Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

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

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

Routing Suggestions:

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

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Medicare A Bulletin

Vol. 9, No. 12
December 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 faxed to:

Medicare Publications
1-904-361-0723

A Message to Providers

2007 Medicare Contractor Provider Satisfaction Survey: A Call to Action

First Coast Service Options, Inc (FCSO) is proud to share our results from the second annual 2007 Medicare Contractor Provider Satisfaction Survey, or MCPSS. This survey is an important new tool used by the Centers for Medicare & Medicaid Services (CMS) to measure providers' satisfaction with the performance of fee-for-service contractors.

We are happy to report that our 2007 scores were above the benchmark average for all Part A and Part B contractors. While this survey helps us see what we are doing right, it also shows us what we can do better. We are listening to you, and wish to share with our provider community some improvement processes that we are implementing this year.

What is the MCPSS?

The survey is designed to collect objective and quantifiable data on provider satisfaction with contractors that process and pay Medicare claims. The results help contractors identify areas for improvement to their systems and procedures. The MCPSS asks providers to rate their contractor(s) on seven business services performed by contractors: provider communications; provider inquiries; claims processing; appeals; medical review; provider enrollment; and provider audit and reimbursement (for Part A only).

When the results were released in July 2007, FCSO's leadership carefully analyzed the findings for each business function, and developed an action plan for areas that scored below average.

A Call to Action

While some processes we perform are mandated by CMS, we have focused on improvement efforts that can make a positive impact.

Some key enhancements that we have implemented this year in response to the MCPSS include:

- **Provider Communications:** Our Provider Outreach and Education team now offers bimonthly teleconferences/webcasts to more quickly disseminate the latest news and up-to-date information on local coverage determinations (LCDs). The best way to stay informed on LCDs and other Medicare news is to sign up for listservs available at *http://www.fcso.com*.
- **Provider Inquiries:** We implemented a new extended service line to deliver comprehensive service for more in-depth provider enrollment inquiries and debt collection activities. Continue to make your first contact with our customer service center to discuss your question or issue. If our representative determines your provider enrollment or debt collection issue requires more extensive research and assistance, they will provide the new toll-free number for the extended service line and assign a referral number.
- **Medical Review:** We will soon offer providers the option of faxing us medical records for post-payment medical review.
- **Appeals:** The survey results revealed that providers would benefit from a better understanding of clerical error reopening. In response, we are drafting an article to describe the process.

We look forward to incorporating additional process improvements throughout the year. Stay tuned!

The 2008 MCPSS Is Approaching

Data collection for the 2008 MCPSS will begin in late November and run until April 2008. Results will be announced in early July. If you are selected to participate in the survey, we encourage you to respond. Your feedback is important to our commitment to delivering excellent customer service. Sampled providers/suppliers have the opportunity to respond by Internet, a telephone interview, or they may request a paper copy of the survey.

More information on the MCPSS, including past and current survey results, is available at *www.cms.hhs.gov/MCPSS* and *www.MCPSStudy.org*. ❖

Source: CMS Joint Signature Memorandum 08016, October 12, 2007

Have You Visited the FCSO Web Site Lately?

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

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

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

About the *Medicare A Bulletin*

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

The Medicare Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Important notifications requiring communication in between publications will be posted to the FCSO Medicare provider education Web site *http://www.floridamedicare.com*.

Who Receives the *Bulletin*?

Anyone may view, print or download the *Bulletin* from our provider education Web site. Providers who cannot obtain the *Bulletin* from the Internet (because of a technical barrier) are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form published in the June 2007 *Medicare A Bulletin*, page 4). Registration forms must be submitted annually or when the provider's business practices have experienced a change in circumstances that impact electronic access.

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

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

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

What Is in the *Bulletin*?

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

- Some issues of the publication may start with an important message from our contractor medical director.
- Following are sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines applicable to all Medicare Part A providers and facilities.
- Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.)
- As needed, the *Bulletin* contains *Electronic Data Interchange* and *Fraud and Abuse* sections.
- The *Local Coverage Determination* (LCD) section contains notification of new finalized medical LCDs and additions, revisions, and corrections to previously published LCDs. In addition, this section may contain information on widespread probe reviews conducted by the fiscal intermediary.
- The *Educational Resources* section includes educational events and materials, such as seminar schedules, Medicare provider education Web site information, and reproducible forms.
- Important addresses and phone numbers are in the back of every issue.

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

Medicare Publications
1-904-361-0723

New Web Site Features and Enhancements

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

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

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

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

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

References

Clinical Trials (*Medicare Part A*)

New Providers

Provider Enrollment

NPI

IVR

Fee Schedule Look-up (*Part A*)

FAQs (*Part A*)

Quarterly Provider Update

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

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

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

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

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

PROVIDER ENROLLMENT

Avoid Delays—Check Your Enrollment Application Before Mailing

Have you completed all required information? Is supporting documentation included?

Did you know that…

CMS provides Medicare contractors with guidelines on returning enrollment applications?

For more detailed information regarding return of enrollment applications visit the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/*.

The following is a list of common reasons why First Coast Service Options, Inc. (FCSO) returns provider enrollment applications to providers and suppliers:

1. **An outdated version of the CMS-855A application(s) was submitted.**
   Effective May 1, 2006, CMS issued new application forms for providers enrolling with Medicare. All applications must be submitted using the April 2006 version or the June 2006 version.
2. **The CMS-855A and/or CMS-588 application was not signed and/or dated.**
   The appropriate individual(s) must sign and date the application in ink. Signatures must not be copied or stamped.
3. **The reassignment package submitted was incomplete.**
4. **An unauthorized official whose signature is not on file with Medicare signed the CMS-855A application**.

Where To Go for Help?

Enrollment applications, tips to facilitate the enrollment or update process, and answers to commonly asked questions may be found on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/*.

Specific instructions for completing the enrollment applications are outlined within each section of the application.

If you are experiencing difficulty accessing the appropriate forms or have general questions regarding the enrollment process, please contact our Provider Customer Service Department at 1-888-664-4112. ❖

Avoid Rejection of a Pending Provider Enrollment Application

Respond Immediately to a Request for Information

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

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

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

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

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

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers Florida Part A or B, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

GENERAL INFORMATION

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

Action Required by All Providers Billing Medicare Claims to Fiscal Intermediaries.

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

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

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

For additional information, please contact Medicare EDI at 1-904-791-8131 option 2. ❖

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

National Uniform Billing Committee Update on Revenue Codes and Corrected Skilled Nursing Facility Spell of Illness Chart

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5734, which updates the *Medicare Claims Processing Manual* by removing two revenue codes with a "9-Other" subcategory code.

CAUTION – What You Need to Know

The National Uniform Billing Committee (NUBC) has discontinued several revenue codes with a "9 – Other" designation. CR 5734 removes revenue codes 0709 and 0719 from the list of "Packaged Revenue Codes in Chapter 3 of the *Medicare Claims Processing Manual*. In addition, for skilled nursing facilities (SNF), a corrected spell of illness chart is included with CR 5734.

GO – What You Need to Do

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

Background

In the process of developing the UB-04 (also known as CMS-1450), the NUBC reviewed the "9 – Other" subcategory codes for necessity, clarity, and redundancy. As a result of their review, several "9" codes were designated as reserved for assignment by the NUBC because the "0 – General Classification" codes were deemed sufficient.

Specific revenue codes removed include:

0599 0709 0719 0749 0759 0779
0789 0799.

As a result of NUBC's decision regarding these codes, the Centers for Medicare & Medicaid Services (CMS) is removing two revenue codes, 0709 and 0719, from the *Medicare Claims Processing Manual*, chapter 3, section 20.5.1.1 (Packaged Revenue Codes), **effective October 1, 2007.** The remaining revenue codes include:

0250 0251 0252 0254 0255 0257 0258
0259 0260 0262 0263 0264 0269 0270
0271 0272 0275 0276 0278 0279 0280
0289 0370 0371 0372 0379 0390 0399
0560 0569 0621 0622 0624 0630 0631
0632 0633 0637 0681 0682 0683 0684
0689 0700 0710 0720 0721 0762 0810
0819 0942.

In addition, CMS discovered that the skilled nursing facility (SNF) spell of illness chart posted in the *Medicare Claims Processing Manual*, chapter 6, section 40.8.1 (Spell of Illness Quick Reference Chart) contained formatting errors.

An updated spell of illness chart is included with CR 5734 and is provided as follows:

National Uniform Billing Committee Update on Revenue Codes and Corrected SNF Spell of Illness Chart (continued)

Level of Care	Patient's Medicare SNF Part A Benefits Are Exhausted	Patient Is In Medicare Certified Area of the Facility *	If in non-Medicare Area, the Facility Meets the Definition of a SNF **	Is the Inpatient Spell of Illness Continued?	Billing Action
Medicare Skilled	YES	YES	N/A	YES	Submit Monthly Covered Claim
	NO	YES	N/A	YES	Submit Monthly Covered Claim
	YES	NO	YES	YES	Submit Monthly Covered Claim
	NO	NO	YES	YES	Patient should be returned to certified area for Medicare to be billed. Submit Monthly Covered Claim
	NO	NO	NO	NO	Facility should determine whether it would be appropriate to a certified area for coverage
Not Medicare Skilled	YES	NO	NO	NO	Do not submit claim if patient came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	YES	YES	N/A	NO	Do not submit claim if patient came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	NO	YES	N/A	NO	Do not submit claim if patient came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	NO	NO	YES	NO	Do not submit claim if patient came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	YES	NO	YES	NO	Do not submit claim if patient came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.

* Whether the facility considers a patient's bed in the certified area to be a Medicare bed or not has no effect on whether the spell of illness is continued and has no effect on the SNF's action.
** In some states, licensing laws for all nursing homes have incorporated requirements of the basic SNF definition (Social Security Act section 1819(a)(1)). When this is the case, any nursing home in such a state would be considered to meet this definition (see *State Operations Manual*, chapter 2, section 2164 on the CMS Web site at *http://www.cms.hhs.gov/manuals*).

Additional Information

The official instruction, CR 5734, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1355CP.pdf*.

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

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

MLN Matters Number: MM5734
Related Change Request (CR) Number: 5734
Related CR Release Date: October 19, 2007
Related CR Transmittal Number: R1355CP
Effective Date: October 1, 2007
Implementation Date: January 22, 2008

Source: CMS Pub. 100-04, Transmittal 1355, CR 5734

2008 Ambulatory Surgical Center Payment System Change Implementation

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

Provider Types Affected

Providers who bill contractors (fiscal intermediaries, carriers and Medicare administrative contractors [A/B MAC]) for ambulatory surgical center (ASC) services for Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is required to implement a new ASC payment system no later than January 1, 2008. An overview of the new system has already been provided in the *MLN Matters* article SE0742, which is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf*.

Change request (CR) 5680, from which this article is taken, provides additional information on the background, policy, and instructions that your Medicare contractor will use to implement this revised payment system.

Background

Section 626 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to implement a new ASC payment system not later than January 1, 2008. In part, the law requires that ASCs be paid the lesser of the actual charge or the ASC fee schedule payment rates. See *MLN Matters* article SE0742 for an overview of the new ASC payment system at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf*.

In addition to the new payment instructions, ASCs will be paid a reduced amount for certain procedures when you receive a partial credit for more than 50 percent of the cost of a medical device. You will need to include a modifier FC on certain procedure codes that include payment for a device, to report that you received a partial credit for more than 50 percent of the cost of the device. For those procedure codes where the modifier FC may be applicable, CMS will provide Medicare contractors with a price for the procedure code, both with and without, the modifier FC.

CR 5680 also includes a number of changes to two Medicare manuals as summarized below. (Only the key changes/ revisions are included in this article). These revised manual instructions are attached to CR 5680.

Revisions to the Medicare Claims Processing Manual

(These revisions are attached to CR 5680 on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf*.)

Key revisions are:

Chapter 1 (General Billing Requirements)
Section 30.3.1 (Mandatory Assignment on Carrier Claims)

For colorectal cancer screening colonoscopies (G0105 and G0121), there is no deductible and a 25 percent coinsurance. Effective January 1, 2008, for service G0104, there will be no deductible and the 25 percent coinsurance rate will apply.

Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)
Section 120 (General Rules for Reporting Outpatient Hospital Services)

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on type of bill (TOB) 83x for ASCs. All ASC providers (including Indian health service providers) must submit their claims to the designated carrier or A/B MAC.

Section 180.1 (General Rules)

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83x for ASCs. All ASC providers (including Indian health service providers) must submit their claims to the designated carrier or A/B MAC.

Chapter 14 (Ambulatory Surgical Centers)
Section 10 (General)

Beginning January 1, 2008, Medicare will:

- Pay ASCs (under Part B) for all surgical procedures except those that CMS determines may pose a significant safety risk to beneficiaries or that are expected to require an overnight stay when furnished in an ASC.
- Pay ASCs (under Part B) for certain ancillary services such as certain drugs and biologicals, pass through devices, brachytherapy sources, and radiology procedures.
- Continue to pay ASCs for new technology intraocular lenses and corneal tissue acquisition as it did prior to January 1, 2008.
- Not pay ASCs for procedures that are excluded from the list of covered surgical procedures or covered ancillary services.

2008 Ambulatory Surgical Center Payment System Change Implementation (continued)

To be paid under this provision, a facility must be certified as meeting the requirements for an ASC and must enter into a written agreement with the Centers for Medicare & Medicaid Services (CMS). The *State Operations Manual* describes the certification process, which you may find at *http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS1201984&intNumPerPage=10*.

Section 10.2. (Ambulatory Surgical Center Services on ASC List)

Under the new payment system, ASC services for which payment is included in the ASC payment include, but are not limited to:

- Nursing technician, and related services.
- Use of the facility where the surgical procedures are performed.
- Any laboratory testing performed under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate waiver.
- Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS).
- Medical and surgical supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42*.
- Equipment
- Surgical dressings
- Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42*).
- Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR located at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42*.
- Splints and casts and related devices.
- Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedures.
- Administrative, recordkeeping and housekeeping items and services.
- Materials, including supplies and equipment for the administration and monitoring of anesthesia.
- Supervision of the services of an anesthetist by the operating surgeon.

In addition, Medicare will pay ASCs separately for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. The services are:

- Brachytherapy sources
- Certain implantable items that have pass-through status under the OPPS.
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue.
- Certain drugs and biologicals for which separate payment is allowed under the OPPS.
- Certain radiology services for which separate payment is allowed under the OPPS.

Beginning January 1, 2008, the ASC facility payment for drugs and biologicals includes those that are not usually self-administered, and are considered to be packaged into the payment for the surgical procedure under the OPPS. Beginning January 1, 2008, Medicare makes separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and are separately payable under the OPPS.

Section 10.4. (Coverage of Services in ASCs, Which Are Not ASC Facility Services)

Physician Services

Includes most covered services performed in ASCs, which are not considered ASC facility services. Consequently, physicians who perform covered services in ASCs may bill and receive separate payment under Part B. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to beneficiaries in ASC's and the beneficiaries' recovery from the anesthesia.

2008 Ambulatory Surgical Center Payment System Change Implementation (continued)

Implantable Durable Medical Equipment (DME)

If the ASC furnishes items of implantable DME items to beneficiaries, the ASC bills and receives payment from the local carrier or A/B MAC for the surgical procedure and the implantable device. When the surgical procedure is not on the ASC list, the physician bills the carrier or A/B MAC for both the surgical procedure and the implanted device, coding the ASC as the place of service (POS code 24) on the bill.

Non-Implantable DME

If the ASC furnishes items of non-implantable DME to beneficiaries, it is treated as a DME supplier, and all the rules and conditions ordinarily applicable to DME are applicable, including obtaining a supplier number and billing the DME MAC where applicable.

Services of Independent Laboratory

As noted in the *Medicare Claims Processing Manual*, chapter 14, section 10.2, only very limited numbers and types of diagnostic tests are considered ASC facility services and are included in the ASC facility payment rate. Since Section 1861(s) of the Act limits coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics, or hospitals to those that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests that an ASC performs directly are not considered ASC facility services and not covered under Medicare.

The ASC's laboratory must be CLIA certified and will need to enroll with the carrier or A/B MAC, as a laboratory and the certified clinical laboratory must bill for the services provided to the beneficiary in the ASC. Otherwise, the ASC must make arrangements with a covered laboratory or laboratories for laboratory services, as set forth in 42CFR416.49 located on the Internet at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=737c29dc4bb9dd89c5b72ca82f9b40c5&rgn=div8&view=text&node=42:3.0.1.1.3.3.1.10&idno=42*.

Section 20 (List of Covered Ambulatory Surgical Center Procedures)

The complete lists of ASC covered surgical procedures and ASC covered ancillary services; the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations; and the wage adjusted payment rates, and wage indices are available on the CMS Web site at *http://www.cms.hhs.gov/ASCPAYMENT*.

Section 20.1 (Nature and Applicability of ASC List)

The ASC list of covered procedures indicates procedures, which are covered and paid for if performed in the ASC setting. It does not require the covered surgical procedures to be performed only in ASCs. The decision regarding the most appropriate care setting for a given surgical procedure is made by the physician based on the beneficiary's individual clinical needs and preferences. In addition, all the general coverage rules requiring that any procedure be reasonable and necessary for the beneficiary are applicable to ASC services in the same manner as all other covered services.

Section 20.2. (Types of Services Included on the List)

The Medicare approved procedures are all considered "surgical procedures" for purposes of ASC coverage, regardless of the use of the procedure. For example, many of the "oscopy" procedures listed – bronchoscopy, laryngoscopy, etc., may be employed for either diagnostic or therapeutic purposes, or even both at the same time, such as when the "oscopy" permits both detection and removal of a polyp. Those procedures are considered "surgical procedures" within the context of the ASC provision. In addition, surgical procedures are commonly thought of as those involving an incision of some type, whether done with a scalpel or (more recently) a laser, followed by removal or repair of an organ or other tissue.

In recent years, the development of fiber optics technology, together with new surgical instruments using that technology, has resulted in surgical procedures that, while invasive and manipulative, do not require incisions. Instead, the procedures are performed without an incision through various body openings. Those procedures, some of which include the "oscopy" procedures mentioned above, are also considered surgical procedures for purposes of the ASC provision, and several are included in the list of covered procedures.

The ASC list of covered surgical procedures is comprised of surgical procedures that CMS determines do not pose a significant safety risk and are not expected to require and overnight stay following the surgical procedure.

Surgical procedures are defined as category I *CPT* codes within the surgical range of *CPT* codes, *10000* through *69999*. Also considered to be included within that code range are level II HCPCS and category III *CPT* codes that crosswalk to or are clinically similar to the category I *CPT* codes in the range.

The surgical codes that are included on the ASC list of covered surgical procedures are those that have been determined to pose no significant safety risk to Medicare beneficiaries when furnished in ASCs and that are not expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay).

Procedures that are included on the inpatient list used under Medicare's hospital outpatient prospective payment system and procedures that can only be reported by using an unlisted category I *CPT* code are deemed to pose significant safety risk to beneficiaries in ASCs and are not eligible for designation and coverage as covered surgical procedures.

Section 30 (Rate-Setting Policies)

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- The cost of the physician's professional services for performing the procedure.

2008 Ambulatory Surgical Center Payment System Change Implementation (continued)

- The cost of services furnished by the facility where the procedure is performed (e.g., surgical supplies and equipment and nursing services). For a discussion of the ASC payment methodology, see *MLN Matters* article SE0742 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf*.

Section 40.3. (Payment for Intraocular Lens [IOLs])

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare payment for the associated surgical procedure. Consequently, no separate payment for the IOL will be made, except for a new technology IOL as discussed under the *Medicare Claims Processing Manual*, chapter 14, section 40.3.1. If an ASC bills for a new technology IOL that is provided in association with a covered ASC procedure, the contractor will make a separate payment adjustment of $50 for the new technology IOL. The payment for the new technology IOL is subject to beneficiary coinsurance but is not wage adjusted. The hard coded system logic that excludes the $150 for IOLs for multiple surgery reduction will not apply effective for dates of services on or after January 1, 2008.

Section 40.4 (Payment for Terminated Procedures)

Facilities use a modifier 73 to indicate that the procedure terminated prior to induction of anesthesia.

Prior to January 1, 2008, carriers or A/B MACs deduct the allowance for an unused IOL prior to calculating payment for a terminated IOL insertion procedure.

Beginning January 1, 2008, payment for an IOL is included in the payment for the surgical procedure to implant the lens.

Beginning January 1, 2008, Medicare contractors will apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia. Facilities use the modifier 52 to indicate the discontinuance of these applicable procedures.

Beginning January 1, 2008, ASC surgical services billed with the modifier 52 or 73 are not subject to the multiple procedure discount.

Section 40.5. (Payment for Multiple Procedures)

Each surgical procedure has its own *CPT-4* code. When more than one surgical procedure is performed in the same operative session, special payment rules apply even if the services have the same *CPT-4* code number.

When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors base the ASC facility payment rate on 100 percent of the highest paid procedure, plus 50 percent of applicable wage adjusted rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.

The multiple procedure payment reduction is the last pricing routine applied beginning January 1, 2008, to applicable ASC procedure codes. In determining the ranking of procedures for application of the multiple procedure reduction, contractors shall use the lower of the billed charge or the ASC payment amount. The ASC surgical services billed with modifier 73 and 52 will not be subjected to further pricing reductions (i.e., the multiple procedure price reduction rules will not apply). Payment for an ASC surgical procedure billed with modifier 74 may be subject to the multiple procedure discount if that surgical procedure is subject to the multiple procedure discount.

Section 40.6 (Payment for Extracorporeal Shock Wave Lithotripsy [ESWL])

Beginning January 1, 2008, with the revised ASC payment system, contractors may pay for any of the ESWL services that are included on the ASC list of covered surgical procedures.

Section 40.7 (Offset for Payment for Pass-Through Devices Beginning January 1, 2008)

Under the revised payment system, there can be situations where contractors must reduce (cut back) the approved payment amount for specifically identified procedures when provided in conjunction with a specific pass-through device. This reduction would only be applicable when services for specific pairs of codes are provided on the same day by the same provider. Code pairs subject to this policy would be updated quarterly. The CMS will inform Medicare contractors of the code pairs and the percent reduction taken from the procedure payment rate through a "look-up" table.

Section 40.8 (Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008)

Contractors pay ASCs a reduced amount for certain specified procedures when a device is furnished without cost or for which either a partial or a full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include a modifier FB on the procedure code when a device is furnished without cost or for which full credit is received.

If the ASC receives a partial credit for the device, the ASC is required to include the modifier FC on the procedure code. A single procedure code should not be submitted with both a modifier FB and FC. The pricing determination related to the modifiers FB and FC is performed prior to the application of the multiple procedure pricing reductions.

Section 40.9 (Payment for Presbyopia Correcting IOLs (P-C IOLs and Astigmatism Correcting IOLs [A-C IOLs])

CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR 3927) and Transmittal 1228 (CR 5527) respectively. See *http://cms.hhs.gov/center/asc.asp* for a current list of CMS recognized P-C IOL and A-C IOL lenses.

2008 Ambulatory Surgical Center Payment System Change Implementation (continued)

Section 50 (ASC Procedures for Completing the Form CMS-1500)

The place of service (POS) code is 24 for procedures performed in an ASC.

Prior to January 1, 2008, type of service (TOS) code is "F" (ASC Facility Usage for Surgical Services) is appropriate when modifier SG appears on an ASC claim. Otherwise TOS "2" (surgery) for professional services rendered in an ASC is appropriate.

Beginning January 1, 2008, ASCs no longer are required to include the modifier SG on facility claims in Medicare. Modifier TC is required unless the code definition is for the technical component only.

Section 60 (Medicare Summary Notices (MSN), Claim Adjustment Reason Codes, Remittance Advice Remark Codes (RAs)

Section 60.1 (Applicable messages for NTIOLs)

Carriers or A/B MACs will return, as unprocessable, any claims for NTIOLs containing Q1003 alone or with a code other than one of the procedure codes listed in section 40.5.2, chapter 14, of the *Medicare Claims Processing Manual*. They will use the following messages for these returned claims:

- Claim adjustment reason code 16 – Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.
- RA remark code M67 – Missing/Incomplete/Invalid other procedure codes.
- RA remark code MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Carriers or A/B MACs will deny payment for HCPCS code Q1003 if services are furnished in a facility other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 16.2 – This service cannot be paid when provided in this location/facility.
- Claims adjustment reason code 58 – Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Carriers or A/B MAC will deny payment for Q1003 if billed by an entity other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 33.1 – The ambulatory surgical center must bill for this service.
- Claim adjustment reason code 170 – Payment is denied when performed/billed by this type of provider.

Carriers or A/B MACs shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011) and use the following messages when denying these claims:

- MSN 21.11 – This service was not covered by Medicare at the time you received it.
- Claim adjustment reason code 27 – Expenses incurred after coverage terminated.

Section 60.2 (Applicable messages for ASC 2008 payment changes effective January 1, 2008)

Contractors shall deny services not included on the ASC facility payment files (ASCFS and ASC DRUG files) when billed by ASCs (specialty 49) for POS 24 using the following messages:

- Claim adjustment reason code 8 – The procedure code is inconsistent with the provider type/specialty.
- RA remark code N95 – This provider type/provider specialty may not bill this service.
- MSN 26.4 – This service is not covered when performed by this provider.

If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors will return pass-through device claims/line items, brachytherapy claims/line items, drug code (including HCPCS code C9399) claims/line items, and any other ancillary service claims/line items such as radiology procedure claim/line items on the ASCFS list or ASC DRUG list as unprocessable using the following messages:

- Claim adjustment reason code 16 – Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.
- RA remark code MA 109 – Claim processed in accordance with ambulatory surgical guidelines.
- RA remark code M16 – Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

Contractors shall deny all ancillary services (e.g., radiology technical component) on the ASCFS list billed by specialties other than specialty 49 provided in an ASC setting (POS 24) using the following messages:

- MSN 16.2 – This service cannot be paid when provided in this location/facility.
- Claim adjustment reason code 171 – Payment is denied when performed/billed by this type of provider in this type of facility.

2008 Ambulatory Surgical Center Payment System Change Implementation (continued)

- RA remark code M97 – Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
- RA remark code M16 – Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

Contractors shall deny separately billed implantable devices using the following messages:

- MSN 16.32 – Medicare does not pay separately for this service.
- RA remark code M97 – Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
- RA remark codes M15 – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
- MA 109 – Claim processed in accordance with ambulatory surgical guidelines.
- M16 – Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (contractor discretion).

If there is a related, approved surgical procedure for the billing ASC for the same date of service, they will also include the following message:

- MSN 16.8 – Payment is included in another service received on the same day.

Chapter 19 (Indian Health Services)
Section 40.2.1 (Provider Enrollment with FI or AB MAC – Ambulatory Surgical Services)

For dates of service prior to January 1, 2008, IHS providers that want to bill for surgeries on the ASC list and receive the ASC rate must contact their designated FI or AB MAC. IHS providers are certified by one of several national accrediting organizations recognized by the Centers for Medicare & Medicaid Services (CMS) and meet the conditions for performing ASC procedures.

IHS hospital outpatient departments are not certified as separate ASC entities. The ASC indication merely means that CMS approved them to bill for ASC services and be paid based on the ASC rates for services on the ASC list. In order to bill for ASC services, the hospital outpatient department must meet the conditions of participation for hospitals defined in 42CFR482 located on the Internet at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&tpl=/ecfrbrowse/Title42/42cfr482_main_02.tpl*.

Authority for Medicare to pay IHS hospital outpatient departments using the freestanding ASC rates was incorporated into public health service (PHS) regulations on December 27, 1989. The first IHS hospital requested and received approval from CMS to bill separately for ASC procedures at the appropriate ASC group payment amount for dates of service on or after October 1, 1987. Previously, the hospital was reimbursed for ASC procedures at the Office of Management and Budget (OMB) negotiated all-inclusive rate (AIR) for outpatient hospital services. The rationale for approving this request was that the hospital was already JCAHO certified; encompassing the ability to perform outpatient surgical procedures, and that acute care hospitals providing surgical inpatient or outpatient services can perform any surgical procedures within their capacity and capability.

Effective for dates of service on or after January 1, 2008, the FI or A/B MAC no longer processes claims for IHS ASCs. All IHS ASC providers, including hospital outpatient departments requesting payment based on freestanding ASC rates and ASCs affiliated with a hospital but operating as a distinct entity for the purpose of performing outpatient surgical services must enroll with and submit their claims to the designated carrier or A/B MAC.

Chapter 26 (Completing and Processing Form CMS-1500 Data Set)
Section 10.7 (Type of Service [TOS])

Effective for services on or after January 1, 2008, the modifier SG is no longer applicable for Medicare ASC services. ASC providers will no longer be required to bill the modifier SG on Medicare ASC facility claims.

Revisions to the Medicare Benefit Policy Manual

Changes to this manual are basically the same, as appropriate, as those made to the *Medicare Claims Processing Manual*. The revised portions of the *Medicare Benefits Policy Manua*l are also attached to CR 5680 on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf*.

Additional Information

The two transmittals related to CR 5680 are on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf*.

Attached to these transmittals are the revised manual chapters discussed in this article. These transmittals are the official instructions issued to your Medicare contractor.

2008 Ambulatory Surgical Center Payment System Change Implementation (continued)

Also, the *MLN Matters* article providing an overview of the new ASC payment system is on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf*.

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

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

MLN Matters Number: MM5680
Related Change Request (CR) Number: 5680
Related CR Release Date: August 29, 2007
Related CR Transmittal Number: R77BP and R1325CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1325, CR 5680

Payment Allowances for Influenza Virus and Pneumococcal Vaccines Based on 95 Percent of the Average Wholesale Price

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

Provider Types Affected

Providers who bill Medicare contractors (fiscal intermediaries (FI), carriers, and Medicare administrative contractors (A/B MACs)) for influenza virus and pneumococcal vaccines.

Provider Action Needed

Be sure your billing staff are aware of the billing rates that are effective for influenza and pneumococcal vaccines provided on or after September 1, 2007. These rates apply, **except where the vaccine is furnished in the hospital outpatient department, in which payment for the vaccine is based on reasonable cost.**

Background

Change request (CR) 5744, from which this article is taken, provides the payment allowances for: influenza virus vaccines (*Current Procedural Terminology* [CPT] codes *90655, 90656, 90657, 90658, and 90660*), and pneumococcal vaccine (*CPT 90732* and *90669*); when payment is based on 95 percent of the average wholesale price (AWP).

Effective September 1, 2007, the Medicare Part B payment allowance in these situations is as follows:

Influenza vaccine payments are:

CPT 90655 is $16.109

CPT 90656 is $17.366

CPT 90657 is $6.609

CPT 90658 is $13.218

CPT 90660 (FluMist, a nasal influenza vaccine) is $21.176 and providers should note that *CPT 90660* may be covered in those cases where the local Medicare contractor determines that its use is medically reasonable and necessary for the beneficiary.

Pneumococcal vaccine payments are:

CPT 90732 is $29.730

CPT 90669 is $78.803

Please note:

- These rates apply, except where the vaccine is furnished in the hospital outpatient department, where payment is based on reasonable cost.
- Annual Part B deductible and coinsurance amounts do not apply.
- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- Your Medicare contractors will not search their files to adjust payment for claims paid prior to implementation of these changes; however, they will adjust claims that you bring to their attention.

Additional Information

The official instruction, CR 5744, issued to your Medicare contractor is located on the Centers for Medicare & Medicaid (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1357CP.pdf*.

Payment Allowances for Influenza Virus and Pneumococcal Vaccines Based on 95 Percent of the AWP (continued)

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

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

MLN Matters Number: MM5744
Related Change Request (CR) Number: 5744
Related CR Release Date: October 26, 2007
Related CR Transmittal #: R1357CP
Effective Date: September 1, 2007
Implementation Date: November 26, 2007

Source: CMS Pub. 100-04, Transmittal 1357, CR 5744

2007-2008 Influenza Season Resources for Health Care Professionals

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, nonphysician practitioners, providers, suppliers, and other health care professionals who bill Medicare for flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider Action Needed

- Keep this special edition *MLN Matters* article and refer to it throughout the 2007-2008 flu season.
- Talk with your patients about their risk of contracting the flu virus and complications arising from the virus and encourage them to get the flu shot. (Medicare provides coverage of the flu vaccine and its administration without any out-of-pocket costs to the Medicare beneficiaries, (i.e., no deductible or copayment/coinsurance.)
- Stay abreast of the latest flu information and inform your patients.
  - Order appropriate provider resources for yourself and your staff.
  - Have appropriate literature on hand about seasonal flu that can be handed out to your patients during the flu season.
- Don't forget to immunize yourself and your staff – **Get the Flu Shot – Not the Flu!**

Introduction

Historically the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

Prevention is Key to Public Health

- While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by recommending that they take advantage of the annual flu shot covered by Medicare.
- Medicare Part B reimburses health care professionals who accept the Medicare-approved payment amount for the flu vaccine and its administration. There is no beneficiary coinsurance or copayment and beneficiaries do not have to meet their deductible to receive the flu shot.
- Health care providers and their staff are also at risk for contracting the flu, so do not forget to immunize yourself and your staff. Protect yourself, your patients, your staff, and your family and friends.

  Get Your Flu Shot – Not the Flu!

Helping You Stay Informed

- CMS has developed a variety of educational resources to help promote increased awareness and utilization of the flu vaccine among beneficiaries, providers, and their staff and to ensure that Medicare FFS health care professionals have the information they need to bill Medicare correctly for the flu vaccines and their administration.

2007-2008 Influenza Season Resources for Health Care Professionals (continued)

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Products

1. MLN Matters Articles

- **MM5744:** Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP) located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf*.
- **MM5511:** Update to Medicare Claims Processing Manual (Publication 100-04), Chapter 18, Section 10 For Part B Influenza Billing located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf*.
- **MM4240:** Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf*.
- **MM5037:** Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf*.

2. MLN Influenza Related Products for Health Care Professionals

- ***Quick Reference Information: Medicare Immunization Billing –*** This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.
- ***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition*** – This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file. Updated August 2007 on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- ***Medicare Preventive Services Adult Immunizations Brochure –*** This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Updated August 2007. Available in print and as a downloadable PDF file on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf*.
- ***Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course*** - This WBT course contains four modules that include information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion. This course can be accessed through the MLN Product Ordering web page located on the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.
- **An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals video program –** This educational video program provides health care professionals with an overview of Medicare-covered preventive services. The program includes a segment on Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Included in the segment are strategies that providers may use to increase the use of these vaccines in their practices and tips for setting up a flu clinic. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered through the MLN Product Ordering Web page located on the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.
- ***Quick Reference Information: Medicare Preventive Services*** – This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B. Available in print or as a downloadable PDF file on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.

2007-2008 Influenza Season Resources for Health Care Professionals (continued)

- ***Medicare Preventive Services Bookmark*** – This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder to health care professionals about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf*.

  MLN Preventive Services Educational Products Web Page – This *Medicare Learning Network* (MLN) Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS providers. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This Web page is updated as new product information becomes available. Bookmark the following page for easy access (*http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*).

3. Other CMS Resources

- CMS Adult Immunizations Web page located on the CMS Web site at *http://www.cms.hhs.gov/AdultImmunizations/*.
- CMS Frequently Asked Questions located on the CMS Web site at *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi*.
- Medicare Benefit Policy Manual – Chapter 15, Section 50.4.4.2 – Immunizations located on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf*.
- Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services located on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf*.

4. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2007-2008 flu season:

- Advisory Committee on Immunization Practices located on the Internet at *http://www.cdc.gov/vaccines/recs/acip/default.htm*.
- American Lung Association's Influenza (Flu) Center located on the Internet at *http://www.lungusa.org*. This site provides a flu clinic locator on the Internet at *http://www.flucliniclocator.org*. Individuals can enter their ZIP code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- Centers for Disease Control and Prevention – *http://www.cdc.gov/flu*
- Immunization Action Coalition – *http://www.immunize.org*
- Immunization: Promoting Prevention for a Healthier Life – *http://www.nfid.org/pdf/publications/naiaw06.pdf*
- Medicare Quality Improvement Community – *http://www.medqic.org*
- National Alliance for Hispanic Health – *http://www.hispanichealth.org/*
- The National Center for Immunization and Respiratory Diseases (NCIRD) (established spring 2007) replaces the name National Immunization Program (NIP) – *http://www.cdc.gov/vaccines/about/*
- National Foundation For Infectious Diseases – *http://www.nfid.org/influenza*
- National Network for Immunization Information – *http:/www.immunizationinfo.org*
- National Vaccine Program – *http://www.hhs.gov/nvpo*
- Office of Disease Prevention and Promotion – *http://odphp.osophs.dhhs.gov*
- Partnership for Prevention – *http://www.prevent.org*
- World Health Organization – *http://www.who.int/csr/disease/influenza/en/*.

Additional Information

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

MLN Matters Number: SE0748
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0748

Key Medicare News for 2008 for Physicians and Other Health Care Professionals

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

Provider Types Affected

Physicians and health care professionals and their staff who bill Medicare carriers and/or Medicare administrative contractors (MACs)

Introduction

This special edition article is being provided to keep you, the Medicare physician and health care professional, informed about important Medicare initiatives and new Medicare benefits available in calendar year (CY) 2008.

As you once again make your decision to enroll in or terminate enrollment in the Medicare participation program, the Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to review some important news for 2008. CMS believes this information provides significant benefits to providers and their Medicare patients. It encourages providers to enroll or stay in the Medicare participation program in order to take full advantage of the upcoming changes.

Information You Need to Know

National Provider Identifier (NPI) – Get it! Share it! Use it!

Medicare carriers and A/B MACs began transitioning their systems to start rejecting claims when the NPI and legacy provider identifier pair that are reported on the claim cannot be found on the Medicare crosswalk. We urge you to pay attention to the reject reports you receive. The reject reports will help you and your staff identify problems that cause claims to reject.

You should also ensure that your Medicare enrollment information is up to date. If you need to submit a completed CMS-855 (Medicare provider enrollment form), remember to list all of the NPIs that will be used in place of legacy identifiers. If you need to apply for an NPI or update your information in the National Plan and Provider Enumeration System (NPPES), please include ALL of your Medicare legacy numbers. (NPPES can accept only 20 other provider identifiers, but is being expanded to accept more in the future.) If the information is different between your Medicare enrollment information and your NPPES record, there is a very good chance your claims will reject. NPPES data may be verified on the CMS Web site at *https://nppes.cms.hhs.gov*.

Contact the NPI Enumerator at 1-800-465-3203 if you need assistance in viewing your NPPES record.

A recent *MLN Matters* article lists the informational edits that preceded the reject report messages and their meanings. To view the article, visit the CMS Web site *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf*.

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

Note that after May 23, 2008, legacy identifiers will not be permitted on any inbound or outbound transactions. This includes inbound claims, crossover claims, both paper and electronic remittance advices, the 276/277 claims status inquiries/replies, NCPDP claims, and the 270/271 eligibility inquiries/replies. Also, for up-to-date information on the NPI, CMS recommends periodic visits to the CMS Web site *http://www.cms.hhs.gov/NationalProvIdentStand/*.

Unique Physician Identification Numbers

CMS discontinued assigning unique physician identification numbers (UPINs) on June 29, 2007, but will maintain its UPIN public "look-up" functionality and registry Web site (*http://www.upinregistry.com/*) through May 23, 2008.

Competitive Acquisition Program for Part B Drugs

The Medicare Modernization Act requires CMS to implement a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment system (PPS) basis. This program is an alternative to the average sales price (ASP) methodology for acquiring certain Part B drugs, which are, administered incident to a physician's services. In it, physicians are given a choice between buying and billing these drugs under the ASP system, or selecting a Medicare-approved CAP vendor that will supply these drugs.

Participation in the CAP is voluntary, and each year Medicare physicians can elect to participate. Those who do participate will obtain drugs through CAP vendors; the vendors will bill Medicare for the administered drug and will bill the beneficiary for any applicable coinsurance or deductible.

All physicians who participated in the CAP in 2007, and wish to participate in 2008, will need to make the 2008 CAP election during the regular fall election period which will run from October 1, 2007, to November 15, 2007.

Participating physicians can sign up to receive CAP updates from the **CMS-CAP-Physicians-L** electronic mailing list at *http://www.cms.hhs.gov/apps/mailinglists/default.asp?audience=3* on the CMS CAP Information for

Key Medicare News for 2008 for Physicians and Other Health Care Professionals (continued)

Physicians Web page (*http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage*).

Physician Quality Reporting Initiative

The Tax Relief and Health Care Act of 2006 (TRHCA) authorizes a physician quality reporting system. This program, which CMS has named the "Physician Quality Reporting Initiative" (PQRI), was implemented on July 1, 2007, and establishes a financial incentive for eligible professionals who participate in a voluntary quality-reporting program.

These eligible professionals, who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment (subject to a cap) of 1.5 percent of total allowed charges for covered Medicare physician fee schedule services during that same period.

The proposed 2008 PQRI quality measures were published in the *Federal Register* as a part of the 2008 Medicare physician fee schedule (MPFS) proposed rule. The final 2008 PQRI measures will be published in the 2008 MPFS final rule and posted on the CMS PQRI Web site at *http://www.cms.hhs.gov/PQRI*.

For more information about the PQRI and to access important educational tools, go to the CMS Web site *http://www.cms.hhs.gov/PQRI*.

New Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity and DME Information Forms for Claims Processing

Certificates of medical necessity (CMN) provide a mechanism for suppliers of durable medical equipment and medical equipment and supplies to demonstrate that the item they provide meets the minimal criteria for Medicare coverage. Durable medical equipment Medicare administrative contractors (DME MAC) review the documentation that physicians, suppliers, and providers supply on the CMNs and DME information forms (DIFs), and determine if the medical necessity and applicable coverage criteria for selected DMEPOS were met.

On April 13, 2007, CMS announced the development of improved CMNs and DIFs that are consistent with current medical practices and that conform to Medicare guidelines. In this improvement process, CMS revised several CMNs, replaced three CMNs with two DIFs, and revised *Medicare Program Integrity Manual*, chapter 5, Items and Services Having Special DME Review Considerations. Additionally, these new Office of Management and Budget (OMB) approved forms permit the use of a signature and date stamp that resulted in revision of the *Medicare Program Integrity Manual*, Chapter 3, Section 3.4.1.1, Documentation Specifications for Areas Selected for Prepayment or Post Payment Medical Review.

You can learn more about these revised forms by reading *MLN Matters* article MM5571 (based on CR 5571, the official instruction issued to the DME MAC); available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5571.pdf*.

The new forms are available on the CMS Web site at *http://www.cms.hhs.gov/CMSForms/CMSforms/list.asp#TopOfPage*.

Preventive Services

Medicare, which began covering preventive services in 1981 with the pneumococcal vaccination, now covers a broad range of services to prevent disease, detect disease early when it is most treatable and curable, and manage disease so that complications can be avoided.

These services include:

- The initial preventive physical examination (IPPE), also known as the "Welcome to Medicare" visit, which now includes coverage of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at-risk beneficiaries (those with a family history of AAA or males age 65 to 75 who have smoked at least 100 cigarettes in their lifetime). It is important to note that in order to receive this AAA ultrasound screening benefit, the physician or other qualified nonphysician practitioner must refer the beneficiaries. You may learn more about the IPPE and AAA ultrasound screening by reading *MLN Matters* article SE0711, which you may find on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0711.pdf*. CMS has also developed a new quick reference information chart entitled "*The ABCs of Providing the Initial Preventive Physical Examination*". Medicare fee-for-service physicians and qualified nonphysician practitioners may use this two-sided laminated chart as a guide when providing the IPPE. The chart is currently available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf*.
- Adult immunization – influenza immunization, pneumococcal vaccination, hepatitis B vaccination
- Colorectal cancer screening
- Screening mammography
- Screening Pap test and pelvic examination
- Prostate cancer screening
- Cardiovascular disease screening
- Glaucoma screening
- Bone mass measurement
- Diabetes screening, and self-management, medical nutrition therapy services, and supplies
- Smoking and tobacco-use cessation counseling.

To learn more details about these preventive benefits, see *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* located on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.

CMS has a variety of educational products and resources to help you become familiar with coverage, coding, billing, and reimbursement for all Medicare-covered preventive services, including:

Key Medicare News for 2008 for Physicians and Other Health Care Professionals (continued)

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

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

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

Section 302(b) of the Medicare Modernization Act, requires Medicare to replace the current durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) payment methodology, for select items in select areas, with a competitive acquisition process to improve the effectiveness of its payment-setting methodology. This new program will establish payment amounts for certain durable medical equipment, enteral nutrition, and off-the-shelf orthotics by replacing the current payment amounts (under Medicare's DMEPOS fee schedule) with payment rates derived from a bidding process.

Suppliers that want to furnish competitively bid items in a competitive bidding area (CBA) will be required to submit bids to furnish those items, and the winning bids will be used to establish a single Medicare payment amount for each item. Contracts will be awarded to a sufficient number of winning bidders in each CBA to ensure access and service to high quality DMEPOS items.

CMS is phasing in this new program. Bidding for the first phase began in 2007 in CBAs within 10 of the largest metropolitan statistical areas (MSAs), excluding New York, Los Angeles, and Chicago. Prices from the first phase of bidding are scheduled to go into effect in 2008. The program will be expanded into 70 additional MSAs in 2009. After 2009, CMS will expand the program to additional areas.

While this program may have no direct impact on most physicians, it might have impact on where your patients receive their DMEPOS. Some suppliers currently serving your patients may not be selected to continue Medicare participation under the new program and your patients may have to go to new suppliers. While this may happen, please be assured that Medicare will continue to meet the same patient needs for DMEPOS as it has prior to the new program. Medicare is just attempting to meet those concerns in a more cost effective manner in order to protect Medicare funding.

You may find more information about the Medicare DMEPOS competitive bidding program on the CMS Web site at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/*

Provider Education Updates

The Medicare Learning Network

The Medicare Learning Network (MLN), the brand name for official CMS provider educational products, is designed to promote national consistency in Medicare provider information developed for CMS initiatives. The *MLN* products available on the *MLN* Web page provide easy access to Web-based training courses, comprehensive training guides, brochures, fact sheets, CD-ROMs, videos, educational Web guides, electronic listservs, and links to other important Medicare program information. All educational products are available free of charge and may be ordered and/or downloaded from the *MLN* Web page located on the CMS Web site at *http://www.cms.hhs.gov/MLNGenInfo*.

Some of the new information for 2007 on the *MLN* Web page follows.

Physician Educational Tools

***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* 2nd Edition** – Provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing and reimbursement (August 2007). Available in downloadable format.

Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians – Contains rural health services information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and the Deficit Reduction Act of 2005. The primary audience includes rural health providers, suppliers, and physicians (February 2007). Available in hard copy, CD ROM, and downloadable formats.

Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals – Offers general information about the Medicare program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, protecting the Medicare trust fund, inquiries, overpayments, and appeals (July 2007). Available in hard copy, CD ROM, and downloadable formats.

Companion Facilitator's Guide To The Medicare Physician Guide – A Resource for Residents, Practicing Physicians, and Other Health Care Professionals – Includes all the information and instructions necessary to prepare for and present a Medicare resident, practicing physician, and other health care professional training program, including instructions for facilitators, a customization guide, two PowerPoint presentations with speaker notes, pre- and post-assessments, master assessment answer keys, and evaluation tools (January 2007). Available in hard copy, CD ROM, and downloadable formats.

Key Medicare News for 2008 for Physicians and Other Health Care Professionals (continued)

Physicians' Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services – Explains how Medicare helps pay for kidney dialysis and kidney transplant services under the fee-for-service program (June 2007). Available in hard copy and downloadable formats.

Other Educational Tools

Medicare Learning Network Guidance Tool – Now available in CD ROM format and can be ordered through the *Medicare Learning Network* product-ordering page. This playable CD will streamline your search to find the most relevant and up-to-date links or URLs for national provider educational materials. A tutorial will show you how to use the guidance tool to locate a new link (URL), refine your search, view, download and order educational articles, brochures, fact sheets, web-based training courses, worksheets and videos. Additionally, the *MLN* guidance tool will demonstrate by example how to navigate through sections of CMS' *Medicare Learning Network* (January 2007). Available in CD ROM format.

Medicare Preventive Services Bookmark – Lists the preventive services and screenings covered by Medicare and provides a message that encourages health care professionals to talk with their Medicare patients about these preventive services and encourage them to take advantage of these potentially life saving benefits. This product is appropriate for distribution at health care professional conferences, provider outreach and education activities, and other appropriate types of provider/supplier events (January 2007). Available in hard copy and downloadable formats.

Quick Reference Information: Medicare Preventive Services – A two-sided laminated reference chart that gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services (May 2007). Available in hard copy and downloadable formats.

Quick Reference Information: Medicare Immunization Billing (Flu, PPV, and HBV) – A two-sided laminated reference chart that gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare billing information for the influenza, pneumococcal, and hepatitis B vaccines and their administration (October 2006). Available in hardcopy and downloadable formats.

An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – An educational video program that provides an overview of coverage criteria for Medicare preventive benefits. This program can be viewed individually or as part of an education session at a conference or other provider meeting. (The program is 75 minutes in length and approved by CMS for continuing education credits for successful completion.)

Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart – Provides Medicare claims processing information related to skilled nursing facilities (SNF) spells of illness (January 2007). Available in downloadable format only.

Brochures

Changes in Medicare Coverage of Power Mobility Devices (PMDs): Power Wheelchairs and Power Operated Vehicles (POVs) – Addresses the CMS multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them (May 2007).

Diabetes-Related Services – This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes (August 2007).

Fact Sheets

Critical Access Hospital Program – Covers information related to the critical access hospital program (March 2007).

Federally Qualified Health Center Fact Sheet – Covers the federally qualified health center (FQHC) benefit under Medicare (March 2007).

Implementation of the UB-04 – Reviews the new UB-04 paper claim form, which is only accepted from institutional providers excluded from the mandatory electronic claims submission. It includes background information, the transition period and a crosswalk (May 2007). Available in downloadable format only.

Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet – This fact sheet provides information about inpatient rehabilitation facility prospective payment system rates and classification criterion (March 2007).

Medicare Disproportionate Share Hospital Fact Sheet – Covers the basics of the Medicare disproportionate share hospital (DSH) (August 2007).

Medicare Physician Fee Schedule Fact Sheet – Provides general information about the Medicare physician fee schedule (January 2007).

Medicare Secondary Payer Fact Sheet – Provides a general overview of the Medicare secondary payer provision for individuals involved in the admission and billing procedures at provider, physician and other supplier settings (June 2007).

Rural Health Clinic Fact Sheet – Covers the basics of the rural health clinic (RHC) program (June 2007).

Rural Referral Center Fact Sheet – Covers the basics of the rural referral center (RRC) program (March 2007).

Web Based Training Programs

CMS-1450 – Provides information that will allow you to file Medicare Part A claims accurately and reduce your chances of receiving unprocessable rejections (January 2007).

CMS-1500 – Provides information that will allow you to file Medicare Part B claims accurately and reduce your chances of receiving unprocessable rejections (May 2007).

Key Medicare News for 2008 for Physicians and Other Health Care Professionals (continued)

Diagnosis Coding: Using the ICD-9-CM – Teaches you how to select accurate diagnosis codes from the ICD-9-CM volumes and how to use diagnosis codes correctly on Medicare claim forms (May 2007).

Medicare Fraud and Abuse – Teaches you how to identify Medicare fraud and abuse. You will also learn what safeguards to use to protect yourself against fraud and abuse and what liability and penalties you could face if you commit fraud or abuse (April 2004.

Outpatient Code Editor (OCE) – Useful for physicians and other health care professionals. This course addresses the OCE in Medicare's fiscal intermediary standard system, which processes outpatient claims (January 2007).

Medicare Preventive Services Series: Part 1 Adult Immunizations – This Web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for influenza, pneumococcal, and hepatitis B vaccines and their administration (Updated September 2007).

National Provider Identifier
Health Care Providers – Who are Sole Proprietors? – A sole proprietor/sole proprietorship is an individual and, as such, is eligible for a single NPI. Read more about sole proprietors and the NPI (July 2007).

Health Care Providers – Who are Organizations? – Organization health care providers apply for NPIs as organizations (entity type 2). Read more about organization providers and the NPI (July 2007).

Tip Sheets – What the "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule" Means for Health Care Providers – Interprets the recently released contingency guidance into helpful steps for providers (May 2007).

National Provider Identifier Training Package – CMS has developed a training package for NPI that will assist providers with self-education, as well as education of staff. This package is also useful to national and local medical societies for group presentations and training. The entire package will consist of five modules: General Information, Electronic File Interchange (EFI), Subparts, Data Dissemination and Medicare Implementation. Each module consists of a PowerPoint presentation (with speaker's notes) and is designed to stand-alone or can be combined with other modules for a training session tailored to the particular audience.

Enrolling in Medicare – CMS has posted a document that will assist physicians in completing the CMS-855I, Medicare Provider Enrollment Application for Physicians and Non-Physician Practitioners. The document is available on the CMS Web site at *http://www.cms.hhs.gov/Medicareprovidersupenroll/downloads/EnrollmentNPI.pdf*.

Physician Quality Reporting Initiative (PQRI) Tool Kit

CMS has developed a "PQRI Tool Kit – Six Steps for Success" that will assist eligible professionals with successful reporting, as well as education of staff. This tool kit is also useful for group presentations and training programs. Currently, the tool kit consists of six educational resources (listed below). Each resource in the tool kit is designed to stand-alone or can be combined with other resource for a training session tailored to the particular audience. The tool kit includes:

2007 PQRI Physician Quality Measures – A numerical listing of all measures included in 2007 PQRI.

***MLN Matters* Article MM5640 – Coding & Reporting Principles –** A publication that introduces the coding and reporting principles underlying successful PQRI reporting.

2007 PQRI Code Master – A numerical listing of all codes included in PQRI intended for incorporation into billing software.

2007 Coding for Quality Handbook – A handbook that delineates coding and reporting principles and provides implementation guidelines for how to successfully report measures using clinical scenarios.

2007 Data Collection Worksheets – Measure-specific worksheets that walk the user step-by-step through reporting for each quality measure.

2007 PQRI Measure Finder Tool and User Guide – A tool designed to assist eligible professionals and their practice staff to quickly search for applicable measures and their detailed specifications.

Physician Quality Reporting Initiative (PQRI) PowerPoint Presentations – CMS has developed PowerPoint presentation modules that will assist eligible professionals with successful reporting, as well as education of staff. These PowerPoint presentation modules are also useful for group presentations and training programs.

Beneficiary Related News

MyMedicare.com

As announced in last year's article, Medicare beneficiaries can access Medicare's free secure online service to view their Medicare information by registering for *MyMedicare.com*. At this site, they can access their personalized information about their Medicare benefits and services, and can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare summary notice (MSN) or replacement Medicare card
- View eligibility, entitlement, and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications, and messages sent by CMS.

Registration is simple. Medicare beneficiaries should go to *http://www.medicare.gov* and click on the box in the upper left of the screen to sign up for *MyMedicare.gov*.

Key Medicare News for 2008 for Physicians and Other Health Care Professionals (continued)

Additional Information

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

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

MLN Matters Number: SE0730
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0730

2008 Open Enrollment for Medicare Part D Coverage and Medicare Advantage Plans

Campaign Features Major Outreach to Beneficiaries Eligible for Low Income Subsidies, Enhanced Publications and Online Tools.

The U.S. Department of Health & Human Services (HHS) announced that, beginning November 15, 2007, Medicare beneficiaries can begin making enrollment changes in their health and prescription drug coverage for 2008, if necessary. The Medicare annual open enrollment period for prescription drug plan runs from **November 15 through December 31, 2007.**

In addition, for Medicare Advantage (MA) plans only, beneficiaries can make one change in enrollment – enrolling in a new plan, changing plans or canceling a plan – **between January 1 and March 31, 2008.**

"Now is the time for beneficiaries to prepare and compare their health and prescription drug coverage options and choose the plan that best meets their needs," said HHS Secretary Mike Leavitt. "We intend to keep building on the success the program has achieved thus far. The most recent satisfaction rate stands at 86 percent, the estimated average premium is 40 percent lower than originally estimated and total estimated costs are running $188 billion below initial projections. Part D is a program that is working well and is helping Medicare beneficiaries with their prescription drug costs."

HHS' Centers for Medicare & Medicaid Services (CMS) encourages all beneficiaries to act soon to compare their current plan with other plan options. If they are satisfied with their current plan, they do not need to do anything in order to maintain their coverage. CMS wants eligible beneficiaries who do not have prescription drug coverage to know that, if they wait, they may pay a penalty on their premium.

During this coordinated election period, beneficiaries are encouraged to review their prescriptions and other health needs when assessing the plan options described in the *"Medicare & You"* handbook or on *www.medicare.gov*. In addition, CMS recommends that beneficiaries gather any Medicare or Social Security mailings they received and materials made available by local counselors to use as a reference when speaking with a 1-800-Medicare representative or entering information on *www.medicare.gov*.

CMS also encourages people to take advantage of the enhanced online *Medicare Prescription Drug Plan Finder* options available on *www.medicare.gov*. This feature offers information on available drug plans, including out-of-pocket costs and pharmacy networks. The enhanced online *Medicare Prescription Drug Plan Finder* and *Medicare Options Compare* tools enable beneficiaries to compare drug plan options for prescription drug plans and Medicare Advantage plans in their area. CMS continues to refine its educational tools, so beneficiaries will find it easier to locate information about available health and drug plans.

Starting today, *www.medicare.gov* also provides beneficiaries with the five-star ratings of the quality and performance of plans that offer Part C and Part D services. These plan ratings allow consumers to compare items such as customer service, complaints, managing chronic conditions and ease in obtaining prescriptions.

To read more about the plan ratings within Medicare Web compare tools, check out the CMS publication available in the Medicare Web site at *http://www.medicare.gov/Publications/Pubs/pdf/11226.pdf*.

To read more of the HHS press release issued on November 15, 2007, click here: *http://www.hhs.gov/news/press/2007pres/11/pr20071115a.html*

Visit the Medicare Learning Network – It's Free! ❖

Source: CMS Provider Education Resource 200711-15

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

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

Note: CMS has revised this *MLN Matters* article on November 7, 2007, to change the title to the chart showing the payment limits. The year for the payment limit for splint and cast has been corrected to read "2008," not "2007." All other information is unchanged. The *MLN Matters* article MM5740 was published in the November 2007 *Medicare A Bulletin* (pages 8-9).

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

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

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

Dialysis Supplies Billed with Modifier AX

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

Dialysis Supplies Billed Without Modifier AX

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

Dialysis Equipment Billed with Modifier AX

E0210NU E1632 E1637 E1639

Dialysis Equipment Billed Without Modifier AX

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

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes. **Contractors** will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are being published at the end of this article.**

Additional Information

Detailed instructions for calculating:

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

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

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

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

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

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

2008 Payment Limits for Splints and Casts

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

MLN Matters Number: MM5740 – Revised
Related Change Request (CR) Number: 5740
Related CR Release Date: September 28, 2007
Related CR Transmittal Number: R1344CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

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

Registration to Access the CMS Online Computer Services Is Now Available

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available. Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC).

A recent *MLN Matters* article, the first in a new series on IACS-PC, addresses key questions and answers about the registration process and may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*. ❖

Source: CMS Provider Education Resource 200711-17

Individuals Authorized Access to CMS Computer Services—Provider Community

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

The First in a Series of Articles

These articles will help providers to register for future access to CMS online computer services. This article contains:

- Ten questions and answers to get you started
- Overview of the registration process for IACS-PC defined provider organization users.

Provider Types Affected

Physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Note: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS-PC at this time. DMEPOS suppliers may want to review question # 10 below.

What Providers Need to Know

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available.

Provider Action Needed

Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC). See the following section for key questions and answers about the registration process.

Ten Questions and Answers to Get You Started

1. **What Is IACS-PC?**
   IACS-PC is a security system CMS uses to control issuance of electronic identities and access to new CMS provider Web-based applications. Through IACS-PC, provider organizations, as defined by IACS-PC (see question # 7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Provider organizations will also be able to manage users who they authorize to conduct transactions on their behalf, which may include staff and contractors.

   Note: This release of IACS-PC will not impact access to FI/carrier/MAC Internet applications or the DME Competitive Bidding System (DBidS) application. New enterprise CMS systems will not offer the Internet services FIs/carriers/MACs are providing in the near future.

2. **Who Can Use this System?**
   Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, the soon-to-be-announced online applications under IACS-PC do not include services to DMEPOS suppliers. (See question # 10 below.)

3. **Why Register Now?**
   Since the new applications have not been announced at the time of this notice, it may be hard to decide if you should register to use the system. However, because IACS-PC registration must precede use, we recommend that individual practitioners and provider organizations (with the exception of DMEPOS suppliers) register now. Even if the IACS-PC registration process goes well and all documentation is in order, it may still take several weeks to finalize registration. Since the system is new, registering now gives you a "cushion" so that if there are delays in processing your registration, you will have the registration process complete in time to request access to the various CMS provider related computer services as soon as they are available early next year.

4. **If I Register Now, How Long Is my Password Valid?**
   Passwords expire in 60 days. After that point, when you log into IACS-PC, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically to IACS-PC to keep your current password active.

5. **How Do I Register as an IACS-PC User?**
   IACS-PC uses a self-registration process. The self-registration process that you will follow will depend on the type of IACS-PC user you are. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

   Note: The CMS Web site contains links to IACS user guides for other communities of users. Only use instruction links for the IACS-PC community as directed by CMS.

   The External User Services (EUS) Help Desk will support this process for IACS-PC. It may be reached by e-mail at ***EUSSupport@cgi.com*** or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

Individuals Authorized Access to CMS Computer Services—Provider Community (continued)

6. When Would I Register as an Individual Practitioner?

An individual practitioner is defined by IACS-PC as a physician or non- physician practitioner. This is intended for practitioners who will be conducting transactions with online applications personally and have **no staff** who will be accessing the applications.

More details can be found in the Individual Practitioner Registration- Quick Reference Guide, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Individual_Practitioner_Registration_QRG_111607.pdf*.

7. When Would I Register as an IACS-PC Provider Organization?

The term "organization," as defined by IACS-PC, should not be confused with the term organization as it applies to provider enrollment or the NPI. For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers and physician group practices.

It also includes individual physicians and nonphysician practitioners who want to delegate staff to conduct transactions on their behalf. In this case, for IACS-PC registration purposes, registration must be as an organization.

IACS-PC provider organizations require security officials (see question # 9 below) that establish the provider organization in IACS-PC. All users will then be grouped together within IACS-PC under the provider organization security official.

8. What Should I Have in Hand Before I Register?

For an individual practitioner (who will be conducting transactions with online applications personally and have no additional staff that will be accessing the applications) they will need to know their:

- Social security number
- Correspondence information.

For an IACS-PC provider organization, the security official (SO) of that organization will be the first person to register within IACS and create their organization. The SO should have the following organizational information available before they sign on to register:

- Taxpayer identification number (TIN)
- Legal business name
- Corporate address
- Internal Revenue Service (IRS) issued CP-575 hard copy form.

9 How Do I Register my IACS-PC Provider Organization?

IACS-PC is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS-PC and then be accountable for users in the organization. Using information supplied via the IACS-PC registration as well as a mailed-in copy of the organization's CP-575 form, CMS will verify the SO's role in the organization, the TIN and the Legal Business Name of the organization. This can take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more detail, please read the Overview section, which follows question #10.

Once you understand IACS-PC user roles, and have designated an SO, the SO should register using the instructions in the Security Official Registration – *Quick Reference Guide*, which is available on the CMS Web site at: *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf*.

The next *MLN Matters* article in this series of articles will provide instructions for additional users to register in IACS-PC.

10. Why Are you Excluding DMEPOS Suppliers from IACS-PC?

DMEPOS suppliers should not register in IACS-PC at this time because we do not expect any new online services will be available to them in 2008. DMEPOS suppliers interested in the second round of DMEPOS competitive bidding should follow CMS DMEPOS competitive bid instructions which will be released closer to the 2008 bid window.

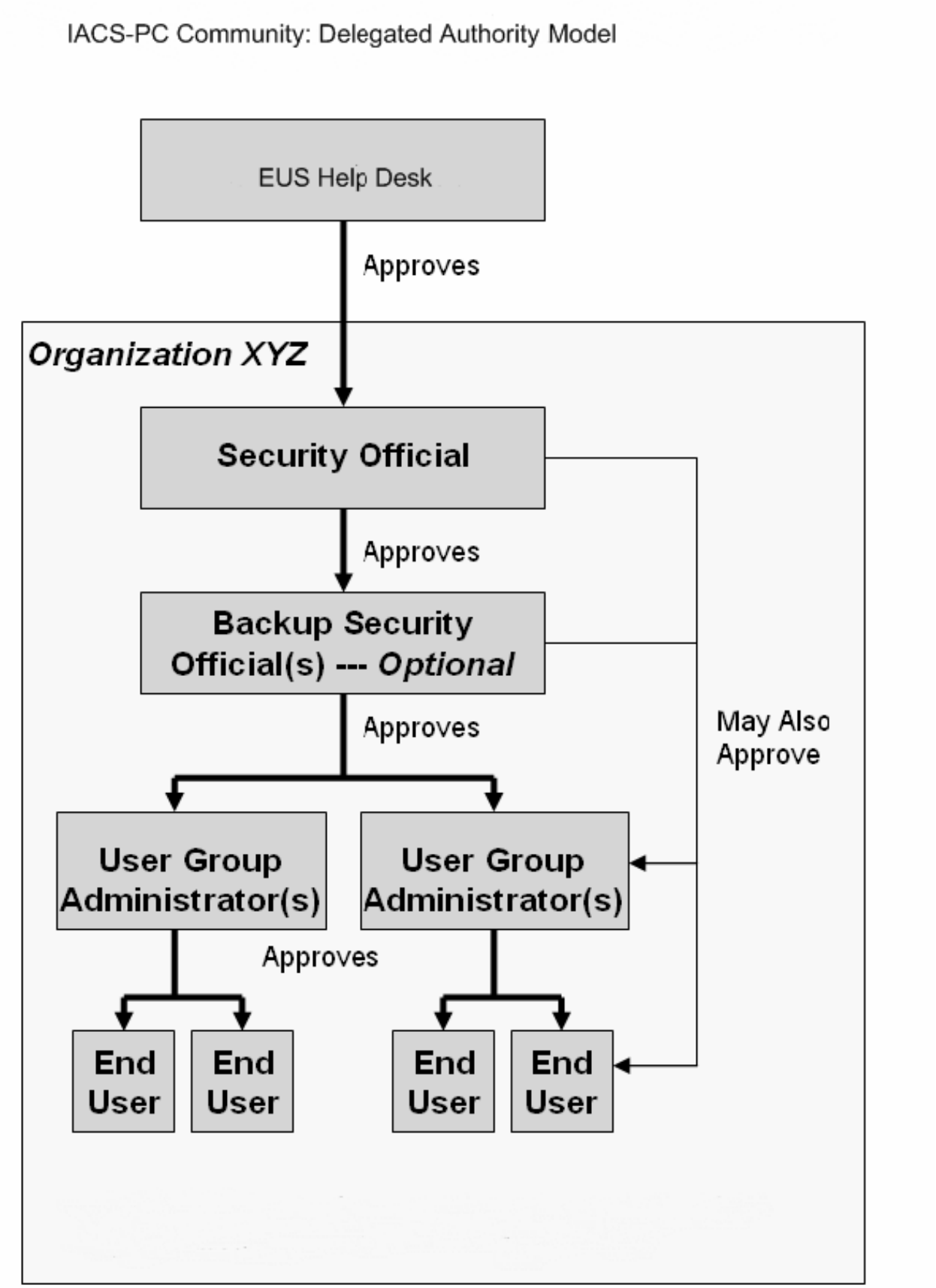
Overview: Registering in IACS-PC as a Provider Organization or a Provider Organization User

For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and physician group practices. It also includes individual physicians and nonphysician practitioners who want to delegate employees to conduct transactions on their behalf.

I. The Registration Process

IACS-PC is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At this time, a provider organization must have at least two users, one of whom will be able to access IACS-PC applications. The "delegated authority model" previously described is below. The EUS help desk will be responsible for approving the organization's security official. Then the security official may approve the backup security official(s) etc.

Individuals Authorized Access to CMS Computer Services—Provider Community (continued)



Individuals Authorized Access to CMS Computer Services—Provider Community (continued)

II. Registration Roles

1. The First Person to Register Must Be the Security Official

The security official is the person who registers their organization in IACS-PC and updates the organization profile information in IACS-PC. There may be only one security official for an organization. The security official is trusted to approve the access request of backup security official(s) and can approve the access requests of user group administrators and end users. The security official will be approved by CMS through its EUS help desk. The security official is held accountable by CMS for the behavior of those they approve including the end users for the organization.

The Security Official Registration – *Quick Reference Guide* may be found on the CMS Web site at: *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf*.

Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS help desk.

2. An Organization May Choose To Have One or More Backup Security Officials (Optional)

This is an optional role. You need not have a backup security official. The security official approves the backup security official. A backup security official performs the same functions as a security official in an organization, with the exception of approving other backup security officials. There can be one or more backup security officials in an organization. The backup security official can approve the access requests of user group administrators and end users and may aid the security official with the administration of user groups and user group administrators' accounts.

3. The Next Registrant Must Be a User Group Administrator

The security official or backup security official approves the user group administrator (UGA). The UGA is trusted to approve the access requests of end users for that user group.

Organizations with 2-9 IACS-PC users must, at a minimum, have a security official and one or more UGAs. If there will be only one user in a group, that user must register as a UGA.

A UGA registers the user group within an organization in IACS-PC and updates the user group profile information in IACS-PC. There can be multiple UGAs for the same user group within an organization.

4. Organizations with Ten or more IACS-PC Users Must also Have End Users

An end user is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An end user is part of a user group within the provider organization. An end user may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An end user may belong to multiple groups in one or more organizations. The end user is approved by the UGA.

Note: End user requests cannot be approved until after the user group administrator has been approved.

III. Surrogate User Groups

This applies to provider organizations that want to delegate online work to individuals or a company outside of the provider organization. Under this scenario, those working on behalf of the provider organization register as a **surrogate user group**. Examples include clearinghouses, credentialing departments, independent contractors. A surrogate user group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A surrogate user group may be associated with multiple provider organizations.

1. The First Contractor Employee To Register in a Surrogate User Group Must Be the UGA

If there will be only one user in a surrogate group, that user must register as a UGA. The UGA for the surrogate user group will register the surrogate user group and update the user group profile information in IACS-PC. There can be multiple UGAs within the same surrogate user group. The UGA is trusted to approve the access requests of end users for their user group.

The UGA of the surrogate user group must be approved by the security official or backup security official in the provider organization on whose behalf it performs work. Once approved, the UGA of a surrogate group may request to associate with other provider organizations for which it performs work without registering again.

2. A Contractor Employee May also Register as an End User

An end user is approved to perform Medicare business for a surrogate or provider user group by their UGA. An end user may belong to multiple groups in one or more organizations.

Additional Help

The EUS help desk will support this process for IACS-PC. It may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

MLN Matters Number: SE0747
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A
Source: CMS Special Edition *MLN Matters* Article SE0747

AMBULANCE SERVICES

Ambulance Inflation Factor for Calendar Year 2008

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

Provider Types Affected

Providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

What You Need to Know

Change request (CR) 5801, from which this article is taken, provides the ambulance inflation factor (AIF) for calendar year (CY) 2008. The AIF for CY 2008 is 2.7 percent.

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services.

Specifically, this section of the Act provides for a 2008 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF).

CR 5801, from which this article is taken, furnishes the CY 2008 AIF, which will be 2.7 percent. The following table displays the AIF for CY 2008 and for the previous five years.

Ambulance Inflation Factor by CY

2008	2.7%
2007	4.3%
2006	2.5%
2005	3.3%
2004	2.1%
2003	1.1%

The national fee schedule for ambulance services was phased in over a five-year transition period beginning April 1, 2002. Further, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) is subject to a "floor amount."

Payment will not be less than this "floor," which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule.

Some key issues related to the AIF include:

National or Regional Fee Schedules

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate.

Payments Based on Blended Methodology

During the five-year transition period, your payments have been based on a blended methodology. For CY 2008, this blend is 20 percent regional ground base rate and 80 percent national ground base rate.

Before January 1, 2006, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional (if it applied)), and to the reasonable cost or charge portion of the blended payment amount. Then, these two amounts were added together to determine each provider or supplier's total payment amount.

As of January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100% of the national ambulance fee schedule. As of January 1, 2008, the total payment amount for ground ambulance providers and suppliers is based on either 100 percent of the national ambulance fee schedule or 80 percent of the national ambulance fee schedule and 20 percent of the regional ambulance fee schedule, whichever is greater.

Part B Coinsurance and Deductible Requirements

Part B coinsurance and deductible requirements apply.

Additional Information

You can find more information about the 2008 ambulance inflation factor by going to CR 5801 located on the Centers for Medicare & Medicaid (CMS) Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1375CP.pdf*.

There you will find updated *Medicare Claims Processing Manual*, chapter 15 (Ambulance), section 20.6.1, *Ambulance Inflation Factor* (AIF) as an attachment to that CR.

Ambulance Inflation Factor for Calendar Year 2008 (continued)

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

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

MLN Matters Number: MM5801
Related Change Request (CR) Number: 5801
Related CR Release Date: November 9, 2007
Related CR Transmittal Number: R1375CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1375, CR 5801

Medicare Payments for Ambulance Transports

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

Note: CMS has revised this special edition *MLN Matters* article on November 16, 2007, to correct a reference to a related change request (CR). The reference should have been to CR 5442 instead of CR 5422. The article had previously been changed on November 8, 2007, to clarify when an ambulance transport claim may result in a beneficiary liability (see Caution section). In addition, there was a change made in the *Documentation Requirements* section to note that a physician certification statement (PCS) is required for nonemergency transports only "in some circumstances". It previously implied that it was always required. All other information is unchanged. The *MLN Matters* article SE0724 was published in the July 2007 *Medicare A Bulletin* (pages 16-17).

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MAC) for ambulance services or who initiate ambulance transports for their Medicare patients.

Provider Action Needed

STOP – Impact to You

According to a recent study conducted by the Office of the Inspector General (OIG), "Medicare Payments for Ambulance Transports," during the calendar year 2002 twenty-five percent of ambulance transports did not meet Medicare's program requirements. This resulted in an estimated $402 million of improper payments. In two out of three cases, third-party providers (most likely not the patient) who requested transports may not have been aware of Medicare's requirements for ambulance transports.

CAUTION – What You Need to Know

Liability for overpayment resulting from a denied ambulance transport claim depends on the type of denial. A denial due to coverage reasons (such as when other forms of transportation are not contraindicated) may result in a liability to the Medicare beneficiary. Claims denied due to level of service requirements are often down-coded to a lower level of ambulance service. In this case, the ambulance supplier is generally liable in the event of an overpayment.

GO – What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified. It is important to know whether Medicare would cover the use of an ambulance transport for your patient, and if so, what level of service would be covered. Please refer to the *Background* section of this special edition *MLN Matters* article for information about payment and level of service requirements for ambulance transports.

Background

Some key provisions of the OIG report are as follows:

Medicare Coverage of Ambulance Transports

When evaluating coverage of ambulance transport services, two separate questions are considered:

1. Would the patient's health at the time of the service be jeopardized if an ambulance service was not used? If so, Medicare will cover the ambulance service whether it is emergency or nonemergency use of the transport. If not, the Centers for Medicare & Medicaid Services (CMS) will deny the transport claim. Additionally, Medicare does not cover nonambulance transports.
2. Once coverage requirements are met, Medicare asks the following question: What level of service (determined by medical necessity) is appropriate with regard to the diagnosis and treatment of the patient's illness or injury? If the incorrect level of service is billed and subsequently denied, Medicare will usually reimburse at a lower rate reflecting the lower level of services judged appropriate.

Levels of ambulance service are differentiated by the equipment and supplies carried in the transport and by the qualifications and training of the crew. They include:

a) Basic life support
b) Advanced life support
c) Specialty care transport
d) Air transport – fixed wing and rotary wing

Medicare Payments for Ambulance Transports (continued)

Emergency Ambulance Transport

An emergency transport is one provided after the sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to:

- Place the patient's health in serious jeopardy
- Result in serious impairment of bodily functions, or
- Result in serious dysfunction of any bodily organ.

Symptoms or conditions that may warrant an emergency ambulance transport include, but are not limited to:

- Severe pain or hemorrhage
- Unconsciousness or shock
- Injuries requiring immobilization of the patient
- Patient needs to be restrained to keep from hurting himself or others
- Patient requires oxygen or other skilled medical treatment during transportation
- Suspicion that the patient is experiencing a stroke or myocardial infarction. See chapter 15 of the *Medicare Claims Processing Manual* (Pub. 100-4) and chapter 10 of the *Medicare Benefit Policy Manual* (Pub. 100-2) on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Nonemergency Ambulance Transports

Nonemergency ambulance transportation is appropriate with a patient who is bed-confined **and** his/her condition is such that other methods of transportation are contraindicated; OR if the patient's condition, regardless of bed-confinement, is such that transportation by ambulance is medically required (patient poses a danger to him or herself or to others). **Bed-confinement alone is neither sufficient nor necessary to determine the coverage for Medicare benefits**.

To be considered bed-confined, **the patient must be unable to do all three of the following**:

- Get up from bed without assistance
- Ambulate
- Sit in a chair or wheelchair.

Documentation Requirements

Ambulance suppliers are not required to submit documentation in addition to the uniform Medicare billing form CMS-1500 submitted by independent ambulance suppliers to Medicare carriers or A/B MACs, or the UB-04 (form CMS-1450) billed to FIs or A/B MACs by ambulance suppliers that are owned by or affiliated with a Medicare Part A provider such as a hospital.

However, ambulance suppliers are required to retain documentation that contains information about the personnel involved in the transport and the patient's condition and to be made available to Medicare FIs, carriers, and A/B MACs upon request. Ambulance suppliers are also required to obtain a physician certification statement (PCS) for nonemergency transports **in some circumstances** (see 42 CFR 410.40 link in the *Additional Information* section).

The PCS states the reason(s) a patient requires nonemergency transportation by ambulance. It is effective for 60 days from the date it is signed. The PCS, or proof of the supplier's attempt to obtain it, is required within 48 hours after provision of the ambulance service. The "trip ticket" is documentation used in emergency transports and contains the date, mileage, crew, origin, destination, type and level of ambulance service provided, patient condition, the type of service, and supplies provided to the patient while in transport.

How to Avoid Improper Billing

- Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation. For guidance, you may wish to refer to change request (CR) 5442 "*Ambulance Fee Schedule – Medical Conditions List – Manualization*," which contains an educational guideline that was developed to assist ambulance providers and suppliers communicate the patient's condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided below.
- Maintain documentation that will help to determine whether ambulance transports meet program requirements when Medicare FIs, carriers, and A/B MACs conduct medical reviews. Be sure to send complete documentation when requested by your FI, carrier, or A/B MAC. Generally, coverage errors for emergency transports were due to documentation discrepancies between the ambulance supplier and the third-party provider (e.g., emergency room records).
- Note whether your FI, carrier, or A/B MAC has implemented origin or destination modifiers such as for a dialysis facility and for nonemergency transports to and from a hospital, nursing home, or physician's office. Be sure to include these modifiers (if available) when billing for ambulance services. They will help your FI, carrier, or A/B MAC to determine, through a prepayment edit process, whether the coverage and/or level of service for ambulance use is correct.

Additional Information

MLN Matters article SE0724 is based on the January 2006 U.S. Department of Health and Human Services (HHS) OIG report, *Medicare Payments for Ambulance Transports*, which is located on the OIG HHS Web site at *http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf*.

CR 5442, dated February 23, 2007, "*Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions*," is located on the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf*.

The regulations at 42 CFR 410.40(d)(2) and (3) state the circumstances when a PCS is required and may be found on the CMS Web site at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_40.pdf*.

Medicare Payments for Ambulance Transports (continued)

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

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

MLN Matters Number: SE0724 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0724

NATIONAL PROVIDER IDENTIFIER

Update to Requirement To Submit National Provider Identifier Notification

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

Provider Types Affected

Physicians, providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier, (hereinafter collectively referred to as "providers") who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs) and regional home health intermediaries (RHHIs)) for claims for services provided to Medicare beneficiaries.

What Providers Need to Know

Providers, except DMEPOS suppliers, are no longer required to submit to the Medicare contractor a copy of the NPI notification received from the National Plan and Provider Enumeration System (NPPES), unless requested to do so by the contractor. Similarly, if the provider, except DMEPOS supplier, obtained the NPI via the electronic file interchange (EFI) mechanism, the provider need not submit a copy of the notification received from the EFI organization (EFIO), unless requested to do so by the contractor. If paper documentation of a provider's NPI is requested by the contractor, the contractor may accept a copy of the provider's NPI registry's details page in lieu of a copy of the NPI notification.

Additional Information

You may see the official instruction (CR 5795) issued to your Medicare A/B MAC, FI, RHHI, or carrier by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R227PI.pdf*.

If you have questions, please contact your Medicare A/B MAC, FI, 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 1-888-664-4112.

MLN Matters Number: MM5795
Related Change Request (CR) Number: 5795
Related CR Release Date: November 2, 2008
Related CR Transmittal Number: R227PI
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-08, Transmittal 227, CR 5795

How to Handle the National Provider Identifier for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims

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 carriers, fiscal intermediaries (FI), and Medicare administrative contractors (A/B MAC) for claims for services provided to Medicare beneficiaries.

What Providers Need to Know

Be cognizant of the fact that in accordance with the NPI final rule, when an identifier is reported on a claim for ordering/referring/attending provider, operating/other/service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier **must be an NPI**. **For Medicare purposes this means that submission of an NPI for an ordering/referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008.**

Medicare has always required that a provider identifier be reported for ordering/referring providers. Effective May 23, 2008, that number **must be an NPI,** regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

Key Points

- Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring/ordering/attending/operating/other/service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering/referring/attending/operating/other/service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred/ordered by other providers must be careful furnishing such services/items unless they first obtain the NPI of the referring/ordering individual. If they furnish services/items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
- If the NPI is not directly furnished by the ordering/referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services/items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
- Physicians and the following nonphysician practitioners are the only types of providers allowed to refer/order services or items for beneficiaries:
  - Nurse practitioners (NP)
  - Clinical nurse specialists (CNS)
  - Physician assistants (PA)
  - Certified nurse midwives (CNM)
- Established NPI business requirements for beneficiary submitted (change request 5328), deceased physician (CR 5416), adjustments (CR 5416), beneficiary submitted (CR 4169), flu claims (CR 4169), foreign claims (CR 4169) and pandemic flu claims (CR 4169) remain as written.

Background

This article is based on CR 5674. Please note that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

Additional Information

You may see the official instruction (CR 5674) issued to your Medicare A/B MAC, FI, or carrier by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf*.

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

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

MLN Matters Number: MM5674
Related Change Request (CR) Number: 5674
Related CR Release Date: October 26, 2007
Related CR Transmittal Number: R225PI
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-08, Transmittal 225, CR 5674

Reporting Social Security and Other Legacy Identification Numbers Under NPI

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

Social Security Numbers Should not Be Reported in FOIA-disclosable NPPES Fields

As the Centers for Medicare & Medicaid Services (CMS) has mentioned in previous outreach messages and on the CMS NPI Web site, some health care providers have reported their SSNs, or the SSNs of other health care providers, in their NPPES records in fields that the Freedom of Information Act (FOIA) requires that CMS make publicly available. For example, there are instances where SSNs are reported in the "Other Provider Identification Numbers," "License Number," and "Employer Identification Number (EIN)" fields in providers' NPPES records. The information that providers report in these (and certain other) fields is fully disclosable by CMS to the public and, therefore, **SSNs should never be reported in any of these fields**.

Because SSNs are nine-digit numbers, CMS has been suppressing all nine-digit numbers found in any FOIA-disclosable field except for ZIP code and telephone/fax number fields. This means that these nine-digit numbers—whether or not they are SSNs—are not displayed in the NPI Registry and cannot be found in the monthly NPPES downloadable file. If these nine-digit numbers are legitimate EINs, "Other Provider Identification Numbers," or "License Numbers," health plans and others who are using the NPI Registry and the downloadable file are not able to see them, which means that they cannot see all of the NPPES data they may need in order to accurately match providers in NPPES to the providers in their own files, thus making it more difficult to link NPIs to legacy identifiers. In some cases, this may adversely affect payments to providers by health plans.

It is imperative that providers immediately look at their NPPES records to ensure that they did not inadvertently report their, or someone else's, SSN in a FOIA-disclosable field; if they did, they need to delete that SSN immediately and, if appropriate, replace it with the correct information (e.g., an EIN). Providers must look in their NPPES records (*https://nppes.cms.hhs.gov/*) in order to view all of the information they reported. If they need assistance in deleting inappropriately reported SSNs, they may contact the NPI Enumerator at 1-800-465-3203. If they need assistance in knowing which NPPES fields are disclosable under FOIA, they should review the document entitled, "National Plan and Provider Enumeration System (NPPES) Data Elements Data Dissemination – Information for Providers," dated June 20, 2007, and found on the CMS NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data_Elements*.

Providers cannot rely on the information disclosed in the NPI Registry or in the downloadable file in trying to determine if they inappropriately reported SSNs in FOIA-disclosable fields because CMS suppresses these numbers, as explained above; these numbers will not be seen in the NPI Registry or the downloadable file.

In order to protect your personal information from public disclosure, please correct this information immediately if this situation pertains to you.

When to Contact the NPI Enumerator for Assistance

The topics with which the NPI Enumerator can assist providers are listed below:

Status of an NPI application, update, or deactivation
How to apply, update, or deactivate
Forgotten/lost NPI
Lost NPI notification
Trouble accessing NPPES
Forgotten password/User ID
Need to request a paper application

Health care providers needing assistance on any of the above topics may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at *CustomerService@NPIenumerator.com*.

The NPI application form, itself, is also a good source of information. Please refer to the NPI application instructions for clarification on information to be submitted in order to obtain an NPI or update an NPPES record. Refer to the 'Application Help' tab located on the NPPES Web site for additional assistance while online.

Important Information for Medicare Providers

As of October 29, 2007, all Medicare contractors have lifted the bypass logic and are editing against the Medicare crosswalk. As a result, claims that include non-matching NPIs and legacy identifiers are now rejecting. The following table is a review of the next set of dates, which are crucial for compliance with the NPI regulations.

Reporting Social Security and Other Legacy Identification Numbers Under NPI (continued)

Medicare's Key Dates

Date	Implementation Steps
January 1, 2008	• 837I electronic claims and UB-04 paper claims without an NPI in fields identifying the primary provider (billing and pay-to) will be rejected. • Legacy identifiers paired with NPIs in the primary provider fields on the claim will still be acceptable as will legacy-only numbers in secondary provider fields.
March 1, 2008	• Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). • You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. • Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable. • Until further notice, you may continue to include legacy identifiers only for the provider secondary fields.
May 23, 2008	• In keeping with the Contingency Guidance issued on April 3, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims and SPR remittance advice. • This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction. • CMS will also stop sending legacy identifiers on COB crossover claims at this time.

Be Sure to List Medicare Legacy Identifiers in the Appropriate Fields in NPPES

It is important for Medicare providers to note that the Medicare crosswalk only uses numbers listed in the Medicare fields within the "Other Provider Identification Numbers" section of the NPPES application; this section has fields for Medicare UPIN, Medicare OSCAR/Certification, Medicare PIN and Medicare NSC as noted in the following sample of the section:

Issuer	Number	State	Issuer (for Other Number Type Only)
Medicare UPIN			
Medicare			
Oscar/Certification			
Medicare PIN			
Medicare NSC			
Medicaid		State is required if Medicaid number is furnished	
Other, Specify:			

If claims are rejecting, providers should review their NPPES records (not their NPI Registry records), to confirm that Medicare legacy identifiers are reported in the appropriate fields of the "Other Provider Identification Numbers" section.

Correct Way to List a Railroad Retirement (RR) Number in NPPES

It has come to our attention that certain clearinghouses are incorrectly instructing Medicare providers who bill as part of the Railroad Retirement (RR) Board program to list their Medicare RR PIN in the "Other" section in the "Other Provider Identification Numbers" field of NPPES (see the diagram in the above paragraph to view a sample of this NPPES field). An RR PIN is a Medicare PIN, and, therefore, should be listed in the Medicare PIN section within this field of NPPES. RR providers should double check their NPPES records and update their information, if necessary. Because Medicare RR PINs are nine-digit numbers, they are temporarily being suppressed and will not be displayed in the NPI Registry or the downloadable file. Providers should review their NPPES records, not their NPI Registry records, to determine if corrections are needed.

What Is Meant by the Term "Billing Provider"?

The term "Billing Provider" means the provider that is identified in the following loops, field locators, or items in the 837I/UB-04 and the 837P/CMS-1500 claim formats, respectively. Although the name of this loop/segment is "Billing Provider," the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop.

Reporting Social Security and Other Legacy Identification Numbers Under NPI (continued)

Institutional Claims

- 837I (electronic claim)
  - Billing Provider 2010AA
- UB-04 (paper claim)
  - Form Locator (FL) 01

Professional Claims

- 837P (electronic claim)
  - Billing Provider 2010AA
- CMS-1500 (paper claim)
  - Field 33

Test Your Claims Now!

Medicare also continues to urge providers to send a small batch of claims now with only the NPI. If the results are positive, begin increasing the number of claims in the batch.

If claims are rejecting, first go into the NPPES Web site located at *https://nppes.cms.hhs.gov/* and validate that your NPPES information is correct and that you reported your Medicare legacy identifier(s) in the appropriate Medicare sections of the "Other Provider Identification Numbers" field. Your Medicare legacy identifier(s) would be the number(s) that you used—prior to using the NPI—as the Billing/Pay-to and Rendering Providers. If the information in your NPPES record is correct and you reported your Medicare legacy identifier(s), print the screen (so you have a copy of your NPPES record on paper), call your contractor and ask they validate what is in their system.

Medicare Is Issuing Informational Warnings to Those Who Are Not Submitting NPIs on Part B Claims

As stated in an earlier November NPI message, since October 15, 2007, Medicare physicians, nonphysician practitioners and other providers and suppliers who bill carriers and Medicare administrative contractors (MACs) using the ASC X12N 837P receive informational warnings that indicate if there was no NPI shown in the primary provider fields in those claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

The informational warnings consist of one or more of the following messages:

M389 2010AA NM108 Billing Provider Identification Code Qualifier Invalid value.
The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid value.
The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M391 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid value.
The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid value.
The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

Medicare informational warnings, called "Provider Identification Code Qualifier Invalid Value" messages, will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

Many Medicare physicians, nonphysician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, 2008, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the billing/pay-to and rendering providers. By doing so, you should have sufficient time to correct any problems that came about prior to the requirement to use only the NPI in claims.

Need More Information?

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

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

Reporting Social Security and Other Legacy Identification Numbers Under NPI (continued)

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

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the CMS Web page *http://www.cms.hhs.gov/NationalProvIdentStand*. ❖

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

Source: CMS Provider Education Resource 200711-22

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

Update About the National Provider Identifier Initiative

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

Requirement to Update Information in the National Plan and Provider Enumeration System

Health care providers who are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) are required by the national provider identifier (NPI) final rule to update their National Plan and Provider Enumeration System (NPPES) data. The final rule [at (162.410(a)(4)] states that covered health care providers must notify the NPPES of changes in their required NPPES data elements within 30 days of the changes. Failure to provide updated information may be considered an act of noncompliance with the NPI regulation, and a complaint may be filed against covered health care providers who do not comply with this provision, or any other provisions of the rule.

Health care providers can make most updates and changes over the Web, using the user IDs and passwords they selected when they first applied for their NPIs. If they applied on paper, most health care providers can submit updates or changes over the Web and may select user IDs and passwords at the time of the update. Certain changes or updates, however, must be made on paper (CMS-10114), as they require the original signature of the health care provider or, for an organization health care provider, the signature of the authorized official. Such changes include:

1) Applications for NPIs, and all updates/changes, from individuals who do not have social security numbers (SSN) or who do not want to report their SSNs to NPPES.
2) All requests to deactivate NPIs.
3) All requests to reactivate NPIs.
4) All changes to incorrectly submitted SSNs.
5) All changes to incorrectly submitted dates of birth.
6) All changes to incorrectly submitted employer identifier numbers (EINs).
7) All changes of EINs.
8) Password resetting changes due to changes to the contact person or authorized official.

When to Contact the NPI Enumerator for Assistance

Your health plans cannot assist you with NPI questions that should be directed to the NPI enumerator. However, the issues with which the NPI Enumerator can assist you are also limited to the following topics:

- Status of an NPI application, update, or deactivation
- Forgotten/lost NPI
- Lost NPI notification
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application

Health care providers needing this type of assistance may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at CustomerService@NPIenumerator.com.

The NPI application is also a good source of information. Please refer to the NPI application instructions for clarification on information to be submitted in order to obtain an NPI or update your record. You can also refer to the "Application Help" tab located on the NPPES Web site for additional assistance while you are online.

Resources for other kinds of questions may be found at the end of this document. Please note that the NPI Enumerator's operation is closed on federal holidays.

Important Information for Medicare Providers

Medicare Announces a New "Key" NPI Date

This is an important message for physicians, other practitioners, providers, and suppliers that bill Medicare carriers, A/B Medicare administrative contractors (MACs), and DME MACs using an electronic claim form (ASC X12 837P) or paper claim form (CMS-1500).

The Centers for Medicare & Medicaid Services (CMS) is pleased to report that the vast majority of Medicare claims are being sent to Medicare with a national provider identifier (NPI). Moreover, the Medicare NPI crosswalk is successfully cross walking NPIs to legacy numbers for most claims. Given these favorable results, we are taking the next step towards full implementation of the NPI in Medicare.

Update About the National Provider Identifier Initiative (continued)

Effective March 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim.

You may not submit claims containing only a legacy identifier in the primary fields.

Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable beginning March 1, 2008. Until further notice, you may continue to include legacy identifiers only for the secondary fields.

Medicare Informational Warnings to Those Who Are Not Submitting NPIs on Claims

Since October 15, 2007, Medicare physicians, nonphysician practitioners and other providers and suppliers who bill carriers and Medicare administrative contractors (MACs) using the ASC X12 837P or CMS-1500 receive informational warnings that indicate there was no NPI shown in the primary provider fields on your claim(s).

Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

Many Medicare physicians, nonphysician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the Billing/pay-to and Rendering Providers.

Medicare informational warnings, called "Provider Identification Code Qualifier Invalid Value" messages, will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

The informational warnings consist of one or more of the following messages:

M389 2010AA NM108 Billing Provider Identification Code Qualifier Invalid Value.

The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid Value.

The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M391 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid Value.

The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid Value.

The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

Testing Claims With Only the NPI

If you already bill using the NPI/legacy pair in the primary fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI. This test will serve to assure your claims will successfully process when only the NPI alone is mandated on all claims. If the results are positive, begin increasing the number of claims in the batch. If your claims reject, first go into the NPPES Web site located at https://nppes.cms.hhs.gov/ and validate that your information is correct and that you reported your Medicare legacy identifier(s) in the Other Provider Identification Numbers section. Your Medicare legacy identifier(s) would be the number(s) that you used—prior to using the NPI—as the Billing/Pay-to and Rendering Providers. If the NPPES information is correct and you reported your Medicare legacy identifier(s), call your contractor and ask that they validate what is in their system.

Need More Information?

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

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

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

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" on the Web site in the left column of the *http://www.cms.hhs.gov/NationalProvIdentStand*. ❖

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

Visit the Medicare Learning Network – it's Free!

Source: CMS Provider Education Resource 200711-05

Key Medicare Dates for National Provider Identifier

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

As we get closer to May 23, 2008, be sure to pay attention to information from Medicare and other health plans regarding NPI implementation timelines.

Important Message for Residents at Teaching Hospitals and Academic Medical Centers: Why Get your NPI now?

- If the hospitals' residents want to enroll in Medicare, you need to obtain NPIs before applying (enrolling) as a Medicare provider.
- Other health plans may require you to obtain NPIs as a condition of enrollment.
- If you prescribe medication, the pharmacies may need to know your NPI before dispensing the medications and submitting claims to health plans.
- If you order or refer services, your NPI may be required on the claims from providers who actually furnished the services.
- Future employers may require you to obtain NPIs as a condition of employment.

Important Information for Medicare Providers Summary of Key Medicare Dates

October 29, 2007 – By this date, all carriers, A/B MACs and DME MACs will be rejecting claims where the NPI/legacy identifier combination used in claims cannot be validated against the NPI crosswalk. Informational edits will no longer be issued once this happens, but will be replaced by reject reports that will assist providers in determining why the claim is being rejected.

January 1, 2008 – As of this date, 837I electronic claims and UB-04 paper claims without an NPI in fields identifying the primary provider (billing and pay-to) will be rejected. Legacy identifiers paired with NPIs in the primary provider fields on the claim will still be acceptable as will legacy-only numbers in secondary provider fields (see clarification below).

CMS has not yet announced the date by which an NPI will be required for primary provider fields on 837 professional electronic claims and CMS-1500 paper claims processed by carriers, A/B MACs and DME MACs. This will occur prior to May 23, 2008; a specific date will be announced once available.

May 23, 2008 – In keeping with the contingency guidance issued on April 3, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims, and SPR remittance advice. This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction. CMS will also stop sending legacy identifiers on COB crossover claims at this time.

Common Claims Problems/Errors Causing Rejections

The following problems/errors are due to providers billing with incompatible NPI/legacy pairs:

- The type of NPI you use (entity type 1 or entity type 2) must match your Medicare enrollment PIN (individual or organization). When compatible NPI/legacy pairs are submitted on a claim, there is a much higher success rate for finding a match on the NPI crosswalk, thus further ensuring timely and accurate processing of your claim.
- Those who are enrolled with Medicare as individuals but obtained an organization (entity type 2) NPI through NPPES (or vice versa) need to ensure their enrollment records are correct and their NPIs were obtained appropriately.
- On professional claims (837P and CMS-1500), the NPI/PIN combination should identify the Billing, Pay-to, and Rendering Provider (the Pay-to Provider is identified only if it is different from the Billing Provider). This includes claims submitted by corporations that physicians and non-physician practitioners have formed or by physicians and nonphysician practitioners who bill Medicare directly. For more information, please refer to *MLN Matters* article SE0744 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0744.pdf*.

  Other problems identified include:

- Providers are not taking proactive action based on the Part B informational edits and reject reports, despite extensive outreach and educational activities designed to make providers aware of the need to take action. Don't let this happen to you. Pay attention to the informational edits prior to October 30 and the reject messages thereafter.
- CMS has received reports of clearinghouses and billing services that may be stripping the NPI from the claim and later adding the NPI back on the remittance advice. Make sure this is not unknowingly happening to your claims. If you suspect your clearinghouse or billing service is stripping your NPI from claims, please contact your contractor to confirm that an NPI was not received.

Clarification: NPI Requirement on Medicare Institutional Claims for January 1, 2008

At the beginning of October, CMS issued a notice that referred to institutional claims. We are further clarifying that effective January 1, 2008, NPIs will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to

Key Medicare Dates for National Provider Identifier (continued)

use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.)

You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims, until May 23, 2008, if you choose.

Test Your Claims Now

Medicare encourages submitters to send a small number of claims using NPIs only (no legacy identifiers). If no claims are rejected, the submitter may gradually increase the volume. And remember, Medicare will require the NPI on paper claims – be sure to begin the testing process now even if you bill paper.

Still Confused?

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

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

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

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

Source: CMS Provider Education Resource 200710-16

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Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers Florida Part A or B, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

GENERAL COVERAGE

Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscopy

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

Provider Types Affected

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

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify billing instructions for the Medicare beneficiary who 1) presents for a screening colonoscopy (or flexible sigmoidoscopy), 2) has no gastrointestinal symptoms, and 3) during their screening colonoscopy (or flexible sigmoidoscopy), have an abnormality identified (such as a polyp, etc.) which is biopsied or removed.

Background

CMS has become aware of confusion regarding billing for colorectal screening arising because of wording in the Medicare physician fee schedule (MPFS) final rule for 2007 (*Federal Register,* Vol. 71, No. 231, page 69665, December 1, 2006 (see the MPFS final rule on the CMS Web site at *http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1321fc.pdf*).

The relevant section of the 2007 MPFS states, regarding screening colonoscopies, that:

> *"if during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal." Based on this statutory language, in such instances the test or procedure is no longer classified as a "screening test." Thus, the deductible would not be waived in such situations.*

The above scenario can be restated as follows:

- A patient presents for a screening colonoscopy (or flexible sigmoidoscopy), and the patient has no gastrointestinal symptoms.
- During the subsequent screening colonoscopy (or flexible sigmoidoscopy), an abnormality is identified (such as a polyp, etc.), and it is biopsied or removed.

CMS advises that, whether or not an abnormality is found, if a service to a Medicare beneficiary starts out as a screening examination (colonoscopy or sigmoidoscopy), then the primary diagnosis should be indicated on the form CMS-1500 (or its electronic equivalent) using the ICD-9-CM code for the screening examination.

As an example, the above scenario should be billed as follows using claim form CMS-1500 (or its electronic equivalent):

- Item 21 (diagnosis or nature of illness or injury)
  - Indicate the primary diagnosis using the *International Classification of Diseases, Ninth Revision, Clinical Modification, (ICD-9-CM)* code for the screening examination (colonoscopy or sigmoidoscopy).
  - Indicate the secondary diagnosis using the ICD-9-CM code for the abnormal finding (polyp, etc.).
  - For example, V76.51 (Special screening for malignant neoplasms, colon) would be used as the first listed code, while the secondary code might be 211.3 (Benign neoplasm of other parts of digestive system, colon).
- Item 24D (procedures, services, or supplies)
  - Indicate the procedure performed using the CMS Healthcare Common Procedure Coding System/ *Common Procedure Terminology* (HCPCS/*CPT*) code for the procedure (biopsy or polypectomy)
- Item 24E (diagnosis pointer)
  - Enter only "2" (to link the procedure (polypectomy or biopsy) with the abnormal finding (polyp, etc.)

A Medicare beneficiary undergoing a screening colonoscopy (no symptoms and no abnormal findings prior to the procedure) will be responsible for the deductible if a polyp is identified and either biopsied or removed.

When there is no need for a therapeutic procedure, the appropriate HCPCS G-code is reported with the ICD-9-CM code reflecting the indication. Effective January 1, 2007, CMS began waiving the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS G-codes listed in the following table:

HCPCS Screening Code	Descriptor
G0104	Colorectal cancer screening: Flexible sigmoidoscopy
G0105	Colorectal cancer screening: Colonoscopy on individual at high risk
G0121	Colorectal cancer screening: Colonoscopy on individual not meeting criteria for high risk
G0106	Colorectal cancer screening: Barium enema as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening: Barium enema as an alternative to G0105, screening colonoscopy

Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscopy (continued)

Additional Information

For related *MLN Matters* articles on colorectal cancer screenings, see articles SE0710 and MM5387, which are available respectively, on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf*.

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

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

MLN Matters Number: SE0746
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0746

Revision Low Vision Rehabilitation Demonstration

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

Provider Types Affected

Providers who bill Medicare fiscal intermediaries (FI), carriers, or Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries under the Medicare low vision rehabilitation demonstration.

What You Need to Know

Change request (CR) 5756, from which this article is taken, revises some of the Medicare low vision rehabilitation demonstration coverage limitations described in CR 4294 (released January 20, 2006). Specifically, it changes the limitation of services from nine hours of rehabilitation services in one consecutive 90-day period (once in a lifetime) to 12 hours of rehabilitation services ***per calendar year*****.** You should make sure that your billing staffs are aware of these Medicare low vision rehabilitation demonstration coverage changes, which are effective for services supplied under the demonstration on or after April 1, 2008.

Background

To improve participation among eye care physicians in the low vision rehabilitation demonstration and to correct unnecessary limitations in level of low vision rehabilitation coverage, CR 5756, from which this article is taken, revises CR 4294 (Revisions to CR 3816 - Low Vision Rehabilitation Demonstration), released January 20, 2006. Specifically, it changes the 90-day, once in a lifetime limitation for vision rehabilitation services to *a calendar year basis*; and increases the number of hours of covered vision rehabilitation services to which a participating beneficiary is entitled from 36 units of 15-minutes each (9 hours), to 48 units of 15 minutes each (12 hours).

Additional Information

You can find the official instruction conveying the revisions to the Medicare low vision rehabilitation demonstration coverage limitations by going to CR 5756, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R54DEMO.pdf*.

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

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

MLN Matters Number: MM5756
Related Change Request (CR) Number: 5756
Related CR Release Date: November 2, 2007
Related CR Transmittal Number: R54DEMO
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-19, Transmittal 54, CR 5756

An Overview of Medicare Covered Diabetes Supplies and Services

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

Provider Types Affected

Physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for Medicare-covered diabetes benefits.

Provider Action Needed

This article is informational only and represents no Medicare policy changes.

Background

Diabetes is the sixth leading cause of death in the United States, and approximately 20 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. Millions of people have diabetes and do not know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, and death related to pneumonia and flu. Scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

This special edition article presents an overview of the diabetes services and supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies and services to Medicare beneficiaries.

Medicare Part B Covered Diabetic Supplies

Medicare covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:

- Blood glucose self-testing equipment and supplies
- Therapeutic shoes and inserts
- Insulin pumps and the insulin used in the pumps

Blood Glucose Self-testing Equipment and Supplies

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. These supplies include:

- Blood glucose monitors
- Blood glucose test strips
- Lancet devices and lancets
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies. If the beneficiary:

- **Uses insulin**, they may be able to get up to 100 test strips and lancets every month, and one lancet device every six months.
- **Does not use insulin**, they may be able to get 100 test strips and lancets every three months, and one lancet device every six months.

If a beneficiary's doctor says it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary's blood glucose self-testing equipment and supplies if they get a prescription from their doctor.

Their prescription should include the following information:

- That they have diabetes
- What kind of blood glucose monitor they need and why they need it (i.e., if they need a special monitor because of vision problems, their doctor must explain that.)
- Whether they use insulin
- How often they should test their blood glucose
- How many test strips and lancets they need for one month.

A beneficiary needing blood glucose testing equipment and/or supplies:

- Can order and pick up their supplies at their pharmacy
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order. Their doctor cannot order it for them
- Must ask for refills for their supplies
- Needs a new prescription from their doctor for their lancets and test strips every 12 months.

Note: Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. A beneficiary cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary's pharmacy or supplier does not accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

An Overview of Medicare Covered Diabetes Supplies and Services (continued)

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two (2) questions is "no," they should call another supplier or pharmacy in their area who answers "yes" to be sure their purchase is covered by Medicare, and to save them money.

If a beneficiary can not find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

Therapeutic Shoes and Inserts

If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

- One pair of depth-inlay shoes and three pairs of inserts; or
- One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity and two additional pairs of inserts.

Note: In certain cases, Medicare may also cover separate inserts or shoe modifications instead of inserts.

In order for Medicare to pay for the beneficiary's therapeutic shoes, the doctor treating their diabetes must certify that they meet all of the following three conditions:

- They have diabetes.
- They have at least one of the following conditions in one or both feet:
  - Partial or complete foot amputation
  - Past foot ulcers
  - Calluses that could lead to foot ulcers
  - Nerve damage because of diabetes with signs of problems with calluses
  - Poor circulation, or
  - Deformed foot
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes, and
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps

Insulin pumps worn outside the body (external), including the insulin used with the pump may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the original Medicare plan, the beneficiary pays 20 percent of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80 percent of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan's formulary.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies after the yearly Medicare part B deductible has been met. In the Original Medicare Plan, Medicare covers 80 percent of the Medicare-approved amount (after the beneficiary meets their annual Medicare Part B deductible of $131 in 2007), and the beneficiary pays 20 percent of the total payment amount (after the annual Part B deductible of $131 in 2007). This amount can be higher if the beneficiary's doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications

This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:

- Diabetes supplies
- Insulin
- Anti-diabetic drugs.

Diabetes Supplies

Diabetes supplies associated with the administration of insulin may be covered for all people with Medicare Part D who have diabetes. These medical supplies include the following:

- Syringes
- Needles
- Alcohol swabs
- Gauze
- Inhaled insulin devices.

An Overview of Medicare Covered Diabetes Supplies and Services (continued)

Insulin

Injectable insulin **not** associated with the use of an insulin infusion pump is covered under Medicare Part D drug plans.

Anti-diabetic Drugs

Blood glucose that is not controlled by insulin may be maintained by anti-diabetic drugs, and Medicare drug plans can cover anti-diabetics drugs such as:

- Sulfonylureas (i.e. Glipizide, Glyburide)
- Biguanides (i.e. metformin)
- Thiazolidinediones (i.e. Starlix® and Prandin®)
- Alpha glucosidase inhibitors (i.e. Precose®)

Medicare Part B Covered Diabetic Services

Medicare Part B covers all of the diabetes services listed in this section unless otherwise noted. For people with diabetes, Medicare covers certain services. A doctor must write an order or referral for the beneficiary to get these services. These services include the following:

- Diabetes screenings
- Diabetes self-management training
- Medical nutrition therapy services
- Hemoglobin A1c tests
- Special eye exams.

Diabetes Screenings

Medicare pays for a beneficiary to get diabetes-screening tests if they are at risk for diabetes. These tests are used to detect diabetes early, and some, but not all, of the conditions that may qualify a beneficiary as being at risk for diabetes include:

- High blood pressure
- Dyslipidemia (history of abnormal cholesterol and triglyceride levels)
- Obesity (with certain conditions)
- Impaired blood glucose tolerance
- High fasting blood glucose.

Diabetes screening tests are also covered if a beneficiary answers "yes" to two or more of the following questions:

- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, siblings)?
- Do you have a history of gestational diabetes (diabetes during pregnancy), or
- Did you deliver a baby weighing more than 9 pounds?

Based on the results of these tests, a beneficiary may be eligible for up to two diabetes screenings every year at no cost (no coinsurance, or copayment or Part B deductible). Medicare will pay for a beneficiary to get two diabetes screening tests in a 12-month period, but not less than 6 months apart. After the initial diabetes-screening test, the beneficiary's doctor will determine when to do the second test. Diabetes screening tests that are covered include the following:

- Fasting blood glucose tests
- Other tests approved by Medicare as appropriate.

Diabetes Self-management Training (DSMT)

Diabetes self-management training helps a beneficiary learn how to successfully manage their diabetes. Their doctor or qualified non-physician practitioner must prescribe this training for them for Medicare to cover it. A beneficiary can get diabetes self-management training if they met one (1) of the following conditions during the last twelve (12) months:

- They were diagnosed with diabetes.
- They changed from taking no diabetes medication to taking diabetes medication, or from oral diabetes medication to insulin.
- They have diabetes and have recently become eligible for Medicare.
- They are at risk for complications from diabetes. A doctor may consider the beneficiary at increased risk if they have any of the following:
  - They had problems controlling their blood glucose, have been treated in an emergency room or have stayed overnight in a hospital because of their diabetes,
  - They have been diagnosed with eye disease related to diabetes,
  - They had a lack of feeling in their feet or some other foot problems like ulcers, deformities, or have had an amputation, or
  - Been diagnosed with kidney disease related to diabetes.

A beneficiary must get this training from an accredited diabetes self-management education program as part of a plan of care prepared by their doctor or qualified non-physician practitioner. The American Diabetes Association or the Indian Health Service accredits these programs. Health care providers who have special training in diabetes education teach classes

A beneficiary is covered by Medicare to get a total of 10 hours of initial training within a continuous 12-month period. One of the hours can be given on a one-on-one basis. The other nine hours must be training in a group class. The initial training must be completed no more than 12 months from the time the beneficiary starts the training.

A doctor or qualified non-physician practitioner may prescribe 10 hours of individual training if the beneficiary is blind or deaf, has language limitations, or no group classes have been available within two months of the doctor's order. To be eligible for 2 more hours of follow-up training each year after the year the beneficiary received initial training, they must get another written order from their doctor. The two hours of follow-up training can be with a

An Overview of Medicare Covered Diabetes Supplies and Services (continued)

group or they may have one-on-one sessions. A doctor or qualified non-physician practitioner must prescribe the follow-up training each year for Medicare to cover it.

Beneficiaries learn how to successfully manage their diabetes in DSMT classes, and the training includes information on self-care and making lifestyle changes. The first session consists of an individual assessment to help the instructors better understand the beneficiary's needs. Classroom training includes topics such as the following:

- General information about diabetes, and the benefits and risks of blood glucose control.
- Nutrition and how to manage ones diet.
- Options to manage and improve blood glucose control.
- Exercise and why it is important to ones health.
- How to take ones medications properly.
- Blood glucose testing and how to use the information to improve ones diabetes control.
- How to prevent, recognize, and treat acute and chronic complications from ones diabetes.
- Foot, skin, and dental care.
- How diet, exercise, and medication affect blood glucose.
- How to adjust emotionally to having diabetes.
- Family involvement and support
- The use of the health care system and community resources.

Note: If a patient lives in a rural area, they may be able to get DSMT in a federally qualified health center (FQHC). For more information about FQHCs, visit the CMS Web site at *http://www.cms.hhs.gov/center/fqhc.asp*.

FQHCs are special health centers, usually located in urban or rural areas, and they can give routine health care at a lower cost. Some FQHCs are community health centers, tribal FQHC clinics, certified rural health clinics, migrant health centers, and health care for the homeless programs.

Medical Nutrition Therapy (MNT) Services

In addition to DSMT, medical nutrition therapy services are also covered for people with diabetes or renal disease. To be eligible for this service, a beneficiary's fasting blood glucose has to meet certain criteria. Also, their doctor must prescribe these services for them. A registered dietitian or certain nutrition professionals can give these services, and the services include the following:

- An initial nutrition and lifestyle assessment
- Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan)
- How to manage lifestyle factors that affect diabetics
- Follow-up visits to check on progress in managing diet.

Medicare covers three hours of one-on-one medical nutrition therapy services the first year the service is provided, and two hours each year after that. Additional MNT hours of service may be obtained if the beneficiary's doctor determines there is a change in their diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and orders additional MNT hours during that episode of care.

Foot Exams and Treatment

If a beneficiary has diabetes-related nerve damage in either of their feet, Medicare will cover 1 foot exam every 6 months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past six months. Medicare may cover more frequent visits to a foot care specialist if a beneficiary has had a non-traumatic (not because of an injury) amputation of all or part of their foot or their feet have changed in appearance which may indicate they have serious foot disease.

Hemoglobin A1c Tests

A hemoglobin A1c test is a lab test ordered by the beneficiary's doctor. It measures how well a beneficiary's blood glucose has been controlled over the past three months. Anyone with diabetes is covered for this test if his or her doctor orders it. Medicare may cover this test when a beneficiary's doctor orders it.

Glaucoma Tests

Medicare will pay for a beneficiary to have their eyes checked for glaucoma once every 12 months. This test must be done or supervised by an eye doctor who is legally allowed to give this service in their state.

Special Eye Exam

People with Medicare who have diabetes can get special eye exams to check for eye disease (called a dilated eye exam). An eye doctor who is legally allowed to provide this service in their state must do these exams. The dilated eye exam is recommended once a year and must be performed by an eye doctor who is legally allowed to provide this service in the beneficiary's state.

Diabetes Supplies and Services not Covered by Medicare

The original Medicare plan and Medicare drug plans (Part D) do not cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction)
- Orthopedic shoes (shoes for people whose feet are impaired, but intact)
- Routine or yearly physical exams (Medicare will cover a one-time initial preventive physical exam (the "Welcome to Medicare" physical exam) within the first six months of the beneficiary enrolling in Part B—coinsurance and Part B deductible applies.)
- Weight loss programs.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For

An Overview of Medicare Covered Diabetes Supplies and Services (continued)

more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit on the CMS Web site *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.

- **Medicare Learning Network** – The *Medicare Learning Network* (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the *Medicare Learning Network's* Web page on the CMS Web site at *http://www.cms.hhs.gov/MLNGenInfo*.
- **Patient Resources** – For literature to share with Medicare patients, please visit on the Internet *http://www.medicare.gov*.
- **The National Diabetes Education Program** – NDEP (*http://ndep.nih.gov/*) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.

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

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

MLN Matters Number: SE0738
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0738

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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 our provider education Web site *http://www.fcso.com*.

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

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

Effective and Notice Dates

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

Electronic Notification

To receive quick, automatic notification when new and revised LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It is very easy to do. Simply go to our Web site *http://www.fcso.com*, hover over Medicare Providers, select Florida Part A or B, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

More Information

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

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

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Advance Beneficiary Notice

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

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

ADDITIONS/REVISIONS TO EXISTING LCDS

AJ0129: Abatacept—Revision to the LCD

The local coverage determination (LCD) for abatacept became effective June 30, 2007. Since that time, the terminology in the Food and Drug Administration (FDA)-approved product label has changed. Therefore, under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the phrase "…slowing the progression of structural damage…" was changed to " …inhibiting the progression of structural damage."

Effective Date

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

The full text for this LCD (L24536) is available on or after this effective date through the provider education Web site *http://www.fcso.com*, select Medicare Providers – Florida Part A or B and click on the ***"Medicare Part A"*** link. ❖

ADDITIONAL MEDICAL INFORMATION

A55876: Implanted Fiducial Markers—Coding and Billing Guidelines

Both fiducial artificial markers and implanted markers are used as a guide to provide a clear and accurate reference point(s) for any type of imaging modality, image guided surgery, or radiation therapy. If the precise location of the target organ is known, dose escalation becomes more feasible for radiation therapy. An interventional radiologist generally performs these procedures. The marker(s) may be implanted with or without general anesthesia and the procedure requires 45 to 60 minutes to perform.

CPT code *55876* was established to report the placement of interstitial device(s) in the prostate for radiation therapy guidance. This procedure is performed in men with malignant neoplasms of the prostate. The following *CPT* codes for image guidance may be paid in addition to *CPT* code *55876* based on the type of procedure utilized:

76942 for ultrasonic guidance

77002 for fluoroscopic guidance

77012 for computed tomography guidance

77021 for magnetic resonance guidance

Unlisted *CPT* codes *19499*, *32999*, or *47399* could be used when placing fiducial markers in the breast, lung or liver. Providers should not submit any medical record documentation with these claims. First Coast Service Options, Inc. (FCSO) will request this by means of an additional development request (ADR) letter. All applicable supporting documentation should be submitted.

Only one image guidance code is expected per episode of fiducial marker placement.

Unlisted codes are not allowable by an ambulatory surgical center (ASC). In addition, *CPT* code *55876* (fiducial marker placed in prostate) cannot be billed by an ASC prior to January 01, 2008. ❖

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Diagnostic Breath Analysis—Coverage Guidelines

Diagnostic breath analyses are tests performed to measure either the hydrogen or carbon dioxide content of the breath after ingestion of certain compounds. The analyses are performed to diagnose certain gastrointestinal diseases.

Indications

A lactose breath hydrogen test to detect lactose malabsorption is eligible for coverage.

CPT code *91065* (*Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit*) should be used to report this service.

ICD-9 Codes that Support Medical Necessity

271.3 Intestinal disaccharidase deficiencies and disaccharide malabsorption
787.91 Diarrhea

Limitations

The following breath tests are excluded from coverage:

Lactulose breath hydrogen for diagnosing small bowel bacterial overgrowth and measuring small bowel transit time.

- CO_2 for diagnosing bile acid malabsorption
- CO_2 for diagnosing fat malabsorption

Screening tests, in the absence of associated signs, symptoms or complaints are denied under 1862(a)(7).

It is understood that any diagnosis information submitted must have (in the patient record) medical justification of the tests. Subsequent determination that the medical record is lacking such justification will result in a retroactive denial under 1862(a)(1)(A).

Documentation Requirements

The ordering physician should retain in the patient's medical record, history and physical, examination notes documenting evaluation and management of one of the Medicare covered conditions/diagnoses, with relevant clinical signs/symptoms or abnormal laboratory test results, appropriate to one of the covered indications. The patient's clinical record should further indicate changes/alterations in medications prescribed for the treatment of the patient's condition. There must be an attending/treating physician's order for each test documented in the patient's medical/clinical record. Documentation must be available to Medicare upon request.

Effective Date

This coverage guideline is effective for services provided **on or after January 18, 2008.** The full text of the Centers for Medicare & Medicaid Services (CMS) national coverage determination regarding this service (Pub 100-03, Chapter 1, Part 2, Section 100.5) may be viewed on the CMS Internet-Only Manual System, *Medicare National Coverage Determinations (NCD)* manual at *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf*. ❖

HOSPITAL SERVICES

New Patient Status Code 70 for Discharges/Transfers to Other Institutions

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

Provider Types Affected

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

Provider Action Needed
STOP – Impact to You

This article is based on change request (CR) 5764, which provides implementing instructions for a new patient discharge status code 70 and a definition change to existing patient discharge status code 05.

CAUTION – What You Need to Know

New patient discharge status code 70 was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for **discharge dates on or after April 1, 2008,** and patient discharge status code 05 has been redefined to indicate a discharge/transfer to a designated cancer center or children's hospital.

GO – What You Need to Do

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

Background

The UB-04 claim form includes the patient status code as field locator (FL) 17. The patient status code is a two-digit code to indicate the disposition or discharge status of the beneficiary on a submitted claim, and it is a required field on all institutional claims. Several members of the National Uniform Billing Committee (NUBC) participated in a workgroup to ensure the clarity of the definitions of patient discharge status codes, and as a result of the NUBC workgroup meeting, the following patient discharge status code changes are being implemented by NUBC effective April 1, 2008:

- New **patient discharge status code 70** was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharges/to dates on or after April 1, 2008.
- **Patient discharge status code 05** has been redefined, effective April 1, 2008, to indicate a discharge/transfer to a designated cancer center or children's hospital.

Note: For inpatient prospective payment system (IPPS) hospitals, the post-acute transfer payment policy will not apply to claims that contain patient discharge status code 70.

CR 5764 also revises the *Medicare Claims Processing Manual*, chapter 1, section 50.2.1 (Inpatient Billing from Hospitals and SNFs), to reflect these patient status code changes and these revisions may be found in the attachment to CR 5764.

Additional Information

The official instruction, CR 5764, issued to your FI and A/B MAC regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1361CP.pdf*.

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

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

MLN Matters Number: MM5764
Related Change Request (CR) Number: 5764
Related CR Release Date: November 2, 2007
Related CR Transmittal Number: R1361CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1361, CR 5764,

Duplicative Transplant Registry Fees

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries that recently, a company known as MatchingDonors, Inc., operating through a Web site at *www.matchingdonors.com* (together referred to herein as MatchingDonors), has been notifying transplant centers and physician organization members about its service. MatchingDonors is a Web-based donor-recipient matching service that lists individuals who potentially intend to donate an organ and individuals in need of a transplant. Another organization, the National Kidney Registry, also operates a living-donor/recipient matching service.

In the notifications sent by MatchingDonors to transplant centers, MatchingDonors states that Medicare will reimburse the fees paid by transplant centers for placing waiting list candidates on MatchingDonors' Web site listing. MatchingDonors charges rates as high as $595 for a lifetime membership. The National Kidney Registry charges a $750 registry fee and states that potential recipients may be able to be reimbursed by Medicare. The MatchingDonors notifications also reference the Medicare Benefit Policy Manual, Chapter 11, Section 104.17, which states:

> A participating hospital which expects to perform a kidney transplant will be reimbursed for the reasonable cost incurred in listing the patient and the patient's blood characteristics with a professionally recognized organization that maintains a registry of potential transplant candidates, and which provides a regular listing of such patients to hospitals engaged in kidney procurement.

The policy noted above was instituted as a result of the Organ Transplant Act of 1984, as amended, (42 U.S.C. 273 et seq.) which created the Organ Procurement and Transplant Network (OPTN) to be operated by a private, non-profit entity under contract with the Health Resources and Services Administration (HSRA). The United Network for Organ Sharing (UNOS) has been awarded the contract to operate OPTN. CMS payment policy was written to allow payment for the fees to OPTN and UNOS. UNOS is professionally recognized throughout the transplant community as the single registry of individuals waiting for an organ transplant. It utilizes medical test results to match donors and recipients and allocate organs for transplantation on a national basis using a scientific methodology. **To date, no other organization, including MatchingDonors and the National Kidney Registry, has been awarded a contract by HRSA.** Section 1861(v)(1)(A) of the Social Security Act states, in pertinent part, that the reasonable cost of any services should exclude costs that are unnecessary in the efficient delivery of needed health services. Payment for organ acquisition costs incurred by a hospital is made on a reasonable cost basis. See 42 CFR 413.113(d). The OPTN's registry contains potential recipients for organs. Any person who wishes to make the altruistic donation of an organ may begin the process by contacting any OPTN member transplant hospital. Once a final decision to donate is made, a match with a suitable recipient determined by the transplant program is made.

CMS pays for living donor and deceased donor transplants by the diagnostic related group (DRG) and the organ acquisition cost. When an altruistic living donor is available, the program's costs for assessing the donor and deciding on a suitable match are included in the organ acquisition cost center of cost report submitted by the transplant center. Accordingly, because potential recipients already have a means of being matched with altruistic donors by the functions of the OPTN member institutions and Medicare already reimburses hospitals for the cost of enrolling in the OPTN registry, paying MatchingDonors or the National Kidney Registry for this function would be unnecessary and duplicative, and would be inconsistent with section 1861(v)(1)(A).

Important Notification to Providers

First Coast Service Options, Inc. is informing all hospitals with transplant centers (kidney, heart, liver, lung, intestine or pancreas) that any costs claimed as a result of fees paid to the National Kidney Registry, MatchingDonors, Inc., MatchingDonors.com, MatchingDonors.org, or MatchingDonors.org, Inc. (or any like organization) **will be disallowed** on the Medicare cost report as they are duplicative of fees that the hospital has properly paid to OPTN and UNOS. ❖

Source: CMS JSM 08029, October 26, 2007

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

Use of Benefit Exhaust Date as Discharge Date

Effective December 3, 2007, inpatient psychiatric facilities (IPFs) paid under the prospective payment system (PPS) **must** report the day the beneficiary has exhausted the Medicare benefits as the discharge date using occurrence code **A3, B3** or **C3**. Additionally, IPFs can submit a no-pay type of bill (TOB) 110 with a patient status **30** every 60 days until the patient is physically discharge or dies. TOB 110 must contain the applicable diagnosis and procedure codes on the applicable claims based on the date of services. This policy also clarifies that for long-term care hospitals (LTCHs) the benefit exhaust date has always been considered the discharge date for payment purposes since the implementation of LTCH PPS on October 1, 2002.

Note: Adjustments under TOB 117 are still required when the beneficiary has benefits and when the patient is in a noncovered level of care.

Policy Changes

For payment purposes, an IPF/LTCH discharge occurs when the benefits exhaust. The claim will be paid either on the discharge date if benefits are available or on the benefit exhaust date if the discharge is after the benefit exhaust date. This change in policy allows the following:

- Benefits exhaust date to substitute for the discharge date, if present, for payment purposes.
- The PRICER version used will be the one in effect at the time the services were provided.
- No-pay TOBs 110 are allowed once benefits have exhausted instead of continually adjusting the claims (TOB 117) until actual discharge occurs once benefits exhaust.

Policy Change Benefits

By redefining this policy, the provider statistical and reimbursement (PS&R) report uses the benefit exhaust date as the discharge date making it easier for contractors to use the PS&R report especially during the blend period to settle the cost report as the days stay with the year they occurred. This policy change means:

- Claims will now be settled on the appropriate cost report.
- The appropriate PPS-TEFRA blend percentage will be paid.
- Patients with long lengths of stay will be counted on the correct PS&R report.
- The PRICER version used will be the one in effect at the time the services were provided (i.e., when the Medicare beneficiary had Medicare benefits).

First Coast Service Options, Inc., your Medicare contractor, will return claims meeting the benefit exhaust criteria submitted with the incorrect discharge date. Providers will then have to split those claims and resubmit, adding the appropriate diagnosis and/or procedure codes based on the date of service.

Source: CMS Pub. 100-04, Transmittal 1231, CR 5474

CRITICAL ACCESS HOSPITAL SERVICES

Correction to Calculation of Coinsurance for Indian Health Service Critical Access Hospitals

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

Provider Types Affected

Indian health service critical access hospitals (IHS CAHs) that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Change request (CR) 5769 corrects the calculation of Medicare Part B coinsurance for IHS CAHs.

CAUTION – What You Need to Know

The calculation of coinsurance for IHS CAHs for services paid on the facility-specific per visit rate is to be based solely on billed charges, not on the payment amount for the particular IHS CAH. On April 7, 2008, Medicare systems will be corrected to calculate coinsurance for IHS CAHs accordingly. FIs or MACs will not search their claim histories to find and correct claims processed by Medicare since April 1, 2007, through April 6, 2008**, but will correct any claims that you bring to their attention.**

GO – What You Need to Do

Make certain that your billing staffs are aware of this change.

Background

The change directed in CR 5769 corrects an error in the Medicare system that calculates Part B coinsurance for IHS CAHs on claims processed since April 1, 2007.

Additional Information

For complete details regarding this CR, please see the official instruction (CR 5769) issued to your Medicare A/B MAC or FI. That instruction may be viewed by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1362.pdf*.

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

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

MLN Matters Number: MM5769
Related Change Request (CR) Number: 5769
Related CR Release Date: November 2, 2007
Related CR Transmittal Number: R1362CP
Effective Date: April 1, 2007
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1362, CR 5769

SKILLED NURSING FACILITY SERVICES

Definition of Skilled Nursing Facility Used in Determining Durable Medical Equipment Coverage and Ending a Benefit Period or "Spell of Illness"

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

Provider Types Affected

Skilled nursing facilities (SNFs), durable medical equipment (DME) suppliers billing Medicare fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), or DME MACs.

What You Need to Know

This article is for informational purposes only and does not represent any change in policy. Instead, it reinforces existing policy by providing legal, regulatory, and Medicare manual references for:

- The definitions of SNFs and NFs
- The policies applicable to restricting payment for DME coverage in SNFs
- The definition of the benefit period and of how one benefit period ends and another begins, especially as it applies to residents of SNFs.

Skilled Nursing Facility Restriction on Coverage of Durable Medical Equipment

Coverage of a beneficiary's SNF stay under Part A (the original Medicare Plan's hospital insurance program) encompasses the overall package of institutional care that the SNF furnishes during the course of the beneficiary's Medicare-covered stay. This comprehensive Part A coverage includes DME under the heading of " …drugs, biologicals, supplies, appliances, and equipment…" as stated in section 1861(h)(5) of the Social Security Act (the Act). (The Social Security Act is available on the Internet at *http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm*.)

When a beneficiary's SNF stay does not qualify for Part A coverage (no qualifying three-day hospital stay, SNF level of care not met, etc.), Part B (the supplementary medical insurance program) generally can still provide limited coverage for certain individual "medical and other health services" described in Section 1861(s) of the Act. However, as explained below, the scope of coverage under the Part B benefit for DME (Section 1861(s)(6) of the Act) specifically excludes items that are furnished for use in the SNF setting.

Section 1861(n) of the Act limits Part B coverage under the DME benefit to those items that are furnished for use in a patient's home. This provision further specifies that any institution meeting the basic definition of a hospital in Section 1861(e)(1) of the Act, or of an SNF in Section 1819(a)(1) of the Act, cannot be considered a patient's "home" for this purpose. Section 1819(a)(1) (formerly Section 1861(j)(1)) of the Act, in turn, defines an "SNF" broadly as any institution that is primarily engaged in providing skilled nursing (clause (A)) or rehabilitation services (clause (B)) to its residents.

This expansive SNF definition omits the specific, more restrictive elements contained in the remainder of sections 1819(a)-(d) of the Act, which list the detailed requirements that an institution must meet in order to participate in the Medicare program as a *certified* SNF. Thus, in excluding Part B coverage for DME furnished in "SNFs" as defined broadly in section 1819(a)(1) of the Act, Congress intended for this exclusion to encompass not only all *Medicare-participating* SNFs, but also any other institutions, which, though not participating in Medicare, do provide the type of care described in that section of the law. This policy is also reflected in the regulations in title 42 of the *Code of Federal Regulations* (42 CFR) at section 410.38(b), and in chapter 15, section 110.1.D of the *Medicare Benefit Policy Manual*, which is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/iom/list.asp*.

The blanket prohibition that Congress imposed on any separate Part B payment for DME furnished in this setting (See section 144(d) of the Social Security Amendments of 1967, Public Law 90-248) would appear to reflect the view that any institution whose primary function is to provide skilled care to its residents would have an inherent responsibility to dispense DME, when needed. This would mean that payment for such items is already an integral part of the skilled facility's basic inpatient rate. Accordingly, any separate, additional DME payment under Part B in this situation would be redundant. Modifying or eliminating the statutory prohibition on Part B payment for DME furnished in this setting would require legislation to amend the law itself.

Additional Considerations for DME Furnished in Medicaid-Only Nursing Facilities

Additional considerations apply in determining whether a Medicaid-only nursing facility (NF) would meet the basic SNF definition in this context. Medicaid NFs were created when the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, Public Law 100-203) enacted nursing home reform legislation that combined the previously separate Medicaid categories of SNFs and intermediate care facilities (ICFs) into a single category. Prior to the OBRA 1987 changes, Medicaid SNFs were *always* considered to meet the law's basic definition of an SNF, while pursuant to a U.S. District Court decision in *Kron v. Heckler* (E.D. La., October 17, 1983), those facilities licensed or certified solely as ICFs were *never* considered to meet the basic SNF definition.

The parallel Medicare SNF and Medicaid NF definitions that OBRA 1987 established in Sections 1819(a)(1) and 1919(a)(1) of the Act, respectively, both turn on the type of care that the facility is primarily engaged in furnishing. However, while the NF definition in Section

Definition of SNF Used in Determining DME Coverage and Ending a Benefit Period or "Spell of Illness" (continued)

1919(a)(1) of the Act contains a clause (A) for skilled nursing and a clause (B) for rehabilitation services that are identical to their SNF counterparts in section 1819(a)(1) of the Act, it also contains an additional clause (C) for health-related institutional care above the level of room and board (comparable to the type of care furnished by ICFs prior to OBRA 1987), which is not found in the SNF definition.

Thus, if a Medicaid NF is primarily engaged in furnishing skilled care under either clauses (A) or (B) of Section 1919(a)(1) of the Act, it would meet the basic SNF definition and cannot be considered a "home" for purposes of DME coverage under Part B. Alternatively, if the NF is primarily engaged in furnishing essentially ICF-level care under clause (C) of this provision, it *would not* meet the basic SNF definition and *can* be considered a home for DME coverage purposes. Thus, because some NFs meet the basic SNF definition while others do not, NFs cannot as a class *automatically* be regarded as either qualifying or not qualifying as a "home" for DME coverage purposes and, therefore, must be evaluated individually under the administrative criteria discussed below.

Administrative Criteria

Administrative criteria to identify those institutions that meet the basic SNF definition are used by each of the state agencies that survey the individual institutions within their jurisdictions, and appear in chapter 2, section 2166 of the *State Operations Manual*. This manual is also available on the CMS Web site at *http://www.cms.hhs.gov/manuals/iom/list.asp*.

These criteria also were published in the *Federal Register* as HCFA Rulings 83-2 (47 FR 54551, December 3, 1982) and 83-3 (49 FR 10710, March 22, 1984). Historically, it has been the state survey agency's responsibility to evaluate an institution in terms of these criteria. This evaluation reflects the type of care that the institution provides to its residents *generally* (rather than the type of care that an individual resident may be receiving at a given point in time), because the requirements of the law relate to the type of care that an institution is *primarily engaged* in providing to its overall resident population.

Further, as indicated in chapter 2, section 2164 of the *State Operations Manual*, states can choose to incorporate the requirements of Section 1819(a)(1) of the Act directly into their own facility licensure standards. In a state that elects to adopt this approach, simply ascertaining that a particular nursing home is licensed under the applicable facility category of state law can also serve to confirm that the facility meets the basic SNF definition in Section 1819(a)(1) of the Act.

Applying the Criteria in Institutions That Contain a Participating "Distinct Part"

Generally, the determination of whether an institution meets the basic SNF definition is made by evaluating it *as a single unit* rather than by separately evaluating and classifying individual areas within the institution. In order to categorize a particular portion of an institution separately from the remainder of that institution, it is necessary for that portion to constitute a "distinct part," i.e., a separate, physically identifiable unit consisting of all the beds in a particular building, floor, wing, or ward (see the regulations at 42 CFR 483.5(b)).

In this situation, if the participating distinct part of an institution meets the basic SNF definition and the remainder of the institution does not, DME payment would be available under Part B only in the portion of the institution that qualifies as a "home" for DME coverage purposes by virtue of *not meeting* the basic SNF definition. Part B payment would not be available for DME furnished in any part of the institution that is identified as meeting the basic SNF definition, regardless of the type of care that a particular resident may be receiving there.

A more detailed discussion of situations in which part of an institution meets the basic SNF definition and part of it does not appears in chapter 5, section 1 of the *Medicare Program Integrity Manual*, also available on the CMS Web site at *http://www.cms.hhs.gov/manuals/iom/list.asp*.

This is the same material that originally appeared in section 4105.1 of the *Medicare Carriers Manual*, Part 3 (CMS Publication 14-3).

The Basic SNF Definition and the Medicare Policy on Ending a Benefit Period, or "Spell of Illness"

The special, broad definition of an SNF discussed above in connection with the DME coverage exclusion also figures in another aspect of Medicare policy, regarding the ending of a benefit period in an SNF. The law (at Section 1812(a)(2)(A) of the Act) provides for a maximum of 100 days of SNF benefits in a benefit period, or "spell of illness" (see Section 1861(a) of the Act). Medicare uses the benefit period concept to keep track of how many of these 100 days of SNF coverage a beneficiary has used, and how many are still available. A benefit period starts on the day that a beneficiary begins receiving Part A hospital or SNF benefits. Once the 100 days of SNF benefits available in the benefit period have been exhausted, they cannot be renewed until the current benefit period ends. Under Section 1861(a)(2) of the Act, this occurs when a period of 60 consecutive days has elapsed throughout which the beneficiary has not been an inpatient of a hospital or an SNF.

There is no limit to the number of benefit periods that a beneficiary can have. However, after a given benefit period ends, the beneficiary must once again meet all of the requirements for SNF coverage (3-day qualifying hospital stay, timely transfer to a Medicare-participating SNF, etc.) in order to begin utilizing the 100 days of renewed SNF benefits. The law's reference to a benefit period as a "spell of illness" sometimes leads to the mistaken belief that a benefit period is linked to a particular medical episode or type of condition, so that the onset of a new and unrelated condition could serve to end the benefit period. In fact, however, this does not end the benefit period, which can occur in an SNF only under the circumstances described below.

As noted previously, section 1861(a)(2) of the Act provides, in part, that a benefit period ends after a beneficiary has not been an inpatient of an SNF for 60 consecutive days. In defining an "SNF" for this purpose, this provision

Definition of SNF Used in Determining DME Coverage and Ending a Benefit Period or "Spell of Illness" (continued)

uses the same broad SNF definition described in the preceding discussion on the DME coverage exclusion. This is reflected in the benefit period regulations at 42 CFR 409.60(b)(1)(iii), and in chapter 3, section 10.4.3.2 of the *Medicare General Information, Eligibility and Entitlement Manual*. This manual is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/iom/list.asp*.

Special "Inpatient" Definition for Ending a Benefit Period in an SNF

However, unlike in the DME context, the benefit period policy additionally uses a special definition of the term "inpatient" as well. The instructions in Chapter 3, Section 10.4.4 of the *Medicare General Information, Eligibility and Entitlement Manual* indicate that a beneficiary in an institution that meets the basic SNF definition would be considered an "inpatient," for benefit period purposes, only while actually receiving a skilled level of care there. These instructions also contain a set of administrative presumptions that simplify the process for determining whether the beneficiary is, in fact, receiving this level of care. This means that a beneficiary who remains in an SNF can nonetheless end a benefit period, after 60 consecutive days elapse during which the beneficiary does not receive a skilled level of care there (and, thus, is not considered an "inpatient" of the SNF for benefit period purposes).

This special "inpatient" definition, which reflects regulations at 42 CFR 409.60(b)(2), (c), and (d), and the Federal circuit court decision in *Mayburg v. Heckler* (740 F.2d 100 (1st Cir. 1984)), is intended to address situations in which a beneficiary essentially uses the SNF as a place of residence rather than as a provider of ongoing medical care. It is important to note as well that, under this policy, a beneficiary would still be considered an SNF "inpatient" (and his or her current benefit period would continue) for as long as the beneficiary keeps receiving a skilled level of care in the SNF – even if Medicare has stopped paying for the SNF stay due to the beneficiary's exhaustion of Part A benefits.

Thus, if a particular nursing home does not meet the basic SNF definition, a beneficiary's stay in that nursing home would not serve to prolong the current benefit period, regardless of the type of care being received there. Further, even when a beneficiary is in a nursing home that *does* meet the basic SNF definition, the beneficiary can nonetheless end a benefit period there after 60 consecutive days elapse during which he or she is not an "inpatient" of the SNF for benefit period purposes (that is, does not receive a skilled level of care). Accordingly, a nursing home stay would serve to prolong a benefit period *only* if *both* of the following two conditions are met:

- The nursing home meets the basic SNF definition; *and*
- The beneficiary remains an "inpatient," for benefit period purposes, by continuing to receive a skilled level of care there.

Additional Information

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

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

MLN Matters Number: SE0745
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0745

ESRD SERVICES

Common Working File Informational Unsolicited Responses for RDF Claims Overlapping Inpatient Hospital Stays

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

Provider Types Affected

Renal dialysis facilities (RDFs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5768, which changes processes for common working file (CWF) informational unsolicited responses for RDF Claims overlapping inpatient hospital stays.

CAUTION – What You Need to Know

CR 5768 implements an informational unsolicited response from the CWF to prompt the Medicare systems to adjust bill type 72x claims that have line item dates of service overlapping a subsequently received inpatient claim.

GO – What You Need to Do

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

Background

CR 5039 implemented line item billing for RDFs effective April 1, 2007. (See related *MLN Matters* article, MM5039 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5039.pdf*.)

In addition, CR 5039 (Transmittal 1084) implemented system functionality in the Medicare systems to compare line item dates of service on RDFs claims to the dates of services on other potential overlapping claims. When an incoming RDF claim (bill type 72x) includes line item dates of service(s) that are included in an inpatient claim, the line item services that are listed with dates that overlap the inpatient stay dates are rejected while allowing the remainder of the claim for dates of service that are not overlapping to be paid. RDFs may bill for and be paid for services on the admission date and discharge date of a hospital stay. Therefore, the inpatient admission date and discharge date are not considered overlapping dates of service. CR 5039 (Transmittal 1084) did not include a process for rejecting services on the RDF claim overlapping an inpatient stay when the RDF claim is received before the inpatient hospital claim.

Therefore, CR 5768 implements processes in the Medicare systems to identify previously processed RDF claims received for a patient where a subsequent inpatient claim is received. When such RDF claims are identified, Medicare systems will adjust the already processed bill type 72x claims that have line item dates of service overlapping the incoming inpatient claim.

Additional Information

The official instruction, CR 5768, issued to FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1364CP.pdf*.

The revised sections of chapter 8 of the Medicare *Claims Processing Manual* are attached to CR 5768.

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

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

MLN Matters Number: MM5768
Related Change Request (CR) Number: 5768
Related CR Release Date: November 2, 2007
Related CR Transmittal Number: R1364CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1364, CR 5768

CORF SERVICES

2008 Annual Update to the Therapy Code List

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

Provider Types Affected

Physicians, therapists, and providers of therapy services billing Medicare carriers, fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), or Part A/B Medicare administrative contractors (A/B MACs) for rehabilitation services.

Provider Action Needed

STOP – Impact to You

One new code will added to the therapy code list for calendar year (CY) 2008. *CPT* code *96125* will be used for standard cognitive performance testing per hour of a qualified health care professional's time, both face-to-face with the patient and time interpreting test results and preparing the report.

CAUTION – What You Need to Know

CPT code *96125* is considered "always therapy" regardless of who performs the service and will always require a therapy modifier (GN, GO, GP).

GO – What You Need to Do

Make certain your office staffs are aware of the new code.

Background

Section 1834(k)(5) of the Social Security Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/*Current Procedural Terminology*, 2008 Edition (HCPCS/*CPT-4*) is the coding system used for the reporting of these services.

Therapy services, including "always therapy" services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, Publication 100-4, chapter 5 and the *Medicare Benefit Policy Manual*, Publication 100-2, chapters 12 and 15. That manual is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

Additional Information

For complete details regarding CR 5810, please see the official instruction issued to your Medicare FI, RHHI, carrier or A/B MAC. That instruction may be viewed on the CMS Web site by going to *http://www.cms.hhs.gov/transmittals/downloads/R1377CP.pdf*.

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

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

MLN Matters Number: MM5810
Related Change Request (CR) Number: 5810
Related CR Release Date: November 23, 2007
Related CR Transmittal Number: R1377CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1377, CR 5810

ELECTRONIC DATA INTERCHANGE

Rejection of Electronic Claim Status Requests Lacking National Provider Identifiers

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 status requests using the electronic data interchange (EDI) standard Health Insurance Portability and Accountability Act (HIPAA) transactions to Medicare contractors (carriers, fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]).

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5726, which describes policy changes that are a result of HIPAA requirements that prohibit the acceptance of EDI transactions that contain legacy provider numbers. CR 5726 specifically address changes around the processing of electronic claim status requests and the responses to such requests.

CAUTION – What You Need to Know

Beginning May 23, 2008, Medicare will return to sender any electronic claim status request (X12 276 transactions) that contain legacy provider numbers instead of or in addition to the national provider identifier (NPI) number. This policy also applies to direct data entry claim status inquiries and to Internet claim status screens operated as demonstration projects by some contractors.

GO – What You Need to Do

No later than May 23, 2008, providers should ensure that all electronic claim status requests sent to Medicare contractors contain only NPI numbers (no legacy provider numbers).

Background

All electronics claim status requests submitted using the EDI standards (X12 276) adopted under HIPAA for national use must use the HIPAA-mandated NPI exclusively for provider identification no later than May 23, 2008. Those that do not are to be returned to the sender beginning May 23, 2008. All claims status responses (X12 277 transactions) will also contain only NPIs as of May 23, 2008. The same policy applies to direct data entry claim status inquiries and to those Internet claim status screens some contractors are permitted to operate under an Internet demonstration program. The absence of an NPI or the presence of a legacy number as of May 23, 2008, will result in rejection of the inquiry by these direct data entry processes.

Providers are advised that Medicare will return an NPI on the claims status response on or after May 23, 2008, even if the claim status request is received prior to May 23, 2008, using a legacy number. In returning the NPI, Medicare will use a crosswalk file that relates the legacy number to the provider's NPI. If the legacy number maps to more than one NPI, Medicare will return the first active NPI in the 277 response.

To avoid confusion, Medicare encourages providers to begin including their NPIs in their X12 276 inquiries as soon as possible prior to May 23, 2008, particularly if the provider has more than one NPI, but was assigned only one legacy number by Medicare for claims submission purposes.

Additional Information

The official instruction, CR 5726, issued to your Medicare contractor may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R302OTN.pdf*.

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

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

MLN Matters Number: MM5726
Related Change Request (CR) Number: 5726
Related CR Release Date: November 2, 2007
Related CR Transmittal Number: R302OTN
Effective Date: May 23, 2008
Implementation Dates: January 7,2008 and April 7, 2008

Source: CMS Pub. 100-20, Transmittal 302, CR 5726

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

December 2007 – January 2007

Ask the Contractor – Evaluation & Management: Consultation & Subsequent Hospital Care

When: **Tuesday, December 11, 2007**

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

Type of Event: **Teleconference**

Hot Topics – Medicare Updates and Webcasts

When: **Tuesday, January 15, 2007**

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

Type of Event: **Teleconference**

Two Easy Ways To Register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

PREVENTIVE SERVICES

November Is American Diabetes Month

Diabetes continues to be a prevalent health concern in the United States. Approximately 20.8 million Americans, or 7.0 percent of the population, have diabetes. Of these, 10.3 million people are age 60 and over. Left undiagnosed, diabetes can lead to serious complications such as heart disease, stroke, blindness, kidney damage, lower-limb amputations, and premature death. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes.

Covered diabetes screening tests include the following:

- A fasting blood glucose test
- A post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults)
- A two-hour post-glucose challenge test alone.

We Need Your Help!

CMS needs your help to ensure that people with Medicare are assessed for and informed about their risk factors for diabetes or pre-diabetes, and that those who are eligible take advantage of the diabetes screening tests.

In addition to providing coverage for diabetes screenings, Medicare also provides coverage for a variety of preventive care and other services for people with diabetes, such as the initial preventive physical examination (must be received within the first six months of the beneficiary's initial Medicare Part B coverage period), cardiovascular screening blood tests, diabetes self-management training, medical nutrition therapy, diabetes supplies, glaucoma screening, and influenza and pneumococcal immunizations. These services can help beneficiaries manage the disease and lower the risk of complications. Talk with your Medicare patients about the preventive services that are right for them and encourage utilization by providing referrals for appropriate services for which they may be eligible. Working together, we can help people with diabetes take steps to reduce the occurrence of serious complications through early detection and treatment, controlling the levels of blood glucose, blood pressure, and blood lipids, life style modifications (diet and exercise), and by receiving other preventive care practices as appropriate.

For More Information

- For more information about Medicare's coverage of diabetes screening services, initial preventive physical examination, cardiovascular screening blood tests, diabetes self management training, medical nutrition therapy, diabetes supplies, influenza and pneumococcal immunizations, and glaucoma screening services, including coverage, coding, billing, and reimbursement guidelines, please visit the CMS Medicare Learning Network (MLN) Preventive Services Educational Products Web page *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- For literature to share with your Medicare patients, please visit *http://www.medicare.gov*.
- For more information about American Diabetes Month, please visit *http://www.diabetes.org/communityprograms-and-localevents/americandiabetesmonth.jsp*.

Thank you for partnering with CMS during American Diabetes Month as we strive to make sure that people with Medicare learn more about diabetes and their risk factors for the disease and that they take full advantage of the diabetes screening tests and other Medicare-covered preventive services for which they may be eligible. ❖

Source: CMS Provider Education Resource 200711-01

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

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers Florida Part A or B, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

New Brochure for Health Care Professionals on Diabetes-Related Services

November Is American Diabetes Month – The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes, as well as other covered services for people with diabetes. CMS has published a new provider brochure entitled ***Diabetes-Related Services.*** This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. You may download, view and print this new brochure by visiting the *Medicare Learning Network (MLN)* on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.

Print copies of the brochure may be ordered, free of charge, from the *MLN* Product Ordering Page on the CMS Web site by visiting *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

For More Information

- For more information about Medicare's coverage of preventive services and screenings for people with diabetes, including the diabetes screening services, diabetes self management training, medical nutrition therapy, diabetes supplies, initial preventive physical examination, cardiovascular screening blood tests, influenza and pneumococcal immunizations, and glaucoma screening services, please visit the CMS *Medicare Learning Network (MLN) Preventive Services Educational Products* Web page *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- For literature to share with your Medicare patients, please visit *http://www.medicare.gov.*
- National Diabetes Education Program (NDEP) *http://ndep.nih.gov/* – NDEP provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.
- For more information about American Diabetes Month, please visit *http://www.diabetes.org/communityprograms-and-localevents/americandiabetesmonth.jsp*. ❖

Source: CMS Provider Education Resource 200711-10

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

Flu Shot Reminder

Flu season is here! Medicare patients give many reasons for not getting their annual flu shot, including—"It causes the flu." "I don't need it." "It has side effects." "It's not effective." "I didn't think about it." "I don't like needles!" The fact is that every year in the United States, on average, about 36,000 people die from influenza. More than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting their annual flu shot – and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. **Get Your Flu Shot. – Not the Flu.**

Remember: Influenza vaccination is a covered Part B benefit.

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

For information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf*. ❖

Source: CMS Provider Education Resource 200711-01

Medicare Preventive Services Series

The Centers for Medicare & Medicaid Services (CMS) has updated the following Web-based training (WBT) course: *Medicare Preventive Services Series: Part 3 Expanded Benefits.* This Web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for the following services: the initial preventive physical exam (also known as the "Welcome to Medicare" physical exam), diabetes screenings, diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as colorectal, prostate, and glaucoma screenings, and bone mass measurements.

Note: CMS has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102.

Participants who successfully complete this course may receive .2 IACET CEU. To register, free of charge for this course, please visit the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*. ❖

Visit the *Medicare Learning Network* – It's Free!

Source: CMS Provider Education Resource 200711-20

OTHER EDUCATIONAL RESOURCES

Medicare Learning Network Publications

The following publications may now be ordered from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network* by visiting *http://www.cms.hhs.gov/mlngeninfo*, scrolling down to "Related Links Inside CMS" and selecting "MLN Product Ordering Page."

- The Rural Health Bookmark, which offers Medicare providers, suppliers, and physicians information about rural educational resources.
- Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program Bookmark, which provides information about the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program.

The revised *Skilled Nursing Facility Prospective Payment System Fact Sheet* (October 2007), which provides the elements of the skilled nursing facility prospective payment system, is now available in downloadable format on the CMS *Medicare Learning Network* Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf*. ❖

Visit the Medicare Learning Network – It's Free!

Source: CMS Provider Education Resource 200710-20

Updated Women's Health Web-Based Training Course

The Centers for Medicare & Medicaid Services (CMS) has updated the following Web-based training (WBT) course: ***Medicare Preventive Services Series: Part 2 Women's Health.*** This WBT course provides information to help fee-for-services providers understand Medicare's coverage and billing guidelines for mammography services, Pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements.
CMS has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. Participants who successfully complete this course may receive .2 IACET CEU. To register, free of charge for this course, please visit the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*. ❖

Visit the *Medicare Learning Network* – It's Free!

Source: CMS Provider Education Resource 200711-08

Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet

The *Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet* (July 2007 version), which provides information about payment for physician services in teaching settings and general documentation guidelines, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf*. ❖

Source: CMS Provider Education Resource 200711-06

2007-2008 Influenza Season Resources for Health Care Professionals

The Centers for Medicare & Medicaid Services (CMS) has released the following special edition *MLN Matters* article, SE0748 – *2007-2008 Influenza (Flu) Season Resources for Health Care Professionals*, located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf*.

This article provides fee-for-service Medicare providers and their staff with access to a variety of seasonal flu related educational resources that they can use during the 2007-2008 flu season.

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

Source: CMS Provider Education Resource 200711-18

Reader Survey—*Medicare A Bulletin*

We want readers to find this publication to be a helpful tool that is easy to use and understand . This survey is your opportunity to suggest ways we can better meet your needs. After the survey closes, we will publish the results on our Web site and work to implement suggested enhancements as appropriate. Thank you for taking the time to complete this survey.

Complete the questions below and fax to us at 1-904-361-0723 by December 21, 2007.

Overall Satisfaction

On a scale of 5 to 1, with 5 being very satisfied and 1 being very dissatisfied, how satisfied are you with the publication overall? Please ***circle*** the number that best applies.

5 4 3 2 1

Accuracy

"When I read the *Medicare A Bulletin* I feel comfortable that the information presented is accurate."

5 4 3 2 1

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5 4 3 2 1

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"Medicare rules and guidelines are complex; however, I generally find the articles in the *Medicare A Bulletin* clear."

5 4 3 2 1

"Medicare rules and guidelines are complex; however, I usually find the articles in the *Medicare A Bulletin* easy to read."

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"The *Medicare A Bulletin* is arranged in a manner that makes it easy to find the information I need."

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Comments/Feedback

What else could we do to improve the publication for you?

Please remove this page and fax your survey to 1-904-361-0723 by December 21, 2007, or click on the following link to complete this survey electronically:
http://ikc.incepture.com:80/ikc/survey?IKCSurveyID=07120304144877386000

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

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

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

PROVIDER EDUCATION

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

Seminar Registration Hotline
1-904-791-8103

Seminar Registration Fax Number
1-904-361-0407

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION

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

OVERPAYMENT COLLECTIONS

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

PROVIDER ENROLLMENT

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

Telephone Numbers

PROVIDERS

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

BENEFICIARY

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

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Web sites

PROVIDERS

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

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

RAILROAD MEDICARE

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

MEDICARE A BULLETIN

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

* ATTENTION BILLING MANAGER *