Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

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

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

Routing Suggestions:

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

CMS Centers for Medicare & Medicaid Services

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

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

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

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About the *Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive publication 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:

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Jacksonville, FL 32232-5270

Sign up to our *eNews* electronic mailing list

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

GENERAL INFORMATION

New HHS National Clearinghouse for Long-Term Care Information Website

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

Provider Types Affected

Physicians and providers and their staff who provide services to Medicare beneficiaries.

Provider Action Needed

This special edition article is for informational purposes and may assist providers when counseling their patients regarding long-term care. The article announces that the U.S. Department of Health & Human Services (HHS) has developed a consumer website to help beneficiaries carefully prepare a safe and secure strategy for their future healthcare needs. Resources on the new website include a long-term care planning kit and detailed information on what long term care needs are; step-by-step planning; and financial preparation. The free long-term planning kit and resources to start the planning process may be found at *http://www.longtermcare.gov*. The planning kit may also be ordered by phone by calling 1-866-PLAN-LTC (1-866-752-6582). TTY users should call 800-427-5605.

Background

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to inform you that the national clearinghouse for long-term care information is a new user-friendly consumer website that provides in-depth objective information on understanding, planning, and paying for long-term care. This important website is a collaborative effort between the Administration on Aging (AoA), the Centers for Medicare & Medicaid Services (CMS), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and it was developed as part of the Deficit Reduction Act (DRA) of 2005 (Section 6021 (d)) which allocated funds to the U.S. Department of Health and Human Services (HHS) to help Americans take an active role in planning for their future.

Located at *http://www.longtermcare.gov*, the clearinghouse website features information and tools to help people better understand the risks for and the costs of long-term care, and it is part of ongoing efforts to increase public awareness about the importance of advance planning for future long-term care needs. Given that one of the biggest barriers to planning is misinformation about long-term care, the clearinghouse website is designed to provide people with the trusted information and resources they need to take an active role in planning for possible future health care needs.

With an emphasis on the importance of future planning, the website provides a number of resources and interactive tools to help people prepare for their future healthcare needs including:

- Objective information on **specific long-term care planning options**, including the pros and cons of private financing options such as personal savings, long-term care insurance, reverse mortgages, and other options.
- In-depth information on the **availability and limitations of Medicaid** in all states, including eligibility and estate recovery requirements.
- **State-specific long-term care insurance partnership programs** under Medicaid.
- **Planning resources** that include an interactive savings calculator, information on the costs of care across the United States, and examples illustrating how individuals have planned successfully.
- **State and national contact information** for a range of long-term care programs and planning services.

The website also includes the long-term care planning kit, initially developed for the "Own Your Future" Campaign. Information regarding this campaign is in *MLN Matters* article SE0671, located on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0671.pdf*.

A survey showed that consumers who received the long-term care planning kit were twice as likely to take some type of planning action, including evaluating their existing coverage, talking to a financial planner, buying long-term care insurance, or considering a reverse mortgage, as those who did not receive the planning kit. The planning kit may be ordered or downloaded on the clearinghouse website at *http://www.longtermcare.gov*, as well as calling 1-866-PLAN-LTC. It may also be ordered or downloaded at *http://www.aoa.gov/ownyourfuture*.

Additional Information

For more information about the "Own Your Future" campaign and the national clearinghouse for long-term care information, please visit *http://www.longtermcare.gov*.

MLN Matters Number: SE0680
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0680

Rules of Behavior Governing Medicare Eligibility Inquiries

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

Provider Types Affected

All providers and suppliers, including their third party billing agents or clearinghouses, who submit eligibility inquiries to Medicare.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. If you, or your biller, do not adhere to these rules of behavior and/or other CMS data privacy and security rules, you could incur revocation of access to the data as well as other penalties.

CAUTION – What You Need to Know

CR 5431, from which this article is taken, restates your responsibilities in obtaining, disseminating, and using beneficiary's Medicare eligibility data; and also delineates CMS' expectations for provider and clearinghouse use of the HIPAA 270/271 Extranet application.

GO – What You Need to Do

Read the key points from CR 5431 in the Background section, below, and make sure that your staffs read the manual section (*Medicare Claims Processing Manual* (100-04), Chapter 31 (ANSI X12N Formats Other than Claims or Remittance), Section 10.3 (Eligibility Rules of Behavior), attached to CR 5431. (See Additional Information, below, for instructions in locating CR 5431.)

Background

Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

CR 5431, upon which this article is based, restates your responsibilities in obtaining, disseminating, and using beneficiary's Medicare eligibility data; and outlines CMS' expectations for providers and clearinghouses who use the HIPAA 270/271 Extranet application.

In October 2005, CMS began offering to Medicare providers and clearinghouses, the HIPAA 270/271 beneficiary eligibility transaction, real-time, via the CMS AT&T communication Extranet; and in June 2006, began to pilot an Internet application for eligibility information. Over time, this application will be available to an increasing number of Medicare providers.

Please keep in mind that the Medicare Electronic Data Interchange (EDI) enrollment process (which collects the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners, and establishes the data exchange expectations for both), must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party (a billing agent or clearinghouse).

First, here are the key points, from the CR, that address your responsibilities in dealing with beneficiary eligibility data.

- The HIPAA privacy rule mandates the protection and privacy of all health information, and specifically defines the authorized uses and disclosures of "individually-identifiable" health information. CMS is committed to maintaining the integrity and security of health care data in accordance with the applicable laws and regulations.
- You should always remember that Medicare eligibility data is to be used for Medicare business only, and that providers and their staffs are expected to use, and disclose, this protected health information according to the CMS regulations.
- Authorized purposes for requesting beneficiary Medicare eligibility information include:
  - To verify eligibility, after screening the patient to determine Medicare Part A or Part B eligibility.
  - To determine beneficiary payment responsibility with regard to deductible/co-insurance.
  - To determine eligibility for services such as preventive services.
  - To determine if Medicare is the primary or secondary payer.
  - To determine if the beneficiary is in the original Medicare plan, Part C plan (Medicare Advantage) or Part D plan.
  - To determine proper billing.

Conversely, examples of unauthorized purposes for requesting beneficiary Medicare eligibility information include:

- To determine eligibility for Medicare without screening the patient to determine if they are Medicare eligible; or
- To acquire the beneficiary's health insurance claim number.

In dealing with Medicare beneficiary eligibility information, you and your employees/staff must:

- Ensure sufficient security measures exist to associate a particular transaction with a particular staff member or employee before requesting the information;
- Cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry;
- Promptly inform CMS or one of CMS's contractors (e.g., your carrier, fiscal intermediary (FI), or Part A/B Medicare administrative contractor [A/B MAC]) if you identify misuse of "individually-identifiable" health information accessed from the CMS database; and
- Limit each inquiry for Medicare beneficiary eligibility data to that for a patient that you are currently treating/serving, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

Rules of Behavior Governing Medicare Eligibility Inquiries (continued)

Penalties

- HHS may impose civil money penalties on a HIPAA-covered entity of $100 per failure to comply with a Privacy Rule requirement (not to exceed $25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year).
- Further, a person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA or a trading partner agreement under 42 U.S.C 1320d-6 faces a fine of $50,000 and up to one-year imprisonment (increasing to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm).
- Under the False Claims Act, anyone who knowingly submits, or causes another person or entity to submit, false claims for payment of government funds is liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

CR 5431 also discusses CMS' expectations for providers and clearinghouses that use the HIPAA 270/271 Extranet application. A synopsis of this discussion follows.

For Providers

In order to access and use this system, you will need to 1) Register, on line, in IACS (individual authorized access to CMS computer services) and provide your social security number and e-mail address so that the system can identify you and communicate with you through email, if necessary; and 2) Adhere to basic desktop security measures and to the CMS computer systems security requirements in order to ensure the security of Medicare beneficiary personal health information.

You will also be required to adhere to the security requirements for users of CMS computer systems and to the basic desktop security measures to ensure the security of Medicare beneficiary personal health information. You must not:

- Disclose or lend your identification number and/or password to someone else. They are for your use only and serve as your electronic signature. This means that you may be held responsible for the consequences of unauthorized or illegal transactions.
- Browse or use CMS data files for unauthorized or illegal purposes.
- Use CMS data files for private gain or to misrepresent yourself or CMS.
- Make any disclosure of CMS data that is not specifically authorized.

As mentioned earlier, violation of these security requirements could result in termination of system access privileges and /or disciplinary/adverse action up to and including legal prosecution.

For Clearinghouses

CMS allows the release of eligibility data to third parties (providers' authorized billing agents or clearing-houses) for the purpose of preparing an accurate Medicare claim or determining eligibility for specific services.

In order to receive such access on behalf of providers, billing agents/clearinghouses must adhere to the following rules:

- Such entities may not submit an eligibility inquiry except as a health care provider's authorized, and through a business associate contract with the provider.
- Each provider that contracts with a billing agent/clearinghouse must sign a valid EDI enrollment form and be approved by a Medicare contractor before eligibility data can be sent to the third party.
- Each billing agent/clearinghouse must sign appropriate agreement(s) (i.e. Rules of Behavior, Trading Partner Agreement and Attestation Form) directly with CMS and/or one of CMS's contractors.
- The billing agent/clearinghouse must be able to associate each inquiry with the provider or billing service making the inquiry.

Additional Information

You can find more information about the rules of behavior with respect to obtaining, disseminating, and using beneficiary's Medicare eligibility data by going to CR 5431, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1149CP.pdf* and reading the attached *Medicare Claims Processing Manual* (100-04), Chapter 31 (ANSI X12N Formats Other than Claims or Remittance), Section 10.3(Eligibility Rules of Behavior).

If you have any questions, please contact your carrier, fiscal intermediary (FI), regional home health intermediary (RHHI), A/B MAC, durable medical equipment regional carrier (DMERC) or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: MM5431
Related Change Request (CR) Number: 5431
Related CR Release Date: January 5, 2007
Related CR Transmittal Number: R1149CP
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1149, CR 5431

Annual Medicare Contractor Provider Satisfaction Survey: Make Your Voice Heard!

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

Provider Types Affected

All Medicare fee-for-service (FFS) providers, especially those receiving the 2007 Medicare Contractor Provider Satisfaction Survey.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this special edition (SE) article to alert providers that in early January 2007 CMS has disseminated the 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS) to a new sample of Medicare providers. If you receive the survey, CMS encourages you to respond because your input is **needed** and will be used to support claim-processing improvement by Medicare FFS contractors and to reform the Medicare program.

Background

The 2007 MPCSS survey is designed so that it **can be completed in about 15 minutes** and providers can submit their responses via a secure website, mail, fax, or over the telephone. CMS is asking providers to respond by February 2007.

The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location.

The MCPSS focuses on seven major aspects of the provider-contractor relationship:

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

Respondents are asked to rate their experience working with Medicare FFS contractors using a scale of 1 to 6, with "1" representing "not at all satisfied" and "6" representing "completely satisfied."

Additional Information

More information about the MCPSS and results of the 2006 survey are available at on the CMS website *http://www.cms.hhs.gov/MCPSS/*.

MLN Matters Number: SE0702
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 SE0702

Flu Shot Reminder

It's Not Too Late to Get the Flu Shot.

We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. Re-vaccination is necessary each year because the flu viruses change each year. Encourage your Medicare patients who haven't already done so to get their annual flu shot and don't forget to immunize yourself and your staff.

Protect yourself, your patients, and your family and friends. Get Your Flu Shot. It's Not Too Late!

Remember: Influenza vaccination is a covered Medicare Part B benefit. Note that influenza vaccine is not a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pd*. ❖

Source: CMS Provider Education Resource 200607-01

Medicare Physician Fee Schedule Fact Sheet now Available

The *Medicare Physician Fee Schedule Fact Sheet*, which provides general information about the Medicare physician fee schedule, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*.

Print versions of the fact sheet will be available in approximately six weeks. ❖

Source: CMS Provider Education Resource 200701-07

Emergency Update to the 2007 Medicare Physician Fee Schedule Database

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

Note: CMS has revised this *MLN Matters* article on January 12, 2007, to reflect changes made to change request (CR) 5459. The CR release date and transmittal number have been changed and the Web address for accessing CR 5459 has been revised. All other information remains the same. The original *MLN Matters* article was published in the January 2007 *Medicare A Bulletin* (page 7-8).

Provider Types Affected

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

Background

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

Key Points

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

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

- The physician fee schedule status indicators for oncology demonstration HCPCS codes G9050 to G9062 for 2007 are "I"; these codes are invalid for Medicare use in 2007, thus, payment will not be made for these codes in 2007. (For more details on the oncology demonstration, see the *MLN Matters* article on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf*.)
- Oncology demonstration HCPCS codes G9076, G9081, G9082, G9118, G9119, G9120, G9121, G9122, and G9127 are **deleted and will not be paid for services provided after December 31, 2006 in 2007.**
- Active oncology demonstration codes in the range G9063 to G9139 have status indicators of "M" on the Medicare physician fee schedule database. (Note: See requirement above for discontinued oncology demonstration codes within this range). Those filing claims may report these codes for oncology disease status in 2007, but payment will not be made for these codes for services provided after December 31, 2006.
- Category II codes *3047F* and *3076F* and category III code *0152T* have been deleted for 2007.
- HCPCS G codes G0377 and G8348 through G8368 will be added to the 2007 HCPCS file.
- HCPCS Q codes Q4083, Q 4084, Q4085, and Q4086 will be added, even though they are not on the 2007 HCPCS file. Note that corresponding average sale price (ASP) amounts will be reflected in updated 2007 ASP files to be posted to the CMS website.
- Incorrect diagnostic supervision indicators were assigned to some codes and these codes and correct indicators are listed in the attachment to CR 5459.
- Corrected multiple procedure codes of 0 and diagnostic family imaging indicators of 99 have been assigned to codes HCPCS codes G0389, G0389-TC, and *CPT* codes *70554, 70554-TC, 70555, 70555-TC, 76776,* and *76776-TC.*
- As identified in the attachment to CR 5459, correct work, practice expense, and/or malpractice relative value units (RVUs) have been assigned for *CPT* codes *44180, 44186, 73223, 73223-26, 76775, 76775-TC, 76775-26, 93503, 93539, 93540, 93541, 93542, 93543, 93544, 93545, 95060, 95065,* and HCPCS codes G0389, G0389-TC, and G0389-26.
- As a result of the Tax Relief and Health Care Act of 2006, effective January 1, 2007, HCPCS code G0377 (Administration of vaccine for Part D drug) is added to the MPFS with a status indicator of X. Payment for HCPCS code G0377 is linked to *CPT* code *90471* (just as payment is made for G0008, G0009, and G0010). For 2007 only, the legislation provides for Part B to pay for the administration of a covered Part D vaccine. When a physician administers a Part D vaccine, the physician should use HCPCS code G0377 to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to this administration. Payment for Part D covered vaccines is made solely by the participating prescription drug plan. Medicare will not pay for the vaccine itself.
- Effective January 1, 2007, the following HCPCS G codes are added to the MPFS database with a status indicator of M: G8348, G8349, G8350, G8351, G8352, G8353, G8354, G8355, G8356, G8357, G9358, G8359, G8360, G8361, G8362, G8363, G8364, G8365, G8366, G8367, and G8368.
- CMS has established separate payment for sodium hyaluronate products that have come on the market since October 2003. Four interim Q codes are in effect for these products as of January 1, 2007:

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

- Procedure status I is assigned to J7319, **effective January 1, 2007.**
- **Effective January 1, 2007,** the HCPCS codes Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, and Q9964 will be assigned to procedure status indicator E.

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

- As a courtesy to the public, CMS has established RVUs for a number of codes, even though the codes are either bundled or not valid for Medicare purposes. These *CPT* codes are *38204, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, and 38215*. The RVUs are listed for these codes in the attachment to CR 5459.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5459) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf*.

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

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

MLN Matters Number: MM5459 – Revised
Related Change Request (CR) Number: 5459
Related CR Release Date: January 11, 2007
Related CR Transmittal Number: R1152CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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

NATIONAL PROVIDER IDENTIFIER

Medicare Fee-for-Service Implementation of the National Provider Identifier

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

Provider Types Affected

All Medicare fee-for-service (FFS) providers who bill Medicare.

Background

The Centers for Medicare & Medicaid Services (CMS) is publishing this special edition (SE) article to remind providers that **on May 23, 2007,** the national provider identifier (NPI) will replace health care provider identifiers that are in use today in HIPAA standard transactions. Health care providers should remember that getting an NPI is free and easy. **Time is running out!** It is estimated that, once a provider obtains an NPI, it may take up to 120 days to implement the NPI in current business practices. The following key points will assist Medicare providers as they transition from the application stage to the implementation stage to ensure NPI readiness.

Applying for an NPI

Visit the official CMS source for NPI-related information, including how to apply for an NPI, as well as free educational products, on the CMS website at *http://www.cms.hhs.gov/NationalProvIdentStand/*.

Key Points

The following are the critical content areas for the Medicare FFS health plan implementation of the NPI.

Medicare Legacy Numbers

After the compliance date, Medicare providers must begin submitting their NPIs instead of their Medicare legacy identifiers on claims they send to Medicare. A provider's taxpayer identification number (TIN), which is the provider's social security number or employer identification number, will continue to be used when a provider needs to be identified as a taxpayer in HIPAA standard transactions. The implementation guides for each of the standard transactions indicate when it is necessary to identify a provider as a taxpayer.

- A related *MLN Matters* article, MM4023, may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf*.

Electronic File Interchange

Health industry organizations that are approved by CMS as electronic file interchange organizations (EFIOs) can submit NPI application data for health care providers, including Medicare providers, in electronic files to the National Plan and Provider Enumeration System (NPPES) after obtaining the permission of the health care providers to do so. This process is called electronic file interchange (EFI). For health care providers who are approached by (EFIOs), EFI is an alternative to having to apply for their NPIs via the Web-based or paper application process. Providers who are enumerated via EFI, receive their NPI notifications from the EFIO that had them enumerated. These notifications are not generated from national plan and provider enumeration system (NPPES).

Designation of Subparts

CMS reminds Medicare providers to visit Medicare's subparts expectation paper (entitled, "Medicare Expectations on Determination of Subparts by Medicare Organiza-

Medicare Fee-for-Service Implementation of the National Provider Identifier (continued)

tion Health Care Providers Who Are Covered Entities Under HIPAA," and located at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf* on the CMS NPI Web page) for suggestions on how to determine their subparts.

Remember: No health plan, not even Medicare, can instruct a provider on how to enumerate subparts. This is a business decision that the organization provider must make considering its unique business operations.

Durable Medical Equipment Enumeration Requirement

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

Submitting your NPI on Medicare Electronic Claims

Until further notice, CMS recommends that Medicare providers submit claims using both the NPI and legacy number. Claims submitted with **only an NPI** may be rejected/returned as unprocessable if Medicare systems are unable to properly match the incoming NPI with a legacy number. The provider will then need to resubmit the claim with the appropriate legacy number.

A related *MLN Matters* article, MM5378, may be viewed on the CMS website at *http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm5378.pdf*.

Required Use of the NPI on Medicare Paper Claims

Medicare, as a health plan, will require the use of the NPI on its paper claims. The paper claim forms used by Medicare have been revised to accommodate use of the NPI. There will be transition periods for each of the revised forms. While the NPI cannot be used on the current paper claim forms, providers may begin using the NPI on the revised forms once the transition period for each form begins.

- The *MLN Matters* article related the transition from UB-92 to UB 04 may be viewed on the CMS website at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf*.
- The *MLN Matters* article related to the transition from CMS 1500 (12/90) to CMS 1500 (08/05) may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf*.

Required Use of Taxonomy Codes on Intuitional Provider Claims

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

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

National Council of Prescription Drug Plan Claims

The National Council of Prescription Drug Plan (NCPDP) format was designed to permit a prescription drug claim to be submitted with either an NPI or a legacy identifier, but no more than one identifier may be reported for a provider (retail pharmacy or prescribing physician) per claim. From October 1, 2006, through May 22, 2007, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have this information). (Refer to *MLN Matters* article MM4023 at the link provided earlier in this article.)

Medicare Remittance Advice Print Software

The 835-PC-print and Medicare remit easy print software were modified to enable either the NPI or a Medicare legacy number, or both, if included in the 835. (Refer to *MLN Matters* article MM4023.)

Communicating Your NPI to Medicare

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

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, all providers, including Medicare providers, that are HIPAA covered providers **must** share their NPI with other providers, health plans, clearinghouses, and any entity that may need those NPIs for use in standard transactions, including the need to identify an ordering or a referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their NPIs for them.

Additional Information

NPI Questions

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

Medicare Fee-for-Service Implementation of the National Provider Identifier (continued)

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

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

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

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

MLN Matters Number: SE0679
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 SE0679

National Provider Identifier—Time is Running Out

NPI: Get It. Share It. Use It.

Failure to prepare could result in a disruption in cash flow. Will you be ready to use your NPI? Time is running out!

To date, over 1.6 million providers have obtained a national provider identifier (NPI). Now, less than 120 days are left to implement the NPI into business practices prior to the compliance date. A recent survey of the health care industry, conducted by the Workgroup for Electronic Data Interchange (WEDI), indicates that providers should have already obtained an NPI and be focusing on implementation and testing with health plans and clearinghouses. If you have not obtained your NPI by now you should do so **immediately** so that you can begin the implementation and testing process

Reminder to Supply Legacy Identifiers on NPI Application

The Centers for Medicare & Medicaid Services (CMS) continues to urge providers to include legacy identifiers, as well as associated provider identifier type(s), on their NPI applications. **This will help all health plans, including Medicare, to get ready for May 23, 2007.** If reporting a Medicaid legacy number, include the associated state name. If providers have already been assigned an NPIs, CMS asks them to go back into the NPPES and update their information with their legacy identifiers if they did not include those identifiers when they applied for NPIs. Providers should make sure that these legacy identifiers are the ones used to bill for services and should be sure that the NPPES is updated with this information for all health plans. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

MLN Matters Article Available

A special edition *MLN Matters* article is posted on the CMS website with important implementation information for Medicare providers, as well as information that may be helpful for all health care providers. You may view this article by visiting the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf*.

Upcoming WEDI Events

WEDI will host the WEDI NPI Industry Forum on February 12, 2007, an audio-cast on the impact of the NPI on standard transactions on February 28, 2007, as well as a question and answer session on March 21, 2007. Visit the WEDI website for more details at *http://www.wedi.org/npioi/index.shtml*.

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

Still Confused?

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

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

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

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

Source: CMS Provider Education Resource 200701-11

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.

GENERAL COVERAGE

Intracranial Percutaneous Transluminal Angioplasty with Stenting

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

Provider Types Affected

Physicians and providers who may wish to submit claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for percutaneous transluminal angioplasty (PTA) stenting.

Provider Action Needed

Be aware that The Centers for Medicare & Medicaid Services (CMS) has reviewed the evidence and determined that, effective for discharges on or after November 6, 2006, Medicare will cover PTA with stenting of intracranial arteries for treatment of cerebral artery stenosis ≥ 50 percent in patients with intracranial atherosclerotic disease when furnished in accordance with Food and Drug Administration (FDA)-approved protocols governing category B investigational device exemption (IDE) clinical trials. Payment for intracranial PTA with stenting is considered reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act under these circumstances. All other indications for intracranial PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries remain noncovered.

Background

This article and related change request (CR) 5432 communicate the findings and revised national coverage determination (NCD) resulting from analysis to determine if Medicare should cover PTA. In the past, PTA to treat obstructive lesions of the cerebral arteries was noncovered by Medicare because the safety and efficacy of the procedure had not been established. This NCD meant that the procedure was also noncovered for beneficiaries participating in FDA-approved IDE clinical trials. On February 9, 2006, a request for reconsideration of this NCD initiated a national coverage analysis.

Key Points

- Effective November 6, 2006, Medicare covers PTA and stenting of intracranial arteries for the treatment of cerebral artery stenosis ≥ 50 percent in patients with intracranial atherosclerotic disease when furnished in accordance with the FDA-approved protocols governing category B IDE clinical trials. CMS determined that coverage of intracranial PTA and stenting is reasonable and necessary under these circumstances.
- Providers billing FIs and A/B MACs should note this coverage applies to claims with:
  - A discharge date on or after November 6, 2006
  - ICD-9-CM procedure codes of 00.62 and 00.65 both being present
  - ICD-9CM diagnosis code 437.0 present
  - The IDE number present on a 0624 revenue code line.
- Noninstitutional providers billing Medicare carriers or A/B MACs should note this coverage applies to claims with:
  - *CPT* code *37799* (*Unlisted procedure, vascular surgery*)
  - Modifier **QA** to denote category B IDE clinical trial
  - The appropriate IDE number.
- All other indications for PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries remain noncovered. The safety and efficacy of these procedures are not established.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5432) issued to your Medicare carrier, FI or A/B MAC. That instruction is contained in two transmittals. The first transmittal is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1147CP.pdf* and it contains the revised portions of the *Medicare Claims Processing Manual*. The second transmittal contains the national coverage determination and it is available at *http://www.cms.hhs.gov/Transmittals/downloads/R64NCD.pdf*.

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

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

MLN Matters Number: MM5432
Related Change Request (CR) Number: 5432
Related CR Release Date: January 5, 2007
Related CR Transmittal Number: R64NCD and R1147CP
Effective Date: November 6, 2006
Implementation Date: February 5, 2007

Source: CMS Pub. 100-04, Transmittal 1147, CR 5432

HOSPITAL SERVICES

Full Recovery Audit Contractor Inpatient Denials

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 306) directs the Secretary of the U.S. Department of Health & Human Services (HHS) to demonstrate the use of recovery audit contractors (RACs) under the Medicare Integrity program in:

- **Identifying** underpayments and overpayments.
- **Recouping** overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

In some cases the RAC will request and review medical records, and will make a determination based on the Centers for Medicare & Medicaid Services (CMS) guidelines of medical necessity.

This instruction is only in relation to claims in which medical records were reviewed for hospital inpatient cases type of bill (TOB) 11x. These cases were audited by the RAC and were determined that the services provided while the patient was admitted did not support admission into an inpatient stay. CMS is providing instructions to providers on how to re-bill for ancillary services (TOB 12x) provided to the beneficiary when timely filing is a factor.

Some of the claims reviewed by the RAC have passed the timely filing requirements. In order for the provider to re-bill the claim for ancillary charges only, specific justification remarks shall be listed on the claim and shall only be used for this specific reason.

Action Required by Affected Providers

Remarks **must include the document control number (DCN)** of the denied inpatient claim that coincides with the re-billed ancillary claim. If these remarks are not on the claim it will reject for timely filing.

The following remarks are required on the claim for timely filing to be overridden by the fiscal intermediary:

Justify: Recovery Audit Contractor (RAC) Involvement. Inpatient-take back. Re-bill of ancillary charges. Refer to (Input DCN number of denied inpatient claim).

What Will Happen Next

Once the appropriate remarks are reviewed by the FI, the ancillary claim will be overridden for processing.

Once processed, the provider **shall refund any excess funds collected from the beneficiary.** This could include the inpatient deductible or a coinsurance amount. Providers shall not collect any additional coinsurance from the beneficiary.

Providers should not re-bill for the ancillary services if the provider is appealing the RAC determination. Providers should wait until they have completed the appeal process before submitting the re-bill for the ancillary services. If the provider is not appealing the RAC determination, the provider should re-bill for the ancillary services once the inpatient claim has been adjusted. ❖

Source: CMS Joint Signature Memorandum 07165, December 28, 2006

Acute Inpatient Prospective Payment System Fact Sheet now Available

The *Acute Inpatient Prospective Payment System Fact Sheet* that provides general information about the acute inpatient prospective payment system, diagnosis related groups, and acute inpatient care is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf*.

Print versions of the fact sheet will be available in approximately six weeks. ❖

Source: CMS Provider Education Resource 200701-06

Sign up to our *eNews* electronic mailing list

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

CRITICAL ACCESS HOSPITAL SERVICES

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

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

Note: CMS has revised this *MLN Matters* article on January 10, 2007, to reflect changes made to change request (CR) 5437. CMS has removed *CPT*/HCPCS codes *77051, 77052, 77055, 77056, 77057,* A4461, and A4463, were removed from the nonreportable list. The CR release date and transmittal number have been changed and the Web address for accessing CR 5437 has been revised. All other information remains the same. The original *MLN Matters* article was published in the January 2007 *Medicare A Bulletin* (page 46).

Provider Types Affected

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

Provider Action Needed

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

Background

The non-OPPS OCE has been updated with numerous new additions, changes, and deletions to Healthcare Common Procedure Coding System/*Current Procedural Terminology* (HCPCS/*CPT*) codes. Rather than duplicate all the additions, deletions and changes in this article, the Centers for Medicare & Medicaid Services directs you to CR 5437, which contains the lengthy lists of these items.

CR 5437 is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1150CP.pdf*.

Additional Information

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

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

MLN Matters Number: MM5437 – Revised
Related Change Request (CR) Number: 5437
Related CR Release Date: January 10, 2007
Related CR Transmittal Number: R1150CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1150, CR 5437

ESRD SERVICES

2007 Pricing Update for Blood and Blood Related Services

Blood and blood related services provided to end-stage renal disease patients in an independent dialysis facility may be paid in addition to the composite rate. Payment is made at the lower of the actual charge on the bill or a reasonable charge that the fiscal intermediary (FI) determines annually. In establishing the reasonable charge, the FI considers price lists of independent blood banks as well as the carrier's allowable charges where available. For additional information, see CMS Internet-Only-Manual Pub. 100-04, *Medicare Claim Processing*, Chapter 8, Section 60.3.

Blood and blood related services are billed to Medicare Part A on a type of bill 72x, using claim Form CMS-1450 or its electronic equivalent.

The following 2007 fees are effective for blood and blood related services provided **on and after January 1, 2007 through December 1, 2007.** Providers may use this pricing update to reconcile Medicare payments for applicable services provided **on and after January 1, 2007.**

Blood Product Services

Description	HCPCS Code	Revenue Code	2007 Fee
Blood (whole), for transfusion, per unit*	P9010	382/39x	$167.74
Blood, split unit*	P9011	382/39x	$85.89
Cryoprecipitate, each unit	P9012	387/39x	$54.32
Red blood cells, leukocytes reduced, each unit*	P9016	385/39x	$177.27
Fresh frozen plasma, (single donor), frozen within 8 hours of collection, each unit	P9017	383/39x	$70.37
Platelets, each unit	P9019	384/39x	$98.13
Platelet rich plasma, each unit	P9020	384/39x	$44.85
Red blood cells, each unit*	P9021	381/39x	$144.22
Red blood cells, washed, each unit*	P9022	380/39x	$217.72
Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	P9023	383/39x	$62.58
Platelets, leukocytes reduced, each unit	P9031	384/39x	$179.92
Platelets, irradiated, each unit	P9032	384/39x	$97.19
Platelets, leukocytes reduced, irradiated, each unit	P9033	384/39x	$131.76
Platelets, pheresis, each unit	P9034	384/39x	$551.96
Platelets, pheresis, leukocytes reduced, each unit	P9035	384/39x	$514.71
Platelets, pheresis, irradiated, each unit	P9036	384/39x	$631.96
Platelets, pheresis, leukocytes reduced, irradiated, each unit	P9037	384/39x	$577.42
Red blood cells, irradiated each unit*	P9038	381/39x	$195.98
Red blood cells, deglycerolized, each unit*	P9039	381/39x	$337.79
Red blood cells, leukocytes reduced, irradiated, each unit*	P9040	381/39x	$240.57
Plasma, cryoprecipitate reduced, each unit	P9044	383/39x	$54.67
Granulocytes, pheresis, each unit	P9050	386/39x	$842.48
Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit*	P9051	381/382/39x	$213.07
Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit*	P9052	384/39x	$826.83
Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit	P9053	384/39x	$626.52
Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit*	P9054	381/382/39x	$281.61
Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit	P9055	384/39x	$552.78
Whole blood, leukocytes reduced, irradiated, each unit*	P9056	382/39x	$248.76
Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, (each unit)*	P9057	381/39x	$377.36
Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit*	P9058	381/39x	$278.83
Fresh frozen plasma between 8-24 hours of collection, each unit	P9059	383/39x	$48.16
Fresh frozen plasma, donor retested, each unit	P9060	383/39x	$58.80

***Blood deductible applied**

2007 Pricing Update for Blood and Blood Related Services (continued)

Transfusion Medicine Services

Description	*CPT*/HCPCS Code	Revenue Code	2007 Fee
Antibody screen, RBC, each serum technique	*86850*	390	$45.86
Antibody elution, (RBC), each elution	*86860*	390	$62.37
Antibody identification, RBC antibodies, each panel for each serum technique	*86870*	390	$113.00
Antihuman globulin test, (Coombs test); direct, each antiserum	*86880*	390	$33.62
indirect, qualitative, each antiserum	*86885*	390	$32.53
indirect, titer, each antiserum	*86886*	390	$65.67
Autologous blood or component, collection processing and storage, predeposited	*86890*	390	$146.68
intra-or postoperative salvage	*86891*	390	Billed Charge
Blood typing; ABO	*86900*	390	$25.15
Rh (D)	*86901*	390	$24.83
antigen screening for compatible blood unit using reagent serum, per unit screened	*86903*	390	$47.93
antigen screening for compatible unit using patient serum, per unit screened	*86904*	390	$27.52
RBC antigens, other than ABO or Rh (D), each	*86905*	390	$52.95
Rh phenotyping, complete	*86906*	390	$169.23
Compatibility test each unit, Immediate spin technique	*86920*	390	$66.76
incubation technique	*86921*	390	$69.02
antiglobulin technique	*86922*	390	$73.27
electronic	*86923*	390	$58.23
Fresh frozen plasma, thawing, each unit	*86927*	390	$34.03
Frozen blood, each unit, freezing (includes preparation)	*86930*	390	$221.74
thawing	*86931*	390	$84.62
freezing (includes preparation) and thawing	*86932*	390	$147.06
Irradiation of blood product, each unit	*86945*	390	$63.15
Leukocyte transfusion	*86950*	390	$29.20
Volume reduction of blood or blood product (eg, red blood cells or platelets), each unit	*86960*	390	$177.39
Pooling of platelets or other blood products	*86965*	390	$42.15
Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing, incubation with chemical agents or drugs, each	*86970*	390	$75.88
incubation with enzymes, each	*86971*	390	$86.22
by density gradient separation	*86972*	390	$140.81
Pretreatment of serum for use in RBC antibody identification, incubation with drugs, each	*86975*	390	$212.43
by dilution	*86976*	390	$112.12
incubation with inhibitors, each	*86977*	390	$212.43
by differential red cell absorption using patient RBCs or RBCs of known phenotype, each absorption	*86978*	390	$145.24
Splitting of blood or blood products, each unit	*86985*	390	$32.30
Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g. T cells, metastatic, carcinoma)	G0267	386	$919.93

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

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

AJ9000: Antineoplastic Drugs—Addition to the LCD

The local coverage determination (LCD) for antineoplastic drugs was last updated on January 18, 2007. Since that time, a revision was made to add additional off-label indication and ICD-9-CM code range for irinotecan (J9206), based on *The United States Pharmacopeia Drug Information (USP DI).*

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the following off-label indication was added to irinotecan (J9206):

- Treatment of epithelial ovarian cancer for platinum-resistant or platinum-refractory patients.

Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, the following diagnosis range was added to irinotecan (J9206):

183.0-183.9 Malignant neoplasm of ovary and other uterine adnexa

Effective Dates

This revision is effective for claims processed **on or after January 25, 2007,** for services provided **on or after November 30, 2006**, for HCPCS code J9206.

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

AJ9041: Bortezomib (Velcade®)—Revision to the LCD

The local coverage determination (LCD) for bortezomib (Velcade®) had an original effective date of January 1, 2006. Since that time, the following revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD:

- Added approved Food and Drug Administration (FDA) indication for treatment of patients with mantle cell lymphoma who have received at least one prior therapy.
- Removed off-label treatment of relapsed or refractory B-cell non-Hodgkin's lymphoma for mantle cell lymphoma.
- Added off-label indication of induction therapy for multiple myeloma patients in combination with one or more drugs.

Effective Dates

This revision is effective for services provided **on or after December 8, 2006.**

The full text for this LCD (L21631) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ATHERSVCS: Therapy and Rehabilitation Services—Revision to the LCD

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on December 9, 2006. Since that time the LCD has been revised. The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5478, dated December 29, 2006, for outpatient therapy cap exception process for calendar year 2007. Based on instructions found in this CR, the LCD was revised to remove language pertaining to the Manual Process Exceptions. In addition, the "Documentation Requirements" section of the LCD was updated based on the revised language found in the *Medicare Benefit Policy Manual*, Pub 100-2, Chapter 15, Section 220-230.

This revision will be effective for claims processed **on or after January 16, 2007** for services provided **on or after January 1, 2007**.

In addition to the above revision, this LCD was also revised based on instructions issued in CMS CR 5421, dated December 15, 2006. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add national noncoverage language issued with this CR for infrared therapy devices. This noncoverage language pertains to *CPT* code *97026*.

The "ICD-9 Codes that **Do Not** Support Medical Necessity" section of the LCD was revised to include the ICD-9-CM codes issued as noncovered with this CR. These include:

250.60-250.63	354.4	354.5	354.9	355.1	355.2	355.3
355.4	355.6	355.71	355.79	355.8	355.9	356.0
356.2	356.3	356.4	356.8	356.9	357.0-357.7	674.10
674.12	674.14	674.20	674.22	674.24	707.00-707.09	707.10-707.19
870.0-879.9	880.00-887.7	890.0-897.7	998.31	998.32.		

ATHERSVCS: Therapy and Rehabilitation Services—Revision to the LCD (continued)

This revision is effective for claims processed **on or after January 16, 2007,** for services provided **on or after October 24, 2006.**

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

AVISCO: Viscosupplementation Therapy for Knee—Revision to the LCD

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised January 1, 2007. The revision consisted of the 2007 annual HCPCS update.

Since that time, change request 5459 issued by the Centers for Medicare & Medicaid Services (CMS), dated December 22, 2006, assigned HCPCS code J7319 hyaluronan (sodium hyaluronate) or derivative, intra-articular injection, per injection a status indicator of I (inactive). New HCPCS codes were assigned for all recognized synthetic hyaluronic preparations used for viscosupplementation therapy for the knee(s).

The LCD has been revised to replace HCPCS code J7319 and J3590 with HCPCS codes Q4083, Q4084, Q4085, and Q4086. The new HCPCS codes and their descriptors are as follows:

Q4083 Hyaluronan or derivative, Hyalgan® or Supartz®, for intra-articular injection, per dose

Q4084 Hyaluronan or derivative, Synvisc®, for intra-articular injection, per dose

Q4085 Hyaluronan, or derivative, Euflexxa™, for intra-articular injection, per dose

Q4086 Hyaluronan, or derivative, Orthovisc®, for intra-articular injection, per dose

Effective Dates

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

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

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SKILLED NURSING FACILITY SERVICES

Claims Submission Instructions for Institutional Providers Billing Vaccine Claims in Cases 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.

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 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 1-877-602-8816.

MLN Matters Number: MM4239
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

Blood Glucose Monitoring Services

Blood glucose monitoring measures blood sugar levels for the management of therapy (insulin, oral medication, diet) in diabetic patients. This service often involves the use of a hand-held device to test the level of glucose in a small sample of the patient's blood obtained by a finger stick. The device immediately displays the glucose level digitally, allowing it to be used by the patient in the home. *CPT* code *82962 (glucose, by glucose monitoring device[s] cleared by the FDA specifically for home use*) describes this service when the hand-held device is used. *CPT* code *82948 (glucose, quantitative, blood, reagent strip*) describes glucose monitoring with reagent strip, rather than with a hand-held device. In the diabetic patient's home, blood glucose monitoring is to be encouraged, and it is considered reasonable and necessary when it is performed by the beneficiary two to four times daily. This home monitoring (monitoring device and related disposable supplies) is paid under the Medicare durable medical equipment (DME) benefit.

If a physician or nonphysician practitioner (NPP) performs blood glucose monitoring as a diagnostic test, it is considered medically reasonable and necessary when the result is used in the active management of the patient's condition. Section 1862(a)(1)(A) of the Social Security Act specifies that in order for a service to be covered by Medicare it must be medically reasonable and necessary for the diagnosis and treatment of an illness or injury. The *Code of Federal Regulations*, Title 42, Volume 2, Section 410.32 specifies that in order for a laboratory test to be considered medically reasonable and necessary, it must be ordered by a physician or NPP, and the ordering physician or NPP must use the result of the test in the management of the patient's care. Implicit in this requirement is the expectation that the result of the test would be promptly

Blood Glucose Monitoring Services (continued)

communicated to the physician or NPP in order for him/her to use the result to continue or modify the patient's treatment regimen. In the office or clinic setting, the physician or NPP may use a home glucose monitoring device for this purpose, billing *CPT* code *82962* to the Medicare carrier. For diagnostic testing by the physician or NPP, the frequency is dependant upon the beneficiary's manifestations of abnormal glucose levels and the physician's or NPP's need to determine those levels in managing the specific condition. For beneficiaries with stable diabetes in the skilled nursing facility (SNF) setting, blood glucose testing is considered to be medically reasonable and necessary up to four times annually. Bedside blood glucose monitoring done in an SNF as a matter of routine to monitor stable diabetic patients is never covered by Medicare, whether the patient is in a covered Part A SNF stay or not.

First Coast Service Options, Inc. (FCSO) Part A is experiencing large numbers of comprehensive error rate testing (CERT) related to blood glucose monitoring. SNFs are billing diagnostic testing services (*CPT* codes *82962* and *82948*) when, in fact, the CERT contractor's review of documentation submitted to support the billed claims demonstrates routine glucose monitoring of diabetic patients. The submitted documentation does not support the three criteria required by the definition of a diagnostic test; therefore, the services are not medically reasonable and necessary. When the three criteria for diagnostic testing are not met, glucose monitoring is considered a patient self-care service, which is custodial in nature and is included in the SNF per-diem rate.

If home use glucose monitoring devices are used in the SNF setting, glucose testing services must be performed in accordance with laboratory coverage criteria to qualify for separate payment under the Medicare laboratory benefit. For blood glucose testing to be considered medically reasonable and necessary:

- It must be ordered by a physician or NPP in response to a clinical change in the patient;
- The laboratory result must be promptly reported to the physician or NPP to allow him/her time to provide active treatment for that blood glucose result; and
- The ordering physician or NPP must use the result to manage the patient's treatment.

Documentation in the medical record must support the services billed. Documentation should be legible and must include the physician's or NPP's order for blood glucose testing, the test results, notification of the physician or NPP, completion of follow-up orders, and the patient's response to continuation or modification of treatment.

Standing orders are not usually acceptable documentation for a covered laboratory service. A physician's order for insulin to be administered on a sliding scale is an example of standing orders.

Claims for blood glucose monitoring services in the SNF setting that do not meet the three medical necessity requirements for a diagnostic test will be denied as not medically necessary. ❖

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

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

Note: CMS has revised this *MLN Matters* article on January 12, 2007, to reflect changes made to change request (CR) 5389. The CR release date and transmittal number have been changed and the Web address for accessing CR 5389 has been revised. All other information remains the same. The original *MLN Matters* article was published in the January 2007 *Medicare A Bulletin* (page 48).

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

SNF CB CWF Edit Bypass Instructions for Hospital ER Services Spanning Multiple Service Dates (continued)

Background

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

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

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

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

Additional Information

You may find the official instruction, CR 5389, issued to your FI or A/B MAC by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1151CP.pdf*.

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

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

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

MLN Matters Number: MM5389 – Revised
Related Change Request (CR) Number: 5389
Related CR Release Date: January 11, 2007
Related CR Transmittal Number: R1151CP
Effective Date: October 1, 2005
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1151, CR 5389

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CORF SERVICES

Outpatient Therapy Cap Exception Process for 2007

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

Provider Types Affected

Providers, physicians, and nonphysician practitioners (NPP) who bill Medicare contractors (fiscal intermediaries (FI) including regional home health intermediaries (RHHI), carriers, and Part A/B Medicare administrative contractors (A/B MAC) under the Part B benefit for therapy services.

Provider Action Needed

Be sure you are aware of the requirements for the therapy cap exceptions for calendar year 2007, especially the use of modifier **KX** and the rules governing the exceptions.

Background

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

On January 1, 2006, Medicare implemented financial limitations on covered therapy services (therapy caps); however, the Deficit Reduction Act of 2006 provided for exceptions to this dollar limitation when the provision of additional therapy services is determined to be medically necessary. This exceptions process has been extended by recent legislation (the Tax Relief and Health Care Act of 2006) for one year (calendar year 2007).

Remember: A therapy cap exception may be made when a beneficiary requires continued skilled therapy, (in other words, therapy beyond the amount payable under the therapy cap) to achieve their prior functional status or maximum expected functional status within a reasonable amount of time. Documentation supporting the medical necessity of those therapy services must be kept on file by the provider.

Additionally, you should note that, in 2006, exception processes fell into two categories, automatic, and manual. **Beginning January 1, 2007,** there is no manual process for exceptions, and all services that require exceptions to caps will be processed using the automatic process.

Key Points

CR 5478, from which this article is taken, provides instructions to contractors regarding the short-term implementation of this legislation. Details about these instructions follow:

Contractors will grant exceptions for any number of medically necessary services if the beneficiary meets the conditions described in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation) for 2007, (displayed in the table below).

The following ICD-9-CM codes describe the most typical conditions (etiology or underlying medical diagnoses) that may result in exceptions (marked X) and complexities that **might** cause medically necessary therapy services to qualify for the automatic process exception (marked *) for each discipline separately. **When the cell in the table is marked with a dash (–), the diagnosis code in the corresponding row is not appropriate for services by the discipline in the corresponding column. Therefore, services provided by that discipline for that diagnosis do not qualify for exception to caps. Services may be appropriate when provided by that discipline for another diagnosis appropriate to the discipline, which may or may not be on this table, and that diagnosis should be documented on the claim, if possible, or in the medical record.**

ICD-9 codes describing diagnoses that may result in excepted conditions (marked X) and complexities (marked *) that **might** cause medically necessary therapy services to qualify for the automatic process exception.

ICD-9-CM Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
V43.61-V43.69	Joint replacement	X	X	–
V45.4	Arthrodesis status	*	*	–
V45.81-V45.82 and V45.89	Other postprocedural status	*	*	–
V49-61-V49.67	Upper limb amputation status	X	X	–
V49.71-V49.77	Lower limb amputation status	X	X	–
V54.10-V54.29	Aftercare for healing traumatic or pathologic fracture	X	X	–
V58.71-V58.78	Aftercare following surgery to specified body systems, not elsewhere classified	*	*	*
244.0-244.9	Acquired hypothyroidism	*	*	*
250.00-251.9	Diabetes mellitus and other disorders of pancreatic internal secretion	*	*	*

Outpatient Therapy Cap Exception Process for 2007 (continued)

ICD-9-CM Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
276.0-276.9	Disorders of fluid, electrolyte, and acid-base balance	*	*	*
278.00-278.01	Obesity and morbid obesity	*	*	*
280.0-289.9	Diseases of the blood and blood-forming organs	*	*	*
290.0-290.43	Dementias	*	*	*
294.0-294.9	Persistent mental disorders due to conditions classified elsewhere	*	*	*
295.00-299.91	Other psychoses	*	*	*
300.00-300.9	Anxiety, disassociative and somatoform disorders	*	*	*
310.0-310.9	Specific nonpsychotic mental disorders due to brain damage	*	*	*
311	Depressive disorder, not elsewhere classified	*	*	*
315.00-315.9	Specific delays in development	*	*	*
317	Mild mental retardation	*	*	*
320.0-326	Inflammatory diseases of the central nervous system	*	*	*
330.0-337.9	Hereditary and degenerative diseases of the central nervous system	X	X	X
340-345.91 and 348.0-349.9	Other disorders of the central nervous system	X	X	X
353.0-359.9	Disorders of the peripheral nervous system	X	X	–
365.00-365.9	Glaucoma	*	*	*
369.00-369.9	Blindness and low vision	*	*	*
386.00-386.9	Vertiginous syndromes and other disorders of vestibular system	*	*	*
389.00-389.9	Hearing loss	*	*	*
401.0-405.99	Hypertensive disease	*	*	*
410.00-414.9	Ischemic heart disease	*	*	*
415.0-417.9	Diseases of pulmonary circulation	*	*	*
420.0-429.9	Other forms of heart disease	*	*	*
430-438.9	Cerebrovascular disease	X	X	X
440.0-448.9	Diseases of arteries, arterioles, and capillaries	*	*	*
451.0-453.9 and 456.0-459.9	Diseases of veins and lymphatics, and other diseases of circulatory system	*	*	*
465.0-466.19	Acute respiratory infections	*	*	*
478.30-478.5	Paralysis, polyps, or other diseases of vocal cords	*	*	*
480.0-486	Pneumonia	*	*	*
490-496	Chronic obstructive pulmonary disease and allied conditions	*	*	*
507.0-507.8	Pneumonitis due to solids and liquids	*	*	*
510.0-519.9	Other diseases of respiratory system	*	*	*
560.0-560.9	Intestinal obstruction without mention of hernia	*	*	*
578.0-578.9	Gastrointestinal hemorrhage	*	*	*
584.5-586	Renal failure and chronic kidney disease	*	*	*
590.00-599.9	Other diseases of urinary system	*	*	*
682.0-682.8	Other cellulitis and abscess	*	*	–
707.00-707.9	Chronic ulcer of skin	*	*	–
710.0-710.9	Diffuse diseases of connective tissue	*	*	*
711.00-711.99	Arthropathy associated with infections	*	*	–
712.10-713.8	Crystal arthropathies and arthropathy associated with other disorders classified elsewhere	*	*	–
714.0-714.9	Rheumatoid arthritis and other inflammatory polyarthropathies	*	*	–
715.00-715.98	Osteoarthrosis and allied disorders (complexity except as listed below)	*	*	–

Outpatient Therapy Cap Exception Process for 2007 (continued)

ICD-9-CM Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
715.09	Osteoarthritis and allied disorders, multiple sites	X	X	–
715.11	Osteoarthritis, localized, primary, shoulder region	X	X	–
715.15	Osteoarthritis, localized, primary, pelvic region and thigh	X	X	–
715.16	Osteoarthritis, localized, primary, lower leg	X	X	–
715.91	Osteoarthritis, unspecified id gen. or local, shoulder	X	X	–
715.96	Osteoarthritis, unspecified if gen. or local, lower leg	X	X	–
716.00-716.99	Other and unspecified arthropathies	*	*	–
717.0-717.9	Internal derangement of knee	*	*	–
718.00-718.99	Other derangement of joint (complexity except as listed below)	*	*	–
718.49	Contracture of joint, multiple sites	X	X	–
719.00-719.99	Other and unspecified disorders of joint (complexity except as listed below)	*	*	–
719.7	Difficulty walking	X	X	–
720.0-724.9	Dorsopathies	*	*	–
725-729.9	Rheumatism, excluding back (complexity except as listed below)	*	*	–
726.10-726.19	Rotator cuff disorder and allied syndromes	X	X	–
727.61-727.62	Rupture of tendon, nontraumatic	X	X	–
730.00-739.9	Osteopathies, chondropathies, and acquired musculoskeletal deformities (complexity except as listed below)	*	*	–
733.00	Osteoporosis	X	X	–
741.00-742.9 and 745.0-748.9 and 754.0-756.9	Congenital anomalies	*	*	*
780.31-780.39	Convulsions	*	*	*
780.71-780.79	Malaise and fatigue	*	*	*
780.93	Memory loss	*	*	*
781.0-781.99	Symptoms involving nervous and musculoskeletal system (complexity except as listed below)	*	*	*
781.2	Abnormality of gait	X	X	–
781.3	Lack of coordination	X	X	–
783.0-783.9	Symptoms concerning nutrition, metabolism, and development	*	*	*
784.3-784.69	Aphasia, voice and other speech disturbance, other symbolic dysfunction	*	*	X
785.4	Gangrene	*	*	–
786.00-786.9	Symptoms involving respiratory system and other chest symptoms	*	*	*
787.2	Dysphagia	*	*	X
800.00-828.1	Fractures (complexity except as listed below)	*	*	–
806.00-806.9	Fracture of vertebral column with spinal cord injury	X	X	–
810.11-810.13	Fracture of clavicle	X	X	–
811.00-811.19	Fracture of scapula	X	X	–
812.00-812.59	Fracture of humerus	X	X	–
813.00-813.93	Fracture of radius and ulna	X	X	–
820.00-820.9	Fracture of neck of femur	X	X	–
821.00-821.39	Fracture of other and unspecified parts of femur	X	X	–
828.0-828.1	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum	X	X	–

Outpatient Therapy Cap Exception Process for 2007 (continued)

ICD-9-CM Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
830.0-839.9	Dislocations	X	X	–
840.0-848.8	Sprains and strains of joints and adjacent muscles	*	*	–
851.00-854.19	Intracranial injury, excluding those with skull fracture	X	X	X
880.00-884.2	Open wound of upper limb	*	*	–
885.0-887.7	Traumatic amputation, thumb(s), finger(s), arm and hand (complete)(partial)	X	X	–
890.0-894.2	Open wound lower limb	*	*	–
895.0-897.7	Traumatic amputation, toe(s), foot/feet, leg(s) (complete)(partial)	X	X	–
905.0-905.9	Late effects of musculoskeletal and connective tissue injuries	*	*	*
907.0-907.9	Late effects of injuries to the nervous system	*	*	*
941.00-949.5	Burns	*	*	*
952.00-952.9	Spinal cord injury without evidence of spinal bone injury	X	X	X
953.0-953.8	Injury to nerve roots and spinal plexus	X	X	*
959.01	Head injury, unspecified	X	X	X

- Medicare contractors will allow automatic process exceptions for diagnoses in the table above or any other diagnosis for which therapy services are appropriate when the beneficiary needs therapy services above the therapy cap (due to the occurrence of any condition or complexity that is appropriately documented).
- For the therapy HCPCS codes subject to the cap limits in your claims to be excepted, you must include modifier **KX** to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record. In CY 2007, when claims contain modifier **KX**, contractors will override edits that indicate that a therapy service has exceeded the financial limitation, and will pay for the service if it is otherwise covered and payable.
- Contractors **will not use** modifier **KX** as the sole indicator of services that do exceed caps in 2007, because, there will be services with appropriately used modifier **KX** that do not represent services that exceed the cap.
- Contractors will require that the documentation for outpatient therapy services include objective, measurable patient function information, either by using one of the four recommended (but not required) measurement tools:
  - National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association,
  - Patient Inquiry by Focus on Therapeutic Outcomes, Inc. (FOTO),
  - Activity Measure – Post Acute Care (AM-PAC), or
  - OPTIMAL by the American Physical Therapy Association),

  or by including other information as described in the *Medicare Benefit Policy Manual*, Publication 100-02, Chapter 15, Covered Medical and Other Health Services, Section 220.3C, Documentation Requirements for Therapy Services – Evaluation/Re-Evaluation and Plan of Care.
- If one of these instruments is not in the patient's medical record, the record must contain documentation to indicate objective, measurable beneficiary physical function including, for example: 1) Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or 2) Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or 3) Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.

The automatic exceptions process for therapy claims reporting modifier **KX** does not preclude these claims from being subject to review. The contractor may review claims when they are potentially fraudulent, where there is evidence of misrepresentation of facts, or where there is a pattern of aberrant billing.

Note: Claims for services above the cap, which are denied, are considered benefit category denials, and the beneficiary is liable. Further, providers do not need to issue an ABN for these benefit category denials.

Be aware that contractors do not have to search their files to either retract payment for claims already paid or to retroactively pay claims, but will reopen and/or adjust claims brought to their attention.

Final Note: CR 5478 also relocates some information. Comprehensive outpatient rehabilitation facilities (CORF) policies for 1) group therapy services and 2) therapy students, are the same as other Part B outpatient services policies for group therapy services and therapy students; and may now be found in the *Medicare Benefit Policy Manual*, Chapter 15, Section 230.

Outpatient Therapy Cap Exception Process for 2007 (continued)

Additional Information

You may find more information about the outpatient therapy cap exception process for 2007 by going to CR 5478. CR 5478 is actually issued in three separate transmittals, one for each manual being revised. The attachments to each of the transmittals include the updates to the *Medicare Claims Processing Manua*l, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services, Section 10.2, The Financial Limitation for 2007; the *Program Integrity Manual*, Chapter 3, Verifying Potential Errors and Taking Corrective Actions, Section 3.4.1.1.1, Exception From the Uniform Dollar Limitation ("Therapy Cap"), and the *Medicare Benefit Policy Manual*, Chapter 15, Covered Medical and Other Health Services, Section 220.3C, Documentation Requirements for Therapy Services – Evaluation/Re-Evaluation and Plan of Care. You are encouraged to be familiar with these important manual sections. You can find these transmittals on the CMS website at:

The *Medicare Claims Processing Manual* transmittal – *http://www.cms.hhs.gov/transmittals/downloads/R1145CP.pdf*.

The *Medicare Benefit Policy Manual* transmittal – *http://www.cms.hhs.gov/transmittals/downloads/R63BP.pdf*.

The *Medicare Program Integrity Manual* transmittal – *http://www.cms.hhs.gov/transmittals/downloads/R181PI.pdf*.

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

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

MLN Matters Number: MM5478
Related Change Request (CR) Number: 5478
Related CR Release Date: December 29, 2006
Related CR Transmittal Number: R1145CP, R181PI, R63BP
Effective Date: January 1, 2007
Implementation Date: On or after January 29, 2007

Source: CMS Pub. 100-4, Transmittal 1145, CR 5478

Elimination of the Manual Process for Therapy Cap Exceptions

Background

The Centers for Medicare & Medicaid Services (CMS) through change request (CR) 4364 implemented exceptions to the therapy financial limitation. Two processes were created to handle requests for exceptions to therapy services exceeding $1740 for calendar year (CY) 2006. These two processes were described as:

1. **The automatic process** allowed providers to automatically submit claims using modifier **KX** for patients with specific diagnoses that met medical necessity criteria.
2. **The manual process** required the provider to submit a request prior to services being provided. The request was sent via medical review for patients who required additional therapy services beyond the therapy cap. Authorization was granted for those services that met documentation and medical necessity requirements, but did not meet the criteria for the automatic process.

Effective January 1, 2007, CR 5478 announces several changes to the therapy cap and the exceptions process. The purpose of this article is to address one of the changes, which discontinues the manual process for CY 2007 for the therapy cap exceptions. Contractors will no longer accept or grant exceptions via the manual request for exceptions to the therapy cap in CY 2007. All exceptions to the CY 2007 therapy cap of $1780 must meet the criteria under the automatic process as outlined in CR 5478 dated December 29, 2006.

Reminder to Providers Included in the Progressive Corrective Action Process

Providers (Part A and Part B) included in the progressive corrective action (PCA) process may submit rehabilitation therapy claims using modifier **KX.** Use of modifier **KX** shall be interpreted as the therapist's attestation that services provided above the cap are medically necessary. If the clinician attests that the requested services are medically necessary by using modifier **KX** on the claim detail line, the contractor may make the determination that the claim is medically necessary. That determination is binding on the contractor in the absence of:

- potential fraud; or
- evidence of misrepresentation of facts presented to the contractor, or
- a pattern of aberrant billing by a provider.

Should such evidence of potential fraud, misrepresentation, or aberrant billing patterns by a provider be found, claims are subject to medical review regardless of whether modifier **KX** was used on the claim. Although the services may meet the criteria for exception from the cap due to condition or complexity, they are still subject to review to determine that the services are otherwise covered and appropriately provided. This includes providers that are currently under a progressive corrective action (PCA) medical review. ❖

Source: CMS Pub. 100-04, Transmittal 1145, CR 5478

Outpatient Therapy Cap Exception Clarifications

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

Note: CMS has revised this *MLN Matters* article on January 12, 2007. Recent legislation extended the therapy cap exceptions for calendar year 2007. For details on the 2007 exceptions and process, see the *MLN Matters* article MM5478 on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5478.pdf*.

***MLN Matters* article MM5478 is included on page 23 of this publication.**

Provider Types Affected

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

Provider Action Needed

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

Background

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

Review of This Exception Process

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

Exception Processes fall into two categories:

1. **Automatic** process exceptions
   Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if they meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 5, (as revised by CR 5271) for exception from the therapy cap for 2006.
2. **Manual** process exceptions
   Medicare beneficiaries may be request an exception using the manual process for exception from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the criteria for automatic exceptions.

Clarifications to Questions Generated from CR 4364

Your FI, RHHI, or carrier:

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

Outpatient Therapy Cap Exception Clarifications (continued)

process exception decisions lead them to believe further exceptions should be allowed.

10. Will not require the additional documentation that is encouraged but not required in the manuals.

11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.

12. Will not deny payment for reevaluation **only** because an evaluation or reevaluation was recently done, as long as documentation supports the need for re-evaluation. A reevaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.

13. Will require clinicians to write progress reports at least during each progress report period. Note that required elements of the progress report that are written into the treatment notes or in a plan of care, acceptably fulfill the requirement for a progress report. In these instances, a separate progress report is not required.

14. Will require, on pre or postpay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each progress report period and sign the progress report.

15. Will continue to use Medicare summary notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: "ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are $1,740 for PT and SLP combined and $1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE."

16. Will continue to enforce local coverage determinations (LCDs).

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

Additional Information

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

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

These manual revisions include numerous additional changes clarifications.

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

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

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

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

Therapy Caps Exception Process

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

Note: CMS has revised this *MLN Matters* article on January 12, 2007. Recent legislation extended the therapy cap exceptions for calendar year 2007. For details on the 2007 exceptions and process, see the *MLN Matters* article MM5478 on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5478.pdf*.

***MLN Matters* article MM5478 is included on page 23 of this publication.**

Provider Types Affected

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

Key Points

- Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims).

  Outpatient rehabilitation services include:

  - **Physical therapy –** including outpatient speech-language pathology: Combined annual limit for 2006 is $1,740; and
  - **Occupational therapy –** annual limit for 2006 is $1,740.

- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g)(5) of the Social Security Act).
- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.
- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:
  - Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 4364) for exception from the therapy cap; or
  - Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.
- Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

  You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.
- Please refer to the *Additional Information* section of this article for more detailed information about the therapy caps exception process.

Background

Financial limitations on Medicare-covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997. These caps were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005.

The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to these dollar limitations of $1,740 for each cap in 2006 may be made when provision of additional therapy services is determined to be medically necessary.

Additional Information

Billing Guidelines

- **Modifier KX –** You must include modifier KX on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests –** You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.
- **Subsequent requests during the same episode of care –** To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.

Therapy Caps Exception Process (continued)

- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using t modifier KX. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process Based Upon Clinical Condition or Complexity

CR 4364 transmittal that contains these codes is the one that revises the *Medicare Claims Processing Manual*, available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.

You may wish to bookmark that link so you may easily reference these codes.

Documentation

Providers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the revised *Medicare Benefit Policy Manual*, Pub.100-02 Chapter 15, Section 220.3; and the revised *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Sections 10.2 and 20, with the request for treatment days in excess of those payable under the therapy cap.

These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR 4364. CR 4364 is in three parts, one each for the revised manuals, i.e.:

- The *Medicare Benefit Policy Manual*, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R47BP.pdf*.
- The *Medicare Claims Processing Manual*, located at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.
- The *Medicare Program Integrity Manual*, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf*.

The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** – 1-2 documents.
2. **Certification** – Physician/NPP approval of the plan required 30 days after initial treatment or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds ten treatment days or 30 days) – These must be sufficient to explain the beneficiary's current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.
4. **Treatment Encounter Notes** – The treatment encounter note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for progress reports if they contain the requirements of interval progress reports at least once every ten treatment days or once in the interval.
5. For therapy caps exceptions purposes, records justifying services over the cap, either included in the above or as a separate document.

Please see the revised Section 220.3 of the *Medicare Claims Processing Manual* located at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf* for more details about the types of documentation required and explanations of what that documentation should contain.

When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary.
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation.
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or reevaluation unless it represents a service.
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

Medicare Contractor Decisions

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology.

It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed.

Your Medicare contractor may also approve additional therapy visits already provided when the request is accom-

Therapy Caps Exception Process (continued)

panied by documentation supporting medical necessity of the services.

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial.

Note: If your Medicare contractor does *not* make a decision within ten business days of receipt of the request and documentation, then the decision for therapy cap exception is considered to be deemed approved as medically necessary for the number of future visits requested (not to exceed 15).

Notification

You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision.

This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights. For examples of the standard letters from the *Medicare Program Integrity Manual*, 100-8, Section 3.3.1.2, please refer to the Attachments to CR 4364. The examples include:

- Letter #1 – Approved
- Letter #2 – Negative Decision-Medical Necessity
- Letter #3 – Denied-Insufficient Documentation

Revised Medicare Summary Notice (MSN) Messages

The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR 4364.

Once again, there are three transmittals that comprise CR 4364. They are:

- The *Medicare Benefit Policy Manual* revision on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R47BP.pdf*.
- The *Medicare Claims Processing Manual* revision, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.
- The *Medicare Program Integrity Manual* revision, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf*.

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

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

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Implementation Date: No later than March 13, 2006

Source: CMS Pub. 100-4, Transmittal 855, CR 4364.

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 2007 Update of the Hospital Outpatient Prospective Payment System: Summary of Payment Policy Changes and OPPS PRICER

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), Part A/B Medicare administrative contractors (A/B MACs) and/or regional home health intermediaries (RHHIs) for outpatient services furnished under the outpatient prospective payment system (OPPS).

Background

This article and related change request (CR) 5438 describes the changes to, and billing instructions for, various payment policies implemented in the January 2007 OPPS update. The January 2007 OPPS outpatient code editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 5438.

Also take note, the language in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 4, 61.3.2, was revised to reflect discussions as to how hospitals should bill in cases in which the credit they receive is for an amount that is less than the amount that the device would cost.

In addition, the January 2007 revisions to OPPS OCE data files, instructions and specifications are provided in CR 5425, "January 2007 outpatient prospective payment system code editor (OPPS OCE) specifications version 8.0." The *MLN Matters* article related to CR 5424 may be found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5425.pdf*.

CR 5348 contains a number of tables and detailed discussion that are not included in this article. For those interested in these details, CR 5438 may be accessed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1139CP.pdf*.

A summary of the key changes of CR 5348 of interest to providers is in the next section of this article.

Key Point

New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that CMS creates additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing two new device pass-through categories as of **January 1, 2007.** Those codes are as follows:

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset From Payment
C1821	January 1, 2007	H	1821	Interspinous implant	Interspinous process distraction device (implantable)	$0.00
L8690	January 1, 2007	H	1032	Aud osseo Dev, int/ext comp	Auditory osseointegrated device, includes all internal and external components	$0.00

Device Offset from Payment

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC amount that CMS determines is associated with the cost of the device (70 FR 68627-8). For the two categories listed above, HCPCS codes C1821 and L8690, CMS determined that there are no similar devices in the respective APCs with which the new device categories would be billed that are similar to the devices of the new categories. Therefore, the device offsets are set to $0 for both of these new device categories.

For calendar year (CY) 2006, when CMS created new category C1820, – Generator, neurostimulator (implantable), with rechargeable battery and charging system, it was determined that CMS was able to identify the portion of the APC amount associated with the cost of the historically utilized device, that is, the nonrechargeable neurostimulator generator implanted through procedures assigned to APC 222, – implantation of neurological device, which HCPCS code C1820 replaces in some cases. The device offset from the pass-through payment for HCPCS code C1820 represents the deduction from the pass-through payment for category C1820 that will be made when HCPCS code C1820 is billed with a service assigned to APC 222.

For CY 2007, the device offset portion for C1820 is $8,668.94. Please note that the offset amount from the APC amount is wage adjusted before it is subtracted from the device cost.

January 2007 Update of the Hospital OPPS: Summary of Payment Policy Changes and OPPS PRICER (continued)

Payment for Brachytherapy Sources

The Medicare Modernization Act of 2003 (MMA) requires Medicare to pay for brachytherapy sources in separately paid APCs, and for the period of January 1, 2004 through December 31, 2006, to pay for brachytherapy sources at hospital charges adjusted to their cost. **Effective January 1, 2007,** Medicare is still paying for specified brachytherapy sources separately, pursuant to the MMA; and at hospital charges adjusted to their cost per the Tax Relief and Health Care Act of 2006, which extends the charges adjusted to cost payment for brachytherapy sources until January 1, 2008. Therefore, the prospective payment rates for each source, which are listed in Addendum B to the CY 2007 final rule, will **not be used for payment.** In addition, because of their cost-based payment methodology for CY 2007, brachytherapy sources will not be eligible for outlier payments in CY 2007. Instead, the status indicators of brachytherapy source HCPCS codes will return to "H" effective **January 1, 2007**, for payment of brachytherapy sources at hospital charges adjusted to their cost. The codes for the CY 2007 separately paid sources, long descriptors and APCs are listed in the following table.

HCPCS	Long Descriptor	SI	APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H	2632
C1716	Brachytherapy source, gold 198, per source	H	1716
C1717	Brachytherapy source, high dose rate iridium 192, per source	H	1717
C1718	Brachytherapy source, iodine 125, per source	H	1718
C1719	Brachytherapy source, non-high dose rate iridium 192, per source	H	1719
C1720	Brachytherapy source, palladium 103, per source	H	1720
C2616	Brachytherapy source, yttrium-90, per source	H	2616
C2632*		D	
C2633	Brachytherapy source, cesium-131, per source	H	2633
C2634	Brachytherapy source, high activity, iodine-125, greater than 1.01 mCi (NIST), per source	H	2634
C2635	Brachytherapy source, high activity, palladium-103, greater than 2.2 mCi (NIST), per source	H	2635
C2636	Brachytherapy linear source, palladium-103, per 1 mm	H	2636
C2637	Brachytherapy source, ytterbium-169, per source	H	2637

*Please note that C2632 has been deleted and replaced by A9527, effective **January 1, 2007.**

Adjustment to Payment in Cases of Devices Replaced without Cost or With Credit for the Replaced Device

Effective for services furnished on or after January 1, 2007, Medicare will reduce the amount of payment for certain APCs when the hospital reports that it received a listed device without cost or where the hospital received a full credit for the cost of a replaced listed device. The reduction applies only to specific APCs when specific devices are replaced. Instructions for reporting these circumstances are contained in CMS Transmittal 1103, CR 5263, "Reporting and Payment of No-Cost Devices Furnished by Outpatient Prospective Payment System (OPPS) Hospitals", issued November 3, 2006. The *MLN Matters* article that relates to CR 5263 is on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5263.pdf*.

It is important that hospitals be familiar with the instructions in CR 5263 regarding the reporting of the modifier **FB**, which is not to be reported if the hospital received partial credit for the device explanted. Incorrect reporting of the modifier may result in incorrect payment. Also, see tables 3 and 4 of CR 5438 for details of reporting devices with modifier **FB**. Where a modifier is reported with any of the APCs in table 3 of CR 5438, Medicare will deduct the amount of the adjustment shown in the table before wage-adjusting the Medicare payment. The copayment will be based on the reduced payment.

Changes to Device Edits for January 2007

Effective for services furnished **on or after January 1, 2007,** there will be two types of device edits that claims for OPPS services must pass to be accepted for processing:

- **Procedure to device edits** that require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. These edits may be found under downloads on the OPPS page at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

  Note: New edits for **January 1, 2007,** are found in yellow highlighting**.**

- **Device to procedure code edits,** which are effective for services furnished **on or after January 1, 2007.** CMS will require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to also contain an appropriate procedure code. Where these devices are currently being billed without an appropriate procedure code, the cost of the device is being packaged into the median cost for an incorrect procedure code and therefore is inflating the payment rate for the incorrect procedure code. Simultaneously the hospital is being paid incorrectly.
  For example, HCPCS code C1722, AICD, single chamber, sometimes appears on a claim on which the only procedure code on the claim is *CPT* code *33241, Remove pulse generator*. Clearly, if a single chamber AICD is correctly reported on a claim, there must have been implantation of a single chamber AICD and the

hospital should have reported HCPCS code G0297, Insert single chamber/cd, or HCPCS code G0299, Inser/repos single icd+leads, with or without *CPT* code *33241*, and the claim is not correct as submitted. In this case, the cost of the device is being packaged into *CPT* code *33241*, which is assigned to APC 105, Revision/ removal of AICD, pacemaker or vascular device, where it clearly does not belong. The median cost for *CPT* code *33241* is being incorrectly inflated and the hospital is being paid for one unit of APC 105 (often with outlier payment) but is not being paid for one unit of APC 107, Insertion of cardioverter-defibrillator, or 108, Insertion/replacement/repair of cardioverter-defibrillator leads. We note that APC 108 is populated by G0299 and G0300, each of which require that an AICD be implanted, as well as leads being inserted, replaced or repaired. These edits are located under downloads on the OPPS page at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

These edits have been open to public comment since August 2006. Comments on these edits should be directed to OutpatientPPS@cms.hhs.gov.

Statewide Default Cost to Charge Ratio

CMS uses default statewide cost to charge ratios (CCRs) for several groups of hospitals, including, but not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, and hospitals that have recently given up their all-inclusive rate status. Current OPPS policy also requires hospitals that experience a change of ownership, but that do not accept assignment of the previous hospital's provider agreement, to use the previous provider's CCR. CR 3756, issued in April 2005, established the current ceiling threshold of 1.2 for replacing a calculated CCR with a statewide default CCR. For CY 2007, CMS will apply this treatment of using the default statewide CCR to include an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR section 489.18, and that has not yet submitted its first Medicare cost report. This policy is effective for hospitals experiencing a change of ownership **on or after January 1, 2007.** A hospital that has not accepted assignment of an existing hospital's provider agreement is similar to a new hospital that will establish its own costs and charges. The hospital that has chosen not to accept assignment may have different costs and charges than the existing hospital. Furthermore, the hospital should be provided time to establish its own costs and charges. Therefore, the FI should use the default statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report.

Changes to the Calculation of the Hospital-Specific Overall CCR

CMS has revised the methodology for calculation of the hospital-specific overall CCR effective January 1, 2007 to remove the costs of nursing and paramedical education programs and to weigh hospital costs by Part B charges. See CMS Transmittal 1030, CR 5238, "Policy Changes to the Fiscal Intermediary Calculation of Hospital Outpatient Payment System (OPPS) and Community Mental Health Center (CMHC) Cost to Charge Ratios (CCRs)" issued November 3, 2006. The hospital-specific overall CCR is used by fiscal intermediaries to calculate the payment for radiopharmaceuticals, brachytherapy sources, and pass-through devices which are paid at charges reduced to cost. The hospital-specific overall CCR is also used to calculate outlier payments, if any, that are due to the provider.

Rural Payments to Essential Access Community Hospitals (EACHs)

Section 5105 of the DRA (Pub. L. 109-171) reinstituted the hold harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). When the OPPS payment is less than the payment the provider would have received under the previous reasonable cost-based system, the amount of payment is increased by 95 percent of the amount of the difference between those two payment systems for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

For CY 2006, CMS has implemented this policy through transmittal 877, issued on February 24, 2006. CMS did not specifically address whether TOPs apply to essential access community hospitals (EACHs), which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Accordingly, under the statute, EACHs are treated as SCHs. Therefore, beginning January 1, 2006, EACHs are not eligible for TOPs payment.

For CY 2007, Medicare will continue to apply a payment increase of 7.1 percent to rural SCHs for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy sources, and services paid under the pass-through payment policy. This adjustment is budget neutral and applied before calculating outliers and coinsurance. CMS did not specifically address whether the adjustment applies to EACHs. Therefore, because EACHs are treated as SCHs, CMS is clarifying that EACHs are treated as SCHs for purposes of receiving this adjustment retroactive to January 1, 2006, assuming these entities otherwise meet the rural adjustment criteria.

Packaged Services

For CY 2007, CMS is creating a new category of packaged codes, called "special" packaged codes, for which CMS pays separately when the codes appear on a claim with no separately payable OPPS services also reported for the same date of service. Through OCE logic, the PRICER will automatically assign payment for a "special" packaged service reported on a claim if there are no other services separately payable under the OPPS on the claim for the same date of service. In all other circumstances, the "special" packaged codes would be treated as packaged services. Medicare assigns status indicator "Q" to these "special" packaged codes to indicate that they are usually packaged, except for special circumstances when they are separately payable. Through OCE logic, the status indicator of a "special" packaged code would be changed either to "N" or to the status indicator of the APC to which the code is assigned for separate payment, depending upon the presence or absence of other OPPS services also reported on the claim for the same date. The table below lists the status

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indicators and APC assignments for these "special" packaged codes when they are separately payable. Note that the payment for these "special" packaged codes is intended to make payment for all of the associated hospital costs, which may include patient registration and establishment of a medical record, in an outpatient hospital setting when the hospitals provides no other separately payable services under the OPPS to the patient on that day.

In the case of a claim with two or more "special" packaged codes only reported on a single date of service, the PRICER will assign separate payment only to the "special" packaged code that will receive the highest payment. The other "special" codes will remain packaged and will not receive separate payment.

Both the OCE and the PRICER will implement these new policies without any coding change required on the part of hospitals.

Table of "Special" Packaged codes

***CPT* Code**	**Descriptor**	**CY 2007 APC**	**Status Indicator**
36540	*Collect blood, venous access device*	0624	S
36600	*Arterial puncture; withdrawal of blood for diagnosis*	0035	T
38792	*Sentinel node identification*	0389	S
75893	*Venous sampling through catheter, with or without angiography, radiological supervision and interpretation*	0668	S
94762	*Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring*	0443	X
96523	*Irrigation of implanted venous access device*	0624	S

CR 5438 clarifies that CMS receives claims that contain only packaged codes. Note that although these claims are processed by the OCE and are ultimately rejected for payment, they are received by CMS, and CMS has cost data for packaged services based upon these claims. While CMS has been told that some hospitals may bill for a low-level visit if a packaged service only is provided so that they receive some payment for the encounter, note that providers should bill a low-level visit code in such circumstances only if the hospital provides a significant, separately identifiable low-level visit in association with the packaged service. This general rule applies to any service provided by a hospital. CMS expects that the hospital resources associated with a visit would be reflected in the hospital's internal guidelines used to select the level of reporting for the visit. The hospital should bill the visit code that most appropriately describes the service provided. In circumstances where there is no applicable HCPCS code to describe a distinct service, hospitals should continue to report the most appropriate unlisted procedure or unlisted services CPT code. In summary, with respect to the billing of low-level visit CPT codes, as described above, our current policy dictates that hospitals may only bill a low-level visit code if the hospital provides a significant, separately identifiable visit from any other services provided.

Earlier guidance, issued January 3, 2003, in section 12 of transmittal A-02-129 was based upon past Medicare policy that a hospital could bill a low-level visit in addition to *CPT* code *97602*, which was packaged in CY 2003 at the time of that instruction. However, beginning in CY 2006, Medicare provided for separate payment for *CPT* code *97602*, when it is performed as a nontherapy service in the hospital outpatient setting. Therefore, hospitals can report and be paid for this wound care service with the more specific *CPT* code available. This OPPS payment policy for nontherapy, nonselective wound care service will continue for CY 2007.

Coding and Payment for Visits

CMS will not replace *CPT/E/M* codes with G-codes for CY 2007. Hospitals should continue to bill *CPT/E/M* codes to report visits provided in hospital outpatient clinics and in emergency departments that meet the definition of a type A emergency department as described below. However, for CY 2007, CMS is distinguishing between two types of emergency departments: type A emergency departments and type B emergency departments.

A type A emergency department is defined as an emergency department that is available 24 hours a day, 7 days a week and is either licensed by the state in which it is located under applicable state law as an emergency room or emergency department or it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

This definition of type A emergency departments should neither narrow nor broaden the group of emergency departments or facilities that are currently correctly billing *CPT* emergency department visit E/M codes.

Type A emergency departments should bill CPT emergency department E/M codes, as they have been billing in the past.

A type B emergency department is defined as an emergency department that meets the definition of a "dedicated emergency department" as defined in 42 CFR 489.24 under the EMTALA regulations. It must meet at least one of the following requirements:

(1) It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

For CY 2007, because there are no *CPT* codes that describe type B emergency departments, CMS is creating five new G-codes, G0380, G0381, G0382, G0383, and G0384, that describe the five levels of emergency visits provided in type B emergency departments. These new codes will allow CMS to track the resource costs of type B emergency departments (EDs) and determine how the costs for services provided in type B EDs differ from clinic and type A emergency department visit costs. The following table lists the short descriptors of the new codes.

New Codes for Emergency Visits Provided in Type B Emergency Departments

HCPCS Code	Short Descriptor
G0380	Lev 1 hosp type B ED visit
G0381	Lev 2 hosp type B ED visit
G0382	Lev 3 hosp type B ED visit
G0383	Lev 4 hosp type B ED visit
G0384	Lev 5 hosp type B ED visit

For CY 2007, Medicare will pay at five payment levels for clinic and emergency department visits, instead of the current three payment levels. This should have minimal impact on hospital coding since hospitals will continue to bill five levels of *CPT* codes. Hospitals should ensure that their guidelines accurately reflect resource distinctions between the five levels of codes. Type A emergency department visits will continue to be paid at emergency department rates. Type B emergency department visits will be paid at clinic visit rates until CMS collects enough data to better determine their resource costs.

CMS will work with the AHA (American Hospital Association), AHIMA (American Health Information Management Association) and other interested parties to develop national guidelines for consistent reporting of hospital visits. CMS continues to encourage public input in the form of suggestions, problems, or successful models. CMS will provide a minimum of 6-12 months notice to hospitals prior to implementation of national guidelines to ensure sufficient time for providers to make the necessary systems changes and educate their staff. CMS does not anticipate implementing guidelines prior to CY 2008.

As indicated in the proposed and final rules, CMS believes the AHA/AHIMA guidelines are promising, although CMS identified some areas that it believed require additional development. The original and modified guidelines are available on the OPPS website at *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage*.

The files are included as supporting documents under the CY 2007 Proposed Rule, CMS-1506-P. CMS continues to welcome input specifically on these models.

Until national guidelines are implemented, providers should continue to apply their current guidelines to the existing *CPT* codes. Hospitals that will be billing the new type B ED visit codes may need to update their internal guidelines for use to report these codes.

Coding and Payment for Critical Care

For CY 2007, Medicare will pay for critical care at two levels, depending on the presence or absence of trauma activation. Providers will receive one payment rate for critical care without trauma activation and will receive additional payment when critical care is associated with trauma activation.

To determine whether trauma activation occurs, providers are to follow the National Uniform Billing Committee (NUBC) guidelines related to the reporting of the trauma revenue codes in the 68x series. The guidelines are listed in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 25, Section 60.4. That manual is available on the CMS site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

In summary, revenue code series 68x may be used only by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons. Different subcategory revenue codes are reported by designated level 1-4 hospital trauma centers. Only patients for whom there has been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response can be billed a trauma activation charge.

CMS created HCPCS code G0390, Trauma response team activation associated with hospital critical care service, **effective January 1, 2007,** which is assigned to APC 0618, Critical care with trauma response. When at least 30 minutes of critical care is provided without trauma activation, the hospital will bill *CPT* code *99291, Critical care evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (and *CPT* code *99292*, if appropriate) as usual, and receive payment for APC 0617, Critical care. If trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under 68x and the hospital provides at least 30 minutes of critical care so *CPT* code *99291* is appropriately reported, the hospital may also bill one unit of HCPCS code G0390, reported with revenue code 68x on the same date of service as *CPT* code *99291*, and the hospital will receive an additional payment under APC 0618. The OCE will edit to ensure that HCPCS code G0390 appears with revenue code 68x on the same date of service as *CPT* code *99291* and that only one unit of HCPCS code G0390 is billed. CMS believes that trauma activation is a one-time occurrence in association with critical care services, and therefore, will only pay for one unit of HCPCS code G0390 per day. CMS will monitor usage of the *CPT* codes for critical care services and the new G-code to ensure that their utilization remains at anticipated levels.

CPT defines *CPT* code *99291* is defined by as the first 30-74 minutes of critical care. This 30-minute minimum has always applied under the OPPS and will continue to apply for CY 2007. CMS is continuing to provide packaged

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payment for *CPT* code *99292*, *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes*, for those periods of critical care services extending beyond 74 minutes, so hospitals do not have the ongoing administrative burden of reporting precisely the time for each critical service provided. As the *CPT* guidelines indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines. Hospitals that provide less than 30 minutes of critical care when trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under revenue code 68x, may report a charge under 68x, but they may not report HCPCS code G0390. In this case, payment for the trauma response is packaged into payment for the other services provided to the patient in the encounter, including the visit that is reported.

Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician or hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.

Billing for Stereotactic Radiosurgery

Stereotactic radiosurgery (SRS) is a form of radiation therapy for treating abnormalities, functional disorders, and tumors of the brain and neck, and most recently has expanded to treating tumors of the spine, lung, pancreas, prostate, bone, and liver. There are two basic methods in which SRS can be delivered to patients, linear accelerator-based treatment and multi-source photon-based treatment (often referred to as cobalt 60). Advances in technology have further distinguished linear accelerator-based SRS therapy into two types: gantry-based systems and image-guided robotic SRS systems. These two types of linear accelerator-based SRS therapies may be delivered in a complete session or in a fractionated course of therapy up to a maximum of five sessions.

For CY 2007, the *CPT* Editorial Panel created four new SRS category I *CPT* codes in the Radiation Therapy section of the 2007 *CPT* manual. These are:

77371 *Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesions(s) consisting of 1 session; multi-source Cobalt 60 based.*

77372 *Radiation treatment delivery stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesions(s) consisting of 1 session; linear accelerator based*

77373 *Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions*

77435 *Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions*

HCPCS G0243 will no longer be reportable, because the code is deleted and replaced with *CPT* code *77371*, **effective January 1, 2007.** For SRS services described by *CPT* codes *77372*, *77373*, and *77435*, hospital outpatient facilities must use the corresponding G-codes that specifically describe these services. Note that for 2007, CMS will continue to not recognize *CPT* code *61793* under the OPPS, because the OPPS uses more specific SRS codes to provide appropriate payment for the facility resources associated with specific types of SRS treatment delivery.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

Several new HCPCS codes relating to drugs, biologicals and radiopharmaceuticals have been created for use in CY 2007. In addition, there is one HCPCS code that has been deleted for CY 2007 and does not have a replacement HCPCS code payable under the OPPS. These new and deleted HCPCS codes are presented in the tables (Tables 7 and 8) within CR 5438, which is available on the CMS site at *http://www.cms.hhs.gov/Transmittals/downloads/R1139CP.pdf*.

Coding Changes for Sodium Hyaluronan Intra-articular Injection Products

CMS has decided to establish separate payment for sodium hyaluronate products that have come on the market since October 2003. To facilitate the separate payment, four interim Q codes will be effective for services performed **on or after January 1, 2007.** Corresponding ASP amounts will be reflected in updated 2007 ASP pricing files to be posted on the CMS website. The following table shows the codes and their descriptors.

HCPCS Code	Long Descriptor
Q4083	Hyaluronan or derivative, Hyalgan® or Supartz®, for intra-articular injection, per dose
Q4084	Hyaluronan or derivative, Synvisc®, for intra-articular injection, per dose
Q4085	Hyaluronan or derivative, Euflexxa™, for intra-articular injection, per dose
Q4086	Hyaluronan or derivative, Orthovisc®, for intra-articular injection, per dose

Effective January 1, 2007, HCPCS code J7319, (Hyaluronan (sodium hyaluronate) or derivative, intra-articular injection, per injection) will not be recognized by Medicare.

Billing for Pre-Administration Related Services Associated with Intravenous Immune Globulin (IVIG) Administration

As noted in the CY 2007 OPPS final rule, Medicare will continue the temporary add-on payment for hospital outpatient departments that administer IVIG to Medicare

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patients. Continue to bill HCPCS code G0332 only once per patient per day of IVIG administration and payment will continue to map to APC 1502 with a payment rate of $75. The G0332 code must continue to be reported on the same claim form as the IVIG product (J1566 and/or J1567) and have the same date of service as the IVIG product and drug administration service. This payment is in addition to Medicare's payment to the hospital for the IVIG product itself and for administration of the IVIG product via intravenous infusion.

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2007

In the CY 2007 OPPS final rule, it was stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. **Effective January 1, 2007,** payment rates for many drugs and biologicals have changed from the values published in the CY 2007 OPPS final rule as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2006. In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in the January 2007 release of the OPPS PRICER. The updated payment rates in CR 5438, which is implementing the January 2007 update of the OPPS. However, the updated payment rates **effective January 1, 2007,** may be found in the January 2007 update of the OPPS Addendum A and Addendum B on the CMS website at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage*.

Coding and Payment for Drug Administration

Drug administration services furnished under the OPPS during CY 2005 were reported using *CPT* codes *90780*, *90781*, and *96400-96459*. Effective January 1, 2006, some of these *CPT* codes were replaced with more detailed *CPT* codes incorporating specific procedural concepts, as defined by the *CPT* manual, such as initial, concurrent, and sequential.

In order to facilitate the transition to more specific *CPT* codes within the hospital environment and to assist hospitals in ensuring continued correct coding concepts, drug administration services provided in CY 2006 under the OPPS were billed using a combination of *CPT* codes and C-codes and did not include the newly introduced *CPT* concepts of initial, concurrent, and sequential.

Hospitals should use the full set of *CPT* codes, including those codes referencing concepts of initial, concurrent, and sequential, to bill for drug administration services furnished in the hospital outpatient department beginning **January 1, 2007.** Continue to bill the HCPCS codes that most accurately describe the service(s) provided. Remember to bill a separate evaluation and management code (with modifier **25**) only if significant, separately identifiable E/M service is performed in the same encounter with OPPS drug administration.

Administration of Vaccines that are Covered Part D Drugs

HCPCS code G0377 (Administration of vaccine for Part D drug) will be effective under the OPPS beginning January 1, 2007. It will be assigned to APC 0437, Level II Drug Administration, with status indicator of "S" and a national unadjusted payment of $24.25, with a minimum unadjusted copayment of $4.85.

Additional Information

Other points of interest contained in CR 5438 include:

- Hospitals reclassified for IPPS effective October 1, 2006, will be reclassified for OPPS **effective January 1, 2007.**
- Section 401 designations and floor MSA designations effective October 1, 2006, will be effective for OPPS **on January 1, 2007.**
- Rural sole community hospitals will receive a 7.1 percent payment increase in 2007.
- For services on or after January 1, 2006, EACHs will receive a 7.1 percent payment increase.
- New OPPS payment rates and coinsurance amounts are effective **on January 1, 2007,** with coinsurance rates limited to 40 percent of the APC payment and coinsurance cannot exceed the inpatient 2007 deductible of $992.
- For hospital outlier payments, there is no change for the multiple threshold in 2007, but there is a change for the fixed threshold. The estimated cost of service must be greater than the APC payment amount plus $1,825 in order to qualify for outlier payment in 2007. The previous fixed threshold was $1,250.
- **Effective January 1, 2007,** blood and blood products will be eligible for outlier payments.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5438) issued to your Medicare FI, RHHI or A/B MAC. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1139CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.
MLN Matters Number: MM5438
Related Change Request (CR) Number: 5438
Related CR Release Date: December 22, 2006
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Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1139, CR 5438

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

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

Note: CMS has revised this *MLN Matters* article on January 16, 2007, to reflect changes made to change request (CR) 5425. The CR release date and transmittal number has been change and the Web address for accessing CR 5389 has been revised. In addition, references to status indicators H and K were deleted from the table below. All other information remains the same. The original *MLN Matters* article was published in the January 2007 *Medicare A Bulletin* (pages 53-54).

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

January 2007 Outpatient Prospective Payment System Outpatient Code Editor Specifications Version 8.0 (continued)

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

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

Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1155CP.pdf*.

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

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

MLN Matters Number: MM5425 – Revised
Related Change Request (CR) Number: 5425
Related CR Release Date: January 12, 2007
Related CR Transmittal Number: R1155CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1155, CR 5425

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

February 2007 – May 2007

Ask the Contractor – Outpatient Therapy Cap Exception Process for 2007

When: **Tuesday, February 13, 2007**

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

Type of Event: **Teleconference**

2007 Medifest Symposium (Medicare Part A and B)

When: **Tuesday – Thursday, March 13 – 15, 2007**

Where: **Jacksonville Marriott**
4670 Salisbury Road
Jacksonville, FL 32256

Type of Event: **Educational Seminar**

Hot Topics (Topics To Be Determined)

When: **Tuesday, March 20, 2007**

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

Type of Event: **Teleconference**

Ask the Contractor (Topic To Be Determined)

When: **Tuesday, April 10, 2007**

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

Type of Event: **Teleconference**

2007 Medifest Symposium (Medicare Part A and B)

When: **Tuesday – Thursday, May 15 – 17, 2007**

Where: **Marriott Tampa Westshore**
Tampa, Florida

Type of Event: **Educational Seminar**

More events will be planned soon for this quarter. Keep checking our website at *http://www.floridamedicare.com*, or listening to information on the FCSO Provider Education and Outreach Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

Please Note: Pre-registration is required for all teleconferences, webcasts and in-person educational seminars. *Dates and times are subject to change prior to event advertisement and/or registration.*

What Is a Webcast?

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

Online Registration

To participate in the above educational events, 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: _____

Medifest Class Schedule
March 13-15, 2007

A– Part A Class
B – Part B Class
(A/B) – Both Parts A&B

Registrant's Name: _____

March 13 – 15, 2007
Jacksonville Marriott
4670 Salisbury Road
Jacksonville, FL 32256
Please contact hotel for directions and/or reservations (904) 296-2222

PLEASE MARK ONLY ONE CLASS PER TIME SLOT
Cost $205.00

Day 1

General Session 8:00 am to 8:30 am

8:45 AM - 10:15 AM SESSION 1
- ❑ Appeals (A)
- ❑ Appeals (B)
- ❑ CPT Coding (A/B)
- ❑ Direct Data Entry (A)
- ❑ Global Surgery (B)
- ❑ Medicare Self Service Techniques (A/B)

10:30 AM – 12:00 PM SESSION 2
- ❑ eLearning (A/B)
- ❑ E/M Coding (B)
- ❑ Fraud & Abuse (A/B)
- ❑ Medicare Easy Remit (B)
- ❑ Modifiers (A)
- ❑ National Correct Coding Initiative (NCCI) Modifiers (B)

1:15 PM – 3:15 PM SESSION 3
- ❑ ANSI 101 (A/B)
- ❑ E/M Documentation (B)
- ❑ Life of a Part A Claim (A)
- ❑ Medicare Secondary Payer (A)
- ❑ Medicare Secondary Payer (B)
- ❑ Provider Enrollment/NPI (A/B)

3:30 PM – 5:30 PM SESSION 4
- ❑ ANSI 102 (A/B)
- ❑ Claims Resolution (B)
- ❑ ICD-9-CM Coding (A/B)
- ❑ Incident to/Locum Tenens/Reciprocal Billing (B)
- ❑ Medical Review/Data Analysis (A/B)

Day 2

8:00 AM - 10:00 AM SESSION 1
- ❑ ANSI 101 (A/B)
- ❑ E/M Documentation (B)
- ❑ Incident to/Locum Tenens/Reciprocal Billing (B)
- ❑ Medicare Secondary Payer (B)
- ❑ Provider Enrollment/NPI (A/B)
- ❑ Reimbursement Efficiency (A)

10:15 AM – 12:15 PM SESSION 2
- ❑ ANSI 102 (A/B)
- ❑ Claims Resolution (B)
- ❑ ICD-9-CM Coding (A/B)
- ❑ Medical Review/Data Analysis (A/B)
- ❑ Medicare Outpatient PPS (A)
- ❑ Medicare Part D (A/B)

1:30 PM – 3:00 PM SESSION 3
- ❑ Appeals (B)
- ❑ CPT Coding (A/B)
- ❑ Direct Data Entry (A)
- ❑ Global Surgery (B)
- ❑ Medicare Easy Remit (B)
- ❑ Primary Care (B)

3:15 PM – 4:45 PM SESSION 4
- ❑ eLearning (A/B)
- ❑ E/M Coding (B)
- ❑ Fraud & Abuse (A/B)
- ❑ Medicare Self Service Techniques (A/B)
- ❑ National Correct Coding Initiative (NCCI) Modifiers (B)

Day 3
March 15, 2007
Cost $126.00

9:00 AM - 12:00 PM
- ❑ Ambulatory Surgery Center (B)
- ❑ Cardiology (B)
- ❑ Independent Diagnostic Testing Facility (B)
- ❑ Rehabilitation Services (A/B)
- ❑ Skilled Nursing Facility (A/B)

For complete class descriptors, please visit the Education page on our website at *www.floridamedicare.com.*

A CMS Contracted Intermediary & Carrier

MEDIFEST 2007, Jacksonville Registration Form
Jacksonville Marriott 4670 Salisbury Road Jacksonville, FL 32256 Please contact hotel for directions and/or reservations (904) 296-2222

Registrant's Name _____

Telephone Number _____

Email Address _____

Fax Number _____

Provider's Name _____

Street Address _____

City, State, ZIP Code _____

Cost for Medifest	
Medifest (Day 1 & 2)	$205.00
Medifest Specialty (Day 3)	$126.00

FAXED REGISTRATION	CANCELLATIONS AND REFUNDS	SUBSTITUTIONS	CONFIRMATION NOTICE	HOTEL INFORMATION
1. Fax registration form to **(904) 791-6035.** 2. A confirmation will be faxed to you. The invoice will be sent under a separate cover. 3. Make checks payable to: **FCSO Account #700390** 4. Mail the forms (after you have faxed them) and payment to: **Medifest Registration P.O. Box 45157 Jacksonville, FL 32231** 5. Bring your Medifest confirmation notice to the event.	All cancellation requests must be received 7 days prior to the event. All refunds are subject to a $25.00 cancellation fee per person. (Rain checks will not be issued for cancellations.)	If you are unable to attend, your company may send one substitute to take your place for the entire seminar. Remember: You must inform the Registration Office of all changes. Once you have signed in at the registration desk, substitutions will not be permitted during the remainder of the event.	**Online registration:** When registering online for an education event, you will automatically receive your confirmation via e-mail notification. **Faxed registration**: A confirmation notice will be faxed or e-mailed to you within 7 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Provider Outreach and Education), please contact us at **(904) 791-8103.**	Jacksonville Marriott 4670 Salisbury Road Jacksonville, FL 32256 (904) 296-2222 Ask for FCSO's Special Room Rate.

For complete class descriptors, please visit the Education page on our website at *www.floridamedicare.com.*

PREVENTIVE SERVICES

January is National Glaucoma Awareness Month

Please join the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of glaucoma and the glaucoma screening benefit provided by Medicare. Nearly three million Americans have glaucoma, the second leading cause of blindness in the world. Often progressing silently, with no symptoms, it is estimated that many people that do have the disease don't know it. With glaucoma, by the time a problem is noticed permanent damage has already occurred. With early detection and treatment, however, blindness may be prevented.

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:

- A dilated eye examination with an intraocular pressure (IOP) measurement; and
- A 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 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, visit on the Web *http://www.medicare.gov*.
- For more information about National Glaucoma Awareness Month, please visit *http://www.preventblindness.org/*. ❖

Source: CMS Provider Education Resource 200701-03

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.

Overview of Medicare Preventive Services

The *Medicare Learning Network* newest educational video program, *An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* provides an overview of preventive services covered by Medicare and information on risk factors associated with various preventable diseases, and highlights the importance of prevention, detection, and early treatment of disease. The program is a great resource to help physicians, providers, suppliers, and other health care professionals involved in providing preventive services to Medicare beneficiaries learn more about the preventive benefits covered by Medicare.

The video program runs approximately 75 minutes in length and is suitable for viewing by an individual or for a larger audience such as at a conference or training session.

The Centers for Medicare & Medicaid Services (CMS), as an authorized provider by the International Association for Continuing Education and Training (IACET), has awarded for this educational video program 0.1 of CEUs (continued education units) to participants who successfully complete this program.

To order your copy today, go to the *Medicare Learning Network* Product Ordering page on the CMS website at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

This educational video is available in DVD or VHS format. ❖

Source: CMS Provider Education Resource 200701-05

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

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

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
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ALL ORDERS MUST BE PREPAID –

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***NOTE:** The Medicare A Bulletin is available **free of charge** online at **www.floridamedicare.com**.*

IMPORTANT ADDRESSES, TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

PROVIDER EDUCATION

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

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION

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

OVERPAYMENT COLLECTIONS

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

MEDICARE REGISTRATION

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

Telephone Numbers

PROVIDERS

Customer Service Center Toll-Free
1-877-602-8816
Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY

Customer Service Center Toll-Free
1-800-MEDICARE
1-800-633-4227
Speech and Hearing Impaired
1-800-754-7820

ELECTRONIC MEDIA CLAIMS

EMC Start-Up
1-904-791-8767, option 4

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

Direct Data Entry (DDE) Support
1-904-791-8131

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

Help Desk (Confirmation/Transmission)
1-904-905-8880

Medicare Websites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators – Gulf Coast
34650 US Highway 19 North, Suite 202
Palm Harbour, FL 34684-2156

RAILROAD MEDICARE

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

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

MEDICARE A BULLETIN

FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. BOX 2078 ❖ JACKSONVILLE, FL 32231-0048

*** ATTENTION BILLING MANAGER ***