# Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

# In This Issue...



### Features



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

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

**Routing Suggestions:**

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

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

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***Medicare A Bulletin***

**Vol. 9, No. 9**
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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 faxed to:

**Medicare Publications**
**1-904-357-6702**

## 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. Important notifications requiring communication in between publications will be posted to the FCSO Medicare provider education Web site *http://www.floridamedicare.com*.

### Who Receives the *Bulletin*?

Anyone may view, print or dowload the *Bulletin* from our provider education Web site. 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 June 2007 *Medicare A Bulletin*, page 4). Registration forms must be submitted annually or when the provider's business practices have experienced a change in circumstances that impact electronic access.

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

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

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

### 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 are sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines 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.
- The Educational Resources section includes educational events and materials, such as seminar schedules, Medicare provider education Web site information, and reproducible forms.
- Important addresses and phone numbers are in the back of every issue.

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

Articles included in each *Medicare A Bulletin* represent formal notice that specific coverage policies have or will take effect on the date given. Providers 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 comments and feedback on the *Bulletin* and appreciates your continued support. Please fax comments to:

Medicare Publications
1-904-357-6702

## Quarterly Provider Update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the Quarterly Provider Update by going to the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU listserv to ensure timely notification of all additions to the QPU. ❖

# PROVIDER ENROLLMENT

## Avoid Provider Enrollment Delays

### Did You Know Incomplete Applications Result in Significant Delays?

First Coast Service Options, Inc. **pre-screens** enrollment applications to verify they include required data elements and supporting documentation. **Applications will be returned without further review if certain conditions exist.** The most common reasons for returned applications include:

- An outdated version of the CMS-855 application(s) was submitted. Only the 06/06 versions are accepted.
- The CMS-855 and/or CMS-588 EFT application was not signed in ink and/or dated.
- All required applications in the reassignment package were not submitted.
- An unauthorized official signed the CMS-855R application.

FCSO processes applications in the order they are received. Providers must correct and resubmit applications that are returned by FCSO. Resubmitted applications are considered a new receipt and will be processed in the order of receipt. The most common items missing from applications include:

- Medical or professional licenses, occupational licenses, certifications, and registrations required by federal or state law.
- National Provider Identifier (NPI) notification letters from NPPES.
- Business licenses such as occupational licenses (business tax receipts).
- Internal Revenue Service (IRS) CP-575 documentation.
- Interim sales agreements.

If an application is missing at least one required data element or supporting document, FCSO will send you a letter (referred to as a pre-screening letter), via fax, requesting the information needed to continue processing your application. When a fax number is not available, FCSO will mail this letter to the correspondence address noted in the application.

Providers have 60 days from the date of the pre-screening letter to return all requested information. If all requested information is not returned in 60 days, FCSO will reject the application. Once rejected, the provider must resubmit the application, which will be processed in the order of receipt.

### For More Information…

Enrollment applications, tips to facilitate the enrollment process and answers to commonly asked questions may be found at *http://www.floridamedicare.com/Reference/General_Topics/Provider_Enrollment/109011.pdf*.

You may also access the Centers for Medicare & Medicaid Services (CMS) Internet-only-Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 10 at *http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf*. ❖

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

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

# GENERAL INFORMATION

## Timeliness Standards for Processing 'Other-than-Clean' Claims

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

### Provider Types Affected

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

### Provider Action Needed

### STOP – Impact to You

This article is based on change request (CR) 5513, which implements requirements for timeliness standards for processing other-than-clean claims. The article is informational in nature and requires no action on your part.

### CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) published instructions in a separate transmittal to implement requirements for all carriers and MACs for timeliness standards for processing other-than-clean claims, and CR 5513 implements those same requirements for FIs, A/B MACs, DME MACs, and RHHIs, effective for claims received on or after January 1, 2008.

### GO – What You Need to Do

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

### Background

The Social Security Act (Section 1869(a)(2); *http://www.ssa.gov/OP_Home/ssact/title18/1869.htm*) mandates that Medicare process all "other-than-clean" claims and notify the provider/supplier filing such claims of the determination within 45 days of receiving such claims. The Social Security Act (Section 1869; *http://www.ssa.gov/OP_Home/ssact/title18/1869.htm*) further defines the term "clean claim" as meaning "a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title." Claims that do not meet the definition of "clean" claims are "other-than-clean" claims, and they require investigation or development external to the contractor's Medicare operation on a prepayment basis.

A Medicare contractor should process all "other-than-clean" claims and notify the provider and beneficiary of their determination within 45 calendar days of receipt. (See *Medicare Claims Processing Manual*, Publication 100-4, Chapter 1, Section 80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims; *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf*.)

However, when the Medicare contractor develops the 'other-than-clean' claim by asking the provider/supplier or beneficiary for additional information, the Medicare contractor should cease counting the 45 calendar days on the day that the Medicare contractor sends the development letter to the provider/supplier and/or beneficiary. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the Medicare contractor should resume counting the 45 calendar days.

**Example:**

A Medicare contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this example, five of the 45 allotted calendar days will have already passed before the Medicare contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the Medicare contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.

Medicare contractors should follow existing procedures relative to both 1) the length of time the provider/supplier and/or beneficiary is afforded the opportunity to return information requested in the development letters and 2) situations where the provider/supplier and or beneficiary does not respond.

This timeliness standard does not apply:

- Where the Social Security Administration blocks a beneficiary's health insurance claim number (HIC).
- Where there is a problem with the beneficiary's record in Medicare's files **are not subject to this instruction.**
- Where the translator software rejects the claim.
- Where CMS instructs Medicare contractors to hold certain claims for processing, e.g., while system changes are being made to handle such claims correctly.
- To claims submitted by a hospice and these claims are to be processed per instructions in the *Medicare Claims Processing Manual* (Chapter 1, Section 50.2.3; *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf*).

### Additional Information

The official instruction, CR 5513, issued to your FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1312CP.pdf*.

***Timeliness Standards for Processing 'Other-than-Clean' Claims (continued)***

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

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

*MLN Matters* Number: MM5513
Related Change Request (CR) Number: 5513
Related CR Release Date: July 20, 2007
Related CR Transmittal Number: R1312CP
Effective Date: January 1, 2007
Implementation Date: January 7, 2007

Source: CMS Pub. 100-04, Transmittal 1312, CR 5513



# Important Guidance on the New CMS-1500 and UB-04 Forms

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

## Provider Types Affected

All providers using the new forms CMS-1500 or UB-04 to bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors MACs]) for services provided to Medicare beneficiaries.

## What You Need to Know

This *MLN Matters* article, SE0729, provides you valuable information about the new CMS-1500 and UB-04 forms.

## Background

**CMS-1500 Form Version 08-05**

In 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised Form CMS-1500 (08-05). This new version of the form, revised to accommodate the reporting of the national provider identifier (NPI), was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC), which is chaired by the American Medical Association (AMA), in consultation with CMS.

The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one health care vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers that you submit all claims to Medicare electronically, the Administrative Simplification Compliance Act Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 provide for exceptions to the mandatory electronic claim submission requirement. Therefore, Medicare will receive, and process, paper claims (using the new [08-05] version of the CMS-1500 form) only from physicians and suppliers who are excluded from the mandatory electronic claims submission requirements.

CMS began accepting the revised form CMS-1500 in January 1, 2007, planning to discontinue the older version on April 1, 2007; however formatting issues forced CMS to extend this date to July 2, 2007. At that time, CMS began returning the 12-90 version of the form. While the Government Printing Office (GPO) is not yet in a position to accept and fill orders for the revised CMS-1500 form, CMS' research indicates the form is widely available for purchase from print vendors.

For assistance in locating the form, you can contact the NUCC at *http://www.nucc.org/*, or you might consider using local print media directories to search for print vendors, contacting other providers to inquire on their source for the form, or searching for "CMS-1500 (08-05)" or "CMS-1500 08/05" on the Internet to locate online print vendors. You should ask for samples before ordering to ensure that the formatting is correct.

Some important details in completing the new CMS-1500 form are as follow:

- If you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should now begin using your NPI also.
- The billing provider NPI goes in box 33a. In addition, if the billing provider is a group, then the rendering provider NPI must go in box 24j. If the billing provider is a solo practitioner, then box 24j is always left blank. A referring provider NPI goes in box 17b.
- If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

You can learn more about the new version of the CMS-1500 by reading *MLN Matters* article MM5060 (Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500), released September 15, 2006. You can find that article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf*.

**UB-04 Information**

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. The UB-04, the basic form that CMS prescribes for the Medicare program, incorporates the national provider identifier (NPI) tax-

*Important Guidance on the New CMS-1500 and UB-04 Forms (continued)*

onomy, and additional codes; and is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

Effective March 1, 2007, institutional claim filers such as hospitals, SNFs, hospices, and others were to have begun using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007 (during which time either the UB-92 or the UB-04 may have been used). **On and after May 23, 2007:** 1) The UB-92 has become no longer acceptable (even as an adjustment claim); and 2) All institutional paper claims must be submitted on the UB-04.

You should note that while most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change. Some details of the form follow:

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

For the UB-04, the billing provider's NPI is entered in form locator (FL) 56. The attending provider's NPI is entered in FL76. The operating provider's NPI is entered in FL77. Up to two other provider NPIs can be entered in FL78 and FL79.

You can find more information about the UB-04 (Form CMS-1450) by reading MLN Matters article MM5072 (Uniform Billing (UB-04) Implementation – UB-92 Replacement), released November 3, 2006. You can find that article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf*.

The CR, from which that article was taken, contains a copy of the UB-04 form (front and back) in PDF format, a crosswalk between the UB-04 and the UB-92, and the revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS-1450 Data Set), Sections 70 (Uniform Bill – Form CMS-1450 (UB-04)) and 71 (General Instructions for Completion of Form CMS-1450 (UB-04)). These sections contain very detailed instructions for completing the form.

For assistance in obtaining UB-04s you can contact the NUBC at *http://www.nubc.org/*.

### Additional Information

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

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

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Related CR Release Date: N/A
Related CR Transmittal Number: N/A
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Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0729



## Unsolicited/Voluntary Refunds

All Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open accounts receivable). Intermediaries generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds. The Centers for Medicare & Medicaid Services reminds providers that:

"The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims." ❖

Source: CMS Pub 100-6 Transmittal 50, CR 3274

## The 2007 Medicare Contractor Provider Satisfaction Survey Shows Positive Results for Medicare Fee-for-Service Contractors

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

### Provider Types Affected

All Medicare physicians, providers, and suppliers billing the Medicare program.

### Provider Action Needed

No action is needed. This article is informational only and provides a summary of the findings from the second annual survey by Medicare to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries [FIs], Medicare administrative contractors (MACs), and durable medical equipment Medicare administrative contractors [DME MACs]).

### Background

The Centers for Medicare & Medicaid Services (CMS) reports that most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors.

The Medicare contractor provider satisfaction survey (MCPSS), recently conducted by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The national average score for 2007 is 4.56.

Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor's handling of provider inquiries surpassed claims processing as the key predictor of a provider's satisfaction. CMS has provided contractors information for process improvement based on individual MCPSS results.

The MCPSS was sent early this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. The survey was expanded this year to include hospice locations and federally qualified health centers.

The full results of the 2007 survey are now available on the CMS Web site at *http://www.cms.hhs.gov/MCPSS*.

In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2008 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

### Additional Information

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

*MLN Matters* Number: SE0733
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 SE0733



## Date of Service for Laboratory Specimens

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

### Provider Types Affected

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

### Provider Action Needed

This article is based on change request (CR) 5573 which implements revisions to the date of service (DOS) policy for tests performed on laboratory specimens, in accordance with updates to 42CFR414.510 that were published in the *Federal Register* on December 1, 2006. **Remember when submitting claims that the general rule is that the date of service is the date the specimen is collected. Where a specimen is collected over a period that spans two calendar days, the date of service is the date the collection period ended.**

*Date of Service for Laboratory Specimens (continued)*

## Background

The general rule for the DOS of a test performed on a laboratory specimen is the date that the specimen is collected. If a specimen is collected over a period that spans two calendar days, then the DOS must be the date that the collection period ended.

The current DOS policy allows an exception to the general rule for tests performed on an archived specimen. If a specimen was stored for more than 30 calendar days before testing (otherwise known as "an archived specimen"), the DOS of the test must be the date that the specimen was obtained from storage.

In the final physician fee schedule regulation published in the *Federal Register* on December 1, 2006, (*http://www.access.gpo.gov/su_docs/fedreg/a061201c.html*), the Centers for Medicare & Medicaid Services (CMS) revised the DOS policy for laboratory specimens to allow additional exceptions to the general rule and the DOS rule for tests performed on an archived specimen.

**CR 5573 implements the revisions to the DOS policy for tests performed on laboratory specimens specified in the final rule, in accordance with the updates to 42 CFR section 414.510** *(http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/06-9086.htm*).

As already mentioned, under the revised DOS policy for laboratory specimens, the g**eneral rule** is that the DOS of the test must be the date the specimen was collected. However, there is a **variation:** If a specimen is collected over a period that spans two calendar days, then the DOS must be the date the collection ended.

The following exceptions apply to the DOS policy for laboratory tests:

**DOS for Tests Performed on Stored Specimens**

In the case of a test performed on a stored specimen, if a specimen was stored for less than or equal to 30 calendar days from the date it was collected, **the DOS of the test must be the date the test was performed only if:**

- The patient's physician orders the test at least 14 days following the date of the patient's discharge from the hospital.
- The specimen was collected while the patient was undergoing a hospital surgical procedure.
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted.
- The results of the test do not guide treatment provided during the hospital stay.
- The test was reasonable and medically necessary for treatment of an illness.

**Note:** If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived, and the DOS of the test must be the date the specimen was obtained from storage.

**DOS for Chemotherapy Sensitivity Tests Performed on Live Tissue**

In the case of a chemotherapy sensitivity test performed on live tissue, **the DOS of the test must be the date the test was performed only if**:

- The decision regarding the specific chemotherapeutic agents to test is made at least 14 days after discharge.
- The specimen was collected while the patient was undergoing a hospital surgical procedure.
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted.
- The results of the test do not guide treatment provided during the hospital stay.
- The test was reasonable and medically necessary for treatment of an illness.

**Note:** For purposes of applying the above exception, a "chemotherapy sensitivity test" is defined as a test that requires a fresh tissue sample to test the sensitivity of tumor cells to various chemotherapeutic agents.

## Additional Information

The official instruction, CR 5573, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1319CP.pdf*.

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

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

*MLN Matters* Number: MM5573
Related Change Request (CR) Number: 5573
Related CR Release Date: August 17, 2007
Related CR Transmittal Number: R1319CP
Effective Date: January 1, 2007
Implementation Date: January 1, 2008

Source: CMS Pub. 100-04, Transmittal 1319, CR 5573

## Use of Nine-Digit ZIP Codes for Establishing Payment Locality

Effective for dates of service **on or after October 1, 2007,** institutional providers must submit a valid nine-digit ZIP code when billing for services paid under the Medicare physician fee schedule for services provided in an area that falls into more than one payment locality.

Fiscal intermediaries (FI) determine the locality for the services provided based on the ZIP code of the provider's physical address. This address, including the ZIP code, is stored on the provider file as the master address.

**Effective for dates of services on or after October 1, 2007,** FI will **return to providers** claims provided in one of the affected cross-payment localities when the provider file master address ZIP code is

- Five-digits,
- The last four-digits of a nine-digit ZIP code are zeroes, or
- The last four-digits of a nine-digit ZIP code do not match a four-digit extension on the ZIP code file.

The affected nine-digit ZIP codes that cross payment localities in Florida are:

| | | | | |
|---|---|---|---|---|
| 32948 | 33440 | 33917 | 33920 | 33955 |
| 33972 | 34141 | 34142 | 34972 | 34974 |

For information about the use of nine-digit ZIP codes, payment determination and exceptions see the revised *MLN Matters* article related to change request CR 5208, published in the April 2007 *Medicare A Bulletin* (pages 12-15).

### Action Required by Providers

Affected institutional providers must submit a **CMS-855A Enrollment Application** (version 06/06) to update the provider file master address ZIP code to a valid nine-digit ZIP code prior to October 1, 2007. The CMS-855A Enrollment Application may be mailed to:

Medicare Provider Enrollment (Florida Part A)
P.O. Box 45169
Jacksonville, FL 32231-5169

Source: CMS Pub. 100-04, Transmittal 1193, CR 5208

## Electronic Funds Transfer Standardizations

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

### Provider Types Affected

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

### Provider Action Needed

### STOP – Impact to You

This article is based on change request (CR) 5586 which revises the *Medicare Claims Processing Manual*, , Chapter 24 (*General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims*).

### CAUTION – What You Need to Know

Effective July 1, 2007, your Medicare contractor will conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20 percent of providers submitting CMS-1500 paper claims who were not already reviewed in the past two years and found to have fewer than 10 full time employees (FTEs) employed by the practice. In addition, contractors will insure that the addenda record is sent with the Medicare claim payment when an ACH format is used to transmit an EFT payment to a financial institution but the remittance advice is separately transmitted to a provider. This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP – Cash Concentration/ Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

### GO – What You Need to Do

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

### Background

CR 5586 provides the following revisions to the *Medicare Claims Processing Manual* (Chapter 24, Sections 40.7 and Section 90.5.3) regarding electronic funds transfer (EFT) and the identification of providers to be reviewed.

**Contractor Roles in Administrative Simplification Compliance Act (ASCA) Reviews and Identification of Providers To Be Reviewed**

Each carrier, DME MAC and B MAC (not FIs or RHHIs at this time) conducts an ASCA review annually of 20 percent of those providers still submitting CMS-1500 paper claims. Medicare contractors will not select a provider for a quarterly review if:

- A prior quarter review is underway and has not yet been completed for that provider;
- The provider has been reviewed within the past two years, determined to be a "small" provider as fewer than 10 FTEs are employed in that practice and there is no reason to expect the provider's "small" status will change within two years of the start of the prior review; or
- The provider submitted fewer than 30 paper claims to Medicare during the prior quarter.

**Electronic Funds Transfer (EFT)**

Although EFT is not mandated by the Health Insurance Portability and Accountability Act (HIPAA), EFT is the required method of Medicare payment for all providers

*Electronic Funds Transfer Standardizations (continued)*

entering the Medicare program for the first time and any existing providers, not currently receiving payments by EFT, who are submitting a change to their existing enrollment data. Providers must submit a signed copy of CMS-588 (Electronic Funds Transfer Authorization Agreement) to their carriers, DME MACs, A/B MACs, FIs, and/or RHHIs. For changes of information, DME MACs will verify the authorized official on the CMS-855 application form. In addition, Medicare contractors will not approve any requests to change the payment method from EFT to check.

Carriers, DME MACs, A/B MACs, FIs and RHHIs must use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an X12 835 transaction, then the NACHA format CCP (Cash Concentration/Disbursement plus Addenda –CCD+) is used to make sure that the addenda record is sent with the EFT, because providers need the addenda record to re-associate dollars with data. Carriers, DME MACs, A/B MACs, FIs, and RHHIs must:

- Transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim, and
- Designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

**Note:** Medicare contractors will not approve any requests to change payment method from EFT to check.

### Additional Information

The official instruction, CR 5586, issued to your carrier, intermediary, RHHI, A/B MAC, or DME MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1284CP.pdf*.

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

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

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Source: CMS Pub. 100-04, Transmittal 1284, CR 5586,



## Clarification About the Medical Privacy of Protected Health Information

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

### Provider Types Affected

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

### Provider Action Needed

The purpose of this special edition (SE) article, SE0726, is be sure that health care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health & Human Services (HHS) has published to clarify the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- the privacy rule protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- that providers are permitted to disclose personal health information needed for patient care and other important purposes.

### HHS Privacy Guidance

HHS' educational materials include a letter to health care providers with the following examples to clarify the privacy rule:

**HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:**

Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization or jumping through other hoops. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) in the "Treatment/Payment/Health Care Operations" subcategory, or search the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found on the HHS Web site at *http://www.hhs.gov/hipaafaq/*.
- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is on the HHS Web site at *http://www.hhs.gov/ocr/hipaa/guidelines/sharingfortpo.pdf*.

*Clarification About the Medical Privacy of Protected Health Information (continued)*

- Review the "Summary of the HIPAA Privacy Rule" on the HHS Web site at *http://www.hhs.gov/ocr/privacysummary.pdf*.

**HIPAA does not require providers to eliminate all incidental disclosures:**

- The privacy rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that rule to clarify that incidental disclosures do not violate the privacy rule when providers and other covered entities have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR website, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the fact sheet on "Incidental Disclosures". The fact sheet is on the HHS Web site at *http://www.hhs.gov/ocr/hipaa/guidelines/incidentalud.pdf*.

**HIPAA does not cut off all communications between providers and the families and friends of patients:**

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.
- The privacy rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.
- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.
- Review the HHS/OCR Web site FAQs *http://www.hhs.gov/hipaafaq/notice/488.html* in the sub-category "Disclosures to Family and Friends."

**HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:**

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.
- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.
- See the FAQs in the "Facility Directories" on the HHS Web site at *http://www.hhs.gov/hipaafaq/administrative/*.

**HIPAA does not prevent child abuse reporting:**

Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which may be found, for instance, by searching on the term "child abuse" or review the fact sheet on "Public Health" that may be reviewed on the HHS Web site at *http://www.hhs.gov/ocr/hipaa/guidelines/publichealth.pdf*.

**HIPAA is not anti-electronic:**

Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the Privacy Rule went into effect. A helpful discussion on this topic may be found on the HHS Web site at *http://www.hhs.gov/hipaafaq/providers/smaller/482.html*.

## Additional Information

The HHS complete listing of all HIPAA medical privacy resources is available on the HHS Web site at *http://www.hhs.gov/ocr/hipaa/*.

For a full list of educational materials, visit on the HHS Web site *http://www.hhs.gov/ocr/hipaa/assist.html*.

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Source: CMS Special Edition *MLN Matters* Article SE0726



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

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

# Reasons for Provider Notification of Medicare Claims Disputed/Rejected by Supplemental Payers/Insurers

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

## Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], Medicare administrative contractors [A/B MACs], and durable medical equipment MACs [DME MACs]).

## Provider Action Needed

**Effective for claims processed on or after July 1, 2007,** when claims crossed over by Medicare to a supplemental payer/insurer are rejected or disputed by that insurer, Medicare will add a standardized message to the notification to the provider. That message will be in the form of a dispute reason code, which will explain why the supplemental insurer disputed the claim. Be sure your billing staff is aware of these codes, as described later in this article, and is ready to take corrective action, as appropriate.

## Background

In *MLN Matters* article, MM3709, the Centers for Medicare & Medicaid Services (CMS) describes the notification process to Medicare providers when Medicare claims that should automatically cross to a supplemental payer/insurer-are not crossed over due to claim data errors. The notification is mailed to the correspondence address that is submitted by the provider, along with all other Medicare enrollment data, and is maintained by CMS Medicare contractors. (MM3709 may be referenced on the CMS website at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3709.pdf*.)

There are also situations where provider notifications are sent **after** the claim has crossed to the supplemental payer/insurer. This occurs in situations where the insurer may not be able to process the Medicare claim for supplemental payment and, therefore, rejects or disputes the claim back to CMS' Coordination of Benefits Contractor (COBC). When these situations occur, the COBC transmits a report containing the "disputed" claims to the Medicare contractor, which then notifies the provider, through a special automated correspondence, that the claim was not crossed automatically.

Beginning in July 2007, provider notifications will include standardized language for claims that have been disputed by the supplemental payer/insurer and the dispute has been accepted by the COBC. The standardized language will read: "Claim rejected by other insurer," and it will include a reason code. The following is a list of the reason codes that may be contained in the standardized language and the definition of each:

**Dispute Reason Codes**

- 000100 – Duplicate claim
- 000110 – Duplicate claim (within the same ISA – IEA loop)
- 000120 – Duplicate claim (within the same ST-SE loop)
- 000200 – Claim for provider ID/state should have been excluded
- 000300 – Beneficiary not on eligibility file
- 000400 – *Reserved for future use*
- 000500 – Incorrect claim count
- 000600 – Claim does not meet selection criteria
- 000700 – HIPAA error
- 009999 – Other

When Medicare providers receive this notification, they may need to take appropriate action to obtain payment from the supplemental payer/insurer for all dispute reason codes **except** for 000100, 000110, 000120, and 000400.

## Additional Information

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

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

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Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0728

# Required Use of Tamper-Resistant Prescription Pads for Outpatient Drugs Prescribed to Medicaid Recipients

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

## Provider Types Affected

This issue impacts all physicians, practitioners, and other providers **who prescribe Medicaid outpatient drugs, including over-the-counter drugs,** in states that reimburse for prescriptions for such items. Pharmacists and pharmacy staff especially should be aware of this requirement as it may affect reimbursement for prescriptions. The requirement is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

## Background

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law on May 25, 2007. Section 7002 (b) of that Act addresses the use of tamper-resistant prescription pads and offers guidance to state Medicaid agencies.

On August 17, 2007, the Centers for Medicare & Medicaid Services (CMS), issued a letter to state Medicaid directors with guidance on implementing the new requirement.

## Key Points of the CMS Letter to Your State Medicaid Director

- As of October 1, 2007, in order for outpatient drugs to be reimbursable by Medicaid, all written, non-electronic prescriptions must be executed on tamper-resistant pads.
- CMS has outlined three baseline characteristics of tamper-resistant prescription pads, but each state will define which features it will require to meet those characteristics in order to be considered tamper-resistant. **To be considered tamper resistant on October 1, 2007, a prescription pad must have at least one of the following three characteristics:**
  - One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
  - One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
  - One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.
- **No later than October 1, 2008, to be considered tamper resistant, states will require that the prescription pad have all three characteristics.**
- Several states have laws and regulations concerning mandatory, tamper-resistant prescription pad programs, which were in effect prior to the passage of section 7002(b). CMS deems that the tamper-resistant prescription pad characteristics required by these states' laws and regulations meet or exceed the baseline standard, as set forth above.
- Your state is free to exceed the above baseline standard.
- Each state must decide whether they will accept prescriptions written in another state with different tamper proof standards.
- **CMS believes that both e-prescribing and use of tamper-resistant prescription pads will reduce the number of unauthorized, improperly altered, and counterfeit prescriptions.**

## Situations in Which the New Requirement Does not Apply

The requirement does not apply:

- When the prescription is electronic, faxed, or verbal. (CMS encourages the use of e-prescribing as an effective means of communicating prescriptions to pharmacists.)
- When a managed care entity pays for the prescription.
- To refills of written prescriptions presented to a pharmacy before October 1, 2007.
- In most situations when drugs are provided in nursing facilities, intermediate care facilities for the mentally retarded, institutions for mental disease, and certain other institutional and clinical facilities.

**Note:** The letter issued by CMS to state Medicaid directors states that emergency fills are allowed as long as a prescriber provides a verbal, faxed, electronic, or compliant prescription within 72 hours after the date on which the prescription is filled. Please note also that Drug Enforcement Administration (DEA) regulations regarding controlled substances may require a written prescription.

## Additional Information

To review the letter from the Center for Medicaid and State Operations go to the CMS Web site *http://www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf*.

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Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0736

# 2007 Physician Quality Reporting Initiative Update

It's been one month since reporting quality data codes for the 2007 Physician Quality Reporting Initiative (PQRI) on claims for dates of service starting July 1 through December 31, 2007 began.

Eligible professionals participating in the 2007 PQRI indicate that the PQRI tool kit and data collection worksheets are an asset to successful reporting. Provider organizations report successful reporting by their members. Information about the 2008 PQRI was released in the *Notice of Proposed Rulemaking* for the 2008 Medicare physician fee schedule (MPFS).

To ensure successful reporting, the Centers for Medicare & Medicaid Services (CMS) brings to your attention the following items:

**Use of Modifiers with PQRI Quality Data Codes**

The PQRI quality data codes should only be reported with ***CPT* II modifier(s) 1P, 2P, 3P or 8P,** if applicable. If any other modifier, i.e., *CPT* I modifier or HCPCS Level II modifier, is placed on the same line as a PQRI code, it may cause the claim to be rejected or denied as an invalid procedure/modifier combination.

**PQRI Letter to Medicare Beneficiaries**

CMS has posted a letter to Medicare beneficiaries with important information about the PQRI on the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

The letter is from Medicare to the patient explaining what the program is, and the implications for the patient. Physicians may choose to provide a copy to their patients in support of their PQRI participation.

**Question of the Week**

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

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

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

**Example:**

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

The 1.5 percent potential bonus is $6000.

Dr. Smith reported quality data codes in 500 instances.

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

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

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

**How To View the Measures and Specifications**

To view the entire list of 2007 PQRI quality measures and the associated measure specifications, visit the PQRI Web site at, *http://www.cms.hhs.gov/PQRI*, and click on the "Measures/Codes" section of the page.

**How To View the List of Eligible Professionals**

To see the complete list of eligible professionals who may choose to participate in the 2007 PQRI, visit the PQRI Web site at *http://www.cms.hhs.gov/PQRI*, and click on the "Eligible Professionals" section of the page.

**PQRI Resources**

New information is continually added to the most reliable source of information for the 2007 PQRI, the CMS Web site, *http://www.cms.hhs.gov/PQRI*. Here you will find new and revised *Frequently Asked Questions*, updates on issues related to both the 2007 and 2008 PQRI, new educational products, and access to the latest information you need to successfully participate in the 2007 PQRI.

**General Information**

**Rejected Claims**

Contractors can reject Medicare fee-for-service claims for a variety of reasons including:

- Incorrect billing information
- Terminated provider
- Beneficiary is not eligible for Medicare
- Claim was sent to the wrong contractor.

If a provider has questions about a claim rejected by a Medicare fiscal intermediary, carrier or administrative contractor, the provider should contact the contractor directly. It is never appropriate to direct the beneficiary who received the service billed on the claim to the 1-800-Medicare toll free line to resolve a claim rejection. ❖

Source: CMS Provider Education Resource 200708-08

## Enhancements to the Provider Part A IVR Available in Late August, 2007

First Coast Service Options, Inc. (FCSO) is committed to providing the best service possible to our customers. In an effort to do so, we are currently working to enhance the provider interactive voice response unit (IVR) menu with more eligibility options.

Providers can expect to receive the following new eligibility information when pressing option 1 on the IVR menu:

- Enhanced eligibility information
- MSP
- Eligibility for a previous date of service
- Physical and occupational therapy information
- Hospice
- Home Health
- Skilled Nursing Facility

This information will be available on the IVR in late August 2007. Look for our new *IVR link* on this Web site, which will take you to additional articles and resources pertaining to the IVR. ❖

# NATIONAL PROVIDER IDENTIFIER

## Implementation Delay for Transaction 835 and Standard Paper Remittance Advice Change

The Centers for Medicare & Medicaid Services (CMS) has advised contractors that the implementation of change request (CR) 5452 (*Stage 3 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice*) scheduled for October 1, 2007, has been delayed.

Until further notice is received by CMS, the electronic remittance advice (ERA), standard paper remittance advice (SPR), PC Print, and MREP software will not report or insert the national provider identifier (NPI) information as directed in CR 5452. Providers will be notified when additional information becomes available.

The *MLN Matters* article MM5452 related to CR 5452 was published in the July 2007 *Medicare A Bulletin* (pages 18-19). ❖

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

## Second in the Series of Special Edition Articles on the National Provider Identifier Rescinded

*CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article*

The Centers for Medicare & Medicaid Services (CMS) has rescinded the second in the series of special edition *MLN Matters* articles on the national provider identifier-related activities on August 9, 2007, due to a number of factors affecting the NPI implementation, especially the contingency plan announced in *MLN Matters* article MM5595. For the latest NPI information, you can view all NPI related *MLN Matters* articles by going to the CMS Web site *http://www.cms.hhs.gov/NationalProvIdentStand/downloads/MMarticles_npi.pdf*.

The *MLN Matters* article MM5595 was published in the May 2007 *Medicare A Bulletin* (pages 17-18). The revised special edition *MLN Matters* article SE0555 was published in the July 2007 *Medicare A Bulletin* (pages 24-27).

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Implementation Date: N/A

Source: CMS Special Edition Medlearn Article SE0555

# Updated Information for Medicare Providers on National Provider Identifier

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

During this testing and implementation phase for the national provider identification (NPI), providers should pay close attention to information from health plans and clearinghouses to understand how claims are being processed and what providers should be doing to assure no disruption in payment. Providers should also ensure that the information they are submitting on a claim is what is being transmitted to each health plan by the billing vendors or clearinghouses that may be submitting the claims on their behalf.

### National Plan and Provider Enumeration System (NPPES) FOIA-Disclosable Data to be Available on August 1, 2007

The NPI registry, a query-only database, will be operational on August 1, 2007. The NPI registry will operate in a real-time environment. This means that the Freedom of Information Act (FOIA)-disclosable data for newly enumerated providers, as well as updates and changes to enumerated provider FOIA-disclosable data, will be available in the NPI registry as that information is applied to the national plan and provider enumeration system (NPPES). The NPI registry will enable a user to query by, for example, NPI or provider name, and will return a list of all NPPES records that meet the query specifications. The user selects from that list the NPPES records he/she wants to see. The NPI registry will then display the FOIA-disclosable data for those records. About a week later, CMS will make available a file for downloading that will contain the FOIA-disclosable NPPES data of enumerated health care providers. Technical expertise will be required to download that file and to import that data into a relational database or to otherwise manipulate the data. CMS will be furnishing more information about data dissemination, including a "Read Me" file, header file, and code value document for the downloadable file, and will make that information available on the CMS NPI Web page at http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp.

### Two New Educational Products Posted

Fact sheets:

- For providers who are organizations *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_FactSheet_Org_Provi_web_07-03-07.pdf*.
- For providers who are sole proprietors *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_FactSheet_Sole_Prop_web.pdf*.

### Group Practices that Conduct Any HIPAA Standard Transactions MUST Have an NPI

A group practice that conducts any of the HIPAA standard transactions is a covered health care provider (a covered entity under HIPAA) and, as such, must obtain and use an NPI. The providers employed by the group practice, on the other hand, are only furnishing services at the group practice; they are not conducting any of the HIPAA standard transactions (such as submitting claims, checking eligibility and obtaining claim status electronically). Therefore, these employed providers are not covered health care providers and are not required by the NPI final rule to obtain NPIs. However, as a condition of employment, the group practice could require these providers to obtain NPIs so that the group practice can use them to identify the employed providers as the rendering providers in the claims that the group submits to health plans. If these physicians prescribe medications, the pharmacies may require their NPIs because the pharmacies may be required by health plans to include the NPIs of prescribers in their claims. Additionally, health plans may require enrolled physicians, or any other enrolled providers, to obtain NPIs in order to participate in those plans.

### Members of Group Practices Need NPIs for Medicare Purposes

Group practices that bill Medicare electronically are covered providers and are required by regulation to obtain and use NPIs to identify themselves as the billing and pay-to providers in Medicare claims. Medicare requires that providers who are identified as rendering providers in Medicare claims be identified by NPIs, whether or not they are covered providers. Therefore, group practices that are enrolled in Medicare will want to ensure that their members (physicians or other practitioners) obtain NPIs in order to ensure payments to the group practices by Medicare.

### Issues with New CMS-1500 (08-05) Version

In 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised CMS-1500 (08-05) to Medicare. This new version of the form was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC). The American Medical Association (AMA) chairs the NUCC in consultation with the CMS. The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one health care vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers all claims be submitted to Medicare electronically, the Administrative Simplification Compliance Act (ASCA) provides for exceptions to the mandatory electronic claim submission requirement.

Therefore, Medicare must be prepared to receive and process paper claims. However, Medicare is not required to accept and process multiple versions of the CMS-1500.

CMS began accepting the revised CMS-1500 (08-05) in January 1, 2007, with a planned cutoff of the old version CMS-1500 (12-90) on April 1, 2007. However, formatting issues, which were identified with the CMS-1500 (08-05) printed stock and images sold by the Government Printing Office (GPO) forced CMS to extend the cut off date of the 12-90 version. CMS closely monitored the situation through our contractors and concluded that the formatting issue was solely limited to the GPO and, as such, moved forward with the planned phase out of the CMS-1500 (12-90) version. Beginning July 2, 2007, CMS began returning the 12-90 version of the form. However, it recently came to

*Updated Information for Medicare Providers on National Provider Identifier (continued)*

CMS attention that the GPO is still not in a position to accept and fill orders for the revised form. CMS recognizes that the ability to purchase the revised form is a critical factor in a provider's ability to comply with the July cut-off.

CMS research of the CMS-1500 form has shown that the revised CMS-1500 (08-05) is widely available for purchase from print vendors. However, CMS is not able to recommend specific print vendors as this would be seen as creating a marketplace advantage.

In order to assist providers in locating the CMS-1500 (08-05), CMS recommends:

- Use local print media directories to search for print vendors.
- Contact other providers to inquire on their source for the form.
- Search "CMS-1500 (08-05)" or "CMS-1500 08/05" via the Internet and locate online print vendors. Ask for samples before ordering to ensure that the formatting is correct.
- Contact the NUCC (*http://www.nucc.org*) for assistance.

Even though the CMS-1500 (08-05) experienced formatting difficulties, those issues were quickly resolved. Medicare contractors are currently receiving and processing the new CMS-1500 form without issue.

Therefore, CMS will continue to adhere to the July 2, 2007, mandatory cutoff of the CMS-1500 (12-90) version.

Note that in using the new CMS-1500 08-05 version, if you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should begin using your NPI also. If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

## Potential Issues Related to Clearinghouse Practices

It has come to CMS attention that some clearinghouses are stripping the NPI off the claim prior to its submission to Medicare. This could adversely affect Medicare providers in two ways. First, providers may be under the false impression that their claims are being successfully submitted to Medicare, through their clearinghouse, using an NPI. Second, without the NPI, these claims will not count toward PQRI participation for eligible professionals. Stripping of NPIs may also be occurring even though the NPI appears on remittance advice because some clearinghouses are adding the NPI to the remittance prior to sending to the provider. CMS urges Medicare providers that use clearinghouses to check with their clearinghouse to assure NPIs are not being stripped from claims. If the provider determines that their clearinghouse is stripping NPIs from the claim, the provider may wish to consider other billing options.

CMS has also become aware that some clearinghouses are not forwarding to providers NPI informational claim error messages being sent by Medicare carriers. Part B carriers currently use logic to bypass validating the NPI/legacy provider pair. While claims are being paid today based on the legacy identifier, these messages are designed to help the provider understand the problems Medicare is encountering in attempts to crosswalk the NPI to legacy identifiers. These informational messages are a critical measure of the extent to which a provider will experience rejected claims once the bypass logic is lifted. Providers who use clearinghouses should make sure they are in fact receiving NPI informational claim error messages so that issues can be addressed timely.

## Reminder: Don't Miss This Important MLN Matters Article

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

## Still Confused?

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

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

Source: CMS Provider Education Resource 200707-16

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

# Dissemination of Data from the National Plan and Provider Enumeration System to Begin September 4, 2007

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

The National Plan and Provider Enumeration System (NPPES) health care provider data that are disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the e-FOIA Amendments, CMS will be disclosing these data via the Internet. Data will be available in two forms:

1. A query-only database, known as the NPI registry.
2. A downloadable file.

CMS is extending the period of time in which enumerated health care providers may view their FOIA-disclosable NPPES data and make any edits they feel are necessary prior to our initial disclosure of the data.

CMS must build in time to resolve any errors or problems that may be encountered with edits that health care providers submit. Therefore, in order to ensure edits are reflected in the NPI registry when it first becomes operational and in the first downloadable file, health care providers need to submit their edits **no later than Monday, August 20, 2007.** Health care providers who submit edits on paper need to ensure that they are mailed in time for receipt by the NPI Enumerator by that date.

CMS will be making FOIA-disclosable NPPES health care provider data available beginning **Tuesday, September 4, 2007.** The NPI registry will become operational on September 4 and the downloadable file will be ready approximately one week later.

For assistance in making their edits health care providers should refer to the document entitled, "Information on FOIA-Disclosable Data Elements in NPPES," dated June 20, 2007, found on the CMS NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf*.

Some of the key data elements that are FOIA-Disclosable are:

- NPI
- Entity Type Code (1-Individual or 2-Organization)
- Replacement NPI
- Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), OR the Legal Business Name for Organizations)
- Provider Other Name (First Name, Middle Name, Last Name, or 'Doing Business As' Name, Former Legal Business Name, Other Name. for Organizations)
- Provider Business Mailing Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Provider Business Location Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Healthcare Provider Taxonomy Code(s)
- Other Provider Identifier(s)
- Other Provider Identifier Type Code
- Provider Enumeration Date
- Last Update Date
- NPI Deactivation Reason Code
- NPI Deactivation Date
- NPI Reactivation Date
- Provider Gender Code
- Provider License Number
- Provider License Number State Code
- Authorized Official Contact Information (First Name, Middle Name, Last Name, Title or Position, Telephone Number).

The delay in the dissemination of NPPES data **does not alter** the requirement that HIPAA covered entities must comply with the requirements of the NPI final rule **no later than May 23, 2008.** All NPI contingencies that may be in place must be lifted by that date.

### Still Confused?

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

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

Source: CMS Provider Education Resource 200708-06

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

***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.***

## Reporting Legacy Numbers in NPPES

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

The reporting of legacy numbers in the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields in the National Plan and Provider Enumeration System (NPPES) will assist Medicare in successfully creating linkages between providers' NPIs and the identifiers that Medicare has assigned to them (such as PINs).

You should be aware that if you remove your legacy numbers from the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields, linkages that Medicare has established using the reported Medicare legacy numbers will be broken and your Medicare claims could be rejected.

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

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

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

Source: CMS Provider Education Resource 200708-09

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

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

# GENERAL COVERAGE

## Revised Information on PET Scan Coding

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

### Provider Types Affected

Physicians and providers who bill Medicare contractors (carriers, fiscal intermediaries [FI]), and Medicare administrative contractors [A/B MAC]) for positron emission tomography [PET] scan services for Medicare beneficiaries.

### Provider Action Needed

### STOP – Impact to You

Effective for services on and after January 28, 2005, your carrier, FI, or A/B MAC will deny claims for PET scan services that contain *CPT* code *78609* and they will deny claims for PET scan services **on or after January 1, 2008** that contain HCPCS code A4641.

### CAUTION – What You Need to Know

Change request (CR) 5665, from which this article is taken, corrects erroneous information that was originally issued in CR 3741, transmittal 527 (New Coding for FDG PET Scans and Billing Requirements for Specific Indications of Cervical Cancer), dated April 15, 2005. CR 5665 updates *Medicare Claims Processing Manual*, Chapter 13, Sections 60.30.1 and 60.30.2 by removing *CPT* code *78609* from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans.

### GO – What You Need to Do

Make sure that your billing staffs are aware of these code changes and submit only covered codes in your claims for PET scan services.

### Background

The Centers for Medicare & Medicaid Services (CMS) recently learned that the *Medicare Claims Processing Manual*, Chapter 13 (Radiology Services), Sections 60.30.1 (Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and 60.30.2 (Tracer Codes Required for PET Scans), and CR 3747 (transmittal 527, dated April 15, 2005), contain incorrect information regarding *CPT* code *78609* (*PET for brain perfusion imaging*) and HCPCS code A4641.

- In Section 60.3.1, Medicare incorrectly lists *CPT* code *78609* as a covered service, and in Section 60.3.2 is incorrectly included in terms of the applicability of certain tracer codes. Similarly, Section 60.30.2 incorrectly lists HCPCS code A4641as an applicable tracer for PET scans.

CR 5665, from which this article is taken, corrects these errors. It updates the manual by removing *CPT* code *78609* from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans. In so doing, it also corrects the erroneous information that was originally issued in CR 3747.

**Notes:** 1) All PET scans services (*CPT* codes *78459, 78491, 78492, 78608,* and *78811-78816*) require the use of a radiopharmaceutical diagnostic imaging agent (tracer). Therefore, the applicable tracer code should always be used when billing for a PET scan service.

2) The correct PET scan *CPT* codes and tracer HCPCS codes are listed below.

### Key Points in Change Request 5665

- Effective January 28, 2005, *CPT* code *78609* became a noncovered service for Medicare.
- Carriers, FIs, and A/B MACS will deny claims submitted with *CPT* code *78609* (effective January 28, 2005).
- When denying these claims, they will use:
  - Medicare summary notice (MSN) 16.10: "Medicare does not pay for this item or service."
  - Claim adjustment reason code 96: "Noncovered charge."
  - Remittance advice remark codes N386: "This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*.

    If you do not have Web access, you may contact the contractor to request a copy of the NCD."
- **Effective January 1, 2008,** HCPCS code A4641 is not an applicable tracer for PET scans.
- You should not report HCPCS code A4641 when submitting claims for PET scans for services **on or after January 1, 2008.** Instead, as of that time, when submitting claims for PET scans containing *CPT* code *78491* or *78492* you should use only tracer code A9555 or A9526; and, when submitting claims for PET scans containing *CPT* code *78459*, *78608*, or *78811-78816*, you should use only tracer code A9552 (see information, below).
- Carriers, FIs, and A/B MACs will not search for, and adjust, claims that have been paid prior to the implementation date, but they will adjust claims brought to their attention.

The following information list the currently covered PET scan *CPT* codes (on or after January 28, 2005) and tracer HCPCS codes, **as of January 1, 2008**).

***Revised Information on PET Scan Coding (continued)***

**Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005**

| CPT Code | Description |
|---|---|
| *78459* | *Myocardial imaging, positron emission tomography (PET), metabolic evaluation* |
| *78491* | *Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress* |
| *78492* | *Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress* |
| *78608* | *Brain imaging, positron emission tomography (PET); metabolic evaluation* |
| *78811* | *Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)* |
| *78812* | *Tumor imaging, positron emission tomography (PET); skull base to mid thigh* |
| *78813* | *Tumor imaging, positron emission tomography (PET); whole body* |
| *78814* | *Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck)* |
| *78815* | *Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh* |
| *78816* | *Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body* |

**Note:** All PET scan services require the use of a radiopharmaceutical diagnostic imaging agent (tracer). The applicable tracer code should be billed when billing for a PET scan service. See below for applicable tracer codes.

**Tracer Codes Required for PET Scans on or after January 1, 2008 (A4641 is allowed for services on or before December 31, 2007)**

The following tracer codes are applicable only to *CPT* codes *78491 and 78492.* **They cannot be reported with any other code.**

**Institutional Providers Billing Fiscal Intermediaries or A/B MACs**

| HCPCS Code | Description |
|---|---|
| A9555* | Supply of radiopharmaceutical diagnostic imaging agent, rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries |
| Q3000* | Supply of radiopharmaceutical diagnostic imaging agent, rubidium Rb-82 (deleted effective December 31, 2005) |
| A9526 | Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13, diagnostic, per study dose, up to 40 millicuries |

***Note:** For claims with dates of service prior to January 1, 2006, providers report Q3000 for supply of radiopharmaceutical diagnostic imaging agent, rubidium Rb-82. For claims with dates of service January 1, 2006, and later, providers report A9555 for radiopharmaceutical diagnostic imaging agent, rubidium Rb-82 in place of Q3000.

**Physicians/Practitioners Billing Carriers or A/B MACs**

| HCPCS Code | Description |
|---|---|
| A4641* | Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified |
| A9526 | Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13, diagnostic, per study dose, up to 40 millicuries |
| A9555 | Supply of radiopharmaceutical diagnostic imaging agent, rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries |

***Note:** Effective January 1, 2008, tracer code HCPCS code A4641 is not applicable for PET scans.

The following tracer codes are applicable only to *CPT* codes *78459, 78608, 78811-78816.* **They cannot be reported with any other code:**

**Institutional Providers Billing Fiscal Intermediaries or A/B MACs**

| HCPCS Code | Description |
|---|---|
| A9552* | Supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18, FDG, diagnostic, per study dose, up to 45 millicuries |
| C1775* | Supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18 (deleted effective December 31, 2005) |
| A4641** | Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified |

***Note:** For claims with dates of service prior to January 1, 2006, OPPS hospitals report HCPCS code C1775 for supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18. For claims with dates of service January 1, 2006 and later, providers report HCPCS code A9552 for radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18 in place of HCPCS code C1775.

****Note:** Effective January 1, 2008, tracer code A4641 is not applicable for PET scans.

**Physicians/Practitioners Billing Carriers or A/B MACs**

| HCPCS Code | Description |
|---|---|
| A9552 | Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, Per study dose, Up to 45 Millicuries |

***Revised Information on PET Scan Coding (continued)***

A4641* Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified

***Note:** Effective January 1, 2008, tracer code A4641 is not applicable for PET scans.

### Additional Information

You can find more information about PET scan codes by going to CR 5665, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1301CP.pdf*.

You will find the updated *Medicare Claims Processing Manual*, Chapter 13 (Radiology Services), Sections 60.30.1 (Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and 60.30.2 (Tracer Codes Required for PET Scans) as an attachment to that CR.

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

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

*MLN Matters* Number: MM5665
Related Change Request (CR) Number: 5665
Related CR Release Date: July 20, 2007
Related CR Transmittal Number: R1301CP
Effective Date: January 28, 2005 and January 1, 2008 (per article)
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1301, CR 5665



## Correct Reporting of Diagnosis Codes on Screening Mammography Claims

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

**Note:** CMS has revised this *MLN Matters* article on July 27 2007, to add a reference to CR 5377. MM5050 erroneously removed type of bill (TOB) 12x as an applicable TOB for diagnostic mammography services supplied to Medicare inpatients and billable under Medicare Part B. CR 5377 announced that effective April 1, 2007, TOB 12x is acceptable by fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs) as an appropriate type of bill for such services. The *MLN Matters* article MM5050 was published in the July 2006 *Medicare A Bulletin* (pages 24-25).

### Provider Types Affected

All providers billing Medicare carriers and fiscal intermediaries (FIs) for screening mammography claims

### Providers Action Needed

This article and change request (CR) 5050 provide specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in loop 2300 of the ANSIX12 837) on claims that contain **only screening** mammography services.
- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or loop 2300 of the ANSI-X12 837, and field 21 of CMS-1500 or loop 2300 of the ANSI-X12 837) on claims that contain **other** services in addition to a screening mammography.

**In addition,** CR 5050 updates Chapter 18, Section 20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:

- It **removes type of bill (TOB) 12x** from the list of applicable TOBs for diagnostic mammography. (See note above.)
- It **adds HCPCS code G0202** to the list of valid codes for the billing of screening mammography.
- It **adds HCPCS codes G0204 and G0206** to the list of valid codes for the billing of diagnostic mammographies.

### Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This CR adjusts that requirement.

### Implementation

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

### Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf*.

***Correct Reporting of Diagnosis Codes on Screening Mammography Claims (continued)***

The revised Section 20.4 of Chapter 18 of the *Medicare Claims Processing Manual* is attached to CR 5050.

To view the instruction (CR 5377) that reversed the removal of TOB 12x, visit the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1117CP.pdf*.

The related *MLN Matters* article maybe found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5377.pdf*.

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

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

MLN Matters Number: MM5050 – Revised
Related Change Request (CR) Number: 5050
Related CR Release Date: April 28, 2006
Related CR Transmittal Number: R916CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 916, CR 5050



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

# 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 Web site *http://www.floridamedicare.com*.

Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part A section under the Part A Medical Coverage section.

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

## Effective and Notice Dates

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

## Electronic Notification

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

## More Information

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

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

## Local Coverage Determination Table of Contents

### Additions/Revisions to Existing LCDs



### Additional Medical Information



## Advance Beneficiary Notice

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

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

# ADDITIONS/REVISIONS TO EXISTING LCDS

## A93875: Non-invasive Extracranial Arterial Studies—Addition to the LCD

The local coverage determination (LCD) for non-invasive extracranial arterial studies was last updated on August 7, 2006. Since that time, the "Training Requirements" section under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised. Revisions include the addition of the following statement:

> However, if the facility has a documented process for grand-fathering experienced technicians who have performed the services referenced in this LCD (a process addressing years of service and experience with number of supervised cases), this documentation should be available to Medicare upon request; otherwise the provider must have documentation available to Medicare upon request which indicates that the technician meets the credentialing requirements as stated above or is in the process of obtaining this credentialing.

### Effective Dates

This addition to the LCD is effective for services provided **on or after August 7, 2006**.

The full text for this LCD (L942) is available through the provider education Web site *http://www.floridamedicare.com* on or after this effective date. ❖

## A93922: Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries—Addition to the LCD

The local coverage determination (LCD) for noninvasive physiologic studies of upper or lower extremity arteries was last updated on April 11, 2006. Since that time, the "Training Requirements" section under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised. Revisions include the addition of the following statement:

> However, if the facility has a documented process for grand-fathering experienced technicians who have performed the services referenced in this LCD (a process addressing years of service and experience with number of supervised cases), this documentation should be available to Medicare upon request; otherwise the provider must have documentation available to Medicare upon request which indicates that the technician meets the credentialing requirements as stated above or is in the process of obtaining this credentialing.

### Effective Dates

This addition to the LCD is effective for services provided **on or after April 11, 2006**.

The full text for this LCD (L952) is available through the provider education Web site *http://www.floridamedicare.com* on or after this effective date. ❖

## A93925: Duplex Scan of Lower Extremity Arteries—Addition to the LCD

The local coverage determination (LCD) for duplex scan of lower extremity arteries was last updated on April 11, 2006. Since that time, the "Training Requirements" section under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised. Revisions include the addition of the following statement:

> However, if the facility has a documented process for grand-fathering experienced technicians who have performed the services referenced in this LCD (a process addressing years of service and experience with number of supervised cases), this documentation should be available to Medicare upon request; otherwise the provider must have documentation available to Medicare upon request which indicates that the technician meets the credentialing requirements as stated above or is in the process of obtaining this credentialing.

### Effective Dates

This addition to the LCD is effective for services provided **on or after April 11, 2006**.

The full text for this LCD (L1101) is available through the provider education Web site *http://www.floridamedicare.com* on or after this effective date. ❖

## A93965: Non-Invasive Evaluation of Extremity Veins—Addition to the LCD

The local coverage determination (LCD) for non-invasive evaluation of extremity veins was last updated on June 30, 2007. Since that time, the "Training Requirements" section under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised. Revisions include the addition of the following statement:

> However, if the facility has a documented process for grand-fathering experienced technicians who have performed the services referenced in this LCD (a process addressing years of service and experience with number of supervised cases), this documentation should be available to Medicare upon request; otherwise the provider must have documentation available to Medicare upon request which indicates that the technician meets the credentialing requirements as stated above or is in the process of obtaining this credentialing.

### Effective Dates

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

The full text for this LCD (L937) is available through the provider education Web site *http://www.floridamedicare.com* on or after this effective date. ❖

# ADDITIONAL MEDICAL INFORMATION

## Descemet's Stripping Endothelial Keratoplasty (DSAEK)—Coding and Billing

Keratoplasty is the general term for several variants of corneal transplant. A newer procedure is termed Descemet's stripping endothelial keratoplasty (DSAEK), and is also known as deep lamellar endothelial keratoplasty. This procedure involves a small incision to allow intraocular placement of endothelium harvested from a donor cornea after the stripping off of diseased corneal endothelium. Microkeratome-based (automated) preparation of the donor endothelium may be used. This technique offers certain clinical advantages while achieving the goal of penetrating keratoplasty in patients with disease largely related to endothelial dysfunction. The beneficiary should be thoroughly educated about the benefits and risks of this modality.

The new Descemet's stripping procedure should be billed using *CPT* code *66999* (*Unlisted procedure, anterior segment of eye*), as a unique *CPT* code does not currently exist which describes this service. Please enter 'DSAEK' in form locator (FL) 80 of the CMS-1450 (UB-04) or its electronic equivalent. Also, remember to use the appropriate modifiers when performing the service on both eyes.

Documentation in the medical record must include the following: patient's history and physical, office/progress notes and operative report. This documentation must also support the medical necessity of the procedure performed. Please note, the assignment of an unlisted code does not guarantee Medicare coverage or payment for services billed. In addition, providers should not submit this information with the claim. First Coast Service Options, Inc. (FCSO) may request it separately with an additional documentation request (ADR) letter.

Note that Medicare does not cover keratoplasty procedures primarily for refractive correction and radial keratotomy. (See CMS Internet-Only Manual, Pub. 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 1, Section 80.7).

Any time there is a question whether Medicare's medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN) and appending **modifier GA** to the billed *CPT* codes. For further details about CMS Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*.

Please note that services that lead up to or are associated with noncovered services are not covered as well. ❖

## Vagal Nerve Stimulation (VNS) for Seizures and Resistant Depression

The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual, Pub. 100-03 *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Section 160.18 B and C indicates the following:

"Effective for services performed on or after July 1, 1999, VNS is reasonable and necessary for patients with medically refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed.

Effective for services performed on or after July 1, 1999, VNS is not reasonable and necessary for all other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed.

Effective for services performed on or after May 4, 2007, VNS is not reasonable and necessary for resistant depression."

Based on the indications in the NCD, only the following ICD-9-CM codes will be covered for seizures:

345.41 Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures with intractable epilepsy

345.51 Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures with intractable epilepsy

*CPT* codes *61885, 61886, 64573, 64585, 64590, 64595, 95970, 95971, 95974, and 95975* billed for vagal nerve stimulation (VNS) for all other types of seizure disorders are not considered reasonable and necessary.

In addition, based on the above NCD, VNS for resistant depression is not considered reasonable and necessary. The local coverage determination (LCD) for vagal nerve stimulation (VNS) for intractable depression (A61885) showing noncoverage of specific *CPT* codes and ICD-9-CM codes for depression is available through our provider education Web site *http://www.floridamedicare.com*. ❖



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

# HOSPITAL SERVICES

## Hospital Charge Limitations for Services Furnished to Individuals Eligible for Indian Health Service Programs

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

### Provider Types Affected

Medicare participating hospitals and skilled nursing facilities servicing individuals eligible for care through Indian Health Service (IHS) programs.

### What You Need to Know

This article was developed from the *Federal Register*, Volume 72, No. 106, Monday, June 4, 2007, and provides you information about a new regulation that may impacts your payments for providing services through Indian health programs.

Effective July 5, 2007, all Medicare-participating hospitals that furnish inpatient services authorized by IHS, tribal, and urban Indian organization entities, must accept no more than the rates of payment, discussed below, plus the usual Medicare coinsurance amount, as payment in full.

### Background

Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, requires hospitals that furnish any Medicare-payable inpatient hospital medical care services, to participate in both:

- The contract health services (CHS) program of the Indian Health Service (IHS) operated by the IHS, tribes, and tribal organizations; and
- IHS-funded programs operated by urban Indian organizations. All of these programs are collectively referred to as I/T/Us, for any care that these programs purchase.

For purposes of this program, a hospital is defined as all hospitals that participate in Medicare, including any hospital clinics located off-site and critical access hospitals, to include:

- Acute care hospitals
- Distinct parts of inpatient hospitals (rehabilitation facilities, psychiatric facilities)
- Hospital based clinics
- Psychiatric hospitals
- Rehabilitation hospitals
- Long-term care hospitals
- Critical access hospitals (including rehabilitation and psychiatric units paid under a prospective payment system [PPS] located within)
- Children's hospitals
- Cancer hospitals
- Skilled nursing facilities (SNFs) and swing beds.

Section 506 also requires such participation to be in accordance with the admission practices, payment methodology, and payment rates set forth in Department of Health & Human Services (DHHS) regulations, including accepting these payment rates as payment in full. Specifically, effective July 5, 2007, all Medicare-participating hospitals that furnish inpatient services must accept no more than the rates of payment under the calculation, described below, as payment in full for all items and services authorized by IHS, tribal, and urban Indian organization entities.

Further, this payment methodology applies to all levels of care, furnished by a Medicare-participating hospital, that is authorized by a contract health service (CHS) program of the Indian Health Service (IHS); or authorized by a tribe or tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act, or that an urban Indian program authorizes for purchase. This includes care provided as inpatient, outpatient, or SNF care; as well as other services of a department, subunit, distinct part, or other hospital component (including services the hospital furnishes directly or under arrangements)

### Basic Payment Determination/Methodology

1. **Prospective Payment System**
   Under this new rule, the basic payment determination for hospital services that Medicare would pay for under a PPS is based on that particular PPS. For example, inpatient hospital services of acute care hospitals, psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals will be paid based on the same PPS systems Medicare uses to pay for similar hospital services under 42 CFR, part 412.
   Similarly, outpatient hospital services and SNF care will be paid based on the PPS systems that Medicare uses to pay for those services under 42 CFR part 419 and 42 CFR part 413, respectively.

2. **Reasonable Costs**
   Medicare participating hospitals that furnish inpatient services but are exempt from inpatient PPS and receive reimbursement based on reasonable costs (for example, critical access hospitals (CAHs), children's hospitals, cancer hospitals, and certain other hospitals reimbursed by Medicare under special arrangements) will be paid per discharge based on the reasonable cost methods established under 42 CFR part 413 (except that the interim payment rate under 42 CFR part 413, subpart E constitutes payment in full for authorized charges).

3. **Coinsurance**
   CHS programs will continue to pay the equivalent of Medicare coinsurance.

***Hospital Charge Limitations for Services Furnished to Individuals Eligible for IHS Programs (continued)***

The I/T/Us' payment calculations will be based on these determinations consistent with the Centers for Medicare & Medicaid Services (CMS) instructions to FIs/MACs at the time the claim is processed. For inpatient services, I/T/Us will pay a providing hospital the full PPS based rate (or the interim reasonable cost rate) without reduction for any co-payments, coinsurance, and deductibles that the Medicare program requires patients to contribute. Similarly, for outpatient, or Part B services, IHS/CHS will pay both the Medicare and beneficiary's portion of the payment, so that, in either instance, the hospital will get 100 percent of whatever the Medicare rate is for the service provided.

**Note:** If the I/T/U has negotiated a payment amount with a hospital or its agent, the I/T/U will pay the lesser of the negotiated amount, or the amount determined from basic determination (above) (including, but not limited to, capitated contracts or contracts per federal law requirements).

You should be aware that in addition to the amount payable for authorized inpatient services (described above), payments will also include an amount to cover (to the extent such costs would be payable if the services had been covered by Medicare):

- The organ acquisition costs that hospitals with approved transplantation centers incur.
- Direct medical education costs.
- Units of blood clotting factor furnished to an eligible hemophiliac patient.
- The costs of qualified non-physician anesthetists.

These payments will be made on a per discharge basis and will be based on standard payments that CMS or its FIs/MACs establish.

There are other specific details about this program that you should know about, i.e.:

- If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payer, the I/T/U:
  1) Will be the payer of last resort.
  2) Will pay the amount that the patient is responsible for (after the provider of services has coordinated benefits and all other alternative resources have been considered and paid), including applicable co-payments, deductibles, and coinsurance that the patient owes.
  3) Will pay only that portion of the payment amount not covered by any other payer.
  4) Payment will not exceed the rate calculated in the Payment Methodology section (above), or the contracted amount (plus applicable cost sharing), whichever is less.
  5) Will make no additional payment to that made by Medicaid, (except for applicable cost sharing), as Medicaid payment is considered payment in full.

     **Note:** Payments made for these services are considered payment in full, and a hospital or its agent may not impose any additional charge on the patient for any I/T/U authorized items and services, or for information that the I/T/U, its agent, or the FI/MAC request to determine payment or for quality assurance use.
- If it is determined that a hospital has submitted inaccurate information for payment (such as admission, discharge, or billing data), an I/T/U may (as appropriate):
  1) Deny payment for these services (in whole or in part).
  2) Disallow costs previously paid.

  Further, if for cost-based payments previously issued, it is determined that actual costs fall significantly below the computed rate actually paid, the computed rate may be retrospectively adjusted. The recovery of overpayments made as a result of the adjusted rate, or of payments made in error, may be accomplished by any method authorized by law.
- For a hospital (or its agent) to be eligible for payment from Indian health programs, it must submit the claim for authorized services:
  1) On a UB-04 paper claim form or the HIPAA 837 electronic claim format ANSI X12N, version 4010A1 and include the hospital's Medicare OSCAR number/national provider identifier.
  2) To the I/T/U, agent, or fiscal intermediary the I/T/U identifies in the agreement with the hospital or in the authorization for services I/T/U provides.
  3) Within a time period equivalent to the timely filing period for Medicare claims under 42 CFR 424.44 and provisions of the *Medicare Claims Processing Manual* applicable to the type of item or service provided.
- Participating Hospitals and CAHs must accept the payment methodology and no more than the rates of payment (explained above), as payment in full for the following programs:
  1) A CHS program of the HIS.
  2) A CHS program carried out by an Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act.
  3) A program funded through a grant or contract by the IHS and operated by an urban Indian organization, under which items and services are purchased for an eligible urban Indian.

***Hospital Charge Limitations for Services Furnished to Individuals Eligible for IHS Programs (continued)***

Hospitals and CAHs may **not** refuse service to an individual on the basis that the payment for such service is authorized under such CHS and IHS funded urban Indian programs.

The following facilities or services are **not** covered by this regulation.

- Free standing ambulatory surgery centers (ASCs)
- Surgical centers
- Physician services
- Services of independent practitioners (nurse practitioners, physician assistants, clinical nurse specialists, etc)
- Independent laboratories
- Any service or supply not covered by the Medicare program
- Services of a renal dialysis facility
- Home health services
- Hospice services

**Remember:**

- Inpatient PPS hospitals are paid based on discharge date. Therefore, if a patient were discharged on July 5, 2007, the entire stay would be paid under the applicable PPS.
- CAHs' and Tax Equity & Fiscal Responsibility Act (TEFRA) of 1982 hospital inpatient services will be paid based on whether the actual date of service falls on or after July 5, 2007. Line item dates of service can apply to OPPS and other Part B outpatient claims.
- Payment for outpatient services is based on the date of service.

**Treating Patients with Serious Health Issues**

IHS payment under this rule will reflect serious health issues faced by its patient population, as patients who are more seriously ill tend to require a higher level of hospital resources than patients who are less seriously ill, even though they may be admitted to the hospital for the same reason. Recognizing this, Medicare payments can be higher for patients in certain diagnostic-related groups (DRGs) based on a secondary diagnosis that could indicate specific complications or co-morbidities.

While these rates are generally not available to non-Indians who are members of an eligible Indian's household, if the individual meets the requirements at 42 CFR Part 136 for CHS coverage (e.g. non-Indian woman pregnant with eligible Indian's child, public health emergency), and payment is authorized by the CHS program (or by an urban program), then the Medicare-like rates (MLR) do apply.

### Additional Information

You can find more information about the limitation on charges for services furnished by Medicare participating inpatient hospitals to individuals eligible for care through Indian health programs by reading the *Federal Register* on the CMS Web site at *http://www.nrepp.samhsa.gov/pdfs/FRN060407.pdf*.

If you have any questions, please contact your CMS Regional Office. Contact information for those offices is available on the CMS Web site at *http://www.cms.hhs.gov/RegionalOffices/*.

*MLN Matters* Number: SE0734
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 SE0734



## CMS Announces Payment Reforms for Inpatient Hospital Services in 2008

### Reforms Continue Transition to More Accurate Payment System; Promote Quality Care for all Hospitalized Patients

The Centers for Medicare & Medicaid Services (CMS) issued a final rule that takes significant steps to improve the accuracy of Medicare's payment under the acute care hospital inpatient prospective payment system (IPPS), while providing additional incentives for hospitals to engage in quality improvement efforts.

"The IPPS payment reforms we are making today finalize the changes we proposed in April and build upon three years of consistent, incremental improvements to Medicare inpatient hospital payments," CMS Acting Deputy Administrator Herb Kuhn said. "With these changes – first proposed by the Medicare Payment Advisory Commission in 2005 – Medicare payments for inpatient services will be more accurate and better reflect the severity of the patient's condition."

The IPPS payment reforms would restructure the inpatient diagnosis-related groups (DRGs) to account more fully for the severity of each patient's condition. In addition, the rule includes important provisions to ensure that Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital.

This final rule was published in the *Federal Register* on August 22, 2007.

This press release is available on the CMS Web site at *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2335&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchDat2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&choOrder=date*.

*CMS Announces Payment Reforms for Inpatient Hospital Services in 2008 (continued)*

The fact sheet is available on the CMS Web site at *http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2336&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchDat*.

To view the display copy of the acute inpatient PPS final rule (CMS-1533-FC) for FY 2008, go to the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/itemdetail.asp?filterType=dual,%20date&filterValue=7|d&filterByDID=-1&sortByDID=4&sortOrder=ascending&itemID=CMS1201726&intNumPerPage=10*.

To view the wage index files, go to *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp*.

To view the acute inpatient files for download, go to *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp*. ❖

Source: CMS Provider Education Resource 200708-04

## CMS Increases Payments to Inpatient Rehabilitation Facilities for Fiscal Year 2008

### Accurate Payments Will Continue to Ensure Program Efficiency, Quality and Sustainability

Inpatient rehabilitation facilities (IRFs) will receive approximately $6.4 billion in payments from Medicare in fiscal year (FY) 2008, under a rule announced by the Centers for Medicare & Medicaid Services (CMS). The rule will update payment rates and modify payment policies for services furnished to Medicare beneficiaries for discharges occurring on or after October 1, 2007, through September 30, 2008. The rule provisions are estimated to increase Medicare payments to approximately 1,220 IRFs in fiscal year (FY) 2008 by approximately $150 million.

"Today's rule is designed to ensure accurate payments for intensive rehabilitation care provided to Medicare beneficiaries in IRFs," CMS Acting Deputy Administrator Herb Kuhn said. "This continues Medicare's commitment to support beneficiary access to IRF services while at the same time improving the appropriateness and consistency of payment for care across all post acute settings." These settings include IRFs, skilled nursing facilities (SNF), home health care, and long-term care hospitals.

"Moreover, combined with payment system rules released today on skilled nursing facilities, we are demonstrating our commitment to ensure that Medicare is affordable for current beneficiaries and is sustained for future generations by paying accurately and efficiently," added Kuhn.

The final rule increases the IRF payments by 3.2 percent, based on the rehabilitation, psychiatric and long-term care hospital (RPL) market basket. The RPL market basket is designed to capture inflation in the costs of goods and services required to provide the specialized services offered by these facilities, similar to the market basket that applies to general acute care hospitals.

The rule also increases the high-cost outlier threshold to $7,362 from $5,534 in FY 2007, based on an analysis of 2006 data, which indicates that this threshold would maintain estimated outlier payments at three percent of estimated total payments under the IRF prospective payment system (PPS). Although the higher threshold would mean that fewer cases would qualify for outlier payments, a lower outlier threshold would require an across-the-board reduction in the base payment for an IRF stay in order to maintain budget neutrality.

The new payment rates also continue to include a special adjustment made to cover the additional services required by nursing home residents with HIV/AIDs. "We are confident that the new payment rates will continue to ensure beneficiary access to the important services SNFs provide," Mr. Kuhn said.

To view the display copy of the SNF PPS final rule (CMS-1545-F) for FY 2008, go to the CMS Web site *http://www.cms.hhs.gov/SNFPPS/LSNFF/itemdetail.asp?filterType=dual,%20date&filterValue=7|d&filterByDID=-1&sortByDID=1&sortOrder=ascending&itemID=CMS1201649&intNumPerPage=10*.

It is expected to be published in the *Federal Register* on Friday, August 3, 2007. ❖

Source: CMS Provider Education Resource 200708-02

## Capturing Days on Which Medicare Beneficiaries Are Entitled to Medicare Advantage in the Medicare/Supplemental Security Income Fraction

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

### Provider Types Affected

Hospitals billing either a Medicare administrative contractor (A/B MAC) or fiscal intermediary (FI) for services provided to Medicare beneficiaries enrolled in a Medicare Advantage plan.

### Provider Action Needed

This article is based on change request (CR) 5647, which states that, **as of January 7, 2008, hospitals (this includes acute care hospitals paid under the inpatient prospective payment system (IPPS), inpatient rehabilitation facilities (IRFs), and long-term care hospitals [LTCHs]) must begin to submit "no pay" bills to their Medicare contractor for stays by Medicare Advantage (MA) beneficiaries.** This will allow for the days of those stays to be eventually captured in the disproportionate share (DSH) (or low income patient [LIP] for IRF) calculations.

*Capturing Days on Which Medicare Beneficiaries Are Entitled to MA in the Medicare/Supplemental... (continued)*

## Background

CR 5647 states that part of the calculation used to determine whether or not a hospital is eligible for Medicare DSH payments is based on the percentage of Medicare days for which the beneficiary was entitled to Medicare Part A and received supplemental security income (SSI) payments from the Social Security Administration (SSA). The SSA provides the SSI information to the Centers for Medicare & Medicaid Services (CMS). CMS then pulls all of the Medicare days for each eligible hospital and determines the percentage of days for which the Medicare beneficiaries were simultaneously eligible for SSI and Medicare. **The Medicare beneficiary days should include MA days in addition to Medicare fee-for-service Part A days**.

- In the past, hospitals were required to submit this information for MA beneficiaries (through 1998) by submitting a no-pay bill.
- Later, managed care organizations (MCOs) (now MA companies) were responsible for submitting this information (through 2001) as part of encounter data submissions to CMS. **Since MCOs are no longer required to submit encounter data, hospitals must submit data on their MA days so that these days may be considered in the Medicare fraction of the DSH calculation**. The IPPS regulations on DSH are located in 42 CFR 412.106.
- The IRF PPS regulations on the LIP are located in 42 CFR 412.624(e)(2).

**Key Points of Change Request 5647**

- Hospitals may go back and submit claims with discharge dates on or after October 1, 2006 (fiscal year 2007), so that SSI data for FY 2007 and beyond will include MA patient days.
- Hospitals should bill claims on a type of bill (TOB) 11x, include **condition code 04,** and all other applicable claim information because patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit a no-pay bill (TOB 11x), which includes condition code 04 to their Medicare contractor. This will ensure that these days are included in the IRF SSI ratio for fiscal year 2007 and beyond.
- Teaching hospitals are already submitting their claims with condition codes 04 and 69 in order to be reimbursed for their indirect medical education payment. They will continue to submit their bills with condition codes 04 and 69.
- To ensure that MA hospital days are included in the FY 2007 Medicare/SSI file (due in the summer of 2008), hospitals should try to submit their FY 2007 claims to their Medicare contractor between the implementation date (January 7, 2008) of this CR through March 2008.
- The Supplemental Security Income (SSI)/Medicare Beneficiary Data for IPPS hospitals is located on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage*.

## Implementation Date

January 7, 2008

## Additional Information

For complete details regarding this CR, please see the official instruction (CR 5647) issued to your Medicare FI or A/B MAC. That instruction may be viewed by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1311CP.pdf*.

The revised sections of the *Medicare Claims Processing Manual* related to this issue are attached to CR 5647.

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

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

*MLN Matters* Number: MM5647
Related Change Request (CR) Number: 5647
Related CR Release Date: July 20, 2007
Related CR Transmittal Number: R1311CP
Effective Date: October 1, 2006
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1311, CR 5647

# Revision to Certification for Hospital Services Covered by Supplementary Medical Insurance Program as It Pertains to Ambulance Services

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

## Provider Types Affected

Physicians and hospitals billing Medicare fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MAC) for ambulance services for Medicare patients.

## Background

Change request (CR) 5684 furnishes the revised certification for hospital services by the supplementary medical insurance program as those requirements pertain to physician certification of ambulance services in Chapter 4, Section 20 of the *Medicare General Information, Eligibility, and Entitlement Manual.*

## Key Points of Change Request 5684

- Prior to the effective date of **September 17, 2007,** of CR 5684, certification by a physician in connection with ambulance services furnished by a participating hospital was required.
- As of the effective date of CR 5684, language requiring physician certification for ambulance services furnished by a participating hospital is deleted from the above-mentioned Medicare manual.
- Your Medicare FI, carrier or A/B MAC has been instructed to comply with this revision.

## Additional Information

To view the official instruction (CR 5684) issued to your Medicare FI, Carrier or A/B MAC, visit the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R47GI.pdf*.

The revised manual section is attached to CR 5684. If you have questions, please contact your Medicare FI, carrier, or A/B MAC at their toll-free number which may be found on the CMS Web site at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

*MLN Matters* Number: MM5684
Related Change Request (CR) Number: 5684
Related CR Release Date: August 17, 2007
Related CR Transmittal Number: R47GI
Effective Date: September 17, 2007
Implementation Date: September 17, 2007

Source: CMS Pub. 100-01, Transmittal 47, CR 5684



# Update of HCPCS Codes for Hemophilia Clotting Factors

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

**Note:** CMS has revised this *MLN Matters* article on July 27 2007, to correct the HCPCS code mentioned in the *CAUTION* and *Background* sections of the article. It incorrectly referenced HCPCS code J1787. It should have referenced HCPCS code J7187, as in the rest of the article. All other information remains the same. The *MLN Matters* article MM5466 was published in the June 2007 *Medicare A Bulletin* (page 48).

## Provider Types Affected

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

## Provider Action Needed

## STOP – Impact to You

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

## CAUTION – What You Need to Know

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

## GO – What You Need to Do

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

## Background

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

- For claims for hospital inpatient care, omit HCPCS code J7187 from the claim.

*Update of HCPCS Codes for Hemophilia Clotting Factors (continued)*

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

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

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

### Additional Information

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

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

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

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

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



## Present on Admission Indicator

*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 August 15, 2007, to show that psychiatric and inpatient rehabilitation hospitals are also exempt from reporting the present of admission indicator as noted in change request (CR) 5679. The *MLN Matters* article MM5499 was published in the June 2007 *Medicare A Bulletin* (pages 44-45).

### Provider Types Affected

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

### Provider Action Needed

### STOP – Impact to You

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

### CAUTION – What You Need to Know

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

### GO – What You Need to Do

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

### Background

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

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

***Present on Admission Indicator (continued)***

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

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

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

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

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

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

**Note:** Critical access hospitals, Maryland waiver hospitals, long-term care hospitals, cancer hospitals, and children's inpatient facilities are exempt from this requirement. Also, as noted in CR 5679 (*http://www.cms.hhs.gov/Transmittals/downloads/R289OTN.pdf*), hospitals paid under a PPS other than the acute care hospital PPS are exempt. Thus psychiatric and rehabilitation hospitals are exempt.

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

**1. General Reporting Requirements**

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

**2. Reporting Options and Definitions**

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

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

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

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

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

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

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

***Present on Admission Indicator (continued)***

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

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

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

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

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

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

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

## Additional Information

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

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

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

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

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



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# ESRD SERVICES

## Erythropoiesis-Stimulating Agents Modification for End-Stage Renal Disease Patients

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

### Provider Types Affected

Renal dialysis facilities billing Medicare fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs) for services related to erythropoietin (EPO) and darbepoetin (Aranesp®) for Medicare end-stage renal disease **(**ESRD) beneficiaries.

### Background

In 2003, the Centers for Medicare & Medicaid Services (CMS) solicited input from the ESRD community in order to develop a national claim monitoring policy for erythropoiesis-stimulating agents, also referred to as ESAs, administered to ESRD patients receiving dialysis in a renal dialysis facility. After considerable input from the ESRD community, CMS implemented the first iteration of the national ESA monitoring policy referred to as EMP, effective for dates of service on or after April 1, 2006. (See earlier articles related to the EMP on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4135.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5251.pdf*.)

Emerging scientific data on the use of ESAs has prompted CMS to again revise the EMP to further control over-utilization and inappropriately sustained high hematocrit or hemoglobin levels.

### What You Need to Know

Change request (CR) 5700 makes the following changes **effective for dates of service on or after January 1, 2008:**

- Requests for payments or claims for type of bill (TOB) 72x for ESAs (HCPCS Q4081, Epogen®, J0882 Aranesp®) for ESRD patients receiving dialysis in renal dialysis facilities and reporting a hematocrit level (value code 49) exceeding 39.0 percent (or hemoglobin (value code 48) exceeding 13.0g/dL) for three or more consecutive billing cycles immediately prior to and including the current billing cycle, will have the reported dosage reduced by 50 percent on which payment may be made.
- Such claims should report **modifiers ED** (Hematocrit greater than 39.0 percent or hemoglobin greater than 13.0g/dL for three or more consecutive billing cycles immediately prior to and including the current billing cycle) **or EE** (Hematocrit greater than 39.0 percent or hemoglobin greater than 13.0g/dL for less than three consecutive billing cycles immediately prior to and including the current billing cycle) with HCPCS Q4081/J0882 on the line.
- Providers may continue to report **modifier GS** (Dosage of EPO or darbepoetin alfa has been reduced and maintained in response to hematocrit or hemoglobin level) when the reported hematocrit or hemoglobin levels exceed the monitoring threshold and a dose reduction has occurred.
- When **modifier GS** is included on claims reporting **modifier EE** and HCPCS J0882/Q4081 on the line, the claim will be paid in full. **Modifier GS,** however, will have no effect on the 50 percent reduction of the reported dose on which payment may be made on claims reporting **modifier ED** and HCPCS J0882/Q4081 line items.
- TOB 72x claims reporting hematocrit greater than 39.0 percent or hemoglobin greater than 13.0g/dL with HCPCS Q4081/J0882 on the line will be returned to provider if neither **modifier ED or EE** are present on at least one of the line items, or if both **modifiers ED and ED** are present.
- When Medicare makes a reported dosage reduction, the remittance advice will contain **reason code 153** (Payment adjusted because the payer deems the information submitted does not support this dosage.)
- The dosage reduction may be taken by reducing covered units on the claim or by reducing the total payment applicable to the line.
- Medicare systems shall continue to allow for medical review override of these payment reductions.
- The medically unlikely edit (MUE) threshold has been revised. The MUE for claims for Epogen® (Q4081) is reduced to 400,000 units from 500,000, and to 1200 units from 1500 units for Aranesp® (J0882). Claims reporting doses exceeding the new thresholds are assumed to have typographical errors and will be returned to providers for correction.
- ESA claims for ESRD patients who receive their dialysis at home and self-administer their ESAs are exempt from this policy as reported in the earlier *MLN Matters* articles referenced above.
- None of the above requirements are applicable to type of bill 72x claims containing **condition code 70 or 76** and method I or II is applicable to the billing cycle.

The following chart on the next page illustrates the resultant claim actions under all possible reporting scenarios.

*Erythropoiesis-Stimulating Agents Modification for End-Stage Renal Disease Patients (continued)*

| Hct Exceeds 39.0% or Hgb Exceeds 13.0g/dL | ED Modifier? (Hct >39.0% or Hgb >13.0g ?3 cycles) | EE Modifier? (Hct >39.0% or Hgb >13.0g <3 cycles | GS Modifier? (Dosage reduced and maintained) | Claim Action |
|---|---|---|---|---|
| No | N/A | N/A | N/A | Do not reduce reported dose. |
| Yes | No | No | No | Return to provider for correction. Claim must report either ED or EE. |
| Yes | No | No | Yes | Return to provider for correction. Claim must report either ED or EE. |
| Yes | No | Yes | Yes | Do not reduce reported dose. |
| Yes | No | Yes | No | Reduce reported dose 25%. |
| Yes | Yes | No | Yes | Reduce reported dose 50%. |
| Yes | Yes | No | No | Reduce reported dose 50%. |

## Additional Information

For complete details regarding these changes please see the official instruction (CR 5700) issued to your Medicare FI or A/B MAC. That instruction is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1307CP.pdf*.

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

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

*MLN Matters* Number: MM5700
Related Change Request (CR) Number: 5700
Related CR Release Date: July 20, 2007
Related CR Transmittal Number: R1307CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1307, CR 5700

# SKILLED NURSING FACILITY SERVICES

## Coverage for Therapy Services Provided In a Skilled Nursing Facility

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

### Provider Types Affected

Skilled nursing facilities (SNF) who bill fiscal intermediaries (FI) or Medicare administrative contractors (A/B MACs) for physical therapy, occupational therapy, or speech-language pathology services to Medicare beneficiaries.

### Provider Action Needed

### STOP – Impact to You

For SNF furnished services, including physical or occupational therapy or speech-language pathology services, to be covered, **an initial therapy evaluation must take place within the SNF** or your fiscal intermediary or A/B MAC will deny the claim under the SNF benefit.

### CAUTION – What You Need to Know

Change request (CR) 5532, from which this article is taken revises the *Medicare Benefit Policy Manual* (CMS Pub.100-02), Chapter 8, Section 30.4.1.1 to clarify that the initial therapy evaluation must be performed in the SNF. If the initial therapy evaluation in the medical record is dated prior to the first day of the SNF admission or readmission, the claim for SNF benefits will be denied.

### GO – What You Need to Do

Make certain that all SNF-related therapy evaluations are performed during the beneficiary's SNF stay, and that this is appropriately documented. Please see the *Background* section for more details.

### Background

Section 1861(h) of the Social Security Act defines certain services (including physical or occupational therapy or speech-language pathology services) that an SNF (or others under arrangements with the SNF) furnishes to its beneficiaries, to be covered under the Extended Care Benefit. To be covered, the care provided to the SNF beneficiary must meet the requirements set forth in 42 C.F.R. 409 Subpart D.

CR 5532, from which this article is taken, re-emphasizes this requirement and clarifies *Medicare Benefit Policy Manual*, Chapter 8 (Coverage of Extended Care (SNF) Services Under Hospital Insurance), Section 30.4.1.1 (General) to state (as previously announced in the SNF prospective payment system (PPS) final rule for FY 2000, (FR 41662, July 30, 1999)) that, in order to for services to be covered under the SNF benefit, the associated initial therapy evaluation of a beneficiary **must take place in the SNF**.

This means that you cannot use an evaluation that was performed, for instance, in the acute care or rehabilitation hospital settings as the therapy evaluation of the beneficiary in the SNF, because the beneficiary's status must be evaluated as he or she presents in the SNF setting. Note that the cost of an initial therapy evaluation in the SNF is included in the SNF PPS payment made for SNF covered services.

**Notes:** Your FI or A/B MAC will:

1) Deny claims for SNF services when the first three alpha characters of the HIPPS (health insurance prospective payment system) rate code are RHA, RHB, RHC, RHL, RHX, RLA, RLB, RLX, RMA, RMB, RMC, RML, RMX, RUA, RUB, RUC, RUL, RUX, RVA, RVB, RVC, RVL, or RVX; and a review of the medical record finds that an initial evaluation for therapy services is dated **prior to** the first day of covered care upon admission and or readmission.
2) Not search its files for claims already processed involving the provision of therapy services to determine if an initial evaluation was provided following admission or readmission, except when a claim is brought to its attention.

### Additional Information

You can find more information about SNF-related therapy evaluations by going to CR 5532, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R73BP.pdf*.

You will find revised *Medicare Benefit Policy Manual*, Chapter 8 (Coverage of Extended Care (SNF) Services Under Hospital Insurance), Section 30.4.1.1 (General) as an attachment to the CR.

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

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

*MLN Matters* Number: MM5532
Related Change Request (CR) Number: 5532
Related CR Release Date: June 29, 2007
Related CR Transmittal Number: R73BP
Effective Date: July 30, 1999
Implementation Date: October 1, 2007

Source: CMS Pub. 100-02, Transmittal 73, CR 5532

# 2008 Annual Update of HCPCS Codes for Skilled Nursing Facility Consolidated Billing

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

## Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], Part A/B MACs) and fiscal intermediaries [FIs]) for services provided to Medicare beneficiaries in a skilled nursing facility (SNFs).

## Provider Action Needed

## STOP – Impact to You

This article is based on change request (CR) 5696, which provides the 2008 annual update of HCPCS codes for SNF consolidated billing (CB) and how the updates affect edits in the Medicare claim processing systems.

## CAUTION – What You Need to Know

CR 5696 provides updates to HCPCS codes that will be used to revise the common working file (CWF) edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manua*l, Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

## GO – What You Need to Do

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

## Background

Medicare claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Physicians and providers are advised that, by the first week in December 2007, new code files will be posted to on the CMS Web site the at *http://www.cms.hhs.gov/SNFConsolidatedBilling/*.

Institutional providers note that this site will include new Excel® and PDF format files.

**Note:** It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed on the CMS Web site at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* in order to understand the major categories including additional exclusions not driven by HCPCS codes.

## Additional Information

The official instruction, CR 5696, issued to your Medicare contractor regarding this change may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1317CP.pdf*.

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

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

*MLN Matters* Number: MM5696
Related Change Request (CR) Number: 5696
Related CR Release Date: August 17, 2007
Related CR Transmittal Number: R1317CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1317, CR 5696



# CMS Increases Payments for Beneficiaries Using Skilled Nursing Facility Care for 2008

## Accurate Payments Continue To Ensure Program Efficiency, Quality and Sustainability

The Centers for Medicare & Medicaid Services (CMS) has announced that Medicare payments for beneficiaries using skilled nursing facility (SNF) care will increase by approximately $690 million in fiscal 2008. The 3.3 percent increase will be reflected in Medicare payment rates to SNFs and hospitals that furnish certain skilled nursing and rehabilitation care to Medicare beneficiaries recovering from serious health problems. The final rule for the SNF prospective payment system (PPS) was placed on display at the *Federal Register*.

"These new payment rates reflect CMS commitment to improving the quality of care in the long-term care setting while maintaining predictability and stability in payments for the providers who deliver those important services," CMS Acting Administrator Herb Kuhn said. "They will enable nursing homes and Medicare to continue to move forward in providing quality services for patients who need post acute care. The SNF rule demonstrates our commitment to ensure that Medicare is affordable for current beneficiaries and is sustained for future generations by paying accurately and efficiently."

***CMS Increases Payments for Beneficiaries Using Skilled Nursing Facility Care for 2008 (continued)***

Under the Medicare SNF PPS, each SNF is paid a daily rate based on the relative needs of individual Medicare patients, adjusted for local labor costs. The daily rate covers the costs of furnishing all covered SNF services, including routine services such as room, board, nursing services, and some medical supplies together with related costs such as therapies, drugs and lab services; and capital costs including land, buildings and equipment.

CMS uses a SNF market basket to measure changes in the prices of an appropriate mix of goods and services included in covered SNF stays.

The price of items in the market basket is measured each year, and Medicare payments are adjusted accordingly. The final rule revises and rebases the SNF market basket, which currently reflects data from fiscal year 1997, to reflect data from fiscal year 2004.

The new payment rates also continue to include a special adjustment made to cover the additional services required by nursing home residents with HIV/AIDs. "We are confident that the new payment rates will continue to ensure beneficiary access to the important services SNFs provide," Mr. Kuhn said.

To view the display copy of the SNF PPS final rule (CMS-1545-F) for fiscal year 2008, go to the CMS Web site *http://www.cms.hhs.gov/SNFPPS/LSNFF/itemdetail.asp?filterType=dual,%20date&filterValue=7|d&filterByDID=-1&sortByDID=1&sortOrder=ascending&itemID=CMS1201649&intNumPerPage=10*.

The final rule was published in the *Federal Register* on Friday, August 3, 2007. ❖

Source: CMS Provider Education Resource 200708-01

## Skilled Nursing Facility Prospective Payment System PRICER Update for Fiscal Year 2008

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

### Provider Types Affected

Skilled nursing facilities (SNFs) billing Medicare fiscal intermediaries (FIs) for services paid under the SNF PPS.

### Background

Annual updates to the PPS rates are required by §1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), relating to Medicare payments and consolidated billing for SNFs.

The Centers for Medicare & Medicaid Services (CMS) published the SNF payment rates for fiscal year (FY) 2007 (October 1, 2006 through September 30, 2007) in the *Federal Register* on July 31, 2006 (71 FR 43159.) This article reminds SNFs that the annual update of the rates will be announced soon.

### Change Request 5688 Key Points

- The FY 2008 SNF payment rates will be effective October 1, 2007, through September 30, 2008.
- The update methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with AIDS.
- The statute mandates an update to the federal rates using the latest SNF full market basket.

### Additional Information

Market Basket Definitions and General Information may be found on the CMS Web site at *http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf*.

The official instruction, CR5688, issued to your Medicare FI or A/B MAC regarding this change may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1306CP.pdf*.

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

*MLN Matters* Number: MM5688
Related Change Request (CR) Number: 5688
Related CR Release Date: July 20, 2007
Related CR Transmittal Number: R1306CP
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1306, CR 5688

# ELECTRONIC DATA INTERCHANGE

## Claim Status Category Code and Claim Status Code Update

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

### Provider Types Affected

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

### Provider Action Needed

### STOP – Impact to You

This article is based on change request (CR) 5687, which provides the January 2008 updates of the claim status codes and claim status category codes for use by Medicare contractors (carriers, A/B MACs, DME MACs, FIs, and RHHIs).

### CAUTION – What You Need to Know

**Effective January 1, 2008,** Medicare contractors are to use codes posted on July 9, 2007, at the Web site *http://www.wpc-edi.com/codes*.

Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 – Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277 discusses these codes in more detail. You may review section 20.7 on the Centers for Medicare & Medicaid Services (CMS) Web site at: *http://www.cms.hhs.gov/manuals/downloads/clm104c31.pdf*.

### GO – What You Need to Do

See the *Background* section of this article for further details.

### Background

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use claim status category and claim status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the version 004010X093A1 health care claim status request and response transaction. These codes indicate the general category of a claim status (accepted, rejected, additional information requested, and so on). The National Code Maintenance Committee maintains the claim status category and claim status codes.

The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at *http://www.wpc-edi.com/content/view/180/223/*.

This page has previously been referenced by the following URL address: *http://www.wpc-edi.com/codes*.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this maintenance committee was to allow the industry more lead time for implementation of code changes. At least six months lead-time will be allowed for industry implementation of all claim status-related code changes as well as claim adjustment reason code changes (the same committee maintains these code sets). As result, **changes approved in June 2007 will be effective January 1, 2008.**

### Additional Information

For complete details regarding this CR please see the official instruction (CR 5687) issued to your Medicare FI, carrier, DME MAC, RHHI or A/B MAC. That instruction may be viewed by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1314CP.pdf*.

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

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

*MLN Matters* Number: MM5687
Related Change Request (CR) Number: 5687
Related CR Release Date: July 23, 2007
Related CR Transmittal Number: R1314CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1314, CR 5687

# Institutional Value Code Changes

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

**Note:** CMS has revised this *MLN Matters* article on July 24 2007, to add clarifying language regarding the use of value codes on adjustments. (See note in the *Background* section.) All other information remains the same. The *MLN Matters* article MM5411 was published in the March 2007 *Medicare A Bulletin* (page 31).

## Provider Types Affected

Providers who bill fiscal intermediaries (FI), Part A/B Medicare administrative contractors (A/B MACs), or regional home health intermediaries (RHHIs) for Medicare services.

## What You Need to Know

Value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 are now restricted to use only in paper claims, and are no longer available for use on X12N 837 institutional claim transactions.

## Background

The National Uniform Billing Committee (NUBC) has restricted the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 to paper claims only. These value codes are no longer available for use on X12N 837 institutional claim transactions.

Your Medicare FI, RHHI, or A/B MAC will create edits to restrict the use of these value codes to paper claims, and to not allow their use on direct data entry claims. Further, Medicare will ensure that any paper claim data from value codes A1, A2, A7, B1, B2, B7, C1, C2, or C7 are migrated to the appropriate X12N 837 2320 claim level adjustment (CAS) segment (claim adjustment reason code "PR") for coordination of benefits files.

**Note:** Change request (CR) 5411 does **not** say that **adjustments** that might previously be reported on an electronic claim using the value codes A1, A2, A7, B1, B2, B7, C1, C2, or C7 must now all be reported in the claim level CAS. Requirements already in the *837-I Implementation Guide* that apply to reporting of adjustments in either the claim or the service level CASs apply when submitting initial electronic claims that involve such adjustments.

## Additional Information

You may find the official instruction, CR 5411, issued to your FI, A/B MAC, or RHHI by visiting the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R261OTN.pdf*.

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

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

MLN Matters Number: MM5411 – Revised
Related Change Request (CR) Number: 5411
Related CR Release Date: January 19, 2007
Related CR Transmittal Number: R261OTN
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-20, Transmittal 261, CR 5411



# Health Care Provider Taxonomy Code Update

**Effective October 1 2007,** the Healthcare Provider Taxonomy Codes (HPTC) will be updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of the HPTC is available from the Washington Publishing Company Web site at: *http://www.wpc-edi.com/codes/taxonomy*.

When an HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level rejection may occur.

To ensure you do not receive a batch or claim level rejection, it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system, please contact your software support vendor. ❖

Source: CMS Pub. 100-04, Transmittal 1300, CR 5673

# FRAUD AND ABUSE

## Department of Health & Human Services and Department of Justice Fight Infusion Therapy Fraud

### *Strike Force Prosecutions and Demonstration Project Target Fraudulent Business Practices in South Florida*

The Health & Human Services (HHS) Secretary Mike Leavitt has announced an initiative designed to protect Medicare beneficiaries from fraudulent providers of infusion therapy. This two-year project will focus on preventing deceptive providers from operating in South Florida. Providers there will be required to reapply to be a qualified Medicare infusion therapy provider.

"HHS continues to work with the Department of Justice to protect the public and Medicare by stopping fraud before it happens," Secretary Leavitt said. "This demonstration project works to bar unlawful infusion therapy providers from entering the Medicare billing system." The new infusion therapy demonstration follows similar demonstration projects previously announced by HHS.

The demonstrations target fraudulent billing by suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) in South Florida and Southern California, and home health agencies in the greater Los Angeles and Houston areas. These geographic areas have shown a high frequency of DMEPOS or home health care fraud. South Florida is also one of the high-risk areas for fraudulent billing by providers of infusion therapy.

The Department of Justice (DoJ) is supporting HHS's new controls through a surge in prosecutions for health care fraud in South Florida. In May, the DoJ and HHS announced the work of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing. Since implementing the "phase one" Strike Force in Miami last March, DoJ prosecutors working with Assistant U.S. Attorneys from the Southern District of Florida have filed 47 indictments charging 65 individuals and/or entities with health care fraud in schemes that collectively billed Medicare more than $345 million. The Strike Force has convicted 26 defendants to date; 23 by plea agreement and three have been convicted in jury trials.

"Through real-time access to Medicare billing data, the Medicare Fraud Strike Force has allowed us to move quickly to make arrests and bring prosecutions as rapidly as possible. The Department of Justice remains fully committed to vigorously protecting the financial integrity of the Medicare program," stated Attorney General Alberto Gonzales.

The Strike Force supplements the ongoing health care fraud enforcement efforts of the United States Attorney's Office in the Southern District of Florida, which has been among the leading offices in combating health care fraud nationwide, presently accounting for over 20 percent of all health care fraud defendants charged nationally. Since announcing a federal-state health care fraud initiative over 18 months ago, the United States Attorney's Office has filed at least 157 criminal cases charging at least 266 defendants with federal violations in various health care fraud schemes and significant civil cases and settlements. Collectively, defendants and subjects billed Medicare over $300 million and received more than $150 million in reimbursements in cases that preceded the announcement today. The vast majority of these cases involved fraudulent DME or human immunodeficiency virus (HIV) infusion fraud schemes.

The Centers for Medicare & Medicaid Services (CMS) will now require infusion providers who operate in several South Florida counties to immediately resubmit applications to be a qualified Medicare infusion therapy provider. Those who fail to reapply within 30 days of receiving a notice to reapply from CMS will have their Medicare billing privileges revoked. Infusion therapy providers that fail to report a change in ownership; have owners, partners, directors or managing employees who have committed a felony; or, no longer meet each and every provider enrollment requirement; will have their billing privileges revoked. Infusion providers that successfully complete the reapplication process may be subject to an enhanced review, including site visits, based on risk assessment.

CMS will also issue Medicare summary notices to beneficiaries in South Florida on a monthly basis, instead of quarterly, to support more frequent scrutiny of infusion provider billings.

"We want to test and compare different fraud prevention tools in these demonstration projects," explains CMS Acting Deputy Administrator Herb Kuhn. "Enhancing our review of these providers will go a long way toward eliminating those who do not meet the needs of beneficiaries and the promises of the program."

The Medicare infusion therapy scam includes recruitment of HIV/AIDS patients by paying them to come to clinics and receive non-rendered or medically unnecessary infusion services. In 2004, Florida had fewer reported AIDS cases than California and New York, yet its total submitted Medicare charges for these cases was three times higher than California and five times higher than New York. And the number of infusion services billed in Florida tripled from 2004 to 2005, jumping from 4.3 percent to 15 percent of national billing.

Steps have been implemented in Florida to control fraudulent activities including joint federal and state site visits, prepayment edits and automatic denial of clinically unbelievable dosages, payment suspensions, provider enrollment onsite visits and other activities. Corrective actions from these steps have resulted in denial of fraudulent and medically unnecessary Medicare infusion claims with charges in excess of $1.8 billion in 2005 and 2006.

*Department of Health & Human Services and Department of Justice Fight Infusion Therapy Fraud (continued)*

"CMS has taken and will continue to take aggressive action to curb infusion therapy fraud and other organized fraud activities," Kuhn said.

This week, the Strike Force filed charges against a medical biller who submitted approximately $170 million in fraudulent medical bills on behalf of approximately 75 health clinics that purported to specialize in treating patients with HIV. From roughly October 2002 through April 2006, HIV clinics in South Florida serviced by this biller, Rita Campos and her company R and I Billing, allegedly provided bills to Medicare that indicated patients were being injected with excessive amounts of HIV medications. Based on the claims filed by Campos, Medicare paid more than $100 million for these fraudulent services. This investigation remains ongoing. Eight other defendants, including Eduardo Moreno, owner of RTC of Miami, an infusion clinic that billed Medicare for more than $5.2 million between August 2006 and March 2007, are fugitives. Moreno, who also owns multiple DME companies in addition to the infusion clinic, was arrested on April 7 after being named in a six-count indictment on fraud charges but fled following his release on bail.

The U.S. Marshals Service is launching a special project to track down Medicare fraud fugitives in South Florida.

HHS has several programs to help Medicare beneficiaries protect themselves against fraud. The Senior Medicare Patrol Program, established by the Administration on Aging, educates and assists beneficiaries in protecting their Medicare information, detecting Medicare billing errors and reporting potential health care fraud and abuse.

Instances of potential Medicare fraud also can be reported to the HHS Office of the Inspector General at 1-800-HHS-TIPS (800-447-8477) or *HHSTips@oig.hhs.gov*.

**Note:** All HHS press releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*. ❖

Source: Department of HHS Press Release, August 20, 2007
CMS Provider Education Resource 200708-14

## Medicare Integrity Program Demonstration for Providers of Infusion Therapy in High-Risk Areas

The Department of Health & Human Services (HHS) announced a two-year demonstration project by the Centers for Medicare & Medicaid Services (CMS) under the authority of Section 402(a)(1)(J) of the Social Security Amendments of 1967 [42 U.S.C. Section 1395b-1(a)(1)(J)] which permits the Secretary to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.

The demonstration, which focuses on South Florida, seeks to develop and demonstrate improved methods for the investigation and prosecution of fraud occurring among infusion providers.

- Infusion providers: Clinics or solo practitioners located in South Florida, who provide intravenous infusion therapy and/or intramuscular and subcutaneous injections in the office setting, will be subject to the demonstration. Infusion providers shifting from infusion to other procedure codes to avoid detection and bypass administrative actions will also be included.
- Infused and injected drugs: Medicare's HealthCare Common Procedure Coding System (HCPCS) categorizes infused and injected medications as J codes and Q codes to specifically identify the medication, dosage and administration route. For example, J0881 is the HCPCS code for "Injection, darbepoetin alfa, 1 microgram (non-ESRD use)." Medicare also separately reimburses drug administration (i.e., injection or infusion). For example *96542* is the *CPT* code for "*Chemotherapy injection*," *90780* is the *CPT* code for "*IV infusion, 1 hour*;" and *90782* is the *CPT* code for "*injection, subcutaneous or intramuscular*."
- Geographic area: The demo focuses on infusion providers in South Florida and, if providers relocate to avoid detection, will expand to other Florida locales designated as high risk by CMS and federal law enforcement.

### Background

In response to spikes in infusion billing detected in late 2003, CMS and its Miami Satellite Division, First Coast Service Options, Inc. (the Florida Medicare carrier), and TriCenturion (then Florida's Medicare program safeguard contractor), launched a multi-faceted initiative in 2004 to address widespread infusion fraud in South Florida. In March 2005, EDS took over as the program safeguard contractor (PSC). In 2005 and 2006, CMS and its contractors participated in Governor Jeb Bush's Federal/State Florida Infusion Task Force with the Department of Justice the Department of Health & Human Services' Office of Inspector General, the Federal Bureau of Investigation and Florida's Medicaid Fraud Control Unit, Department of Health, Agency for Health Care Administration, Office of the Attorney General, Office of Drug Control and the Governor's Office.

Medicare billing for infusion services in South Florida is disproportionately high. Although significant progress has been made, fraudulent billing practices of unscrupulous infusion providers continue to cost the Medicare program millions of dollars. The demonstration will provide additional tools for removal of fraudulent providers from the Medicare program and for more effective and efficient fraud detection and investigation.

#### Enormity of the Problem

The Medicare infusion scam began when for-profit clinics and doctors recruited HIV/AIDS patients and paid them to come to their clinics for non-rendered or medically unnecessary infusion services, which they billed to Medicare at clinically unbelievable frequencies and toxic dosages.

Florida's 2004 average Medicare submitted charges per HIV/AIDS beneficiary ($16,389) were four times higher than California ($3,932) and nearly eight times higher than New York ($1,935).

*Medicare Integrity Program Demonstration for Providers of Infusion Therapy in High-Risk Areas (continued)*

Florida, with fewer AIDS cases in 2004 (94,725) than California (133,292) or New York (162,466), had total submitted Medicare charges for HIV/AIDS beneficiaries ($1,552,417,426) that were three times higher than California ($524,100,645) and five times higher than New York ($314,315,002).

**Key Actions Taken by CMS and its Partners in 2005 and 2006:**

Combinations of corrective actions have been implemented in Florida such as joint federal/state site visits, prepayment edits, autodenials of clinically unbelievable dosages, payment suspensions, provider enrollment on-site and activity checks, enrollment revocations and deactivations, data analysis, complaint investigations, prosecutions and plea agreements. In 2005 and 2006, carrier and PSC prepayment reviews and edits have directly resulted in denial of fraudulent and medically unnecessary Medicare infusion claims with charges in excess of $1.8 billion. The United States Attorney's Office for the Southern District of Florida has filed criminal charges in 20 infusion therapy health care fraud cases involving 42 defendants during 2006 and 2007, to date. (See case list below.)

**Components of the Demonstration:**

1. **Immediate submission of enrollment application.** Letters will be sent to targeted South Florida infusion providers asking that they resubmit Medicare provider enrollment applications within 30 days of CMS' notification.
2. **Revocation of billing privileges.** Medicare billing privileges will be revoked (and appropriate recoupment measures applied) if an infusion provider fails to reapply within 30 days of receipt of CMS' letter; fails to report a change in ownership or address; fails to report owners, partners, directors or managing employees who have committed a felony within the past 10 years; or fails to comply with all of the Medicare provider enrollment requirements.
3. **Enhanced review of infusion providers.** Infusion providers that successfully complete the reapplication process will be subject to enhanced review, including site visits driven by established risk factors.
4. **Consumer fraud prevention.** The infusion therapy demonstration will introduce two features to help consumers support this fraud prevention effort. A new toll-free Part B Florida beneficiary infusion fraud hotline will be established in the near future. CMS will also issue Medicare summary notices (MSNs) to beneficiaries in South Florida on a monthly basis instead of quarterly, to support more frequent and timely scrutiny of infusion provider billings.

## Infusion Clinic Fraud Cases

**United States Attorney's Office for the Southern District of Florida**

In 2006 and 2007, the United States has filed 20 criminal cases against 42 defendants involved in infusion clinic health care fraud in the Southern District of Florida:

1. United States vs. Frantz Achille, No. 06-20496-CR
2. United States vs. Onelio Baez, et al., No. 05-20849-CR
3. United States vs. Gregory Delatour, No. 06-20029-CR
4. United States vs. Pedro Diaz, et al., No. 05-20869-CR
5. United States vs. Luis Manuel Fernandez, et al., No. 06-20322-CR
6. United States vs. Magda Lavin, No. 05-20814-CR
7. United States vs. Thaiz Parra, et al., No. 06-60167-CR
8. United States vs. Isaac Nosovsky, et al., No. 06-20178-CR
9. United States vs. Rafael Walled, No. 06-20030-CR
10. United States vs. Rosa Walled, No. 06-20031-CR
11. United States vs. Cesar Romero, No. 06-20740-CR
12. United States vs. Arnold Garcia, et al., No. 07-20057-CR
13. United States vs. Luis G. Henriquez Delgado, No. 07-20180-CR
14. United States vs. Jose Prieto, et al., No. 07-20177-CR
15. United States vs. Leider Alexis Munoz, No. 07-20225-CR
16. United States vs. Jorge Luis Mocega, et al., No. 07-20419-CR
17. United States vs. Orestes Alvarez-Jacinto, MD, No. 07-20420-CR
18. United States vs. Lester Miranda, et al., No. 07-20612-CR
19. United States vs. Rupert Francis, No. 07-20631-CR
20. United States vs. Rita Campos Ramirez, No 07-20633-CR. ❖

Source: Department of HHS Fact Sheet, August 20, 2007
CMS Provider Education Resource 200708-14

# EDUCATIONAL EVENTS

## Upcoming Provider Outreach and Education Events

***September 2007***

### Hot Topics (Topics To Be Determined)

**When:** **Tuesday, September 11, 2007**

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

**Type of Event:** **Teleconference**

### Two Easy Ways To Register

**Online –** To register for this seminar, please visit our new training Web site at *www.fcsomedicaretraining.com*.

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

**Fax –** If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to (904) 361-0407. Keep listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events. Providers without Internet access may leave a message on our FCSO Provider Education and Outreach Registration Hotline 1-904-791-8103 requesting a fax registration form.

**Please Note:**

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

More educational events (teleconferences, webcasts, etc.) will be planned to help providers with hot issues. Keep checking our Web site *http://www.floridamedicare.com* or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

# PREVENTIVE SERVICES

## August is National Immunization Awareness Month

### Vaccines Aren't Just for Kids!

Too many adults become ill, disabled, and die each year from diseases that could have been prevented by vaccines. Everyone from the very young to senior citizens can benefit from immunizations. While many consider this to be a time to ensure that children are immunized for school, National Immunization Awareness month is the perfect time to remind patients, health care employees, family members, friends, co-workers, and others to take advantage of opportunities to get up-to date on their vaccinations.

Medicare covers both the cost of pneumococcal and influenza vaccine and their administration by recognized providers. No beneficiary coinsurance or copayment applies and a beneficiary does not have to meet his or her deductible to receive an influenza or pneumococcal immunization. Medicare also covers hepatitis B vaccination for persons at high or intermediate risk. The coinsurance or copayment applies for hepatitis B vaccination after the yearly deductible has been met.

Disease prevention is key to public health. It is always better to prevent a disease than to treat it. For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Medicare will cover a booster pneumococcal vaccine for high-risk persons if five years have passed since their last vaccination.

### How Can You Help?

As a health care professional, you can help your Medicare patients and others understand the importance of disease prevention through immunizations. Your recommendation is the most important factor in increasing immunization rates among adults. You can help your Medicare patients take full advantage of the Medicare benefits that are right for them, including an annual influenza vaccination, a pneumococcal vaccination and the hepatitis B vaccination (for beneficiaries at high to intermediate risk for contracting the disease) by encouraging utilization of these benefits as appropriate.

### For More Information

- For more information about Medicare's coverage of adult immunizations, including coverage, coding, billing and reimbursement, please visit the following CMS Web sites:
  - The MLN Preventive Services Educational Products Web Page *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.
  - Adult Immunizations *http://www.cms.hhs.gov/AdultImmunizations/01_Overview.asp#TopOfPage*.
- For information to share with your Medicare patients, please visit on the Web *http://www.medicare.gov*.
- To learn more about National Immunization Awareness month, please visit on the Web *http://www.cdc.gov/vaccines/events/niam/default.htm#oview*.

Thank you for partnering with the Centers for Medicare & Medicaid Services as we strive to increase awareness and promote utilization of vaccines that can prevent infectious disease and save lives. ❖

Source: CMS Provider Education Resource 200708-07

***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.***

## Medicare Preventive Services—Quick Reference Information

The May 2007 *Quick Reference Information: Medicare Preventive Services* laminated chart is now available to order or download from the Medicare Learning Network. To order, go to the "MLN Product Ordering Page" located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* or to view online, go to the CMS Web site *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*. ❖

Source: CMS Provider Education Resource 200707-19

# OTHER EDUCATIONAL RESOURCES

## The Medicare Physician Guide July 2007 Version Is now Available

The *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (July 2007 version) may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf*.

This guide offers general information about the Medicare program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, fraud, abuse, inquiries, overpayments, and appeals. The Facilitator's Guide, companion to the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* that includes all the information and instructions necessary to prepare for and present a Medicare resident, practicing physician, and other health care professional training program, is also now available at *http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=facilitator&filterByDID=0&sortByDID=1&itemID=CMS061390&intNumPerPage=10*.

The *Medicare Billing Information for Rural Providers, Suppliers, and Physicians*, which consists of charts that provide billing information for rural health clinics, federally qualified health centers, skilled nursing facilities, home health agencies, and critical access hospitals, is available at *http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf*.

**Visit the Medicare Learning Network – It's Free.** ❖

Source: CMS Provider Education Resource 200708-11

## The Guide to Medicare Preventive Services Second Edition Is now Available

The second edition of ***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*** is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS), Medicare Learning Network (MLN). This comprehensive guide provides fee-for-services health care providers and suppliers with coverage, coding, billing and reimbursement information for preventive services and screenings covered by Medicare. This guide gives clinicians and their staff the information they need to help them in recommending Medicare-covered preventive services and screenings that are right for their Medicare patients and provides information needed to effectively bill Medicare for services furnished.

To view this guide online, go to on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*. ❖

Source: CMS Provider Education Resource 200708-12
CMS Provider Education Resource 200708-13

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

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

# ORDER FORM – PART A MATERIALS

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

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**First Coast Service Options, Inc.**

**Medicare Publications**

**P.O. Box 406443**

**Atlanta, GA 30384-6443**

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***ALL ORDERS MUST BE PREPAID –***

***DO NOT FAX - PLEASE PRINT***

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

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

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

# 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-04 (MSP Related)**
**Conditional Payment**
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

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

### *PROVIDER EDUCATION*

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

**Seminar Registration Hotline**
1-904-791-8103

**Seminar Registration Fax Number**
1-904-361-0407

### *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

### *PROVIDER ENROLLMENT*

**American Diabetes Association Certificates**
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

## Telephone Numbers

### *PROVIDERS*

**Customer Service Center Toll-Free**
1-888-664-4112
**Speech and Hearing Impaired**
1-877-660-1759

### *BENEFICIARY*

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

### *ELECTRONIC MEDIA CLAIMS*

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

**Electronic Eligibility**
1-904-791-8131

**Electronic Remittance Advice**
1-904-791-6865

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

**PC-ACE Support**
1-904-355-0313

**Testing**
1-904-791-6865

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

## Medicare Web sites

### *PROVIDERS*

**Florida Medicare Contractor**
***www.floridamedicare.com***
**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**
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

# MEDICARE A BULLETIN

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

## * ATTENTION BILLING MANAGER *