Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

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

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

Routing Suggestions:

- ☐ Medicare Manager
- ☐ Reimbursement Director
- ☐ Chief Financial Officer
- ☐ Compliance Officer
- ☐ DRG Coordinator
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CMS Centers for Medicare & Medicaid Services

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

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Vol. 9, No. 4
April 2007

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

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

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About the *Medicare A Bulletin*

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

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

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

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

Who Receives the *Bulletin*?

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

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

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

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

What Is in the *Bulletin*?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

Editor, *Medicare A Bulletin*
Medicare Publications – 10T
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Jacksonville, FL 32232-5270

Sign up to our *eNews* electronic mailing list

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

GENERAL INFORMATION

Services Not Provided Within the United States

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

Provider Types Affected

Physicians, suppliers and providers who submit claims to Medicare carriers, fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs).

Key Points

CR 5427 clarifies that payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States.

Note: Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States.
For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India.

Background

This article and related change request (CR) 5427 outlines the limited items and services that are reimbursable by Medicare outside the United States according to Section 1862(a)(4) of the Social Security Act.

The law specifies the following **exceptions** to the "foreign" exclusion:

- Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
  - emergency arose within the U.S.; or
  - emergency arose in Canada while the individual was traveling by the most direct route and without unreasonable delay between Alaska and another state.
- Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual's residence within the U.S. than the nearest U.S. hospital that is adequately equipped and available to treat the individual's condition, whether or not an emergency exists.
- Physician and ambulance services in connection with, and during, a foreign inpatient hospital stay that is covered in accordance with either of the above.

Additional Information

CR 5427 is the official instruction issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R66BP.pdf*.

Note: The previously published CR 3781 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3781.pdf* also provides information and instructions about services not provided within the United States by defining "United States" for the purposes of the Social Security Act (Section 1814 (f) along with the parameters of this Medicare rule.

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

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

MLN Matters Number: MM5427
Related Change Request (CR) Number: 5427
Related CR Release Date: February 23, 2007
Related CR Transmittal Number: R66BP
Effective Date: November 13, 2006
Implementation Date: April 2, 2007

Source: CMS Pub. 100-02, Transmittal 66, CR 5427

Sign up to our *eNews* electronic mailing list

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

Medically Unlikely Edits

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

Provider Types Affected

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

Background

In order to lower the Medicare fee-for-service paid claim error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as medically unlikely edits (MUEs). The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs.

- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- For carrier claims, the MUEs will automatically deny or suspend claim line items containing units of service billed in excess of the MUE criteria and for FI claims, the MUEs will return to provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points

- Change request (CR) 5495 announces the upcoming release of the next version of the MUEs, which is version 1.1.
- CR 5495 states that Medicare carriers and A/B MACs will deny the entire claim line from noninstitutional providers with units of service that exceed MUE criteria and pay the other services on the claims.
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria.
- An appeal process will not be allowed for claims returned to providers as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding contractor.
- Excess **charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"),** and this provision can neither be waived nor subject to an advanced beneficiary notice (ABN).

Additional Information

For complete details regarding this CR please see the official instruction (CR 5495) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1202CP.pdf*.

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

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

MLN Matters Number: MM5495
Related Change Request (CR) Number: 5495
Related CR Release Date: March 9, 2007
Related CR Transmittal Number: R1202CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1202, CR 5495

Provider Call Center Phone Number Change

Currently, the customer service representative (CSR) and the interactive voice response (IVR) toll-free telephone number lines are combined as 1-877-602-8816.

In an effort to better serve the Medicare Part A provider community, **effective Monday April 23, 2007, the CSR and the IVR toll-free telephone number lines will be separated.**

With this change, the IVR number will remain the same as 1-877-602-8816; however, a new CSR toll-free telephone number has been established. **The new number is 1-888-664-4112**.

- The hours of operation for the CSR line are 8:00 a.m. – 4:00 p.m., Monday through Friday (excluding holidays).
- The hours of operation for the IVR line are 6:00 a.m. – 6:00 p.m., Monday through Friday for specific claim information.
- Recorded information on current Medicare issues is available 24 hours a day, 7 days a week. ❖

Flu Shot Reminder

It's Not Too Late to Give and Get the Flu Shot. The peak of flu season typically occurs between late December and March; however, flu season can last until May.

Protect yourself, your patients, and your family and friends by getting and giving the flu shot.

Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination.

Remember: Influenza pneumococcal vaccination and their administration are covered Medicare Part B benefits. Note that influenza and pneumococcal vaccines are not Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf*. ❖

Source: CMS Provider Education Resource 200703-04

April Update to the 2007 Medicare Physician Fee Schedule Database

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

Provider Types Affected

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

Background

This article and related change request (CR) 5528 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS final rule. CR 5528 amends those payment files.

The following information reflects the key changes from CR 5528:

***CPT*/ HCPCS**	**Action**
17311	Multiple Procedure Indicator – 0
17313	Multiple Procedure Indictor – 0
36478	Transitional Non-Facility PE RVU = 41.71 Fully Implemented Non-Facility PE RVU = 26.53 **(Informational Only)**
37210	Transitional Non-Facility PE RVU = 79.88 Fully Implemented Non-Facility PE RVU = 79.88 **(Informational Only)**
77056 – Global	Fully Implemented Non-Facility PE RVU = 1.96 **(Informational Only)** Fully Implemented Facility PE RVU = 1.96 **(Informational Only)**
77056 TC	Fully Implemented Non-Facility PE RVU = 1.72 **(Informational Only)** Fully Implemented Facility PE RVU = 1.72 **(Informational Only)**
93225	Transitional Non-Facility PE RVU = 1.14 Fully Implemented Non-Facility PE RVU = 0.85 **(Informational Only)** Transitional Facility PE RVU = 1.14 Fully Implemented Facility PE RVU = 0.85 **(Informational Only)**
93226	Transitional Non-Facility PE RVU = 1.93 Fully Implemented Non-Facility PE RVU = 1.18 **(Informational Only)** Transitional Facility PE RVU = 1.93 Fully Implemented Facility PE RVU = 1.18 **(Informational Only)**
93231	Transitional Non-Facility PE RVU = 1.32 Fully Implemented Non-Facility PE RVU = 0.71 **(Informational Only)** Transitional Facility PE RVU = 1.32 Fully Implemented Facility PE RVU = 0.71 **(Informational Only)**
93232	Transitional Non-Facility PE RVU = 1.97 Fully Implemented Non-Facility PE RVU = 1.34 **(Informational Only)** Transitional Facility PE RVU = 1.97 Fully Implemented Facility PE RVU = 1.34 **(Informational Only)**
95991	Transitional Facility PE RVU = 0.17 Fully Implemented Facility PE RVU = 0.18 **(Informational Only)**

The following codes are either **bundled or not valid for Medicare purposes.** Values for these codes have been established as a courtesy to the general public. These codes will remain bundled or not valid for Medicare purposes even though relative value units have been established.

***CPT*/ HCPCS**	**Action**
78351	Transitional Non-Facility PE RVU = 1.41 Fully Implemented Non-Facility PE RVU = 0.47 **(Informational Only)**
98960	Transitional Non-Facility PE RVU = 0.57 Fully Implemented Non-Facility PE RVU = 0.57 **(Informational Only)** Transitional Facility PE RVU = 0.57 Fully Implemented Facility PE RVU = 0.57 **(Informational Only)**
98961	Transitional Non-Facility PE RVU = 0.27 Fully Implemented Non-Facility PE RVU = 0.27 **(Informational Only)** Transitional Facility PE RVU = 0.27 Fully Implemented Facility PE RVU = 0.27 **(Informational Only)**

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

98962 Transitional Non-Facility PE RVU = 0.20 Fully Implemented Non-Facility PE RVU = 0.20 **(Informational Only)** Transitional Facility PE RVU = 0.20 Fully Implemented Facility PE RVU = 0.20 **(Informational Only)**

These changes are effective January 1, 2007. However, providers may wish to note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims that you bring to their attention.

Additional Information

CR 5528 is the official instruction issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1188CP.pdf*.

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

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

MLN Matters Number: MM5528
Related Change Request (CR) Number: 5528
Related CR Release Date: February 26, 2007
Related CR Transmittal Number: R1188CP
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1188, CR 5528

April 2007 Quarterly Average Sale Price Medicare Part B Drug Pricing File, and Revisions to the January 2007 File

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5517, which informs Medicare contractors to download the April 2007 average sales price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 ASP files.

Background

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

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

Average Sale Price Methodology

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

Beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for the following:

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

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as

April 2007 Quarterly ASP Medicare Part B Drug Pricing File, and Revisions to the January 2007 File (continued)

reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the ambulatory payment classification (APC) to which the product is assigned.

- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded.
- Payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for **drugs that are not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file** (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration [FDA]) are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 17, Drugs and Biologicals) for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood-clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood-clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file.
- The payment allowance limits for **new drugs that are produced or distributed under a new drug application approved by the FDA** and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent of the WAC or invoice pricing, if the WAC is not published. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

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

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

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

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm*) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1204CP.pdf*.

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

April 2007 Quarterly ASP Medicare Part B Drug Pricing File, and Revisions to the January 2007 File (continued)

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

MLN Matters Number: MM5517
Related Change Request (CR) Number: 5517
Related CR Release Date: March 16, 2007
Related CR Transmittal Number: R1204CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1204, CR 5517

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

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5537, which provides the April 2007quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure billing staff are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 60; *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*).

CR 5537 provides specific instructions regarding the April quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act, sections 1834(a), (h), and (i). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in title 42 of the *Code of Federal Regulations* (42 CFR 414.102).

Key Changes

The following are key changes in the April 2007 quarterly update of the DMEPOS fee schedule:

HCPCS L8690 and L8691

The A/B MACs, local carriers, and FIs will adjust previously processed claims for HCPCS code L8690 (Auditory osseointegrated device, includes all internal and external components) and HCPCS code L8691 (Auditory osseointegrated device, external sound processor, replacement), with dates of service on or after January 1, 2007, if you resubmit such claims as adjustments.

HCPCS Code E1002

HCPCS code E1002 (Wheelchair accessory, power seating system, tilt only) was added to the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2004. The fee schedule amounts that were calculated and implemented for this code included systems with tilts less than 45 degrees from horizontal. As described in the November 2006 policy article for wheelchair options/accessories, power tilt seating systems (falling under code E1002) must have the ability to tilt to greater than or equal to 45 degrees from horizontal. Therefore as part of this quarterly update, the fee schedule amounts for code E1002 are being revised in order to remove pricing information for power seating systems with tilts less than 45 degrees.

The DME MACs, and DMERCs will adjust previously processed claims for code E1002 with dates of service on or after January 1, 2007, if they are resubmitted as adjustments.

HCPCS Code E2377

Code E2377 (Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue) was added to the HCPCS effective January 1, 2007, for use in paying claims for upgraded expandable controllers and mounting hardware provided at initial issue. The fee schedule amounts for code E2377 do not include payment for the proportional joystick and electronics/cables/junction boxes necessary to upgrade from a nonexpendable controller. **Suppliers need to submit claims for the upgraded proportional joysticks and electronics provided at initial issue for dates of service on or after January 1, 2007, using HCPCS code E2399.**

Further Changes for Power Wheelchairs

CMS is in the process of making refinements to the fee schedule amounts for several HCPCS codes for power wheelchairs to be implemented as part of the April quarterly update for the 2007 DMEPOS fee schedule. Additional instructions regarding these changes will be issued in the near future under separate cover.

April 2007 Quarterly Update for DMEPOS Fee Schedule (continued)

Additional Information

The official instruction, CR 5537, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1203CP.pdf*.

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

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

MLN Matters Number: MM5537
Related Change Request (CR) Number: 5537
Related CR Release Date: March 9, 2007
Related CR Transmittal Number: R1203CP
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1203, CR 5537

Differentiating Mass Adjustments from Other Types of Adjustments for Crossover Claims

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5472 which implements changes to Medicare contractor systems so that their claim transmissions to the coordination of benefits contractor (COBC) for mass adjustments and other kinds of adjustments may be differentiated from all other types of claims sent for crossover.

CAUTION – What You Need to Know

This will be accomplished through modifications to the 837 COB flat files and National Council for Prescription Drug Program (NCPDP) Part B drug claim files, all of which are transmitted to the COBC on a daily basis.

Through CR 5472, the Medicare contractor systems will be modified so that the COBC detailed error report information that is printed on the outgoing special provider notification letters/report that you receive when claims will not be crossed over due to claim data errors will be modified to also include the error/trading partner rejection code and accompanying description. These changes to the special provider letters should enable your billing service to determine why claims that were previously selected by Medicare for crossover were not actually crossed over.

Without these changes, Centers for Medicare & Medicaid Services (CMS) would be unable to isolate mass adjustment claims as part of the national COBA crossover process. This change corrects a problem that CMS encountered as part of its implementation of the Deficit Reduction Act (DRA). Also, providers would continue to be unaware of the specific reasons as to why their patients' claims were not crossed over.

GO – What You Need to Do

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

Background

All Medicare contractors currently send processed claims, for which Medicare systems show the beneficiary has other insurance to the COBC for crossover under the National Coordination of Benefits Agreement (COBA) program.

CMS requires a method whereby its COBC can differentiate among the various categories of adjustment crossover claims including:

- Mass adjustments – Medicare physician fee schedule (MPFS)
- Mass adjustments – other
- All other adjustments.

Having the ability to differentiate among the various categories of adjustment crossover claims will enable CMS (and the COBC) to better address the kinds of contingencies that arise with the passage of legislation such as the DRA, which mandate changes for Medicare that can affect claims already processed.

CR 5472 instructs that the COBC detailed error report process be modified to ensure that the contractor-generated special provider letters, which are created and sent in accordance with CR 3709, contain the specific Claredi rejection code returned for the claim along with its description. (See the *MLN Matters* article at

Differentiating Mass Adjustments from Other Types of Adjustments for Crossover Claims (continued)

http://www.cms.hhs.gov/mlnMattersArticles/downloads/MM3709.pdf for information on CR 3709.)

Providers may wish to contact their billing agent/vendor to obtain a better understanding of these error codes and accompanying descriptions, which, in turn, explains why their patients' claims were not crossed over successfully. In addition, providers should notify their billing agent/vendor when they receive special provider letters or reports stating why their patients' claims were not crossed over.

Additional Information

The official instruction, CR 5472, issued to your carrier, FI, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1189CP.pdf*.

Attached to CR5472, you will find the new chapter of the *Medicare Claims Processing Manual* explaining in detail the new special mass adjustment process for COB. In addition, you will also find revised chapters for other portions of that manual, which discuss the COB process.

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

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

MLN Matters Number: MM5472
Related Change Request (CR) Number: 5472
Related CR Release Date: February 28, 2007
Related CR Transmittal Number: R1189CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1189, CR 5472,

Part C Plan Type Description Display on Medicare Common Working File System

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 March 27, 2007, to reflect that the Medicare Advantage (MA) plan directory has been posted on the CMS website. The directory is located at *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/*.

See the *Additional Information* section of this article for more details. The original *MLN Matters* article was published in the March 2007 *Medicare A Bulletin* (page 4).

Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through the common working file (CWF) eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed

Be aware of the expanded list of MA plan type descriptions that are being displayed by Medicare CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in private fee-for-service (PFFS) plans.

A plan directory will soon be published that contains the list of all active Medicare contracts and their corresponding plan type. The directory will be posted at the following URL no later than March 1, 2007: *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/*.

Background

When you query Medicare regarding a beneficiary's entitlement and eligibility, Medicare CWF system responds with information on the Medicare managed care contract number in which a beneficiary is enrolled, including the plan type description associated with the contract. Currently, CWF largely displays the label "HMO" for these contracts. In many cases, the "HMO" label is incorrect since the list of possible plan type values has grown far larger since the creation of the MA program.

For example, under the MA Part C program, Medicare beneficiaries can enroll in PFFS plans. PFFS plans are very different from the more traditional MA HMO type plan.

Private Fee-for-Service Plans

PFFS plans generally have no plan specific provider network. Enrollees in a PFFS plan can obtain plan covered health care services from any Medicare FFS enrolled provider in the U.S. who is willing to furnish services to a PFFS plan beneficiary. It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan.

In most cases, a PFFS enrollee will inform a provider before obtaining a service that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or a Web address where the provider can obtain the PFFS plan's terms and conditions of participation.

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services
- Provider billing procedures, including:
  - The amount the provider is permitted to collect from the enrollee; and

Part C Plan Type Description Display on Medicare Common Working File System (continued)

- Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers in the U.S. from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a website and also make them available upon written or phoned request.

To be paid by a PFFS organization, the provider must send their bill to the address (or electronic address) provided in the PFFS plan's terms and conditions of participation.

For more detailed information on PFFS plans as they relate to providers, see the "Provider Q&A" downloadable document on *http://www.cms.hhs.gov/PrivateFeeforServicePlans/*.

Additional Information

If you have questions regarding the plan of a specific Medicare MA enrolled patient, you may wish to contact that plan.

A plan directory and MA claims processing contact directory are available on the CMS website at *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/*.

CMS updates this site on a monthly basis.

To view the official instruction (CR 5349) issued to your Medicare FI, carrier, MAC, DMERC or RHHI, visit the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf*.

To review a related article that explains Medicare's CWF system Part C (Medicare Advantage Managed Care) data exchange and data display changes go to the CMS website *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf*.

MLN Matters Number: MM5349 – Revised
Related Change Request (CR) Number: 5349
Related CR Release Date: February 2, 2007
Related CR Transmittal Number: R1175CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1175, CR 5349

Medicare Advantage and Prescription Drug Plan Addresses

The Centers for Medicare & Medicaid Services (CMS) provides an address list for claim-processing submission to Medicare Advantage (MA) plans, Medicare Advantage-prescription drug (MA-PD) plans, and prescription drug plans (PDPs).

Note: MA plans include health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

The list of addresses for MA and PDPs is available on the CMS website at *http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/claims_processing_20060120.pdf*.

For additional information on Medicare managed care plans, refer to CMS Internet-only-Manual (IOM), Pub 100-16, *Medicare Managed Care Manual*. You may also find additional information on manage care plans on the CMS website at *http://www.cms.hhs.gov/HealthPlansGenInfo/TopOfPage*. ❖

Use of Nine-Digit ZIP Codes for Determining Payment Locality Paid Under the Medicare Physician Fee Schedule and Anesthesia Services

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 March 9, 2007, to reflect a revised change request (CR) transmittal number and CR release date. Also the Web address for accessing CR 5208 was changed. All other information is the same. The original *MLN Matters* article was published in the March 2007 *Medicare A Bulletin* (pages 6-8).

Provider Types Affected

Physicians and providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [MACs]) for services paid under the MPFS and for anesthesia services.

Provider Action Needed

STOP – Impact to You

Effective for dates of service **on or after October 1, 2007,** for services rendered in the ZIP code areas displayed below, if you do not include the full nine-digit ZIP code on your claims for services paid by Medicare carriers or MACs under the Medicare physician fee schedule (MPFS) and for anesthesia services, your claim will be treated as unprocessable.

Effective for dates of service **on or after October 1, 2007,** for services rendered in the ZIP code areas displayed below, if a valid full nine-digit ZIP code is not present on the provider master file address ZIP code, services paid by the FIs/MACs under the MPFS and for anesthesia services, your claim will be treated as unprocessable.

Use of Nine-Digit ZIP Codes for Determining Payment Locality Paid Under the MPFS and Anesthesia (continued)

CAUTION – What You Need to Know

Effective October 1, 2007, for services rendered in the areas defined by the ZIP codes indicated below, Medicare will require that you provide the nine-digit ZIP code for the location where services were rendered on your claims for services paid by carriers/MACs under the MPFS and for anesthesia services. CMS is implementing this requirement to prevent payment issues generated by ZIP codes that cross payment localities.

Effective October 1, 2007, for services rendered in the areas defined by the nine-digit ZIP codes indicated below, Medicare will require a valid nine-digit ZIP code on the provider file master address for services paid by the FIs/MACs under the MPFS and for anesthesia services.

GO – What You Need to Do

Make sure that your billing staffs are aware that if you provide services paid by carriers/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears below, effective for dates of service **on or after October 1, 2007,** they must include the nine-digit ZIP code in the claim.

Make sure that if you provide services paid by FIs/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears below, a valid nine-digit ZIP code is present on the provider file master address. If a valid nine-digit ZIP code is not on the file, submit a CMS-855A, the Medicare Enrollment Application, with a valid nine-digit ZIP code.

Background

Reimbursement Based on the Location Where the Service Was Rendered

Where you actually provide services paid under the MPFS and anesthesia services determines the amount of your reimbursement. More specifically, Medicare reimburses you for these services based on the locality, which is determined from the ZIP code that is on the claim submitted to carriers/MACs. The ZIP code on the provider file master address is used to determine the locality on the claims submitted to FIs/MACs.

The ZIP codes that your Medicare contractors use to determine the payment locality come from the CMS ZIP code file, which conforms to the United States Postal Service convention of assigning ZIP codes into dominant counties.

CMS has become aware that some ZIP codes cover more than one payment locality; in some cases, while the service may actually be rendered in one county, because of the ZIP code it may be assigned into a different county. This causes a payment issue when each of the counties is associated with a different payment locality and therefore a different payment amount.

Nine-Digit ZIP Codes

CR 5208, from which this article was taken, corrects this issue. **Effective October 1, 2007**, you will have to include the full nine-digit ZIP code for anesthesia services and for services paid under the MPFS by carriers/MACs when those services are provided in a ZIP code area that crosses payment localities (see below). Note that services on the purchased diagnostic abstract file are all payable under the MPFS, thus the nine-digit ZIP code requirement also applies to those services.

There are some important details that you should know:

Exceptions

There are two instances in which you do not need to submit the nine-digit ZIP code in claims for services payable under the MPFS and for anesthesia services:

- You may continue to submit claims with five-digit ZIP codes if you provide these services in ZIP code areas that do not cross payment localities (not listed below).
- There is no current requirement for the submission of a ZIP code when the place of service (POS) is "Home" or any other places of service that your Medicare contractor currently considers to be the same as "Home."

As necessary, CMS will provide quarterly updates of the list of the ZIP codes that cross localities.

You should submit your claims for ambulance and laboratory services using five-digit ZIP codes, as your carrier/MAC will continue to use the five-digit codes for determining payment.

Claims for ambulance services will continue to be priced using five-digit ZIP codes by the FIs/MACs. Laboratory services will continue to be priced by the FIs/MACs using the locality for non-fee based services.

Master Address

FIs determine locality based upon the ZIP code of the provider's physical address, which, including the ZIP code is stored on the provider file as the master address.

Effective July 1, 2007, institutional providers, with a ZIP code displayed below, will need to submit a valid nine-digit ZIP code on the CMS 855-A when the provider file master address ZIP code is five-digits, the last four-digits of a nine-digit ZIP code are zeroes, or the last four-digits of a nine-digit ZIP code do not match a four-digit extension on the ZIP code file.

Claims Returned as Unprocessable

To re-emphasize, if you provide only a five-digit ZIP code on a claim for services payable under the MPFS and for anesthesia services that you provide in one of the ZIP code areas that crosses localities (and therefore requires a nine-digit ZIP code to be processed), your carrier/MAC will return this claim as unprocessable. Returned claims will have the following remittance advice and remark code messages:

Adjustment Reason Code 16 – Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Remark Code MA 130 – Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Remark Code MA114 – "Missing/incomplete information on where the services were furnished."

Use of Nine-Digit ZIP Codes for Determining Payment Locality Paid Under the MPFS and Anesthesia (continued)

Effective for dates of service on or after October 1, 2007, if an invalid ZIP code is present on the provider file master address for claims payable under the MPFS and for anesthesia services provided in one of the ZIP code areas that crosses localities, your FI/MAC will return the claim as unprocessable.

ZIP Codes that Cross Payment Localities by State

Arkansas (AR)
71749 71953 72338 72395 72444 72644

Arizona (AZ)
85534

California (CA)
90265 90623 90630 90631 90638 91304 91307
91311 91361 91362 91709 91766 91792 93013
93243 93252 93536 93560 94303 94514 94515
94550 94571 95023 95033 95076 95304 95377
95391 95476 95616 95690 95694 96056

Delaware (DE)
19952 19973

Florida (FL)
32948 33440 33917 33920 33955 33972 34141
34142 34972 34974

Georgia (GA)
30011 30014 30019 30025 30040 30055 30056
30101 30102 30107 30120 30135 30143 30153
30178 30179 30180 30183 30184 30185 30187
30205 30223 30224 30228 30233 30234 30248
30268 30276 30506 30517 30518 30519 30534
30548 30559 30620 30641 30650 30663 30730
31029

Idaho (ID)
83342 83856

Illinois (IL)
60007 60010 60013 60015 60021 60042 60050
60051 60074 60081 60089 60090 60102 60103
60118 60120 60126 60133 60140 60142 60151
60172 60178 60401 60407 60410 60416 60423
60431 60432 60439 60447 60449 60464 60466
60467 60468 60475 60477 60481 60504 60506
60511 60521 60523 60527 60538 60543 60544
60554 60559 60935 60940 60950 62031 62044
62052 62053 62054 62075 62080 62081 62082
62083 62231 62237 62238 62253 62262 62263
62268 62272 62280 62286 62355 62361 62366
62538 62546 62553 62557 62558 62630 62638
62643 62667 62690 62692 62801 62808 62831
62877 62882 62883 62907 62916

Iowa (IA)
51630 51640 52542 52573 52626 52761

Kansas (KS)
66012 66013 66018 66021 66025 66083 66102
66109 66112

Kentucky (KY)
40965 42079 42223 42602

Massachusetts (MA)
01432 01434 01930 02324 02339 02762

Maryland (MD)
20601 20607 20613 20714 20736 20754 20842
20871 21757 21771 21776 21787 21791

Michigan (MI)
48005 48041 48062 48118 48137 48160 48166
48169 48178 48189 48353 48371 48380 48428
48430 48438 48439 48442 48455 48462 49229
49236 49240 49285

Minnesota (MN)
56136 56144 56164 56219 56220 56257 56744

Missouri (MO)
63005 63015 63020 63023 63028 63030 63041
63060 63069 63071 63072 63087 63348 63357
63535 63548 63627 64024 64034 64048 64061
64062 64070 64075 64077 64080 64082 64147
64439 64444 64484 64492 64733 64784

Montana (MT)
59030 59847

Nebraska (NE)
68719 68755 68777 69168 69212 69216 69352
69358

Nevada (NV)
89061

New Hampshire (NH)
03579 03813

New Jersey (NJ)
07735 07747 08512 08525 08530 08540 08558
08560

New York (NY)
10505 10541 10579 11001 11040 11096 12167
12434 13750

North Dakota (ND)
58030 58041 58043 58053 58225 58413 58436
58439 58568 58623 58653

Oregon (OR)
97002 97014 97032 97056 97064 97071 97119
97123 97128 97132 97140 97231 97362 97375

Pennsylvania (PA)
17527 17555 18036 18041 18042 18055 18070
18077 18092 18951 19087 19310 19344 19362
19363 19464 19504 19505 19512 19520 19525
19543

South Dakota (SD)
57005 57026 57030 57034 57068 57078 57255
57260 57270 57430 57437 57441 57446 57457
57523 57632 57638 57641 57642 57645 57648
57660 57717 57724

Tennessee (TN)
37317 37391 37821 38326

Use of Nine-Digit ZIP Codes for Determining Payment Locality Paid Under the MPFS and Anesthesia (continued)

Texas (TX)

75007	75019	75028	75044	75048	75050	75051
75052	75054	75067	75080	75082	75088	75089
75098	75104	75115	75125	75146	75148	75154
75159	75182	75248	75252	75287	75839	75844
75847	75851	75856	75862	76008	76020	76028
76036	76051	76052	76063	76065	76071	76092
76108	76126	76177	76262	77047	77053	77082
77083	77085	77099	77339	77357	77365	77381
77382	77426	77430	77444	77447	77450	77474
77477	77480	77484	77485	77489	77493	77494
77511	77520	77521	77532	77535	77539	77546
77550	77568	77581	77583	77622	77656	77665
77833	78610	78612	78613	78615	78617	78620
78621	78634	78641	78652	78654	78657	78663
78664	78669	78727	78728	78729	78734	78736
78737	78738	78750	78759	78933	78940	78950
78954	79835	79922	79932			

Virginia (VA)

20120	20135

Washington (WA)

98019	98022	98047	98072	98077	98092	98177
98251	98354	99033	99128			

Wisconsin (WI)

54540

Wyoming (WY)

82063	82082	82240	82716	82725	82731	82930
83114	83120	83127				

Additional Information

You can find more information about the use of nine-digit ZIP codes for determining the correct payment locality for anesthesia services and services paid under the MPFS by going to CR 5208, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1193CP.pdf*.

You might also want to look at updated *Medicare Claims Processing Manual*, Publication 100-04, Chapter 1 (*General Billing Requirements*), Section 10.1.1 (*Payment Jurisdiction among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services*) that you will find as an attachment to this CR.

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

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

MLN Matters Number: MM5208 – Revised
Related Change Request (CR) Number: 5208
Related CR Release Date: March 9, 2007
Related CR Transmittal Number: R1193CP
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

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

2007 Physician Quality Reporting Initiative—Program Overview

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

Provider Types Affected

Physicians, practitioners, and therapists (as defined in the "Eligible Professionals" section of this article) submitting claims to Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5558, which provides overview-level information on the Physician Quality Reporting Initiative (PQRI). The Centers for Medicare & Medicaid Services (CMS) encourages all physicians to be familiar with the PQRI, its importance, and benefits.

Background

CMS is developing and implementing payment for performance to encourage quality improvement and avoidance of unnecessary costs in the care of Medicare beneficiaries. Physician services comprise a significant component of the larger CMS value-based purchasing enterprise initiative that also includes hospitals, nursing homes, home health agencies, and dialysis facilities.

Introduction to the 2007 Physician Quality Reporting Initiative

On December 20, 2006, President Bush signed the Tax Relief and Health Care Act of 2006 (TRHCA). Division B, Title I, Section 101 of the TRHCA authorizes a financial incentive for eligible professionals to participate in a voluntary quality-reporting program. Eligible professionals, who choose to participate and successfully report on a designated set of quality measures for services paid under the Medicare physician fee schedule and provided between **July 1 and December 31, 2007,** may earn a bonus payment of 1.5 percent of their charges during that period, subject to a cap. CMS has titled the statutory program the 2007 Physician Quality Reporting Initiative (PQRI).

The purpose of this document is to give a high-level overview of CMS approach to 2007 PQRI implementation, as directed by the statute. Detailed program instructions, educational materials, and supportive tools will be posted as they become available on the CMS PQRI website at *http://cms.hhs.gov/PQRI*.

2007 Physician Quality Reporting Initiative—Program Overview (continued)

This overview of the 2007 PQRI will address: (1) eligible professionals, (2) quality measures, (3) form and manner of reporting, (4) determination of successful reporting, (5) bonus payment, (6) validation, (7) appeals, (8) confidential feedback reports, (9) transition from the 2006 Physician Voluntary Reporting Program (PVRP), and (10) 2008 considerations.

Eligible Professionals

TRHCA Section 101 defines "eligible professional" as the following:

1. Medicare physician, as defined in Social Security Act (SSA) section 1861(r):
   - Doctor of Medicine
   - Doctor of Osteopathy
   - Doctor of Podiatric Medicine
   - Doctor of Optometry
   - Doctor of Oral Surgery
   - Doctor of Dental Medicine
   - Chiropractor
2. Practitioners described in SSA section 1842(b)(18)(C):
   - Physician assistant
   - Nurse practitioner
   - Clinical nurse specialist
   - Certified registered nurse anesthetist
   - Certified nurse midwife
   - Clinical social worker
   - Clinical psychologist
   - Registered dietician
   - Nutrition professional
3. Therapists:
   - Physical therapist
   - Occupational therapist
   - Qualified speech-language pathologist

All Medicare-enrolled professionals in these categories are eligible to participate in the 2007 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims.

Quality Measures for Reporting

For 2007, TRHCA section 101 specifies that the quality measures for the PQRI shall be the "2007 physician quality measures under the PVRP as published on the public website of the Centers for Medicare & Medicaid Services as of the date of enactment of this subsection, except as may be changed … based on the results of a consensus-based process in January 2007 …." This provision refers to the list of 66 PVRP measures that CMS had posted on its website on December 5, 2006 (see Transition from 2006 PVRP section below). The list referred to in the statute was expanded based on actions approved at the January 22, 2007 AQA Alliance consensus process. The result is a final 2007 PQRI quality measures list, which is available at *www.cms.hhs.gov/PQRI*, as a download from the measures/codes Web page.

In addition, the statute allows modifications or refinements, such as code additions, corrections, or revisions to the detailed specifications for the measures included in the final 2007 PQRI measures list until the beginning of the reporting period. The final 2007 PQRI Quality Measure Specifications will be available on the CMS PQRI website well in advance of the July 1, 2007, start date for the reporting period. The detailed specifications for each measure describe: (1) when that measure is reportable and (2) which quality-data code to report.

Prior to the July 1, 2007 start date, eligible professionals that plan to participate in the 2007 PQRI should familiarize themselves and their office staff with the PQRI quality measures list and the specifications for each measure that applies to their patient populations.

Form and Manner of Reporting

TRHCA section 101 allows CMS to specify the form and manner of reporting. For 2007, CMS will be building on the claims-based quality reporting system implemented for the 2006 PVRP, which ended December 31, 2006 (see Transition from 2006 PVRP section below). Participating eligible professionals whose Medicare patients fit the specifications of the 2007 PQRI quality measures will report the corresponding appropriate *CPT* category II codes or G-codes (where *CPT* category II codes are not yet available) on their claims. *CPT* category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. Claims-based reporting may be via: (1) the paper-based CMS-1500 claim form or (2) the equivalent electronic transaction claim, the 837-P. Importantly, there is no need to enroll or register to begin claims-based reporting for 2007 PQRI.

The applicable *CPT* category II code or G-code quality data must be reported on the same claim as the patient diagnosis and service to which the quality-data code applies. The analysis algorithms that determine successful reporting match the quality-data codes to the diagnosis, service, and procedure codes on the claim. Thus, quality-data codes that are not submitted on the same claim as the applicable patient diagnosis, service, and procedure codes will not count toward successful reporting or for calculation of a potential bonus payment.

Determination of Successful Reporting

The statutory description of satisfactory reporting depends on how many quality measures are applicable to the services furnished by the eligible professional during the entire reporting period of July 1-December 31, 2007. If there are no more than three quality measures applicable to the services provided by the eligible professional, then each measure must be reported for at least 80 percent of the cases in which the measure was reportable. If there are four or more quality measures applicable to the services provided by the eligible professional, then at least three measures, selected by the eligible professional, must be reported for at least 80 percent of the cases in which each measure was reportable.

The analysis of whether an eligible professional has successfully reported is expected to be performed at the individual eligible professional level using the individual-level national provider identifier (NPI). The eligible professional's individual NPI must be listed along with the HCPCS codes for services, procedures, and quality data on the claim. Thus, to participate in the 2007 PQRI, eligible professionals must have their individual-level NPIs and must consistently use their individual NPIs to correctly

2007 Physician Quality Reporting Initiative—Program Overview (continued)

identify their services, procedures, and quality-data codes for an accurate determination of satisfactory reporting.

Eligible professionals select the quality measures that are applicable to their practices. If an eligible professional submits data for a quality measure, then that measure is presumed to be applicable for the purposes of determining satisfactory reporting. CMS recommends that eligible professionals report on every quality measure that is applicable to their patient populations to: (1) increase the likelihood that they will reach the 80 percent satisfactorily reporting requirement for the requisite number of measures and (2) increase the likelihood that they will not be affected by the bonus payment cap.

As detailed instructions, education, and tools to support successful claims-based reporting become available, they will be posted on the CMS PQRI website at *http://www.cms.hhs.gov/PQRI*.

Payment for Reporting

Participating eligible professionals who successfully report as prescribed by TRHCA section 101 may earn a 1.5 percent bonus, subject to cap. The potential 1.5 percent bonus will be based on allowed charges for covered professional services: (1) furnished during the reporting period of July 1 through December 31, 2007, (2) received into the CMS national claims history (NCH) file by February 29, 2008, and (3) paid under the Medicare physician fee schedule. Because claims processing times may vary by time of the year and Medicare carrier/Medicare administrative contractor (MAC), participating eligible professionals should submit claims from the end of 2007 promptly, so that those claims will reach the NCH file by February 29, 2008. Bonuses will be paid as a lump sum in mid-2008. There is no beneficiary copayment or notice to the beneficiary regarding the bonus payments.

The bonus will apply to allow charges for all covered professional services, not just those charges associated with reported quality measures. The term "allowed charges" refers to total charges, including the beneficiary deductible and copayment, not just the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the physician fee schedule amounts for assigned and non-assigned claims will not apply to the bonus. The statute defines PQRI covered services as those paid under the physician fee schedule only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology. Other Part B services and items that may be billed by eligible professionals but are not paid under the physician fee schedule, such as clinical laboratory services, pharmaceuticals billed by physicians, and rural health center/federally qualified health center services, do not apply to the bonus.

A payment cap that would reduce the potential bonus below 1.5 percent of allowed charges may apply in situations where an eligible professional reports relatively few instances of quality measure data. Eligible professionals' caps are calculated by multiplying: (1) their total instances of reporting quality data for all measures (not limited only to measures meeting the 80 percent threshold), by (2) a constant of 300 percent, and by (3) the national average per measure payment amount.

The national average per measure payment amount is one value for all measures and all participants that is calculated by dividing: (1) the total amount of allowed charges under the physician fee schedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program by (2) the total number of instances for which data were reported by all participants in the program for all measures during the reporting period. (Note that the national average per measure payment amount calculation only takes into account the charges on claims for which quality measures were reported, whereas the individual bonus calculation takes into account charges for all services furnished during the reporting period.) Thus, while the purpose of the cap is clear, it is not possible to determine the impact of the cap until the national average per measure payment amount can be calculated after the end of the reporting period.

TRHCA section 101 specifies that for 2007, CMS must use the taxpayer identification number (TIN) as the billing unit, so any bonuses earned will be paid to the TIN holder of record. Though the analysis of satisfactory reporting will be performed at the individual eligible professional level using individual-level NPI data (as discussed above in the Form and Manner of Reporting section), bonuses will paid to the holder of the TIN, aggregating individual bonuses for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS plans to group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the bonus payment under more than one TIN will receive a separate bonus payment associated with each TIN.

In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, the statute specifies that any bonus payment earned will be paid to the employers or facilities.

Validation

TRHCA section 101 requires CMS to validate, using sampling or other means, whether quality measures applicable to the services furnished by a participating eligible professional have been reported. CMS plans to focus on situations where eligible professionals have successfully reported fewer than three quality measures. If CMS finds that eligible professionals who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then CMS cannot pay those eligible professionals the bonus incentive payment.

Appeals

The statute specifically states that there shall be no administrative or judicial review of the determination of: (1) quality measures applicable to services furnished by eligible professionals, (2) satisfactory reporting, (3) the payment limitation or cap, or (4) the bonus incentive payment. However, CMS will establish a process for eligible professionals to inquire about these matters.

Confidential Feedback Reports

CMS will provide confidential feedback reports to

2007 Physician Quality Reporting Initiative—Program Overview (continued)

participating eligible professionals at or near the time that the lump sum bonus payments are made in mid-2008. There will be no interim feedback during 2007. Quality data reported under the 2007 PQRI will not be publicly reported.

Access to confidential feedback reports may require eligible professionals to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required to participate in the 2007 PQRI or to receive a bonus payment.

Transition from the 2006 Physician Voluntary Reporting Program

The 2007 PQRI will build on and replace the 2006 PVRP, which was implemented as the first step toward pay for performance for physician services. For services provided to Medicare beneficiaries from January 1 through December 31, 2006, physicians were able to voluntarily report to CMS a starter set of 16 evidence-based performance measures that captured quality of care data. The data were collected via claims using *CPT* category II codes and G-codes where *CPT* codes were not yet available. In December 2006, CMS provided confidential feedback reports containing reporting and performance rates to the physicians who had submitted performance data during the second calendar quarter of 2006. Though PVRP ended December 31, 2006, feedback reports for services provided during the third and fourth calendar quarters of 2006 will be made available during 2007.

2008 Considerations

For 2008, quality measures for eligible professionals must be proposed and finalized through rulemaking. According to the statue, the measures shall: (1) have been adopted or endorsed by a consensus organization, such as the AQA Alliance or National Quality Forum (NQF), (2) include measures that have been submitted by a physician specialty, (3) be identified by CMS as having used a consensus-based process for development, and (4) include structural measures, such as the use of electronic health records and electronic prescribing technology. The proposed 2008 quality measures set must be published by August 15, 2007 and finalized by November 15, 2007.

Though the short lead time for implementation of the 2007 PQRI will not allow CMS to offer registry-based or electronic health record-based reporting for 2007, CMS is exploring the use of these reporting mechanisms for 2008. CMS has already begun a series of meetings with representatives of physicians, medical boards, group practices, and therapists to discuss how CMS can promote the use of standardized specifications for centralized, electronic reporting.

Additional Information

Additional information is available on the CMS PQRI website at: *http://www.cms.hhs.gov/PQRI* or by contacting your Medicare carrier/MAC at their toll-free number, which may be found on the CMS website at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.

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

MLN Matters Number: MM5558
Related Change Request (CR) Number: 5558
Related CR Release Date: March 9, 2007
Related CR Transmittal Number: R265OTN
Effective Date: March 2, 2007
Implementation Date: N/A

Source: CMS Pub. 100-20, Transmittal 265, CR 5558

Physician Quality Reporting Initiative—Frequently Asked Questions

The Centers for Medicare & Medicaid Services (CMS) now has over 50 frequently asked questions (FAQs) about the Physician Quality Reporting Initiative (PQRI) available on its website. You may access these FAQs by visiting the PQRI Web page at *http://www.cms.hhs.gov/PQRI*.

Once on the Overview page, scroll down to the "Related Links Inside CMS" section and click on the "Frequently Asked Questions" link. ❖

Source: CMS Provider Education Resource 200703-13 & 14

Clinical Laboratory Services Competitive Bidding Demonstration

Information about the Medicare Clinical Laboratory Services Competitive Bidding Demonstration project may be found at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=keyword&filterValue=lab&filterByDID=0&sortByDID=3&sortOrder*.

The Centers for Medicare & Medicaid Services (CMS) is waiting for final approval of the demonstration design from the Office of Management and Budget (OMB). Once we receive OMB approval, we will make announcements – including start date and demonstration area.

Announcements will be made via the CMS (clinical labs) listserv and the CMS press office. ❖

Source: CMS Provider Education Resource 200703-18

AMBULANCE SERVICES

Medical Condition List and Instructions for Ambulance Services

The *"Medical Condition List"* is intended primarily as an educational guideline. It will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew.

Use of the medical condition list information does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, and miles traveled, all of which must be available in the event the claim is selected for medical review (MR) by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage. The Healthcare Common Procedure Coding System (HCPCS) code or the medical condition list information by themselves are not sufficient to justify coverage.

All current Medicare ambulance policies remain in place.

CMS issued the medical condition list as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are not precluded from use on ambulance claims, they are currently not required (per Health Insurance Portability and Accountability Act [HIPAA]) on most ambulance claims, and these codes generally do not trigger a payment or a denial of a claim. Some carriers and fiscal intermediaries have local coverage determinations (LCD) in place that cite ICD-9-CM codes that may be added to the claim to assist in documenting that the services are reasonable and necessary, but this is not common. Since ICD-9-CM codes are not required and are not consistently used, not all carriers or fiscal intermediaries edit on this field, and it is not possible to edit on the narrative field. The ICD-9-CM codes are generally not part of the edit process, although the medical condition list is available for those who do find it helpful in justifying that services are reasonable and necessary.

The medical condition list is set up with an initial column of primary ICD-9-CM codes, followed by an alternative column of ICD-9-CM codes. The primary ICD-9-CM code column contains general ICD-9-CM codes that fit the transport condition as described in the subsequent columns. Ambulance crew or billing staff with limited knowledge of ICD-9-CM coding would be expected to choose the one or one of the two ICD-9-CM codes listed in this column to describe the appropriate ambulance transport and then place the ICD-9-CM code in the space on the claim form designated for an ICD-9-CM code. The option to include other information in the narrative field always exists and may be used whenever an ambulance provider or supplier believes that the information may be useful for claims processing purposes. If an ambulance crew or billing staff member has more comprehensive clinical knowledge, then that person may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed. An ICD-9-CM code does not need to be selected from both the primary column and the alternative column. However, in several instances in the alternative ICD-9-CM code column, there is a selection of codes and the word "PLUS." In these instances, the ambulance provider or supplier would select an ICD-9-CM code from the first part of the alternative listing (before the word "PLUS") and at least one other ICD-9-CM code from the second part of the alternative listing (after the word "PLUS"). The ambulance claim form does provide space for the use of multiple ICD-9-CM codes. Please see the example below:

> The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 from the alternative column on the medical condition list). In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 fits the "PLUS any other code" requirement when using the alternative list for this condition [abnormal vital signs]). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other abnormal clinical findings) would work just as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

While the medical condition/ICD-9-CM code list is intended to be comprehensive, there may be unusual circumstances that warrant the need for ambulance services using ICD-9-CM codes not on this list. During the medical review process contractors may accept other relevant information from the providers or suppliers that will build the appropriate case that justifies the need for ambulance transport for a patient condition not found on the list.

Because it is critical to accurately communicate the condition of the patient during the ambulance transport, most claims will contain only the ICD-9-CM code that most closely informs the Medicare contractor why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. For example, if an advanced life support (ALS) ambulance responds to a condition on the medical condition list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport. (All claims are required to have HCPCS codes on them, and may have modifiers as

Medical Condition List and Instructions for Ambulance Services (continued)

well.) Similarly, if a basic life support (BLS) ambulance responds to a condition on the medical condition list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport.

When an ambulance dispatch personnel receives a request for service for a condition that necessitates the skilled assessment of an ALS paramedic based upon the medical condition list, an ALS-level ambulance would be appropriately sent to the scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when MR is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

Contractors may have (or may develop) individual local policies that indicate that some codes are not appropriate for payment in some circumstances. These continue to remain in effect.

Information on Appropriate Use of Transportation Indicators

When a claim is submitted for payment, an ICD-9-CM code from the medical condition list that best describes the patient's condition and the medical necessity for the transport may be chosen.

In addition to this code, one of the transportation indicators below may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

Air and Ground Transportation

- **Indicator "C1"** – indicates an inter-facility transport (to a higher level of care) determined necessary by the originating facility based upon EMTALA (Emergency Medical Treatment and Labor Act) regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or nonemergency category on the list.
- **Indicator "C2"** – indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or nonemergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.
- **Indicator "C3"** – may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on-scene – are appropriately advanced level service responses. A code that describes the patient's condition found on-scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.
- **Indicator "C4"** – indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appears to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

Ground Transportation Only

- **Indicator "C5"** – added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available.

  For example, a BLS ambulance is dispatched at the emergency level to pick up a 76-year-old beneficiary who has undergone cataract surgery at the eye surgery center. The patient is weak and dizzy with a history of high blood pressure, myocardial infarction, and insulin-dependent diabetes melitus. Therefore, the on-scene ICD-9-CM equivalent of the medical condition is 780.02 (unconscious, fainting, syncope, near syncope, weakness, or dizziness – ALS Emergency). In this case, the ICD-9-CM code 780.02 would be entered on the ambulance claim form as well as transportation indicator C5 to provide the further information that the BLS ambulance transported a patient with an ALS-level condition, but there was no intervention by an ALS service. This claim would be paid at the BLS level.
- **Indicator "C6"** – added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. If once on-scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the

Medical Condition List and Instructions for Ambulance Services (continued)

information obtained in the operation's dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.

- **Indicator "C7"** – use for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a nonemergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., normal saline, lactate ringers, 5 percent dextrose in water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.

Air Transportation Only

All "transportation indicators" imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.

- **D1** Long Distance – patient's condition requires rapid transportation over a long distance.
- **D2** Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.
- **D3** Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits to the patient.
- **D4** Pick up point not accessible by ground transportation.

The medical condition list and entire text of this transmittal is available on CMS website at *http://new.cms.hhs.gov/Transmittals/Downloads/R1185CP.pdf*. ❖

Source: CMS Pub. 100-04, Transmittal 1185, CR 5442

Ambulance Services—Non-Traumatic Emergency Medical Conditions

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
535.50	458.9, 780.2, 787.01, 787.02, 787.03, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60 through 789.69, or 789.40 through 789.49 PLUS any other code from 780 through 799 except 793, 794, and 795.	Severe abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	A0427/A0433
789.00	726.2, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, or 789.09.	Abdominal pain	Without other signs or symptoms	BLS		A0429
427.9	426.0, 426.3, 426.4, 426.6, 426.11, 426.13, 426.50, 426.53, 427.0, 427.1, 427.2, 427.31, 427.32, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 785.0, 785.50, 785.51, 785.52, or 785.59.	Abnormal cardiac rhythm/Cardiac dysrythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks,non-sinus tachycardias, PVC's >6, bi and trigeminy, ventricular tachycardia , ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED Fired	A0427/A0433
780.8	782.5 or 782.6	Abnormal skin signs		ALS	Diaphorhesis, cyanosis, delayed cap refill, poor turgor, mottled.	A0427/A0433

Ambulance Services—Non-Traumatic Emergency Medical Conditions (continued)

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
796.4	458.9, 780.6, 785.9, 796.2, or 796.3 PLUS any other code from 780 through 799.	Abnormal vital signs (includes abnormal pulse oximetry).	With or without symptoms.	ALS		A0427/A0433
995.0	995.1, 995.2, 995.3, 995.4, 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, 995.69 or 995.7.	Allergic reaction	Potentially life-threatening	ALS	Other emergency conditions, rapid progression of symptoms, prior hx. Of anaphylaxis, wheezing, difficulty swallowing.	A0427/A0433
692.9	692.0, 692.1, 692.2, 692.3, 692.4, 692.5, 692.6, 692.70, 692.71, 692.72, 692.73, 692.74, 692.75, 692.76, 692.77, 692.79, 692.81, 692.82, 692.83, 692.89, 692.9, 693.0, 693.1, 693.8, 693.9, 695.9, 698.9, 708.9, 782.1.	Allergic reaction	Other	BLS	Hives, itching, rash, slow onset, local swelling, redness, erythema.	A0429
790.21	790.22, 250.02, or 250.03.	Blood glucose	Abnormal <80 or >250, with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration.	A0427/A0433
799.1	786.02, 786.03, 786.04, or 786.09.	Respiratory arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.	A0427/A0433
786.05		Difficulty breathing		ALS		A0427/A0433
427.5		Cardiac arrest—Resuscitation in progress		ALS		A0427/A0433
786.50	786.51, 786.52, or 786.59.	Chest pain (non-traumatic)		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.	A0427/A0433
784.99	933.0 or 933.1.	Choking episode	Airway obstructed or partially obstructed	ALS		A0427/A0433
991.6		Cold exposure	Potentially life or limb threatening	ALS	Temperature< 95F, deep frostbite, other emergency conditions.	A0427/A0433
991.9	991.0, 991.1, 991.2, 991.3, or 991.4.	Cold exposure	With symptoms	BLS	Shivering, superficial frostbite, and other emergency conditions.	A0429

Ambulance Services—Non-Traumatic Emergency Medical Conditions (continued)

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
780.97	780.02, 780.03, or 780.09.	Altered level of consciousness (non-traumatic)		ALS	Acute condition with Glascow Coma Scale<15.	A0427/A0433
780.39	345.00, 345.01, 345.2, 345.3, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.80, 345.81, 345.90, 345.91, or 780.31.	Convulsions, seizures	Seizing, immediate post-seizure, postictal, or at risk of seizure & requires medical monitoring/observation.	ALS		A0427/A0433
379.90	368.11, 368.12, or 379.91.	Eye symptoms, non-traumatic	Acute vision loss and/or severe pain	BLS		A0429
437.9	784.0 PLUS 781.0, 781.1, 781.2, 781.3, 781.4, or 781.8	Non traumatic headache	With neurologic distress conditions or sudden severe onset	ALS		A0427/A0433
785.1		Cardiac symptoms other than chest pain.	Palpitations, skipped beats	ALS		A0427/A0433
536.2	787.01, 787.02, 787.03, 780.79, 786.8, or 786.52.	Cardiac symptoms other than chest pain.	Atypical pain or other symptoms	ALS	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.	A0427/A0433
992.5	992.0, 992.1, 992.3, 992.4, or 992.5.	Heat exposure	Potentially life-threatening	ALS	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.	A0427/A0433
992.2	992.6, 992.7, 992.8, or 992.9.	Heat exposure	With symptoms	BLS	Muscle cramps, profuse sweating, fatigue.	A0429
459.0	569.3, 578.0, 578.1, 578.9, 596.7, 596.8, 623.8, 626.9, 637.1, 634.1, 666.00, 666.02, 666.04, 666.10, 666.12, 666.14, 666.20, 666.22, 666.24, 674.30, 674.32, 674.34, 786.3, 784.7, or 998.11.	Hemorrhage	Severe (quantity) and potentially life threatening	ALS	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active postsurgical bleeding.	A0427/A0433

Ambulance Services—Non-Traumatic Emergency Medical Conditions (continued)

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
038.9	136.9, any other condition in the 001 through 139-code range, which would require isolation.	Infectious diseases requiring isolation procedures/ public health risk.		BLS		A0429
987.9	981, 982.0, 982.1, 982.2, 982.3, 982.4, 982.8, 983.0, 983.1, 983.2, 983.9, 984.0, 984.1, 984.8, 984.9, 985.0, 985.1, 985.2, 985.3, 985.4, 985.5, 985.6, 985.8, 985.9, 986, 987.0, 987.1, 987.2, 987.3, 987.4, 987.5, 987.6, 987.7, 987.8, 989.1, 989.2, 989.3, 989.4, 989.6, 989.7,989.9, or 990.	Hazmat exposure		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.	A0427/A0433
996.00	996.01, 996.02, 996.04, 996.09, 996.1, or 996.2.	Medical device failure	Life or limb threatening malfunction, failure, or complication.	ALS	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device.	A0427/A0433
996.30	996.31, 996.40, 996.41, 996.42, 996.43, 996.44, 996.45, 996.46, 996.47, 996.49, or 996.59.	Medical device failure	Health maintenance device failures that cannot be resolved on location.	BLS	Oxygen System supply malfunction, orthopedic device failure.	A0429
436	291.3, 293.82, 298.9, 344.9, 368.16, 369.9, 780.09, 780.4, 781.0, 781.2, 781.94, 781.99, 782.0, 784.3, 784.5, or 787.2.	Neurologic distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak	ALS		A0427/A0433

Ambulance Services—Non-Traumatic Emergency Medical Conditions (continued)

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
780.96		Pain, severe not otherwise specified in this list.	Acute onset, unable to ambulate or sit due to intensity of pain.	ALS	Pain is the reason for the transport. Use severity scale (7–10 for severe pain) or patient receiving pharmalogic intervention	A0427/A0433
724.5	724.2 or 785.9.	Back pain—non-traumatic (T and/or LS).	Suspect cardiac or vascular etiology	ALS	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.	A0427/A0433
724.9	724.2, 724.5, 847.1, or 847.2.	Back pain—non-traumatic (T and/or LS).	Sudden onset of new neurologic symptoms	ALS	Neurologic distress list.	A0427/A0433
977.9	Any code from 960 through 979.	Poisons, ingested, injected, inhaled, absorbed.	Adverse drug reaction, poison exposure by inhalation, injection or absorption.	ALS		A0427/A0433
305.0	303.00, 303.01, 303.02, 303.03, or any code from 960 through 979.	Alcohol intoxication or drug overdose (suspected).	Unable to care for self and unable to ambulate. No airway compromise.	BLS		A0429
977.3		Severe alcohol intoxication.	Airway may or may not be at risk. Pharmacological intervention or cardiac monitoring may be needed. Decreased level of consciousness resulting or potentially resulting in airway compromise.	ALS		A0427/A0433
998.9	674.10, 674.12, 674.14, 674.20, 674.22, 674.24, 997.69, 998.31, 998.32, or 998.83.	Post—operative procedure complications.	Major wound dehiscence, evisceration, or requires special handling for transport.	BLS	Non-life threatening.	A0429
650	Any code from 660 through 669 or from 630 through 767.	Pregnancy complication/ childbirth/labor		ALS		A0427/A0433
292.9	291.0, 291.3, 291.81, 292.0, 292.81, 292.82, 292.83, 292.84, or 292.89.	Psychiatric/behavioral	Abnormal mental status; drug withdrawal.	ALS	Disoriented, DT's, withdrawal symptoms	A0427/A0433

Ambulance Services—Non-Traumatic Emergency Medical Conditions (continued)

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
298.9	300.9	Psychiatric/ behavioral	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior	BLS	Suicidal, homicidal, or violent.	A0429
036.9	780.6 PLUS either 784.0 or 723.5.	Sick person - fever	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	BLS	Suspected spinal meningitis.	A0429
787.01	787.02, 787.03, or 787.91.	Severe dehydration	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	ALS		A0427/A0433
780.02	780.2 or 780.4	Unconscious, fainting, syncope, near syncope, weakness, or dizziness.	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433

Ambulance Services—Trauma Emergency Medical Conditions

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
959.8	800.00 through 804.99, 807.4, 807.6, 808.8, 808.9, 812.00 through 812.59, 813.00 through 813.93, 813.93, 820.00 through 821.39, 823.00 through 823.92, 851.00 through 866.13, 870.0 through 879.9, 880.00 through 887.7, or 890.0 through 897.7.	Major trauma	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glascow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20'', 20'' deformity in vehicle or 12'' deformity of patient compartment, auto pedestrian/ bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.	ALS	See "Condition Specific" Column	A0427/A0433

Ambulance Services—Trauma Emergency Medical Conditions (continued)

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
518.5		Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.	A0427/A0433
958.2	870.0 through 879.9, 880.00 through 887.7, 890.0 through 897.7, or 900.00 through 904.9	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.	A0427/A0433
829.0	805.00, 810.00 through 819.1, or 820.00 through 829.1.	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee, and ankle, deformity of bone or joint.	A0429
880.00	880.00 through 887.7 or 890.0 through 897.7.	Other trauma	Penetrating extremity injuries	BLS	Isolated with bleeding stopped and good CSM.	A0429
886.0 or 895.0	886.1 or 895.1.	Other trauma	Amputation—digits	BLS		A0429
887.4 or 897.4	887.0, 887.1, 887.2, 887.3, 887.6, 887.7, 897.0, 897.1, 897.2, 897.3, 897.5, 897.6, or 897.7.	Other trauma	Amputation—all other	ALS		A0427/A0433
869.0 or 869.1	511.8, 512.8, 860.2, 860.3, 860.4, 860.5, 873.8, 873.9, or 959.01.	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.	A0427/A0433
949.3	941.30 through 941.39, 942.30 through 942.39, 943.30 through 943.39, 944.30 through 944.38, 945.30 through 945.39, or 949.3.	Burns	Major—per American Burn Association (ABA)	ALS	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma	A0427/A0433
949.2	941.20 through 941.29, 942.20 through 942.29, 943.20 through 943.29, 944.20 through 944.28, 945.20 through 945.29, or 949.2.	Burns	Minor—per ABA	BLS	Other burns than listed above.	A0429

Ambulance Services—Trauma Emergency Medical Conditions (continued)

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
989.5		Animal bites, stings, envenomation	Potentially life or limb-threatening	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.	A0427/A0433
879.8	Any code from 870.0 through 897.7.	Animal bites/sting/envenomation	Other	BLS	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.	A0429
994.0		Lightning		ALS		A0427/A0433
994.8		Electrocution		ALS		A0427/A0433
994.1		Near drowning	Airway compromised during near drowning event.	ALS		A0427/A0433
921.9	870.0 through 870.9, 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, or 921.0 through 921.9.	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS		A0429
995.83	995.53 or V71.5 PLUS any code from 925.1 through 929.9, 930.0 through 939.9, 958.0 through 958.8, or 959.01 through 959.9.	Sexual assault	With major injuries	ALS	Reference Codes 959.8, 958.2, 869.0/869.1	A0427/A0433
995.80	995.53 or V71.5 PLUS any code from 910.0 through 919.9, 920 through 924.9, or 959.01 through 959.9.	Sexual assault	With minor or no injuries	BLS		A0429

Ambulance Services—Non-Emergency Medical Conditions

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition	Service Level	Comments/ Examples	HCPCS Crosswalk
428.9		Cardiac/hemodynamic monitoring required en route.	ALS	Expectation monitoring is needed before and after transport.	A0426
518.81 or 518.89	V46.11 or V46.12.	Advanced airway management.	ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426, A0434
293.0		Chemical restraint.	ALS		A0426
496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Suctioning required en route, need for titrated O_2 therapy or IV fluid management.	BLS	Per transfer instructions.	A0428

Ambulance Services—Non-Emergency Medical Conditions (continued)

ICD-9-CM Primary Code	ICD-9-CM Alternative Specific Code	Condition	Service Level	Comments/ Examples	HCPCS Crosswalk
786.09		Airway control/positioning required en route.	BLS	Per transfer instructions.	A0428
492.8	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Third party assistance/attendant required applying, administering, or regulating or adjusting oxygen en route.	BLS	Does not apply to patient capable of self-administration of portable or home O_2. Patient must require oxygen therapy and be so frail as to require assistance.	A0428
298.9	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - in restraints.	BLS	Refer to definition in 42 C.F.R Sec. 482.13(e).	A0428
293.1		Patient Safety: Danger to self or others monitoring.	BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.	A0428
298.8	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others seclusion (flight risk).	BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 C.F.R. Sec. 482.13(f)(2) for definition	A0428
781.3	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).	BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.	A0428
041.9		Special handling en route - isolation.	BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
907.2		Special handling en route to reduce pain - orthopedic device.	BLS	Backboard, halotraction, use of pins and traction, etc. Pain may be present.	A0428
719.45 or 719.49	718.40, 718.45, 718.49, or 907.2.	Special handling en route – positioning requires specialized handling.	BLS	Requires special handling to avoid further injury (such as with >grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of <1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures — post-op hip as an example	A0428

Ambulance Services—Transportation Indicators

Indicator	Category	Indicator Description		Service Level	Comments/ Examples	HCPCS Crosswalk
C1	Interfacility Transport	EMTALA-certified inter-facility transfer to a higher level of care.	Beneficiary requires higher level of care.	BLS, ALS, SCT, FW, RW	Excludes patient requested EMTALA transfer	A0428, A0429, A0426, A0427, A0433, A0434
C2	Interfacility Transport	Service not available at originating facility, and must meet one or more emergency or non-emergency conditions.		BLS, ALS, SCT, FW, RW		A0428, A0429, A0426, A0427, A0433, A0434

Ambulance Services—Transportation Indicators (continued)

Indicator	Category	Indicator Description		Service Level	Comments/ Examples	HCPCS Crosswalk
C3	Emergency trauma dispatch condition code	Major incident or mechanism of injury	Major Incident-This transportation indicator is to be used ONLY as a secondary code when the on-scene encounter is a BLS-level patient.	ALS	Trapped in machinery, close proximity to explosion, building fire with persons reported inside, major incident involving aircraft, bus, subway, metro, train and watercraft. Victim entrapped in vehicle.	A0427/A0433
C4	Medically necessary transport but not to the nearest facility.	BLS or ALS response	Indicates to carrier/intermediary that an ambulance provided a medically necessary transport, but that the number of miles on the Medicare claim form may be excessive.	BLS/ ALS	This should occur if the facility is on divert status or the particular service is not available at the time of transport only. In these instances the ambulance units should clearly document why the beneficiary was not transported to the nearest facility.	Based on transport level.
C5	BLS Transport of ALS level patient	ALS-level condition treated and transport by a BLS-level ambulance	This transportation indicator is used for ALL situations where a BLS-level ambulance treats and transports a patient that presents an ALS-level condition. No ALS-level assessment or intervention occurs at all during the patient encounter.	BLS		A0429
C6	ALS-level response to BLS-level patient	ALS response required based upon appropriate dispatch protocols - BLS-level patient transport	Indicates to carrier/intermediary that an ALS-level ambulance responded appropriately based upon the information received at the time the call was received in dispatch and after a clinically appropriate ALS-assessment was performed on scene, it was determined that the condition of the patient was at a BLS level. These claims, properly documented, should be reimbursed at an ALS-1 level based upon coverage guidelines under the Medicare ambulance fee schedule.	ALS		A0427

Ambulance Services—Transportation Indicators (continued)

Indicator	Category	Indicator Description		Service Level	Comments/ Examples	HCPCS Crosswalk
C7		IV meds required en route.	This transportation indicator is used for patients that require an ALS level transport in a nonemergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.	ALS	Does not apply to self-administered IV medications.	A0426

Ambulance Services—Air Transportation Indicators

Indicator	Indicator Description	Service Level	Comments/ Examples	HCPCS Crosswalk
D1	Long Distance-patient's condition requires rapid transportation over a long distance	FW, RW	If the patient's condition warrants only.	A0430, A0431
D2	Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.	FW, RW		A0430, A0431
D3	Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits for the patient.	FW, RW		A0430, A0431
D4	Pick-up point not accessible by ground ambulance	FW, RW		A0430, A0431

Note: HCPCS crosswalk to ALS1E (A0427) and ALS2 (A0433) would ultimately be determined by the number and type of ALS level services provided during transport. All medical condition codes may be cross walked to fixed wing and rotor wing HCPCS codes provided the air ambulance service has documented the medical necessity for air ambulance service versus ground or water ambulance. As a result, codes A0430 (fixed wing) and A0431 (rotor wing) may be included in Column 7 for each condition listed. ❖

Source: Source: CMS Pub. 100-04, Transmittal 1185, CR 5442

NATIONAL PROVIDER IDENTIFIER

National Provider Identifier—Will You Be Ready?

NPI: Get It. Share It. Use It.

There are less than 60 days left for the national provider identifier (NPI) compliance date of May 23, 2007. It is estimated that it may take at least this much time to implement the NPI into your business practices. Failure to prepare could result in a disruption in cash flow. Will you be ready to use your NPI? Time is running out!

Updating National Plan and Provider Enumeration System (NPPES) Information

All health care providers, including Medicare providers, should include their legacy identifiers, as well as associated provider identifier type(s), on their NPI applications. If a provider has already completed an application and did not submit a legacy identifier, this provider should go back and update its information in the national plan and provider enumeration system (NPPES). A provider can easily do so by using the Web page *https://nppes.cms.hhs.gov*.

While doing so, providers should also validate other data in NPPES, such as address, contact person information, etc., and update anything that has changed.

Sharing NPIs

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

New Frequently Asked Questions Posted

CMS has posted new NPI frequently asked questions (FAQs) on its website.

Questions include:

- For Medicare provider enrollment purposes, will group practices need to submit new CMS-855R enrollment applications for every member of the group practice to let Medicare know their NPIs?
- Will health plans link the national provider identifiers (NPIs) of group practices to the NPIs of the health care providers who are members of the group practices?
- Who needs an NPI – who is not eligible to apply for an NPI – what if I have a drug enforcement administration (DEA) number – what if I only bill on paper – what if I do not submit claims to Medicare?
- Can my office employer identification number (EIN) be used instead of an NPI?
- When do I need to use my NPI?
- Is a corporation that owns pharmacies that have NPIs required to have an NPI to receive payments on behalf of the owned pharmacies?

To view these FAQs, please go to the CMS dedicated NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/*.

Click on Educational Resources. Scroll down to the section that says *"Related Links Inside CMS"* and click on *Frequently Asked Questions*. To find the latest FAQs, click on the arrows next to *"Date Updated"*.

Upcoming WEDI Events

WEDI has several NPI events scheduled in the upcoming month. To learn more about these events, visit *http://www.wedi.org/npioi/index.shtml*.

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

Important Information for Medicare Providers

Sharing National Provider Identifiers with Medicare

In addition to updating critical data and legacy identifiers in the NPPES, Medicare providers should include both their NPIs and their Medicare legacy numbers on their Medicare claims. This will help Medicare build its NPI crosswalk by enabling Medicare to link the provider NPI to their Medicare legacy identifiers. Also, when Medicare providers make changes to their Medicare enrollment information, they are now required to furnish their NPIs when making those changes. Providers applying for Medicare enrollment must furnish their NPIs on their enrollment applications. These actions inform Medicare of the provider NPI.

There are no additional actions that Medicare providers need to take to inform Medicare of their NPIs.

Still Confused?

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

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

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

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

Source: CMS Provider Education Resource 200702-14

National Provider Identifier—Will You Be Ready?

GET IT. The compliance date, **May 23, 2007,** is only **two months** away. Covered health care providers have had 22 months to apply for their NPI – further procrastination could disrupt your cash flow. Act **now** if you still don't have your NPI! **It's easy and it's free!**

SHARE IT. Have your NPI and don't know what to do with it? Share it. Share it with health plans you bill and the colleagues who rely on having your NPI to submit their claims (e.g., those who bill for ordered or referred services). You should also share it with your business associates, such as a billing service, vendor, or clearinghouse. Pay attention to information from health plans with which you do business as to when they will begin accepting the NPI in claims and other standard transactions.

USE IT. Once your health plans have informed you that they are ready to accept NPIs, begin the testing process. Consider sending only a few claims at first as you test the ability of plans to accept the NPI. Fewer claims will make it easier to keep track of status and payment, as well as troubleshooting any potential problems that may arise during the testing process.

Revisions to the NPPES Website

We are revising some of the language on the NPPES NPI Application Help page that relates to the selection of the Entity Type. Among other changes, our revision will remove a reference to "atypical services." This reference is being removed because entities that furnish only "atypical services" are not eligible to apply for NPIs.

NPI Disclosures by Industry Entities to Industry Entities

A new guidance document is available on the CMS NPI Web page at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIdisclosures.pdf.

This guidance relates to the disclosure of health care providers' NPIs by health industry entities for the purpose of using NPIs in HIPAA standard transactions.

New Frequently Asked Questions Posted

CMS has posted new NPI frequently asked questions (FAQs) on its website.

Questions include:

- I have been told to protect my national provider identifier (NPI) and I have been told to share my NPI – How am I to protect my NPI if I must share it with others?
- With whom should I share my NPI?
- Am I required to share my NPI with health plans, other providers and any other entity that requests it?
- Does the National Plan and Provider Enumeration System (NPPES) handle applications for health plan identifiers, as it does for health care provider identifiers?
- May a health plan require that an individual health care provider obtain two NPIs if that provider has two separate business roles – for example, as a physician seeing patients at a group practice, and as a durable medical equipment (DME) supplier?

To view these FAQs, please go to the CMS dedicated NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/* . Click on Educational Resources. Scroll down to the section that says "Related Links Inside CMS" and click on Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated".

Important Information for Medicare Providers

Reminder to Use the NPI and Legacy Identifiers on Medicare Claims

Medicare is accepting the NPI on claims; however, providers should also submit their Medicare legacy identifiers on their claims until further instructions are released.

Important Notice: Medicare Extends Date for Accepting Form CMS-1500 (12-90)

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

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

National Provider Identifier—Will You Be Ready? (continued)

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

The following will help to properly identify whether their version of the form needs to be updated. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version. Checking the information at the upper right hand corner of the form is the best way to identify if that particular version is correct. On properly formatted claim forms, there will be approximately a ¼" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper.

If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

Upcoming WEDI Events

WEDI will host the 16th WEDI National Conference May 14 – 17, 2007, in Baltimore, Maryland. Visit the WEDI website for more details on this event, as well as others, at *http://www.wedi.org/npioi/index.shtml*.

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

Still Confused?

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

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

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

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

Source: CMS Provider Education Resource 200703-19

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

GENERAL COVERAGE

Extracorporeal Photopheresis

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

Provider Types Affected

All providers that bill Medicare carriers, fiscal intermediaries (FI), or Part A/B Medicare administrative contractors (A/B MACs) for rendering extracorporeal photopheresis services.

Provider Action Needed

STOP – Impact to You

For services provided on or after December 19, 2006, coverage for extracorporeal photopheresis is now expanded to include additional health conditions.

CAUTION – What You Need to Know

Change request (CR) 5464, from which this article is taken, announces (effective December 19, 2006), the expansion of coverage of extracorporeal photopheresis to include patients with acute cardiac allograft rejection and chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

GO – What You Need to Do

Make sure that your billing staffs are aware of this expanded coverage for extracorporeal photopheresis, and bill accordingly.

Background

Extracorporeal photopheresis is a medical procedure in which a patient's white blood cells are exposed first to a drug called 8-methoxypsoralen (8-MOP) and then to an ultraviolet A (UVA) light. The procedure starts with the removal of the patient's blood, which is centrifuged to isolate the white blood cells. The drug is typically administered directly to the white blood cells after they have been removed from the patient (referred to as ex vivo administration), but the drug can alternatively be administered directly to the patient before the white blood cells are drawn. After UVA light exposure, the treated white blood cells are then re-infused into the patient.

Formerly, Medicare covered extracorporeal photopheresis only when used in the palliative treatment of the skin manifestations of cutaneous T-cell lymphoma that has not responded to other therapy. On April 6, 2006, a request for reconsideration of this national coverage determination (NCD) to allow additional indications initiated a national coverage analysis.

CR 5464 announces the NCD resulting from that analysis. It provides that CMS has reviewed the evidence and determined that extracorporeal photopheresis is reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act for patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment, and for patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment. Therefore, effective December 19, 2006, coverage has been expanded to include these conditions.

Billing Requirements for Extracorporeal Photopheresis

You should use *Current Procedural Terminology (CPT)* code *36522 (Photopheresis, extracorporeal)* when submitting your outpatient or physician claims for this service under these expanded coverage guidelines. Effective for dates of service on or after December 19, 2006, Medicare contractors will pay hospital inpatient, including critical access hospital (CAH), claims for extracorporeal photopheresis, based on the normal payment methodology for type of bills (TOBs) 11x, 13x or 85x, according to the expanded coverage conditions. Specifically, Medicare will accept claims for extracorporeal photopheresis:

- With *CPT* code *36522* when submitted for the treatment of hospital outpatients and for physician services with ICD-9-CM diagnosis codes: 996.83 or 996.85; and
- With ICD-9-CM procedure code 99.88 when submitted for the treatment of hospital inpatients, including CAHs, with ICD-9-CM codes: 996.83 or 996.85.

Medicare contractors will not search for claims for services on or after December 19, 2006, but processed prior to the April 2, 2007, implementation date for this change. However, they will adjust such claims if you bring them to their attention.

Note: All other indications for extracorporeal photopheresis remain noncovered. Further, note that contractors will edit for an appropriate oncological and autoimmune disorder diagnosis prior to paying according to the NCD.

Medicare Summary Notices, Remittance Advice Remark Codes and Claim Adjustment Reason Code

Contractors will continue to use the appropriate existing messages that they have in place when denying claims submitted that do not meet the Medicare coverage criteria for extracorporeal photopheresis.

Contractors will deny claims when the service is not rendered to an inpatient or outpatient of a hospital, including CAHs, using the following codes:

- **Claim adjustment reason code 58** – "Claim/service denied/reduced because treatment was deemed by payer to have been rendered in an inappropriate or invalid place of service."
- **Medicare Summary Notices (MSN) 16.2** – "This service cannot be paid when provided in this location/facility." Spanish translation: "Este servicio no se puede pagar cuando es suministrado en esta sitio/facilidad." (Include either MSN 36.1 or 36.2 dependant on liability.)
- **Remark Codes (RA) MA 30** – "Missing/incomplete/invalid type of bill." (FIs and A/MACs only.)

Extracorporeal Photopheresis (continued)

- **Group Code CO** (contractual obligations) or **PR** (patient responsibility) dependant on liability.

Advance Beneficiary Notice and Hospital Issued Notice of Noncoverage Information

- If this service is not reasonable and necessary under 1862(a)(1)(A) of the Act (falls outside the scope of the revised NCD found in Publication 100-03, Chapter 1, Section 110.4), the physicians and/or hospital outpatient departments, including CAHs, will be held liable for charges unless the physician and/or hospital has the beneficiary sign an advance beneficiary notice (ABN) in advance of providing the service.
- If this service is provided to a hospital inpatient, including CAHs, for a reason unrelated to the admission (outside of the bundled payment), the hospital billing for the inpatient services will be held liable for charges unless the hospital has the beneficiary sign a hospital issued notice of noncoverage (HINN) letter 11 in advance of providing the service.

Note: This addition/revision of section 110.4 of the *Medicare National Coverage Determinations Manual* (100-03) is a NCD. NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

Additional Information

You may find the official instruction, CR 5464, issued to your carrier, FI or A/B MAC by visiting:

- *http://www.cms.hhs.gov/Transmittals/downloads/R66NCD.pdf* for the updated *Medicare National Coverage Determinations Manual (*100-03), Chapter 1, Part 2 (Sections 90-160.25) (Coverage Determinations), Section 110.4 (Extracorporeal Photopheresis).
- *http://www.cms.hhs.gov/Transmittals/downloads/R1206CP.pdf* for the updated *Medicare Claims Processing Manua*l (100.04), Chapter 32 (Billing Requirements for Special Services), Section 190 (Billing Requirements for Extracorporeal Photopheresis).

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

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

MLN Matters Number: MM5464
Related Change Request (CR) Number: 5464
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Related CR Transmittal Number: R1206CP and R66NCD
Effective Date: December 19, 2006
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 5464, CR 1206

Extracorporeal Photopheresis (*CPT* Code *36522*)—National Coverage Guideline Clarification

Since April 8, 1988, the Centers for Medicare & Medicaid Services (CMS) has allowed coverage for extracorporeal photopheresis for the pallative treatment of skin manifestations of cutaneous T-cell lymphoma (CTCL). For this covered indication, the following ICD-9-CM codes are considered medically necessary and appropriate:

202.10-202.18 Mycosis fungoides

202.20-202.28 Sezary's disease

Effective for dates of services **on or after December 19, 2006,** CMS has expanded coverage for extracorporeal photopheresis to include the following indications and ICD-9-CM codes:

- Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment; and
- Patients with chronic graft versus host disease whose disease is refractory to standard immunopsuppressive drug treatment.
- Appropriate ICD-9-CM codes for these new indications are 996.83 (complications of transplanted heart) and 996.85 (complications of transplanted bone marrow).

All other indications for extracorporeal photopheresis remain noncovered.

For additional information on this national coverage decision (NCD) please refer to change request 5464, transmittal 1206, dated March 16, 2007, available on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R1206CP.pdf*.

A *MLN Matters* article is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5464.pdf*. ❖

Coverage of One-Time Ultrasound Screening for Abdominal Aortic Aneurysms

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for the initial preventive physical examination (IPPE) and the ultrasound screening for abdominal aortic aneurysms (AAA).

Provider Action Needed

This article conveys no new policy information. This article is for informational purposes only and serves as a reminder that Medicare provides coverage of a one-time initial preventive physical examination and a one-time preventive ultrasound screening for AAA subject to certain coverage, frequency, and payment limitations. The Centers for Medicare & Medicaid Services (CMS) needs your help to get the word out and to encourage eligible beneficiaries to take full advantage of these benefits and all preventive services and screenings covered by Medicare.

Background

In January 2005, the Medicare program expanded the number of preventive services available to Medicare beneficiaries, as a result of Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, to include coverage under Medicare Part B of a one-time IPPE, also referred to as the "Welcome to Medicare" physical exam, for all Medicare beneficiaries whose Medicare Part B effective date began on or after January 1, 2005.

On January 1, 2007, Medicare further expanded the number of preventive benefits, as provided for in Section 5112 of the Deficit Reduction Act (DRA) of 2005, to include coverage under Medicare Part B of a one-time preventive ultrasound screening for the early detection of AAA for at risk beneficiaries as part of the IPPE. Both benefits (the IPPE and AAA) are subject to certain eligibility and other limitations.

The information in this special edition *MLN Matters* article reminds health care professionals that Medicare now pays for these benefits as well as a broad range of other preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their "Welcome to Medicare" physical exam within the first six months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the preventive ultrasound screening as part of their "Welcome to Medicare" physical exam.

Benefit Coverage Summary

The Initial Preventive Physical Examination ("Welcome to Medicare" Physical Exam)

Effective for dates of service on or after January 1, 2005, Medicare beneficiaries whose Medicare Part B effective date is on or after January 1, 2005, are covered for a one-time IPPE visit. The beneficiary must receive the IPPE within the first six months of their Medicare Part B effective date. The IPPE is a preventive evaluation and management (E/M) service that includes the following seven components:

1. A review of an individual's medical and social history with attention to modifiable risk factors.
2. A review of an individual's potential (risk factors) for depression.
3. A review of the individual's functional ability and level of safety.
4. An examination to include an individual's height, weight, blood pressure measurement, and visual acuity screen.
5. Performance of an electrocardiogram (EKG) and interpretation of the EKG.
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements.
7. Education, counseling, and referral (including a brief written plan such as a checklist provided to the individual for obtaining the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits).

Important Reminders About the Initial Preventive Physical Examination

1. The IPPE is a unique benefit available only for beneficiaries new to the Medicare program and must be received within the first six months of the effective date of their Medicare Part B coverage.
2. This exam is a preventive physical exam and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare does not provide coverage for routine physical exams.

The Part B deductible and coinsurance/copayment apply to this benefit.

Note: The deductible does not apply for an IPPE provided in a federally qualified health center (FQHC). Only the coinsurance/copayment applies.

Other preventive services and screenings covered under Medicare Part B include:

- Adult immunizations (flu, pneumococcal, and hepatitis B)
- Bone mass measurements
- Cardiovascular screening
- Diabetes screening
- Glaucoma screening
- Screening mammograms
- Screening Pap test and pelvic exam
- Colorectal and prostate cancer screenings
- Diabetes self-management training

Coverage of One-Time Ultrasound Screening for Abdominal Aortic Aneurysms (continued)

- Medical nutrition therapy for beneficiaries diagnosed with diabetes or renal disease
- Smoking and tobacco use-cessation counseling.

Benefits are subject to certain eligibility and other limitations.

Note: The IPPE/ "Welcome to Medicare" physical exam does not include any clinical laboratory tests. The physician, qualified nonphysician practitioner, or hospital may also provide and bill separately for the preventive services and screenings that are currently covered and paid for by Medicare Part B. (See the *Additional Information* section below for links to *MLN Matters* articles MM3771 and MM3638, which provide detailed coverage criteria and billing information about the IPPE benefit.)

Preventive Ultrasound Screening for Abdominal Aortic Aneurysms

Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time preventive ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime). Eligible beneficiaries must receive a referral for the screening as a result of their "Welcome to Medicare" physical exam. There is no Part B deductible applied to this benefit, but coinsurance/copayment applies.

Note: Only Medicare beneficiaries who receive a referral from their physician or other qualified nonphysician practitioner for the preventive ultrasound screening, as part of their "Welcome to Medicare" physical exam, will be covered for the AAA benefit. (See the *Additional Information* section below for a link to *MLN Matters* article MM5235, which provides detailed coverage criteria and billing information about the AAA benefit.)

Additional Information

For more information about Medicare's coverage criteria and billing procedures for the AAA and IPPE benefits, refer to the following *MLN Matters* articles:

- MM5235 (2006), Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination, *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf*.
- MM3771 (2005), MMA – Clarification for Outpatient Prospective Payment system (OPPS) Hospitals Billing the Initial Preventive Physical Exam (IPPE), *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3771.pdf*.
- MM3638 (2004), MMA – Initial Preventive Physical Examination, *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf*.

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

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

For products to share with your Medicare patients, visit the website *http://www.medicare.gov/*.

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Prostate Cancer Screening Coverage

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for Medicare-covered prostate cancer screening services.

Provider Action Needed

This article conveys no new policy that requires provider action. The article is for informational purposes only and serves as a reminder that Medicare provides coverage of certain prostate cancer screening tests subject to certain coverage, frequency, and payment limitations.

Introduction

Effective for services furnished on or after January 1, 2000, Medicare Part B covers annual preventive prostate cancer screening tests/procedures for the early detection of prostate cancer. The information in this special edition *MLN Matters* article reminds health care professionals about the coverage criteria, eligibility requirements, frequency parameters, and correct coding when billing for prostate cancer screening services so that you may talk with your Medicare patients about this preventive benefit and file claims properly for the screening service.

The Screening Services Defined

A. Screening Digital Rectal Examination

Medicare defines a screening digital rectal examination (DRE) as a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. This screening must be performed by a doctor of medicine or osteopathy, physician assistant, nurse practitioner, clinical nurse specialist, or by a certified nurse midwife who is authorized under state law to perform the examination, fully knowledgeable about the beneficiary's medical condition, and would be responsible for explaining the results of the examination to the beneficiary.

B. Screening Prostate Specific Antigen Tests

Medicare defines a screening prostate specific antigen (PSA) as a test that measures the level of prostate specific antigen in an individual's blood. This screening must be ordered by the beneficiary's physician (doctor of medicine or osteopathy) or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is fully knowledgeable about the beneficiary's medical condition, and would be responsible for explaining the results of the test to the beneficiary.

Coverage Information

Medicare Provides Coverage of the Following Prostate Cancer Screening Tests:

- Screening digital rectal examination (DRE)
- Screening prostate specific antigen (PSA) blood test.

Eligibility and Frequency

Medicare provides coverage of an annual preventive prostate cancer screening PSA test and DRE once every 12 months for all male beneficiaries age 50 and older (coverage begins the day after the beneficiary's 50th birthday), if at least 11 months have passed following the month in which the last Medicare-covered screening DRE or PSA test was performed for the early detection of prostate cancer.

Calculating Frequency

When calculating frequency, to determine the 11-month period, the count starts beginning with the month after the month in which a previous test/procedure was performed.

Example: The beneficiary received a screening PSA test in January 2006. The count starts beginning February 2006. The beneficiary is eligible to receive another screening PSA test in January 2007 (the month after 11 months have passed).

Deductible and Coinsurance/Copayment

- The screening PSA blood test is a lab test for which neither the deductible nor coinsurance/copayment apply.
- The screening DRE the Medicare Part B deductible and coinsurance/copayment apply.

Claim Filing Information

The following Healthcare Common Procedure Coding System (HCPCS) codes and diagnosis code must be reported when filing claims for prostate cancer screening services:

HCPCS Codes and Descriptors

G0102 Prostate cancer screening; digital rectal examination

G0103 Prostate cancer screening; prostate specific antigen test (PSA), total

Diagnosis Code and Description

V76.44 Prostate cancer screening DRE and screening PSA blood tests must be billed using screening ("V") code V76.44 (Special screening for malignant neoplasms, prostate).

Note: When submitting claims for the annual preventive prostate cancer screening PSA test it is important to bill for a screening test, which is covered once every 12 months, and not for a diagnostic test.

Payment for Prostate Cancer Screening Services

- Screening PSA tests (G0103) are paid under the clinical diagnostic laboratory fee schedule.
- Screening DREs (G0102) are paid under the Medicare physician fee schedule (MPFS) except for the following type of bills (TOBs) identified below.

For Fiscal Intermediary Only

TOBs not identified below are paid under the MPFS.

- 12x, 13x, and 14x* – Outpatient prospective payment system
- 71x and 73x – Included in all inclusive rate
- 85x – Cost (payment should be consistent with amounts paid for *CPT* code *84153* or code *86316*.)

*Effective April 1, 2006, the TOBs 14x is for nonpatient laboratory specimens.

Prostate Cancer Screening Coverage (continued)

Additional Notes

- Rural health clinics (RHCs) and federally qualified health centers (FQHCs) should include the charges on the claims for future inclusion in encounter rate calculations.
- Billing and payment for a DRE (G0102) is bundled into the payment for a covered evaluation and management service (*CPT* codes *99201 – 99456* and *99499*) when the two services are furnished to a patient on the same day. If the DRE is the only service or is provided as part of an otherwise non-covered service, HCPCS code G0102 would be payable separately if all other coverage requirements are met.

Additional Information

For more information about Medicare's prostate cancer screening benefit, visit the CMS prostate screening Web page at *http://www.cms.hhs.gov/ProstateCancerScreening/*.

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

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

For products to share with your Medicare patients, visit *http://www.medicare.gov/* on the Web.

Medicare beneficiaries may obtain information about Medicare preventive benefits at *http://www.medicare.gov/* and then click on "Preventive Services".

They may also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Coverage and Billing for Colorectal Cancer Screening

Colorectal Cancer: Preventable, Treatable, and Beatable

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, nurse practitioners, physician assistants, clinical nurse specialists, outpatient hospital departments, and community surgical centers who furnish or provide referrals for and/or file claims for Medicare-covered colorectal cancer screening services.

Provider Action Needed

STOP – Impact to You

March is National Colorectal Cancer Awareness Month. The Centers for Medicare & Medicaid Services (CMS) would like to remind providers to encourage their eligible patients, age 50 and older, to get screened for colorectal cancer. This special edition *MLN Matters* article highlights coverage changes that became **effective January 1, 2007** and reviews Medicare coverage and billing processes for colorectal cancer screening.

CAUTION – What You Need to Know

Medicare covers colorectal cancer screening since 1998, but the benefit is underused. Claim data from 1998-2002 indicate that less than half of Medicare beneficiaries had any screening test during this five-year period, and less than one-third were tested according to recommended intervals.

GO – What You Need to Do

Be sure your staff is aware of this coverage and the CMS urges physicians to encourage their patients to take advantage of this important coverage.

Background

Colorectal cancer is the second leading cause of cancer death in the U.S., and the third most common type of cancer. In 2006, colorectal cancer was expected to account for 55,170 deaths and 148,610 new cases. Colorectal cancer primarily affects men and women ages 50 and older, and risk increases with age. If detected early, colorectal cancer can be treated and cured.

In January 1998, Medicare began covering colorectal cancer screening. **The data currently available (1998-2002) indicate the Medicare colorectal cancer screening benefit is underused.** Less than half of enrollees had any colorectal cancer test during the five-year period and less than one-third were tested according to recommended intervals.

The U.S. Preventive Services Task Force (USPSTF) evaluates the clinical merits of preventive measures, and strongly recommends ("A" rating) that clinicians screen men and women ages 50 and older for colorectal cancer. The choice of screening strategy should be based on patient

Coverage and Billing for Colorectal Cancer Screening (continued)

preferences, medical contraindications, patient adherence, and resources for testing and follow-up. There are insufficient data to determine which screening strategy is best in terms of the balance of benefits and potential harms or cost-effectiveness. Studies reviewed by the USPSTF indicate that colorectal cancer screening is likely to be cost-effective (less than $30,000 per additional year of life gained) regardless of the strategy chosen. To read the full recommendation, go to the following link on the Web: *http://www.ahrq.gov/clinic/uspstf/uspscolo.htm*.

The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on two criteria–burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer screening was among the services considered to be of the greatest value. To read about the ranking of clinical preventive services, go to the following link on the Web: *http://prevent.org/content/view/46/96/*.

Risk Factors

Beneficiaries are considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp.
- A family history of adenomatous polyposis.
- A family history of hereditary nonpolyposis colorectal cancer.
- A personal history of adenomatous polyps.
- A personal history of colorectal cancer.
- A personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Coverage Information

Medicare covers the following colorectal cancer screening tests and procedures:

- **Fecal occult blood test (FOBT)**: Medicare covers **one** FOBT annually for beneficiaries 50 and older. A written order from the beneficiary's attending physician is required. Medicare will pay for an immunoassay-based FOBT as an alternative to the guaiac-based FOBT, but will only pay for one FOBT, not both, per year. Beneficiaries do not have to pay coinsurance for the FOBT, and do not have to meet the annual Medicare Part B deductible.

  Note: In 2006, and effective for services provided January 1, 2007 and later, CMS adopted the more specific *CPT* code *82270* (patient was provided three single cards or single triple card for consecutive collection) and discontinued code G0107 (FOBT, 1-3 simultaneous determinations) to encourage quality colorectal cancer screening practices. Two studies published in January 2005 in the *Annals of Internal Medicine* suggested that the office-based single sample screening fecal occult blood test is of limited value, and that many physicians are not following practice guidelines for screening and follow-up.

- **Screening flexible sigmoidoscopy**: Medicare covers a screening flexible sigmoidoscopy once every **four** years for beneficiaries 50 and older. If a beneficiary had a screening colonoscopy in the previous 10 years, then the next screening flexible sigmoidoscopy would be covered only after 119 months have passed following the month in which the last screening colonoscopy was performed. A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist may perform a screening flexible sigmoidoscopy.
- **Screening colonoscopy**: Medicare coverage for a screening colonoscopy is based on beneficiary risk. For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers **one** screening colonoscopy every 10 years, but not within 47 months of a previous screening flexible sigmoidoscopy. For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers **one** screening colonoscopy every **two** years, regardless of age. A doctor of medicine or osteopathy must perform a screening colonoscopy.
- **Screening barium enema**: Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy for all beneficiaries under the same coverage requirements and at the same frequency as for the screening flexible sigmoidoscopy. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening flexible sigmoidoscopy or the barium enema, but not both. Medicare also covers a barium enema as an alternative to a screening colonoscopy rendered to a beneficiary at high risk for developing colorectal cancer under the same coverage requirements, at the same frequency. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening colonoscopy for the high-risk beneficiary or the barium enema rendered in lieu of it, but not both.
  A screening barium enema must be ordered in writing and collected by a doctor of medicine or osteopathy once it is determined that it is the appropriate screening method for a beneficiary. A double contrast barium enema is preferable, but the physician may order a single contrast barium enema if it is more appropriate for the beneficiary.

The beneficiary is liable for paying 20 percent of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema. **See "2007 Changes" for changes to coinsurance amount.**

2007 Changes

- **Starting January 1, 2007**, the Medicare Part B deductible has been waived for **screening** colonoscopy, sigmoidoscopy, and barium enema (as an alternative to colonoscopy or sigmoidoscopy). However, the deductible is not waived if the colorectal cancer-screening test becomes a diagnostic colorectal test; that is the service actually results in a biopsy or removal of a lesion or growth.

Coverage and Billing for Colorectal Cancer Screening (continued)

- **Starting January 1, 2007**, for a screening flexible sigmoidoscopy or a screening colonoscopy performed in a non-outpatient prospective payment system (OPPS) hospital outpatient department, the beneficiary is liable for paying 25 percent of the Medicare-approved amount (the coinsurance). The 25 percent coinsurance is currently being applied in the OPPS for OPPS hospitals. However, it is not being applied to non-OPPS hospitals.
- **Starting January 1, 2007**, for a screening colonoscopy performed in an ambulatory surgical center, the beneficiary is liable for paying 25 percent of the Medicare-approved amount (the coinsurance).

In addition, G0107 (FOBT, 1-3 simultaneous determinations) has been discontinued. *CPT* code *82270* (patient was provided 3 single cards or single triple card for consecutive collection) has been adopted to encourage quality colorectal cancer screening.

How to Bill Medicare

The following Healthcare Common Procedure Coding System/*Current Procedure Terminology* (HCPCS/*CPT*) codes should be used to bill for colorectal cancer screening services:

HCPCS/ CPT Code	Code Descriptors
G0104	Colon cancer screening; flexible sigmoidoscopy
G0105*	Colon cancer screening; colonoscopy on individual at high risk
G0106	Colon cancer screening; barium enema as an alternative to G0104
82270	*Colon cancer screening; FOBT, patient was provided 3 single cards or single triple card for consecutive collection*
G0120	Colon cancer screening; barium enema as an alternative to G0105
G0121	Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk
G0122**	Colon cancer screening; barium enema (noncovered)
G0328	Colon cancer screening; fecal occult blood test, immunoassay

*When billing for the "high risk" beneficiary, the screening diagnosis code on the claim must reflect at least one of the high-risk conditions mentioned previously. Examples of diagnostic codes are in the colorectal cancer-screening chapter of the Guide to Preventive Services. This guide is available on the CMS website at: *http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf*.

**Medicare covers colorectal barium enemas only in lieu of covered screening flexible sigmoidoscopies (G0104) or covered screening colonoscopies (G0105). However, there may be instances when the beneficiary has elected to receive the barium enema for colorectal cancer screening other than specifically for these purposes. In such situations, the beneficiary may require a formal denial of the service from Medicare in order to bill a supplemental insurer who may cover the service. These non-covered barium enemas are to be identified by G0122 (colorectal cancer screening; barium enema). Code G0122 should not be used for covered barium enema services, that is, those rendered in place of the covered screening colonoscopy or covered flexible sigmoidoscopy. The beneficiary is liable for payment of the noncovered barium enema.

If billing carriers, the appropriate HCPCS and corresponding diagnosis codes must be provided on Form CMS-1500 (or the HIPAA 837 professional electronic claim record).

If billing intermediaries, the appropriate HCPCS, revenue, and corresponding diagnosis codes must be provided on Form CMS-1450 (or the HIPAA institutional electronic claim record). Information on the type of bill and associated revenue code is also provided in the colorectal cancer-screening chapter of the Guide to Preventive Services. Once again, this guide is available on the CMS website at: *http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf*.

This guide provides also reimbursement information.

Additional Information

CMS has developed a comprehensive prevention website that provides information and resources for all Medicare preventive benefits. The following link is to the colorectal cancer screening section, and includes website links to information and resources developed by other organizations interested in promoting colorectal cancer screening, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American Cancer Society *http://www.cms.hhs.gov/ColorectalCancerScreening/*.

Other *MLN Matters* articles on colorectal cancer screening changes mentioned in this special edition are MM5387 (coinsurance changes) *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf* and MM5127 (deductible change) *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf*.

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

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

For products to share with your Medicare patients, visit on the Web *http://www.medicare.gov*.

Medicare beneficiaries can obtain information about Medicare preventive benefits at *http://www.medicare.gov/*, and then click on "Preventive Services." Medicare beneficiaries may also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For more information about National Colorectal Cancer Awareness Month, please visit *http://www.crfa.org/colorectal/* on the Web.

Coverage and Billing for Colorectal Cancer Screening (continued)

MLN Matters Number: SE0710
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 SE0710

April 2007 Changes to the Laboratory National Coverage Determination Edits

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

Provider Types Affected

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

Provider Action Needed

This article and related change request (CR) 5514 announces the changes that will be included in the April 2007 release of the edit module for clinical diagnostic laboratory national coverage determinations (NCDs). Assure your billing staff is aware of these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the Laboratory Negotiated Rulemaking Committee and published as a final rule on November 23, 2001. Subsequently, the Centers for Medicare & Medicaid Services (CMS) contracted for nationally uniform software to be developed and incorporated into its claims processing systems so that laboratory claims subject to one of the 23 NCDs can be processed uniformly throughout the nation effective April 1, 2003. The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 16, Section 120.2, available on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf*.)

These updating changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and biannual updates of the ICD-9-CM codes. In addition, many of the listed changes may correct *Current Procedural Terminology (CPT)* codes to reflect the current *CPT* update.

CR 5514 informs your Medicare carrier, FI, or A/B MAC about changes to the laboratory edit module and changes in laboratory NCD code lists **effective for services furnished on or after April 1, 2007.**

Key Point of Change Request 5514

Effective for dates of service **on or after April 1, 2007:**

- The **new HCPCS code G0394** for blood occult test (e.g., guaiac), feces, for single determination for colorectal neoplasm (i.e., patient was provided three cards or single triple card for consecutive collection) is added to the list of HCPCS codes for the fecal occult blood test NCD (190.34).

Additional Information

To see the official instruction (CR 5514) issued to your Medicare carrier, FI, or A/B MAC, go to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1200CP.pdf*.

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

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

MLN Matters Number: MM5514
Related Change Request (CR) Number: 5514
Related CR Release Date: March 9, 2007
Related CR Transmittal Number: R1200CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1200, CR 5514

HOSPITAL SERVICES

Payment and Billing for Islet Isolation Add-On in National Institutes of Health Clinical Trial

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for services related to islet cell transplantation for patients with type I diabetes participating in a National Institutes of Health (NIH) sponsored clinical trial.

Provider Action Needed

This article is based on change request (CR) 5505 which announces that for services performed/discharges on or after October 1, 2004, Medicare covers islet cell transplantation for patients with type I diabetes who are participating in a NIH sponsored clinical trial. In addition, Medicare will also pay an add-on payment for islet isolation services as discussed below. Note that although Medicare began covering this trial for discharges on or after October 1, 2004, patients are not expected to participate in the trial until mid-2007.

Background

For services performed or discharges on or after October 1, 2004, Medicare covers islet cell transplantation for patients with type I diabetes that are participating in a NIH sponsored clinical trial.

Inpatient hospitals participating in this trial are entitled to an add-on payment of $18,848.00 for islet isolation services. This amount is in addition to the final inpatient prospective payment system (IPPS) amount made to the hospital. Should two infusions occur during the same hospital stay, Medicare will pay for two add-ons for isolation of the islet cells, but never for more than two add-ons for a hospital stay.

Note: The islet cell transplant may be done alone or in combination with a kidney transplant.

Medicare will pay IPPS hospitals participating in the trial for claims billed with

- ICD-9-CM procedure code 52.85 (All transplantation of cells of islets of Langerhaus), and
- ICD-9-CM diagnosis code V70.7 (Examination of participant in clinical trial). **Note that V70.7 must be in the secondary diagnoses code position.**

The add-on payment will be based on the number of times the ICD-9-CM procedure code 52.85 appears.

Hospitals participating in the trial should report in the organ acquisition revenue center (0810, 0811, 0812, 0813, or 0819), charges for pre-transplant items and services related to the acquisition and delivery of pancreatic islet cell transplantation.

There are no donor charges associated because islet cells are acquired from a cadaveric pancreas. Like other Medicare covered organ transplants, these charges are subtracted from the total charges on the claim and paid as a pass-through. Pancreata procured for islet cell transplant are not included in the IPPS payment. They are paid on a reasonable cost basis. This is a pass-through cost for which interim payments may be made.

Hospitals paid under periodic interim payment (PIP) will be paid this add-on in addition to their PIP.

Additional Information

The official instruction, CR 5505, issued to your FI and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1192CP.pdf*.

A revised portion of the *Medicare Claims Processing Manual* is attached to CR 5505 and that manual change includes additional information regarding this issue. You may also wish to review the *Medicare National Coverage Determinations Manual*, Section 260.3.1, regarding this issue. That manual is available on the CMS website at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

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

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

MLN Matters Number: MM5505
Related Change Request (CR) Number: 5505
Related CR Release Date: March 2, 2007
Effective Date: April 1, 2007
Related CR Transmittal Number: R1192CP
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1192, CR 5505

Claims for Hemophilia Clotting Factor—HCPCS Code J7187

The Centers for Medicare & Medicaid Services (CMS) HCPCS Committee changed one of the codes for hemophilia clotting factors with the January 1, 2007, HCPCS update. **Effective January 1, 2007,** the following HCPCS code change is:

Old Code	J7188
Replacement Code	J7187
Name of Factor	von Willebrand factor complex, human, ristocetin cofactor, per IU VWF: RCO

Unfortunately, this information was not received early enough in the year to update the appropriate edits in the Fiscal Intermediary Shared System (FISS).

Payment for HCPCS code J7187 requires FISS modifications. The earliest FISS can make the changes is the October 2007 quarterly release. Until then, CMS is asking providers to omit both the old code, HCPCS code J7188 and the new code, HCPCS code J7187, from the inpatient hospital claims. Once the system has been appropriately updated, providers can submit an adjustment request to include HCPCS code J7187. At that time, contractors will be able to process claims for this HCPCS code and make payment.

As a result of this problem with the revised code, CMS has developed the following instructions to be used for hospital discharges between January 1, 2007, and production of the October 2007 FISS release:

- Providers shall submit claims for hospital inpatient care (this includes hospitals paid under the inpatient prospective payment system, paid under the long term care prospective payment system, paid under the inpatient rehabilitation facility prospective payment system, and those paid on the basis of reasonable cost [TEFRA hospitals, and critical access hospitals], as well as Indian health service hospital inpatient services [actually paid on a DRG basis]) omitting HCPCS code J7187 (or J7188). This does not apply to claims from inpatient psychiatric facilities (IPFs) paid under IPF prospective payment system (PPS); IPFs receive a comorbidity adjustment under IPF PPS based on the presence of a hemophilia diagnosis.
- Once the provider has received PPS payment for the inpatient claim, the provider is to immediately submit an adjustment request (type of bill [TOB] = 117), this time including HCPCS code J7187.
- Medicare contractors will return to the provider any initial claims containing HCPCS code J7187.
- Medicare contractors will hook any inpatient claims/provider initiated adjustment requests containing HCPCS J7187 with discharge dates between **January 1, 2007, and September 30, 2007.**
- FISS will replace editing for inpatient claims containing HCPCS code J7188 with editing for HCPCS code J7187 **for discharge dates on and after January 1, 2007.**
- FISS will include this coding update in its October 2007 release.

There is no impact on payment of outpatient hospital claims or on any skilled nursing facility claims. Contractors will continue payment of hospital outpatient claims for hemophilia clotting factors, as the payment amount for HCPCS J7187 is included on both the January 2007 average sales price files and in the January 2007 hospital outpatient PPS PRICER. ❖

Source: CMS Joint Signature Memorandum 07291, March 20, 2007

Reporting of Type of Bill 12x for Billing of Diagnostic Mammographies

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

Provider Types Affected

Hospitals that bill Medicare administrative contractors (A/B MACs) or fiscal intermediaries (FIs) for diagnostic mammography services provided to hospital inpatients under Medicare Part B.

Provider Action Needed

A previous instruction, change request (CR 5050), from the Centers for Medicare & Medicaid Services (CMS), erroneously removed type of bill (TOB) 12x as an applicable TOB for diagnostic mammography services supplied to Medicare inpatients and billable under Medicare Part B. CR 5377 announces that, **effective April 1, 2007,** TOB 12x is acceptable by FIs and A/B MACS as an appropriate bill type for such services. Be sure your billing staff are aware.

Background

Effective April 1, 2007, hospitals should use TOB 12x to bill Medicare FIs and/or A/B MACs for diagnostic mammography services provided to hospital inpatients, where those services are being billed to Medicare Part B. As appropriate, hospitals should continue to use TOBs 13x, 22x, 23x, or 85x when billing for diagnostic mammographies provided to Medicare patients who are other than hospital inpatients.

Additional Information

To view the official instruction, CR 5377, issued to your FI or A/B MAC, visit on the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1117CP.pdf*.

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

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

MLN Matters Number: MM5377
Related Change Request (CR) Number: 5377
Related CR Release Date: November 24, 2006
Related CR Transmittal Number: R1117CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1117, CR 5377

LOCAL COVERAGE DETERMINATIONS

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

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

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

Local Coverage Determination Table of Contents

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

ADDITIONS/REVISIONS TO LCDS

A72192: Computed Tomography of the Abdomen and Pelvis—Revision to the LCD

The local coverage determination (LCD) for computed tomography of the abdomen and pelvis was last revised on January 1, 2006. Since that time, the LCD has been revised to add an additional indication for computed tomography of the pelvis for follow-up metastasis (i.e., breast, lung cancer, etc.) in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective Dates

This revision is effective for services **provided on or after March 8, 2007.**

The full text for this LCD (L995) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AEPO: Epoetin alfa—Revision to the LCD and Coding Guidelines

The local coverage determination (LCD) for epoetin alfa was last updated on January 1, 2007. Since that time the LCD has been revised. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add diagnosis codes 238.71(essential thrombocythemia) and 238.76 (myelofibrosis with myeloid metaplasia) as medically necessary for HCPCS code J0885. The coding guideline was revised accordingly.

Effective Date

This revision to the LCD is effective for services **provided on or after March 8, 2007.**

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

AJ9000: Antineoplastic Drugs—Addition to the LCD

The local coverage determination (LCD) for antineoplastic drugs was last updated on January 25, 2007. Since that time, a revision was made to add an additional off-label indication for alemtuzumab (Campath®) – J9010, based on *The United States Pharmacopeia Drug Information (USP DI).*

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the following off-label indication was added to alemtuzumab (J9010):

- First-line monotherapy for the treatment of progressive, B-cell chronic lymphocytic leukemia.

In addition to the above, references were updated under the "Sources of Information and Basis for Decision" section of the LCD.

Effective Dates

This revision is effective for services provided **on or after February 8, 2007**.

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

ANESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—Revision to the LCD and Coding Guidelines

The local coverage determination (LCD) for darbepoetin alfa (Aranesp) (novel erythropoiesis stimulating protein [NESP]) was last updated on October 1, 2006. Since that time the LCD has been revised. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add diagnosis codes 238.71(essential thrombocythemia) and 238.76 (myelofibrosis with myeloid metaplasia) as medically necessary for HCPCS code J0881. The coding guideline was revised accordingly.

Effective Date

This revision to the LCD is effective for services **provided on or after March 8, 2007.**

The full text for this LCD (L13796) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ANESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—Revision to the LCD

The local coverage determination (LCD) for darbepoetin alfa (Aranesp) (novel erythropoiesis stimulating protein [NESP]) was last updated March 8, 2007. Since that time, the FDA (U.S. Food and Drug Administration) notified health care professionals of new safety information for erythropoiesis-stimulating agents (ESAs) Aranesp (darbepoetin alfa), Epogen® (epoetin alfa), and Procrit® (epoetin alfa), drugs used to treat certain causes of anemia. Four new studies in patients with cancer found a higher chance of serious and life-threatening side effects or death with the use of ESAs. These research studies were evaluating an unapproved dosing regimen, a patient population for which ESAs are not approved, or a new unapproved ESA. In another study, patients scheduled for orthopedic surgery had a higher rate of deep venous thrombosis when treated with ESA at the approved dose. This new information is consistent with risks found in two clinical studies in patients with chronic renal failure treated with an unapproved regimen of an ESA that were reported in November 2006.

The Agency will present this new information to the Oncologic Drugs Advisory Committee on May 10, 2007. The FDA will seek advice on the need for additional labeling changes and/or additional studies to further assess safety.

Medicare covers all labeled (FDA-approved) indications for the drugs, though issues of dose and endpoints have been raised by the recent studies. Also, First Coast Service Options, Inc. (FCSO) as well as other Medicare contractors allow off-label (non FDA-approved) drug coverage based on the local coverage determination process that includes review of the evidence based medical literature and input from practicing physicians. ESAs currently have coverage for off-label indications such as the anemia of cancer not due to concurrent chemotherapy for Medicare patients in Florida. Given the preliminary data and warning released by the manufacturer to health care professionals and now the FDA notification, FCSO has evaluated all off-label coverage of darbepoetin alfa (Aranesp) and will be removing coverage for anemia of malignancy **not** due to concurrent chemotherapy for Medicare patients in Florida.

With this decision, the LCD for Aranesp (darbepoetin alfa), will be revised in several ways:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD:
  - Removed the indication for anemia of malignancy not due to concurrent chemotherapy.
  - Revised the FDA-approved covered indications to read exactly per the FDA-approved label.
  - Under general indications and limitations, removed recommended dosing for anemia associated with malignancy not due to concurrent chemotherapy.
- Under the "Utilization Guidelines" section of the LCD:
  - Added a statement about endpoints for administering Aranesp for anemia associated with concurrent chemotherapy and added language from the FDA-approved label regarding the safety and effectiveness of Aranesp.
- Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD for HCPCS code J0881:
  - Removed ICD-9-CM codes 205.00-205.91, 206.00-206.91 and 207.00-208.91 as these ICD-9-CM codes are no longer supported as medically necessary.
  - Added a dual diagnosis requirement for the following ICD-9-CM codes:

140.0-149.9	150.0-159.9	160.0-165.9
170.0-176.9	179-189.9	190.0-199.1
200.00-200.88	201.00-201.98	202.00-202.98
203.00-203.81	204.00-204.91	230.0-234.9
235.0-235.9	236.0-236.99	237.0-237.9
238.0	238.1	238.2
238.3	238.4	238.5
238.6	238.8	238.9
239.0-239.9	995.20	995.29
V58.11		

One of the malignancy ICD-9-CM codes in the list above and one of the following ICD-9-CM: 995.20, 995.29 and V58.11 must be billed when Aranesp is given for anemia of malignancy related to concomitantly administered chemotherapy. ICD-9-CM V58.11 would be billed with a malignancy code if the patient is currently receiving chemotherapy treatment. ICD-9-CM 995.20 or 995.29 would be billed with one of the malignancy codes if the patient has received chemotherapy treatment and it has been no more than 120 days since the last chemotherapy treatment.

FCSO is making these revisions in accordance with the Program Integrity Manual, Pub 100-08, Chapter 13, Section 13.7.3, "being issued for compelling reasons."

CMS announced on March 14, 2007, the opening of a national coverage analysis (NCA) on the use of ESAs for the condition other than end-stage renal disease (ESRD). This is the first step toward issuing a national coverage determination (NCD). Information on this national coverage analysis may be found at *http://www.cms.hhs.gov/mcd/viewtrackingsheet.asp?id=203*.

FCSO is continuing to evaluate all off-label coverage of darbepoetin alfa (Aranesp) and epoetin alfa (Epogen, Procrit). FCSO will communicate to physicians and allied providers if and when such off-label indications are removed from the local coverage determinations.

Effective Date

These revisions to the LCD are effective for services **provided on or after April 19, 2007.**

The full text for this LCD (L13796) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ADDITIONAL MEDICAL INFORMATION

Screening and Noncovered Services

Medicare does not cover items and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

Section 1862 (a) (1) of the Social Security Act is the basis for denying payment for types of care, or specific items, services, or procedures that are not excluded by any other statutory clause and meet all technical requirements for coverage, but are determined to be any of the following:

Medicare never pays for the following services. There is no Medicare fee schedule amount associated with a noncovered procedure. Therefore, the provider may charge the patient what is appropriate without having the patient sign a waiver, also called an advance beneficiary notice (ABN). These services include, but are not limited to:

- Routine (annual or otherwise) physicals*****
- Screening tests with no symptoms or documented conditions*****
- Personal comfort or convenience items
- Cosmetic surgery
- Custodial care
- Routine foot care
- Prophylactic dental care
- Exams for purposes of prescribing a hearing aid or eyeglasses; and/or
- Care provided in facilities located outside of the United States, Puerto Rico, Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Services "related to" noncovered services, including services related to follow-up care and complications of noncovered services, which require treatment during a hospital stay in which the noncovered service was performed, are also not covered under Medicare. For example, a routine physical exam is not covered under Medicare, therefore all lab tests and other services related to the routine physical exam are also not covered under Medicare.

*****Medicare allows specific routine screening tests. These services may be viewed at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*. ❖

Sign up to our *eNews* electronic mailing list

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

CRITICAL ACCESS HOSPITAL SERVICES

April 2007 Non-Outpatient Prospective Payment System Outpatient Code Editor

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

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs] and Part A/B Medicare administrative contractors [A/B MACs] for outpatient services rendered to Medicare beneficiaries, where those services are not paid under the outpatient prospective payment system (OPPS).

Provider Action Needed

This article is based on change request (CR) 5523, which informs FIs that the April 2007 non-outpatient prospective payment system (non-OPPS) outpatient code editor (OCE) specifications, version 22.2, have been updated to ensure correct billing and payment of claims. Be sure your billing staff is aware of the code changes in CR 5523.

Background

The non-OPPS OCE has been updated with numerous new additions, changes, and deletions to Healthcare Common Procedure Coding System/*Current Procedural Terminology* (HCPCS/*CPT*) codes. Rather than duplicate all the additions, deletions and changes in this article, the Centers for Medicare & Medicaid Services (CMS) directs you to CR 5523, which contains the lengthy lists of these items. CR 5523 is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1199CP.pdf*.

Providers may want to be aware that the new version of the non-OPPS OCE with updated HCPCS/*CPT* codes listed in CR 5523 is effective April 1, 2007, but they need to look at the specific HCPCS/*CPT* code changes that are, in some instances, effective earlier than April 1, 2007.

Additional Information

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

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

MLN Matters Number: MM5523
Related Change Request (CR) Number: 5523
Related CR Release Date: March 9, 2007
Related CR Transmittal Number: R1199CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1199, CR 5523

ESRD SERVICES

End-Stage Renal Disease Composite Payment Rates Update for 2007

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5535 which informs FIs and Part A/B MACs of the 2007 composite payment rates for end-stage renal disease (ESRD) facilities. Be sure billing staff are aware of these changes.

Background

The Social Security Act (Section 1881(b): *http://www.ssa.gov/OP_Home/ssact/title18/1881.htm*), as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA; Section 623; *http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf*), directed that revisions should be made to 1) the composite rate payment system, and 2) payment for separately billable drugs furnished by ESRD facilities.

For services furnished on or after January 1, 2006, (and before April 1, 2007), the current composite rate component of the basic case-mix adjusted system for dialysis services remains unchanged.

On December 20, 2006, the Tax Relief and Health Care Act (TRHCA) of 2006 was enacted, and the TRHCA increased the amount of the composite rate component of the basic case-mix adjusted system by 1.6 percent for services furnished **on or after April 1, 2007.**

Effective April 1, 2007, the base composite payment rates will be:

- Increased to $132.49 for independent ESRD facilities.
- Increased to $136.68 for hospital-based ESRD facilities.

The Centers for Medicare & Medicaid Services (CMS) also updated the wage adjusted composite rate table that reflects the metropolitan statistical area (MSA)-based ("old") wage data for purposes of calculating the blended wage-adjusted base payment rates for calendar year 2007, and this table is included as an attachment to CR 5535.

In addition, because the drug add-on adjustment is determined as a percentage of the composite rate, CMS adjusted the drug add-on adjustment to account for the 1.6 percent increase in the composite rate to ensure that the total dollars allocated from the drug add-on adjustment remains constant. Using the updated composite payment rates, the updated drug add-on adjustment is 14.3 percent, and the inflation adjustment of 0.5 percent is unchanged. **Therefore, the total drug add-on adjustment for services furnished on or after April 1, 2007 is 14.9 percent.**

In summary, no changes are made and the current composite rate remains in effect for services provided between January 1, 2007, and April 1, 2007. CR 5535 implements the following changes to be applied to the composite-rate payment for all Medicare certified ESRD facilities for services performed on or after April 1, 2007:

- The base composite rates will be adjusted to include an increase of 1.6 percent.
- The drug add-on factor is changed to 14.9 percent for services furnished on or after April 1, 2007.

Additional Information

The official instruction, CR 5535, issued to your FI and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R67BP.pdf*.

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

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

MLN Matters Number: MM5535
Related Change Request (CR) Number: 5535
Related CR Release Date: March 9, 2007
Related CR Transmittal Number: R67BP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-02, Transmittal 67, CR 5535

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

April 2007 Outpatient Prospective Payment System Outpatient Code Editor

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider Action Needed

This article is based on change request (CR) 5522, which informs the FIs and A/B MACs that the April 2007 OPPS outpatient code editor (OCE) specifications, version 8.1, have been updated with new additions, deletions, and changes. It provides the revised OPPS OCE instructions and specifications that will be utilized under the OPPS for hospital outpatient departments, community mental health centers (CMHCs), and limited services provided in a home health agency (HHA) not under the home health prospective payment system or to a hospice patient for the treatment of a non-terminal illness.

Background

Full details of version 8.1 of the OPPS OCE are contained in CR 5522 and will not be repeated in this article; especially since many of the details are not changing, and providers paid under the OPPS are likely to be familiar with these details. The modifications of the outpatient code editor/ambulatory patient classification (OCE/APC) for the April 2007 release (V8.1) are summarized in the following table:

	Mod. Type	Effective Date	Edit	
1.	Logic	January 1, 2007	71	Modify edit 71 to trigger only when a procedure is missing a required device(s) as previously. (Create a new edit for the reverse condition).
2.	Logic	January 1, 2007	77	New edit 77 – Claim lacks allowed procedure code (for coded device) (Return to Provider (RTP)) If a specified device is submitted on a claim without a code for an allowed procedure
3.	Content			Make HCPCS/APC/SI changes, as specified by CMS.
4.	Content		19,20, 39,40	Implement version **13.0** of the NCCI file, removing all code pairs that include anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911).
5.	Content	**April 1, 2005**	71	Update procedure/device edit requirements
6.	Doc	April 1, 2007	71	Modify description for edit 71: Claim lacks required device code
7.	Doc	April 1, 2007		UB-92 form locators for claim input values removed from tables #1 and #2
8.	Doc	April 1, 2007		All references to UB-92 changed to UB-04

You may also want to review the specifications in the official instruction (CR 5522) issued to your intermediary, and note the highlighted sections, which also indicate changes from the prior release of the software. Some OCE/APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date appears in the "Effective Date" column in the above table.

Additional Information

The official instruction, CR 5522, issued to your intermediary, RHHI, and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1198CP.pdf*.

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

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

MLN Matters Number: MM5522
Related Change Request (CR) Number: 5522
Related CR Release Date: March 9, 2007
Related CR Transmittal Number: R1198CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1198, CR 5522

April 2007 Update of the Hospital Outpatient Prospective Payment System

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

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for radiation therapy services provided to Medicare beneficiaries and paid under the hospital outpatient prospective payment system (OPPS).

Provider Action Needed

This article is based on change request (CR) 5544, which describes changes to, and billing instructions for, various payment policies implemented by the Centers for Medicare & Medicaid Services (CMS) in the April 2007 OPPS update.

Background

The April 2007 OPPS outpatient code editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) and modifiers, ambulatory payment classification (APC), and revenue code changes, additions, and deletions identified in CR 5544.

CR 5544 describes the following changes to, and billing instructions for, payment policies implemented in the April 2007 OPPS update.

Additional Payment Information for Current Pass-Through Category C1820

Section 1833(t)(6)(D)(ii) of the Social Security Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

For calendar year (CY) 2006, when creating new category C1820, (Generator, neurostimulator (implantable), with rechargeable battery and charging system), CMS determined that it could identify the portion of the APC payment amount associated with the cost of the historically utilized device, that is, the non-rechargeable neurostimulator generator implanted through procedures assigned to APC 222, Implantation of neurological device, which C1820 replaces in some cases. The device offset from the pass-through payment for C1820 represents the deduction from the pass-through payment for category C1820 that will be made when C1820 is billed with a service assigned to APC 222. In Transmittal 1139, CR 5438, issued December 22, 2006, CMS indicated that for CY 2007, the device-offset portion for C1820, when billed with a procedure in APC 0222, is $8,668.94.

CMS has recently been informed that at least some rechargeable neurostimulators described by C1820 may also be used and therefore be billed with *CPT* code *61885*, *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to single array*, and CMS has changed the procedure to device edits accordingly. This change is effective January 1, 2006, and is implemented in the April 2007 OPPS OCE.

CPT code *61885* maps to APC 0039, which has a CY 2007 offset percent of 78.85 percen (71 FR 68077). Based on this percent, the device offset to be subtracted from the payment for C1820, when it is billed with *CPT* code *61885*, is $9,081.94. Note that the offset amount from the APC payment is wage adjusted before it is subtracted from the device cost.

Payment for Certain Laboratory Services

Effective for services furnished on or after the date listed in the table below, the unlisted laboratory *CPT* codes are assigned to a status indicator of "A." The clinical lab fee schedule does not provide a payment amount for these unlisted laboratory codes, since the Medicare carrier prices them. Therefore, your FI must review the narrative description of the test submitted by the hospital to determine if a specific HCPCS code is available to describe the laboratory test. If a specific HCPCS code is available, this code should be reported by the hospital for the laboratory test, rather than an unlisted laboratory *CPT* code. If there is no appropriate specific code, the FI will contact the carrier in your jurisdiction to obtain an appropriate payment amount for services reported with these laboratory *CPT* codes. If that carrier cannot provide a payment amount for the services, then to obtain a payment rate, the FI must contact the carrier in the jurisdiction of the reference laboratory that performed the test. If neither carrier has a payment amount for the test and the FI determines that the service is covered, the FI will determine the payment amount. (Note that FIs will not search their files for to adjust previously processed claims, but will adjust claims affected by this issue if you bring those claims to your FI attention.) FIs will follow this same procedure to develop payment amounts for such laboratory tests when it is paying a non-OPPS claim for an unlisted laboratory *CPT* code.

Beneficiary coinsurance and deductible are not applied to unlisted clinical laboratory services.

***CPT* Code**	**Long Descriptor**	**Effective Date**
81099	*Unlisted urinalysis procedure*	August 1, 2000
84999	*Unlisted chemistry procedure*	August 1, 2000
85999	*Unlisted hematology and coagulation procedure*	August 1, 2000
86849	*Unlisted immunology procedure*	August 1, 2000
87999	*Unlisted microbiology procedure*	August 1, 2000

Clarification to Billing and Payment for Intensity Modulated Radiation Therapy Planning

Payment for services identified by the *CPT* codes in the following table is included in the APC payment for intensity modulated radiation therapy (IMRT) planning when these services are performed as part of developing an IMRT plan that is reported using *CPT* code *77301*:

***CPT* Code(s)**	**Descriptor(s)**
77280-77295	*Simulation for brachytherapy*
77305-77321	*Tele-therapy isodose plan*
77331	*Special dosimetry*
77336	*Continuing medical radiation physics consultation*
77370	*Special medical radiation physics consultation*

April 2007 Update of the Hospital Outpatient Prospective Payment System (continued)

When these services are performed as part of developing an IMRT plan, these *CPT* codes should **not be billed** in addition to *CPT* code *77301* for IMRT planning.

However, payment for IMRT planning does not include payment for services described by the following *CPT* codes:

***77332 – 77334** Treatment devices, designs and construction*

When provided, the services identified by *CPT* codes *77332-77334* should be billed in addition to the IMRT planning code (CPT code *77301*).

Clarification to Payment Policy for *CPT* Code *77435*
(Stereotactic Body Radiation Therapy, Treatment Management, per Treatment Course, to One or More Lesions Including Image Guidance, Entire Course not to Exceed Five Fractions)

CR 5544 clarifies payment policy for stereotactic radiosurgery (SRS) service described by *CPT* code *77435*. In CR 5438, issued December 22, 2006, CMS inadvertently listed *CPT 77435* with status indicator of "B." However, the January 2007 update of the OPPS Addendum B posted on the CMS website and the January 2007 OPPS OCE contained the correct status indicator of "N."

Payment Status Indicators for "Special" Packaged *CPT* Codes *36540, Collection of Blood Specimen from a Completely Implantable Venous Access Device*; and *CPT* Codes *96523, Irrigation of Implanted Venous Access Device for Drug Delivery System*

"Special" packaged *CPT* code *36540* and *CPT* code *96523* were erroneously listed with status indicator "S" in CR 5438, issued on December 22, 2006, and in the calendar year 2007 OPPS final rule. Although this error does not affect payment rates for the services described by these *CPT* codes, CMS is clarifying that the correct status indicator assigned by the OCE for separate payment is "X," as assigned to APC 624, minor vascular access device procedures, in the January 2007 OPPS update of Addendum A.

Billing for Drugs Biologicals, and Radiopharmaceuticals

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

Drugs and Biologicals with Payments Based on Average Sales Price, Effective April 1, 2007

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

Updated Payment Rates for Certain Drugs and Biologicals Effective July 1, 2006, through September 30, 2006

The payment rates for the drugs and biologicals listed below were incorrect in the January 2007 OPPS PRICER. The corrected payment rates will be installed in the April 2007 OPPS PRICER effective for services furnished on July 1, 2006, through September 30, 2006.

CPT/HCPCS Codes	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	$118.29	$23.66
J2430	0730	Pamidronate disodium /30 MG	$36.17	$7.23
J7340	1632	Metabolic active D/E tissue	$25.66	$5.13
J7344	9156	Nonmetabolic active tissue	$93.06	$18.61
J9015	0807	Aldesleukin/single use vial	$723.38	$144.68

Updated Payment Rates for Certain Drugs and Biologicals Effective October 1, 2006, through December 31, 2006

The payment rates for the drugs and biologicals listed below were incorrect in the January 2007 OPPS PRICER. The corrected payment rates will be installed in the April 2007 OPPS PRICER effective for services furnished on October 1, 2006, through December 31, 2006.

CPT/HCPCS Codes	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	$113.27	$22.65
J2430	0730	Pamidronate disodium /30 MG	$35.46	$7.09
J7340	1632	Metabolic active D/E tissue	$21.37	$4.27
J7344	9156	Nonmetabolic active tissue	$89.31	$17.86
90716	9142	Chicken pox vaccine, sc	$72.28	$14.46
J0637	9019	Caspofungin acetate	$32.22	$6.44
J9265	0863	Paclitaxel injection	$15.11	$3.02

April 2007 Update of the Hospital Outpatient Prospective Payment System (continued)

Correct Reporting of Units for Drugs

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

The full descriptors for the Level II HCPCS codes can be found in the latest code books or from the latest Level II HCPCS file, which is available for downloading from the CMS website at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage*.

Providers are reminded to check HCPCS descriptors for any changes to the units per HCPCS when HCPCS definitions or codes are changed.

Modification of Blood Deductible Edits

CMS notified Medicare contractors (FI, MAC, or RHHI) on January 26, 2007, that blood deductible is acceptable for ALL 38x revenue codes, instead of only **revenue codes 380-382.**

Changes to Device Edits in the April 2007 OCE

CMS has made the following changes to the device edits in the April 2007 OCE. Providers who have claims that were returned for failure to pass the device edits that were in place before April 1, 2007, should review the changes to determine if the claims will now pass the edits. If the provider believes that the changes made in the April 2007 OCE enable the claims to satisfy (and thus pass) the edits, the provider should submit the claims for payment.

Device to Procedure Edit Changes Being Implemented in the April 2007 OCE; Effective for Services Furnished on or After January 1, 2007

C1820 (Generator, neuro rechg bat sys) is now allowed with 61885 (Insrt/redo neurostim 1 array)

C1898 (Lead, pmkr, other than trans) is now allowed with G0300 (Insert reposit lead dual+gen)

C1779 (Lead, pmkr, transvenous VDD) is now allowed with G0300 (Insert reposit lead dual+gen)

Procedure to Device Edit Changes Being Implemented in the April 2007 OCE with Effective Dates as Shown:

93651 *(Ablate heart dysrhythm focus) is now allowed with C2630 (Cath EP, Cool tip)*; effective 1/1/07

33206 *(Insertion of heart pacemaker) is now allowed with C2621 (Pmkr, single, non rate-resp)*; effective 10/01/05

33212 *(Insertion of pulse generator) is now allowed with C2621 (Pmkr, single, non rate-resp)*; effective 04/01/05

61885 *(Insrt/redo neurostim 1 array)* is now allowed with C1820 (Generator, neuro rechg bat sys); effective 1/01/06

Coverage Determinations

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

Additional Information

The official instruction, CR 5544, issued to your Medicare FI, RHHI, and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1209CP.pdf*.

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

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

MLN Matters Number: MM5544
Related Change Request (CR) Number: 5544
Related CR Release Date: March 21, 2007
Related CR Transmittal Number: R1209CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1209, CR 5544

FRAUD AND ABUSE

Medicare Finds Billions in Savings to Taxpayers

New Contractors To Help Identify Fraud, Waste and Abuse

Through more aggressive local oversight and specially targeted fraud and abuse initiatives, the Centers for Medicare & Medicaid Services (CMS) has saved more than $2 billion in Medicare claims in special projects focusing on infusion therapy and those services provided by independent diagnostic testing facilities (IDTFs). CMS has made more than 980 Medicare fee-for-service (FFS) program referrals to law enforcement authorities since October 2004.

In addition, CMS is continuing its aggressive local efforts in FFS oversight and helping to identify and combat fraud in the new Medicare prescription drug benefit with the addition of four new Medicare drug integrity contractors (MEDICs).

"CMS is using every tool available to find and fight waste, fraud and abuse across Medicare and Medicaid, to help ensure that drug benefit dollars are spent appropriately," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "Our fraud and abuse prevention programs are already working to save money, and today's actions will provide even more protections for beneficiaries and taxpayers."

In 2006, CMS expanded its satellite offices in Miami and Los Angeles, providing additional on-the-ground efforts to identify and report fraud, waste and abuse in Medicare. In Los Angeles, Medicare has:

- Revoked the billing numbers of 117 Medicare providers who submitted false claims or invalid business operations, generating a savings of approximately $200 million.
- Implemented claim processing edits that prevent the payment of claims submitted with a deceased provider's identification number, resulting in savings of more than $4 million.
- Implemented plans that have denied approximately $163 million in charges for IDTFs, revoked the billing privileges of 83 IDTFs and denied $445 million in claims for beneficiary Sharing or "Capping."
- Denied the enrollment of highly suspicious providers in Medicare, resulting in the prevention of potentially inappropriate payments of more than $10 million.

In the Miami office, CMS is:

- Working with the Governor's office, federal and state law enforcement officials, state health and licensure agencies, the Medicare carrier and payment safeguard contractors, CMS is participating in the Florida Infusion Fraud Federal/State Task Force. Through the use of administrative actions, auto denial and medical record reviews, site visits, data analysis and complaint investigations, the initiative has saved more than $1 billion and resulted in the suspension of 104 payment claims submitted by more than 300 providers. Approximately 400 new investigations have resulted from this effort.
- Using a variety of prepayment edits that have contributed to the Medicare savings (Medically unbelievable service edits – $200+ million; high claim volume infusion beneficiary edits – $400+ million; service-specific edits – $200+ million). In addition, the U.S. Department of Justice opened 63 criminal and 38 civil Medicare fraud cases since October 2005. The Agency for Health Care Administration has suspended or revoked 11 clinic licenses and the Department of Health revoked the licenses of five practitioners involved in criminal activity associated with these clinics. CMS and the State are also pursuing legislative and regulatory changes to address programmatic vulnerabilities.
- Leading an identity theft initiative in South Florida involving 2,500 Medicare beneficiaries whose Medicare numbers have been compromised or who are participating in fraud. Through the use of prepayment edits, more than $600 million has been saved.
- Revoking the provider numbers of more than 500 durable medical equipment suppliers, resulting in a drop in Medicare billing from $93 million in 2004 to $16 million in 2005 and in Medicare payment from $74 million to $13 million in that same timeframe.

By using the Medicare integrity contractors, CMS is able to use new and innovative techniques to monitor and analyze data to help identify fraud; work with law enforcement, prescription drug plans, consumer groups and other key partners to protect consumers and enforce Medicare's rules; and provide basic tips for consumers so they can protect themselves from potential scams. The three new regional MEDICs are:

- Science Applications International Corporation in the West
- Electronic Data Systems (EDS) in the North and Northeast
- Health Integrity (the current MEDIC serving the entire country, which will now cover) the Southeast only.

In addition to the three regional MEDIC contractors, CMS awarded a fourth MEDIC contract entitled the "One Program Integrity System Integrator" (One PI) to EDS. EDS is tasked with assisting CMS in the development of a centralized data approach for program integrity activities. The One PI MEDIC will assist CMS by:

- Providing data analysis tools necessary for CMS, the three regional MEDICs and other CMS contractors to detect potential fraud, waste and abuse in Medicare and Medicaid programs.

Medicare Finds Billions in Savings to Taxpayers (continued)

- Using data analysis methods to uncover potential fraud, waste and abuse on a national level.
- Identifying duplicate payments for Medicare Part B and Part D medications.
- Assisting CMS, the three regional MEDICs and other CMS contractors with the fulfillment of data requests from law enforcement and other entities.

The work of the new MEDICs will add to the range of steps already in place to prevent fraud and abuse in the Medicare prescription drug benefit. MEDICs are already responding to and investigating beneficiary complaints; looking proactively at claims and enrollment data to identify suspicious activities; and conducting education and outreach activities to plans, law enforcement, and other agencies. More specifically, with the support of the MEDICs, CMS has:

- Referred to HHS Office of the Inspector General (OIG) and the Federal Bureau of Investigation the $299 ring, a scam where beneficiaries are offered a "Medicare sponsored prescription drug plan" in exchange for an initial "payment" of $299 or up to $379. In some instances, the callers have prior access to the beneficiary's personal data such as Medicare related numbers or social security numbers. CMS and local partners, including state attorneys general and insurance commissioners, worked to increase awareness of these scams, resulting in nearly 300 complaints and a significant reduction in the number of potential victims to the scam.
- Identified and referred cases to the OIG where beneficiaries may have been enrolled in plans against their will.
- Identified and referred potential cases of drug diversion to the OIG.

"Vigilance in protecting beneficiaries and taxpayers from waste, fraud and abuse is one of our top priorities in Medicare," said Dr. McClellan. ❖

Medicare Continues To Reduce Improper Claim Payments

The Centers for Medicare & Medicaid Services (CMS) Administrator, Mark B. McClellan, M.D., Ph.D., announced on October 12, 2006, that aggressive oversight and improvement efforts have resulted in a further reduction of the number of improper Medicare claims payments from 5.2 percent in 2005 to 4.4 percent in 2006; a $1.3 billion reduction in improper payments.

"We have been increasing our efforts to reduce improper Medicare claim payments, and for the second year in a row, it's paying off," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "Because we are able to measure the accuracy of payments more closely now, we are able to target our efforts more effectively with Medicare contractors and providers."

The Medicare fee-for-service (FFS) error rate has declined from 14.2 percent in 1996, when the Medicare improper payment rate was first reported, to the current 4.4 percent in 2006. The recent error rate reductions have led to approximately $11 billion less in improper payments over the past two years. CMS pays more than one billion FFS claims each year.

CMS conducted detailed reviews of randomly sampled Medicare FFS claims submitted between April 1, 2005, and March 31, 2006. Approximately 160,000 claims spanning all types of Medicare FFS payments were included in the Medicare error rate-testing program. By providing accurate statistical information to its personnel and contractors, CMS can identify where problems exist and target improvement efforts to address the problems.

This effort reflects the agency's increased commitment to use more detailed data and analysis to identify and eliminate improper payments. CMS has worked with the contractors to apply the data collected to improve system edits, update coverage policies, and direct provider education efforts. In addition, CMS has developed national and state-specific models for predicting inpatient-hospital payment errors to study the areas prone to payment error.

CMS reports its Medicare FFS improper payment findings in an annual report released every November. The complete report will contains additional error rate information along with more specific improper payment estimates. Once completed, the report will be released to the public via the CMS website at *http://www.cms.hhs.gov/cert/01_overview.asp?*. ❖

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

May 2007 – July 2007

Ask the Contractor (Topics To Be Determined)

When: **Tuesday, May 8, 2007**

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

Type of Event: **Teleconference**

2007 Medifest Symposium (Medicare Part A and B)

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

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

Type of Event: **Educational Seminar**

Hot Topics (Topics To Be Determined)

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

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

Type of Event: **Teleconference**

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

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

What Is a Webcast?

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

Online Registration

To participate in the above educational events, access *http://www.floridamedicare.com*. Select "Calendar" or "Event List" on the left navigation menu. Providers with Internet barriers may complete and fax this form to 1-904-791-6035.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Provider Address: _____

City, State, ZIP Code: _____

Medifest Class Schedule
May 15-17, 2007

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

Registrant's Name: _____

May 15 – 16, 2007
Marriott Tampa Westshore
1001 N. Westshore Blvd.
Tampa, FL 33607
Please contact hotel for directions and/or reservations (813) 287-2555

PLEASE MARK ONLY ONE CLASS PER TIME SLOT
Cost $233.00

Day 1

General Session 8:00 am to 8:30 am

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

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

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

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

Day 2

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

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

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

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

Day 3
May 17, 2007
Cost $149.00

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

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

A CMS Contracted Intermediary & Carrier

MEDIFEST 2007, Tampa Registration Form

Marriott Tampa Westshore
1001 N. Westshore Blvd.
Tampa, FL 33607
Please contact hotel for directions and/or reservations (813) 287-2555

Registrant's Name _____

Telephone Number _____

Email Address _____

Fax Number _____

Provider's Name _____

Street Address _____

City, State, ZIP Code _____

Cost for Medifest	
Medifest (Day 1 & 2)	$233.00
Medifest Specialty (Day 3)	$149.00

FAXED REGISTRATION	CANCELLATIONS AND REFUNDS	SUBSTITUTIONS	CONFIRMATION NOTICE	HOTEL INFORMATION
1. Fax registration form to **(904) 791-6035.** 2. A confirmation will be faxed to you. The invoice will be send under a separate cover. 3. Make checks payable to: **FCSO Account #700390** 4. Mail the forms (after you have faxed them) and payment to: **Medifest Registration P.O. Box 45157 Jacksonville, FL 32231** 5. Bring your Medifest confirmation notice to the event.	All cancellation requests must be received 7 days prior to the event. All refunds are subject to a $25.00 cancellation fee per person. (Rain checks will not be issued for cancellations.)	If you are unable to attend, your company may send one substitute to take your place for the entire seminar. Remember: You must inform the Registration Office of all changes. Once you have signed in at the registration desk, substitutions will not be permitted during the remainder of the event.	**On-line registration:** When registering on-line for an education event, you will automatically receive your confirmation via e-mail notification. **Faxed registration**: A confirmation notice will be faxed or e-mailed to you within 7 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Provider Outreach and Education), please contact us at **(904) 791-8103.**	Marriott Tampa Westshore 1001 N. Westshore Blvd. Tampa, FL 33607 (813) 287-2555 Ask for FCSO's Special Room Rate.

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

PREVENTIVE SERVICES

March is National Nutrition Month®

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of nutrition, healthful eating and the medical nutrition therapy (MNT) benefit covered by Medicare. Approximately 8.6 million Americans (source: The United States Renal Data System and National Diabetes Information clearinghouse; *http://diabetes.niddk.nih.gov/dm/pubs/statistics*) at least 60 years or older are diagnosed with diabetes or acute renal failure. MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

Medicare Coverage

Medicare provides coverage of MNT for beneficiaries diagnosed with diabetes or renal disease (except for those receiving dialysis) when provided by a registered dietitian or nutrition professional who meets the provider qualifications requirement, or a "grandfathered" dietitian or nutritionist who was licensed or certified as of December 21, 2000. A referral by the beneficiary's treating physician indicating a diagnosis of diabetes or renal disease is required.

Medicare provides coverage for three hours of MNT in the first year and two hours in subsequent years.

What Can You Do?

As a trusted source of health care information, your patients rely on their physician's or other health care professional's recommendations. CMS requests your help to ensure that all eligible people with Medicare take full advantage of the medical nutrition therapy benefit. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT and encourage them to make an appointment with a registered dietitian or nutrition professional qualified to provide MNT services covered by Medicare.

For More Information

For more information about Medicare's coverage of MNT services, visit the CMS website *http://www.cms.hhs.gov/MedicalNutritionTherapy/*.

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

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

For information to share with your Medicare patients, visit *http://www.medicare.gov* on the Web.

For more information about National Nutrition Month®, please visit *http://www.eatright.org*. ❖

Source: CMS Provider Education Resource 200703-01

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

One-time Ultrasound Screening for Abdominal Aortic Aneurysms

New in 2007 – Medicare Now Provides Coverage for a One-time Ultrasound Screening for Abdominal Aortic Aneurysms as Part of the Initial Preventive Physical Examination

The Centers for Medicare & Medicaid Services (CMS) invites you to join with us in promoting awareness of abdominal aortic aneurysms (AAA) and the new screening benefit for the early detection of this disease.

Three in four aortic aneurysms are AAAs. Aortic aneurysms account for about 15,000 deaths in the United States annually; of these 9,000 are AAA-related. Men are five to ten times more likely than women to have an AAA and the risk increases with age. Although AAAs may be asymptomatic for years, as many as one in three eventually rupture if left untreated [i] [ii] [iii]. Early diagnosis allows for more effective treatment and cure.

Diagnosis of an AAA can be done painlessly with a simple ultrasound scan. Medicare now provides coverage for this screening service for eligible beneficiaries.

Medicare Coverage

Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime). Eligible beneficiaries must receive a referral for the screening as a result of their initial preventive physical examination (IPPE) also referred to as the welcome to Medicare physical exam. There is no Part B deductible. The coinsurance/copayment applies.

Note: Only Medicare beneficiaries who receive a referral for the AAA ultrasound screening as part of the welcome to Medicare physical exam will be covered for the AAA benefit.

One-time Ultrasound Screening for Abdominal Aortic Aneurysms (continued)

How Can You Help?

As a trusted source, your recommendation is the most important factor in increasing the use of preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their welcome to Medicare physical exam within the first six months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the ultrasound screening as part of their welcome to Medicare physical exam. It could save their lives!

For More Information

For more information about Medicare coverage of the AAA benefit, refer to *MLN Matters* article MM5235 (2006), "Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination" located on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf*.

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

The MLN Preventive Services Educational Products Web page provides descriptions and ordering information for all provider specific educational products related to preventive services.

The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

For information to share with your Medicare patients, visit on the Web *http://www.medicare.gov*.

For more information about AAA, please visit on the Web http://www.nhlbi.nih.gov/health/dci/Diseases/arm/arm_what.html.

Thank you for helping CMS to increase awareness of AAA disease and the new AAA preventive benefit. ❖

Source: CMS Provider Education Resource 200703-07

i[i] National Heart Lung and Blood Institute Diseases and Conditions Index
http://www.nhlbi.nih.gov/health/dci/Diseases/arm/arm_what.html

ii[ii] U.S. Preventive Services Task Force *Screening for Abdominal Aortic Aneurysm: A Best Evidence Systematic Review*
http://www.ahrq.gov/clinic/uspstf05/aaascr/aaarev.htm

March is National Colorectal Cancer Awareness Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare. Colorectal cancer is largely preventable through screening, which can find colon growths called polyps that can be removed before they turn into cancer. Screening can also detect cancer early when it is easier to treat and cure.

Screening for colorectal cancer is recommended for all adults ages 50 and older, although screening may start at younger ages for individuals who are at high risk for colon cancer. The frequency of screening is based on an individual's risk for colorectal cancer and the type of screening test that is used.

An individual is considered to be at high risk for colorectal cancer if he or she has had colorectal cancer before or has a history of polyps, has a family member who has had colorectal cancer or a history of polyps, or has a personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

In addition, risk for colorectal cancer increases with age. It is important to encourage patients who were screened before entering Medicare to continue with screening at clinically appropriate intervals.

Medicare Covers Screening Tests

Medicare covers the following screening tests to detect colorectal cancer early, when it is most treatable, and to identify people at high risk for developing this type of cancer:

- Fecal occult blood test (FOBT)—Medicare covers both guaiac and immunoassay tests, but Medicare will only pay for **one** FOBT **each year.**
- Colonoscopy—Medicare covers every **ten** years for normal risk; more frequently for high-risk persons.
- Sigmoidoscopy—Medicare covers every **four** years.
- Barium enema—Medicare covers every **four** years for normal risk; every **two** years for high risk.

For specific details on Medicare coverage criteria and billing procedures for colorectal cancer screening services, refer to special edition *MLN Matters* article SE0710 available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf*.

New Coverage Information for 2007

Starting in January 2007, Medicare waived the requirement that beneficiaries meet the deductible for **screening** colonoscopy, sigmoidoscopy, or barium enema (as an alternative to colonoscopy or sigmoidoscopy). In addition, the coinsurance for colonoscopy and sigmoidoscopy is now 25 percent when performed in ambulatory surgical centers and non-outpatient prospective payment system hospital outpatient departments.

For specific details about these changes, click on the following links:

- *MLN Matters* article MM5387 (coinsurance changes) *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf*.

March is National Colorectal Cancer Awareness Month (continued)

- *MLN Matters* article MM5127 (deductible change) *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf*.

CMS Needs Your Help

CMS needs your help to get the word out to your Medicare patients and their caregivers about the benefits of colorectal cancer screening. We hope that you will encourage your eligible Medicare patients to take advantage of this potentially life saving benefit.

For information and resources to help you discuss colorectal cancer screening with your patients, visit the following American Cancer Society website: *http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp*.

Thank you for supporting CMS effort to increase awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives. ❖

Source: CMS Provider Education Resource 200703-12

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

Colorectal Cancer Awareness Month

Are You and Your Staff Ready?

March is National Colorectal Cancer Awareness Month. Is your practice or office organized to make sure that your patients are screened for colorectal cancer and get the appropriate follow-up? Several resources are available to help practitioners and their office staff to improve their practices – including delivery of colorectal cancer screening, referrals for screening, care transitions, and follow-up.

The American Cancer Society and the National Colorectal Cancer Roundtable developed a guide titled, ***What You Should Know about Screening for Colorectal Cancer: A Primary Care Clinician's Evidence-Based Toolbox and Guide***. The guide is designed to help clinicians improve office practices to support colorectal cancer screening. This resource is available at the following link:

http://www.cancer.org/docroot/PRO/content/PRO_4_1x_ColonMD_Clinicians_Manual.pdf.asp?utm_source=CMSlistserves&utm_medium=email&utm_term=Colon&utm_content=ColonMD%2Bmanual.

The American Cancer Society has developed materials to help support practitioners in discussing colorectal cancer screening with their patients. These resources include reminder letters, phone reminder scripts, brochures, and wall charts, and are available for downloading or ordering at the following link:

http://www.cancer.org/docroot/PRO/PRO_4_2_ColonMD_Educating_Patients.asp?utm_source=CMSlistserve&utm_medium=email&utm_term=colon&utm_content=ColonMDeducatingP.

For specific details on Medicare coverage criteria and billing procedures for colorectal cancer screening services, refer to special edition *MLN Matters* article SE0710 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf*.

Thank you for supporting CMS effort to increase awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives. ❖

Source: CMS Provider Education Resource 200703-17

OTHER EDUCATIONAL RESOURCES

The Medicare Guide to Rural Health Service Information now Available

The *Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians* (Second Edition) which contains rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005 is now available in downloadable format on the Centers for Medicare & Medicaid Services *Medicare Learning Network* publication page located at *http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf*. ❖

Source: CMS Provider Education Resource 200703-09

Revised Physician Quality Reporting Initiative Presentation—Module One

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a revised version of the 2007 Physician Quality Reporting Initiative (PQRI) module one PowerPoint® presentation has been posted to the CMS website. Updates have been made to the presentation and speaker's notes have been added to assist in the explanation and understanding of the training module.

To access the presentation, visit *http://www.cms.hhs.gov/PQRI* on the CMS website and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the "Downloads" section and click on the "Physician Quality Reporting Initiative PowerPoint Module One" link.

We would also like to remind you that frequently asked questions (FAQ) about the PQRI are now available on the CMS website. As new FAQs are added regularly, you may want to check this site often.

You can access these FAQs by visiting the PQRI Web page at, *http://www.cms.hhs.gov/PQRI*, on the CMS website. Once on the Overview page, scroll down to the "Related Links Inside CMS" section and click on the "Frequently Asked Question" link. ❖

Source: CMS Provider Education Resource 200703-15

Sign up to our *eNews* electronic mailing list

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

ORDER FORM - PART A MATERIALS

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

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
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***NOTE:** The Medicare A Bulletin is available **free of charge** online at **www.floridamedicare.com**.*

IMPORTANT ADDRESSES, TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

PROVIDER EDUCATION

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

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION

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

OVERPAYMENT COLLECTIONS

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

MEDICARE REGISTRATION

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

Telephone Numbers

PROVIDERS

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

BENEFICIARY

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

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Websites

PROVIDERS

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

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

RAILROAD MEDICARE

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

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

MEDICARE A BULLETIN

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

* ATTENTION BILLING MANAGER *