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

Table of Contents

Medicare A Bulletin

Vol. 9, No. 3
March 2007

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

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

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Publications – 10T
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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 – 10T
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Jacksonville, FL 32232-5270

Sign up to our *eNews* electronic mailing list

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

GENERAL INFORMATION

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

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's 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 will soon be published that contains the list of all active Medicare contracts and their corresponding plan type. The directory will be posted at the following URL no later than March 1, 2007: *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage*.

Background

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

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

Private Fee-for-Service Plans

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

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

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services
- Provider billing procedures, including
  - The amount the provider is permitted to collect from the enrollee; and
  - Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

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

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

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

Additional Information

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

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

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

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

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

Update on CMS Actions to Reverse Invalid Overpayments Generated by Managed Care Informational Unsolicited Responses

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

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare contractors (fiscal intermediaries [FIs], carriers, Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment regional carriers [DMERCs], and/or DME Medicare administrative contractors [DME/MACs]).

Provider Action Needed

This article provides information regarding overpayment recovery actions that may be taken by your Medicare contractor and the circumstances that have caused these recovery actions. We estimate that between 150,000 – 300,000 claims may be affected by these actions. If, due to the conditions stated below, an overpayment recovery action has occurred for your claims, your Medicare contractor is in the process of correcting the payment. **You need not take any action at this time.** Because these actions will affect Medicare contractors in varying degrees, you should stay tuned to your Medicare contractor's website for additional details.

Background

In *MLN Matters* article SE0681 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0681.pdf*), the Centers for Medicare & Medicaid Services (CMS) advised providers of certain eligibility system issues related to managed care Medicare beneficiaries. In brief, article SE0681 alerted providers that, in some instances, Medicare may be recovering certain overpayments due to system updates on beneficiary eligibility. When such overpayments are identified, Medicare systems generate a managed care informational unsolicited response (MCIUR), which triggers the overpayment recovery.

During the week of December 17, 2006, Medicare systems were updated with some incorrect managed care enrollment data, which, in turn, caused the systems to create some incorrect MCIURs. Medicare files have now been corrected and CMS is working diligently with Medicare contractors to stop the invalid overpayment recoveries from occurring. In addition, where action to recover the overpayments has already occurred, CMS has instructed your contractor to reverse the action and reissue payment to you.

Key Points

- CR 5507 states that recovery action should stop if it has been initiated and reversed if MCIURs have already effected a recovery.
- Physicians and other providers who bill Medicare contractors need not take any action since contractors will automatically make the necessary adjustments as CR5507 is implemented.
- Your contractor will post more detailed information on their website as CR 5507 is implemented.

Additional Information

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

For complete details regarding this issue, please see the official instruction (CR5507) issued to your Medicare carrier, FI, A/B MAC, DME MAC, and/or DMERC. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R262OTN.pdf*.

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

MLN Matters Number: MM5507
Related Change Request (CR) Number: 5507
Related CR Release Date: January 26, 2007
Related CR Transmittal Number: R262OTN
Effective Date: January 26, 2007
Implementation Date: April 26, 2007

Source: CMS Pub. 100-20, Transmittal 262, CR 5507

Flu Shot Reminder

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

The peak of flu season typically occurs between late December and March; however, flu season can last until May. **Protect yourself, your patients, and your family and friends by getting and giving the flu shot.**

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

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

Source: CMS Provider Education Resource 200701-13

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

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

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

CAUTION – What You Need to Know

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

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

GO – What You Need to Do

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

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

Background

Reimbursement Based on the Location Where the Service Was Rendered

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

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

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

Nine-Digit ZIP Codes

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

There are some important details that you should know:

Exceptions

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

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

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

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

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

Master Address

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

Effective July 1, 2007, institutional providers, with a ZIP code displayed below, will need to submit a valid nine-digit ZIP code on the CMS 855-A when the provider file

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

master address ZIP code is five-digits, the last four-digits of a nine-digit ZIP code are zeroes, or the last four-digits of a nine-digit ZIP code do not match a four-digit extension on the ZIP code file.

Claims Returned as Unprocessable

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

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

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

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

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

ZIP Codes that Cross Payment Localities by State

Arkansas (AR)
71749 71953 72338 72395 72444 72644

Arizona (AZ)
85534

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

Delaware (DE)
19952 19973

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

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

Idaho (ID)
83342 83856

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

Iowa (IA)
51630 51640 52542 52573 52626 52761

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

Kentucky (KY)
40965 42079 42223 42602

Massachusetts (MA)
01432 01434 01930 02324 02339 02762

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

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

Minnesota (MN)
56136 56144 56164 56219 56220 56257 56744

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

Montana (MT)
59030 59847

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

Nevada (NV)
89061

New Hampshire (NH)
03579 03813

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

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

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

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

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

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

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

Tennessee (TN)
37317 37391 37821 38326

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

Virginia (VA)
20120 20135

Washington (WA)
98019 98022 98047 98072 98077 98092 98177
98251 98354 99033 99128

Wisconsin (WI)
54540

Wyoming (WY)
82063 82082 82240 82716 82725 82731 82930
83114 83120 83127

Additional Information

You can find more information about the use of nine-digit ZIP codes for determining the correct payment locality for anesthesia services and services paid under the MPFS by going to CR 5208, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1167CP.pdf*.

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

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

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

MLN Matters Number: MM5208
Related Change Request (CR) Number: 5208
Related CR Release Date: January 26, 2007
Related CR Transmittal Number: R1167CP
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Source: CMS Pub. 100-04, Transmittal 1167, CR 5208

Additional Changes to the 2007 Medicare Physician Fee Schedule Database

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

Provider Types Affected

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

Background

This article and change request (CR) 5498 wants providers to know that payment files were issued to carriers based upon the December 1, 2006, MPFS final rule and Transmittal 1143, Change Request 5459, *Emergency Update to the 2007 Medicare Physician Fee Schedule Database*. (*MLN Matters* MM5459 is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf*.)

This CR, 5498, **amends those payment files** and **includes new** outpatient prospective payment system (OPPS) **payment amounts for codes subject to the OPPS cap and other miscellaneous corrections.**

Key Points of CR 5498

The changes to the 2007 MPFSDB are listed in **Attachment 1** of CR 5498 and those changes are:

CPT/HCPCS	ACTION
31545	Bilateral Indicator = 1
31546	Bilateral Indicator = 1
70555 – 26	Work RVU = 2.54
76998 – 26	Work RVU = 1.20
77013 – 26	Work RVU = 3.99
77022 – 26	Work RVU = 4.24
77055 – Global	Work RVU = 0.70
77055 – 26	Work RVU = 0.70
93624 – 26	Status Indictor = A Work RVU = 4.80 Transitional Non-Facility PE RVU = 2.31 Fully Implemented Non-Facility PE RVU = 2.67 (Informational Only) Transitional Facility PE RVU = 2.31 Fully Implemented Facility PE RVU = 2.67 (Informational Only) Malpractice RVU = 0.33
96020 – 26	Work RVU = 3.43
G0103	Short Descriptor = PSA screening
S0147	Status Indicator = I
S0180	Status Indicator = I
S0345	Status Indicator = I
S0346	Status Indicator = I
S0347	Status Indicator = I
S2325	Status Indicator = I
S2344	Status Indicator = I
S3855	Status Indicator = I

Note: **In addition to the changes listed above,** all records subject to the OPPS payment cap are also included since these payment amounts have been changed. These codes may be identified by OPPS indicator = 1.

Providers take note that the Medicare contractors will not search their files for claims affected by these changes in order to retract payment for claims already paid or retroactively pay claims. However, contractors will adjust claims that you bring to their attention.

Additional Information

You can see the official instruction issued to your Medicare carrier, FI or A/B MAC by going to CR 5498, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1161CP.pdf*.

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

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

MLN Matters Number: MM5498
Related Change Request (CR) Number: 5498
Related CR Release Date: January 24, 2007
Related CR Transmittal Number: R1161CP
Effective Date: January 1, 2007
Implementation Date: February 26, 2007

Source: CMS Pub. 100-04, Transmittal 1161, CR 5498

Timely Claim Filing Guidelines for All Medicare Providers

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

Dates of Service	Last Filing Date
October 1, 2004 – September 30, 2005	by December 31, 2006
October 1, 2005 – September 30, 2006	by December 31, 2007
October 1, 2006 – September 30, 2007	by December 31, 2008
October 1, 2007 – September 30, 2008	by December 31, 2009

If December 31 falls on a Saturday, Sunday, federal nonworking or legal holiday, the last filing date is extended to the next succeeding workday.

Periodic interim payment (PIP) providers must submit claims by the last day of the year following the year of the discharge date.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned to the provider (RTP) for correction, is not protected from the timely filing guidelines. ❖

Source: CMS Pub.100-04 (*Medicare Claim Processing Manual*), Chapter 1, Section 70

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GENERAL COVERAGE

Guidelines for Payment of Diabetes Self-Management Training

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

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs) for DSMT services provided in institutional settings to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5433, which corrects, clarifies, and provides guidelines for the payment of diabetes self-management training (DSMT) services in various institutional provider settings.

CAUTION – What You Need to Know

Medicare Part B covers **ten** hours of initial training for a beneficiary who has been diagnosed with diabetes, and beneficiaries are eligible to receive **two** hours of follow-up training each calendar year following the year in which they were certified as requiring initial training. **The physician or qualified nonphysician practitioner who is managing the beneficiary's diabetic condition must order the DSMT.**

GO – What You Need to Do

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

Background

The Balanced Budget Act of 1997 (Section 4105) permits Medicare coverage of diabetes self-management training (DSMT) services when these services are furnished by a certified provider who meets certain quality standards, and CR 5433 corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings. Note that no new codes are being created by CR 5433. Also, deductible and coinsurance apply to these services.

The DSMT program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

Initial Training

The initial year for DSMT is the 12-month period following the initial date, and Medicare will cover initial training that meets the following conditions:

- DSMT is furnished to a beneficiary who has not previously received initial or follow-up training under Healthcare Common Procedure Coding System (HCPCS) code G0108 or G0109.
- DSMT is furnished within a continuous 12-month period.
- DSMT does not exceed a total of ten hours (the ten hours of training can be done in any combination of 1/2-hour increments.
- With the exception of 1 hour of individual training, the DSMT training is usually furnished in a group setting with the group consisting of individuals who need not all be Medicare beneficiaries.
- The one hour of individual training may be used for any part of the training including insulin training.

Follow-Up Training

Medicare covers follow-up training under the following conditions:

- No more than two hours individual or group training is provided per beneficiary per year.
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries.
- Follow-up training for subsequent years is based on a 12 month calendar after completion of the full 10 hours of initial training
- Follow-up training is furnished in increments of no less than one-half hour.
- The physician (or qualified nonphysician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

Note: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

Examples

Example #1: Beneficiary Exhausts 10 hours in the Initial Year (12 continuous months)

Beneficiary receives first service in April 2006.

Beneficiary completes initial 10 hours DSMT training in April 2007.

Beneficiary is eligible for follow-up training in May 2007 (13th month begins the subsequent year).

Beneficiary completes follow-up training in December 2007.

Beneficiary is eligible for next year training in January 2008.

Example #2: Beneficiary Exhausts 10 Hours Within the Initial Calendar Year

Beneficiary receives first service in April 2006.

Beneficiary completes initial 10 hours of DSMT training in December 2006.

Guidelines for Payment of Diabetes Self-Management Training (continued)

Beneficiary is eligible for follow-up training in January 2007.

Beneficiary completes follow-up training in July 2007.

Beneficiary is eligible for next year follow-up training in January 2008.

Coding and Payment of DSMT Services

The following HCPCS codes should be used for DSMT:

G0108 Diabetes outpatient self-management training services, individual, per 30 minutes

G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Payment to physicians and providers for outpatient DSMT is made as follows:

Type of Facility/Provider	Payment Method	Type of Bill
Physician/non-physician practitioner (billing carrier/MAC)	Medicare physician fee schedule	N/A
Hospitals subject to outpatient prospective payment system (OPPS)	OPPS	12x, 13x
Method I and method ii critical access hospitals (CAHs) (technical services)	101 percent of reasonable cost	12x and 85x
Indian health service (IHS) providers billing hospital outpatient	Office of Management and Budget (OMB)-approved outpatient per visit all-inclusive rate (AIR)	13x and revenue code 051x
IHS providers billing inpatient Part B	All-inclusive inpatient ancillary per diem rate	12x and revenue code 024x
IHS CAHs billing outpatient	101 percent of the all-inclusive facility specific per visit rate	85x and revenue code 051x
IHS CAHs billing inpatient Part B	101 percent of the all-inclusive facility specific per diem rate	12x and revenue code 024x
Rural health clinics (RHCs)	All-inclusive encounter rate	71x with revenue code 0520, 0521, 0522, 0524, 05225, 0527, 0528, or 0900
Federally qualified health centers (FQHCs)*	All-inclusive encounter rate	73X with revenue code 0520, 0521, 0522, 0524, 0525, 0527, 0528, 0r 0900
Skilled nursing facilities (SNFs) **	Medicare physician fee schedule (MPFS) non-facility rate	22x, 23x
Maryland hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	Payment in accordance with the terms of the Maryland waiver	12x, 13x
Home health agencies (can be billed if service is outside of the treatment plan)	MPFS non-facility rate	34x

* Effective January 1, 2006, payment for DSMT provided in an FQHC, that meets all the requirements as above, may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB 73x, with HCPCS code G0108 or G0109, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.

** The SNF consolidated billing provision allows separate Part B payment for training services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a TOB 22x. Training services provided by other provider types must be reimbursed by the SNF.

Note: An end-stage renal disease (ESRD) facility is a reasonable site for this DSMT service, however, because it is required to provide dietician and nutritional services as part of the care covered in the composite rate, ESRD facilities are not allowed to bill for it separately and do not receive separate reimbursement.

Advanced Beneficiary Notices (ABNs)

Providers should also be aware that the beneficiary is liable for services denied over the limited number of hours with referrals for DSMT. An ABN should be issued in these situations and absent evidence of a valid ABN, the provider would be held liable.

However, an ABN should not be issued for Medicare-covered services such as those provided by hospital dieticians or nutrition professionals who are qualified to render the service in their state, but who have not obtained Medicare provider numbers.

Additional Information

For complete details, please see the official instruction, CR 5433, issued to your FI, RHHI, and A/B MAC regarding this change. There are two transmittals related to CR 5433, one which revises the *Medicare Benefit Policy Manual* and one that modifies the *Medicare Claims Processing Manual*.

Guidelines for Payment of Diabetes Self-Management Training (continued)

These transmittals are at *http://www.cms.hhs.gov/Transmittals/downloads/R64BP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1158CP.pdf*, respectively.

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

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

Source: CMS Pub. 100-04, Transmittal 1158, CR 5433

Infrared Therapy Devices

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 February 9, 2007, to correct the range of ICD-9-CM codes shown in bold print to ICD-9-CM range 880.00-887.7. The article was also revised to reflect the new change request (CR) transmittal number, the CR release date, and the Web address for accessing CR 5421. All other information remains the same. The original *MLN Matters* article was published in the January 2007 *Medicare A Bulletin* (pages 32).

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare carriers, Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME/MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs), for the use of infrared therapy devices for treatment of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5421. Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services (CMS) has made a national coverage determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), **is noncovered for the treatment,** including symptoms such as pain arising from these conditions, of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Background

The use of infrared therapy devices has been proposed for a variety of disorders, including treatment of diabetic neuropathy, other peripheral neuropathy, skin ulcers and wounds, and similar related conditions, including symptoms such as pain arising from these conditions. A wide variety of devices are currently available. Previously there was no NCD concerning the use of infrared therapy devices, leaving the decision to cover or not cover up to local Medicare contractors.

The following requirements are in effect as of October 24, 2006:

- **Effective for services provided on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) **are noncovered** as DME or PT/OT services when used for the treatment of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.
- Claims will be denied with *CPT 97026* (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9-CM codes:

  250.60-250.63

  354.4, 354.5, 354.9

  355.1-355.4

  355.6-355.9

  356.0, 356.2-356.4, 356.8-356.9

  357.0-357.7

  674.10, 674.12, 674.14, 674.20, 674.22, 674.24

  707.00-707.07, 707.09-707.15, 707.19

  870.0-879.9

  880.00-887.7

  890.0-897.7

  998.31-998.32.
- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects type of bills (TOBs) 12x, 13x, 22x, 23x, 34x, 74x, 75x and 85x.
- If you submit a claim for one of the noncovered services, your patient will receive the Medicare summary notice (MSN) message stating "This service was not covered by Medicare at the time you received it." The Spanish translation is: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."
- If you submit a claim for one of the noncovered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, "These are

Infrared Therapy Devices (continued)

noncovered services because this is not deemed a 'medical necessity' by the payer."

- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that **you are liable** if the service is performed, unless the beneficiary signs an advanced beneficiary notice (ABN).
- DME suppliers and HHA be aware that **you are liable** for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

For complete details regarding this CR please see the official instruction (CR5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR 5421. The first is the national coverage determination transmittal, located at on the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf*.

In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1183CP.pdf*.

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

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

MLN Matters Number: MM5421 – Revised
Related Change Request (CR) Number: 5421
Related CR Release Date: February 9, 2007
Related CR Transmittal Number: R1183CP and R62NCD
Effective Date: October 24, 2006
Implementation Date: January 16, 2007

Source: CMS Pub. 100-04, Transmittal 1183, CR 5421.

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HOSPITAL SERVICES

Payment of Same Day Transfer Claims Under the Long Term Care Hospital Prospective Payment System

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

Provider Types Affected

Providers submitting long term care hospital LTCH same day transfer claims to Medicare contractors (fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs]).

Provider Action Needed

This article is for informational purposes and is based on change request (CR) 5323 which clarifies how to process LTCH same day transfer claims which have been suspended in the fiscal intermediary standard system (FISS) since implementation of LTCH (prospective payment system) PPS on October 1, 2002.

Background

The Centers for Medicare & Medicaid Services (CMS) recently found that same-day transfer LTCH PPS claims have been suspending in FISS since the implementation of the LTCH PPS on October 1, 2002.

A same day transfer occurs when a patient is admitted to a LTCH and is subsequently transferred for acute care (or another type facility care) on the same day.

If the patient is admitted to a LTCH with the expectation that the patient will remain overnight but is discharged before midnight, the day is:

- **Counted** as **a total day** (i.e., a cost report day), and
- **Not counted** as **a Medicare covered day**.

In other words, this day will be considered covered and counted for cost reporting purposes, but will not be counted as a Medicare utilization day for the beneficiary.

Currently, same day transfer claims are suspending in the FISS system because:

- The LTCH PPS PRICER cannot accept a '0' day, and
- There is no transfer policy under LTCH PPS.

CR 5323 clarifies how to process LTCH same day transfer claims that have been suspended in FISS since implementation of the LTCH PPS on October 1, 2002, and instructs that same day transfer LTCH PPS claims that have been suspended are to be released as of July 2, 2007, and are to be paid with interest applied.

Additional Information

The official instruction, CR 5323, issued to your FI or A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1172CP.pdf*.

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

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

MLN Matters Number: MM5323
Related Change Request (CR) Number: 5323
Related CR Release Date: February 2, 2007
Related CR Transmittal Number: R1172CP
Effective Date: October 1, 2002
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1172, CR 5323

Long-Term Care Hospital Year Rate Proposed Rule

The proposed rule issued by the Centers for Medicare & Medicaid Services (CMS), "Medicare Program; Prospective Payment System for Long Term Care Hospitals RY (rate year) 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes" (CMS-1529-P), which was published in the *Federal Register* on February 1, 2007, incorrectly states that the 60-day public comment period will close on April 2, 2007 (72 FR 4776). A correction notice will be issued shortly to specify that **comments on CMS-1529-P must be received no later than 5 p.m. on March 26, 2007** to be assured consideration. ❖

Source: CMS Provider Education Resource 200702-05

Outpatient Clinical Laboratory Tests Furnished by Hospitals with Fewer Than 50 Beds in Qualified Rural Areas

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

Provider Types Affected

Hospitals with fewer than 50 beds in qualified rural area submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for outpatient clinical laboratory tests provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5493 which instructs that payment for outpatient clinical laboratory tests to hospitals (with fewer than 50 beds in qualified rural areas) will be made on a reasonable cost basis for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2007.

Background

The Balanced Budget Refinement Act of 1999 provided payment (on a reasonable cost basis) for outpatient clinical laboratory tests to critical access hospitals (CAHs). Subsequently, a provision in Section 416 of the Medicare Modernization Act (MMA) of 2003 provided for payment on a reasonable cost basis for outpatient clinical laboratory tests:

- To hospitals with fewer than 50 beds in qualified rural areas,
- For cost reporting periods **beginning during the two-year period** beginning on July 1, 2004.

This was implemented by CR 3130 (*http://www.cms.hhs.gov/transmittals/Downloads/R100CP.pdf*).

The corresponding MLN Matters article may be found at *http://www.cms.hhs.gov/mlnMattersArticles/downloads/MM3130.pdf*.

The provision (in Section 416 of the MMA) **was recently extended** (by Section 105 of the Tax Relief and Health Care Act of 2006) **for an additional year** for cost reporting periods **beginning during the three-year period** beginning on July 1, 2004.

Therefore, CR 5493 instructs that payment will be made on a reasonable cost basis for outpatient clinical laboratory tests:

- To hospitals with fewer than 50 beds in qualified rural areas,
- For cost reporting periods **beginning during the three-year period** beginning on July 1, 2004 (i.e., beginning on or after July 1, 2004 but before July 1, 2007).

CR 5493 also instructs your FI or A/B MAC to adjust any affected laboratory claims (those containing lines with revenue code 030x) from hospitals meeting the requirements for reasonable cost payment for such services during this additional year.

Note: Medicare outpatient covered clinical laboratory services are generally paid based on a fee schedule, and Medicare beneficiaries are not liable for coinsurance, deductibles or other cost sharing amounts for these services.

Reasonable costs (for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2007) are determined by 1) using the ratio of costs to charges for the laboratory cost center 2) multiplied by the provider statistical and reimbursement's report (PS&R's) billed charges for outpatient laboratory services.

The same rules used to determine whether clinical laboratory services are furnished as an outpatient CAH service apply for outpatient clinical laboratory tests to hospitals with fewer than 50 beds in qualified rural areas (i.e., one with a population density in the lowest quartile of all rural county populations). Condition of participation for hospitals 42 CFR 485.620(a) (*http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?YEAR=currents&TITLE=42&PART=485&Section=620&SUBPART=&TYPE=TEXT* and State Operations Manual (Appendix W, Section 485.62(a); *http://cms.hhs.gov/manuals/Downloads/som107ap_w_cah.pdf*) establish the rules for bed count for CAHs.

Additional Information

The official instruction, CR 5493, issued to your FI and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1180CP.pdf*.

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

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

MLN Matters Number: MM5493
Related Change Request (CR) Number: 5493
Related CR Release Date: February 2, 2007
Related CR Transmittal Number: R1180CP
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1180, CR 5493

Correction to the Inpatient Psychiatric Facility Prospective Payment System PRICER

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

Provider Types Affected

Inpatient psychiatric facilities (IPFs) submitting claims to Medicare contractors (fiscal intermediaries [FIs], and Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5455 which announces that a new version of the IPF PPS PRICER will be released which will account for new diagnosis-related groups (DRGs) effective on October 1, 2006. CR 5455 also instructs Medicare contractors to add International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code 238.73 (High grade myelodysplastic syndrome lesions) which needs to receive a comorbidity adjustment of 1.07 for discharges **on or after October 1, 2006.**

Background

The IPF PPS PRICER (rate year 2007 effective October 1, 2006) was not updated to include new diagnosis related groups (DRGs). Although the IPF PPS PRICER only makes a DRG adjustment on 15 DRGs, psychiatric facility claims are still grouped and receive a DRG. Prior to October 1, 2006, there were 559 DRGs (DRGs 1 through 559), but 19 DRGs have been added (DRGs 560 through 579). A list containing DRGs 560 through 579 is included below in the Additional Information section of this article. Medicare contractors are currently holding IPF claims received that group to DRGs 560 through 579, and these claims will be released (and paid with interest) once the April 2007 PRICER is in production on April 2, 2007.

The IPF PPS PRICER (rate year 2007 effective October 1, 2006) also did not include ICD-9-CM diagnosis code 238.73 (High grade myelodysplastic syndrome lesions). This code should appear in the oncology comorbidity list, and it should receive a comorbidity adjustment of 1.07. After April 2, 2007, IPFs should resubmit claims (with discharges on or after October 1, 2006 through March 31, 2007) that contain ICD-9-CM diagnosis code 238.73 if the comorbidity adjustment should apply.

Additional Information

For complete details, please see the official instruction, CR 5455, issued to your FI and A/B MAC regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1166CP.pdf*.

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

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

DRGs 560 through 579 and their descrptors are listed below:

DRG	DRG Description
560	bacterial and tuberclous infections of nervous system
561	non-bacterial infections of nervous system except viral meningitis
562	seizure age >17 w cc
563	seizure age >17 w/o cc
564	headaches age >17
565	respiratory system diagnosis with ventilator support 96+ hours
566	respiratory system diagnosis with ventilator support < 96 hours
567	stomach, esophageal & duodenal proc age >17 w cc w major gi dx
568	stomach, esophageal & duodenal proc age >17 w cc w/o major gi dx
569	major small & large bowel procedures w cc w major gi dx
570	major small & large bowel procedures w cc w/o major gi dx
571	major esophageal disorders
572	major gastrointestinal disorders and peritoneal infections
573	major bladder procedures
574	major hematologic/immunologic diag exc sickle cell crisis & coagul
575	septicemia w mv 96+ hours age >17
576	septicemia w/o mv 96+ hours age >17
577	carotid artery stent procedure
578	o. r. procedure w pdx exc postoperative or post-traumatic infection
579	o. r. procedure w pdx of postoperative or post-traumatic infection

MLN Matters Number: MM5455
Related Change Request (CR) Number: 5455
Related CR Release Date: January 26, 2007
Related CR Transmittal Number: R1166CP
Effective Date: October 1, 2006
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1166, CR 5455

Inpatient Psychiatric Facility Prospective Payment System for Oncology Treatment Payment Adjustment

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

Provider Types Affected

Inpatient psychiatric facilities (IPFs) submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for oncology treatment services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5470, which states that an oncology adjustment factor should be applied when the oncology procedure code appears in either the principal procedure code field or any of the other procedure code fields. However, the adjustment may not have been applied to some claims. **Be sure your billing staff is aware of this issue and takes appropriate action as noted in this article.**

Background

Currently, the inpatient psychiatric facility (IPF) prospective payment system (PPS) PRICER program receives only the 'other' procedure codes from Medicare's fiscal intermediary standard system (FISS). Therefore, if a radiation or chemotherapy procedure code appears in the principal procedure code field, the claim will not receive the oncology treatment payment adjustment.

The IPF PPS provides a comorbidity adjustment of 1.07 for oncology treatment, and in order to receive this adjustment, a claim must have:

- An ICD-9-CM code in the range from 1400 through 2399, and
- A procedure code 99.25 (chemotherapy) or 92.21 through 92.29 (radiation).

CR 5470 states that the FISS will pass the IPF PPS PRICER all procedure codes, including the principal procedure code and allow this capability back to January 1, 2005 (the implementation date of the IPF PPS).

The oncology adjustment factor should be applied when the oncology procedure code appears in either the principal procedure code field or any of the other procedure code fields.

If an IPF believes that they are entitled to a comorbidity adjustment for oncology treatment, the IPF should resubmit their claim **after July 1, 2007,** so that they may be reimbursed accurately. Timely filing rules will not apply to claims re-submitted by IPFs as a result of this issue.

Additional Information

The official instruction, CR 5470, issued to FIs and A/B MACs regarding this change may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1170CP.pdf*.

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

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

MLN Matters Number: MM5470
Related Change Request (CR) Number: 5470
Related CR Release Date: February 2, 2007
Related CR Transmittal Number: R1170CP
Effective Date: January 1, 2005
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1170, CR 5470

Inpatient Hospital Therapeutic Services

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

Provider Types Affected

Hospitals that bill Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for therapy services.

Provider Action Needed

CR 5405, from which this article is taken: 1) Cross references, and contrasts, Part A current rehabilitation therapy coverage guidelines in the *Medicare Benefit Policy Manual* (Publication 100-02), Chapter 1 (Inpatient Hospital Services Covered Under Part A), to the Part B current rehabilitation therapy coverage guidelines found in chapter 15 (Covered Medical and Other Health Services); and 2) restores, into chapter 1, information related to respiratory therapy services in hospitals that was omitted from the 2003 IOM revision.

Read the following background section of this article for more information.

Background

As mentioned above, CR 5405, from which this article is taken, cross references Part A current rehabilitation therapy coverage guidelines in chapter 1 of Medicare Benefit Policy Manual (Publication 100-02), to the similar Part B therapy coverage guidelines in chapter 15 (see **Part 1**, below); and restores, into chapter 1, information about hospital respiratory therapy services that was omitted from the 2003 IOM revision (see **Part 2**, below).

Part 1

The following discussion provides some specific details related to the current rehabilitation therapy coverage guidelines.

Inpatient Psychiatric Facility Prospective Payment System for Oncology Treatment Payment Adjustment (continued)

- In the *Medicare Benefit Policy Manual*, (Publication 100-02), Chapter 1 (Inpatient Hospital Services Covered Under Part A), Section 50.5 (Physical Therapy, Occupational Therapy and Speech-Language Pathology Services), references to "therapy" services describe physical therapy, occupational therapy, and speech-language pathology services.
- With certain exceptions (below) the policies in this Subsection apply to ALL inpatient hospitals for therapy services covered under Part A (including, for example, the services of rehabilitation hospitals, psychiatric hospitals, critical access hospitals, and long term care hospitals), regardless of differing payment methodologies across settings).
- With certain exceptions (below), the policies that apply to outpatient therapy services also apply to inpatient hospital therapy services. Further, when an FI or A/B MAC has reason to interpret inpatient hospital therapy policies, they will generally apply the same policies applicable for Part B outpatient therapy services found in Publication 100-02, Chapter 15, Sections 220 and 230.
- The following are examples of inpatient hospital therapy policies consistent with Part B Policies:
  - Qualifications of staff identified as therapists and assistants
  - Supervision of assistants
  - Group therapy (note the term "concurrent therapy" does not apply)
  - Plans of care (with the exception that certification and recertification of the plans do not apply in inpatient hospitals)
  - Clinician participation in treatment
  - Documentation requirements for therapy services
  - Definitions of reasonable and necessary services (unless inpatient hospital policy is more stringent).

Exceptions to Part B Policies

As mentioned above, there are some exceptions to the Part B policies. You should be aware that since inpatient hospital has a separate benefit category, specific national inpatient hospital therapy policies that differ from the outpatient therapy policies.

The inpatient hospital therapy policies require that therapy services provided to hospital inpatients:

- Require an order (follow the inpatient hospital policies for orders); but
- Follow the certification and recertification requirements appropriate to the applicable prospective payment system (PPS), since the plan of care for therapy services is part of the overall plan of care for the inpatient setting;
- Do not require a renewed therapy plan of care for each 30 day period;
- May be documented as therapy services when provided by students only if a therapist, who is responsible for the services, provides direct supervision at all times; and
- Are not limited by the therapy caps that apply to Part B.

Moreover, in billing or documenting physical therapy, occupational therapy, or speech-language pathology services, you should not identify inpatient hospital services as therapy services if they are not consistent with therapy policies in Publication 100-02, Chapter 15, Sections 220 and 230 unless they are consistent with the exceptions.

For example:

- Inpatient hospital therapy services that do not require the skills of a therapist to perform them or to supervise a physical therapist assistant or occupational therapy assistant in their performance are not therapy services;
- Services provided by aides, even if under the supervision of a therapist are not therapy services; and
- Nurses, respiratory therapists, or other inpatient hospital staff assisting or encouraging a patient to do independent activities recommended by the clinician between treatment sessions are also not therapy services.

Part 2

The following discussion provides specific details (in Subsection 50.6 added to Chapter 1, Section 50) related to respiratory therapy furnished by the hospital (or by others under arrangements with the hospital and under its supervision).

Subsection 50.6 contains criteria for respiratory therapy that hospitals furnish under Medicare DRG (diagnosis related group) payments. Note that respiratory therapy services in hospitals are included in the DRG payment system and are not separately payable.

Subsection 50.6 defines respiratory therapy (respiratory care) as those services that a physician prescribes for the assessment, diagnostic evaluation, treatment, management, and monitoring (as defined, below) of patients with deficiencies and abnormalities of cardiopulmonary function.

Such services, if reasonable and necessary, and performed by respiratory therapists or technicians, physical therapists, nurses and other qualified personnel, are covered regardless of where they are furnished in the hospital (for example, emergency room, ICU, etc.).

Notes: *To qualify for reimbursement under Medicare, such therapy (1) must qualify as a covered service, and (2) must be reasonable and necessary for the diagnosis or treatment of an illness or injury. These services qualify as covered ancillary services under the inpatient hospital benefit when furnished by a respiratory therapist or technician; but when furnished by a nurse, respiratory services are considered nursing services and would be covered as such under the inpatient hospital benefit.*

Subsection 50.6 further describes respiratory therapy services to include (but not to be limited to):

- The application of techniques for support of oxygenation and ventilation in the acutely ill patient. These techniques include, but are not limited to:

Inpatient Psychiatric Facility Prospective Payment System for Oncology Treatment Payment Adjustment (continued)

- Establishment and maintenance of artificial airways
- Ventilator therapy and other means of airway pressure manipulation
- Precise delivery of oxygen concentration
- Techniques to aid removal of secretions from the pulmonary tree.

- The therapeutic use and monitoring of medical gases (especially oxygen), bland and pharmacologically active mists and aerosols and such equipment as resuscitators and ventilators.
- Bronchial hygiene therapy, including deep breathing and coughing exercises, IPPB, postural drainage, chest percussion and vibration, and nasotracheal suctioning.
- Diagnostic tests for evaluation by a physician, e.g., pulmonary function tests, spirometry, and blood gas analyses. (Note: Although the diagnostic testing referred to here is considered respiratory therapy, coverage of such tests is governed by the guidelines relating to the coverage of diagnostic tests.)
- Pulmonary rehabilitation techniques which include:
  - exercise conditioning
  - breathing retraining
  - patient education regarding the management of the patient's respiratory problems
- Periodic assessment and monitoring of the acute and chronically ill patients for indications for, and the effectiveness of, respiratory therapy services.

When reviewing bills to determine if respiratory services are reasonable and necessary, fiscal intermediaries and A/B MACS will use specific criteria, including those summarized as follows:

- The respiratory therapy services furnished to a beneficiary are:
  - Consistent with the nature and severity of the individual's symptoms and diagnosis.

  Note: *In these cases, the provider will need to furnish the FI or A/B MAC with documentation that explains the medical necessity for the therapy.*
  - Reasonable in terms of modality, amount, frequency and duration of the treatment.
  - Generally accepted by the professional community as being safe and effective treatment for the purpose used.

The FIs and A/B MACs will also determine if the services are respiratory therapy services rather then routine nursing services. Finally, while there are many conditions for which respiratory therapy may be indicated, coverage of respiratory therapy services cannot be recognized (for Medicare purposes) when performed on a mass basis with no distinction made as to the individual patient's actual condition and need for such services. **It is important to see the revised manual sections attached to CR 5405 for full details of these policies.**

Also, note that Chapter 8 of the *Medicare Benefit Policy Manual* has been updated to provide correct references to Chapter 1.

The revised manual sections attached to CR 5405 provides a number of examples of the application of these guidelines.

Additional Information

You can find the official instruction (CR 5405) issued to your FI or A/B MAC by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R65BP.pdf*.

Attached to that CR, you will find the updated Chapters 1 and 8 of the *Medicare Benefit Policy Manual* (Publication 100-02).

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

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

MLN Matters Number: MM5405
Related Change Request (CR) Number: 5405
Related CR Release Date: January 26, 2007
Related CR Transmittal Number: R65BP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

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

Direct Billing and Payment for Nonphysician Practitioner Services Furnished to Hospital Inpatients and Outpatients

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

Provider Types Affected

All hospitals, clinical nurse specialists (CNSs), nurse practitioners (NPs), and the employers of physician assistants (PAs) who bill Medicare for hospital inpatient and outpatient services.

Background

Section 4511(a)(2)(B) of the Balanced Budget Act of 1997 amended section 1861(b)(4) of the Social Security Act **to exclude the professional services of NPs, CNSs and PAs from hospital inpatient services**. Accordingly, upon the effective date of change request (CR) 5221, NPs and CNSs are authorized to bill Medicare carriers directly for their professional services when furnished to hospital patients, both inpatients and outpatients. The **employer of a PA**, rather than the hospital, **must bill the carrier for their professional services when furnished to hospital patients**. **Hospitals should not bill for the professional services of a PA, unless the PA is employed by the hospital.**

Key Points

This article and CR 5221 describe the removal of the paragraph in the *Medicare Claims Processing Manual*, Chapter 12 , Section 120.1 that contains outdated policy on payment for NP and CNS services furnished in a hospital setting. The changes are as follows:

- The professional services of NPs and CNSs furnished to hospital inpatients and outpatients may be billed directly by the NP or CNS to the carrier under their respective Medicare billing number or their National Provider Identifier (NPI), once the NPI is effective.
- The employer of a PA may bill the carrier directly for the professional services of the PA furnished to hospital inpatients and outpatients under the PA's Medicare billing number or the PA's NPI, once the NPI is effective.
- Hospitals may bill the carrier for the professional services of an NP or a CNS furnished to hospital inpatients and outpatients when payment for the NP and CNS services has been reassigned to the hospital and when the hospital bills for these services under the NP's or CNS's unique provider identifier number (UPIN).
- Your Medicare carrier will identify and reprocess any claims submitted by NPs, CNSs, or the employer of a PA that have been denied since January 1, 2006, because the claim listed a hospital inpatient or outpatient setting place of service.
- For claims for dates of service prior to January 1, 2006, the carrier will reopen claims that were denied because they listed a hospital inpatient or outpatient place of service. However, the carrier will only reopen these claims if the NP, CNS, or employer of the PA brings the claim to the attention of the carrier and the carrier will pay these claims for dates of services on or after the January 1, 1998, effective date retroactive to the actual date that the services were rendered.

Additional Information

The official instructions, CR 5221, issued to your Medicare carrier regarding this change can be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1168CP.pdf*.

A revised Chapter 12, Section 120.1—Direct Billing and Payment—of the *Medicare Claims Processing Manual* is attached to CR 5221.

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

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

MLN Matters Number: MM5221
Related Change Request (CR) Number: 5221
Related CR Release Date: January 26, 2007
Related CR Transmittal Number: R1168CP
Effective Date: April 26, 2007
Implementation Date: April 26, 2007

Source: CMS Pub. 100-04, Transmittal 1168, CR 5221

Edit Modification to Revenue Codes for Blood and Blood Products Reported on 38x Revenue Code Line

Background

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 3681 instructing providers how to bill for blood and blood products under the hospital outpatient prospective payment system (OPPS). Instructions related to CR 3681 were published in the Third Quarter 2005 *Medicare A Bulletin* (pages 118-119). Effective for dates of service on or after July 1, 2005, blood charges were to be reported on revenue codes 038x (Blood) and 039x (Blood storage/processing) so that proper payment and blood deductible could be applied. In August 2006, CMS learned of a discrepancy between the OPPS PRICER output and the common working file (CWF) edit E61#8. Fiscal intermediaries (FIs) were instructed to identify OPPS claims that edit with reason code E61#8 and inform Medicare providers to resubmit the claims by changing revenue code lines 383-389 to revenue code lines 380, 381, or 382. This notification was published in the October 2006 *Medicare A Bulletin* (page 35).

Issue and Resolution

CMS had scheduled to disable CWF edit E61#8 by January 1, 2007, however, after some delay, the modified CWF edit was placed in production **on January 29, 2007,** effective for dates of service **on or after July 1, 2005.** CWF has also modified all other CWF edits that require blood deductible or "blood pints left" to be acceptable only on revenue code 0380, 0381 and 0382.

Action Required by Providers

Providers that have claims rejected or returned with CWF edit E61#8 for services provided **on or after July 1, 2005,** may resubmit these claims by reporting the appropriate revenue code line 038x.

Note: Please indicate "JSM-07202" in the Remarks section of the claim. ❖

Source: CMS Joint Signature Memorandum 07202, January 26, 2007

LOCAL COVERAGE DETERMINATIONS

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

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

Effective and Notice Dates

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

Electronic Notification

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

More Information

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

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

Local Coverage Determination Table of Contents

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

ADDITIONS/REVISIONS TO LCDs

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 ICD-9-CM codes that support medical necessity were revised to remove the dual diagnosis requirement. In addition, ICD-9-CM code V58.11 (Encounter for antineoplastic chemotherapy) was removed from the list of diagnosis codes that support medical necessity. This decision was made after reviewing the indications and limitations found in this LCD and after reviewing the rules applied to this code found in the *Current Procedural Terminology, CPT* 2007. This review found that V58.11 was not appropriate for this LCD.

Effective Date

This revision 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. ❖

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

The local coverage determination (LCD) for bortezomib (Velcade®) was last updated on December 8, 2006. The revision at that time included the addition of the off-label indication of induction therapy for multiple myeloma patients in combination with one or more drugs. Since that time, the following revision was made under the "Documentation Requirements" section of the LCD. The phraseology was changed to read:

- "Documentation in the medical record must support that bortezomib is administered for an indication specified in this LCD and all applicable coverage criteria must be clearly documented."

In addition, the following statement was **removed** based on the above mentioned added off-label indication:

- "If the treatment is for multiple myeloma, the medical record must clearly document that the patient received one prior therapy.

Effective Dates

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

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

ANCSVCS: The List of Medicare Noncovered Services—Addition to the LCD

The local coverage determination (LCD) for the list of Medicare noncovered services was last updated on February 28, 2007. Since that time, the following revision was made:

- Added new category of "National Noncoverage Decisions" under the "CPT/HCPCS Codes" section of the LCD, and *CPT* code and descriptor "55899 *(Unlisted procedure, male genital system)* for cavernous nerves electrical stimulation with penile plethysmography for beneficiaries undergoing nerve-sparing prostatic or colorectal, surgical procedures (Pub. 100-03, *National Coverage Determination*, Transmittal 61, CR 5294, effective for claims processed on or after January 8, 2007 for services provided on or after August 24, 2006)" was added to this new category.

Effective Dates

This LCD addition is effective for services provided **on or after February 28, 2007,** the effective date of the LCD.

The full text for this LCD (L24028) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

AVISCO: Viscosupplementation Therapy for Knee—Revision to the LCD

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised January 1, 2007. Since that time, the LCD has been revised to define significant knee effusion(s). Significant knee effusion(s) are characterized by a tense, bulging knee. Medical documentation should include the presence and size of the effusion(s).

Effective Dates

This revision is effective for claims processed **on or after February 27, 2007.**

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

ADDITIONAL MEDICAL INFORMATION

Billing Unlisted/non-Specific Procedure Codes to Medicare Part A

Note: This information was previously published in the January 2006 *Medicare A Bulletin* Special Issue (page 55) available at *http://www.floridamedicare.com*. A billing instruction note below has been added to the previous notification. All other information remains the same.

Billing Instructions: In addition to the previously published guidelines below, when billing as a fiscal intermediary for an unlisted/non-specific code, the drug and dosage/description of the service should be entered in form locator 84 of the claim form CMS-1450 (UB-92) or the electronic equivalent. After the implementation of the uniform billing form UB-04 (replacing UB-92 form), the drug and dosage/description of the service should be entered in form locator 80 of the claim form CMS-1450 (UB-04) or the electronic equivalent.

Effective January 1, 2006, First Coast Service Options, Inc. (FCSO) implemented a new process for bills submitted for payment where one or more services are reported with an unlisted/non-specific *CPT*/HCPCS code. The following situations may occur:

- Type of bills subject to the outpatient prospective payment system (PPS) with an ambulatory payment classification (APC) assigned to the unlisted/non-specific *CPT*/HCPCS code will be processed according to the assigned APC.
- Type of bills not subject to the outpatient PPS with an APC assigned to the unlisted/non-specific *CPT*/HCPCS code will generate an additional development request (ADR) letter to the provider, with reason code 77700.
- Claims billed with unlisted/non-specific *CPT*/HCPCS that are not paid based on an APC will generate an ADR letter to the provider, with reason code 77700.

The ADR will ask for documentation to substantiate the unlisted/non-specific code being billed.

Action Required by Providers

Providers may follow these instructions within 30 days of receiving an ADR letter:

- If you use the Direct Data Entry (DDE) system, you will be able to see the ADR letter on page 7 of your claim. Once you are on page 7, F8 to get the rest of the information. Follow the instructions on the ADR and provide the requested information and/or documentation.
- If you are not a DDE user, you will receive the ADR letter in the mail. Follow the instructions on the ADR and provide the requested information and/or documentation.

Note: When returning the documentation, be sure to include a copy of the ADR letter.

If a response is not received within 30 days, the entire claim will be rejected under reason code 39721. When the claim is rejected, you may rebill the claim as a new claim with a more specific *CPT*/HCPCS code.

If the additional information/documentation submitted is insufficient to warrant a medical review consideration, the line item for the unlisted/non-specific procedure code will be rejected with reason code 77720.

Unlisted Reason Codes

77720

The claim or adjustment has been submitted with an unlisted (non-specific) *CPT*/HCPCS code. Please contact your internal coding area to determine a more specific code to be billed. If a more specific code is identified, please correct the claim or adjustment by submitting a new transaction with the coding correction. If the claim has been rejected, submit a new claim with corrections. If a portion of the claim was paid and one or more lines were rejected with reason code 77720, submit an adjustment transaction to correct the unlisted (non-specific) CPT/HCPCS code. If the service provided does not have a specific *CPT*/HCPCS code, additional documentation will be requested upon submission of a corrected claim or adjustment. The intermediary cannot process a transaction with an unlisted (non-specific) *CPT*/HCPCS code without medical documentation to support the service being provided.

Billing Unlisted/non-Specific Procedure Codes to Medicare Part A (continued)

Once the line item for the unlisted/non-specific procedure code has been rejected, you may adjust the claim with the correct *CPT*/HCPCS code. If you do not resubmit the claim correctly the second time, the claim will be submitted through the review process and the additional required documentation will have to be submitted again.

Additional information

If a claim or one or more line items is rejected, the provider may receive payment if the claim is submitted with a more specific code. A rejected claim would be resubmitted as a new claim with corrections to coding and a partially paid claim would be submitted as an adjustment correcting the *CPT*/HCPCS coding from the unlisted/non-specific code to a more specific code.

For additional information on how to select the correct *CPT*/HCPCS code, refer to the *Current Procedural Terminology, Fourth Edition (CPT®)* and the *Healthcare Common Procedure Coding System (HCPCS)* Level II reference manuals. ❖

WIDESPREAD MEDICAL REVIEW PROBE

CPT Code *99212*—Widespread Probe Review Results

CPT code *99212* was chosen for comprehensive data analysis for fiscal year 2005 based on July 1, 2004 to December 31, 2004 Medicare Part A data. Based on the conclusions of the findings with claim review indicating same and similar service groups billing without an evaluation and management (E/M) code, as well as with varying E/M codes (*99211, 99212, 99213*, etc.) on almost all providers (chemotherapy, wound care, ophthalmic diagnostic tests, hyperbaric treatments), a recommendation was made to perform a widespread probe. Therefore, a widespread probe of ninety-six (96) claims, which encompassed ninety-six (96) services from twelve (12) providers for the time period from January 1, 2006, through June 30, 2006 was performed. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed, appropriately coded and medically reasonable and necessary.

Summary of the Findings

Ninety-six (96) claims, which encompassed ninety-six (96) services, were reviewed for twelve (12) providers. It was determined that the services billed were documented as having been performed, appropriately coded and medically reasonable and necessary. Therefore, these services were allowed as billed. ❖

Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology. CPT* codes, descriptions and other data only are copyrighted 2006 American Medical Association (or other such date of publication of *CPT*). All rights reserved. Applicable FARS/DFARS apply.

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CRITICAL ACCESS HOSPITAL SERVICES

Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change

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

Provider Types Affected

Non-outpatient prospective payment system (non-OPPS) hospital outpatient departments and ambulatory surgical centers (ASCs) who bill Medicare fiscal intermediaries (FIs), carriers, or Part A/B Medicare administrative contractors (A/B MACs) for colorectal cancer screening flexible sigmoidoscopy, and colonoscopy.

Impact on Providers

Effective for services **on or after January 1, 2007,** Medicare requires:

1. A 25 percent beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies, and colonoscopies performed in the outpatient departments of non-OPPS hospitals.
2. A 25 percent beneficiary coinsurance for colorectal cancer screening colonoscopies performed in ASCs.

Background

Section 1834(d)(2) of the Social Security Act, imposes a 25 percent beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies (*Healthcare Common Procedure Coding System [HCPCS] code G0104 – Colorectal cancer screening; flexible sigmoidoscopy*) that are performed in hospital outpatient departments. While this coinsurance has already been applied in the OPPS for OPPS hospitals (effective for services performed on or after January 1, 1999), it will now be applied to non-OPPS hospitals, **effective January 1, 2007.**

Similarly, Section 1834(d)(3) of the Social Security Act, in part, imposes a 25 percent beneficiary coinsurance for colorectal cancer screening colonoscopies (*HCPCS codes G0105 - Colorectal cancer screening; colonoscopy on individual at high risk, and G0121 – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk*) that are performed in ASCs) and in hospital outpatient departments. And while, as above, this coinsurance has already been applied in the OPPS for OPPS hospitals (effective for services performed on or after January 1, 1999), it is being applied to these services performed in ASCs or non-OPPS hospitals, **effective January 1, 2007.**

Therefore, effective for services on or after January 1, 2007 (as is currently done for OPPS hospitals), FIs, carriers, A/B Macs will apply the 25 percent coinsurance to colorectal cancer screening flexible sigmoidoscopies (G0104) and colonoscopies (G0105 and G0121) that are performed in non-OPPS hospitals and to colorectal cancer screening colonoscopies (HCPCS codes G0105 and G0121) that are performed in ASCs.

Pertinent details included in CR 5387 are:

- For services beginning January 1, 2007, FIs, carriers, A/B MACS will base the coinsurance amounts for colorectal screening sigmoidoscopies and colonoscopies, performed in non-OPPS hospitals, on the payment methodology currently in place for colorectal screening services and, for those performed in ASCs, on Medicare's ASC facility payment for services.
- FIs, carriers, and A/B MACs will neither search for nor adjust claims for colorectal screening colonoscopies and sigmoidoscopies that have been paid prior to the implementation of this change by Medicare on July 2, 2007, but they will adjust such claims that are brought to their attention.
- While prior to January 1, 2007, both a deductible and a coinsurance applied to these colorectal screening procedures, effective for services on or after January 1, 2007, **(as part of Section 5113 of the Deficit Reduction Act [DRA]), the deductible is waived for colorectal screening sigmoidoscopies and colonoscopies performed in ASCs or hospital outpatient departments.** (This change is implemented under CR 5127, transmittal 1004, dated July 21, 2006. The related *MLN Matters* MM5127 is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf*.)
- For procedures performed in ASCs, this change applies to the ASC bills, not to the physician bills.
- FIs, carriers, and A/B MACs will change the Medicare Summary Notices (MSNs) issued to beneficiaries to reflect this change in the coinsurance/copayment amount. They will use MSN message 61.41 – "You pay 25 percent of the Medicare-approved amount for this service."

Additional Information

You can find more information about the change in the coinsurance payment amount for colorectal cancer screening flexible sigmoidoscopy and colonoscopy performed in hospital outpatient departments and ASCs, by going to CR 5387, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1160CP.pdf*.

Attached to the CR 5387, you will find updated *Medicare Claims Processing Manual* (Publication 100-04), Chapter 1 (General Billing Requirements), Section 30.3.1 (Mandatory Assignment on Carrier Claims); Chapter 14 (Ambulatory Surgical Centers), Section 40.2 (Carrier

Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change (continued)

Adjustment of Base Payment Rates); and Chapter 18 (Preventive and Screening Services), Sections 60.1 (Payment), 60.1.1 (Deductible and Coinsurance); and 60.2.2 (Ambulatory Surgical Center [ASC] Facility Fee).

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

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

MLN Matters Number: MM5387
Related Change Request (CR) Number: 5387
Related CR Release Date: January 19, 2007
Related CR Transmittal Number: R1160CP
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Source: CMS Pub. 100-04, Transmittal 1160, CR 5387

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SKILLED NURSING FACILITY SERVICES

April Quarterly Update to 2007 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

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

Provider Types Affected

Skilled nursing facilities (SNFs) and other providers submitting claims to Medicare fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in SNFs.

What You Need to Know

Three Healthcare Common Procedure Coding System (HCPCS) codes (***96521, 96522*** and ***96523***), that are subject to the consolidated billing (CB) provision of the SNF prospective payment system (PPS), were included in the January 2007 update to the carrier file, but not in the FI file. CR 5502, from which this article is taken, adds these three codes to the FI file.

Please refer to the Background section for more information.

Background

Quarterly, CMS updates the lists of HCPCS codes (for both FIs and carriers/DMERCs) that are subject to the consolidated billing provision of the SNF PPS. This particular update, however, applies only to providers billing Medicare FIs, because in the January 2007 update, these three codes were included in the carrier file, but were omitted from the FI file. CR 5502, from which this article is taken, adds these codes to the FI file only.

The following chemotherapy administration-related HCPCS codes have been added to Major Category III, EXCLUSIONS, effective for claims with dates of service **on or after January 1, 2007**:

96521	*Refilling and maintenance of portable pump*
96522	*Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g. intravenous, intra-arterial*
96523	*Irrigation of implanted venous access device for drug delivery systems.*

Remember that:

- With the exception of SNFs, Medicare will not pay providers for services appearing on this list when they are included in SNF CB.
- Conversely, Medicare will pay non- SNF providers for beneficiary services **excluded** from SNF PPS and CB, even when in a SNF stay.
- SNF CB applies to nontherapy services only when furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.
- FIs and A/B MACs will not search their files for claims affected by this change to either retract payment for claims already paid or to retroactively pay claims, but will adjust such claims that you bring to their attention.

Additional Information

You can find the official instruction, CR 5502, issued to your FI or A/B MAC by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1182CP.pdf*.

In addition, you can view the 2007 annual update file for FIs on the CMS website at *http://www.cms.hhs.gov/SNFConsolidatedBilling/01a_SNFCBforFIs.asp#TopOfPage*.

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

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

MLN Matters Number: MM5502
Related Change Request (CR) Number: 5502
Related CR Transmittal Number: R1182CP
Related CR Release Date: February 9, 2007
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1182, CR 5502

RURAL HEALTH CLINIC SERVICES

Holding of Claims Submitted with Type of Bill 71x and Revenue Code 900

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries (FIS) that psychiatric services submitted by rural health clinics on a type of bill (TOB) 71x with revenue code 900 were reimbursed incorrectly or not reimbursed at all.

Effective January 2, 2007, all claims for psychiatric services submitted on a TOB 71x with revenue code 900 are being held in location **S/MSPRR with reason code 77719** until system changes are implemented.

Upon the system change implementation, scheduled for July 1, 2007, processing of psychiatric claims submitted with TOB 71x and revenue code 900 will resume according with the established instructions stated in the Internet-only-Manual (IOM), Pub. 100-04, Chapter 9, Section 20.

Also at this time, all suspended claims resulting from this direction will be released for payment. ❖

Source: CMS Joint Signature Memorandum 07217, February 8, 2007

ELECTRONIC DATA INTERCHANGE

Institutional Value Code Changes

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

Provider Types Affected

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

What You Need to Know

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

Background

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

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

Additional Information

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

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

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

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

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

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

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

Provider Action Needed

CR 5456, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective April 2, 2007. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities .The health care claim adjustment reason code list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at *http://wpc-edi.com/codes*. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5456, effective on and after April 1, 2007.**

CMS has also developed a new tool to help you search for a specific category of code and that tool is at *http://www.cmsremarkcodes.info*. Note that this website does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

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

Additional Information

You can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5456, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1163CP.pdf*.

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

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

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

X12N 835 Remittance Advice Remark Code Changes

New Codes	Current Narrative	Medicare Initiated
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf. **Note:** New code December 1, 2006.	No
N374	Primary Medicare Part A insurance has been exhausted and a Part B remittance advice is required. **Note:** New code December 1, 2006.	No
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility. **Note:** New code December 1, 2006.	No
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE. **Note:** New code December 1, 2006.	No
N377	Payment adjusted based on a processed replacement claim. **Note:** New code December 1, 2006.	No
N378	Missing/incomplete/invalid prescription quantity. **Note:** New code December 1, 2006.	No
N379	Claim level information does not match line level information. **Note:** New code December 1, 2006.	No

Modified Code	Current Narrative	Modification Date
M143	The provider must update license information with the payer.	December 1, 2006
N181	Additional information is required from another provider involved in this service. **Note:** New code February 28,2003.	December 1, 2006
N361	Payment adjusted based on multiple diagnostic imaging procedure rules **Note:** New code November 18, 2005.	December 1, 2006

There are **no** deactivated codes.

Note II: Some remark codes may provide information that may not necessarily supplement the explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. An example of an informational code:

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

The above information is sent per state regulation, but does not explain any adjustment. These informational codes should be used only if specific information needs to be communicated but not as default codes.

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

X12 N 835 Health Care Claim Adjustment Reason Codes

New Code	Current Narrative	Notes
197	Payment denied/reduced for absence of precertification/authorization.	New as of October 2006
198	Payment denied/reduced for exceeded, precertification/authorization.	New as of October 2006
199	Revenue code and Procedure code do not match.	New as of October 2006
200	Expenses incurred during lapse in coverage.	New as of October 2006
201	Workers compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR).	New as of October 2006

Modified Code	Current Narrative	Notes
42	Charges exceed our fee schedule or maximum allowable amount. **Note:** This code will be deactivated on June 1, 2007.	Modified as of October 2006.
45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective June 1, 2007: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability). **Note:** This code replaces code 42 (above) on June 1, 2007.	Modified as of October 2006. Effective June 1, 2007.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. **Note:** Changed as of February 2001, and October 2006. This code will be deactivated on April 1, 2007.	Modified as of October 2006.
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. **Note:** Changed as of February 1999 and October 2006.	Modified as of October 2006.
107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim. **Note:** Changed as of June 2003 and October 2006.	Modified as of October 2006.
136	Claim adjusted based on failure to follow prior payer's coverage rules. (Use Group Code OA). **Note:** Changed as of June 2000 and October 2006.	Modified as of October 2006.
196	Claim/service denied based on prior payer's coverage determination. **Note:** New as of June 2006. Changed October 2006. This code will be deactivated on 2/1/2007. Beginning on that date, value 136 will be used.	Modified as of October 2006.
A1	Claim/service denied. At least one remark code must be provided (may be comprised of either remittance advice remark code or NCPDP reject reason code). **Note:** Changed as of October 2006.	Modified as of October 2006.
B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note:** Changed as of February 2001 and October 2006.	Modified as of October 2006.
D17	Claim/Service has invalid noncovered days. **Note:** This code was deactivated on February 1, 2007, and code 16 will then be used with appropriate claim payment remark code [M32, M33].	Modified as of October 2006.
D18	Claim/service has missing diagnosis information. **Note:** This code was deactivated on February 1, 2007, and then code 16 will be used with appropriate claim payment remark code [MA63, MA65].	Modified as of October 2006.
D19	Claim/service lacks physician/operative or other supporting documentation. **Note:** This code was deactivated on February 1, 2007, and code 16 will be used with appropriate claim payment remark code [M29, M30, M35, M66].	Modified as of October 2006.
D20	Claim/service missing service/product information. **Note:** This code was deactivated on February 1, 2007, and code 16 will be used with appropriate claim payment remark code [M20, M67, M19, MA67].	Modified as of October 2006.
D21	This (these) diagnosis(es) is (are) missing or are invalid. **Note:** New as of June 2005. This code was deactivated on February 1, 2007.	Modified as of October 2006.

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

MLN Matters Number: MM5456
Related Change Request (CR) Number: 5456
Related CR Release Date: January 26, 2007
Related CR Transmittal Number: R1163CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1163, CR 5456

Health Care Provider Taxonomy Code Update

Effective April 1 2007, the health care provider taxonomy code (HPTC) set will be updated. The HPTC set is a national code set that allows medical providers to indicate their specialty on their claim submission. The National Uniform Claim Committee (NUCC) maintains and updates this code set twice a year with changes effective April 1 and October 1. The latest version of HPTC set is available from the Washington Publishing Company website at *http://www.wpc-edi.com/codes/taxonomy*.

If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level rejection may occur. To ensure that the batch and/or claim is not rejected, providers need to verify that the HPTC submitted is a valid code on the most recent HPTC set list.

For assistance in updating the taxonomy code in your practice management system please contact your software support vendor.

Note: Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a taxonomy code on all claims submitted to their fiscal intermediaries. ❖

Source: CMS Pub. 100-04, Transmittal 1154, CR 5436

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

March 2007 – May 2007

2007 Medifest Symposium (Medicare Part A and B)

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

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

Type of Event: **Educational Seminar**

Hot Topics (Topics To Be Determined)

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

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

Type of Event: **Teleconference**

Ask the Contractor (Topics To Be Determined)

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

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

Type of Event: **Teleconference**

Ask the Contractor (Topics To Be Determined)

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

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

Type of Event: **Teleconference**

2007 Medifest Symposium (Medicare Part A and B)

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

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

Type of Event: **Educational Seminar**

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

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

What Is a Webcast?

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

Online Registration

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Provider Address: _____

City, State, ZIP Code: _____

Medifest Class Schedule
May 15-17, 2007

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

Registrant's Name: _____

May 15 – 17, 2007
Marriott Tampa Westshore
1001 N. Westshore Blvd.
Tampa, FL 33607
Please contact hotel for directions and/or reservations (813) 287-2555

PLEASE MARK ONLY ONE CLASS PER TIME SLOT
Cost $233.00

Day 1

General Session 8:00 am to 8:30 am

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

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

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

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

Day 2

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

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

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

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

Day 3
May 17, 2007
Cost $149.00

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

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

A CMS Contracted Intermediary & Carrier

MEDIFEST 2007, Tampa Registration Form

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

Registrant's Name _____

Telephone Number _____

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Provider's Name _____

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City, State, ZIP Code _____

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

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

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

PREVENTIVE SERVICES

February Is American Heart Month

Heart disease is the leading cause of death for men and women in the United States.

Found more often among people aged 65 or older, heart disease is largely preventable. The Centers for Medicare & Medicaid Services (CMS) wants to take this opportunity to remind health care professionals that Medicare beneficiaries are covered for certain cardiovascular screening blood tests.

Medicare provides coverage of the following cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke:

- Total cholesterol test
- Cholesterol test for high-density lipoproteins
- Triglycerides test

Coverage of cardiovascular screening blood tests is provided as a Medicare Part B benefit. The beneficiary will pay nothing for the blood tests (there is no coinsurance or copayment and no deductible for this benefit).

What Can You Do?

This benefit presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing heart disease and how they can control their cholesterol levels through diet, physical activity, or if necessary with medication. CMS needs your help to get the word out about the Medicare cardiovascular screening benefit.

Talk to your patients about their risk for cardiovascular disease and encourage them to take full advantage of this potentially life saving benefit.

Important Note: The cardiovascular screening benefit covered by Medicare is a stand alone billable service separate from the initial preventive physical examination or welcome to medicare visit and does not have to be obtained within the first six months of a beneficiary's Medicare Part B coverage.

For More Information

- For more information about Medicare's coverage of cardiovascular screening blood test, visit the CMS website *http://www.cms.hhs.gov/CardiovasDiseaseScreening/*.
- CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.
  - The *MLN Preventive Services Educational Products Web Page* – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
  - The CMS website provides information for each preventive service covered by Medicare. Go to *http://www.cms.hhs.gov*. Select "Medicare", and scroll down to the "Prevention" heading.
- For information to share with your Medicare patients, visit on the Web at *http://www.medicare.gov*.
- For information about American Heart Month, please visit the American Heart Association's website at *http://www.americanheart.org/presenter.jhtml?identifier=1200000*.

and the Centers for Disease Control and Prevention's website at *http://www.cdc.gov/DHDSP/announcements/american_heart_month.htm*.

Flu Shot Reminder

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

The peak of flu season typically occurs between late December and March; however, flu season can last until May.

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

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

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

Source: CMS Provider Education Resource 200702-04

EDUCATIONAL RESOURCES

The Acute Inpatient Prospective Payment System Fact Sheet now Available

The *Acute Inpatient Prospective Payment System Fact Sheet*, which provides general information about the acute inpatient prospective payment system (IPPS) and how IPPS rates are set, is now available in print format from the Centers for Medicare & Medicaid Services **Medicare Learning Network**. To place your order, visit *http://www.cms.hhs.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page." ❖

Source: CMS Provider Education Resource 200702-12

SNF Spell of Illness Quick Reference Chart now Available

The *Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart*, which provides Medicare claims processing information related to SNF spells of illness, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/snfspellillnesschrt.pdf*. ❖

Source: CMS Provider Education Resource 200701-14

Revised Medicare Physician Fee Schedule Fact Sheet now Available

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

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

Source: CMS Provider Education Resource 200702-02

Sign up to our *eNews* electronic mailing list

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

ORDER FORM - PART A MATERIALS

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

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
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Attention:_____ Area Code/Telephone Number:_____

Please make check/money order payable to: FCSO Account #700284

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID –

DO NOT FAX - PLEASE PRINT

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

IMPORTANT ADDRESSES, TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

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

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

PROVIDER EDUCATION

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

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION

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

OVERPAYMENT COLLECTIONS

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

MEDICARE REGISTRATION

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

Telephone Numbers

PROVIDERS

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

BENEFICIARY

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

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Websites

PROVIDERS

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

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

RAILROAD MEDICARE

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

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

MEDICARE A BULLETIN

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

* ATTENTION BILLING MANAGER *