taxonomy code)	2000-2299*	282E00000X
Hospital-based renal dialysis facilities	2300-2499*	261QE0700X
Independent-renal dialysis facilities	2500-2899*	261QE0700X
Rehabilitation hospitals	3025-3099*	283X00000X
Children's hospitals	3300-3399*	282NC2000X
Hospital-based satellite renal dialysis facilities	3500-3699	TOB 72x and taxonomy code of 261QE0700X and a ZIP code different than any renal dialysis facility issued an OSCAR number that is located on that hospital's campus
Psychiatric hospitals	4000-4499*	283Q00000X
Organ procurement organization (OPO)	P in third position of the OSCAR number	335U00000X

Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims (continued)

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Psychiatric unit	M or S in third Position	273R00000X
Rehabilitation unit	R or T in third Position	273Y00000X
Swing-bed unit/facility	U, W, Y, or Z in third position	TOB X8X with one of the following to show type of facility in which the swing-bed is located: 275N00000X short term hospital (U); 282E00000X long-term care hospital (W); 283X00000X rehabilitation facility (Y); or 282NC0060X critical access hospital (Z)

Be sure to follow the following billing instructions contained in CR 5243:

- Report the service facility locator loop (2310E) in an 837-I claim whenever the service was furnished at an address other than the address reported on the claim for the billing or pay-to-provider.
- Input the taxonomy code in the 837-I provider loop 2000A (billing or pay-to-provider taxonomy code).
- Submit separate batches of claims for each subpart identified by a different taxonomy code.
- Providers submitting claims for their primary facility and its subparts must submit a nine-digit ZIP code on their claims.
- Submitters of institutional claims (X12 837-I version 4010A1) that bill and are to be paid for services furnished by a subpart, **and** that **subpart does** not have a unique NPI separate from that of the main entity or another subpart, the subpart that furnished the billed care must be identified in the billing provider loop (2010AA) of the claim and the entity to be paid in the pay-to provider loop (2010AB). The taxonomy code of the subpart must also be reported in the PRV segment in the 2000A loop.
- CMS recommends submitting both the OSCAR number and the NPI on claims submitted through May 22, 2007. (Note that failure to report an OSCAR number that corresponds to your NPI could result in a payment delay.)

Implementation Date

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

Additional Information

MM4023 "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms" is located on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf*.

CR 5243 is the official instruction issued to your Medicare FI regarding changes mentioned in this article. CR 5243 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1133CP.pdf*.

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

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

MLN Matters Number: MM5243 – Revised
Related Change Request (CR) Number: 5243
Related CR Release Date: December 19, 2006
Related CR Transmittal Number: R1133CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1133, CR 5243

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

July 2007 – September 2007

Hot Topics (Topics To Be Determined)

When: **Tuesday, July 10, 2007**

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

Type of Event: **Teleconference**

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.***

What Is a Webcast?

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

Online Registration

To participate in the above educational events, 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: _____

Provider Address: _____

City, State, ZIP Code: _____

PREVENTIVE SERVICES

May Is National Osteoporosis Awareness and Prevention Month

In conjunction with this national health observance, the Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to remind health care professionals that Medicare provides coverage of **bone mass measurements** for beneficiaries at clinical risk for osteoporosis.

The facts are that one out of every two women and one in four men over 50 will have an osteoporosis-related fracture in their lifetime. Twenty percent of seniors who suffer a hip fracture die within one year.

According to the US surgeon general's 2004 report *Bone Health and Osteoporosis: A Report of the Surgeon General*, due to the aging of the population and the previous lack of focus on bone health, the number of hip fractures in the United States could double or triple by the year 2020.

The report found that many patients were not being given appropriate information about prevention, and many patients were not having appropriate testing to diagnose osteoporosis or establish osteoporosis risk. The good news is that osteoporosis is a disease that largely can be prevented and bone loss can be slowed with treatment. Medicare's bone mass measurement benefit can aid in the early detection of osteoporosis before fractures occur, provide a precursor to future fractures, and determine rate of bone loss.

What Can You Do?

National Osteoporosis Awareness and Prevention Month presents an excellent opportunity for health care professionals to promote prevention, detection, and treatment of osteoporosis.

- Become familiar with Medicare's coverage of bone mass measurements.
- Talk with your patients about their risks for osteoporosis, prevention measures they can take, and the importance of utilizing bone mass measurements.
- Encourage eligible Medicare patients to take full advantage of Medicare's bone mass measurement benefit.

As a health care professional, you play a critical role in helping your patients maintain strong, healthy bones throughout their life. Please join with CMS in spreading the word about prevention and early detection of osteoporosis and ensuring that all eligible Medicare beneficiaries take full advantage of the bone mass measurement benefit.

For More Information

- For more information about Medicare's coverage of bone mass measurements, please visit the CMS website *http://www.cms.hhs.gov/BoneMassMeasurement/*.
- U.S. Department of Health and Human Services. *Bone Health and Osteoporosis: A Report of the Surgeon General.* U.S. Department of Health and Human Services, Office of the Surgeon General, 2004. This document may be downloaded from the Department of Health and Human Services website at *http://www.hhs.gov/surgeongeneral/library/bonehealth/*.
- To learn more about National Osteoporosis Awareness and Prevention Month, please visit The National Osteoporosis Foundation website *http://www.nof.org/*.

Thanks for your help in this worthwhile endeavor!

"Osteoporosis. It's beatable. It's treatable." ❖

Source: CMS Provider Education Resource 200705-11

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May Is Healthy Vision Month

Join the Centers for Medicare & Medicaid Services (CMS) and the National Eye Institute (NEI) in promoting increased awareness of glaucoma and the glaucoma screening benefit provided by Medicare.

An estimated 2.2 million Americans have been diagnosed with primary open-angle glaucoma, the most common form of the disease. An additional 2 million Americans have glaucoma and don't even know it. Glaucoma has no warning signs and, if left untreated, may result in permanent vision loss. If glaucoma is detected early, there is treatment available to slow or stop vision loss and reduce the risk of blindness.

Medicare Coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older.

A covered glaucoma screening includes:

- Dilated eye examination with an intraocular pressure (IOP) measurement.
- Direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

What Can You Do?

As a trusted source of health care information, your patients rely on their physician's or other health care professional's recommendations. CMS needs your help to

May Is Healthy Vision Month (continued

ensure that all eligible people with Medicare take full advantage of the annual glaucoma screening benefit. Talk to your Medicare patients that are in the high-risk groups identified above about their risk for glaucoma and encourage them to get regular yearly glaucoma screening examinations.

For More Information

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

CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- The CMS website provides information for each preventive service covered by Medicare. Go to *http://www.cms.hhs.gov*, select "Medicare", scroll down to the "Prevention" heading.

For information to share with your Medicare patients, please visit *http://www.nei.nih.gov/glaucomaeducation* and *http://www.nei.nih.gov/glaucoma/*.

For more information about Healthy Vision Month, please visit *http://healthyvision2010.nei.nih.gov/hvm/*.

Help your at risk patients protect their vision. Encourage regular annual glaucoma screenings. ❖

Source: CMS Provider Education Resource 200705-06

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National Women's Health Week

The Centers for Medicare & Medicaid Services (CMS) endorses the annual observance of "National Women's Health" as a perfect opportunity to help women learn how they can live longer, better, healthier lives through the promotion of disease prevention, early detection and lifestyle modifications that support a healthier life.

Heart disease, stroke, cancer, diabetes, osteoporosis, influenza, pneumonia, and other chronic diseases have a significant impact on the health and well being of women in the US. Yet the reality is, many of these diseases can be prevented and complications can be reduced. Medicare now provides coverage for a full range of preventive services and screenings that can help women stay healthy, detect disease early and manage conditions to reduce complications. Medicare-covered preventive benefits include:

- Abdominal aortic aneurysm screening (new as of January 2007)
- Adult immunizations
  - Flu
  - Pneumococcal
  - Hepatitis B
- Cancer screenings
  - Breast (mammogram and clinical breast exam)
  - Cervical & vaginal (Pap test and pelvic exam)
  - Colorectal
- Cardiovascular screening
- Diabetes screening
- Diabetes supplies
- Diabetes self-management training
- Glaucoma screening
- Initial preventive physical exam ("Welcome to Medicare" physical exam)
- Medical nutrition therapy (beneficiaries with diabetes or renal disease)
- Smoking and tobacco-use cessation counseling

Although Medicare is now helping to pay for more preventive benefits, many women with Medicare are not yet taking full advantage of them, leaving significant gaps in prevention. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. With your help, we can begin to close the prevention gap.

How Can You Help?

As a trusted source, your recommendation is the most important factor in increasing women's use of Medicare preventive benefits. We need your help to ensure that women with Medicare are aware of these covered benefits and that they are encouraged to take advantage of the preventive services for which they may be eligible.

For Women Patients New to Medicare – When appropriate, provide the "Welcome to Medicare" physical exam**.** This one-time exam, which must be received within the first six months of a beneficiary's Medicare Part B effective date, is an excellent opportunity to orient new women patients to Medicare, assess risk factors for disease, discuss lifestyle modifications that support a healthy lifestyle and may reduce the complication of disease, and encourage utilization of preventive benefits through referral for

National Women's Health Week (continued)

appropriate services. Remember to follow up with patients on all screening results, even negative ones – every one likes to hear good news.

For Established Patients – Remember to talk with your patients about their risk for disease and the importance and value of prevention, detection, early treatment, and lifestyle modifications. Encourage appropriate utilization of preventive services for which they may be eligible, follow up on all screening results and continue to promote a prevention-oriented lifestyle.

Working together we can begin to:

- Educate women about steps they can take to prevent disease.
- Increase awareness of risk factors for developing disease while promoting prevention, early detection and treatment of disease affecting women's health.
- Prevent and reduce serious complications of disease through better disease management.
- Reduce mortality for many diseases affecting women.
- Improve women's health and quality of life.
- Ensure that women with Medicare take advantage of preventive benefits for which they may be eligible, before they become sick.
- Ultimately save health care dollars.

For More Information

For more information about Medicare-covered preventive services and screenings, including coverage, coding and billing guidelines, please visit the following CMS websites:

- For the MLN Preventive Services Educational Products web page, go to *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 Women's Health Week, please visit *http://www.4woman.gov/whw/*.

Thank you for joining with CMS to spread the message about prevention, early detection and treatment. ❖

Source: CMS Provider Education Resource 200705-18

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

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IMPORTANT ADDRESSES, TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

PROVIDER EDUCATION

Medicare Communication and Education
P. O. Box 45157
Jacksonville, FL 32232-5157

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

"DDE Startup"
Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE

Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

PART A RECONSIDERATION

Claims Denied at the Redetermination Level
MAXIMUS
QIC Part A East Project
Eastgate Square
50 Square Drive
Victor, NY 14564-1099

OVERPAYMENT COLLECTIONS

Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

MEDICARE REGISTRATION

American Diabetes Association Certificates
Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

Telephone Numbers

PROVIDERS

Customer Service Center Toll-Free
1-888-664-4112
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 Goverment Benefit Administrators – Gulf Coast
34650 US Highway 19 North, Suite 202
Palm Harbour, FL 34684-2156

RAILROAD MEDICARE

Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
Palmetto Goverment Benefit Administrators
P. O. Box 100141
Columbia, SC 29202-3141

MEDICARE A BULLETIN

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* ATTENTION BILLING MANAGER *