

In This Issue...



Nine-Digit ZIP Code Update

Outpatient Claims Paid Under the Medicare Physician Fee Schedule Must Have the Correct Nine-Digit ZIP Code Where the Services Were Provided..... 6

National Provider Identifier Mandatory Reporting

Effective January 1, 2008, Primary Provider Field Must Have the Correct NPI 12

Magnetic Resonance Imaging

Payment for the Contrast Medium Will Be Paid Separately 17

Local Coverage Determinations

Additional Medical Information 20

Inpatient Prospective Payment System

Technical Error Correction Notice with Comment for Fiscal Year 2008 22

Health Professional Shortage Area

Information About the 2008 Bonus Payment..... 23

Skilled Nursing Facility Consolidated Billing

Additional Information on Vaccines and Part D Benefit 24

Electronic Data Interchange

The Latest Update to X12N 835 and X12N 837 28

Medicare A Bulletin Reader Survey

A Great Opportunity for Our Readers to Provide Comments by December 14, 2007 37

Features

About This Bulletin	3
Provider Enrollment	5
General Information	6
General Coverage.....	17
Local Coverage Determinations	20
Hospital Services	22
Critical Access Hospital Services	23
Skilled Nursing Facility Services	24
Electronic Data Interchange	28
Educational Resources	32
Reader Survey	37

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 Web site at www.fcso.com.

Routing Suggestions:

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



Table of Contents

In This Issue	1
Have You Visited the FCSO Web Site Lately?	3
About the <i>Medicare A Bulletin</i>	3
New Web Site Features and Enhancements	4
Quarterly Provider Update	4
Provider Enrollment	
Avoid Rejection of a Pending Provider Enrollment Application.....	5
General Information	
Update to the Nine-Digit ZIP Code List for Establishing Payment Based on Locality	6
Flu Shot Reminder	7
Medicare Summary Notice Message—Revised MSN 38.13	7
Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses	8
New Contractor Workload Number for Cahaba Part A Iowa Data	9
Update to Wage-Index Tables	9
Required Use of Tamper-Resistant Prescription Pads for Outpatient Drugs Prescribed to Medicaid Recipients	10
National Provider Identifier	
Medicare Fee-for-Service National Provider Identifier Final Implementation	11
Mandatory Reporting of the National Provider Identifier on all Part A Claims	12
Successful Implementation of Medicare National Provider Identifier Crosswalk	12
What To Do if Claims Are Rejected Due to National Provider Identifier Issues	12
News Update About the National Provider Identifier	13
Potential Issues Related to Clearinghouse and Billing Service Practices	14
Stage 3 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice	15
General Coverage	
Magnetic Resonance Imaging Procedures	17
Correction to July, 2007 Quarterly Update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®	18
Local Coverage Determinations	
LCD Table of Contents	20
Hospital Services	
Correction Notice for Fiscal Year 2008 Inpatient PPS Final Rule with Comment Period	22
Critical Access Hospital Services	
2008 Annual Update for the Health Professional Shortage Area Bonus Payment	23
Skilled Nursing Facility Services	
Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services	24
Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Services	26
Electronic Data Interchange	
Remittance Advice Remark Code and Claim Adjustment Reason Code Update	28
Educational Resources	
Educational Events	
Upcoming Provider Outreach and Education Events	32
Preventive Services	
October Is National Breast Cancer Awareness Month	33
Other Educational Resources	
Medicare Preventive Services Quick Reference Information Chart	34
Preventive Services Brochures for Health Care Professionals now Available To Order ..	34
Updated Adult Immunizations Web-Based Training Course	34
Medicare Billing Information for Rural Providers, Suppliers, and Physicians	35
Revised Medicare Physician Guide	35
Order Form – Part A Materials	36
Reader Survey	37
Important Addresses, Telephone Numbers and Web sites	39

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Publication Staff

Millie C. Pérez
Terri Drury
Mary Barnes
Betty Alix

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:

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Have You Visited the FCSO Web Site Lately?

In response to feedback we received from you, our valued customers, we recently completed a redesign of the Florida and Connecticut Medicare Web sites. If you haven't visited our Web sites lately, here are some of the things you have missed, hot off the presses!

- A quick 15-second animation that shows you all the latest tips and tools at your disposal to help successfully complete the CMS-855 form (Provider Enrollment Application).
- Information about the latest enhancements and user tools for the provider automated customer service telephone lines.
- The latest list of final Local Coverage Determinations (LCDs).
- The latest information on the National Provider Identifier (NPI).

This information and much more are just a few clicks away! "You can access the Florida or Connecticut Medicare provider Web sites anytime by going to www.fcsso.com. Once there, select the Medicare Provider's pull-down menu and click on the Florida Part A or B." ❖

About the Medicare A Bulletin

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

The Medicare Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. 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 download 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
1-904-361-0723

New Web Site Features and Enhancements

We recently performed a major overhaul of our Web site, but do you know why? One of the primary reasons is to provide you with more timely and relevant content. Our redesign also makes it easier for us to keep the site fresh and dynamic.

In this spirit of continuous improvement, we recently added new pages for Clinical Trials and New Providers, and made the Provider Enrollment and NPI (National Provider Identifier) sections easier to find. We have also added Flash “simulations” to help you with various provider enrollment forms. Initial response to these simulations has been very positive; if you have not checked them, refer to the Provider Enrollment page and look for the Flash content icon.

We have added instructions and tips for using our recently updated IVR (interactive voice response) unit, and enhanced the Contacts page to eliminate duplicate, and sometimes contradictory, information.

And we have completely revised the Frequently Asked Questions (FAQ) section to provide more accessible, up-to-date answers to some of your most important Medicare issues.

We are excited about our new look and functionality, and hope you are as well. Keep checking back for even more enhancements on the horizon, including a brand-new search engine!

References

Clinical Trials ([Medicare Part A](#))

[New Providers](#)

[Provider Enrollment](#)

[NPI](#)

[IVR](#)

Fee Schedule Look-up ([Part A](#))

FAQs ([Part A](#))

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 Rejection of a Pending Provider Enrollment Application

Respond Immediately to a Request for Information

Our goal at First Coast Service Options, Inc. (FCSO) is to help facilitate your enrollment into the Medicare program. In accordance with 42 CFR section 424.525(a), FCSO may reject an application if the provider fails to furnish all of the information and/or documentation within 60 calendar days from the date of the request. To prevent rejection of your pending enrollment application, we request that you respond immediately to any request for information and/or documentation.

If an application is rejected after this 60-day window, the provider or supplier must complete and submit a new enrollment application, including all supporting documentation, for review and approval. Enrollment applications that are rejected are not afforded appeal rights.

Remember: The sooner you respond to our request, the sooner you will be enrolled or your request will be resolved.

Sources: <http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf>

http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr424_main_02.tpl

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 e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site <http://www.fcsso.com>, hover over Medicare Providers, select Florida Part A or B, click on the "eNews" link located on the upper-right-hand corner of the page and follow the prompts.

GENERAL INFORMATION

Update to the Nine-Digit ZIP Code List for Establishing Payment Based on Locality

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

Provider Types Affected

Physicians, providers, and other health care practitioners submitting claims to Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for services paid under the Medicare physician fee schedule (MPFS) and for anesthesia services.

Provider Action Needed

STOP – Impact to You

Change request (CR) 5208, issued March 09, 2007, had attached to it the list of ZIP codes that would require the nine-digit ZIP codes effective for claims with dates of service on or after October 1, 2007. **CR 5730 updates this ZIP code list.** To review the list in CR 5208, go to the CMS Web site <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5208.pdf>.

CAUTION – What You Need to Know

The *Key Points* section of this CR provides the complete updated list of additions and deletions to the ZIP code list identified in CR 5208.

GO – What You Need to Do

Make certain that your billing staffs are aware that Medicare requires the submission of nine-digit ZIP codes to carriers/A/B MACs for services paid under the MPFS and anesthesia services, when the services are provided in those ZIP code areas listed in CR 5208 (except those identified as deleted in this article) as well as those ZIP codes listed in this article as added to the CR 5208 list. The exception occurs when the place of service (POS) is “Home,” and for any other places of service that your Medicare carrier or A/B MAC currently considers to be the same as “Home.” (Currently, there is no requirement for the submission of a ZIP code when the POS is “Home.”)

Background

Medicare contractors have been directed to determine payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. CMS realizes that some ZIP codes fall into more than one payment locality. The

CMS ZIP code file uses the convention of the United States Postal Service, which assigns these ZIP codes into dominant counties. In some cases, though the service may actually be rendered in one county, but per the ZIP code it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount.

Key Points

Additions to the ZIP code list in CR 5208 requiring nine-digit zip codes are as follows:

30132	51001	51023	57533	58639	58649	60502
60503	60585	60586	67762	69145	69128	69343
77578	78660	78653	82701	98068		

Deletions to the ZIP code list in CR 5208 requiring nine-digit zip codes are as follows:

01432	19525	62231	68755	77550	78657
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Additional Information

For complete details regarding this CR please see the official instruction (CR 5730) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1337CP.pdf>.

If you have questions, please contact your Medicare 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: MM5730

Related Change Request (CR) Number: 5730

Related CR Release Date: September 21, 2007

Related CR Transmittal Number: R1337CP

Effective Date: October 22, 2007

Implementation Date: October 22, 2007

Source: CMS Pub. 100-04, Transmittal 1337, CR 5730

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Flu Shot Reminder

Flu Season Is Upon Us! Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu. Encourage them to get their flu shot. It's their best defense against combating the flu this season. Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies. And don't forget, health care professionals need to protect themselves also. **Get Your Flu Shot. – Not the Flu.**

Remember: Influenza vaccination is a covered Part B benefit.

Note: Influenza vaccine is not a Part D covered drug.

For information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to the CMS Web site

http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf. ❖

Source: CMS Provider Education Resource 200710-11, 200710-10, 200710-08, 200710-03

Medicare Summary Notice Message—Revised MSN 38.13

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

Provider Types Affected

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

Provider Action Needed

This article is informational for providers and the article is based on change request (CR) 5722, which outlines a change to Medicare summary notice (MSN) message 38.13 that will advise beneficiaries that they may need to pay their provider before receiving their MSN due to the change to quarterly mailing schedule (see CR 5062).

Background

In an effort to reduce overall operating costs, CR 5062 changed the No-Pay MSN mailing schedule from a monthly schedule to a quarterly schedule. As a result, it is possible that a beneficiary may receive a bill from a provider before receiving the MSN and may not be able to wait for the MSN before provider payment is due.

The change to MSN Message 38.13 clarifies this potential timing conflict to beneficiaries. The revised MSN message is as follows:

"If you aren't due a payment check from Medicare, your Medicare summary notices (MSN) will now be mailed to you on a quarterly basis. You will no longer get a monthly statement in the mail for these types of MSNs. You will now get a statement every 90 days summarizing all of your Medicare claims. Your provider may send you a bill that you may need to pay before you get your MSN. When you get your MSN, look to see if you paid more than the

MSN says is due. If you paid more, call your provider about a refund. If you have any questions about the bill from your provider, you should call your provider."

Additional Information

You can review the official instruction issued to your A/B MAC, FI, carrier, DME MAC, or RHHI regarding this message modification by going to CR 5722, located on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R1347CP.pdf>.

You can review CR 5062 on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R955CP.pdf>.

The related *MLN Matters* article (MM5062: Quarterly Medicare Summary Notice (MSN) Printing Cycle) is on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5062.pdf>.

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

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

MLN Matters Number: MM5722

Related Change Request (CR) Number: 5722

Related CR Release Date: September 27, 2007

Related CR Transmittal Number: R1347CP

Effective Date: October 29, 2007

Implementation Date: October 29, 2007

Source: CMS Pub. 100-04, Transmittal 1347, CR 5722

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Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, fiscal intermediaries, [FIs], Medicare administrative contractors (A/B MACs), and durable medical equipment Medicare administrative contractors [DME MACs]) for splints, casts, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Affected providers may want to be certain their billing staffs know of these changes.

Background

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes.

This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 on the Internet at: <http://www.gpoaccess.gov/cfr/retrieve.html>.

The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The *MLN Matters* article related to CR 5382 may be viewed on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf>.

For intraocular lenses, payment is made **only on a reasonable charge basis for lenses implanted in a physician's office**. CR 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 inflation-indexed charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the following identified codes using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the following identified codes that were not paid using gap-filled amounts in 2007. These codes are:

Dialysis Supplies Billed with Modifier AX

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

Dialysis Supplies Billed Without Modifier AX

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Dialysis Equipment Billed with Modifier AX

E0210NU	E1632	E1637	E1639
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Dialysis Equipment Billed Without Modifier AX

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes.

Contractors will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article.**

Additional Information

Detailed instructions for calculating:

- Reasonable charges are located in chapter 23 (Section 80) of the *Medicare Claims Processing Manual*.
- Customary and prevailing charge are located in section 80.2 and 80.4 of chapter 23 of the *Medicare Claims Processing Manual*.
- The IIC are located in section 80.6 of chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You can find chapter 23 of the *Medicare Claims Processing Manual* on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>.

For complete details regarding this CR please see the official instruction (CR 5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf>.

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies/Equipment, and ... (continued)

If you have questions, please contact your Medicare FI, carrier, DME MAC, 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: MM5740

Related Change Request (CR) Number: 5740

Related CR Release Date: September 28, 2007

Related CR Transmittal Number: R1344CP

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

2007 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit	Code	Payment Limit	Code	Payment Limit
A4565	\$7.38	Q4013	\$13.52	Q4026	\$101.30	Q4039	\$7.08
Q4001	\$42.01	Q4014	\$22.81	Q4027	\$16.23	Q4040	\$17.68
Q4002	\$158.81	Q4015	\$6.76	Q4028	\$50.66	Q4041	\$17.16
Q4003	\$30.18	Q4016	\$11.40	Q4029	\$24.81	Q4042	\$29.30
Q4004	\$104.49	Q4017	\$7.82	Q4030	\$65.31	Q4043	\$8.59
Q4005	\$11.12	Q4018	\$12.47	Q4031	\$12.41	Q4044	\$14.66
Q4006	\$25.08	Q4019	\$3.91	Q4032	\$32.65	Q4045	\$9.96
Q4007	\$5.58	Q4020	\$6.24	Q4033	\$23.14	Q4046	\$16.03
Q4008	\$12.54	Q4021	\$5.78	Q4034	\$57.56	Q4047	\$4.97
Q4009	\$7.43	Q4022	\$10.44	Q4035	\$11.57	Q4048	\$8.02
Q4010	\$16.72	Q4023	\$2.91	Q4036	\$28.79	Q4049	\$1.82
Q4011	\$3.71	Q4024	\$5.22	Q4037	\$14.12		
Q4012	\$8.36	Q4025	\$32.45	Q4038	\$35.37		

Source: CMS Pub. 100-04, Transmittal 1344, CR 5740

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New Contractor Workload Number for Cahaba Part A Iowa Data

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

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

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

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

Source: CMS Pub. 100-20, Transmittal 294, CR 5566

Update to Wage-Index Tables

The Centers for Medicare & Medicaid Services (CMS) has updated the previous posting of more user-friendly versions of select tables from the final rule (CMS-1541-FC) to include more user-friendly versions of the wage index related addendums, Addendum A and Addendum B, for non-urban and urban areas as defined by the Office of Management and Budget determined core based statistical areas (CBSAs).

The revised tables are available at: (http://www.cms.hhs.gov/HomeHealthPPS/downloads/CMS-1541-F_Tables.zip). ❖

Source: CMS Provider Education Resource 200710-11

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.

Note: CMS has revised this *MLN Matters* article on October 2, 2007, to change the effective date from October 1, 2007, to April 1, 2008. This change was a result of the “Extenders Law”, which was signed September 29, 2007, delaying the implementation date for all paper Medicaid prescriptions to be written on tamper-resistant paper. Under the new law, all written Medicaid prescriptions must be on tamper-resistant prescription pads as of April 1, 2008. CMS will issue additional guidance on this implementation delay as it becomes available. All other information remains the same. The special edition *MLN Matters* article SE0736 was published in the September 2007 *Medicare A Bulletin* (page 14).

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 April 1, 2008, 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 April 1, 2008, 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 April 1, 2008.
- 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.

MLN Matters Number: SE0736 – Revised
 Related Change Request (CR) Number: N/A
 Related CR Release Date: N/A
 Related CR Transmittal Number: N/A
 Effective Date: April 1, 2008
 Implementation Date: N/A
 Source: CMS Special Edition *MLN Matters* Article SE0736

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NATIONAL PROVIDER IDENTIFIER

Medicare Fee-for-Service National Provider Identifier Final Implementation

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

Provider Types Affected

Physicians, providers, and suppliers who submit any Health Insurance Portability and Accountability Act (HIPAA) standard transactions to Medicare contractors (carriers, fiscal intermediaries, [FIs], including regional home health intermediaries [RHHIs], Medicare administrative contractors [A/B MACs], and DME Medicare administrative contractors [DME MACs]).

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5728, which describes the policy change brought about as a result of HIPAA of 1996, that requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions.

CAUTION – What You Need to Know

Once the Center for Medicare & Medicaid Services (CMS) ends its NPI contingency, the legacy number will **not** be permitted on any inbound electronic and outbound electronic transaction (there are exceptions to the 835 remittance advice [(see CR 5452)]. Medicare contractors will begin rejecting claims, electronic, including direct data entry, that contain legacy provider numbers for any primary provider instead of or in addition to the NPI number. The following HIPAA transactions are also affected:

- X12N 276/277 Claim Status Inquiry/Response – (see CR 5726 for details.)
- X12N 837 Coordination of Benefits (COB) – NPI only will be sent on the 837 coordination of benefits. Legacy numbers are not allowed. An exception will exist for claims that have not cleared the system by the date that CMS ends its NPI contingency plan. Such claims may contain the legacy number and, therefore, the COB transaction will also include the legacy number.

GO – What You Need to Do

No later than May 23, 2008, providers should ensure that all HIPAA transactions sent to Medicare contractors contain only valid NPI numbers (no legacy provider numbers).

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and

other provider of health care who conducts HIPAA standard electronic transactions. CMS began to issue NPIs on May 23, 2005. CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers. They are:

- NPI only
- Medicare legacy only; or
- NPI and legacy combination.

On April 2, 2007, the Department of Health & Human Services (DHHS) provided guidance to covered entities regarding contingency planning for the implementation of the NPI. As long as a health plan is compliant, meaning they can accept and send NPIs on electronic transactions, they may establish contingency plans to facilitate the compliance of their trading partners. As a compliant health plan, Medicare fee-for-service (FFS) established a contingency plan on April 20, 2007, that followed this guidance. CR 5728 directs Medicare contractors to begin rejecting HIPAA inbound claims when directed by CMS, if they contain legacy provider identifiers.

Since paper claims are not HIPAA transactions, these requirements do not apply to paper claims, however, providers should not submit legacy numbers on paper claims once CMS ends its NPI contingency plan.

Additional Information

The official instruction, CR 5728, issued may be found on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1349CP.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: MM5728

Related Change Request (CR) Number: 5728

Related CR Release Date: October 5, 2007

Related CR Transmittal Number: R1349CP

Effective Date: No later than May 23, 2008

Implementation Date: January 7, 2008 and April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1349, CR 5728

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Mandatory Reporting of the National Provider Identifier on all Part A Claims

Effective January 1, 2008, your Medicare fee-for-service claims must include a national provider identifier (NPI) in the primary provider fields on the claim (i.e., the billing and pay-to provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., attending, operating and other) may continue to include only your legacy number, if you choose.

Failure to submit an NPI in the primary provider fields will result in your claim being rejected, beginning January 1, 2008.

In addition, if you already bill using the NPI/legacy pair in the primary provider fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI in the primary provider fields. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims. ❖

Source: CMS Joint Signature Memorandum 08007, October 2, 2007

Successful Implementation of Medicare National Provider Identifier Crosswalk

The Centers for Medicare & Medicaid Services (CMS) is pleased to report that the vast majority of institutional provider claims are being sent to Medicare with a national provider identifier (NPI). Moreover, the Medicare NPI crosswalk has been in successful operation for all institutional provider claims since June 2007. Given these favorable results, CMS is taking the next step towards full implementation of the NPI in Medicare.

Effective January 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary provider fields on the claim (i.e., the billing and pay-to provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. Claims with only a legacy provider identifier for the primary fields will be returned to the provider. You may continue to include legacy only for the secondary fields, if you choose. Failure to submit an NPI in the primary fields will result in your claim being returned to the provider, beginning January 2, 2008.

In addition, if you already bill using the NPI/legacy pair in the primary provider fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims. ❖

Source: CMS Provider Education Resource 200709-21

What To Do if Claims Are Rejected Due to National Provider Identifier Issues

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

- Check Medicare reject report messages.
- If you use billing companies, clearinghouses and administrative staff, check to find out if they have been contacted by Medicare contractors concerning problems in matching the national provider identifier/provider identification number (NPI/PIN) combinations to the Medicare NPI crosswalk.
- Check your information in the national plan and provider enumeration system (NPPES) to ensure that the NPI(s) were properly obtained. For example, if you are a sole proprietor, you should have an individual PIN and you should have obtained an NPI as an individual (entity type 1), not as an organization (entity type 2).
- Ensure that the NPPES data are correct, and that the NPPES record(s) contains the Medicare legacy identifier(s) that was assigned to the provider to whom the NPPES record belongs. For example, a physician/practitioner applying for an NPI would list his/her Medicare PIN in the "Other Provider Identifiers" section of the NPI application, but would not list the PIN of the group in which he/she is a member. Medicare uses this information in building the Medicare NPI crosswalk and incorrect reporting will flow into the NPI crosswalk and cause problems down the road. To view or edit your NPPES record, go to the CMS Web site <https://nppes.cms.hhs.gov>.

For assistance, call the NPI enumerator at 1-800-465-3203.

- If the NPI(s) was properly obtained and the NPPES information is correct and you continue to get informational NPI edits:
 - Ensure that your Medicare enrollment information is up to date.
 - If you need to re-enroll or update the enrollment information, ensure that a complete application is submitted.
 - Also, make sure that the Medicare enrollment record reflects the correct taxpayer identification number (TIN) for use by Medicare in reporting your income to the Internal Revenue Service (IRS) on the 1099 form.

Important NPI and Enrollment Information for Physicians and Nonphysician Practitioners

By October 31, 2007, all Medicare carriers (and A/B MACs that service providers who formerly billed carriers) will be rejecting Part B claims if they are unable to "match" an NPI and a PIN combination submitted on a claim to an NPI/PIN combination in the Medicare NPI crosswalk. The NPI/PIN combination may be used to identify the 'Billing,' 'Pay-to,' or 'Rendering Provider' (the 'Pay-to Provider' is

What To Do if Claims Are Rejected Due to National Provider Identifier Issues (continued)

identified only if it is different from the 'Billing Provider'). This applies to claims that are submitted by corporations that physicians and nonphysician practitioners have formed, or by physicians and nonphysician practitioners who bill Medicare directly. In this article, we refer to these physicians and nonphysician practitioners as "physicians/practitioners."

For more information, please refer to the special edition *MLN Matters* article on this subject. You can view the article on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0744.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

Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information. ❖

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

Source: CMS Provider Education Resource 200710-12

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News Update About the National Provider Identifier

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

Information for Physicians and Nonphysician Practitioners Who Bill Medicare

Your Medicare carrier has contacted, or will be contacting you, about the date Medicare will begin rejecting your claims if the NPI and legacy number pairs used on your Medicare claims are not compatible. If you bill using only the NPI, please skip to the last paragraph.

Some incorporated physicians and nonphysician practitioners have obtained NPIs as follows: an individual (entity type 1) NPI for the physician or nonphysician practitioner and an organization (entity type 2) NPI for the corporation. If you enrolled in Medicare as an individual and obtained a Medicare provider identification number (PIN) as an individual, and you want to use your NPI and your PIN pair in your Medicare claims, be sure you use your individual NPI with your individual PIN. Pairing your corporation's NPI with your individual PIN will result in your claims being rejected. If you wish to bill Medicare with your corporation's NPI, then you must be sure your corporation is enrolled in Medicare so that it can be assigned a PIN. Please contact your servicing Medicare carrier for more information about this enrollment. Until your corporation has been enrolled in Medicare, you may continue to bill by using your individual NPI with your individual PIN to ensure no disruption in your claims being processed and paid. Please note that similar problems may result if you bill Medicare by using your individual NPI with your corporation's PIN (if the corporation is enrolled and has been assigned a PIN). In other words, when billing with the NPI/PIN pair, you must use compatible NPIs and PINs.

NPI-Only Billers: Make sure the NPI you are using is compatible with your Medicare enrollment. For example, if you enrolled in Medicare as an individual, then you should be using an individual (entity type 1) NPI.

Enumeration Tip for DME Suppliers

Medicare has also reported instances of incorrect billing by DME suppliers to DME MACs. DME suppliers must ensure that if they enumerate as individuals in the national supplier clearinghouse (NSC), they must obtain NPIs for themselves as individuals (entity type 1) in NPPES. If they enumerate as organization in the NSC, they must obtain NPIs for the organizations (entity type 2) in NPPES.

Pay Attention: Informational Edits Today – Future Claim Rejections!

We strongly urge Medicare providers to pay attention to the informational edits they may be receiving on the remittance advice (either electronic or paper). These edits are generated to help providers identify problems that will cause claims to reject in the future. A recent *MLN Matters* article lists these informational edits and their meanings. To view the article, visit the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf>.

Reminder: Medicare carriers and DME MACs will begin transitioning their systems to start rejecting claims when the NPI and legacy provider identifier pair cannot be found on the Medicare crosswalk.

Since May 29, 2007, Medicare fiscal intermediaries, as well as Part B CIGNA Idaho and Tennessee, have been validating NPIs and legacy provider identifier pairs submitted on claims against the Medicare NPI crosswalk. Between the period of September 3, 2007, and October 29, 2007, all other Part B carriers and DME MACs began to turn on edits to validate the NPI/legacy pairs submitted on claims. If the pair is not found on the Medicare NPI crosswalk, the claim will reject. Contractors have been instructed to inform providers at a minimum of seven days

News Update About the National Provider Identifier (continued)

prior to turning on the edits to validate the NPI/legacy pairs against the NPI crosswalk.

If your remittance advice contains informational edits today, we strongly urge you to validate that the NPPES has ALL of the NPI and legacy numbers you intend to use on claims and for billing purposes. If NPPES is correct, and you continue to receive informational edits, you should ensure that your Medicare enrollment information is up to date. If it is not, you may need to submit a completed CMS-855 (Medicare provider enrollment form). When completing the CMS-855, please list all of the NPIs that will be used in place of legacy identifiers. When applying for an NPI, please include ALL of your Medicare legacy numbers. (NPPES can accept only 20 other provider identifiers, but is being expanded to accept more in the future.) If the information is different between Medicare and NPPES, there is a very good chance your claims will reject. NPPES data may be verified on the Web site at <https://nppes.cms.hhs.gov>.

Clarification Regarding Provider Response Times for Contractor Inquiries

As stated in CR 5649, transmittal number 1262 dated June 8, 2007, all Medicare providers could receive phone calls and/or letters from their contractors in the event that a

claim suspends due to problems with mapping a provider's NPI to a legacy provider identifier. In last month's NPI message, CMS noted the number of days for a provider to respond to this type of contractor inquiry. To clarify, if the provider does not respond within the timeframe issued during the phone call with, or on the letter they receive from their contractor, the contractor will return the claim as unprocessable. The contractor will ensure that it is in compliance with the *Medicare Program Integrity Manual* (Publication 100-08), chapter 10, section 17.2 regarding the release of information.

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

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

Source: CMS Provider Education Resource 200709-16

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Potential Issues Related to Clearinghouse and Billing Service Practices

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

As part of efforts to fully implement the national provider identifier (NPI), Medicare fiscal intermediaries, carriers, and A/B Medicare administrative contractors have begun calling providers who are not sending their NPI on claims or are sending incorrect NPI information. It has come to CMS' attention that:

- Some clearinghouses may be stripping the NPI off the claim prior to its submission to Medicare for claims processing. Clearinghouses may be adding the NPI back onto the remittance advice, so that providers are unaware that NPIs are being removed prior to being sent forward.
- Some billing services (or "key" shops) are not putting the NPI on the claim, contrary to provider instructions.
- Some clearinghouses are not forwarding, to providers, carrier NPI informational claim error messages designed to help the provider understand the problems Medicare is encountering in attempts to crosswalk the NPI to legacy identifiers.

Medicare contractors are turning on edits to begin validating the NPI/legacy pair against the Medicare NPI crosswalk. If the pair on the claim is not found on the crosswalk, the claim will reject. Stripping the NPI submitted by a provider from the claim adversely affects Medicare provider incentive cash flow, payers that receive crossover claims, and the efforts of Medicare to fully implement NPI.

If you are a clearinghouse or billing service that is stripping or not sending the NPI, Medicare would like to better understand the reasons behind this practice as well as the expected timeframe during which this will continue to occur. Therefore, CMS those willing to discuss this problem with the Centers for Medicare & Medicaid Services staff to please contact Aryeh Langer at Aryeh.langer@cms.hhs.gov or Nicole Cooney at Nicole.cooney@cms.hhs.gov before October 10, 2007. ❖

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

Source: CMS Provider Education Resource 200710-04

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

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

Note: CMS has revised this *MLN Matters* article on September 21, 2007, to reflect a change made to the implementation dates in change request (CR) 5452. For DME suppliers billing DME MACs, the implementation date remains the same. For other providers who bill Medicare carriers, fiscal intermediaries, including regional home health intermediaries, and/or Part A/B Medicare administrative contractors (A/B MACs), the implementation date is now April 7, 2008. The CR transmittal date, number, and Web address for accessing CR 5452 were also changed. All other information remains the same. The *MLN Matters* article MM5452 was published in the July 2007 *Medicare A Bulletin* (pages 18-19).

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

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

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

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

The companion documents and flat files for both Part A and B will be updated to reflect these changes and the

updated documents will be posted on the CMS Web site at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage.

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

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

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

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

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

- **ERA** – Under this scenario, Medicare will report the NPI at the payee level as the payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then add any relevant rendering provider NPI at the claim level if different from the

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

payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add any relevant Rendering NPI(s) at the service line level if different from the claim level-rendering provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.

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

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

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

Implementation

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

- For claims submitted to DMERCs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur **on April 7, 2008**.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5452) issued to your Medicare carrier, fiscal intermediary (FI), Part A/B Medicare administrative contractors (MAC), regional home health intermediary (RHHI), durable medical equipment regional carrier (DMERC), or DME/MAC. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1343CP.pdf>.

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

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

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

MLN Matters Number: MM5452 – Revised
Related Change Request (CR) Number: 5452
Related CR Release Date: September 21, 2007
Related CR Transmittal Number: R1343CP
Effective Date: July 2, 2007
Implementation Date for DME suppliers: July 2, 2007
Implementation Date for other providers: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1343, CR 5452

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GENERAL COVERAGE

Magnetic Resonance Imaging Procedures

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

Provider Types Affected

Independent diagnostic testing facilities and other providers submitting claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for magnetic resonance imaging (MRI) services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Effective January 1, 2007, separate payment is made for the contrast media used in various imaging procedures. The cost of the contrast media is no longer included in the practice expense (PE) relative values units (RVUs) for the procedures.

CAUTION – What You Need to Know

In addition to the *Current Procedural Terminology (CPT)* code representing the imaging procedure, the appropriate Healthcare Common Procedure Coding System (HCPCS) “Q” code (Q9945-Q9954; Q9958-Q9964) can be separately billed and paid for the contrast medium utilized in performing the service.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes. See the *Background and Key Points* sections of this article for further information.

Background and Key Points

Prior to January 1, 2007, separate payment was not made for contrast media used in certain MRI procedures because the contrast media was included in the payment for the procedure. To read the complete change in the *Medicare Claims Processing Manual*, Chapter 13 – Radiology Services and Other Diagnostic Procedures, see the *Additional Information* section of this article and click on the

official instruction that was issued with change request (CR) 5677. The key points of CR 5677 are:

- Medicare FIs, carriers, and A/B MACs will pay separately for the contrast medium identified with the appropriate HCPCS “Q” code (Q9945-Q9954; Q9958-Q9964) used in performing various MRI procedures.
- Medicare FIs, carriers, and A/B MACs will not search their files for claims affected by this change to retroactively pay claims, but will adjust such claims that you bring to their attention that were denied with dates of service on or after January 1, 2007.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5677) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1339CP.pdf>.

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

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

MLN Matters Number: MM5677

Related Change Request (CR) Number: 5677

Related CR Release Date: September 21, 2007

Related CR Transmittal Number: R1339CP

Effective Date: January 1, 2007

Implementation Date: October 22, 2007

Source: CMS Pub. 100-04, Transmittal 1239, CR 5677

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

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare fiscal intermediaries (FI) and Medicare administrative contractors (A/B MACs) for providing albuterol, levalbuterol, Reclast®, and Zometa® to Medicare beneficiaries.

Provider Action Needed

Review the tables in this article that detail the appropriate HCPCS codes for albuterol, levalbuterol, and Reclast®, effective for claims with **on or after July 1, 2007**. Make certain that your billing staffs are aware of these HCPCS code changes.

Key Points

Effective July 1, 2007, the HCPCS codes in table 1 are **no longer payable for Medicare**.

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

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

In place of the table 1 codes, the HCPCS codes displayed in **table 2** are payable, effective **July 1, 2007**.

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

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

Also, effective July 1, 2007, a new HCPCS code applies for Reclast® as follows:

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

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

Also, please note the following:

- Currently, Reclast® 5 mg/100 ml bottle (NDC 0078-0435-61) is the only product that should be billed using HCPCS code Q4095. If other products under the Food and Drug Administration (FDA) approval for Reclast® become available, HCPCS code Q4095 would be used to bill for such products.
- **HCPCS code J3487** (short description: zoledronic acid; long description: Injection, zoledronic acid, 1 mg) is used to bill for products under the FDA approval for Zometa® or such therapeutically equivalent products that may become available as identified in the FDA Orange Book.
- Your FI or A/B MAC will not search their files to adjust claims processed prior to the implementation of this change. However, if claims were not processed correctly, the FI or A/B MAC will adjust them if you bring the claims to their attention.

Correction to July, 2007 Quarterly Update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®**Additional Information**

You may see the official instructions (CR 5735) issued to your Medicare FI or A/B MAC by visiting the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1351CP.pdf>.

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

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

MLN Matters Number: MM5735

Related Change Request (CR) Number: 5735

Related CR Release Date: October 5, 2007

Related CR Transmittal Number: R1351CP

Effective Date: July 1, 2007

Implementation Date: November 5, 2007

Source: CMS Pub. 100-04, Transmittal 1351, CR 5735

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LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by LCMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from our provider education Web site <http://www.fcso.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 LCDs 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 FCSSO *eNews* mailing list. It is very easy to do. Simply go to our Web site <http://www.fcso.com>, hover over Medicare Providers, select Florida Part A or B, click on the “eNews” link located on the upper-right-hand corner of the page 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

Additional Medical Information

Descemet's Stripping Automated Endothelial Keratoplasty Coding and Billing—Revision to Article 21

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.fcso.com>.

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ADDITIONAL MEDICAL INFORMATION

Descemet's Stripping Automated Endothelial Keratoplasty Coding and Billing—Revision to Article

An article was previously published in the September 2007 *Medicare A Bulletin* (page 27) regarding coding and billing for the Descemet's stripping automated endothelial keratoplasty (DSAEK) procedure. The following information is meant to replace/supersede the previous instructions given for reporting the DSAEK procedure.

Lamellar keratoplasty is a term that describes partial thickness corneal tissue replacement. In anterior lamellar keratoplasty (ALK), as opposed to posterior lamellar keratoplasty (PLK), a varying amount of anterior corneal stromal tissue replacement is done, with retention of the recipient Descemet's membrane and endothelium. Posterior lamellar keratoplasty includes any corneal lamellar procedure where the Descemet's membrane and endothelium are excised with or without host corneal stroma. Both DSAEK and deep lamellar endothelial keratoplasty (DLEK) are types of posterior lamellar keratoplasty. DSAEK is a two-tissue removal, namely endothelium and Descemet's membrane. DLEK is a three-tissue removal procedure, including endothelium, Descemet's membrane and stroma removed from the host cornea. There are other terminologies and technique variations that are in use.

DSAEK had been presented to Medicare beneficiaries as a new surgical procedure for corneal transplant with advantages over conventional procedures. Until new codes and RVUs have been assigned by the AMA/RUC to the PLK procedures, First Coast Service Options, Inc. (FCSO) will allow billing and coding of PLK within the keratoplasty CPT range of codes (65710, 65730, 65750, 65755) as determined by the operating physician trained in the technique. The procedure must meet the medical necessary and reasonable criteria for a keratoplasty. Also, remember to use the appropriate modifiers when performing the service on both eyes. It is assumed that in the near future the PLK procedures will be addressed by the AMA for unique level I coding, so this decision is temporary in order to allow beneficiary access to ambulatory surgical center (ASC) and facility cover.

Documentation in the medical record maintained by the performing provider 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.

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

Anytime 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. ❖

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HOSPITAL SERVICES

Correction Notice for Fiscal Year 2008 Inpatient PPS Final Rule with Comment Period

On September 28, 2007, the Centers for Medicare & Medicaid Services (CMS) issued a correction notice (CMS-1533-CN2), which corrects technical errors that appeared in the fiscal year (FY) 2008 inpatient prospective payment system (IPPS) final rule with comment period (CMS-1533-FC). This correction notice was printed in the October 10, 2007 *Federal Register*. This correction notice was developed prior to the enactment of the “TMA, Abstinence Education, and QI Programs Extension Act of 2007” on September 29, 2007, which, among other things, changed the IPPS MS-DRG documentation and coding adjustment from -1.2 percent to -0.6 percent for FY 2008. Consequently, the change to the documentation and coding adjustment for FY 2008 is not reflected in rates presented in the aforementioned correction notice. CMS is in the process of implementing this change in the law and further information will be forthcoming. Updated rates will be posted in the near future on the CMS Web site and our implementation of the “TMA, Abstinence Education, and QI Programs Extension Act of 2007” will be detailed in the *Federal Register*.

Claims Processing Information Under the IPPS and the LTCH PPS Related to the TMA, Abstinence Education, and QI Programs Extension Act of 2007

Medicare claims processing systems have incorporated the software updates to accommodate both the September 28, 2007, correction notice and the “TMA, Abstinence Education, and QI Programs Extension Act of 2007”, thus ensuring that claims with discharge dates of October 1, 2007, or later are processed with the correct rates. However, in order to provide sufficient time to fully test Medicare claim processing systems before claims under the IPPS are processed, those claims received by Medicare during the first few days of October may have a slight delay in payment by only a few days. The extra couple of days will ensure accurate claim processing and obviate the need for reprocessing hospital claims. Note, this legislation may affect short stay outlier (SSO) LTCH PPS claims because of the calculation of the “IPPS comparable amount,” but we do not foresee any delay in LTCH payments.

Below are links to the correction notice (CMS-1533-CN2) and the associated FY 2008 IPPS final rule with comment period (CMS-1533-FC):

Correction Notice (CMS-1533-CN2):

<http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/itemdetail.asp?itemID=CMS1203964>.

FY 2008 IPPS Final Rule with Comment Period (CMS-1533-FC)

<http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/itemdetail.asp?itemID=CMS1201726>. ❖

Source: CMS Provider Education Resource 200710-08

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CRITICAL ACCESS HOSPITAL SERVICES

2008 Annual Update for the Health Professional Shortage Area Bonus Payment

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

Provider Types Affected

Physicians and providers submitting claims to Medicare administrative contractors (A/B MACs), carriers, and fiscal intermediaries (FIs) for services provided in a health professional shortage areas (HPSAs).

Impact on Providers

This article is based on change request (CR) 5698, which alerts affected physicians, carriers, A/B MACs and FIs that the new HPSA bonus payment information for 2008 will be available soon. This article is informational only for physicians that the 2008 automated bonus payments applies to claims with dates of service on or after January 1, 2008, through December 31, 2008.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Section 413(b)) mandated an annual update to the automated HPSA bonus payment files, and the Centers for Medicare & Medicaid Services (CMS) creates these new automated HPSA bonus payment files annually. The 2008 HPSA bonus payment file will be used for the automated bonus payment for claims with dates of service on or after January 1, 2008, through December 31, 2008. Physicians and providers should review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in their ZIP code area or whether a modifier must be submitted.

In addition, physicians will find annual HPSA bonus payment files, as they become available, and other important HPSA information on the CMS Web site at

<http://www.cms.hhs.gov/hpsapsaphysicianbonuses/>.

Additional Information

The official instruction (CR 5698) issued to your Medicare A/B MAC, carrier, or FI is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1320CP.pdf>.

For the CMS information about HPSA/PSA (physician scarcity area) bonuses, you may visit the CMS Web site at <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/>.

If you have questions, please contact your Medicare A/B MAC, carrier, 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: MM5698

Related Change Request (CR) Number: 5698

Related CR Release Date: August 20, 2007

Related CR Transmittal Number: R1320CP

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1320, CR 5698

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SKILLED NURSING FACILITY SERVICES

Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services

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

Note: CMS revised this article on October 9, 2007, to add additional information on vaccines as well as information on the Part D benefit. The special edition *MLN Matters* article SE0436 was published in the Third Quarter 2005 *Medicare A Bulletin* (page 115).

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, and providers.

Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to preventive and screening services provided to SNF residents.

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services may be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their durable medical equipment Medicare administrative contractor (DME MAC).

Background

When the SNF prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF’s residents receive during the course of a covered Part A stay. See *MLN Matters* article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf>.

Preventive and Screening Services

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF’s resident (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list preventive

and screening services among the services identified for exclusion, these services are included within the scope of the CB provision.

However, reimbursement for covered preventive and screening services, such as vaccines and mammographies, is subject to special billing procedures. As discussed in the May 12, 1998 *Federal Register* (63 FR 26296), since preventive services (such as vaccinations) and screening services (such as screening mammographies) do not appear on the exclusion list, they are subject to CB. Accordingly, if an SNF resident receives, for example, a flu vaccine during a covered Part A stay, the SNF itself is responsible for billing Medicare for the vaccine, even if it is furnished to the resident by an outside entity.

Billing for Preventive and Screening Services

Nevertheless, even though the CB requirement makes the SNF itself responsible for billing Medicare for a preventive or screening service furnished to its Part A resident, the SNF would not include the service on its Part A bill, but would instead submit a separate bill for the service. This is because the Part A SNF benefit is limited to coverage of “diagnostic or therapeutic” services (i.e., services that are reasonable and necessary to diagnose or treat a condition that has already manifested itself). (See sections 1861(h) following (7), 1861(b)(3), and 1862(a)(1) of the Social Security Act.)

Accordingly, the Part A SNF benefit does not encompass screening services (which serve to check for the possible presence of a specific condition while it is still in an early, asymptomatic stage) or preventive services (which serve to ward off the occurrence of a condition altogether). As discussed below, such services are always covered under the applicable Part B benefit (or, in certain circumstances, under the Part D drug benefit), even when furnished to a beneficiary during the course of a covered Part A SNF stay.

Priority of Payments

Priority of payment between the various parts of the Medicare law (title XVIII of the Social Security Act) basically proceeds in alphabetical order: Part A is primary to Part B (see section 1833(d) of the Social Security Act), and both Parts A and B are primary to Part D (see section 1860D-2(e)(2)(B) of the Social Security Act). In the case of a vaccine, for example, this means that Part B can cover the vaccine only to the extent that it is not already coverable under Part A; similarly, the Part D drug benefit can cover such a vaccine only to the extent that it is not already coverable under either Part A or Part B.

Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services (continued)

Thus, when an SNF's Part A resident receives a preventive vaccine for which a specific Part B benefit category exists (i.e., pneumococcal pneumonia, hepatitis B, or influenza), the vaccine would be covered under Part B. It would not be covered under Part A (because, as explained above, the scope of the Part A SNF benefit does not encompass preventive services), and it also would not be covered under Part D (because Part B already includes a specific benefit category that covers each of these three types of vaccines and, as discussed above, Part B is primary to Part D). Similarly, a preventive vaccine (such as polio-myelitis) for which no Part B benefit category exists would be coverable under the Part D drug benefit when administered to the SNF's Part A resident, rather than being covered under the Part A SNF benefit.

Example of Special Circumstance

However, there are certain limited circumstances in which a vaccine would no longer be considered preventive in nature, and this may affect how the vaccine is covered. For example, while a booster shot of tetanus vaccine would be considered preventive if administered routinely in accordance with a recommended schedule, it would not be considered preventive when administered in response to an actual exposure to the disease (such as an animal bite, or a scratch on a rusty nail). In the latter situation, such a vaccine furnished to an SNF's Part A resident would be considered reasonable and necessary to treat an existing condition and, accordingly, would be included within the SNF's global Part A per diem payment for the resident's Medicare-covered stay.

In terms of billing for an SNF's Part A resident, a vaccine that is administered for therapeutic rather than preventive purposes (such as a tetanus booster shot given in response to an actual exposure to the disease) would be included on the SNF's global Part A bill for the resident's covered stay. Alternatively, if a vaccine is preventive in nature and is one of the three types of vaccines for which a Part B benefit category exists (i.e., pneumococcal pneumonia, hepatitis B, or influenza), then the SNF would submit a separate Part B bill to its fiscal intermediary for the vaccine. (Under section 1888(e)(9) of the Social Security Act, payment for an SNF's Part B services is made in accordance with the applicable fee schedule for the type of service being billed.) Finally, if the resident receives a type of preventive vaccine for which no Part B benefit category exists (e.g., poliomyelitis), then the vaccine would not be covered under either Parts A or B, and so would be coverable under the Part D drug benefit.

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Additional Information

See *MLN Matters* special edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf>.

The Centers for Medicare & Medicaid Services (CMS) MLN Consolidated Billing Web site is at <http://www.cms.hhs.gov/SNFCConsolidatedBilling/>.

It includes the following relevant information:

- General SNF consolidated billing information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
- Therapy codes that must be consolidated in a noncovered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Web site may be found on the CMS Web site at http://www.cms.hhs.gov/SNFPSPS/05_ConsolidatedBilling.asp.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publication (including transmittals and *Federal Register* notices).

MLN Matters Number: SE0436 – Revised
 Related Change Request (CR) Number: N/A
 Related CR Release Date: N/A
 Related CR Transmittal Number: N/A
 Effective Date: N/A
 Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0436

Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Services

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

Note: CMS revised this article on October 9, 2007, to provide clarification regarding “trips for excluded outpatient services”. This clarification is intended to state explicitly that the CB exclusion for ambulance trips related to the receipt of excluded outpatient hospital services would apply to the entire ambulance roundtrip (the SNF-to-hospital trip plus the return trip back to the SNF), and not just to the outbound (SNF-to-hospital) portion alone. All other information remains the same. The special edition *MLN Matters* article SE0433 was published in the Third Quarter 2005 *Medicare A Bulletin* (pages 106-108).

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, ambulance suppliers, and providers

Provider Action Needed

This special edition article describes SNF consolidated billing (CB) as it applies to ambulance services for SNF residents.

Clarification: The SNF CB requirement makes the SNF responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their durable medical equipment Medicare administrative contractor (DME MAC).

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See *MLN Matters* special edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf>.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e. based on the reason the ambulance service is needed. This policy is comparable to the one governing ambulance services furnished in the inpatient

hospital setting, which has been subject to a similar comprehensive Medicare billing or “bundling” requirement since 1983. Since the law describes CB in terms of services that are furnished to a “resident” of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary’s SNF “resident” status. The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH). (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.)
- A trip to the beneficiary’s home to receive services from a Medicare-participating home health agency under a plan of care.
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF’s comprehensive care plan (see further explanation below).
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance Trips to Receive Excluded Outpatient Hospital Services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary’s status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization
- Computerized axial tomography imaging (CT) scans
- Magnetic Resonance Imaging (MRI) services

Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Services (continued)

- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite)
- Emergency room services
- Radiation therapy
- Angiography
- Lymphatic and venous procedures.

Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, the outside supplier should bill separately under Part B an ambulance trip from the SNF to the hospital for the receipt of such services. Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Other Ambulance Trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers Between Two SNFs

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)). Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under section 411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by

midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

Roundtrip to a Physician's Office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate. The preamble to the July 30, 1999 final rule (64 *Federal Register* 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Additional Information

See *MLN Matters* special edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf>.

The Centers for Medicare & Medicaid Services (CMS) MLN Consolidated Billing is on the CMS Web site at <http://www.cms.hhs.gov/SNFConsolidatedBilling/>.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Web site may be found on the CMS Web site at http://www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

MLN Matters Number: SE0433 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0433

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ELECTRONIC DATA INTERCHANGE

Remittance Advice Remark Code and Claim Adjustment Reason 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 claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Part A/B Medicare administrative contractors [A/B MACs], and DME Medicare administrative contractors [DME MACs]) for services.

Provider Action Needed

Change request (CR) 5721, from which this article is taken, announces the latest update of X12N 835 health care remittance advice remark codes (RARC) and X12N 835 and 837 health care claim adjustment reason codes (CARCs), effective October 1, 2007. Be sure billing staff are aware of these changes.

Background

For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – CARC and RARC – that must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 coordination-of-benefits (COB), CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers. Additions, deactivations, and modifications to the list may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by the National Code Maintenance Committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

As mentioned earlier in CR 5634, at least one remark code must be used with the following five CARCs:

- 16** Claim/service lacks information, which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- 17** Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code).
- 96** Noncovered charge(s). At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code).
- 125** Payment adjusted due to a submission/billing error(s). At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code).
- A1** Claim/Service denied. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)

Both code lists are updated three times a year, and are posted on the Internet at <http://wpc-edi.com/codes>.

Please note that in order to synchronize with the CARC update schedule, the RARC list will be updated in early November, March and July instead of the current schedule of early December, April and August. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5721, to be effective on and after October 1, 2007, for Medicare.**

CMS has also developed a new tool to help you search for a specific category of code and that tool is on the CMS Web site at <http://www.cmsremarkcodes.info>.

Note that this Web site does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You can see the official instruction issued to your A/B MAC, FI, carrier, DME MAC, or RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5721, located on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/RI345CP.pdf>.

For additional information about Remittance Advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers on the CMS Web site at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found on the

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

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.

Remittance Advice Remark Code Changes**New Remark Codes**

Code	Current Narrative	Medicare Initiated
N380	The original claim has been processed, submit a corrected claim.	No
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	No
N382	Missing/incomplete/invalid patient identifier.	No
N383	Services deemed cosmetic are not covered.	No
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	No
N385	Payment has been adjusted because notification of admission was not timely according to published plan procedures.	No
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.	Yes
N387	You should submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	Yes

Modified Remark Codes

The following codes have been identified as “Informational” codes, and modified to add the word “Alert” in front of the current text.

M4	M6	M9	M17	M27	M32	M39	M70	M118	MA01
MA07	MA08*	MA10	MA13	MA14	MA15	MA18	MA19	MA26	MA28
MA44	MA45	MA59	MA62	MA68	MA72	MA77	N1	N21	N23
N59	N84	N85	N88	N89	N130	N132	N133	N134	N136
N137	N138	N139	N140	N154	N155	N156	N162	N177	N183
N185	N187	N189	N196	N202	N210	N211	N215	N220	N352
N353	N355	N358	N360	N363	N364	N367			

Code MA08 text has been modified further as follows:

Old Text for MA08	New Text for MA08
You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.	Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

Notes: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Codes that are “Informational” will have “Alert” in the text to identify them as informational rather than explanatory codes. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated. An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation but does not explain any adjustment. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes.

Deactivated Remark Codes

Code	Current Narrative	Notes
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	Deactivated effective 10/1/07. Consider using reason code 45
N361	Payment adjusted based on multiple diagnostic imaging procedure rules	Deactivated effective 10/1/07. Consider using reason code 59

ELECTRONIC DATA INTERCHANGE

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

X12 N Health Care Claim Adjustment Reason Code Changes

Explanation of Start, Last Modified, and Stop

- **Start**– Every code has a start date. This is the date when the code was first available in the code list.
- **Last Modified** – When populated, this is the date of the code list release when the definition of the specific code was last modified by the committee. This date represents a point when the definition changed from one wording to another.
- **Stop** – When populated, this date identifies that the code can no longer be used in original business messages after that date. The code can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a CARC with a stop date of 02/01/2007 would not be able to be used by a health plan in a CAS segment in a claim payment/remittance advice transaction (835) dated after 02/01/2007 as part of an original claim adjudication. The code would still be able to be used after 02/01/2007 in derivative transactions, as long as the original usage was prior to 02/01/2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or health plan to a secondary or tertiary health plan, an 835 from the original health plan to the provider as a reversal of the original adjudication. The deactivated code is usable in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

New Reason Codes

Code	Current Narrative	Notes
202	Payment adjusted due to noncovered personal comfort or convenience services.	Start: 2/28/2007
203	Payment adjusted for discontinued or reduced service.	Start: 2/28/2007
204	This service/equipment/drug is not covered under the patient's current benefit plan	Start: 2/28/2007
205	Pharmacy discount card processing fee	Start: 7/09/2007
206	NPI denial – missing	Start: 7/09/2007
207	NPI denial – Invalid format	Start: 7/09/2007 Stop: 5/23/2008
208	NPI denial – not matched	Start: 7/09/2007
209	Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use group code OA)	Start: 7/09/2007
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	Start: 7/09/2007
211	National drug codes (NDC) not eligible for rebate are not covered.	Start: 7/09/2007

Modified Reason Codes

Code	Current Narrative	Notes
59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	Start: 1/01/1995 Last Modified: 2/28/2007
197	Payment adjusted for absence of recertification/authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/authorization/notification.	Start: 10/31/2006 Last Modified: 7/09/2007
115	Payment adjusted as procedure postponed or canceled. This change effective 1/1/2008: Payment adjusted as procedure postponed, canceled, or delayed.	Start: 1/01/1995 Last Modified: 7/09/2007
85	Interest amount. This change effective 1/1/2008: Patient Interest Adjustment (Use only group code PR) Notes: only use when the payment of interest is the responsibility of the patient	Start: 1/01/1995 Last Modified: 7/09/2007

Deactivated Reason Codes

Code	Current Narrative	Notes
A2	Contractual adjustment. Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code. The "Stop" date of 1/1/2008 may change.	Start: 1/01/1995 Stop: 1/01/2008 Last Modified: 2/28/2007
207	NPI denial – Invalid format	Start: 7/09/2007 Stop: 5/23/2008

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

In addition, CR 5721 contains a comprehensive list of deactivated reason codes. These codes have been deactivated prior to publication of CR 5721 and have been included in previous CRs. Because of a policy change, the deactivation date may have moved from a specific version to a specific date. Contractors will not use any of these codes in any original business messages, but these codes may be used in derivative business messages (messages where the code is being reported from the original business message). This list may be viewed by accessing CR 5721 at the Web address cited in the *Additional Information* section (above) of this article.

MLN Matters Number: MM5721

Related Change Request (CR) Number: 5721

Related CR Release Date: September 28, 2007

Related CR Transmittal Number: R1345CP

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1345, CR 5721

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EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

November 2007 – December 2007

Hot Topics – Medicare Updates

When: Tuesday, November 13, 2007
Time: 11:30 a.m. – 12:30 p.m. Eastern Standard Time
Type of Event: Teleconference

Ask the Contractor – Topics To Be Determined

When: Tuesday, December 11, 2007
Time: 11:30 a.m. – 1:00 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

October Is National Breast Cancer Awareness Month

In conjunction with National Breast Cancer Awareness Month (NBCAM), the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join in helping to promote increased awareness of the importance of early detection of breast cancer, and ensure that all eligible women with Medicare know that Medicare provides coverage of screening mammograms and clinical breast exams for the early detection of breast cancer.

Next to skin cancer, breast cancer is the most common form of cancer diagnosed in women in the United States. National Breast Cancer Awareness Month educates women about the importance of early detection. The good news is, more and more women are getting mammograms to detect breast cancer in its earliest stages. As a result, breast cancer deaths are on the decline. This is exciting progress. Yet, while mammography screening remains the best available method to detect breast cancer, there are still many eligible women with Medicare who do not take advantage of early detection at all and others who do not get screening mammograms and clinical breast exams at regular intervals.

Medicare Coverage

Medicare provides coverage of an annual screening mammogram for all female beneficiaries age 40 and older and one baseline mammogram for female beneficiaries between the ages of 35 and 39. Medicare also provides coverage of clinical breast exams, every 12 or 24 months depending on risk level for the disease. (Medicare covers clinical breast exams as part of the pelvic screening exam).

How Can You Help?

“Pass the Word.” Early detection of breast cancer results in earlier potentially less invasive treatment and an improved chance of survival. CMS needs your help to ensure that all women with Medicare take full advantage of the preventive services and screenings for which they may be eligible.

- Help your patients understand their risk for breast cancer and the benefits of regular screening mammograms and clinical breast exams.
- Encourage your patients to talk about any barriers that may keep them from obtaining mammography services on a routine basis and help them overcome those barriers.
- Make sure that all eligible female patients are aware that Medicare covers mammography screenings every year and regular clinical breast exams.

Please encourage women with Medicare to take full advantage of these vitally important benefits.

For More Information

For more information about Medicare’s coverage of screening mammography, and clinical breast exams, including coverage, coding, billing, and reimbursement, please visit the CMS *Medicare Learning Network* Web page: <http://www.cms.hhs.gov/Mammography/>.

- The MLN Preventive Services Educational Products Web Page provides descriptions and ordering information for all provider specific educational products related to preventive services http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp.

For literature to share with your Medicare patients, please visit <http://www.medicare.gov>.

For more information about NBCAM, please visit <http://www.nbcam.org>.

Thank you for joining with CMS in promoting increased awareness of early breast cancer detection and mammography and clinical breast exam services covered by Medicare. ❖

Source: CMS Provider Education Resource 200709-20

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OTHER EDUCATIONAL RESOURCES

Medicare Preventive Services Quick Reference Information Chart

The Centers for Medicare & Medicaid Services (CMS) has developed a new preventive services quick reference chart entitled *The ABCs of Providing the Initial Preventive Physical Examination*, ICN# 006904. Medicare fee-for-service physicians and qualified nonphysician practitioners can use this two-sided laminated chart as a guide when providing the initial preventive physical examination (IPPE) (also known as the “Welcome to Medicare” Physical Exam or the “Welcome to Medicare” Visit). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information. Currently available in downloadable PDF format, the chart may be viewed on the CMS Medicare Learning Network publications Web page at

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf. ❖

Source: CMS Provider Education Resource 200709-10

Preventive Services Brochures for Health Care Professionals now Available To Order

The following preventive service brochures from the Centers for Medicare & Medicaid Services (CMS), for health care professionals, have been updated and are now available in print and PDF format:

- *Expanded Benefits*
- *Diabetes-Related Services*
- *Cancer Screenings*
- *Adult Immunizations*
- *Bone Mass Measurements*
- *Glaucoma Screenings*
- *Smoking and Tobacco-Use Cessation Counseling Services.*

To download and view online, please visit the *MLN Publications* Web page located at <http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp#TopOfPage> and select the title of the brochure from the list.

To order copies of these brochures, please visit the *MLN Product Ordering Page* located on the CMS Web site at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5. ❖

Source: CMS Provider Education Resource 200710-2

Updated Adult Immunizations Web-Based Training Course

The Centers for Medicare & Medicaid Services (CMS) has updated the following Web-based training (WBT) course: Medicare Preventive Services Series: Part 1 Adult Immunizations. This WBT course provides information to help fee-for-services providers and suppliers understand Medicare’s coverage and billing guidelines for influenza, pneumococcal, and hepatitis B vaccines and their administration. This Web-based training course is the first in a series of three WBT courses developed by CMS as part of a comprehensive provider information program designed to promote awareness and increase utilization of preventive benefits covered by Medicare and to help those who bill Medicare for these service to file claims effectively. CMS has been reviewed and approved as an authorized provider by:

International Association for Continuing Education and Training (IACET)
1620 I Street, NW, Suite 615
Washington, DC 20006

Participants who successfully complete this course may receive .1 IACET CEU. To register free of charge for this course, please visit the CMS Web site at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5. ❖

Source: CMS Provider Education Resource 200710-05

Medicare Billing Information for Rural Providers, Suppliers, and Physicians

The *Medicare Billing Information for Rural Providers, Suppliers, and Physicians* informational resource, 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 now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit <http://www.cms.hhs.gov/mlngeninfo>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.” ❖

Source: CMS Provider Education Resource 200710-10

Revised Medicare Physician Guide

The revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (Ninth Edition), which 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, is now available in print and CD-ROM formats from the Centers for Medicare & Medicaid Services *Medicare Learning Network*.

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Source: CMS Provider Education Resource 200709-18

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Reader Survey—*Medicare A Bulletin*

We want our readers of the *Medicare A Bulletin* to find it to be a helpful tool that is easy to use and understand. This survey is your opportunity to let us know how we are doing. After the survey closes, we will publish the results and implement suggested enhancements, as appropriate. Thank you for taking the time to complete this survey.

Please complete the questions below and fax to us at 1-904-361-0723 by Friday, December 14, 2007.

1. What sections of the bulletin do you refer to the most?
 - ☐ Local Coverage Determinations (LCD)
 - ☐ Hospital Services
 - ☐ ESRD Services
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 - ☐ General Information
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5. What changes or additions do you recommend for the *Medicare A Bulletin*?

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

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

PART A REDETERMINATION

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

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

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

General MSP Information**Completion of UB-04 (MSP Related)****Conditional Payment**

Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Automobile Accident Cases**Settlements/Lawsuits****Other Liabilities**

Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

PROVIDER EDUCATION

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

RAILROAD MEDICARE**Railroad Retiree Medical Claims**

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

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

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



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

*** ATTENTION BILLING MANAGER ***