Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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

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

Routing Suggestions:

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

CMS Centers for Medicare & Medicaid Services

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

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

Sign up to our *eNews* electronic mailing list

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

General Information

Change in the Amount in Controversy Requirement for Federal District Court Appeals

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) 5518, which notifies Medicare contractors of an increase in the amount in controversy required to sustain federal district court appeal rights beginning January 1, 2007.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an administrative law judge (ALJ) hearing or federal district court review. Therefore, **CR 5518 updates the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 29, Sections 330.1 and 345.1) to announce the amount in controversy requirements for ALJ or federal district court appeals during 2007.**

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2006 was $100. The amount in controversy requirement increased to $110 for requests made on or after January 1, 2006. **CR 5518 announces that for ALJ hearing requests made on or after January 1, 2007, the amount that must remain in controversy did not change and remains at $110.**

The amount remaining in controversy requirement for federal district court review prior to January 1, 2006, was $1,000. That amount increased to $1,090 on or after January 1, 2006.

CR 5518 announces that for federal district court review requests made on or after January 1, 2007, the amount that must remain in controversy is increased to $1,130.

Additional Information

The official instruction, CR 5518, 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/R1211CP.pdf*.

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

MLN Matters Number: MM5518
Related Change Request (CR) Number: 5518
Related CR Release Date: March 30, 2007
Related CR Transmittal Number: R1211CP
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1211, CR 5518

The Implementation of the UB-04 Fact Sheet Is now Available

The *Implementation of the UB-04* fact sheet is now available in downloadable format from the *Medicare Learning Network* (*MLN*). This fact sheet reviews the new UB-04 paper claim form, which is only accepted from institutional providers excluded from the mandatory electronic claims submission. It includes background information, the transition period and a crosswalk.

To view, download, or print, select the title of the fact sheet on the *MLN* Publications Web page *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*. ❖

Source: CMS Provider Education Resource 200704-31

Emergency Update to the 2007 Medicare Physician Fee Schedule Database

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

Note: CMS revised this *MLN Matters* article on January 5, 2007, to correct two codes. HCPCS code G9358 should be G8358 and HCPCS code Q4095 should be Q4085. In addition, CMS revised this *MLN Matters* article on January 12, 2007, to reflect changes made to change request (CR) 5459. The CR release date, transmittal number and the Web address for accessing CR 5459 has been revised.
MLN Matters article MM5459 was previously published in the February 2007 *Medicare A Bulletin* (page 8-9).

Provider Types Affected

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

Background

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

Key Points

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

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

- The physician fee schedule status indicators for oncology demonstration HCPCS codes G9050 to G9062 for 2007 are "I"; these **codes are invalid** for Medicare use in 2007, thus, payment will not be made for these codes in 2007. (For more details on the oncology demonstration, see the *MLN Matters* article on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf*.)
- Oncology demonstration HCPCS codes G9076, G9081, G9082, G9118, G9119, G9120, G9121, G9122, and G9127 are **deleted and will not be paid for services provided after December 31, 2006 in 2007.**
- Active oncology demonstration codes in the range G9063 to G9139 have status indicators of "M" on the Medicare physician fee schedule database. (Note: See requirement above for discontinued oncology demonstration codes within this range). Those filing claims may report these codes for oncology disease status in 2007, but payment will not be made for these codes for services provided after December 31, 2006.
- Category II *CPT* codes *3047F* and *3076F* and category III *CPT* code *0152T* have been deleted for 2007.
- HCPCS G codes G0377 and G8348 through G8368 will be added to the 2007 HCPCS file.
- HCPCS Q codes Q4083, Q4084, Q4085, and Q4086 will be added, even though they are not on the 2007 HCPCS file. Note that corresponding average sale price (ASP) amounts will be reflected in updated 2007 ASP files to be posted to the CMS website.
- Incorrect diagnostic supervision indicators were assigned to some codes and these codes and correct indicators are listed in the attachment to CR 5459.
- Corrected multiple procedure codes of 0 and diagnostic family imaging indicators of 99 have been assigned to HCPCS codes G0389, G0389-TC, and *CPT* codes *70554*, *70554-TC*, *70555*, *70555-TC*, *76776*, and *76776-TC*.
- As identified in the attachment to CR 5459, correct work, practice expense, and/or malpractice relative value units (RVUs) have been assigned for *CPT* codes *44180*, *44186*, *73223*, *73223-26*, *76775*, *76775-TC*, *76775-26*, *93503*, *93539*, *93540*, *93541*, *93542*, *93543*, *93544*, *93545*, *95060*, *95065*, and HCPCS codes G0389, G0389-TC, and G0389-26.
- As a result of the Tax Relief and Health Care Act of 2006, effective January 1, 2007, HCPCS code G0377 (Administration of vaccine for Part D drug) is added to the MPFS with a status indicator of X. Payment for HCPCS code G0377 is linked to *CPT* code *90471* (just as payment is made for G0008, G0009, and G0010). For 2007 only, the legislation provides for Part B to pay for the administration of a covered Part D vaccine. When a physician administers a Part D vaccine, the physician should use HCPCS code G0377 to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to this administration. Payment for Part D covered vaccines is made solely by the participating prescription drug plan. Medicare will not pay for the vaccine itself.
- Effective January 1, 2007, the following HCPCS G codes are added to the MPFS database with a status indicator of M: G8348, G8349, G8350, G8351, G8352, G8353, G8354, G8355, G8356, G8357, G8358, G8359, G8360, G8361, G8362, G8363, G8364, G8365, G8366, G8367, and G8368.
- CMS has established separate payment for sodium hyaluronate products that have come on the market since October 2003. Four interim Q codes are in effect for these products as of January 1, 2007:

  Q4083 Hyalgan/supartz inj per dose
  Q4084 Synvisc inj per dose
  Q4085 Euflexxa inj per dose
  Q4086 Orthovisc inj per dose.

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

- Procedure status I is assigned to J7319, **effective January 1, 2007.**
- **Effective January 1, 2007,** the HCPCS codes Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, and Q9964 will be assigned to procedure status indicator E.
- As a courtesy to the public, CMS has established RVUs for a number of codes, even though the codes are either bundled or not valid for Medicare purposes. These *CPT* codes are *38204, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, and 38215*. The RVUs are listed for these codes in the attachment to CR 5459.

Additional Information

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

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

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

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

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

New Web Page Regarding Medicare Advantage and Part D Plans

The Centers for Medicare & Medicaid Services (CMS) announces the launch of a new section on the CMS website to house contract and enrollment data about Medicare Advantage (MA) and Part D plans. The new section may be found at: *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/*.

This section provides: a) a plan directory, and b) an MA claim processing contact directory. These directories contain basic information about the contract as well as contact information for the plan itself. CMS will update these directories on a monthly basis. Also, CMS is providing this data in three formats: a PDF document sorted by contract name, a PDF document sorted by contract number, and an Excel® version. ❖

Source: CMS Provider Education Resource 200703-22

Part C Plan Type Display on Medicare Common Working 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 who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed

Be aware of the expanded list of Medicare Advantage (MA) plan type descriptions that are being displayed by Medicare common working file (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, which is quite descriptive, is now available at *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/*.

Background

The CWF displays information on the Medicare Part C (now known as Medicare Advantage) contract number in which a beneficiary is enrolled, including the plan type description associated with the contract, and currently, CWF displays the label "HMO" for these contracts. In many of these cases, the "HMO" label is incorrect because the list of possible plan type descriptions has grown much larger since the creation of the MA programs.

This situation has especially become problematic for Medicare beneficiaries who are enrolled in MA PFFS contracts because PFFS contracts are labeled as "HMO" in CWF. Consequently, some providers are not recognizing that they can offer services to those beneficiaries enrolled in a MA PFFS contract.

To address this issue, the Health Plan Management System (HPMS) will modify the existing HMO address file exchange process with CWF in order to supply the list of available contract numbers and their corresponding plan type descriptions. With this new data, CWF can correctly display one of the following plan type descriptions: HMO, PPO, POS, indemnity, or FFS demonstration. The following table provides additional information to providers regarding these plan type descriptions:

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

Plan Type Description	Brief Guidance on Treating Patient	Additional Information
HMO	Call plan for authorization.	Managed Care plan with a provider network. Limited or no out-of-network coverage with the exception of emergency services.
PPO	You may treat the patient.	Has a network of providers. In return for higher cost sharing, members can go out of the plan network for all plan services, including supplemental benefits.
POS	You may treat the patient subject to plan rules. Contact the plan for details.	A limited out-of-network option offered by HMO plans. Contact plan for details.
Indemnity	You may treat the patient.	If this is a PFFS plan, you must follow the PFFS plan's terms and conditions of payment. If this is a Medical Savings Account (MSA) plan, the member may pay you directly.
FFS Demo	You may treat the patient.	Beneficiaries remain in original Medicare and are entitled to all fee-for-service benefits. There are no changes to Medicare FFS billing instructions or claims processing

Additional Information

The official instruction, CR 5538, 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/R1219CP.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 1-888-664-4112.

MLN Matters Number: MM5538
Related Change Request (CR) Number: 5538
Related CR Release Date: April 13, 2007
Related CR Transmittal Number: R1219CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1219, CR 5538

CMS Launches the Doctor's Office Quality Information Technology University

New Interactive Learning Tool Educates Physicians in the Adoption and Implementation of Electronic Health Records and Care Management Practices

The Centers for Medicare & Medicaid Services (CMS) announced the national launch of the Doctor's Office Quality Information Technology University, or DOQ-IT U, to support health information technology (HIT) in physicians' offices.

DOQ-IT U is an interactive, Web-based tool designed to provide solo and small-to-medium sized physician practices with the education for successful HIT adoption, including lessons on culture change, vendor selection and operational redesign, along with clinical processes. The nationally available e-learning system is available at no charge.

"CMS is pleased to launch DOQ-IT University, the first of its kind e-learning platform, to provide assistance to physicians across the United States in the adoption and implementation of electronic health records and care management practices," said CMS Acting Administrator Leslie V. Norwalk, Esq. "DOQ-IT U's interactive platform, self-paced curriculum, and associated tools provide physicians with easy access to the resources they need to help ensure that patients receive the highest quality of care at all times."

DOQ-IT U will provide lessons in assessment, planning and implementation methodologies that will be disease and population specific, incorporating clinical decision support and evidence-based medicine guidelines. This e-learning platform will be utilized to provide physicians with a self-paced curriculum and associated tools, based on adult learning principles, available at their convenience. Additional features, such as surveys, utilization tracking, and continuing medical education/continuing education unit (CME/CEU) offering/issuing capabilities will also be included in the near future.

CMS Launches the Doctor's Office Quality Information Technology University (continued)

The first learning sessions (modules), available now, focus on physician office workflow redesign, culture change, and communication necessary for successful electronic health record (EHR) adoption, implementation of care management, and the incorporation of a strong patient self-management component to clinical care. Disease specific modules, starting with diabetes, will include a patient self-management component, which is critical to successfully managing patients with chronic disease.

DOQ-IT U is being developed and managed by the quality improvement organization (QIO) program, under contract to CMS. A QIO is present in each U.S. state, territory, and the District of Columbia.

A technical advisory panel (TAP) composed of leading medical experts from the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), the American Board of Internal Medicine (ABIM), Healthcare Information and Management Systems Society (HIMSS), American Health Information Management Association (AHIMA), private payers,and patient self-management experts, has been convened and will provide content, consultation and evaluation of the care management/DOQ-IT U modules.

For more information, please see CMS' DOQ-IT U website at: *http://elearning.qualitynet.org/*. ❖

Source: CMS Provider Education Resource 200704-18

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

Medicare Announces Measure Specifications for the Physician Quality Reporting Initiative

The Centers for Medicare & Medicaid Services (CMS) today announced the posting of detailed specifications for the 74 measures included in the 2007 Physician Quality Reporting Initiative (PQRI).

PQRI establishes a financial incentive for physicians and other health practitioners to participate in a voluntary quality-reporting program. Eligible professionals who successfully report data for a designated set of quality measures may earn a bonus payment, subject to a cap, of 1.5 percent of total allowed charges for covered Medicare physician fee schedule services provided during the reporting period of July 1, 2007, to December 31, 2007.

"CMS is committed to becoming an active purchaser of high quality, efficient health care, and the PQRI program is an important step in that transformation," said CMS Acting Administrator Leslie V. Norwalk.

The 2007 PQRI quality measures relate to important processes of care that are linked to improved healthcare quality outcomes. They are evidence and consensus based measures that reflect the work of national organizations involved in quality measure development, consensus endorsement, and adoption. These include the American Medical Association Physician Consortium for Performance Improvement, the National Committee for Quality Assurance, the National Quality Forum, the AQA Alliance, and other physician and nonphysician professional organizations. The professional organizations are also assisting CMS in providing PQRI education and assistance to their members.

The specifications have been posted well in advance of the statutory deadline of July 1, 2007. This is to help eligible professionals to identify measures applicable to their practices and to prepare for submission of quality data in advance of the July 1, 2007, start date of the program. CMS anticipates a small number of additional specification changes, which may expand the applicability of the measures to additional eligible professionals.

The PQRI measures apply to services that eligible professionals provide to Medicare beneficiaries in their offices and other settings. CMS is implementing an extensive outreach and education plan to assist eligible professionals to understand the program and the measures and to implement processes to efficiently capture the quality data that is to be reported under the PQRI program.

The measure specifications document and other programmatic information are available at *http://www.cms.gov./pqri/*. ❖

Source: CMS Provider Education Resource 200704-05

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.

Special Open Door Forum on Registry-Based Reporting for the Physician Quality Reporting Initiative

The Centers for Medicare & Medicaid Services (CMS) will host a special open door forum on the use of registries for reporting data on quality measures to the Physician Quality Reporting Initiative (PQRI).

This special open door forum will take place from 1:00 p.m. – 5:00 p.m., EDT, on Monday, May 14, 2007, in the CMS auditorium, 7500 Security Blvd., Baltimore, MD. A toll-free number will be available for those who will participate by telephone.

Division B, Title 1-Medicare Improved Quality and Provider Payments, Section 101 (b) of the Tax Relief and Health Care Act (TRHCA) of 2006, states that as part of the publication of proposed and final quality measures for 2008... the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database), as identified by the Secretary.' This special open door forum will build on the broad overview of the 2007 PQRI program presented on two recent national provider conference calls by giving providers and organizations that use or produce registries and other members of the public the opportunity to discuss the potential use of registries for reporting data on quality measures to PQRI.

For the most up to date information on PQRI, please visit *http://www.cms.hhs.gov/PQRI*.

To participate in the special open door forum in person or by phone, you will need to register on this website: *http://registration.intercall.com/go/cms2*.

Registration will close at 4:00 p.m. EDT on Wednesday May 9, 2007. Please be sure to register prior to this time.

For those who will be unable to attend, the special open door forum will be recorded. A replay option will be available beginning the close of business May 18, 2007, and will be accessible for three days.

To download an audio recording, you may visit the following website *http://www.cms.hhs.gov/center/hospital.asp*.

If you have questions or require special accommodations, please contact Diane Stern at diane.stern@cms.hhs.gov at 1-410-786-1133. ❖

Source: CMS Provider Education Resource 200704-27

New "K" Codes for Oral/Mask for Use with Continuous Positive Airway Pressure Device

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

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], durable medical equipment regional carrier [DMERCs], DME Medicare administrative contractors [DME MAC]), for services to Medicare beneficiaries for continuous positive airway pressure (CPAP) device.

Provider Action Needed

Be sure billing staff are aware that, effective July 1, 2007, three new "K" codes will be established for oral/mask for use with a CPAP device.

Background

This article is based on change request (CR) 5525 and you need to be aware that effective July 1, 2007, the following codes will be added to the system:

K0553	Combination oral/nasal mask, used with continuous positive airway pressure device, each
K0554	Oral cushion for combination oral/nasal mask, replacement only, each
K0555	Nasal pillows for combination oral/nasal mask, replacement only, pair

Additional Information

To see the official instruction (CR 5525) issued to your Medicare FI, DME MAC, DMERC or A/B MAC, go to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1210CP.pdf*.

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

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

MLN Matters Number: MM5525
Related Change Request (CR) Number: 5525
Related CR Release Date: March 23, 2007
Related CR Transmittal Number: R1210CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1210, CR 5525

Announcing the Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) has announced that the Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program final regulation is now on display at the Office of the Federal Register. CMS has also announced the first 10 metropolitan areas in which competition will occur as well as the first items to be competitively bid.

To view the rule and obtain additional information, visit the CMS website at *http://www.cms.hhs.gov/competitiveacqfordmepos/*. ❖

Source: CMS Provider Education Resource 200704-06

Accreditation Information for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

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

Provider Types Affected

All suppliers of durable medical equipment (DME) that wish to participate in the Medicare DME and prosthetics, orthotics and supplies (POS) program.

Provider Action Needed

This special edition (SE) *MLN Matters* article, SE0713, provides the information that DME suppliers need to comply with section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). That MMA section requires the Secretary of the Department of Health & Human Services (HHS) to establish and implement quality standards for DMEPOS suppliers. All DMEPOS suppliers wishing to bill Medicare for DMEPOS provided to Medicare patients must comply with these standards to receive Medicare Part B payments. In addition, section 1847 (b)(2)(A)(i) of the Social Security Act requires DMEPOS suppliers meet these standards before being awarded a contract under the upcoming Medicare DMEPOS Competitive Bidding program.

Background

Section 302 of the MMA required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers of DMEPOS must comply with the quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. Covered items include (Section 1834 (a) (13 and (h) (4)):

- Medical supplies
- Home dialysis supplies and equipment
- Therapeutic shoes
- Parenteral and enteral nutrient, equipment and supplies
- Electromyogram devices
- Salivation devices
- Blood products
- Transfusion medicine
- Prosthetic devices, orthotics.

The standards will be applied prospectively and are published on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS*.

Also, note that Section 1847(b)(2)(A)(i) of the Act requires DMEPOS suppliers to meet the quality standards before being awarded a contract under the Medicare DMEPOS Competitive Bidding program.

Please note that suppliers must be accredited or be pending accreditation to submit a bid. CMS cannot accept a bid from any supplier that is not accredited or has not applied for accreditation. Additionally, suppliers will need to be accredited to be awarded a contract. **The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers must be accredited before this date in order to be awarded a contract.** Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

The quality standards are separated into two sections and have three appendices, as follows:

- Section I includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management, consumer services, performance management product safety, and information management.
- Section II contains product-specific service standards, including intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver, and follow-up service.
- Appendix A deals with respiratory equipment, supplies, and services.
- Appendix B deals with manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.
- Appendix C deals with custom fabricated, custom fitted and custom made orthotics, prosthetic devices, somatic, ocular and facial prosthetics, and therapeutic shoes and inserts.

In order to participate in the Medicare Part B program, DMEPOS suppliers will need to be accredited and in compliance with these standards. The accreditation will be phased in and to accommodate the suppliers who wish to participate in the Medicare Competitive Bidding program for DMEPOS, CMS will require accreditation organizations to prioritize their surveys of suppliers to accredit suppliers in the selected metropolitan statistical areas (MSAs) where

Accreditation Information for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (continued)

the bidding program will begin. To provide additional information on the accreditation surveys, suppliers should note that:

- All surveys are performed on site at the supplier location.
- All surveys are unannounced.
- Accreditation cannot be transferred upon merger, acquisition or sale – CMS, the national supplier clearinghouse (NSC) and the accreditation organization must be notified when these events occur.
- The accreditation organization and the NSC will be coordinating efforts so that the supplier number can be revoked when accreditation is revoked.

Status of Accreditations

- Almost 5,000 suppliers are already accredited (329 of those are in the 20 MSAs proposed in the NPRM for the Competitive Bidding program).
- One thousand surveys have been scheduled since the start of 2007.
- Ten accreditation organizations were deemed by CMS in Nov. 2006. Those organizations are listed on the CMS website at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf*.

Suppliers may contact the deemed accrediting organizations directly based on the information provided at that website.

Additional Information

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

The CMS Web page for the competitive bidding program is *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS*.

MLN Matters Number: SE0713
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 SE0713

Instructions for Competitive Bidding Areas and Product Categories Included in the Calendar Year 2007 DMEPOS Competitive Bid Program

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

Provider Types Affected

Section 1847 of the Social Security Act requires the Secretary of the Department of Health & Human Services (HHS) to establish and implement programs for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) under which competitive bidding areas are established throughout the United States for the furnishing of certain competitively priced items and services for which payment is made under Part B (the Medicare DMEPOS Competitive Bidding program"). **Suppliers who bill Medicare for DMEPOS must be aware of this program.**

Provider Action Needed

This article and change request (CR) 5574, recently released by the Centers for Medicare & Medicaid Services (CMS), provide an overview of the DMEPOS Competitive Bidding program that will be implemented starting in 2007. **Suppliers who bill Medicare for DMEPOS must be aware of this program.**

Background

Section 1847 of the Social Security Act requires Medicare to establish and implement programs under which competitive bidding areas are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items for which payment is made under Medicare Part B (the "Medicare DMEPOS Competitive Bidding Program"). Competitive bidding provides a way to harness marketplace dynamics to create incentives for suppliers to provide quality items in an efficient manner, at a reasonable cost to the Medicare beneficiaries while producing significant savings to the Medicare program.

Section 1847(a)(1)(A) of the Act requires that competitive bidding programs be established and implemented in areas throughout the United States. Section 1847(a)(1)(B) of the Act provides the Centers for Medicare & Medicaid Services (CMS) with the authority to phase-in competitive bidding programs so that the competition under the programs occurs in 10 of the largest metropolitan statistical areas (MSAs) in 2007; 70 additional MSAs in 2009; and additional areas after 2009.

CMS will conduct competitive bidding programs in which certain suppliers will be awarded contracts to provide certain DMEPOS items to Medicare beneficiaries. Suppliers must submit bids for items that fall within product categories for which they want to be considered for selection as a contract supplier.

The Medicare DMEPOS Competitive Bidding program will apply to a variety of DMEPOS product categories. The product categories will be comprised of products identified by individual Healthcare Common Procedure Coding System (HCPCS) codes. Contract suppliers will be selected from the suppliers that have the lowest bids and that meet all relevant Medicare program requirements.

Instructions for Competitive Bidding Areas and Product ... DMEPOS Competitive Bid Program (continued)

The MSAs, product categories and HCPCS codes for each product category are available on the CMS website at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp*.

Exceptions to this program may be granted for items and services for which the application of competitive acquisition is not likely to result in significant savings or to permit continuity of an existing relationship between a beneficiary and supplier with respect to furnishing either a rental item or oxygen. The statute also allows CMS to exempt certain areas from the program, such as rural areas or areas with low population density within urban areas that are not competitive, unless there is a significant national market for mail order for a particular item or service.

Additional Information

To view the official instruction, CR 5574 issued to your Medicare contractor, go to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1218CP.pdf*.

Information on the final rule is available by going to the CMS website at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/02_regsnotices.asp*.

Once there, click on the download for CMS-1270-F.

If you have questions or need assistance regarding competitive bidding, contact the Competitive Bidding program helpline on the Web at 1-877-577-5331 or use the "Contact Us" feature at *http://www.dmecompetitivebid.com*.

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

MLN Matters Number: MM5574
Related Change Request (CR) Number: 5574
Related CR Release Date: April 3, 2007
Related CR Transmittal Number: R1218CP
Effective Date: April 2, 2007
Implementation Date: April 9, 2007

Source: CMS Pub. 100-04, Transmittal 1218, CR 5574

Initial Supplier Registration for Competitive Bidding Program for DMEPOS Is now Open

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

Provider Types Affected

All suppliers of durable medical equipment (DME) that wish to participate in the Medicare Competitive Bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Provider Action Needed
STOP – Impact to You

Suppliers wishing to participate in the program must register and obtain a user identification (USER ID) number and password in order to submit their bids electronically to Medicare.

CAUTION – What You Need to Know

Without the USER ID and password, suppliers will not be able to submit electronic, online bids. Further, incorrect information could delay issuance of your USER ID and password.

GO – What You Need to Do

Register for the USER ID early in order to confirm that correct information is on file with Medicare and the national supplier clearinghouse (NSC) so you can avoid any delays in submitting bids. The background and additional information sections of this article provide important information about the registration process.

Background

The Centers for Medicare & Medicaid Services (CMS) will be using an on-line system to accept bids for the Medicare DMEPOS Competitive Bidding program. To take advantage of this opportunity, bidders must first complete an on-line registration process. The name of the online registration program is the Individuals Authorized Access to CMS Computer Services (IACS) system. To complete the initial registration and obtain a USER ID and password, please go to *https://applications.cms.hhs.gov*.

The on-line registration will be available up to 14 days prior to the close of the bidding window.

The process will require the supplier to have its authorizing official, the person identified in Section 15 on the CMS-855S application form, register and receive a USER ID and password. The authorized official's information must match the information on file at the NSC.

If an organization has one authorizing official but many NSC numbers, the organization needs to submit only **one** registration request to obtain access to the IACS system. During the registration process, the bidding organization will have to report one of its NSC numbers—the correspondence address associated with that NSC number will be used for mailing the IACS system USER ID and password.

If an organization has multiple authorizing officials for the same NSC number, only one authorizing official needs to obtain access to the IACS system.

An authorizing official only needs one USER ID and password in order to submit bids for every company for which he/she was listed as such on the CMS-855S.

Initial Supplier Registration for Competitive Bidding Program for DMEPOS Is now Open (continued)

Potential registrants should first read the CMS document entitled, "Individuals Authorized Access to CMS Computer Services (IACS): Competitive Bid Submission System/Durable Medical Equipment (CBSS/DME) User Guide." You may view this guide on the competitive bidding implementation contractor's (CBIC) website at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home*.

If you have any questions about the initial registration process, please contact the competitive bidding implementation contractor's helpdesk at 1-877-577-5331. The helpdesk will be available Monday – Friday 6:00 a.m. – 9:00 p.m. prevailing Eastern Standard Time and on Saturday 9:00 a.m. – 3:00 p.m. prevailing Eastern Standard Time.

Suppliers are required to register through IACS and get USER IDs and passwords before access to the CBSS/DME will be granted. The bidding window is not strongly urged to register now, so any issues with USER IDs and passwords may be resolved before the bidding window opens. The issues could include:

- Incorrect authorized official information maintained by the national supplier clearinghouse (NSC) as identified in Section 15 of your CMS-855S.
- Incorrect authorized official date of birth or social security number.
- NSC number does not match the authorizing official information.
- Incorrect correspondence address maintained by the NSC as listed on your CMS-855S in Section 2A.2.

The USER ID and password will be mailed to the authorized official if his/her submitted information matches exactly the data on file for last name, date of birth, Social Security number and supplier number. The USER ID and password will be delivered in **two** separate mailings to the authorized official at the correspondence address (Section 2A.2) listed on the CMS 855S.

It may take up to 15 days for the NSC to correct authorized official information. Correcting a correspondence address may take up to 45 days. These timeframes for correcting NSC data may be longer depending on the number of requests received by the NSC. This underscores the need to start early.

Note: For added security, when suppliers use their USER IDs and passwords to access the competitive bid submission system for the first time, they will need to complete a brief authentication process. The information required for this process must also match the information in the national supplier clearinghouse file. If you successfully completed the initial registration and received your USER ID and password, please enter your information exactly as you did for initial registration when completing the competitive bid submission system authentication process. Failure to do so may delay your ability to use the system.

Additional Information

Detailed instructions on how to register for CMS application access may be found in the *Guide* at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home*.

Remember that **this first step is the registration to gain access** to on-line bidding materials—it is not the actual bidding process.

The competitive bidding implementation contractor (CBIC) help desk can help you with any problems or questions you have regarding the IACS registration process. The help desk number is 1-877-577-5331.

You may also want to review a related *MLN Matters* article that covers accreditation requirements for suppliers wishing to participate in the Competitive Bidding program. That article, SE0713, is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf*.

Periodically, you may also want to visit *http://cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp* to stay abreast of developments for this program.

MLN Matters Number: SE0717
Related Change Request (CR) Number: 5574
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 SE0717

Initial Registration Is now Open for Suppliers Interested in Competitive Bidding for DMEPOS

The initial registration process is now open and available to all suppliers interested in participating in the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Bidding Program. Interested suppliers will submit their bids using an Internet application. To help ensure the privacy of all bids, all suppliers must complete initial registration in the Internet application to get a USER ID and password. **Suppliers need to complete this initial registration process early. CMS** strongly recommends that suppliers do so well before the bid window opens to avoid a delay in being able to submit bids. Bidding is currently scheduled to open in late April 2007.

The initial registration process requires the **authorized official**, as identified in Section 15 of the CMS 855S, to complete the information required in the Internet application. The authorized official information must match the information on file at the national supplier clearinghouse. The USER ID and password will be mailed to the authorized official if his/her submitted information matches exactly the data on file for last name, date of birth, social security number and supplier number. The USER ID and password will be delivered in two separate mailings to the authorized official at the correspondence address (Section 2A.2) listed on the CMS 855S. An authorized official only needs **one** USER ID and password in order to submit bids for any company for which he/she was listed as the authorized official on the CMS 855S. To complete this initial registration and obtain a USER ID and password, please go to *https://applications.cms.hhs.gov*.

Suppliers must have the USER ID and password before they can enter a bid into the competitive bidding Internet application. However, the USER ID and password cannot be used until the bidding window opens, which is expected in late April 2007.

Please read the user guide for the individuals authorized access to CMS computer services (IACS) application before attempting initial registration. This guide may be found on the competitive bidding implementation contractor's website at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home*.

If you have any questions about the initial registration process, please contact the Competitive Bidding Implementation Contractor (CBIC) helpdesk on **1-877-577-5331.** The helpdesk will be available:

Monday – Friday: 6:00 a.m. – 9:00 p.m. ET
Saturday: 9:00 a.m. – 3:00 p.m. ET

An *MLN Matters* article regarding this registration process will be forthcoming. Additional information on the DMEPOS Competitive Bid Program may be found in *MLN Matters* article MM5574 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf*.

Information on accreditation for suppliers may be found in *MLN Matters* article SE0713 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf*.

Note: For added security, when suppliers use their USER IDs and passwords to access the competitive bid submission system for the first time, they will need to complete a brief authentication process. The information required for this process must also match the information in the national supplier clearinghouse file. If you successfully completed the initial registration and received your USER ID and password, please enter your information exactly as you did for initial registration when completing the competitive bid submission system authentication process. Failure to do so may delay your ability to use the system. ❖

Source: CMS Provider Education Resource 200704-16

Get Accredited for DMEPOS Competitive Bidding

In order to participate in the Medicare DMEPOS Competitive Bidding program, suppliers must meet quality standards and be accredited by a CMS-approved deemed accreditation organization.

Suppliers that are interested in bidding under the new program must be aware of two key deadlines:

- Suppliers must be accredited or be pending accreditation to submit a bid. CMS cannot accept a bid from any supplier that is not accredited or has not applied for accreditation.
- To be awarded a contract, suppliers will need to be accredited. The accreditation deadline for the first round of competitive bidding is August 31, 2007.

Suppliers must be accredited before this date to be awarded a contract. Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

Bidding is expected to open in late April 2007. For a list of the CMS-approved deemed accreditation organizations and information about the Medicare DMEPOS Competitive Bidding program, visit *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/*.

To view a special edition MLN Matters article on this topic, visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf*. ❖

Source: CMS Provider Education Resource 200704-25

Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies Competitive Bidding Program

The Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now published at the *Federal Register* at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/Downloads/CMS-1270-F.pdf*.

The Centers for Medicare & Medicaid Services (CMS) has also announced the first **ten** metropolitan areas in which competition will occur, as well as the first items to be bid competitively.

To view the rule and for additional information, visit the CMS website at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/*. ❖

Source: CMS Joint Signature Memorandum 07364, April 26, 2007

AMBULANCE SERVICES

Revision to the Specialty Care Transport Definition—Ground Ambulance Services

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

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (fiscal itermediaries [FIs], Medicare administrative contractors [MACs] and carriers), for ambulance services to Medicare beneficiaries.

Provider Action Needed

Providers and suppliers are reminded that the Centers for Medicare & Medicaid Services (CMS) expanded the interpretation of "interfacility" to include both hospitals and skilled nursing facilities (SNFs) in the December 1, 2006, final rule (71 FR 69716).

Background

In the February 27, 2002 *Federal Register* (67 FR 9100), a final rule was published with comment period entitled "*Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services*" that implemented the ambulance fee schedule. In that rule, CMS defined specialty care transport (SCT) at section 414.605. In the December 1, 2006 final rule (71 FR 69716), CMS expanded the definition of "interfacility" to include both hospitals and (SNFs).

In addition, CMS further clarified the kinds of facilities included as origin or destination points for "interfacility" transport for SCT purposes. Therefore, for purposes of SCT payment, CMS considers a "facility" to include:

- Only an SNF or a hospital that participates in the Medicare program, or
- A hospital-based facility that meets the requirements for provider-based status.

Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children's hospitals, psychiatric hospitals, critical access hospitals (CAHs), inpatient acute-care hospitals, and sole community hospitals (SCHs).

Note: Contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5533) issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R68BP.pdf*.

Providers may review the federal regulations for the ambulance fee schedule located on the CMS website at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/04_CFRAFS.asp#TopOfPage*.

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

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

MLN Matters Number: MM5533
Related Change Request (CR) Number: 5533
Related CR Release Date: March 30, 2007
Related CR Transmittal Number: R68BP
Effective Date: January 1, 2007
Implementation Date: April 30, 2007

Source: CMS Pub. 100-02, Transmittal 68, CR 5533

NATIONAL PROVIDER IDENTIFIER

CMS Clarifies Guidelines for National Provider Identifier Deadline Implementation

NPI: Get It. Share It. Use It.

The Centers for Medicare & Medicaid Services (CMS) announced that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007, deadline for compliance with the national provider identifier (NPI) regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The final rule establishing the NPI as the standard unique health provider identifier for health care providers was published in 2004 and requires all covered entities to be in compliance with its provisions **by May 23, 2007, except for small health plans,** which must be in compliance **by May 23, 2008.**

"The enforcement guidance released today clarifies that covered entities that have been making a good faith effort to comply with the NPI provisions may, for up to 12 months, implement contingency plans that could include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flows," said CMS Acting Administrator Leslie V. Norwalk, Esq.

The NPI is an identifier that will be used by covered entities to identify health care providers, eliminating the current need for multiple identifiers for the same provider. The NPI replaces all "legacy" identifiers that are currently being used, such as Medicaid provider IDs, individual plan provider IDs, UPINs, etc., and will be required for use on health care claims and other HIPAA transactions.

CMS made the decision to announce this guidance on its enforcement approach after it became apparent that many covered entities would not be able to fully comply with the NPI standard by May 23, 2007.

This guidance would protect covered entities from enforcement action if they continue to act in good faith to come into compliance, and they develop and implement contingency plans to enable them and their trading partners to continue to move toward compliance. HHS recognizes that transactions often require the participation of two covered entities and that noncompliance by one covered entity may put the second covered entity in a difficult position.

The enforcement process is complaint driven and will allow covered entities to demonstrate good faith efforts and employ contingency plans. If a complaint is filed against a covered entity, CMS will evaluate the entity's "good faith efforts" to comply with the standards and would not impose penalties on covered entities that have deployed contingencies to ensure that the smooth flow of payment continues. Each covered entity will determine the specifics of its contingency plan. Contingency plans may not extend beyond May 23, 2008, but entities may elect to end their contingency plans sooner. Medicare will announce its own contingency plan shortly.

CMS encourages health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance. Likewise, we encourage health care providers that have not yet obtained NPIs to do so immediately, and to use their NPIs in HIPAA transactions as soon as possible. Applying for an NPI is fast, easy and free. Visit the National Plan/Provider Enumeration System (NPPES) website at *https://nppes.cms.hhs.gov/*.

A critical aspect of implementing the NPI is the ability for covered entities to match a provider's NPI with the many legacy provider identifiers that have been used to process administrative transactions.

CMS plans to make data available from the NPPES system that will assist covered entities in developing these "crosswalks."

Further information concerning this issue is available on the CMS website at *http://www.cms.hhs.gov*.

The site also contains contingency plan guidance for the industry in a document titled "Guidance on Compliance with the HIPAA National Provider Identifier Rule."

To view this guidance, visit the CMS website at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf*.

A press release on this topic is also available on the CMS website at *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

More information and education on the NPI may be found at the CMS NPI Web page *http://www.cms.hhs.gov/NationalProvIdentStand*. ❖

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

Source: CMS Provider Education Resource 200704-08
CMS Provider Education Resource 200704-03

Medicare Fee-for-Service National Provider Identifier Implementation Contingency Plan

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

Provider Types Affected

Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare contractors (carriers, fiscal intermediaries, [FIs], including regional home health intermediaries [RHHIs], Medicare administrative contractors [MACs], durable medical equipment regional carriers [DMERCs], and DME Medicare administrative contractors [DME MACs]).

Provider Action Needed

STOP – Impact to You

As early as July 1, 2007, Medicare fee-for-service (FFS) contractors may begin rejecting claims that do not contain a national provider identifier (NPI) for the primary providers.

CAUTION – What You Need to Know

Change request (CR) 5595, from which this article is taken, announces that **effective May 23, 2007,** Medicare FFS is establishing a contingency plan for implementing the NPI. In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007.

GO – What You Need to Do

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

You should also make sure that your billing staff begin to include your NPI on your claims as soon as possible.

Background

The 1996 Health Insurance Portability and Accountability Act (HIPAA) required that each physician, supplier, and other health care provider conducting HIPAA standard electronic transactions, be issued a unique national provider identifier (NPI). CMS began to issue NPIs on May 23, 2005; and to date, has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only
- Medicare legacy only, or
- An NPI and legacy combination.

On April 2, 2007, the Department of Health & Human Services (DHHS) provided guidance to covered entities regarding contingency planning for NPI implementation. **As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners.** You may find this guidance on the CMS website at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf*.

In CR 5595, from which this article is taken, Medicare FFS announces that it is establishing a contingency plan that follows this DHHS guidance. For some period after May 23, 2007, Medicare FFS will:

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

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

As part of this plan, Medicare FFS has been assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is determined sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers following appropriate notification. (*See Important Information* below.)

In May 2007, Medicare FFS will evaluate the number of submitted claims containing a NPI. If this analysis demonstrates a sufficient number of submitted claims contain a NPI, Medicare will begin to reject claims without NPIs on July 1, 2007. If, however, there are not sufficient claims containing NPIs in the May analysis, Medicare FFS will assess compliance in June 2007 and determine whether to begin rejecting claims in August 2007.

CMS also recognizes that the National Council of Prescription Drug Programs (NCPDP) format only allows for reporting of one identifier. Thus, NCPDP claims may contain either the NPI or the legacy number, but not both, until May 23, 2008.

In addition, in regards to the 835 remittance advice transactions and 837 coordination of benefit (COB) transactions, Medicare FFS will do the following until May 23, 2008:

- If a claim is submitted with an NPI, the NPI will be sent on the associated 835 remittance advice; otherwise, the legacy number will be sent on the associated 835.
- If a claim is submitted with an NPI, the associated 837 COB transaction will be sent with both the NPI and the legacy number; otherwise, only the legacy number will be sent.

By May 23, 2008, the X12 270/271 eligibility inquiry/response supported by CMS via the Extranet and Internet must contain the NPI.

Medicare Fee-for-Service National Provider Identifier Implementation Contingency Plan (continued)

Important Information

CR 5595 also provides specific important information that you should be aware of:

- Once a decision is made to require NPIs on claims, Medicare FFS will notify (in advance) providers and Medicare contractors about the date that claims without NPIs for primary providers will begin to be rejected. **That date will supersede all dates announced in previous CRs and *MLN Matters* articles.**
- In editing NPIs, Medicare considers billing, pay-to and rendering providers to be primary providers who must be identified by NPIs, or the claims will be rejected once the decision is made to reject.
- All other providers (including referring, ordering, supervising, facility, care plan oversight, purchase service, attending, operating and "other" providers) are considered to be secondary providers. Legacy numbers are acceptable for secondary providers until May 23, 2008. If a secondary provider's NPI is present, it will only be edited to assure it is a valid NPI.

Additional Information

You may read CR 5595 by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1227CP.pdf*.

You may also learn more about the NPI on the CMS website at *http://cms.hhs.gov/NationalProvIdentStand/*.

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

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

MLN Matters Number: MM5595
Related Change Request (CR) Number: 5595
Related CR Release Date: April 24, 2007
Related CR Transmittal Number: R1227CP
Effective Date: May 23, 2007
Implementation Date: May 23, 2007

Source: CMS Pub. 100-04, Transmittal 1227, CR 5595

GENERAL COVERAGE

Colorectal Screening Services—Clarification to the Medicare Claim Processing Manual

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 for screening and diagnostic colorectal services to Medicare contractors (fiscal intermediaries [FIs], carriers, Part A/B Medicare administrative contractors [A/B MACs]).

Background

The Centers for Medicare & Medicaid Services (CMS) is aware that Chapter 18, Section 60.1 of the *Medicare Claims Processing Manual* (Publication 100-04) needed clarification regarding application of the annual Part B deductible for **diagnostic** colorectal services. Section 5113 of the Deficit Reduction Act (DRA) of 2005 **waived** the requirement for the annual Part B deductible for **screening** colorectal services, **not** diagnostic colorectal services. Change request (CR) 5541 clarifies that portion of the manual.

Key Points

The following are the key points of the revised portion of Chapter 18, Section 60.1 of the *Medicare Claims Processing Manual*, which is attached to CR 5541 (the Web address for CR 5541 is provided in the *Additional Information* section of this article).

- **Prior to January 1, 2007,** deductible and coinsurance apply to HCPCS codes G0104, G0105, G0106, G0120, and G0121. **On or after January 1, 2007,** the annual Part B deductible is waived for the listed HCPCS coded screening services. Coinsurance still applies.
- **Coinsurance and deductible applies to the diagnostic colorectal service *CPT* codes *45330*, *45378*, and *74280*.**

Additional Information

You may see the official instruction (CR 5541) issued to your Medicare carrier, FI, or A/B MAC by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1217CP.pdf*.

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

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

MLN Matters Number: MM5541
Related Change Request (CR) Number: 5541
Related CR Release Date: March 30, 2007
Related CR Transmittal Number: R1217CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1217, CR 5541

Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors

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

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Medicare administrative contractors [MACs] and carriers).

What Providers Need to Know

Effective for claims with dates of service on or after March 20, 2007, the use of osmotic blood brain barrier disruption is not considered reasonable and necessary when it is used as part of a treatment regimen for brain tumors in Medicare patients.

Background

This article and change request (CR) 5530 states that Medicare does not currently have a national coverage determination (NCD) for osmotic blood brain barrier disruption (BBBD) as part of a treatment regimen for brain tumors. The Centers for Medicare & Medicaid Services (CMS) accepted a formal request for **noncoverage** of BBBD used for this indication.

CMS determined that the use of osmotic blood brain barrier disruption is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors.

Be aware that the BBBD process includes all items and services necessary to perform the procedure, including hospitalization, monitoring, and repeated imaging procedures.

This NCD does not alter in any manner the coverage of anti-cancer chemotherapy.

Additional Information

CR 5530 is the official instruction issued to your Medicare FI, carrier or MAC. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R67NCD.pdf*.

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

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

MLN Matters Number: MM5530
Related Change Request (CR) Number: 5530
Related CR Release Date: April 6, 2007
Related CR Transmittal Number: R67NCD
Effective Date: March 20, 2007
Implementation Date: May 7, 2007

Source: CMS Pub. 100-03, Transmittal 67, CR 5530

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.

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

New LCD Implementation

Additions/Revisions to Existing LCDs

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

NEW LCD IMPLEMENTATION

AJ0129: Abatacept—New LCD

Abatacept is indicated for reducing signs and symptoms, inducing major clinical response, slowing the progression of structural damage, and improving physical function in adult patients with moderately to severe active rheumatoid arthritis who have had an inadequate response to one or more disease-modifying antirheumatic drugs (DMARDs), such as methotrexate or tumor necrosis factor (TNF) antagonists. Abatacept may be used as monotherapy or concomitantly with DMARDs other than TNF antagonists. It should not be administered concomitantly with TNF antagonists and it is not recommended for use concomitantly with anakinra.

This local coverage determination (LCD) was developed after evaluation of data identified abatacept as one of two drugs which were a factor in causing a 277 percent increase in reimbursements for HCPCS code J3590 (unlisted biological drugs). New HCPCS code J0129 for abatacept became effective January 1, 2007. The LCD provides coverage guidelines for the administration of abatacept.

Effective Dates

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

The full text for this LCD (L24536) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ADDITIONS/REVISIONS TO LCDS

A0145T: Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries—Revision to the LCD

The local coverage determination (LCD) for computed tomographic angiography of the chest, heart and coronary arteries was last updated on January 1, 2007. Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD for *CPT* code *71275* has been revised to add ICD-9-CM code 441.2 (Thoracic aneurysm without mention of rupture).

Effective Dates

This revision is effective for services **provided on or after May 3, 2007.**

The full text for this LCD (L23080) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

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

The local coverage determination (LCD) for non-invasive evaluation of extremity veins was last revised on October 5, 2006. Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to include the following diagnosis codes as medically necessary for *CPT* codes *93965, 93970* and *93971*:

427.31 451.82 518.81 782.5 785.0 799.02 996.62

Effective Date

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

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

A95860: Electromyography and Nerve Conduction Studies (formerly A95900: Nerve Conduction Studies)—Revision to the LCD

The local coverage determination (LCD) for nerve conduction studies (NCS) covered *CPT* code range *95900-95904* and was last updated on October 1, 2006. Since that time, the LCD was completely struck out due to a major revision that included additional *CPT* codes for H-reflex studies, neuromuscular junction, and electromyography (EMG). Also, the LCD title and contractor's determination number were changed to *"Electromyography and Nerve Conduction Studies (95860)."* The LCD was presented at the February 2007 Carrier Advisory Committee (CAC) meeting.

This major revision to the LCD also included changes/additions to the indications and limitations of coverage that included credentialing/supervision requirements, documentation requirements, utilization guidelines, and ICD-9-CM codes that support medical necessity. In addition, coding guidelines were added to the LCD for recommended maximum number of EMG/NCS for specific indications.

Effective Dates

This revision is effective for services provided **on or after June 30, 2007**.

The full text for this LCD (L885) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

A95934: H-Reflex Study—Retirement of the LCD

This local coverage determination (LCD) for H-reflex study was last revised on September 29, 2005. Since that time, this LCD is being retired as it has been incorporated into the LCD for electromyography and nerve conduction studies (A95860).

Effective Dates

The retirement of this LCD (L1360) is effective for services provided **on or after June 30, 2007**.

The full text for the LCD A95860 – Electromyography and Nerve Conduction Studies (L885) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AEPO: Epoetin alfa—Revision to the LCD

This local coverage determination (LCD) was last updated March 8, 2007. Since that time, the U. S. FDA (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 and will remove coverage for the off-label indication for anemia of malignancy not due to concurrent chemotherapy for Medicare patients in Florida.

With this decision, the LCD for epoetin alfa (EPO, Procrit), will be revised as follows:

- 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 the "Utilization Guidelines" section of the LCD:
  - Added a statement about endpoints for administering EPO for anemia associated with concurrent chemotherapy.
- Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD for HCPCS code J0885:
  - Removed ICD-9-CM codes 205.00-205.91, 206.00-206.91, 207.00-208.91 and 285.22 as these ICD-9-CM codes are no longer supported as medically necessary.

AEPO: Epoetin alfa—Revision to the LCD (continued)

- 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 EPO 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.

In evaluating the new coding requirements as noted above, FCSO determined that there were not appropriate ICD-9-CM codes for the covered off-label indication anemia associated with the management of hepatitis C. Therefore, FCSO has added ICD-9-CM codes 571.40, 571.41 and 571.49 as medically necessary for this off-label indication. The coding instructions found in the coding guideline for this indication were updated with this revision.

- The coding guideline was revised accordingly for all other revisions mentioned in this article.

FCSO is continuing to evaluate all other off-label coverage found in the epoetin alfa LCD. FCSO will communicate to physicians and allied providers if and when such off-label indications are removed from the local policies.

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 conditions 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*.

Effective Date

These revisions to the LCD are effective for services **provided on or after May 3, 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. ❖

AJ2505: Pegfilgrastim (Neulasta®)—Revision to the LCD

The local coverage determination (LCD) for pegfilgrastim (Neulasta®) was last revised on October 1, 2006. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to correct wording related to the administration of Neulasta. The following sentence, "The administration should not occur within 14 days before, **or** 24 hours after, administration of cytotoxic chemotherapy", was revised to read per the product label. The revised sentence reads as follows: "The administration should not occur within 14 days before, **and** 24 hours after, administration of cytotoxic chemotherapy.

Effective Date

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

The full text for this LCD (L14001) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

APULMDIAGSVCS: Pulmonary Diagnostic Services—Revision to the LCD

The local coverage determination (LCD) for pulmonary diagnostic services was last revised on January 1, 2007.

Pulmonary diagnostic tests are important in clinical situations in which the patient has a history or symptoms suggestive of lung disease or when risk factors for lung disease (e.g., exposure to toxic substances) are present. Pulmonary diagnostic testing may include pulmonary function tests (e.g., spirometry, lung volume determination and diffusion capacity tests), pulmonary stress tests (e.g., 6-minute walk test, carbon monoxide diffusing capacity,) and lung compliance studies (e.g., plethsmography, volume and pressure measurements).

The LCD was revised to include credentialing requirements for providers performing pulmonary diagnostic services, a noncoverage statement for screening and patient initiated spirometry, information that must be included in the documentation requirements, and a statement related to frequency of services.

Effective Dates

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

The full text for this LCD (L16651) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

ATHERSVCS: Therapy and Rehabilitation Services—Revision to the LCD

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on January 16, 2007. Since that time, the LCD has been revised. A request was received asking that First Coast Service Options, Inc. (FCSO) revise the language found in the LCD for *CPT* code *97532*. After reviewing the literature submitted with this request, FCSO has revised the language found in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, under general physical and occupational therapy guidelines, for *CPT* code *97532* to read as follows:

> Development of cognitive skills to improve attention, memory or problem solving, may be medically necessary for patients having neurological conditions such as head injury or trauma, stroke, muscular dystrophy and/or multiple sclerosis or other neurological diseases. It is not appropriate for patients with chronic, progressive or stable brain conditions who do not have potential for improvement of or restoration of current cognitive function. Reassessment of the patient's progress should occur every 2-3 months showing significant and measurable improvement. These procedures may be medically necessary when included in a patient's individual treatment plan aimed at improving or restoring specific functions which were impaired by an identified illness or injury and when the improved functional physical/cognitive abilities of the patient that are expected to be achieved are specified in the plan. If at anytime during the treatment period it becomes obvious that continued cognitive rehabilitation is not likely to be effective, that the service is no longer needed, or that all realistic attainable goals have been met, then the treatment should be discontinued. The patient must have the capacity to learn from instructions.

Effective Date

This revision to the LCD is effective for services **provided on or after April 17, 2007.**

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

ATHERSVCS: Therapy and Rehabilitation Services—Revision to the LCD

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on April 17, 2007.

Therapy services provided to the beneficiary must be restorative or for the purpose of designing and teaching a maintenance program required in connection with a specific disease state. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program.

The LCD has been revised to include *CPT* code *97750 [Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes]*. *CPT* codes that would be inappropriate to bill with *CPT* code *97750* are also identified.

Effective Dates

This revision is effective for services provided **on or after June 30, 2007.**

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

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HOSPITAL SERVICES

Revision to Billing Instructions for Hemophilia Clotting Factor Claims—HCPCS Code J7187

The Centers for Medicare & Medicaid Services (CMS) has revised the temporary instructions addressing the billing for hemophilia clotting-factor services provided on or after January 1, 2007, through September 30, 2007.

First Coast Service Options, Inc, notified hospital providers of this temporary instructions on March 21, 2007,via the provider educational website and in the April 2007 *Medicare A Bulletin* (page 45).

Revision Summary

CMS is requesting that hospital providers, **including hospitals paid under the inpatient psychiatric prospective payment system (PPS),** to omit **also** the old HCPCS code, J7188 in addition to the new HCPCS code, J7187, from inpatient hospital claims.

Once providers have received payment for the inpatient stay, without the add-on for (the hemophilia clotting factor) von Willebrand's factor, CMS is requesting that providers submit an adjustment request that includes HCPCS code J7187.

Revised Billing Instructions

CMS has revised the following instructions to be used for hospital discharges from January 1, 2007, through September 30, 2007. Revisions to the previous published instructions have been bolded for easy identification.

- Providers shall submit claims for hospital inpatient care (this includes hospitals paid under the inpatient PPS, the long-term care PPS, the inpatient rehabilitation facility PPS, 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).

  Note: While hospitals paid under the inpatient psychiatric PPS do not receive an add-on payment, CMS has been informed that these claims will also error out if HCPCS code J7187 is on the claim as a covered service.

- Once the provider has received the 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. **This direction also applies to inpatient psychiatric facilities.**
- 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 07328, April 11, 2007

Inpatient Hospital Therapeutic Services

The Centers for Medicare & Medicaid Services (CMS) has **rescinded** change request (CR) 5405 on March 26, 2007. As a result of this decision, **the information communicated through the *MLN Matters* article MM5405 has also been rescinded.**

The original *MLN Matters* article related to CR 5405 was published in the March 2007 *Medicare A Bulletin* (pages 18-20). ❖

Source: CMS Pub. 100-02, Transmittal 65, CR 5405

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Ventricular Assist Devices

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

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5516, which announces that, effective March 27, 2007, new facility criteria are established and hospitals must receive certification from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under their disease specific certification program for ventricular assist devices (VADs). The new criteria apply to hospitals that implant VADs for the destination therapy indication.

CAUTION – What You Need to Know

Currently approved hospitals will have until March 27, 2009, to become certified by the JCAHO or they will be removed from the approved list.

GO – What You Need to Do

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

Background

A VAD is an implantable device used to assist a damaged or weakened heart in pumping blood. These devices are used for support of blood circulation 1) post-cardiotomy, 2) as a bridge to a heart transplant, or 3) as destination therapy. Destination therapy is defined as use of a device as the end result of treatment (i.e., permanent transplantation), instead of a "bridge" to transplantation. Destination therapy is an indication for patients that are not heart transplant eligible, and therefore, they expect to require use of the VAD through the end of life.

Through the *National Coverage Determination* (NCD) *Manual* (Publication 100-03), Section 20.9, "Artificial Hearts and Related Devices" issued on October 14, 2003, (CR 2958, Transmittal 2; (*http://www.cms.hhs.gov/Transmittals/Downloads/R2NCD.pdf*), Medicare began coverage of the destination therapy indication. The 2003 decision established hospital criteria and an application process through which hospitals were required to submit information to the Centers for Medicare & Medicaid Services (CMS). If approved, the hospital(s) were listed as an approved VAD destination therapy hospital on the CMS website (*http://www.cms.hhs.gov/MedicareApprovedFacilitie/VAD/list.asp#TopOfPage*).

At that time, Medicare contractors were instructed to use this VAD destination therapy facilities website to determine which hospitals in their area were Medicare approved for VADs as destination therapy.

CR 5516 announces the criteria for new facilities effective March 27, 2007. Requirement included in the new facility criteria are:

- Facilities must have at least **one** member of the VAD team with experience implanting at least 10 VADs (as bridge to transplant or destination therapy) or artificial hearts over the course of the previous 36 months.
- Facilities must be a member of the Interagency Registry for Mechanically Assisted Circulatory Support (INTERMACS).
- By March 27, 2009, all facilities must meet the updated CMS facility criteria and be credentialed by the JCAHO under their disease specific certification program for VADs (standards dated February 2007).

The VAD destination therapy facilities website will be continuously updated by CMS to maintain a current list of approved facilities. Medicare contractors will continue to use this website to determine which hospitals are covered by Medicare when VADs are implanted as destination therapy.

Additional Information

The official instruction, CR 5516, issued to your carrier, intermediary, or A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R68NCD.pdf*.

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

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

MLN Matters Number: MM5516
Related Change Request (CR) Number: 5516
Related CR Release Date: April 13, 2007
Related CR Transmittal Number: R68NCD
Effective Date: March 27, 2007
Implementation Date: May 14, 2007

Source: CMS Pub. 100-03, Transmittal 68, CR 5516

MedPAR Data Requests

The Centers for Medicare & Medicaid Services (CMS) makes available for purchase the expanded modified MedPAR data that are being used in simulating the policies proposed in the inpatient prospective payment system (IPPS) proposed rule. If interested parties have already ordered the proposed rule data, we will begin filling the orders and providing the fiscal year (FY) 2006 MedPAR data used to model the proposed changes to diagnosis related groups (DRGs) and relative weights once the FY 2008 IPPS proposed rule goes on public display.

If readers have not ordered the proposed rule MedPAR data but are interested in receiving them, CMS encourages them to order the data as soon as possible by following the directions provided below. CMS will process requests in the order they are received.

For information on how to order the expanded modified MedPAR, go to the following website: *http://www.cms.hhs.gov/LimitedDataSets/*. Click on MedPAR Limited Data Set (LDS)-Hospital (National). This Web page will describe the file and provide directions to further detailed instructions for how to order.

Persons placing order must send the following:

- Letter of Request
- LDS Data Use Agreement and Research Protocol (see Web site for further instructions)
- LDS Form
- A check for $3,655

Send this documentation to:

Centers for Medicare & Medicaid Services
Public Use Files – Accounting Division
P.O Box 7520
Baltimore, MD 21207-0520. ❖

Source: CMS Provider Education Resource 200704-09

Common Working File Duplicate Claim Edit for the Technical Component of Radiology and Pathology Laboratory Services Provided to Hospital Patients

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 April 20, 2007, to show that important new information on this issue is available in *MLN Matters* article MM5468 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5468.pdf*). In essence, according to MM5468, qualifying independent laboratories may continue to bill Medicare for the technical component (TC) of physician pathology services furnished to Medicare patients of a covered hospital stay during calendar year 2007. Be sure to view MM5468 for details. The *MLN Matters* article MM5347 was published in the December 2006 *Medicare A Bulletin* (pages 21-22).

Provider Types Affected

Radiology suppliers, physicians and nonphysician practitioners billing Medicare carriers for the TC of **radiology** laboratory services provided to Medicare fee-for-service hospital inpatients. Also affected are independent laboratories billing Medicare carriers for the TC of **pathology** laboratory services provided to Medicare fee-for-service hospital patients.

Provider Action Needed

Effective April 1, 2007, CMS will install systems edits to prevent improper payments to radiology suppliers, physicians and nonphysician practitioners for the TC of radiology laboratory services during an inpatient stay. The system edits will also apply to independent laboratories for the TC of pathology laboratory services provided to beneficiaries during a covered inpatient hospital stay or provided on the same date of service as an outpatient service. This change applies to claims with dates of service on or after January 1, 2007, where the claim is received on or after April 1, 2007. Please be sure billing staff are aware of these changes.

Background

Current Medicare billing practices allow either the hospital or the supplier performing the technical component (TC) of physician pathology laboratory services to bill the carrier for these services. This policy has contributed to the Medicare program paying twice for the TC service, first through the prospective payment system (PPS) to the hospital and again to the supplier that bills the carrier, instead of the hospital, for the TC service.

Effective for claims received on or after April 1, 2007 for services on or after January 1, 2007, CMS will install systems edits to prevent additional improper payments to radiology suppliers, physicians and nonphysician practitioners billing Medicare carriers for the TC of **radiology** laboratory services during an inpatient stay. The edits will also apply to independent laboratories for the TC of pathology services provided to beneficiaries during an inpatient stay or for the same date of service as an outpatient service.

CWF Duplicate Claim Edit for the TC of Radiology and Pathology Lab Services Provided to Hospital Patients (continued)

Key Points

- Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed radiology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay. Such services will also be rejected/denied when they match with a date of service of a hospital inpatient previously processed by Medicare.
- Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed pathology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay when billed by a physician/supplier. Such services will also be rejected/denied when they match with a date of service of a hospital outpatient bill (bill types 13x and 85x previously processed by Medicare.
- If providers submit a TC of a radiology or pathology service with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay the carrier will use remittance advice reason code 109 "Claim not covered by this payer/contractor." when denying a service line item.
- Where Medicare systems detect that a Part B TC or globally billed radiology or physician pathology service has been paid and Medicare subsequently receives a hospital inpatient bill for the same date of service, the Medicare carrier will adjust a TC of a radiology or physician pathology service line item and recoup the payment made for that service from the physician/supplier. The Medicare carrier will also adjust a TC of a pathology service for an outpatient claim. The same remittance advice reason code of 109 will be used in such cases.
- Effective for claims received on or after April 1, 2007, the carrier will deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (noncovered level of care) from and through dates plus one day on a posted hospital inpatient bill. Again, the carrier will use remittance advice reason code 109. In addition, the Medicare carrier will recoup payment made to the physician/supplier if a subsequent hospital inpatient bill is received for those same services.
- Carriers will not search their files to either retract payment or retroactively pay claims prior to the implementation of change request (CR) 5347. However, they will adjust claims if they are brought to their attention.

Implementation

This change will be implemented on April 2, 2007.

Additional Information

For complete details regarding this CR, please see the official instruction issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1221CP.pdf*.

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

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

Source: CMS Pub. 100-04, Transmittal 1221, CR 5347

Audio Download of Listening Session on Medicare Hospital Value-Based Purchasing

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the audio download for the Medicare hospital value-based purchasing (VBP) listening sSession #2, held on April 12, 2007, is now available on the CMS hospital center website: *http://www.cms.hhs.gov/center/hospital.asp*.

The agenda, slide presentations, and option paper are also posted at this location.

Written comments on the options paper will be accepted until 5 p.m. EDT on April 19, 2007 and may be sent by e-mail to cmshospitalVBP@cms.hhs.gov.

Comments may also be sent by fax to 410-786-0330 or mailed to

Robin Phillips, Medicare Feedback Group,
Centers for Medicare & Medicaid Services, Mail Stop C4-13-07
7500 Security Blvd.
Baltimore, MD 21244-1850. ❖

Source: CMS Provider Education Resource 200704-23

ESRD SERVICES

Clarification of Billing for Separately Billable End-Stage Renal Disease Drugs

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 April 13, 2007, to delete a sentence regarding the payment basis for separately billable supplies. Previously, this article was revised on August 24, 2006, to delete mention in the "Caution" section regarding payment methodology. For payment information, please see change request (CR) 3451 on the CSM website at *http://www.cms.hhs.gov/Transmittals/downloads/R318CP.pdf*. All other information remains the same. The revised *MLN Matters* article MM3176 related to CR 3176 was published in the October 2007 *Medicare A Bulletin* (page 62-63).

Provider Types Affected

Hospital-based and independent dialysis facilities

Provider Action Needed

STOP – Impact to You

This instruction clarifies the billing procedures for separately billable end-stage renal disease (ESRD) injectable drugs and administration-supply charges. It also includes a correction to the provider series numbers for dialysis providers: 3300-3399 (Children's hospitals excluded from prospective payment system [PPS]).

CAUTION – What You Need to Know

Separately billable drugs furnished in ESRD dialysis centers must be of the appropriate category of drugs, and the most appropriate method of administration-supply will be paid for these separately billable injectable drugs.

GO – What You Need to Do

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

Background

Multiple categories of drugs are not included in the ESRD composite rate. These drugs are considered to be separately billable drugs when used to treat the patient's renal condition. The separately billable injectable drugs allow for an administration-supply charge. The allowable administration-supply charges are determined by the most appropriate method of administration.

This instruction clarifies the billing procedures for separately billable ESRD injectable drugs and administration-supply charges. Separately billable drugs furnished in ESRD dialysis centers must be of the appropriate category of drugs, and the most appropriate method of administration-supply will be paid for these separately billable injectable drugs. The instruction also includes corrections to the provider series numbers for dialysis providers: 3300-3399 (Children's hospitals).

Separately Billable ESRD Drugs

The following categories of drugs are separately billable when furnished in hospital-based facilities or independent dialysis facilities to treat the patient's renal condition:

- Antibiotics
- Analgesics
- Anabolics
- Hematinics
- Muscle relaxants
- Sedatives
- Tranquilizers
- Thrombolytics: used to declot central venous catheters.

Note: Erythropoietin replacement therapies are separately billable and paid at established rates through appropriate billing methodology: epotein (EPO) alfa (Epotein®) and darbepoetin alfa (Aranesp®) (see the *Medicare Claims Processing Manual, Pub. 100-04, Sections 60.4* and *60.7*). Also, note that there is an exception for separate payment for antibiotics. Antibiotics are included in the composite rate when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis.

These separately billable drugs may only be billed by an ESRD facility if they are actually administered in the facility by the facility staff. Staff time used to administer separately billable drugs is covered under the composite rate and may not be billed separately.

Drugs Furnished in Dialysis Facilities

Payment is made for drugs furnished in independent dialysis facilities and paid outside the composite rate, based on:

- The lower of billed charges; or
- Ninety five percent average wholesale price (AWP) for the calendar year 2004.

Coinsurance and deductible are applied to billed charges.

Hospital-based facilities are paid at cost with applicable coinsurance and deductibles.

The *Medicare Benefit Policy Manual, Chapter 11* provides a description of drugs that are part of the composite rate and when other drugs may be covered. Except for epoetin alfa (Epogen, EPO) and darbepoetin alfa (Aranesp,

Clarification of Billing for Separately Billable End Stage Renal Disease Drugs (continued)

DPA), drugs and biologicals, such as blood, may be covered in the home dialysis setting only if the "incident to a physician's services" criteria are met (i.e., it is not covered under the composite rate).

Normally, a physician is not in the patient's home when the drugs or biologicals are administered, and therefore, drugs and biologicals generally are not paid in the home setting.

Billing Procedures for Drugs for Facilities

The following billing procedures apply to independent and hospital based facilities. Facilities identify and bill for drugs by HCPCS code, along with revenue code 0636, "Drugs Requiring Specific Information." The example below includes the Healthcare Common Procedure Coding System (HCPCS) code and indicates the dosage amount specified in the descriptor of that code. Facilities use the units field as a multiplier to arrive at the dosage amount.

Example 1: HCPCS – J3360, Drug – Valium, dosage (lowest denominator) – 5mg, Amount - $200.

Actual dosage: 10 mg

On the bill, the facility shows J3360 and 2 in the units field (2 x 5 mg = 10 mg). For independent facilities, fiscal intermediaries (FIs) compare the price of $4.00 (2 x $2.00) to the billed charge and pay the lower, subject to coinsurance and deductible.

Note:

- When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units.
- When the dosage amount is less than the amount indicated for the HCPCS code, use one (1) as the unit of measure.

In the above example, if the dosage were 7 mg, the facility would show 2 in the unit field, if the dosage were 3 mg, the facility would show one (1) in the unit field. Facilities bill for supplies used to administer drugs with revenue code 0270, "Medical/Surgical Supplies." The number of administrations is shown in the units field.

Example 2: Revenue Code – 0270, Units – 3T

The number of units for supply codes billed should match the number of injections billed on the claim form. Appropriate HCPCS codes for administration-supply of separately billable drugs would include:

- **A4657:** Injection administration-supply charge: include the cost of alcohol swab, syringe, and gloves.
- **A4913:** IV administration-supply charge: include the cost of IV solution administration set, alcohol swab, syringe, and gloves. This code should only be used when an IV solution set is required for a drug to be given. This rate will not be paid for drugs that only require a syringe for administration.

Drug Payment Amouns for Facilties

Hospital-based facilities are paid at cost with applicable coinsurance and deductibles. Independent facilities are paid based on the lower of billed charges or 95 percent AWP for the calendar year 2004: coinsurance and deductibles are applied to billed charges. Payment for separately billable ESRD drugs is subject to the Medicare policy that the program does not pay for items that are not medically necessary, or pay for the cost of luxury items beyond the basic item required to treat the patient's medical condition.

Therefore, payment is limited to the reimbursement that would be made for the generic form of the drug or the lowest cost-equivalent drug. Payment for the additional price of a brand name drug in excess of the price of the generic drug may be made only if the FI determines that the brand name drug is medically necessary.

Dialysis Provider Number Series

There are multiple facilities that provide dialysis services to ESRD beneficiaries. To ensure that provider data is correct, facilities are required to use a provider number based on facility type issued by the Centers for Medicare & Medicaid Services (CMS).

The provider number series for dialysis providers are as follows:

- 2300-2499 Chronic renal dialysis facilities (hospital–based)
- 2500-2899 Non–hospital renal facilities
- 2900-2999 Independent special purpose renal dialysis facility
- 3300-3399 Children's hospitals (excluded from PPS)
- 3500-3699 Renal disease treatment centers (hospital satellites)
- 3700-3799 Hospital based special purpose renal dialysis facilities.

All facilities should use their appropriately assigned provider numbers on the 72x type of bill. In the event that a facility changes from one type to another, the provider number must reflect the facility's present provider type. Listings of the transplant centers may be found on the CMS website at *http://www.cms.hhs.gov/ESRDGeneralInformation/downloads/trancenterslist_23dec2005.pdf*.

Implementation

The implementation date for this instruction is October 4, 2004.

Related Instructions

Transmittal 39 (CR 2963) dated January 6, 2004, *Change in Coding on Medicare Claims for Darbepoetin Alfa (trade name Aranesp) and Epoetin Alfa (trade name Epogen, EPO) for Treatment of Anemia In End Stage Renal Disease (ESRD) Patients On Dialysis*, may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R39OTN.pdf*.

Clarification of Billing for Separately Billable End Stage Renal Disease Drugs (continued)

Also, Transmittal 118 (CR 2984) dated March 5, 2004, *Frequency Limitations for Darbepoetin Alfa (trade name Aranesp) for Treatment of Anemia in End Stage Renal Disease (ESRD) Patients on Dialysis*, may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R118CP.pdf*.

Additional Information

As a result of these changes, the following sections are being revised or added to the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 8 (*Outpatient ESRD Hospital, Independent Facililty, and Physician/Supplier Claims*):

10.9 – Dialysis Provider Number Series – revised
60.2 – Drugs Furnished in Dialysis Facilities – revised
60.2.1 – Billing Procedures for Drugs for Facilities – revised
60.2.1.1 – Separately Billable ESRD Drugs – new
60.2.2 – Drug Payment Amounts for Facilities – revised.

These revised manual sections can be viewed as an attachment to CR 3176. The official instruction issued to your intermediary regarding this change may be found by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R146CP.pdf*.

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

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

MLN Matters Number: MM3176 Revised
Related Change Request (CR) Number: 3176
Related CR Release Date: April 23, 2004
Related CR Transmittal Revised: 146
Effective Date: October 1, 2004
Implementation Date: April 3, 2006

Source: CMS Pub. 100-04, Transmittal 146, CR 3176

New Conditions of Participation for Transplant Centers

On Friday, March 30, 2007, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* its new conditions of participation for transplant centers: *CMS-3835-F, Hospital Conditions of Participation: Requirements for Approval and Re-approval of Transplant Centers to Perform Organ Transplants.* This final rule announces new requirements that hospitals must conform to when applying for Medicare certification of their renal and extra-renal transplant center programs.

The effective date of the rule is June 28, 2007, which is 90 days from the publication of the final rule. Prior to this final rule, Medicare-approved extra-renal transplant centers have been governed by criteria published in national coverage decisions (NCDs) and related program memoranda. Extra-renal transplant centers that are Medicare-approved as of the effective date of the final rule will continue to be governed by those criteria until they apply for and receive a survey under the criteria of the final rule.

Effective immediately, an extra-renal transplant center that seeks to participate in and receive payment from the Medicare program and has not yet filed an application for Medicare payment approval must apply under the criteria contained in the final rule. That is, except as noted below with respect to pediatric centers, CMS will no longer accept extra-renal transplant center applications under the NCD process (because there may be insufficient time to approve the application prior to the effective date of the final rule). CMS will, however, continue processing applications already in progress. CMS will also continue to accept letter applications from pediatric centers that seek Medicare payment approval based on their association with a Medicare-approved adult transplant center, provided that such letter applications are received by June 22, 2007.

Transplant programs that want to submit an application for Medicare certification under the hospital conditions of participation may find additional information on the application and certification process at *http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp*. ❖

Source: CMS Provider Education Resource 200703-28

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

May 2007 – August 2007

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**

Ask the Contractor (Topics To Be Determined)

When: **Tuesday, August 14, 2007**

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

Type of Event: **Teleconference**

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.

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Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Provider Address: _____

City, State, ZIP Code: _____

PREVENTIVE SERVICES

National Colorectal Cancer Awareness Month Is Over

Don't Forget To Follow-Up!

National Colorectal Cancer Awareness Month is almost over, but that doesn't mean the messages to your patients should stop until next year. Remind patients who have taken home a fecal occult blood test kit to use it. Follow up with patients on all screening results, even negative ones—everyone likes to hear good news. Remember, the appropriate follow-up for a positive fecal occult blood test result is a colonoscopy, not another fecal occult blood test.

Follow the Guidelines to Guide Next Steps when Polyps Are Found

A recent survey by the National Cancer Institute found that gastroenterologists and surgeons are performing surveillance colonoscopies at more frequent intervals than those recommended by evidence-based guidelines. For example, 24 percent of gastroenterologists and 54 percent of surgeons recommended a colonoscopy, either alone or with another procedure, at least every five years after the identification of a small, benign, hyperplastic polyp (Mysliwiec et al., 2004). Medical guidelines do not recommend any follow-up colonoscopy for hyperplastic polyps because their presence has not been shown to increase the risk of colorectal cancer. In contrast, adenomatous polyps ARE associated with cancer and people who have multiple polyps of this kind should be screened at shorter intervals.

Guidelines for surveillance after polypectomy were recently updated—here are references to two publications featuring these guidelines:

- Winawer, Zauber, Fletcher et al. Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society. *Gastroenterology* 2006; 130:1872-1885.
- Winawer, Zauber, Fletcher et al. Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society. *CA Cancer J Clin* 2006; May-Jun; 56(3):143-59

For More Information

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* .

The Centers for Medicare & Medicaid Services (CMS) website also has a "Prevention" website, which contains a section on colorectal cancer screening. From the CMS home page, *http://www.cms.hhs.gov*, select "Medicare" and scroll down to "Prevention" to find the colorectal cancer screening section.

Thank You for the Great Work!

Thank you for helping CMS spread the word regarding the importance of colorectal cancer screening. We are interested in knowing if the information we have provided over the last few weeks has been helpful, and if it has influenced your colorectal cancer screening practices. Please e-mail CMS at: *Prevention@cms.hhs.gov*

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

Source: CMS Provider Education Resource 200703-27

See How Well Your County or State Has Done in Providing Colorectal Cancer Screening to People with Medicare

Click on the following link: *http://www.mrnc.org/crcreport2/*.

The Carolinas Centers for Medical Excellence, Inc., the Quality Improvement Organization for North and South Carolina, calculated national, state, and county colorectal cancer screening rates using Medicare claims data from 1998-2004. The data indicate that over half (52 percent) of those eligible for screening had at least one test in the seven-year period.

Other highlights from the data:

- Although the largest group of people eligible for screening was composed of persons between the ages 65-74 (41 percent of those eligible), the rate of screening was highest among people ages 75-84 (59 percent screened).
- Test use was highest among Caucasians (53 percent), followed by Asians (46 percent), African Americans (45 percent), persons of Hispanic descent (45 percent), and Native Americans (35 percent).
- There was considerable disparity between the test rates for those eligible for only Medicare (54 percent) and persons eligible for both Medicare and Medicaid (43 percent).
- Persons eligible for Medicare due to a disability also had lower test rates (45 percent) than those eligible because of age (54 percent).
- Among the four covered tests, fecal occult blood test was the most commonly used test with a rate of 34 percent. Colonoscopy had the second highest use rate (31 percent), followed by sigmoidoscopy (14 percent) and barium enema (6 percent).
- Test use varied across states. In 2004, Rhode Island Medicare consumers had the highest test use (26 percent had one of the tests) and the lowest in Wyoming (13 percent).

CMS Needs Your Help

No part of the Medicare population has high rates of use of colorectal cancer screening tests. The Centers for Medicare & Medicaid Services (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 More Information

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/colonmd?utm_source=CMSlistserve&utm_medium=email&utm_term=colon&utm_content=colonMD

Medicare-Covered Colorectal Cancer Screening Tests/Procedures:

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 200703-20

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

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OTHER EDUCATIONAL RESOURCES

Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet now Available

The *Inpatient Rehabilitation Facility Prospective Payment System (PPS) Fact Sheet*, which provides information about inpatient rehabilitation facility PPS rates and classification criterion, is now available in downloadable format on the Centers for Medicare & Medicaid Services *Medicare Learning Network* Publications Page located at *http://www.cms.hhs.gov/MLNProducts/downloads/IRFPPSFactSheet0307.pdf*. ❖

Source: CMS Provider Education Resource 200704-02

Critical Access Hospital Fact Sheet Available

The *Critical Access Hospital Fact Sheet*, which provides general information about critical access hospitals, is now available in downloadable format on the Centers for Medicare & Medicaid Services *Medicare Learning Network Publications* page located at *http://www.cms.hhs.gov/MLNProducts/downloads/CritAccessHosp07fctsht.pdf*.

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

Source: CMS Provider Education Resource 200704-11

Medicare Physician Fee Schedule Fact Sheet Available in Print Format

The Medicare Physician Fee Schedule Fact Sheet, which provides general information about the Medicarephysician fee schedule, is now available in print format. To place an order for the fact sheet, visit the *Medicare Learning Network* at *http://www.cms.hhs.gov/mlngeninfo* on the Centers for Medicare & Medicaid Services website and select "MLN Product Ordering Page" under the "Related Links Inside CMS" section. ❖

Source: CMS Provider Education Resource 200704-01

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IMPORTANT ADDRESSES, TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

PROVIDER EDUCATION

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

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION

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

OVERPAYMENT COLLECTIONS

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

MEDICARE REGISTRATION

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

Telephone Numbers

PROVIDERS

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

BENEFICIARY

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

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Websites

PROVIDERS

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

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

RAILROAD MEDICARE

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

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

MEDICARE A BULLETIN

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

* ATTENTION BILLING MANAGER *