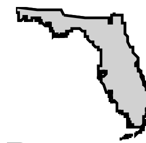
Medicare A Bulletin

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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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

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A Message to Providers

2008 Medifest Symposium—MARK YOUR CALENDARS

May 6, 2008 and May 7, 2008 – Orlando

First Coast Service Options, Inc. (FCSO) invites Florida providers to save the date for our annual **Medifest Symposium** on **May 6 – 7, 2008,** in Orlando.

Our popular educational seminar brings together Medicare experts, providers, billing staff, coders and suppliers throughout Florida to learn the latest on the Medicare program and to network with your peers. And this year, we have implemented exciting new changes to Medifest that you won't want to miss!

What's New This Year

This year's Medifest will be more rewarding and convenient than ever. New changes include:

- **Two One-Day Sessions**: to better accommodate your schedule, we will conduct Medifest as two one-day sessions, offering general classes in the morning and specialty courses in the afternoon. Come for one day or stay for two, there will be a diversity of classes for you to chose.
- **Panel Discussion Sessions**: participants will have the opportunity to dialogue with a panel of representatives from FCSO's staff and leadership levels, and to network with their peers.
- **More Advanced Classes**: based on your recommendations, we will conduct all courses at a more advanced level this year. To ensure everyone benefits from this new curriculum, participants must complete one Web-based training (WBT) course prior to registering for each class. These pre-requisite WBTs will be made available in February 2008.

More information on registration and how to complete pre-requisite WBT courses will be coming soon in future communications. Stay tuned to our Web site at *www.fcso.com*, or through our event registration hotline at 1-904-791-8103.

This will be the only Medifest event for Florida providers in 2008, so don't forget to mark your calendars:

Marriott Orlando Downtown
400 West Livingston Street
Orlando, FL 32801
May 6 & 7, 2008

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.

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. ❖

General Information

Update to Medicare Deductible, Coinsurance and Premium Rates for 2008

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], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC], durable medical equipment Medicare administrative contractors [DME MAC] and carriers) for care provided to Medicare beneficiaries.

What You Need to Know

Change request (CR) 5830, from which this article is taken, instructs Medicare contractors to update the claims processing system with new Medicare rates for deductible, coinsurance and premium payment amounts for calendar year (CY) 2008, as published in the *Federal Register*, CMS-8033-N, on October 2, 2007.

Background

The details of CR 5830 follow:

2008 Part A – Hospital Insurance (HI)

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements.

Hospital

- A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode.
- When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st -90th day spent in the hospital.

  Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

Skilled Nursing Facility

- A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a illness episode.

  These details are summarized in Table 1A, below.

Table 1A – 2008 Part A Hospital Insurance (HI)

Deductible	$1,024.00		
Coinsurance	**Hospital**		**Skilled Nursing Facility**
	Days 61-90	Days 91-150 (Lifetime Reserve Days)	Days 21-100
	$256.00	$512.00	$128.00

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for health insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a two-year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A.

Details of this coverage are summarized in table 1B, below.

Table 1B – Voluntary Enrollees Part A Premium Schedule

Base premium (BP)	$423.00 per month
Base premium with 10 percent Surcharge	$465.30 per month
Base premium with 45 percent Reduction	$233.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45 percent reduction and 10 percent surcharge	$256.30 per month

Update to Medicare Deductible, Coinsurance and Premium Rates for 2008 (continued)

2008 Part B – Supplementary Medical Insurance

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2008, the standard premium for SMI services is $96.40 a month; the deductible is $135.00 a year; and the coinsurance is 20 percent.

You should be aware that the Part B premium is influenced by the beneficiary's income. This influence is summarized in Table 2.

Table 2 – Income Parameters for Determining Part B Premium

Premium per month	Individual Income*	Joint Income (Married)^	Married but file Separate#
$ 96.40	$ 82,000.00 or less	$164,000.00 or less	$82,000.00 or less
$122.20	$ 82,000.01 – $102,000.00	$164,000.01 – $204,000.00	
$160.90	$102,000.01 – $153,000.00	$204,000.01 – $306,000.00	
$199.70	$153,000.01 – $205,000.00	$306,000.01 – $410,000.00	$82,000.01 – $123,000.00
$238.40	$205,000.01 or more	$410,000.01 or more	$123,000.01 or more

*Individual Income = Beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year)

^Joint Income = Beneficiaries who are married and lived with their spouse at any time during the taxable year, and also file a joint tax return.

#Married but File Separate = Beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse

Additional Information

You may find the official instruction, CR 5830, issued to your Medicare contractor by visiting on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R49GI.pdf*.

If you have any 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: MM5830
Related Change Request (CR) Number: 5830
Related CR Release Date: December 14, 2007
Effective Date: January 1, 2008
Related CR Transmittal Number: R49GI
Implementation Date: January 7, 2008

Source: CMS Pub. 100-01, Transmittal 49, CR 5830

Disclaimer – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Change in the Amount in Controversy Requirements for Administrative Law Judge and Federal District Court Appeals

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for annual reevaluation of the dollar amount in controversy (AIC) required for an administrative law judge (ALJ) hearing and federal district court review.

For requests made **on or after January 1, 2008,** the amount that must remain in controversy is increased:

- To $120 for an ALJ hearing requests
- To $1,180 for a federal district court review. ❖

Source: CMS Joint Signature Memorandum 08089, December 19, 2007

2008 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

Provider Types Affected

Clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

What Providers Need to Know

This article and related change request (CR) 5813 contain important information regarding:

- The 2008 annual updates to the clinical laboratory fee schedule
- Mapping for new codes for clinical laboratory tests
- Laboratory costs related to services subject to reasonable charge payments.

Key Points

Updates to Fees

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2008 is 0 percent. Payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). For a cervical or vaginal smear test (Pap smear), section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount.

Remember that the Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

The 2008 national minimum payment amount is $14.76 ($14.76 plus 0 percent update for 2008). The affected codes for the national minimum payment amount include the following:

88142	*88143*	*88147*	*88148*	*88150*	*88152*	*88153*
88154	*88164*	*88165*	*88166*	*88167*	*88174*	*88175*
G0123	G0143	G0144	G0145	G0147	G0148	P3000

National Limitation Amounts (Maximum)

For tests for which national limitation amounts NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with section 1833(h)(4)(B)(viii) of the Act.

Access to 2008 Clinical Laboratory Fee Schedule

Internet access to the 2008 clinical laboratory fee schedule data file should be available after November 16, 2007, on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/ClinicalLabFeeSched*.

Medicaid state agencies, the Indian Health Service, the United Mine Workers, Railroad Retirement Board, and other interested parties should use the Internet to retrieve the 2008 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 16, 2007, CMS hosted a public meeting to solicit input on the payment relationship between 2007 codes and new 2008 *Current Procedural Terminology* codes. Notice of the meeting was published in the *Federal Register* on May 25, 2007 and on the CMS Web site on June 18, 2007.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the CMS Web site at *http://www.cms.hhs.gov/ClinicalLabFeeSched*.

Additional written comments from the public were accepted until October 5, 2007.

Comments after the release of the 2008 laboratory fee schedule may be submitted to the following address so that CMS may consider them for the development of the 2009 laboratory fee schedule. A comment should be in written format and include clinical, coding, and costing information. To make it possible for CMS and its contractors to meet a January 3, 2009 implementation date, comments must be submitted before August 1, 2008.

Centers for Medicare & Medicaid Services (CMS)
Center for Medicare Management
Division of Ambulatory Services
Mailstop: C4-02-14
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Additional Pricing Information

The 2008 laboratory fee schedule includes separately payable fees for certain specimen collection methods (*CPT*/HCPCS codes *36415*, P9612, and P9615).

For dates of service January 1, 2008 through December 31, 2008, the fee for clinical laboratory travel code P9603 is $0.935 per mile and for code P9604 is $9.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for calendar year 2008, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2008 laboratory fee schedule also includes codes that have a modifier QW to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease Oriented Panel Codes

Similar to prior years, the 2008 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

2008 Annual Update for Clinical Laboratory FS and Lab Services Subject to Reasonable Charge Payment (continued)

The *CPT* Editorial Panel has created *CPT* code *80047* (Basic metabolic panel [Calcium, ionized]), which is an automated multi-channel chemistry (AMCC) code.

New *CPT* code *80047* is not a replacement for code *80048* (Basic metabolic panel). Code *80047* is comprised of eight component test codes, i.e.:

- Calcium, ionized (*82330*)
- Carbon dioxide (*82374*)
- Chloride (*82435*)
- Creatinine (*82565*)
- Glucose (*82947*)
- Potassium (*84132*)
- Sodium (*84295*)
- Urea nitrogen (BUN) (*84520*)

Note: *CPT* code *80047* cannot be billed for services ordered through an end-stage renal disease (ESRD) facility. All tests billed for services ordered through an ESRD facility must be billed individually, not in an organ disease panel.

Mapping Information

CMS advises the following:

- New *CPT* code *80047* is priced at the same rate as *80048* with final payment determined by the AMCC Panel Payment Algorithm
- New *CPT* code *82310QW* is priced at the same rate as *CPT 82310*
- New *CPT* code *82565QW* is priced at the same rate as *CPT 82565*
- New *CPT* code *82610* is priced at the same rate as *CPT 83883*
- New *CPT* code *83655QW* is priced at the same rate as *CPT* 83655
- New *CPT* code *83993* is priced at the same rate as *CPT 83631*
- New *CPT* code *84704* is priced at the same rate as *CPT 84702*
- New *CPT* code *86356* is priced at the same rate as *CPT 86361*
- New *CPT* code *87500* is priced at the same rate as *CPT 87641*
- New *CPT* code *87809* is priced at the same rate as *CPT 87802*
- New *CPT* code *89321QW* is priced at the same rate as *CPT 89321*
- New *CPT* code *89322* is priced at the sum of the rates of *CPT 89320* and *CPT 85007*
- New code *CPT 89331* is priced at the sum of the rates of *CPT 89320* and *CPT 87015*
- New AMCC code ATP23 is priced at the same rate as ATP22

Laboratory Costs Subject to Reasonable Charge Payment in 2008

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as prescribed by section 1842(b)(3) of the Act and 42 CFR 405.509(b)(1). The inflation-indexed update for year 2008 is 2.7 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, chapter 23, section 80-80.8. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. The *Medicare Claims Processing Manual* is located at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS Web site.

When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual*, chapter 8, section 60.3 instructs that the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood Products

P9010 P9011 P9012 P9016 P9017 P9019 P9020
P9021 P9022 P9023 P9031 P9032 P9033 P9034
P9035 P9036 P9037 P9038 P9039 P9040 P9043
P9044 P9048 P9050 P9051 P9052 P9053 P9054
P9055 P9056 P9057 P9058 P9059 P9060

Also, the following codes should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, chapter 3, section 20.5-20.54 located on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*:

P9010 P9016 P9021 P9022 P9038 P9039 P9040
P9051 P9054 P9056 P9057 P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on section 1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for HCPCS codes P9041, P9043, P9045, P9046, P9047, and P9048 should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine

86850 86860 86870 86880 86885 86886 86890
86891 86900 86901 86903 86904 86905 86906
86920 86921 86922 86923 86927 86930 86931
86932 86945 86950 86960 86965 86970 86971
86972 86975 86976 86977 86978 86985
G0267

2008 Annual Update for Clinical Laboratory FS and Lab Services Subject to Reasonable Charge Payment (continued)

Reproductive Medicine Procedures

89250 89251 89253 89254 89255 89257 89258 89259 89260 89261 89264 89268 89272 89280 89281 89290 89291 89335 89342 89343 89344 89346 89352 89353 89354 89356

Additional Information

To see the official instruction, CR 5813, issued to your Medicare FI, carrier or A/B MAC, go to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1400CP.pdf*.

Instruction for calculating reasonable charges are located in the *Medicare Claims Processing Manual*, chapter 23, section 80-80.8 on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*.

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

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

MLN Matters Number: MM5813
Related Change Request (CR) Number: 5813
Related CR Release Date: December 20, 2007
Related CR Transmittal Number: R1400CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1400, CR 5813

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Fee Schedule Update for 2008 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies

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

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5803, which provides the annual update to the 2008 DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure your billing staff are aware of these changes.

Background

This recurring update notification, CR 5803, provides specific instructions regarding the 2008 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained at 42 CFR 414.102.

The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), chapter 23, section 60; *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*) on the Centers for Medicare & Medicaid Services (CMS) website. Other information on the fee schedule, including access to the DMEPOS fee schedules is on the CMS Web site at *http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp*.

Key Points

- The following HCPCS codes are being **deleted** from the HCPCS effective January 1, 2008, and are therefore being removed from the DMEPOS and PEN fee schedule files:

  B4086 E2618 K0553 K0554 K0555 L0960
  L1855 L1858 L1870 L1880 L3800 L3805
  L3810 L3815 L3820 L3825 L3830 L3835
  L3840 L3845 L3850 L3855 L3860 L3907
  L3910 L3916 L3918 L3820 L3922 L3924
  L3926 L3928 L3930 L3932 L3934 L3936
  L3938 L3940 L3942 L3944 L3946 L3948
  L3950 L3952 L3954 L3985 L3986

- The payment category for HCPCS code K0730 is revised to move the controlled dose inhalation drug delivery system from the DME payment category for

Fee Schedule Update for 2008 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (continued)

capped rental items to the DME payment category for inexpensive and routinely purchased items, effective January 1, 2008. The total payment for inexpensive and/or routinely purchased items may not exceed the fee schedule amount for purchase of the equipment. In the case of controlled dose inhalation drug delivery systems furnished on a purchase basis on or after January 1, 2008, the allowed payment amount will be reduced by the total rental payments previously made for the item.

- The fee schedule amounts established for HCPCS codes K0553, K0554 and K0555 will directly crosswalk to new HCPCS codes A7027, A7028 and A7029, respectively.
- As of the July 2007 HCPCS quarterly update, the following composite dressing HCPCS codes are noncovered by Medicare, effective July 1, 2007: A6200, A6201 and A6202. To reflect this change, the fee schedule amounts for codes A6200, A6201 and A6202 will be removed from the fee schedule file as part of this update. Medicare contractors will deny claims for A6200, A6201 and A6202 with dates of service July 1, 2007 through December 31, 2007.
- CMS will establish fee schedule amounts for the following HCPCS codes: B4087, B4088, E2312, E2312KC, E2373, E2313, L1846, L3808, L3923, L3764, L3763, L3925, L3929, and L3931. These fee schedule amounts will be added to the fee schedule file on January 1, 2008, and are effective for claims with dates of service on or after January 1, 2008. The existing fee schedule amounts for HCPCS code E2373 will become the full replacement E2373 KC fees, effective January 1, 2008.
- Suppliers are to submit modifier KC when billing for the full replacement of HCPCS power wheelchair interface codes E2373 and E2312.
- Note that HCPCS codes E0328 and E0329 are rarely appropriate for Medicare billings, payment for pediatric beds represented by these codes will be based on individual Medicare contractor consideration.
- As part of this update, CMS is implementing the 2008 national monthly payment rates for stationary oxygen equipment, (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2008. CMS is revising the fee schedule file to include the new 2008 monthly payment rate of $199.28 for stationary oxygen equipment. As required by statute, these payment rates are adjusted annually to assure budget neutrality on the addition of the new oxygen generating portable equipment class. Accordingly, a reduction to the national monthly payment amount for stationary oxygen equipment for 2008 that is necessary to offset payments under the new class will be slightly lower ($0.56) (from $199.84 to $199.28) than previously announced.
- As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.
- The following are the new HCPCS codes, effective January 1, 2008:

A4252	A5083	A6413	A7027	A7028
A7029	A9274	A9276	A9277	A9278
A9283	B4087	B4088	E0328	E0329
E0856	E2227	E2228	E2312	E2313
E2397	L3925	L3927	L3929	L3931
L7611	L7612	L7613	L7614	L7621
L7622	V2787			

Additional Information

You may see the official instruction (CR 5803) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going on the CMS Web site to *http://www.cms.hhs.gov/Transmittals/downloads/R1388CP.pdf*.

If you have questions, please contact your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier at their toll-free number which may be found on the CMS 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: MM5803
Related Change Request (CR) Number: 5803
Related CR Release Date: December 7, 2007
Related CR Transmittal Number: R1388CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1388, CR 5803

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Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (fiscal intermediaries [FIs], carriers, regional home health intermediaries [RHHIs], and DME Medicare administrative contractors [DME MACs] and Part A/B Medicare administrative contractors [A/B MACs]) for medical supply or therapy services.

What Providers Need to Know

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2008. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional Information* section of this article.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA). As a result, billing for all such items and services is to be done by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physician
- Supplies incidental to physician services
- Supplies used in institutional settings.

Medicare has issued a recurring update notification, which provides the annual HH consolidated billing updates for non-routine supplies and therapies effective January 1, 2008. These lists are updated annually, effective each January 1, to reflect the annual changes to the HCPCS code set. The lists may also be updated as frequently as quarterly if required by the creation of temporary HCPCS codes during the year.

Change request (CR) 5829 provides the annual HH consolidated billing update effective January 1, 2008. The following tables describe the HCPCS codes and the specific changes to each that this notification is implementing for claims with dates of service on or after January 1, 2008.

Table 1: Non-Routine Supplies

HCPCS Codes	Description	Action
A5083	Continent device, stoma absorptive cover for continent stoma	Add
A5105	Urinary suspensory with leg bag with or without tube, each	Redefine
A6200	Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing	Delete
A6201	Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	Delete
A6202	Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing	Delete
A6413	Adhesive bandage, first-aid type, any size, each	Add

Table 2: Therapies

CPT Code	Description	Action	Replacement Code or Code being Replaced
96125	*Standardized cognitive performance testing per hour*	Add	*96125*

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (continued)

Additional Information

For details regarding this CR, please see the official instruction issued to your Medicare FI, carrier, A/B MAC, RHHI, or DME MAC. This may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1391CP.pdf*.

A complete historical listing of codes subject to HH consolidated billing may be found on the CMS Web site at *http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp*.

To review the Medicare manual instructions discussed in this article see the *Medicare Claims Processing Manual,* chapter 10, section 20.1 on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf*.

If you have questions, please contact your Medicare FI, carrier, A/B MAC, RHHI, or DME 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: MM5829
Related Change Request (CR) Number: 5829
Related CR Release Date: December 14, 2007
Related CR Transmittal Number: R1391CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1391, CR 5829

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Handling Personally Identifiable Information on the Medicare Summary Notice

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

Provider Types Affected

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

What You Need to Know

When the health insurance claim number (HICN) and name of the beneficiary **do not match** on the submitted claim, Medicare carriers, intermediaries, and A/B MACs will return the claim to the provider as unprocessable. When noninstitutional providers submit claims to Medicare carriers or A/B MACs that do not result in a match on name and HICN, the claim is returned with reason code 140 (Patient/Insured health identification number and name do not match).

In addition, effective January 7, 2008, on ALL MSNs, the first five digits of the HICN will be replaced with "XXX-XX" to avoid displaying the Medicare beneficiary's personally identifiable information (PII). This applies to pay, no pay, and duplicate copies of the MSN.

Background

This article is based on CR 5770, which describes new procedures resulting from the Centers for Medicare & Medicaid Services (CMS) implementation of the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). CR 5770 ensures that (1) MSNs are not issued when the HICN and name do not match, and (2) beneficiaries' PII is protected on the MSN.

Additional Information

You may see the official instruction, CR 5770, issued to your Medicare carrier, FI, A/B MAC or DME MAC on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1399CP.pdf*.

If you have questions, please contact your Medicare carrier, FI, A/B MAC or DME 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: MM5770
Related Change Request (CR) Number: 5770
Related CR Release Date: December 19, 2007
Related CR Transmittal Number: R1399CP
Effective Date: January 7, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1399, CR 5770

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Centers for Medicare & Medicaid Services Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

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

Provider Types Affected

Sample of 35,000 Medicare providers served by Medicare fee-for-service (FFS) contractors, including Medicare administrative contractors (A/B MACs), carriers, fiscal intermediaries (FIs), durable medical equipment Medicare administrative contractors (DME/MACs) and regional home health intermediaries (RHHIs).

Provider Action Needed

STOP – Impact to You

CMS offers providers the opportunity to voice your opinions about the services you receive from your FFS contractors. CMS announced it has begun its third annual provider satisfaction survey of Medicare FFS contractors who process and pay more than $280 billion in Medicare claims each year. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to gather quantifiable data on provider satisfaction with the performance of FFS contractors as well as aid future process improvement efforts at the contractor level. The survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all MACs will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

CAUTION – What You Need to Know

CMS is sending the 2008 survey to about 35,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. Those providers selected to participate in the survey will be notified by December 2007. The survey is designed so that it can be completed in about 15 minutes. Providers can submit their responses via a secure Web site, mail, fax, or over the telephone. CMS is urging all Medicare providers selected to participate in the survey by completing and returning their surveys upon receipt.

GO – What You Need to Do

Be alert for a notification via e-mail, phone or mail by the survey contractor, Westat. If you are selected to participate in the survey, please take the time to complete and submit your survey responses upon receipt.

Background

The 2008 MCPSS is designed to gather quantifiable data on provider satisfaction levels with the key services that comprise the provider-contractor relationship. The survey focuses on seven major parts of the relationship:

- Provider inquiries
- Provider outreach and education
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement.

Respondents are asked to rate their experience working with contractors using a scale of 1 to 6 with “1” representing “not at all satisfied” and “6” representing “completely satisfied.” The results of the second MCPSS are available to health care providers and contractors on the CMS Web site at *http://www.cms.hhs.gov/MCPSS*.

Last year’s findings showed that 85 percent of respondents rated their contractors between 4 and 6.

Further, the 2007 MCPSS results indicate that the provider inquiry function has the greatest influence on whether providers are satisfied with their contractors. This indicated a shift from 2006, when the claims processing function was the strongest predictor of a provider’s overall satisfaction.

Additional Information

CMS plans to make the survey results publicly available in July 2008. For questions or additional information about the MCPSS please visit on the CMS Web site at *http://www.cms.hhs.gov/MCPSS*.

MLN Matters Number: SE0750
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Special Edition *MLN Matters* Article SE0750

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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 Second in a Series of Articles

This article contains:

- Three questions and answers about the registration process for provider organizations. (See Note below.)
- Information on the Guides available for completing the registration process for provider organizations. (See Note below.)

Note: For purposes of the IACS-PC, "Provider Organizations" include individual practitioners who will delegate IACS-PC work to staff as well as their staff using IACS-PC.

Provider Types Affected

Physicians, providers, and suppliers (collectively referred to as providers) 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]).

Special Note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matter*s article in this new series on IACS-PC, which may be found on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

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 and/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).

What Providers Need to Know

In the near future, the 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. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

Registering in IACS-PC

The provider community is the first in a series of IACS communities, which are the front door to protecting and allowing access to CMS enterprise applications. Communities are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (ex. Providers need access to provider-related CMS applications). The next community which will become available in early 2008 is the FI/carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FI's, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider Community."

The first *MLN Matters* article in this series provided an overview of the IACS-PC registration process as well as registration instructions for security officials (SOs) and individual practitioners using IACS-PC personally. This article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Three Questions and Answers about the Provider Organization Registration Process

1. **How can I get registered in IACS-PC? Can I just figure it out by myself?**

   We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and interpretations of error messages. To directly access IACS-PC go to *https://applications.cms.hhs.gov*, then click on **Enter CMS Applications Portal.**

2. **I want to register as an SO. I do not have my organization's IRS CP-575. What else can I send?** In addition to the CP-575, SOs may also submit copies of other official Internal Revenue Service (IRS) documentation. An official IRS document should have the following information:

   Required:

   - IRS letterhead
   - Legal business name (not handwritten)
   - TIN/EIN (not handwritten).

   Optional:

   - Form number in upper right; and
   - Reference to a letter or form number in body of text.

Examples of acceptable IRS documents include, but are not limited to:

- Copy of IRS CP-575
- Copy of IRS 147C Letter; or
- Copy of Federal Tax Deposit Coupon.

All documents received must be legible.

1. **My organization is too small to fill all these roles. What should I do?**

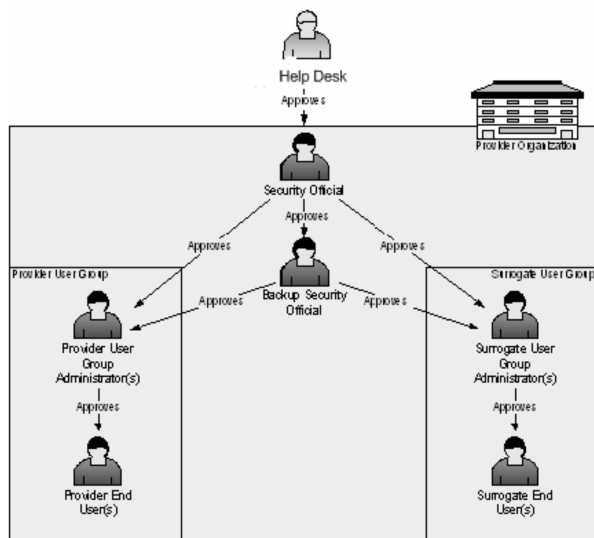
   As few as two staff can be registered in IACS-PC for a provider organization to access CMS enterprise applications. The first person must register as a SO, the second registers as a user group administrator (UGA). The UGA may access CMS applications as approved by the SO.

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

The backup security official is an optional role. End users are only required for provider organizations with 10 or more IACS-PC users.

If you are an individual practitioner who will be using IACS-PC personally, please refer to the first *MLN Matters* article, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Quick Reference Guides for Completing the Provider Organization Registration Process



IACS-PC Registration Approval Process

1. **Backup Security Official Guide**

   Backup security officials (BSOs) will request access to an organization using the BSO Registration Quick Reference Guide on the CMS Web site at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_backup_security_official_registration_qrg_12_06_07.pdf*.

2. **User Group Administrator Guide**

   UGAs are the first user type able to request access to CMS Web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.

   Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which s/he is responsible, so they should know everyone in their user group.

   The *UGA Registration Quick Reference Guide* may be found at on the CMS Web site *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_user_group_administrator_registration_qrg_12_06_07.pdf*.

Special note for UGAs of Surrogate User Groups

A surrogate user group is established by individuals or a company outside of the provider organization, which performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: *Surrogate Billing Company ABC will work on behalf of Provider Organization XYZ. Once the Provider Organization XYZ is approved in IACS, the Surrogate Billing Company ABC can register in IACS and request to create a surrogate user group under the Provider Organization XYZ.* Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.

At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of three different provider organizations, the UGA for the surrogate user group will need to make three different requests to create three different surrogate user groups, one for each provider with which the UGA needs to associate. If a provider organization does not appear in IACS-PC, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider appears in IACS-PC.

If the provider organization does appear in IACS-PC, each provider's SO or BSO must approve the request to associate that surrogate user group with their

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

organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS-PC. In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to individual practitioners within IACS.

3. **An End User Registration Quick Reference Guide** may be found on the CMS Web site at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_end_user_registration_qrg_12_06_07.pdf*.
4. **Approver Quick Reference Guide**
The *Approver Quick Reference Guide* provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS-PC. The *Approver Quick Reference Guide* may be found on the CMS Web site at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_approver_qrg_12_07_07.pdf*.

Next Steps in Accessing a CMS Enterprise Application

A third MLN article discussing the final steps in accessing CMS enterprise applications has been released on this issue, and may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf*.

Additional Help

CMS has established an end user support (EUS) help desk to assist with your access to IACS-PC. The EUS help desk 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.

In addition, you can find an informative reference chart outlining the steps for accessing CMS enterprise applications on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf*.

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Source: CMS Special Edition *MLN Matters* Article SE0753

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2008 Holiday Schedule

First Coast Service Options, Inc. will observe the following holiday schedule in 2008:

Date	Holiday
January 1, (Tuesday)	New Year's Day
January 21, (Monday)	Martin Luther King Jr. Day
March 21, (Friday)	Good Friday
May 26, (Monday)	Memorial Day
July 4, (Friday)	Independence Day
September 1, (Monday)	Labor Day
November 27, (Thursday)	Thanksgiving Holiday
November 28, (Friday)	Thanksgiving Holiday
December 25, (Thursday)	Christmas Holiday
December 26, (Friday)	Christmas Holiday

Additional Call Center Closures

In addition to the above observed holiday schedule for 2008, FCSO's Provider Contact Center will be closed the following additional federal holidays:

Date	Holiday
February 1, (Monday)	Presidents' Day
October 13, (Monday)	Columbus Day
November 11, (Tuesday)	Veterans' Day

The Medicare Part A IVR (interactive voice response) will be available via toll-free telephone number 1-877-602-8816.

- For specific claim information, the IVR hours are 6:00 a.m. – 6:00 p.m. Monday through Friday.
- For recorded information on current Medicare issues, the IVR hours are 24 hours a day, 7 days a week. ❖

AMBULANCE SERVICES

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 December 12, 2007, to provide additional clarification. Some language regarding emergency and nonemergency transports and the physician certification statement was removed and readers are referred instead to the actual regulations. In addition, some language was added and is reflected in bold and italicized. The revised *MLN Matters* article SE0724 was published in the December 2007 *Medicare A Bulletin* (pages 32-34).

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. ***Please keep in mind that any discussion in this article does not supersede CMS' rules, regulations, manual instructions, or the Social Security laws.***

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 ***(BLS)***

b) Advanced life support (***ALS) – Level 1 (ALS1) and Level 2 (ALS2)***

c) Specialty care transport ***(SCT)***

d) Air transport – fixed wing and rotary wing

In addition, both the BLS and ALS1 levels of ambulance service can be categorized as either emergency or nonemergency. As defined in 42 CFR 414.605, an emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance entity begins as quickly as possible to take the steps necessary to respond to the call.

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 ***make that documentation available to*** Medicare FIs,

Medicare Payments for Ambulance Transports (continued)

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.** ***These circumstances are defined in 42 CFR 410.40(d)(2) and 42 CFR 410.40(d)(3)*** (see 42 CFR 410.40 link in the *Additional Information* section).

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 CR 5442 "*Ambulance Fee Schedule – Medical Conditions List – Manualization,*" which contains an educational guideline that was developed to assist ambulance providers and suppliers ***in*** communicat***ing*** 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 & 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*.

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.

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NATIONAL PROVIDER IDENTIFIER

Start Testing Your NPI on Your Medicare Claims Now and Other Important Reminders

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

Reminder: Clarification on NPI Enumerator's Responsibilities

The topics with which the national provider identifier (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 should not contact the NPI enumerator for questions other than those related to the above topics. A new *MLN Matters* article clarifies the specific responsibilities of the NPI enumerator. This article is located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0751.pdf*.

Important Information for Medicare Providers

Reminder: NPI Requirement on Medicare Electronic and Paper Institutional Claims Begins January 1, 2008!

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 use the legacy identifier in these fields as long as you also

Start Testing Your NPI on Your Medicare Claims Now and Other Important Reminders (continued)

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.

Urgent: Test Your Claims Now!

After you have submitted claims containing both NPIs and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with **only the NPI** in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch.

Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.

If Your Claims Are Rejecting…

If you are submitting an NPI and a legacy identifier pair on your claims and they are being rejected 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 in the appropriate Medicare sections of the "Other Provider Identification Numbers" field.

Your Medicare legacy identifier is the identifier that Medicare assigned to you upon enrollment.

Sometimes, Medicare assigned multiple identifiers to a single provider, usually because the provider had multiple locations or, if the provider is an individual and worked in multiple locations. An enrolled physician/non-physician practitioner and the group practice to which the physician/non-physician practitioner assigns his/her benefits would both have unique legacy identifiers. Legacy identifiers are the ones that were used prior to using NPIs to identify Billing/Pay-to and Rendering Providers.

If the information in your NPPES record is correct and contains your Medicare legacy identifier(s), print the screen (so you have a copy of this portion of your NPPES record on paper), call your Medicare contractor, and ask that they confirm that this information is present in the Medicare NPI Crosswalk. If your contractor confirms you are not on the crosswalk, please ask them to validate what information they have in their provider file.

Reminder – Medicare's Key Dates

Date	Implementation Steps
January 1, 2008	• 837I electronic claims and UB-04 paper claims and DDE 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, for all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500) and SPR remittance advice. • 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.

Start Testing Your NPI on Your Medicare Claims Now and Other Important Reminders (continued)

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" 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 200712-09

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Clarification on the National Provider Identifier Enumerator's Responsibilities

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is issuing this special edition *MLN Matters* article SE0751 to clarify the type of assistance that the NPI enumerator can and cannot provide to health care providers.

CAUTION – What You Need to Know

CMS is providing this information so you and your staff will know what issues should be referred to the NPI Enumerator and to identify issues on which the NPI enumerator will not be able to help you. This will save you valuable time in resolving your Medicare questions.

GO – What You Need to Do

Please share this information with your office staff.

Background

The NPI enumerator is responsible for assisting health care providers in applying for their NPIs and updating their information in the National Plan and Provider Enumeration System (NPPES). The NPI enumerator's responsibilities include:

- Processing NPI applications/updates/deactivations
- Providing blank NPI application forms to health care providers upon request
- Assisting health care providers with questions or problems regarding the processing of their NPI applications, updates, or deactivations (web-based or paper)
- Resolving errors on applications/updates/deactivations
- Investigating potential duplicate applications/updates/deactivations to ensure the uniqueness of the provider
- Resetting web users' NPPES passwords
- Tracking NPPES accessibility and reporting NPPES inaccessibility issues to the CMS
- Maintaining a call center for health care providers' questions regarding NPI application processing
- Working with Electronic File Interchange Organizations (EFIOs) (approval of EFIOs, resolving problems with EFI files).

Health care providers needing the above types 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* on the Internet. Please note that application-processing times may vary based on current inventories. Please allow 15 working days to process your application/updates before contacting the NPI Enumerator.

Health care providers should **NOT contact** the NPI Enumerator for the following issues:

- The NPI enumerator cannot provide assistance with the Medicare NPI crosswalk and Medicare claims processing issues.
  - The NPI Enumerator does **not** generate, maintain or have access to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** have the means/authority to alter/add/remove any information on the Medicare NPI Crosswalk.
  - The NPI Enumerator **cannot** report problems to CMS or to the Medicare Fee-for-Service contractors concerning the Medicare NPI Crosswalk or claims processing problems.
  - The NPI Enumerator does **not** send updates to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** know how/when the Medicare NPI Crosswalk will be updated.

Clarification on the National Provider Identifier Enumerator's Responsibilities (continued)

- The NPI Enumerator **cannot** advise a provider as to how to complete the paper or electronic claim.
- The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.

- The NPI enumerator cannot provide assistance with information disseminated or not disseminated via the NPI registry or the NPPES downloadable file:
  - The NPI Enumerator **cannot** assist providers with questions regarding "temporarily suppressed" information found on the NPI Registry or downloadable file.
  - Although the NPI Enumerator can confirm whether or not the information still exists in the provider's active NPPES record; this confirmation is limited to the health care provider or contact person on the provider's NPPES record. Third party sources, including Medicare contractors, **cannot** call the NPI Enumerator for confirmation of information in a health care provider's NPPES record. If this type of confirmation is needed, the third party should request the information from the provider directly.
- The NPI Enumerator cannot provide assistance with Medicare-related provider enrollment information:
  - The NPI Enumerator **cannot** determine how providers are enrolled with Medicare (e.g., as an individual or as a group).
  - The NPI Enumerator **cannot** determine which identifiers (Unique Physician Identification Number (UPIN), Provider Identification Number (PIN), Online Survey Certification and Reporting System (OSCAR), or National Supplier Clearinghouse (NSC)) should be included on health care providers' NPPES records.
  - The NPI Enumerator has no way of knowing which type(s) of legacy number(s) were assigned to a provider by the Medicare contractor(s).
  - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI Enumerator cannot provide assistance with NPI-to-legacy number linkages (i.e., how to properly link multiple legacy numbers to one NPI or how to properly link one legacy number to multiple NPIs).
- The NPI Enumerator cannot provide assistance with questions related to:
  - Defining subparts
  - Which subparts should receive NPIs
  - Where NPIs or legacy identifiers are to be placed in claims transactions
  - Health Insurance Portability and Accountability Action (HIPAA) regulations or regulatory policies
  - Proper use of NPIs in transactions with health plans
  - Determining if the provider is a sole proprietor or an incorporated individual.

Additional Information

CMS advises providers to read the information available on the CMS NPI Web site at *http://www.cms.hhs.gov/NationalProvIdentStand/*.

Included on this site are NPI frequently asked questions and answers that may assist you with issues for which the NPI enumerator is not responsible.

In addition, the NPI Application/Update form itself is also a good source of information. Providers should refer to the instructions (they are part of the form) for clarification on information to be submitted in order to obtain NPIs or update their records. You can also refer to the *"Application Help"* tab located on the NPPES Web site at: *https://nppes.cms.hhs.gov* for additional assistance when you are online.

If you have questions related to Medicare issues, 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.

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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.

Note: CMS has revised this *MLN Matters* article on December 18, 2007, to add durable medical equipment Medicare administrative contractors (DME MACs) as affected providers. In addition, references to change request (CR) 5328, CR 5416 and CR 4169 at the end of the article were remove. These CRs were incorrect. All other information remains unchanged. The *MLN Matters* article MM5674 was published in the December 2007 *Medicare A Bulletin* (page 35).

Provider Types Affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FI), durable medical equipment Medicare administrative contractors (DME MACs) and Part A/B MACs 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 a national provider identifier (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)

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, DME 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.

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

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General Coverage

Mammography: Change Certification-Based Action from Return to Provider/Return as Unprocessable to Reject/Denial

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, carriers, and Part A/B Medicare administrative contractors (MACs) for mammography services.

What You Need to Know

CR 5577, from which this article is taken, instructs FIs, carriers and A/B MACs to deny claims for mammography services (rather than returning them as unprocessable) if the appropriate Food and Drug Administration (FDA)-certification status is not listed on the FDA-created, CMS-supplied, Mammography Quality Standard Act (MQSA) data file.

You should make sure that your billing staffs list the FDA certification status as required.

Background

Depending on which contractor you bill, FIs and A/B MACs return to provider (RTP), and carriers or A//B MACs return as unprocessable, claims for mammography services when:

- A film mammography Healthcare Common Procedure Coding System (HCPCS) code is submitted on a claim, and the facility is FDA-certified for only digital mammography.
- A digital mammography HCPCS code is submitted on a claim, and the facility is FDA certified for only film mammography; or
- Either a film or digital mammography HCPCS code is submitted (*carriers/B MACs only*) on a claim and there is no FDA certification number on the claim's Mammography Quality Standard Act (MQSA) data file.

In order to ensure that the facility has a right to appeal an inappropriate denial based on the status of its FDA certification, CR 5577, from which this article is taken, instructs Medicare FIs, carriers and A/B MACs to **deny** all claims for screening or diagnostic mammography services (rather than return them to the provider, or return as unprocessable to the supplier), if the appropriate FDA-certification status is not listed on the claim. Please note, however, that carriers/B MACs will continue to return the claim as unprocessable if the facility's FDA-assigned certification number is missing from the claim.

The MQSA requires that all facilities providing mammography services meet national quality standards, and provides the specific standards for those qualified to perform screening and diagnostic mammograms and how they should be certified.

The FDA Center for Devices and Radiological Health is responsible for collecting certificate fees and surveying mammography facilities; and effective October 1, 1994, all facilities that provide screening and mammography services (except those in the Veterans Administration) must have an FDA-issued certificate to continue to operate.

In addition, Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000 provided new payment methodologies for both diagnostic and screening mammograms that use digital technology. Medicare pays for film mammography and digital mammography at different rates, and moreover, pays for a service only if the provider or supplier is certified by the FDA to perform those types of mammograms for which payment is sought.

Medicare determines whether the mammography facility is certified to perform the mammography services billed by using data that the FDA sends to CMS on a weekly basis. This information indicates whether a mammography facility is certified to perform digital mammography.

To verify that the facility is certified by the FDA to perform mammography services, carriers/B MACs match the supplier's (i.e., independent facility) mammography certification number submitted on the claim to the six-digit FDA-assigned certification number appearing on the file for the billing facility (in item 32 of the Form CMS-1500 for paper claims, or in the 2400 loop (REF02 segment, where 01=EW segment) of the ASC X12 837 professional claim format, version 4010A1, for electronic claims). If the facility's FDA-assigned six-digit number is not on the claim, the carrier/B MAC will return the claim as unprocessable using remittance reason code 16 (Claim/service lacks information which is needed for adjudication.) and remark code MA128 (Missing/incomplete/invalid FDA approval number.).

Intermediaries/A MACs identify the facility using the provider number submitted on the claim and use the certification data contained on the MQSA file. In addition, both intermediaries/A MACs and carriers/B MACs look for the film indicator (designated by "1") or the digital indicator (designated by "2") on the MQSA file to verify the type of mammography (film and/or digital) that the facility is certified to perform.

Therefore, effective April 1, 2008:

- FIs/A MACs will verify that the provider number on the claim corresponds with a certified mammography facility on the MQSA file, and if it does not, they will deny the claim. In denying these claims submitted by providers not listed as certified facilities on the MQSA file, the Medicare contractor will use:
  - Medicare summary notice (MSN) message 16.2 (This service cannot be paid when provided in this location/facility).
  - Remittance advice (RA) reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service).

Mammography: Change Certification-Based Action from Return to Provider/Unprocessable to Reject/Denial (continued)

- RA remark code N110 (This facility is not certified for film mammography).

- Carriers/B MACs will verify that the FDA-assigned, six-digit mammography certification number on the claim corresponds to the FDA mammography certification number appearing on the billing facility's file. They will deny the claim if:
- The facility's certification number submitted on the claim does not match the certification number on the MQSA file;
- The facility certification number on the claim matches the facility certification number on the MQSA file, but the facility name reported on the claim does not match the facility name on the MQSA file; or
- The facility certification number reported on the claim matches the facility certification number on the MQSA file, but the facility address reported on the claim does not match the facility address on the MQSA file.
- In denying the claim because of an invalid facility certification number, they will use MSN message 9.4 (This item or service was denied because information required to make payment is missing); and RA reason code 125 (Payment adjusted due to a submission/billing error(s).) and remark code MA128 (Missing/ incomplete/ invalid FDA approval number).

Further, Medicare contractors will use the FDA certification data to verify that the billing facility is eligible to bill for the type of mammography service submitted on the claim.

They will deny the claim if the facility is not certified by the FDA to perform such service (if the HCPCS code on the claim, for either film or digital mammogram, does not match the type of certification indicated on the MQSA file).

In denying these claims because the facility is not certified by the FDA to perform **either** a screening or diagnostic mammography service, Medicare contractors will use:

- MSN 16.2 (This service cannot be paid when provided in this location/facility);
- RA reason code B7 (This provider was not certified/ eligible to be paid for this procedure/service on this date of service), and
- Remark code N110 (This facility is not certified for film mammography).
- They will deny the claim if it contains a film mammography HCPCS code and the facility is certified for digital mammography only. In denying these claims because the facility is not certified to perform film mammography, they will use MSN message MSN 16.2.

In this instance, carriers/B MACs will use RA reason code B6 (this payment is adjusted when performed/ billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty) and remark code N110 and FIs/A MACs will use reason code B7.

Similarly, Medicare contractors will deny the claim if it contains a digital mammography HCPCS code and the facility is certified for film mammography only. In denying these claims because the facility is not certified to perform digital mammography, they will again use MSN message 16.2. In this instance:

- Carriers/B MACs will use:
  - RA reason code 171 (Payment is denied when performed/billed by this type of provider in this type of facility) and
  - Remark code N92 (This facility is not certified for digital mammography).
- FIs/A MACs will use reason code B7
- Carriers/B MACs will continue to use the MQSA file to verify the facility's FDA-assigned six-digit certification number submitted on the claim, and will return claims to the supplier as **unprocessable** if it does not contain the facility's certification number.

Additional Information

You may find the official instruction, CR 5577, issued to your carrier, FI, or A/B MAC by visiting the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1387CP.pdf*.

Additionally, you may find the revised sections of the *Medicare Claims Processing Manual*, chapter 18 (Preventive and Screening Services), section 20.2 (HCPCS and Diagnosis Codes for Mammography Services) as an attachment to CR 5577.

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

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

MLN Matters Number: MM5577
Related Change Request (CR) Number: 5577
Related CR Release Date: December 7, 2007
Related CR Transmittal Number: R1387CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1387, CR 5577

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Pulmonary Rehabilitation Services

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

Provider Types Affected

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

Impact on Providers

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR 5834) detailing the decision regarding a national coverage determination (NCD) for pulmonary rehabilitation services.

- Effective with dates of service on and after September 25, 2007, Medicare contractors will continue to process claims for pulmonary rehabilitation services using their local coverage determination (LCD) process or case-by-case adjudication.
- No changes to process or policy are made with CR 5834.

Background

Currently, CMS does not cover pulmonary rehabilitation as a single entity. However, there is a limited benefit for some pulmonary rehabilitation services provided in a comprehensive outpatient rehabilitation facility (CORF). Also, certain components of pulmonary rehabilitation may fall under other existing benefit categories and may be provided independently outside of a CORF. On November 15, 2006, CMS received a request for a NCD that would address components of pulmonary rehabilitation services in the hospital outpatient, physician office, and CORF settings. CR 5834 communicates the findings resulting from that request. To see the complete analysis, visit the CMS Web site at *http://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=199*.

Additional Information

You may see the official instruction (CR 5834) issued to your Medicare Carrier, A/B MAC, FI, DME MAC or RHHI by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R78NCD.pdf*.

The actual revision to the *National Coverage Determination* manual containing this NCD is attached to CR 5834.

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

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

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Related Change Request (CR) Number: 5834
Related CR Release Date: December 5, 2007
Related CR Transmittal Number: R78NCD
Effective Date: September 25, 2007
Implementation Date: January 7, 2008

Source: CMS Pub. 100-03, Transmittal 78, CR 5834

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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.

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

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 documents why 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.

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.
- Must ask for refills for their supplies.

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.

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 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 cannot 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.

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

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.

Insulin

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

Anti-diabetic Drugs

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?

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

- Do you have a family history of diabetes (parents, siblings)?
- Do you have a history of gestational diabetes (diabetes during pregnancy)
- Did you deliver a baby weighing more than nine 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 six 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

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

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

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 (MNT) 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 one foot exam every six 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
- 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 more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit the CMS Web site at *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* 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.

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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*, 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.

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

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

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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.**

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New LCD Implemention

AJ2778: Ranibizumab (Lucentis®)—New LCD

Ranibizumab (Lucentis®), a recombinant humanized immunoglobulin G1 kappa (IgG1 kappa) monoclonal antibody fragment designed for intraocular use is a vascular endothelial growth factor A (VEGF-A) antagonist. Ranibizumab binds to active forms of human VEGF-A, including the cleaved form (VEGF 110), and inhibits their biologic activity.

VEGF-A induces neovascularization (angiogenesis) and increases vascular permeability, which appears to play a role in the pathogenesis and progression of the neovascular (wet) form of age-related macular degeneration, a leading cause of blindness in adults older than 60 years of age in developed countries. Binding of ranibizumab to VEGF-A prevents VEGF-A from binding to VEGF receptors (i.e., VEGFR-1, VEGFR-2) on the surface of endothelial cells, reducing endothelial cell proliferation, angiogenesis, and vascular permeability.

The Food and Drug Administration (FDA) approved ranibizumab on June 30, 2006 for treatment of patients with exudative senile macular degeneration. The recommended dosage and frequency of treatment is 0.5 mg/0.05mL (10mg/mL), administered by intravitreal injection once a month (approximately 28 days). Treatment may be continued monthly or reduced to one injection every three months after the first four injections, if monthly treatments are not feasible. Compared to monthly dosing, however, it is expected that quarterly dosing may be less effective, and as such, patients should be evaluated regularly.

First Coast Service Options, Inc. (FCSO) Medicare will consider ranibizumab (Lucentis®) medically reasonable and necessary for patients with established exudative senile macular degeneration for services provided on or after the FDA approval date of June 30, 2006.

This local coverage determination (LCD) has been developed to provide the indications and limitations of coverage and/or medical necessity, documentation requirements and coding guidelines for this medication.

Effective Date

This new LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L26299) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9025: Azacitidine (Vidaza®)—New LCD

Azacitidine (Vidaza®) is believed to exert its antineoplastic effects by causing hypomethylation of DNA and direct cytotoxicity on abnormal hematopoetic cells in bone marrow. The concentration of azacitidine required for maximum inhibition of DNA methylation in vitro does not cause major suppression of DNA synthesis. Hypomethylation may restore normal function to genes that are critical for differentiation and proliferation. The cytotoxic effects of azacitidine cause the death of rapidly dividing cells, including cancer cells that are no longer responsive to normal growth control mechanism. Non-proliferating cells are relatively insensitive to Vidaza®.

This new local coverage determination (LCD) was written to outline the medical necessity criteria for Vidaza® and to clarify the appropriate coding for the indications covered by Medicare. This new LCD includes indications, limitations, ICD-9-CM codes, documentation requirements and utilization requirements.

Effective Date

This new LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L26284) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9305: Pemetrexed—New LCD

Pemetrexed is an antifolate containing the pyrrolopyrimidine-based nucleus that exerts its antineoplastic activity by disrupting folate-dependent metabolic processes essential for cell replication.

Pemetrexed is approved by the Food and Drug Administration (FDA) for use in combination with cisplatin for the treatment of patients with malignant pleural mesothelioma (MPM). It is also used alone for treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) after prior chemotherapy.

This LCD was developed to include indications and limitations of coverage, documentation requirements, utilization guidelines, and ICD-9-CM codes that support medical necessity.

Effective Date

This new LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L26294) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

ADDITIONS/REVISIONS TO EXISTING LCDs

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

The local coverage determination (LCD) for computed tomographic angiography of the chest, heart and coronary arteries was last updated on October 1, 2007. Since that time, a revision was made to add additional diagnosis codes based on two separate reconsiderations for this LCD.

The following ICD-9-CM codes were added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD for CT angiography of the chest for non-cardiac indications (*CPT* code *71275*):

337.9 Unspecified disorder of autonomic nervous system (Horner's syndrome)

441.1 Thoracic aneurysm, ruptured

441.6 Thoracoabdominal aneurysm, ruptured

441.7 Thoracoabdominal aneurysm, without mention of rupture

458.9 Hypotension, unspecified

729.5 Pain in limb

729.81 Swelling of limb

785.0 Tachycardia, unspecified

786.06 Tachypnea

786.09 Other dyspnea and respiratory abnormalities

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

Effective Date

This revision to the LCD is effective for services provided **on or after January 10, 2008.** The full text of this LCD (L23080) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

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A90901: Biofeedback—Revision to LCD

The local coverage determination (LCD) for biofeedback was last updated on October 1, 2005. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) published this LCD as a draft for notice and comment on September 20, 2007. Language was added to clarify the appropriate use of the diagnostic tests described in *CPT* codes *51784* (*Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique)* and *91122* (*Anorectal manometry*). FCSO came across the issue of providers billing these diagnostic tests on a frequent basis for services that were more accurately described by *CPT* code *90911* (*Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry*). Language has been added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD and to the "Coding Guideline" attachment to address the appropriateness and utilization of these codes.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L15018) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

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A93875: Non-invasive Extracranial Arterial Studies—Revision to LCD

The local coverage determination (LCD) for non-invasive extracranial arterial studies was last updated on August 7, 2006. Since that time, the LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to reword the second sentence in the first bullet and move the 7th bullet and the 15th bullet under the first bullet. The "Documentation Requirements" section of the LCD was revised to add a paragraph regarding the requirement for documentation to support the criteria for coverage as set forth in this LCD and to also reflect how the results of this test will be used in the patient's plan of care.

Effective Date

This revision to the LCD is effective for services provided **on or after December 20, 2007.** The full text of this LCD (L942) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AEPO: Epoetin alfa—Revision to LCD

The local coverage determination (LCD) for epoetin alfa was last revised on October 1, 2007. Since that time, the LCD has been revised to clarify coverage of the off-label indication for myelodysplastic syndrome (MDS), and to include language from change requests (CRs) 5545 and 5700. A statement regarding the national coverage decision (NCD) for erythropoietin stimulating agents (ESAs) use, issued on July 30, 2007, is also being added.

For revisions related to the off-label indication of MDS, First Coast Service Options, Inc. (FCSO) is revising the language to clarify that chronic myelomonocytic leukemia (CMML) **not** chronic myeloid leukemia (CML) can be considered a form of MDS, and as such the anemia associated with CMML may be eligible for coverage with epoetin alfa. If a physician is classifying a patient with CMML he or she must code with one of the MDS ICD-9-CM diagnosis codes (238.71-238.76) in the LCD. If the physician cannot code a patient with one of these diagnosis codes, then the epoetin alfa will be considered **not** medically necessary. In addition, FCSO will be removing the ICD-9-CM diagnosis codes for CML (205.10-205.11), that are currently in the LCD, as these diagnosis codes are in conflict with the NCD issued on **July 30, 2007**, that noncovers CML for ESA therapy.

FCSO has not received final instruction from the Centers for Medicare & Medicaid Services (CMS) regarding implementing the NCD for ESA use in non-ESRD conditions. FCSO will issue a revised LCD once final instruction is issued by CMS. FCSO would like to remind providers that CMS issued the NCD on July 30, 2007, as effective on that date, meaning providers must be following the coverage and noncoverage criteria outlined.

These revisions are effective for services provided **on or after January 18, 2008.**

Coding Guideline Revision

For revisions related to CRs 5545 and 5700, FCSO is revising the "Coding Guideline" attachment for this LCD to include the following language:

- CR 5700 is a revision to the national EPO monitoring policy. The following changes are being made and are effective for HCPCS code Q4082 and type of bill (TOB) 72x: Requests for payments for claims for ESAs for ESRD patients receiving dialysis in renal dialysis facilities (RDFs) and reporting a hematocrit level exceeding 39 percent (or hemoglobin exceeding 13.0 g/dL) for three or more consecutive billing cycles immediately prior to and including the current billing cycle, the dosage payable shall be reduced by 50 percent, based on the reported dose. In addition, claims must report modifiers **ED** or **EE** for Hct levels exceeding 39 percent or Hgb exceeding 13.0g/dL. Providers may continue to report modifier **GS** when the reported Hct or Hgb levels exceed the monitoring threshold and a dose reduction has occurred. As intended in CR 4135 and CR 5251, the revision to the national EPO monitoring policy in CR 5545 does not apply to ESA claims for ESRD patients who receive their dialysis at home and self-administer their ESA. **Modifier ED** is defined as Hct greater than 39 percent or Hgb greater than 13.0g/dL for three or more consecutive billing cycles immediately prior to and including the current billing cycle. **Modifier EE** is defined as Hct greater than 39 percent or Hgb greater than 13.0g/dL for less than three consecutive billing cycles immediately prior to and including the current billing cycle.
- CR 5545 is related to billing requirements for RDFs for epoetin alfa submitted on ESRD claims (TOB 72x). RDFs will bill for each administration of epoetin alfa on a separate line indicating the line item date of service for the administration. RDFs will no longer be required to report value code 68 with the total monthly dosage. When RDFs report modifier **GS**, it is not required to report it on every line. Modifier **GS** should be reported on those line item(s) that represent an administration of epoetin alfa at the reduced dosage following existing instructions in Pub. 100-04, *Medicare Claims Processing Manual,* Chapter 8, Section 60.4. RDFs should include condition code 70 on claims billing for home dialysis patients that self-administer anemia management drugs, including EPO. For patients beginning to self-administer epoetin alfa at home receiving an extra month supply of the drug, RDFs should bill the one-month reserve supply on one claim line and include modifier **EM**, Emergency reserve supply (for ESRD benefit only).

Effective Date

The revision to the Coding Guideline is effective for services provided **on or after January 1, 2008.**

The full text of the LCD for epoetin alfa (L895) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ1561: Intravenous Immune Globulin—Revision to LCD

The local coverage determination (LCD) for intravenous immune globulin (IVIG) was last updated on January 1, 2008. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) received an external request to add the off-label indication of stiff-man syndrome to the LCD as medically reasonable and necessary. FCSO has determined that this request is valid and has revised the LCD to include this off-label indication as medically reasonable and necessary when specific coverage related criteria are met. Those coverage criteria are as follows:

- The patient must be under the care of a physician who is competent in the diagnosis of the syndrome. Criteria for the diagnosis must be met.
- The patient would have to demonstrate failure of conservative treatments.
- Initial coverage would be limited to up to 2g of immune globulin per kilogram of body weight per month.
- The patient's medical record must document the response to therapy after initial treatment (0 and 1 month). Documentation must support objective response for continued coverage each month or at longer intervals.

The "Documentation Requirements" and "Utilization Guidelines" sections of the LCD have been revised to incorporate the above coverage criteria. In addition, ICD-9-CM code 333.91 has been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

Effective Date

This revision to the LCD is effective for services provided **on or after January 5, 2008.** The full text of this LCD (L1405) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ3487: Zoledronic Acid (Zometa®)—Revision to LCD

The local coverage determination (LCD) for zoledronic acid (Zometa®) was last updated on January 1, 2008. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) published this LCD as a draft for notice and comment on September 20, 2007. Language was added for the newly approved Food and Drug Administration (FDA) drug zoledronic acid (Reclast®) (HCPCS code J3488), whose indications are different from those for zoledronic acid (Zometa). Reclast was approved by the FDA on April 16, 2007 for the treatment of Paget's Disease of the bone in both men and women. On August 17, 2007, the FDA also approved Reclast for the treatment of post-menopausal osteoporosis in women. This LCD revision incorporates indications and limitations, documentation requirements and utilization guidelines for Reclast. In addition, the title of the LCD was changed to "Zoledronic Acid" and type of bill 22x was added to the LCD.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L2962) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9055: Cetuximab (Erbitux®)—Revision to LCD

The local coverage determination (LCD) for cetuximab (Erbitux®) was effective on September 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label.

Under the "Indications and Limitations of Coverage and/or Medical Necessity"section of the LCD for FDA approved indications, a revision to the LCD was made to include "cetuximab for treatment of EGFR-expressing, metastatic colorectal carcinoma after failure of both irinotecan and oxaliplatin-based regimens." In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD is effective for services provided **on or after October 2, 2007.** The full text of this LCD (L25277) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9178: Epirubicin Hydrochloride (Ellence®)—Revision to LCD

The local coverage determination (LCD) for epirubicin hydrochloride (Ellence®) was last updated on October 1, 2007. Since that time, a revision was made to update the language for approved indications based on the Food and Drug Administration (FDA) drug label and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI).

Revisions for FDA approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" and "Documentation Requirements" sections of the LCD were updated and type of bill 22x was added to the LCD.

Effective Date

This new LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25115) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9181: Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16)—Revision to LCD

The local coverage determination (LCD) for etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) was last updated on October 1, 2007. Since that time, a revision was made to update the language for approved indications based on the Food and Drug Administration (FDA) drug label and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI).

Revisions for FDA approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" and "Documentation Requirements" sections of the LCD were updated and type of bill 22x was added to the LCD.

Effective Date

This new LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25116) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9185: Fludarabine (Fludara®)—Revision to LCD

The local coverage determination (LCD) for fludarabine (Fludara®) was last revised on October 1, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, and to update the off-labeled indications based on the United States Pharmacopeia Drug Information (USP DI) for fludarabine (Fludara®) – HCPCS code J9185.

The revisions to the LCD include the following:

- Revisions for FDA approved indications and off–labeled indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.
- Type of bill 22x was added.
- Additional documentation requirements were added.
- The "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25117) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9200: Floxuridine (FUDR)—Revision to LCD

The local coverage determination (LCD) for floxuridine (FUDR) was last revised on May 24, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, and to update the off-labeled indications based on the United States Pharmacopeia Drug Information (USP DI) for floxuridine (FUDR) – HCPCS code J9200.

The revisions to the LCD include the following:

- Revisions for FDA-approved indications and off-labeled indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.
- Type of bill 22x was added.
- Additional documentation requirements were added.
- The "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25118) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9201: Gemcitabine (Gemzar®)—Revision to LCD

The local coverage determination (LCD) for gemcitabine (Gemzar®) was last revised on October 1, 2007. Since that time, a revision was made to update off-labeled indications based on the United States Pharmacopeia Drug Information (USP DI) for gemcitabine (Gemzar®) – HCPCS code J9201.

The revisions to the LCD include the following:

- Revisions for FDA-approved indications and off-labeled indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.
- ICD-9-CM code 198.1 (Secondary malignant neoplasm of other urinary organs) was added to the "ICD-9 Codes That Support Medical Necessity" section of the LCD.
- Type of bill 22x was added.
- Additional documentation requirements were added.
- The "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25119) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9265: Paclitaxel (Taxol®)—Revision to LCD

The local coverage determination (LCD) for paclitaxel (Taxol®) was last updated on May 24, 2007. Since that time, a revision was made to update the language for approved indications based on the Food and Drug Administration (FDA) drug label and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI).

Revisions for FDA-approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" and "Documentation Requirements" sections of the LCD were updated and type of bill 22x was added to the LCD..

Effective Date

This new LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25122) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9280: Mitomycin (Mutamycin®, Mitomycin-C)—Revision to LCD

The local coverage determination (LCD) for mitomycin (Mutamycin®, Mitomycin-C) was last updated on May 24, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI) for mitomycin – J9280.

Revisions for FDA-approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" and "Documentation Requirements" sections of the LCD were updated and type of bill 22x was added to the LCD.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25123) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9310: Rituximab (Rituxan®)—Revision to LCD

The local coverage determination (LCD) for rituximab was last revised on October 1, 2007. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) received a request to add the off-label indication of autoimmune hymolytic anemia to the LCD. Supporting literature was submitted and reviewed and the request was found to be valid. The indications and limitations, documentation requirements, and utilization guidelines were revised to incorporate this indication. In addition, the "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to include ICD-9-CM diagnosis code 283.0 (Autoimmune hemolytic anemias) as appropriate for this off-label indication and type of bill 22x was added to the LCD.

Effective Date

This revision to the LCD is effective for services provided **on or after January 24, 2008.** The full text of this LCD (L25125) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9390: Vinorelbine Tartrate (Navelbine®)—Revision to LCD

The local coverage determination (LCD) for vinorelbine tartrate (Navelbine®) was last updated on May 24, 2007. Since that time, the LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD in accordance with the Food and Drug Administration (FDA)-approval language regarding vinorelbine for use as a single agent or in combination with cisplatin for the first-line treatment of ambulatory patients with unresectable, advanced non-small cell lung cancer (NSCLC) and the 'off-label' language has been revised under the third bullet to read: metastatic breast carcinoma in patients who did not respond to standard first-line chemotherapy for metastatic disease.

The "Documentation Requirements" section of the LCD was also revised to include language regarding the amount of drug, route and timing of administration, and any reaction to the patient. In addition, type of bill 22x was added to the LCD.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25128) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9395: Fulvestrant (Faslodex®)—Revision to LCD

The local coverage determination (LCD) for fulvestrant (Faslodex®) was last updated on May 24, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, and to update the off-label indication to include male breast cancer.

Revisions for FDA-approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "CMS National Coverage Policy," "Documentation Requirements" and "Sources of Information and Basis for Decision" sections of the LCD were updated. Under the "Utilization Guidelines" section of the LCD, dosage and administration information was added. In addition, type of bill 22x was added to the LCD.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25129) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

AJ9600: Porfimer (Photofrin®)—Revision to LCD

The local coverage determination (LCD) for porfimer (Photofrin®) was last updated on May 24, 2007. Since that time, the LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD in accordance with the Food and Drug Administration (FDA)-approval language in regard to the treatment of microinvasive endobronchial non-small cell lung cancer and an additional FDA-approved indication has been added for reduction of obstruction and palliation of symptoms in patients with completely or partially obstructing endobronchial non-small cell lung cancer.

The "Documentation Requirements" section of the LCD was also revised to include language regarding the amount of drug, route and timing of administration, and any reaction to the patient. In addition, type of bill 22x was added to the LCD.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L25130) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

ANCSVCS: The List of Medicare Noncovered Services—Revision to LCD

The local coverage determination (LCD) for the list of Medicare noncovered services was last updated on January 1, 2008. Since that time, the LCD has been revised to add *category III CPT* codes *0062T (Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level)* and *0063T (Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels [List separately in addition to 0062T for primary procedure])* to the "*CPT*/HCPCS Codes, Local Noncoverage Decisions, Procedures" section of the LCD, as these procedures are considered experimental and investigational.

Effective Date

This revision to the LCD is effective for services provided **on or after February 29, 2008.** The full text of this LCD (L24028) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

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

The local coverage determination (LCD) for darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) was last revised on October 1, 2007. Since that time, the LCD has been revised to clarify coverage of the off-label indication for myelodysplastic syndrome (MDS), and to include language from change requests (CRs) 5545 and 5700. A statement regarding the national coverage decision (NCD) for erythropoietin stimulating agents (ESAs) use, issued on July 30, 2007, is also being added.

For revisions related to the off-label indication of MDS, First Coast Service Options, Inc. (FCSO) is revising the language to clarify that chronic myelomonocytic leukemia (CMML) can be considered a form of MDS, and as such the anemia associated with CMML may be eligible for coverage with darbepoetin alfa (Aranesp®). If a physician is classifying a patient with CMML he or she must code with one of the MDS ICD-9-CM diagnosis codes (238.71-238.76) in the LCD. If the physician cannot code a patient with one of these diagnosis codes, then the darbepoetin alfa (Aranesp®) will be considered **not** medically necessary.

FCSO has not received final instruction from the Centers for Medicare & Medicaid Services (CMS) regarding implementing the NCD for ESA use in non-ESRD conditions. FCSO will issue a revised LCD once final instruction is issued by CMS. FCSO would like to remind providers that CMS issued the NCD on July 30, 2007, as effective on that date, meaning providers must be following the coverage and noncoverage criteria outlined.

These revisions will be effective for services provided **on or after December 20, 2007.**

Coding Guideline Revision

For revisions related to CRs 5545 and 5700, FCSO is revising the "Coding Guideline" attachment for this LCD to include the following language:

- CR 5700 is a revision to the national Aranesp® monitoring policy. The following changes are being made and are effective for HCPCS code J0882 and type of bill (TOB) 72x: Requests for payments for claims for ESAs for ESRD patients receiving dialysis in renal dialysis facilities (RDFs) and reporting a hematocrit level exceeding 39 percent (or hemoglobin exceeding 13.0 g/dL) for three or more consecutive billing cycles immediately prior to and including the current billing cycle, the dosage payable shall be reduced by 50 percent, based on the reported dose. In addition, claims must report modifiers **ED** or **EE** for Hct levels exceeding 39 percent or Hgb exceeding 13.0g/dL. Providers may continue to report modifier **GS** when the reported Hct or Hgb levels exceed the monitoring threshold and a dose reduction has occurred. As intended in CR 4135 and CR 5251, the revision to the national Aranesp® monitoring policy in CR 5545 does not apply to ESA claims for ESRD patients who receive their dialysis at home and self-administer their ESA. **Modifier ED** is defined as Hct greater than 39 percent or Hgb greater than 13.0g/dL for three or more consecutive billing cycles immediately prior to and including the current billing cycle. **Modifier EE** is defined as Hct greater than 39 percent or Hgb greater than 13.0g/dL for less than three consecutive billing cycles immediately prior to and including the current billing cycle.
- CR 5545 is related to billing requirements for RDFs for Aranesp® submitted on ESRD claims (TOB 72x). RDFs should include condition code 70 on claims billing for home dialysis patients that self-administer anemia management drugs, including Aranesp®. For patients beginning to self-administer Aranesp® at home receiving an extra month supply of the drug, RDFs should bill the one-month reserve supply on one claim line and include modifier **EM**, Emergency reserve supply (for ESRD benefit only).

Effective Date

The revision to the Coding Guideline is effective for services provided **on or after January 1, 2008.**

The full text of the LCD for Aranesp® (L13796) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

ADDITIONAL MEDICAL INFORMATION

2008 HCPCS Local Coverage Determination Changes

Florida Medicare has revised local coverage determinations (LCDs) impacted by the 2008 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

LCD Title	2007 Changes
AEPO – Epoetin alfa(**Coding Guidelines only)**	• Added modifiers EA, EB, and EC for HCPCS code J0885
AJ1566 – Intravenous Immune Globulin	• Descriptor change for HCPCS code J1566 • Deleted HCPCS codes Q4087, Q4088, Q4091, and Q4092 • Added HCPCS codes J1568, J1569, J1572, and J1561 • Changed contractor's determination number to AJ1561
AJ1950 – Luteinizing Hormone-Releasing Hormone (LHRH) Analogs	• Descriptor change for HCPCS code J9225
AJ2792 – Rho (D) Immune Globulin Intravenous	• Deleted HCPCS code Q4089 • Added HCPCS code J2791
AJ3487 – Zoledronic Acid (Zometa®)	• Descriptor change for HCPCS code J3487
AJ7187 – Hemophilia Clotting Factors	• Descriptor change for HCPCS code J7187
ANCSVCS – The List of Medicare Non-covered Services	• Added *CPT* codes *0183T*, 0186T*, 0187T*, 20985*, 20986*, 20987*, 34806*, 50593*,90661*, 90662*, 90663** and *93982** to the Local Noncoverage Decisions section of the LCD • Added *CPT*/HCPCS codes J7307, *0185T, 21073, 99605, 99606,* and *99607* to the Local Noncoverage Decisions section of the LCD • Added HCPCS code A9155 to the National Noncoverage Decisions section of the LCD
ANESP – Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) **(Coding Guidelines only)**	• Added modifiers EA, EB, and EC for HCPCS code J0881
APPHPROG – Psychiatric Partial Hospitalization Program	• Descriptor change for *CPT* codes *96101* and *96118*
AVISCO – Viscosupplementation Therapy For Knee	• Deleted HCPCS codes Q4083, Q4084, Q4085, and Q4086 • Added HCPCS codes J7321, J7322, J7323, and J7324
A0145T – Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries	• Descriptor changes for *CPT* codes *0145T, 0146T, 0147T, 0148T, 0149T, 0150T, and 0151T* • Descriptor change for *CPT* code *71275*
A11000 – Debridement Services **(Coding Guidelines only)**	• Descriptor change for *CPT* code *11008*
A92135 – Scanning Computerized Ophthalmic Diagnostic Imaging	• Descriptor change for *CPT* code *92135*
A93303 – Transthoracic Echocardiography (TTE)	• Added HCPCS codes C8921, C8922, C8923 and C8924
A93312 – Transesophageal Echocardio-gram	• Added HCPCS codes C8925, C8926, and C8927

* = Investigational

Final LCDs are available on the Florida Medicare provider education website *http://www.fcso.com*. ❖

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AJ0881: Erythropoietin Stimulating Agents (ESAs)—Draft LCD Implementation Delayed

The draft local coverage determination (LCD) for erythropoietin stimulating agents (ESAs) was issued for notice and comment on September 20, 2007. The comment period ended on November 3, 2007. First Coast Service Options, Inc. (FCSO) issued this draft LCD with language from the national coverage decision (NCD) for ESA use for non-ESRD conditions issued on July 30, 2007. FCSO has not received final instruction from the Centers for Medicare & Medicaid Services (CMS) for implementing the NCD. Because of this, FCSO has elected to delay implementing this draft LCD until final instruction is issued to contactors. Until then, providers are reminded that the NCD was issued by CMS as effective on July 30, 2007, and they should be following the coverage and noncoverage criteria outlined in the NCD. For conditions not addressed in the NCD, providers can refer to FCSO's current active LCDs for epoetin alfa and darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]).

FCSO has published the comment summary for this draft LCD. FCSO will publish an article once the draft LCD is posted for final notice. The effective date will be included in that article.

The full text of this draft LCD is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

Electrocardiogram, 64 Leads or Greater—Coverage Guidelines

Body surface potential mapping (BSPM), also known as body surface mapping (BSM) is an electrocardiographic (ECG) technique that uses numerous leads (as many as 120) to record and measure electrocardiac activity over a much larger portion of the torso than the traditional 12 lead-ECG to provide a comprehensive three-dimensional picture of the effects of electrical currents from the heart on the body surface.

This service should be billed with *CPT* code *93799* (*Unlisted cardiovascular service or procedure*) for services provided prior to July 1, 2007. For services provided on or after July 1, 2007, the following *CPT category III* codes should be billed:

0178T *Electrocardiogram, 64 leads or greater with graphic presentation and analysis; with interpretation and report*
0179T *tracing and graphics only, without interpretation and report*
0180T *interpretation and report only*

Note that based on medical necessity, payment would be made for either BSPM/BSM **or** a standard electrocardiogram (EKG/ECG), but not both, during the same occurrence. EKG/ECG services are represented by *CPT* codes *93000-93010.* ❖

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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.

Hospital Services

Fiscal Year 2008 Inpatient, Long Term Care Hospital, and Inpatient Psychiatric Facility Prospective Payment System Changes

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 and paid under the inpatient prospective payment system (IPPS), the long term care hospital (LTCH) PPS, or the inpatient psychiatric facility (IPF) PPS.

Provider Action Needed

This article is based on change request (CR) 5748, which announces changes to the IPPS and LTCH PPS payment policies based on the fiscal year (FY 08) IPPS final rule. It also includes the ICD-9-CM coding changes that affect the IPF PPS comorbidity adjustment. The FY 08 IPPS final rule also established a new diagnosis-related group (DRG) system, the Medicare severity DRGs, or MS-DRGs, effective October 1, 2007. Be sure billing staff are aware of the changes.

Background

The Centers for Medicare & Medicaid Services (CMS) annually updates the IPPS, and CR5748 announces changes for the IPPS hospitals for FY 2008. The policy changes for FY 2008 appeared in the *Federal Register* on August 22, 2007 (*http://www.access.gpo.gov/su_docs/fedreg/a070822c.html*) and the final IPPS rates are available on the CMS Web site. All items covered in CR 5748 are effective for hospital discharges occurring on or after October 1, 2007, unless otherwise noted.

The FY 08 IPPS final rule established a new DRG system, the MS-DRGs, effective October 1, 2007. By better taking into account severity of illness in Medicare payment rates, the MS-DRGs encourage hospitals to improve their coding and documentation of patient diagnoses. To assure that improvements in coding and documentation do not lead to an increase in the aggregate payments without corresponding growth in actual patient severity, the final rule established documentation and coding adjustment of 1.2 percent for FY 2008. However, section 7 of the "TMA, Abstinence Education, and QI Programs Extension Act of 2007" limits that adjustment to 0.6 percent for discharges occurring in FY 2008. This 0.6 percent adjustment is not being applied to the hospital-specific rates in the PRICER. This is consistent with the policy established in the IPPS notice issued on November 1, 2007.

CR 5748 also addresses new GROUPER and diagnosis-related group (DRG) changes that are effective October 1, 2007 for hospitals paid under the IPPS, as well as under LTCH PPS. LTCH PPS rate changes occurred on July 1, 2007. (Please refer to CR 5652 (Transmittal 1268, published on June 15, 2007 at *http://www.cms.hhs.gov/transmittals/downloads/R1268CP.pdf* or its corresponding MLN Matters articles MM5652 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5652.pdf* on the CMS Web site for LTCH policy changes).

The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment effective October 1, 2007. Rate changes occurred on July 1, 2007. Please refer to CR 5619 (Transmittal 1256, published on May 25, 2007 at *http://www.cms.hhs.gov/transmittals/downloads/R1256CP.pdf* or it corresponding MLN Matters article MM5619 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5619.pdf* on the CMS Web site) for IPF PPS policy changes.

ICD-9-CM coding changes are effective October 1, 2007. The new ICD-9-CM codes are listed, along with their DRG classifications in Tables 6A and 6B of the August 22, 2007, *Federal Register*, and the ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6C and 6D. You can also find the revised code titles in Tables 6E and 6F. See the August 22, 2007 *Federal Register* (Pages 47129-48175) on the Internet at *http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-3820.htm*.

A new DRG Grouper, version 25, software package is effective for discharges on or after October 1, 2007. GROUPER 25.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2007. The Medicare code editor (MCE) 24.0 uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2007. Key changes in CR 5748 are as follows:

A. Furnished Software Changes

The following software programs were issued for FY 2008:

IPPS PRICER 08.0

The IPPS PRICER, version 08.0, will be used for discharges occurring **on or after October 1, 2007.** The IPPS PRICER 08.0 also processes bills with discharge dates on or after October 1, 2002.

Fiscal Year 2008 Inpatient, Long Term Care Hospital, and Inpatient Psychiatric Facility PPS Changes (continued)

Rates

Standardized Amount Update Factor	1.033 1.013 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.033 1.013 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	$22,185.00
Federal Capital Rate	$426.14
Puerto Rico Capital Rate	$201.67
Outlier Offset-Operating National	0.948983
Outlier Offset-Operating Puerto Rico	0.964060
Indirect medical education (IME) Formula	1.35*[(1 + resident-to-bed ratio)**.405-1]
MDH/SCH Budget Neutrality Factor	0.995743

Operating Rates

Rates with Full Market Basket & Wage Index Greater than 1

	Labor Share	Non-Labor Share
National	3478.45	1512.15
Puerto Rico/National	3478.45	1512.15
Puerto Rico Specific	1462.27	896.23

Rates with Full Market Basket & Wage Index Less Than 1

	Labor Share	Non-Labor Share
National	3094.17	1896.43
Puerto Rico/ National	3094.17	1896.43
Puerto Rico Specific	1384.44	974.06

Rates with Reduced Market Basket & Wage Index Greater Than 1

	Labor Share	Non-Labor Share
National	3411.10	1482.87

Rates with Reduced Market Basket & Wage Index Less Than 1

	Labor Share	Non-Labor Share
National	3034.26	1859.71

Cost-of-Living Adjustment Factors - Alaska and Hawaii Hospitals:

Area	Cost of Living Adjustment Factor
Alaska	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25
Hawaii	
City and County of Honolulu	1.25
County of Hawaii	1.17
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Fiscal Year 2008 Inpatient, Long Term Care Hospital, and Inpatient Psychiatric Facility PPS Changes (continued)

Postacute Care Transfer Policy
The DRGs determined in the post-acute care transfer policy have been modified due to MS-DRGs. See section B (Grouper 25.0) below regarding MS-DRGs. The special pay DRGs are paid at 50 percent of the appropriate PPS rate for the first day of the stay and 50 percent of the amount calculated for the rest of the stay. These special pay DRGS are as follows:

028	029	030	040	041	042	219	220
221	477	478	479	480	481	482	492
493	494	500	501	502	515	516	517
956							

Note: See attachment A of CR 5748 for list of the postacute care transfer DRGs.

New Technology Add-On Payment
Effective for discharges on or after October 1, 2007, there will be no continuing add-on payments from last year and no new ones starting for this year.

Burn DRGs
Burn DRGs receive 90 percent of costs exceeding the outlier threshold instead of the 80 percent that other DRGs receive. The burn-DRGs for FY08 are 927, 928, 929, 933, 934 and 935. These have been updated for MS-DRGs.

B. GROUPER 25.0
For discharges occurring on or after October 1, 2007, PRICER calls the appropriate GROUPER based on discharge date. This version of GROUPER will include logic to group to MS-DRGS. GROUPER will have increased field lengths for the diagnosis and procedure codes and dates and fields for the present on admission (POA) indicator. The Medicare severity DRGs or MS-DRGs are modifications of the CMS-DRGs to better account for severity of illness and resource consumption for Medicare patients. The MS-DRGs increase the number of DRGs by 207 to a total of 745, while maintaining the reasonable patient volume in each DRG. There are three levels of severity in the MS-DRGs based on the secondary diagnosis codes: MCC (major complication/comorbidity), CC (complication/comorbidity), and non-CC. Diagnosis codes classified as MCCs reflect the highest level of severity. The next level of severity includes diagnosis codes classified as CCs. The lowest level is for non-CCs. Non-CCs are diagnosis codes that do not significantly affect severity of illness and resource use. Therefore, secondary diagnoses that are non-CCs do not affect the DRG assignment under either the CMS DRGs or the MS-DRGs.

C. Medicare Code Editor (MCE) 24.0
For discharges occurring on or after October 1, 2007, the MCE selects the proper internal tables based on discharge date. Effective October 1, 2007, MCE will have increased field lengths for diagnosis and procedure codes, fields for the POA indicator, other new edits and retroactivity.

D. Provider Specific Information
Tables 8A and 8B of Section VI of the addendum to the PPS final rule contain the FY 2008 statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.238 and the capital ceiling is 0.152. See the August 22, 2007 *Federal Register* (Pages 47129-48175) on the Internet at *http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-3820.htm*.

Core-Based Statistical Area (CBSA) Designations
Attachment B of CR 5748 shows the IPPS providers that will be receiving a "special" wage index for FY 2008 (i.e., receives an out-commuting adjustment under section 505 of the Medicare Modernization Act [MMA]). For any provider with a special wage index from FY 2007, fiscal intermediaries (FIs) shall remove that special wage index, unless they receive a new special wage index as listed in attachment B of CR5748. Micropolitan areas are "rural" areas, but hospitals in these areas were given an urban area wage index for three years (known as the hold harmless provision. This provision expired on September 30, 2007 and these hospitals now receive 100 percent of their wage index based upon the CBSA configurations.

Low Volume Hospitals
Hospitals considered low volume will receive a 25 percent bonus to the operating final payment. To be considered "low volume" the hospital must have fewer than 200 discharges and be located at least 25 road miles from another hospital. The discharges are determined from the latest cost report. Hospitals shall notify FIs if they believe they are a low volume hospital.
The low volume hospital status should be re-determined at the start of the federal fiscal year. The most recent filing of a provider cost report can be used to make the determination. If the hospital is no longer low volume, the 'Y' indicator should be removed. If the hospital does meet the low volume criteria, a 'Y' should be inserted into the low volume indicator field.

Hospital Quality Initiative
The hospitals that will receive the quality initiative bonus are listed on the Internet at *http://www.qualitynet.org*.

Attachment C of CR 5748 includes the list of providers that did not meet the criteria for FY 08. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site and FIs must update the provider file as needed.
For new hospitals, FIs will provide information to the appropriate Quality Improvement Organization (QIO) as soon as possible so that the QIO can follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative.

Fiscal Year 2008 Inpatient, Long Term Care Hospital, and Inpatient Psychiatric Facility PPS Changes (continued)

E. Other Changes

Capital PPS Adjustment for Hospitals Located in Large Urban Areas

In the FY 2008 final rule, the capital PPS 3.0 percent "large urban add-on" was eliminated effective for discharges on or after October 1, 2007. That is, the regulations at section 412.316(b) were revised to specify that beginning in FY 2008 and after, there will no longer be any additional payment under the capital PPS for hospitals located in large urban areas, as currently provided under that section. The PRICER has been updated to reflect this policy change.

Capital PPS Payment for Providers Redesignated Under Section 1886(d)(8)(B) of the Act

Under this section of the Act, certain rural counties (commonly referred to as "Lugar counties") adjacent to one or more urban areas are redesignated as urban for the purposes of payment under the IPPS. Hospitals located in these "Lugar counties" are deemed to be located in an urban area and they receive the Federal payment amount for the urban area to which they are redesignated. Such hospitals, however, may decline this redesignation and retain their rural status.

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103 for Purposes of Capital PPS Payments

Hospitals reclassified as rural under 42 CFR 412.103 (*http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html*) are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see 42 CFR 412.320(a)(1); *http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html*).

Similarly, the geographic adjustment factor (GAF) for hospitals reclassified as rural under 42 CFR 412.103 is determined from the applicable statewide rural wage index.

F. LTCH Changes

A new patient classification system is being adopted under the LTCH PPS , beginning in FY 2008. It is the same as the one being adopted under the IPPS (i.e., MS-DRGs), but under LTCH, the DRGs are referred to as "MS-LTC-DRGs". The LTCH PRICER has been updated with the MS-LTC-DRG table and weights.

In the IPPS computation of the "IPPS Comparable Amount" for LTCH short-stay outlier (SSO) cases, in the calculation of the capital IPPS comparable payment amount, the 3 percent large urban add-on has been eliminated effective with discharges occurring on or after October 1, 2007.

G. Inpatient Psychiatric Facility Changes

Coding Changes -DRG Adjustment Update:

The IPF PPS has DRG specific adjustments for 15 DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in chapter five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG will receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of CMS' identified 15 psychiatric DRGs, the IPF will still receive the federal per diem base rate and all other applicable adjustments.

Since the IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and DRG classification system, the IPF PPS is adopting IPPS' new MS DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, please note these are the same adjustment factors in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Below is the crosswalk of current DRGs to the new MS- DRGs, which will be effective October 1, 2007.

(version 24) DRG	(version 25) MS-DRG	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521-522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Fiscal Year 2008 Inpatient, Long Term Care Hospital, and Inpatient Psychiatric Facility PPS Changes (continued)

Comorbidity Adjustment Update:

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes of co-morbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. The IPFs must enter the full ICD-9-CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.

Co-morbidities are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Co-morbid conditions must co-exist at the time of admission, develop subsequently, and affect the treatment received, the length of stay or both treatment and length of stay.

As explained above, the IPF PPS is adopting the new MS-Severity DRG coding system in order to maintain consistency with the IPPS, which are effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. The FY 2008 GROUPER, Version 25.0, is effective for discharges occurring on or after October 1, 2007.

There are two tables in CR 5748 listing the FY 2008 new ICD-9-CM diagnosis codes and the one invalid FY 2008 ICD diagnosis code, respectively, which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2008 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

One table in CR 5748 is an extensive table that lists the FY 2008 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table only lists the FY 2008 new codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. CR 5748 may be accessed at *http://www.cms.hhs.gov/Transmittals/downloads/R1374CP.pdf on the CMS Web site*.

There is one ICD-9-CM codes no longer applicable for the comorbidity adjustment. This code is:

Diagnosis Code	Description	Comorbidity Category
233.3	Carcinoma in situ, other and unspecified female genital organs	Oncology Treatment

Additional Information

The official instruction (CR 5748) 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/R1374CP.pdf*.

If you have any questions, please contact your Medicare intermediary 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: MM5748
Related Change Request (CR) Number: 5748
Related CR Release Date: November 7, 2007
Related CR Transmittal Number: R1374CP
Effective Date: Discharges on or after October 1, 2007
Implementation Date: October 18, 2007

Source: CMS Pub. 100-04, Transmittal 1354, CR 5748

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Acute Inpatient Prospective Payment System Fact Sheet

The *Acute Inpatient Prospective Payment System* fact sheet (revised November 2007), which provides general information about the acute inpatient prospective payment system (IPPS) and how IPPS rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf*.

If the URL above does not take you directly to the fact sheet, please copy and paste the URL in your Web browser. ❖

Source: CMS Provider Education Resource 200712-5

Supplemental Security Income/Medicare Beneficiary Data for Fiscal Year 2006 for IPPS Hospitals, IRFs, and LTCHs

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

Provider Types Affected

IPPS hospitals, IRFs, and LTCHs 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

This article is based on change request (CR) 5846, which 1) provides updated Supplemental Security Income (SSI)/Medicare beneficiary data for determining additional payment amounts for hospitals with a disproportionate share of low income patients and 2) furnishes links to the electronic files containing the data used for interim payments and for cost settlement purposes.

Background

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA; Section 9105) provides additional payment amounts for inpatient prospective payment system (IPPS) hospitals with a disproportionate share of low-income patients. This is done by making adjustments to the prospective payment rate.

Under the inpatient rehabilitation facility prospective payment system (IFR PPS), IRFs receive additional payment amounts to account for the cost of furnishing care to low-income patients. (See 42 CFR section 412.624(e)(2) on the Internet at *http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi*.)

This is done by making adjustments to the prospective payment rate. The SSI data is updated on an annual basis, and these data are one of the components used to determine an appropriate low-income percentage adjustment for each IRF.

Under the long term care hospital prospective payment system (LTCH PPS), the payment adjustment for short-stay outlier (SSO) cases is based on the calculation of an amount comparable to equivalent to an amount that would otherwise be paid under the IPPS, i.e., the "IPPS comparable amount." (See 42 CFR section 412.529 on the Internet at *http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi*).

The calculation of the "IPPS comparable amount" in the LTCH PPS SSO payment adjustment includes an IPPS comparable adjustment for the costs of serving a disproportionate share of low-income patients, where applicable, which utilizes SSI data (see section 412.529(d)(4)). The best available SSI data are used in this calculation and generally is updated on an annual basis.

CR 5846 provides links to the electronic files containing updated SSI/Medicare beneficiary data for determining additional payment amounts for hospitals with a disproportionate share of low-income patients. The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during FY 2006 (cost reporting periods beginning on or after October 1, 2005, and before October 1, 2006).

The files are located at the following CMS website addresses:

- The IPPS data is available on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage*.
- The IRF PPS data is at *http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage*.
- The LTCH PPS data is at *http://www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp#TopOfPage*.

Note that the cost settlement requirements (requirements 5846.2 and 5846.3) in CR 5846 do not apply to LTCH PPS as the SSI ratio is only used in determining the payment adjustment for short stay outlier cases.

Additional Information

The official instruction, CR 5846, issued to your Medicare FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1396CP.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: MM5846
Related Change Request (CR) Number: 5846
Related CR Release Date: December 14, 2007
Related CR Transmittal Number: R1396CP
Effective Date: January 4, 2008
Implementation Date: January 4, 2008

Source: CMS Pub. 100-04, Transmittal 1396, CR 5846

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Critical Access Hospital Services

Addition to Medicare Telehealth Services

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5628, which adds the neurobehavioral status exam (as represented by *CPT* code *96116*) to the list of Medicare telehealth services.

CAUTION – What You Need to Know

Effective January 1, 2008, the telehealth modifiers “GT” (via interactive audio and video telecommunications system) and modifier “GQ” (via asynchronous telecommunications system) are valid when billed with CPT code 96116.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) announced in CR 5628 that the neurobehavioral status exam *CPT* code *96116* has been added to the list of Medicare telehealth services (see the final rule for the calendar year (CY) 2008 physician fee schedule (CMS-1385-FC)). Previously, CMS determined that, if the eligibility criteria, and conditions of payment are satisfied, the use of a telecommunications system may substitute for a face-to-face, “hands on” encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. CR 5628 added neurobehavioral status exam to the list of telehealth services (bolded). Medicare telehealth services are listed below.

- Consultations (*CPT* codes *99241-99275*) – Effective October 1, 2001 – December 31, 2005
- Consultations (*CPT* codes *99241-99255*) – Effective January 1, 2006
- Office or other outpatient visits (*CPT* codes *99201-99215*)
- Individual psychotherapy (*CPT* codes *90804-90809*)
- Pharmacologic management (*CPT* code *90862*)
- Psychiatric diagnostic interview examination (*CPT* code *90801*) – Effective March 1, 2003
- End-stage renal disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) – Effective January 1, 2005
- Individual medical nutrition therapy (HCPCS code G0270 and *CPT* codes *97802*, and *97803*) – Effective January 1, 2006
- **Neurobehavioral status exam (CPT code 96116) – (Effective January 1, 2008).**

In addition, effective January 1, 2008, the following modifiers are valid when billed with *CPT* code *96116*:

Modifier	Descriptor
GT	Via interactive audio and video telecommunications system
GQ	Via asynchronous telecommunications system

The expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, or payment or billing methodology applicable to Medicare telehealth services as set forth in the *Medicare Benefit Policy Manual* (Publication 100-02, chapter 15, section 270) and the *Medicare Claims Processing Manual* (Publication 100-04, chapter 12, section 190).

For example, originating sites must be located in either a non-metropolitan statistical area (non-MSA) county or rural health professional shortage area (HPSA) and must be one of the following:

- Physician’s or practitioner’s office
- Hospital
- Critical access hospital (CAH)
- Rural health clinic
- Federally qualified health center.

Also, an interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary, and as a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used.

Effective January 1, 2008, CR 5628 instructs that:

- Your local part B carriers and or A/B MACs will pay for *CPT* code *96116* according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GT or GQ.
- Your local FIs and or A/B MACs will pay for *CPT* code *96116* when submitted with a modifier GT or GQ, by CAHs that have elected method II payment on type of bill (TOB) 85x.

Addition to Medicare Telehealth Services (continued)

Additional Information

To view the official instructions issued to your carrier, FI, or A/B MAC, see the two transmittals for CR 5628 on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1277CP.pdf* and *http://www.cms.hhs.gov/transmittals/downloads/R74BP.pdf*.

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: MM5628
Related Change Request (CR) Number: 5628
Related CR Release Date: June 29, 2007
Related CR Transmittal Number: R1277CP and R74BP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1277, CR 5628

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ESRD SERVICES

Implementation of Changes in End-Stage Renal Disease Payment for Calendar Year 2008

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for end-stage renal disease (ESRD) services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5827, which provides payment updates for ESRD facilities.

CAUTION – What You Need to Know

ESRD facilities payment changes include a growth update to the drug add-on adjustment to the composite rate and an update to the wage index adjustments to reflect current wage data, including a revised budget neutrality adjustment. CR 5827 also clarifies weight calculation instructions for double amputee dialysis patients.

GO – What You Need to Do

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

Background

The Social Security Act (Section 1881(b)), as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 623), directed revisions to the composite rate payment system as well as payment for separately billable drugs furnished by ESRD facilities.

For calendar year (CY) 2008, the Centers for Medicare & Medicaid Services (CMS) did not propose any significant changes to composite rate payment methodology.

However, with CR 5827, CMS makes the following payment changes, effective January 1, 2008 to ESRD facilities, and upon the implementation of CR 5827, these payment changes will be applied to all Medicare certified ESRD facilities:

- Update the drug add-on adjustment to the composite rate for 2008 of 0.5 percent. As a result, the drug add-on adjustment to the composite payment rate for 2008 will increase from 14.9 percent to 15.5 percent.
- Update the wage data, and implement the third year of the wage index transition using a 25/75 blended wage adjusted composite rate.

Wage Index Transition Example:

An ESRD facility has a wage-adjusted composite rate (without regard to any case-mix adjustments) of $135.00 per treatment in CY 2007. Using core based statistical area (CBSA) based geographic area designations, the facility's CY 2008 wage-adjusted composite rate, reflecting its wage index value would be $145.00. During the third year (CY 2008) of the four-year transition period to the new CBSA based wage index values, this facility's blended rate would be calculated as follows:

CY 2008: (**0.25** × $135.00) + (**0.75** × $145.00) = $142.50.

CR 5827 also clarifies weight calculation instructions for double amputee dialysis patients. Previously reported in CR 4196, the requirement for value code A8 (weight) is that it should be calculated with pre-amputation weight. In CR 4196, the formula for pre-amputation weight was incorrectly stated as actual weight x 1.5. The correct formula for pre-amputation weight is actual weight x 1.15. Through CR 5827, the instruction for how to calculate the height and weight of double amputee dialysis patients is being placed into Publication 100-04, which is the *Medicare Claims Processing Manual*.

Additional Information

The official instruction, CR 5827, issued to your Medicare FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1389CP.pdf*.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at on the CMS Web site *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: MM5827
Related Change Request (CR) Number: 5827
Related CR Release Date: December 7, 2007
Related CR Transmittal Number: R1389CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1389, CR 5827

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Skilled Nursing Facility Services

Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services

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

Note: CMS has revised this article on November 28, 2007, to clarify that services covered under the Part D benefit are not subject to skilled nursing facility (SNF) consolidated billing (CB). The revised special edition *MLN Matters* article SE0436 was published in the November 2007 *Medicare A Bulletin* (pages 24-25).

Provider Types Affected

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

Provider Action Needed

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

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

Background

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

Preventive and Screening Services

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

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

Billing for Preventive and Screening Services

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

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

Priority of Payments

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

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

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

Example of Special Circumstance

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

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

Further, it is worth noting that unlike preventive services covered under Part B, those services covered under Part D are not subject to CB, even when furnished to an SNF's Part A resident. This is because section 1862(a)(18) of the Social Security Act specifies that CB applies to ***". . . covered skilled nursing facility services described in section 1888(e)(2)(A)(i) . . . ." Section 1888(e)(2)(A)(i), in turn, defines "covered skilled nursing facility services" specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of CB) would be types of services ". . . for which payment may be made under Part B . . ."***

Additional Information

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

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

It includes the following relevant information:

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

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

It includes the following relevant information:

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

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Source: CMS Special Edition *MLN Matters* Article SE0436

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Skilled Nursing Facility Prospective Payment System Fact Sheet

The *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 print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit http://www.cms.hhs.gov/mlngeninfo/, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." If the URL above does not take you directly to the MLN product ordering page, please copy and paste the URL in your Web browser. ❖

Source: CMS Provider Education Resource 200712-11

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Hospital Outpatient Prospective Payment System

Adjustment to Payment Under Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System for Partial Device Credit

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 (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries, which are paid under the OPPS or the ASC payment system.

Provider Action Needed

STOP – Impact to You

This article informs affected providers of how partial credits for medical devices are to be reported and paid under the OPPS and ASC payment systems.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is implementing a partial device credit policy for hospitals paid under the OPPS and for ASCs paid under the revised ASC payment system (for services furnished on or after January 1, 2008). The partial credit policy applies to the same devices, ambulatory payment classifications (APCs), and ASC procedures to which the no cost or full credit policy applies. Medicare payment will be reduced by 50 percent of the estimated cost of the device (i.e., the device offset percentage) in cases in which the hospital or ASC reports that it received a partial credit of 50 percent or more of the cost of the new device that is being implanted. See the table of applicable APCs at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* for the percentage reduction to the payment when the hospital reports a partial credit of 50 percent or more for a specified replacement device (also listed in those tables).

A table of covered ASC surgical procedures to which the partial device credit policy applies is available at *http://cms.hhs.gov/ASCPayment/*. Table 58 provides the device offset percentages for the selected OPPS APCs to which the partial device credit policy applies under the revised ASC payment system. ASCs will receive the same amount of payment reduction (in dollars) as a hospital when reporting a partial credit for a new replacement device.

GO – What You Need to Do

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

Background

In general, CMS includes the full payment for devices with the payment for the service in which the device is used by using only outpatient hospital claims that contain the full cost of medical devices in setting the Medicare payment rates.

In some cases, the cost of the device is a very large proportion of the cost of the procedure on which the APC payment for the procedure is based. Thus, when the provider receives partial credit for the device and therefore, does not incur the full cost of the procedure, it is necessary to adjust the payment so that the payment reflects the reduced cost of the device. This is necessary to:

- Provide an appropriate payment for the service.
- Ensure that the Medicare beneficiary's co-payment liability is reduced when appropriate.

CMS determined that partial credits occur more commonly than do full credits or no cost devices. In addition, CMS has learned that typical industry practice for some types of devices is to:

- Provide a 50 percent credit in cases of device failure (including battery depletion) under warranty if a device failed before three years of use.
- Prorate the credit over time between three and five years after the initial device implantation, as the useful life of the device declines.

In these cases, neither the hospital nor ASC is incurring the full cost of the device, although the Medicare payment is calculated based on the full cost of the device.

Effective for services furnished on or after January 1, 2007, CMS implemented a policy to adjust the OPPS payment for procedures assigned to selected APCs when any of the specified devices was implanted in a beneficiary (and remained in the patient at least temporarily) and was furnished either without cost or with full credit for the cost of the device being replaced. See CR 5263 (Transmittal 1103, November 3, 2006, *http://www.cms.hhs.gov/transmittals/downloads/R1103CP.pdf*) or related *MLN Matters* article MM5263 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5263.pdf*) and the *Medicare Claims Processing Manual* (Pub.100-4, Chapter 4, Section 61.3 *http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf*) on the CMS Web site.

Hospitals report the occurrence of a no cost or full credit device to CMS by reporting modifier **FB** on the line with the procedure code in which the no cost or full credit device is used when the device is on the list of specified devices to which this policy applies. The lists of affected devices and APCs are located on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

Adjustment to Payment Under Hospital OPPS and ASC Payment System for Partial Device Credit (continued)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 626) requires implementation of a revised ASC payment system no later than January 1, 2008. The revised payment system to be implemented January 1, 2008, is based on the relative payment weights established under the OPPS and many of the payment policies of the OPPS, including the full device credit policy. A special edition *MLN Matters* article outlining the new ASC payment system is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf*.

Effective January 1, 2008, CMS is also implementing a partial device credit policy under both the OPPS and the ASC payment system.

Hospitals and ASCs report the occurrence of a partial credit device to CMS by reporting modifier **FC** on the line with the procedure code in which the partial credit device is used when the device is on the list of specified devices to which this policy applies. The devices, APCs, and covered ASC surgical procedures to which the partial device credit policy applies are the same as the devices, APCs, and covered ASC surgical procedures to which the full device credit policy applies (modifier **FB**).

For services furnished on or after January 1, 2008, hospitals and ASCs are required to report modifier **FC** with the procedure code for all cases in which:

- The device being implanted is on the list of creditable devices.
- The procedure code in which the device is used is assigned to an APC that is on the list of APCs to which the policy applies in the case of hospitals, or on the list of procedures to which the policy applies in the case of ASCs.
- The hospital or ASC received a credit of 50 percent or more of the estimated cost of the new replacement device.

The list of devices, APCs, and ASC procedures to which this policy applies is available on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

The reduction to the APC payment amount when the hospital reports a partial credit for the new replacement device is available on that web site as well. An ASC will receive the same amount of payment reduction (in dollars) as a hospital when it reports receiving a partial device credit for a particular procedure.

Remember that both hospitals and ASCs are required to report modifier the **FC** with the code for the device implantation procedure, not with the code for the device. Failure to include the proper modifiers on claims as appropriate may result in payment to which the provider is not entitled. If hospitals report the modifier with the device code instead of the procedure code, the claim will be returned.

Because hospitals may not know the amount of credit the manufacturer will provide for the replacement device when the replacement procedure takes place, hospitals will have the option of either: (1) submitting the claim for the device replacement procedure to their Medicare contractor immediately without modifier **FC** and then submitting a claim adjustment with modifier **FC** at a later date once a credit determination is made; or (2) holding the claim for the device replacement procedure until a determination is made by the manufacturer on the partial credit amount, and submitting the claim with modifier **FC** appended to the implantation procedure code if the partial credit is 50 percent or more of the cost of the replacement device.

ASCs have the same two billing options as outlined above for hospitals, but if an ASC chooses Option 1 and bills for a replacement device procedure prior to receiving a manufacturer's credit determination, it must subsequently contact the Medicare contractor regarding a claims adjustment if a credit of 50 percent or more is received.

When hospitals or ASCs use Option 1, they should be mindful that the initial Medicare payment for the procedure involving the replacement device is conditional and subject to adjustment.

Following are some hypothetical examples that illustrate the revised policy:

OPPS Examples (all payment amounts are hypothetical)

Example	*CPT/* **HCPCS**	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 1: Full Credit or No Cost Replacement Device	*33240* **FB**	*Implant ICD*	T	1	0107	$18,000	$17,000	$1,000
	C1721	ICD	N	1	==	---	---	---
	93005	*EKG*	S	1	0099	$24	---	$24
Because claim 1 is being billed as a full credit or no cost replacement device, it receives the full offset of $17,000.								
Claim 2: Partial Credit Replacement Device	*33240* **FC**	*Implant ICD*	T	1	0107	$18,000	$8,500 ($17,000 x 0.5)	$9,500 ($8,500 + $1,000)
	C1721	ICD	N	1	==	---	---	---
	93005	*EKG*	S	1	0099	$24	---	$24
Because claim 2 is being billed with a partial credit replacement device, the offset is half of the full offset value.								

Adjustment to Payment Under Hospital OPPS and ASC Payment System for Partial Device Credit (continued)

Example	*CPT*/ HCPCS	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 3: Multiple Procedure Discount and Partial Credit Replacement Device	*33240* **FC**	*Implant ICD*	T	1	0107	$18,000	$8,500 ($17,000 x 0.5)	$9,500 ($8,500 + $1,000)
	C1721	ICD	N	1	==	---	---	---
	93005	*EKG*	S	1	0099	$24	---	$24
	35180	*Fistula Repair*	T	1	0093	$1,500	---	$750 ($1,500 x 0.5)
Because claim 3 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0093 is discounted according to the multiple procedure discount rule. If the payment for APC 0093 were greater than the payment for APC 0107 after discount for the partial device credit, the multiple procedure discount would have been applied to further discount payment for APC 0107. The post-offset payment rate is used in discount determination, rather than the pre-offset payment rate.								
Claim 4: Terminated Procedure and Partial Credit Replacement Device	*33240* FC and 73	*Implant ICD*	T	1	0107	$18,000	$8,500 ($17,000 x 0.5)	$4,750 (($8,500 + $1,000) x 0.5)
	C1721	ICD	N	1	==	---	---	---
	93005	*EKG*	S	1	0099	$24	---	$24
Because claim 4 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0107 is discounted due to the presence of modifier 73, which identifies the service as being terminated prior to the administration of anesthesia or initiation of the procedure.								
Claim 5: FC Modifier on Partial Credit Replacement Device Line	*33240*	*Implant ICD*	T	1	0107	**I/OCE Edit #75:** Incorrect billing of modifier **FB** or **FC**		
	C1721 **FC**	ICD	N	1	==			
	93005	*EKG*	S	1	0099			
Because modifier FC is located on the line for the device, instead of the procedure used to implant the device, the claim is returned to the provider due to I/OCE edit #75.								

ASC Examples (All payment amounts are hypothetical)

Note: Payment for devices, with the exception of pass through devices, are packaged into payment for the device implantation procedure. In the below examples, the device is not shown as a separate line item on the ASC claim because, in order to ensure appropriate payment, ASCs should not report packaged devices as separate line items on the claim.

Example	*CPT*/ HCPCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
Claim 1: Full Credit or No Cost Replacement Device ASC implants ICD replacement device (procedure *33240*, device C1721) and receives full credit or incurs no cost for the replacement device.	*33240* **FB**	*Implant ICD*	J8	1	$17,500	$17,000	$500

Adjustment to Payment Under Hospital OPPS and ASC Payment System for Partial Device Credit (continued)

Example	*CPT/* HCPCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
Claim 2: Partial Credit Replacement Device ASC implants ICD replacement device (procedure *33240*, device C1721) and receives partial credit for the replacement device.	*33240* **FC**	*Implant ICD*	J8	1	$17,500	$8,500 ($17,000 x 0.5)	$9,000 ($8,500 + $500)
Claim 3: Multiple Procedure Discount and Partial Credit Replacement Device ASC implants ICD replacement device (procedure *33240*, device C1721) and receives partial credit for the replacement device. ASC also performs an additional procedure (*33218*), to which the multiple procedure discount applies.	*33240* **FC**	*Implant ICD*	J8	1	$17,500	$8,500 ($17,000 x 0.5)	$9,000 ($8,500 + $500)
	33218	*Electrode Repair*	G2	1	$1000	--	$500 ($1000 x 0.5)
Claim 4: Terminated Procedure and Partial Credit Replacement Device ASC brings patient into operating room to implant ICD (procedure *33240*, device C1721) and receives partial credit for the replacement device. ASC terminates the procedure prior to the administration of anesthesia or initiation of the procedure.	*33240* **FC and 73**	*Implant ICD*	J8	1	$17,500	$8,500 ($17,000 x .5)	$4,500 (($8,500 + $500) x 0.5)

Adjustment to Payment Under Hospital OPPS and ASC Payment System for Partial Device Credit (continued)

Example	*CPT*/ HCPCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
Claim 5: FC modifier on Partial Credit Replacement Device Line ASC implants ICD replacement device (procedure *33240*, device C1721) and receives partial credit for the replacement device.	*33240*	*Implant ICD*	J8	1	**Incorrect billing** because ASCs may not report device HCPCS codes or device charges on a separate line on the claim. Device payment is packaged into payment for the device implantation procedure, and charges for the device should be included in the line-item charge for the device implantation procedure. This bill will not result in accurate payment because there is no ASC payment rate for the device, and the payment for the implantation procedure will be made at the lesser of the ASC charges or the ASC rate.		
	C1721 **FC**	ICD	N1	1			
Claim 6: Partial Credit Replacement Device But FC Modifier Not Reported on Procedure Code ASC implants ICD replacement device (procedure *33240*, device C1721) and receives partial credit for the replacement device, but fails to append the FC modifier to the procedure code.	*33240*	*Implant ICD*	J8	1	**Incorrect billing** if partial credit is known at the time of billing. FC modifier should have been appended to the procedure code. If partial credit is unknown at the time of billing and the partial credit is received by the ASC at a later time, the ASC should contact the contractor to request an adjustment.		

Disclaimer: The above claim examples are hypothetical only and aim to reflect the pricing concepts, effective January 1, 2008. The rates above do not represent actual payment rates.

Additional Information

To view the official instruction (CR 5668) on which this article is based, providers may visit the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1383CP.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.

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Electronic Data Interchange

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

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

Impact on Providers

Change request (CR) 5800, from which this article is taken, announces the latest update of remittance advice remark codes used in electronic and paper remittance advice and claim adjustment reason codes used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective January 1, 2008. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

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

The lists at the end of this article summarize the latest changes to the remark code lists, as announced in CR 5800, effective on January 1, 2008. As a reminder, CMS notes that the claim adjustment reason code of A2 (Contractual adjustment) is deactivated effective January 1, 2008.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site, you can find some other information that is also available from the Washington Publishing Company (WPC) Web site. The new Web site address on the Internet is *http://www.cmsremarkcodes.info/*.

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

Additional Information

You may see the official instruction (CR 5800) issued to your Medicare carrier, A/B MAC, FI, DME MAC or RHHI on the CMS Web site by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1384CP.pdf*.

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

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

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

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Comment
N388	Missing/incomplete/invalid prescription number. **Note: (New Code 8/1/07)**	Medicare initiated
N389	Duplicate prescription number submitted. **Note: (New Code 8/1/07)**	Medicare initiated
N390	This service cannot be billed separately. **Note: (New Code 8/1/07)**	Medicare initiated
N391	Missing emergency department records. **Note: (New Code 8/1/07)**	Not Medicare initiated
N392	Incomplete/invalid emergency department records. **Note: (New Code 8/1/07)**	Not Medicare initiated
N393	Missing progress notes or report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N394	Incomplete/invalid progress notes or report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N395	Missing laboratory report. **Note: (New Code 8/1/07)**	Not Medicare initiated

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

Code	Current Narrative	Comment
N396	Incomplete/invalid laboratory report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N397	Benefits are not available for incomplete service(s)/undelivered item(s). **Note: (New Code 8/1/07)**	Not Medicare initiated
N398	Missing elective consent form. **Note: (New Code 8/1/07)**	Not Medicare initiated
N399	Incomplete/invalid elective consent form. **Note: (New Code 8/1/07)**	Not Medicare initiated
N400	Alert: Electronically enabled providers should submit claims electronically. **Note: (New Code 8/1/07)**	Not Medicare initiated
N401	Missing periodontal charting. **Note: (New Code 8/1/07)**	Not Medicare initiated
N402	Incomplete/invalid periodontal charting. **Note: (New Code 8/1/07)**	Not Medicare initiated
N403	Missing facility certification. **Note: (New Code 8/1/07)**	Not Medicare initiated
N404	Incomplete/invalid facility certification. **Note: (New Code 8/1/07)**	Not Medicare initiated
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service. **Note: (New Code 8/1/07)**	Not Medicare initiated
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service. **Note: (New Code 8/1/07)**	Not Medicare initiated
N407	You are not an approved submitter for this transmission format. **Note: (New Code 8/1/07)**	Medicare Initiated
N408	This payer does not cover deductibles assessed by a previous payer. **Note: (New Code 8/1/07)**	Not Medicare initiated
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. **Note: (New Code 8/1/07)**	Not Medicare initiated
N410	This is not covered unless the prescription changes. **Note: (New Code 8/1/07)**	Not Medicare initiated
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N418	Misrouted claim. See the payer's claim submission instructions. **Note: (New Code 8/1/07)**	Not Medicare initiated
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change. **Note: (New Code 8/1/07)**	Not Medicare initiated
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. **Note: (New Code 8/1/07)**	Not Medicare initiated
N421	Claim payment was the result of a payer's retroactive adjustment due to a Peer Review Organization decision. **Note: (New Code 8/1/07)**	Not Medicare initiated
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. **Note: (New Code 8/1/07)**	Not Medicare initiated

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

Code	Current Narrative	Comment
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program. **Note: (New Code 8/1/07)**	Not Medicare initiated
N424	Patient does not reside in the geographic area required for this type of payment. **Note: (New Code 8/1/07)**	Medicare initiated
N425	Statutorily excluded service(s). **Note: (New Code 8/1/07)**	Medicare initiated
N426	No coverage when self-administered. **Note: (New Code 8/1/07)**	Medicare initiated
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery. **Note: (New Code 8/1/07)**	Medicare initiated
N428	Service/procedure not covered when performed in this place of service. **Note: (New Code 8/1/07)**	Medicare initiated
N429	This is not covered since it is considered routine. **Note: (New Code 8/1/07)**	Medicare initiated

***Note:** Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Codes that are informational will have "Alert" in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment:

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

These informational codes will be used only if specific information needs to be communicated but not as default codes.

Modified Codes

Code	Current Modified Narrative	Comment
M27	Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07
M70	**Alert:** The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
MA14	**Alert:** The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
M62	**Alert:** This is a telephone review decision.	Modified 4/1/07, 8/1/07
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.)	Modified 8/1/07
N84	**Alert:** Further installment payments are forthcoming.	Modified 4/1/07, 8/1/07
N85	**Alert:** This is the final installment payment.	Modified 4/1/07, 8/1/07
N129	Not eligible due to the patient's age.	New Code 10/31/02, Modified 8/1/07

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Ambulance Service Fee Schedule

2008 Ambulance Fee Schedule

The following ambulance fee schedule (AFS) rates for 2007 based on localities are effective for services provided **on or after January 1, 2008.**

Medicare Part B coinsurance and deductible requirements apply to these services.

2008 Revised Ambulance Fee Schedule Rates

HCPCS Code	Loc 01/02	Loc 03	Loc 04
A0425	6.42	6.42	6.42
A0426	229.04	240.27	249.50
A0427	362.64	380.44	395.04
A0428	190.86	200.23	207.92
A0429	305.38	320.37	332.67
A0430	2,624.31	2,715.08	2,789.59
A0430*	3,936.46	4,072.62	4,184.39
A0431	3,051.13	3,156.67	3,243.31
A0431*	4,576.70	4,735.01	4,864.96
A0432	334.01	350.40	363.85
A0433	524.88	550.63	571.77
A0434	620.31	650.74	675.73

* Rural Rate

Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that service. ❖

Mammography Services

The following fee schedules are effective for mammography services furnished **on or after January 1, 2008.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that services.

Code/MOD	Loc 01/02	Loc 03	Loc 04
G0202 TC	95.33	103.13	110.46
G0204 TC	103.89	112.31	120.14
G0206 TC	82.99	89.76	96.12
77051 TC	11.27	12.22	13.13
77052 TC	11.27	12.22	13.13
77055 TC	46.94	51.14	55.38
77056 TC	60.00	65.27	70.53
77057 TC	47.51	51.89	56.41

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Oupatient Rehabilitation Services

The following fee schedules are effective for outpatient rehabilitation services furnished **on or after January 1, 2008.** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Code/MD	Loc. 01/02	Loc. 03	Loc. 04	O/P
G0101	34.21	35.85	37.46	1
G0102	19.13	20.23	21.26	1
G0128	3.95	4.18	4.50	1
G0281	10.94	11.43	11.96	0
G0283	10.94	11.43	11.96	0
G0329	7.82	8.39	8.98	0
64550	15.23	16.02	16.80	0
90804	61.01	62.88	64.82	1
90805	67.41	69.36	71.36	1
90806	86.50	88.78	91.18	1
90807	95.61	98.30	101.18	1
90808	127.79	131.07	134.56	1
90809	136.19	139.83	143.74	1
90810	65.01	67.06	69.27	1
90811	74.62	76.98	79.44	1
90812	93.85	96.42	99.05	1
90813	102.99	105.94	109.02	1
90814	134.43	137.94	141.62	1
90815	142.83	146.70	150.80	1
90845	79.58	81.53	83.66	1
90846	84.29	86.49	88.83	1
90847	104.94	107.84	110.88	1
90849	31.65	32.77	33.96	1
90853	29.65	30.50	31.32	1
90857	33.29	34.32	35.29	1
90901	34.83	36.62	38.36	0
92506	139.49	147.82	155.05	0
92507	60.41	63.76	66.77	0
92508	28.24	29.78	31.17	0
92526	79.01	83.64	87.70	0
92552	20.83	22.88	25.09	1
92553	28.74	31.64	34.81	1
92555	16.54	18.29	20.25	1
92556	22.67	25.14	27.96	1
92557	53.40	57.46	62.39	1
92561	28.74	31.64	34.81	1
92562	20.47	22.50	24.69	0
92563	18.68	20.58	22.67	1
92564	19.61	21.71	24.10	1
92565	14.05	15.61	17.43	1
92567	22.04	23.97	26.34	1
92568	20.74	22.07	23.70	1
92569	17.69	19.03	20.65	1
92571	16.90	18.67	20.65	1
92572	12.70	13.75	14.74	1
92575	27.19	29.41	31.50	1
92576	21.04	23.24	25.72	1
92577	21.46	23.98	26.97	1
92579	46.29	48.75	51.57	1
92582	37.31	40.82	44.49	1
92583	33.44	36.96	40.91	1
92584	80.43	89.14	99.06	1
92587	47.04	51.79	57.28	1
92587TC	40.50	44.94	50.05	1
9258726	6.54	6.85	7.24	1
92588	69.38	75.44	82.26	1
92588TC	51.63	57.15	63.40	1
9258826	17.75	18.29	18.86	1
92596	31.95	35.08	38.44	1
92597	96.31	101.55	106.25	0
92607	140.59	151.35	160.84	0
92608	28.53	31.27	34.19	0
92609	74.36	80.24	85.59	0
92610	96.25	104.26	111.89	0
92611	100.54	108.85	116.73	0
92612	146.99	155.02	162.13	0
92614	132.72	139.72	146.00	0
92616	183.68	193.14	201.70	0
94664	15.12	16.76	18.64	1
94667	21.75	24.01	26.52	1
94668	18.26	19.85	21.42	1
95831	25.43	26.71	27.89	0
95832	23.53	24.78	26.08	0
95833	36.02	37.76	39.46	0
95834	42.59	44.61	46.67	0
95851	16.96	17.93	18.87	0
95852	13.30	14.12	14.92	0
96105	71.23	78.86	87.50	0
96125	93.33	98.17	104.26	0
97001	68.19	70.88	73.75	0
97002	36.31	37.74	39.19	0
97003	73.04	76.22	79.62	0
97004	43.09	45.01	46.85	0
97012	13.94	14.48	15.06	0
97016	14.16	14.87	15.59	0
97018	7.11	7.62	8.18	0
97022	15.92	16.79	17.63	0
97024	4.97	5.33	5.76	0
97026	4.61	4.95	5.35	0
97028	6.09	6.47	6.92	0
97032	15.37	16.01	16.67	0
97033	22.17	23.27	24.31	0
97034	13.49	14.10	14.74	0
97035	10.99	11.43	11.92	0
97036	23.65	24.80	25.88	0
97110	26.72	27.82	28.99	0
97112	27.58	28.60	29.57	0
97113	31.84	33.19	34.44	0
97116	23.18	24.02	24.85	0
97124	21.30	22.12	22.92	0
97140	24.68	25.55	26.39	0
97150	16.85	17.54	18.24	0
97530	27.91	28.99	30.00	0
97532	22.92	23.63	24.35	0
97533	24.34	25.16	25.97	0
97535	28.29	29.37	30.38	0
97537	25.44	26.31	27.15	0
97542	25.79	26.69	27.56	0

Outpatient Rehabilitation Services (continued)

Code/MD	Loc. 01/02	Loc. 03	Loc. 04	O/P
97597	53.66	56.82	60.07	0
97598	66.25	69.79	73.35	0
97605	32.62	33.93	35.26	0
97606	35.45	36.96	38.60	0
97750	27.79	28.97	30.20	0
97755	32.07	33.15	34.30	0
97760	30.50	32.01	33.65	0
97761	27.08	28.20	29.39	0
97762	30.21	32.05	33.83	0

O/P Indicator
0 = Fee applicable in hospital outpatient setting
1 = Fee not applicable in hospital outpatient setting

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Surgical Dressing Services

The following fee schedules are effective for surgical dressing items furnished **on or after January 1, 2008.** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Code/MD	Fee
A4461	3.29
A4463	13.31
A6010	30.96
A6011	2.28
A6021	21.02
A6022	21.02
A6023	190.30
A6024	6.19
A6154	13.93
A6196	7.35
A6197	16.44
A6199	5.29
A6203	3.35
A6204	6.23
A6207	7.34
A6209	7.48
A6210	19.92
A6211	29.37
A6212	9.70
A6214	10.29
A6216	0.05
A6217	0.00
A6219	0.95
A6220	2.58
A6222	2.13
A6223	2.42
A6224	3.61
A6229	3.61
A6231	4.66
A6232	6.88
A6233	19.19
A6234	6.54
A6235	16.82
A6236	27.25
A6237	7.91
A6238	22.79
A6240	12.24
A6241	2.57
A6242	6.07
A6243	12.31
A6244	39.28
A6245	7.27
A6246	9.92
A6247	23.78
A6248	16.24
A6251	1.99
A6252	3.25
A6253	6.34
A6254	1.21
A6255	3.03
A6257	1.53
A6258	4.30
A6259	10.94
A6266	1.92
A6402	0.12
A6403	0.43
A6407	1.88
A6410	0.39
A6411	0.00
A6441	0.67
A6442	0.17
A6443	0.29
A6444	0.56
A6445	0.32
A6446	0.41
A6447	0.67
A6448	1.16
A6449	1.75
A6450	0.00
A6451	0.00
A6452	5.91
A6453	0.61
A6454	0.77
A6455	1.39
A6456	1.28
A6457	1.14
A6501	0.00
A6502	0.00
A6503	0.00
A6504	0.00
A6505	0.00
A6506	0.00
A6507	0.00
A6508	0.00
A6509	0.00
A6510	0.00
A6511	0.00
A6513	0.00
A6531AW	43.27
A6532AW	60.96

Orthotic/Prosthetic Devices

The following fee schedules are effective for orthotic and prosthetic devices furnished **on or after January 1, 2008.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that service.

Code/MD	Fee
A4216	0.43
A4217AU	3.13
A4280	5.33
A4310	6.56
A4311	12.61
A4312	18.04
A4313	15.74
A4314	21.50
A4315	22.43
A4316	24.14
A4320	5.33
A4321	0.00
A4322	2.82
A4326	10.79
A4327	42.27
A4328	9.86
A4330	7.15
A4331	3.18
A4332	0.12
A4333	2.20
A4334	4.93
A4338	12.26
A4340	31.75
A4344	16.02
A4346	19.59
A4349	2.02
A4351	1.81
A4352	5.46
A4353	6.99
A4354	10.03
A4355	7.57
A4356	45.63
A4357	9.70
A4358	6.63
A4361	18.37
A4362	3.39
A4363	2.36
A4364	2.62
A4365	11.32
A4366	1.30
A4367	7.35
A4368	0.26
A4369	2.42
A4371	3.65
A4372	4.18
A4373	6.28
A4375	17.18
A4376	47.58
A4377	4.29
A4378	30.75
A4379	15.02
A4380	37.33
A4381	4.61
A4382	24.62
A4383	28.19
A4384	9.62
A4385	5.10
A4387	0.00
A4388	4.36
A4389	6.22
A4390	9.61
A4391	7.07
A4392	8.18
A4393	9.04
A4394	2.58
A4395	0.05
A4396	40.48
A4397	4.13
A4398	13.81
A4399	12.26
A4400	41.54
A4402	1.42
A4404	1.69
A4405	3.40
A4406	5.74
A4407	8.76
A4408	9.87
A4409	6.22
A4410	9.04
A4411	5.10
A4412	2.70
A4413	5.50
A4414	4.93
A4415	6.00
A4416	2.75
A4417	3.72
A4418	1.81
A4419	1.74
A4420	0.00
A4422	0.12
A4423	1.86
A4424	4.75
A4425	3.58
A4426	2.73
A4427	2.78
A4428	6.51
A4429	8.25
A4430	8.52
A4431	6.22
A4432	3.59
A4433	3.34
A4434	3.76
A4450AU	0.09
A4450AV	0.09
A4450AW	0.11
A4452AU	0.36
A4452AV	0.36
A4452AW	0.40
A4455	1.22
A4481	0.37
A4483	0.00
A4561	20.59
A4562	51.18
A4623	6.55
A4625	6.93
A4626	2.71
A4629	4.63
A5051	2.07
A5052	1.49
A5053	1.68
A5054	1.79
A5055	1.44
A5061	3.52
A5062	2.09
A5063	2.70
A5071	6.01
A5072	2.99
A5073	2.74
A5081	3.30
A5082	10.11
A5083	0.00
A5093	1.95
A5102	22.58
A5105	34.65
A5112	34.62
A5113	4.70
A5114	8.06
A5120AU	0.25
A5120AW	0.24
A5121	6.34
A5122	12.85
A5126	1.12
A5131	13.48
A5200	11.29
A7040	40.68
A7041	76.43
A7042	181.58
A7043	28.92
A7501	105.03
A7502	49.91
A7503	11.33
A7504	0.67
A7505	4.68
A7506	0.33
A7507	2.49
A7508	2.87
A7509	1.41
A7520	47.48
A7521	47.05
A7522	45.16
A7524	77.40
A7525	2.07
A7526	3.37
A7527	3.58
L0112	1,213.49
L0120	24.26
L0130	175.40
L0140	60.52
L0150	100.93
L0160	143.70
L0170	608.11
L0172	123.30
L0174	221.50
L0180	301.25
L0190	453.47
L0200	416.39
L0210	43.23
L0220	98.75
L0430	1,206.00
L0450	163.03
L0452	0.00
L0454	300.70
L0456	862.32
L0458	773.24
L0460	870.34
L0462	1,082.56
L0464	1,288.77
L0466	331.39
L0468	415.48
L0470	591.54
L0472	371.30
L0480	1,148.15
L0482	1,316.20
L0484	1,534.67
L0486	1,520.27
L0488	870.34
L0490	245.26
L0491	665.86
L0492	431.54
L0621	77.30
L0622	209.63
L0623	0.00
L0624	0.00
L0625	47.78
L0626	67.59
L0627	356.40
L0628	72.72
L0629	0.00
L0630	140.40
L0631	890.05
L0632	0.00
L0633	248.62
L0634	0.00
L0635	921.96
L0636	1,360.40
L0637	1,180.33
L0638	1,143.51
L0639	1,180.33
L0640	907.25
L0700	1,866.71
L0710	2,037.64
L0810	2,164.68
L0820	1,751.14
L0830	2,528.45
L0859	982.29
L0861	186.88
L0970	92.15
L0972	94.20
L0974	192.48
L0976	171.90
L0978	155.21
L0980	14.08
L0982	15.34
L0984	48.96
L1000	1,637.03
L1001	0.00
L1005	2,775.02
L1010	65.92
L1020	90.07
L1025	102.37
L1030	68.39
L1040	82.32
L1050	71.28
L1060	80.40
L1070	82.19
L1080	56.96
L1085	158.23
L1090	73.91
L1100	130.48
L1110	220.99
L1120	35.21
L1200	1,401.29
L1210	210.98
L1220	178.63
L1230	458.35
L1240	78.88
L1250	77.67
L1260	79.81
L1270	79.71
L1280	71.06
L1290	80.57
L1300	1,346.91
L1310	1,385.97
L1500	1,531.58
L1510	968.95

Orthotic/Prosthetic Devices (continued)

Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees
L1520	2,301.41	L2034	1,780.25	L2492	82.22	L3330	490.68	L3808	263.56
L1600	103.90	L2035	150.20	L2500	254.37	L3332	63.95	L3900	1,232.65
L1610	35.40	L2036	1,495.99	L2510	681.07	L3334	33.08	L3901	1,382.13
L1620	116.57	L2037	1,378.64	L2520	371.45	L3340	73.90	L3904	2,813.63
L1630	139.10	L2038	1,152.83	L2525	1,274.39	L3350	19.83	L3905	782.50
L1640	372.06	L2040	147.25	L2526	686.90	L3360	30.87	L3906	332.87
L1650	197.30	L2050	392.16	L2530	189.45	L3370	43.01	L3908	47.28
L1652	309.07	L2060	503.31	L2540	340.90	L3380	43.01	L3909	11.16
L1660	137.99	L2070	144.58	L2550	231.58	L3390	43.01	L3911	19.57
L1680	1,134.49	L2080	308.33	L2570	512.08	L3400	35.30	L3912	75.84
L1685	1,197.07	L2090	380.06	L2580	485.42	L3410	80.51	L3913	213.71
L1686	803.08	L2106	548.23	L2600	165.60	L3420	47.40	L3915	419.45
L1690	1,676.60	L2108	861.52	L2610	195.82	L3430	138.94	L3917	83.35
L1700	1,394.82	L2112	409.06	L2620	215.59	L3440	66.16	L3919	213.71
L1710	1,639.53	L2114	468.02	L2622	247.27	L3450	91.50	L3921	253.44
L1720	1,211.12	L2116	616.63	L2624	336.15	L3455	35.30	L3923	68.64
L1730	913.77	L2126	1,097.12	L2627	1,384.92	L3460	29.75	L3925	41.69
L1755	1,330.00	L2128	1,382.63	L2628	1,626.85	L3465	50.71	L3927	0.00
L1800	71.52	L2132	650.44	L2630	199.66	L3470	54.02	L3929	66.43
L1810	104.97	L2134	779.86	L2640	270.97	L3480	54.02	L3931	160.69
L1815	96.20	L2136	953.56	L2650	96.76	L3500	25.38	L3933	168.37
L1820	104.55	L2180	94.43	L2660	150.28	L3510	25.38	L3935	174.33
L1825	46.61	L2182	73.90	L2670	137.54	L3520	27.57	L3956	0.00
L1830	87.46	L2184	133.18	L2680	126.18	L3530	27.57	L3960	650.41
L1831	255.17	L2186	147.57	L2750	67.40	L3540	44.12	L3961	1,325.72
L1832	653.62	L2188	321.98	L2755	113.31	L3550	7.73	L3962	677.22
L1834	768.97	L2190	83.63	L2760	48.99	L3560	19.83	L3967	1,565.22
L1836	115.68	L2192	287.50	L2768	112.99	L3570	73.90	L3971	1,485.73
L1840	808.32	L2200	38.34	L2770	49.79	L3580	56.23	L3973	1,565.22
L1843	777.94	L2210	62.22	L2780	57.95	L3590	46.31	L3975	1,325.72
L1844	1,347.99	L2220	71.43	L2785	34.07	L3595	36.38	L3976	1,325.72
L1845	812.10	L2230	61.87	L2795	68.51	L3600	66.16	L3977	1,485.73
L1846	1,030.41	L2232	83.76	L2800	86.01	L3610	87.11	L3978	1,565.22
L1847	498.69	L2240	67.43	L2810	62.98	L3620	66.16	L3980	243.93
L1850	232.09	L2250	286.51	L2820	70.02	L3630	87.11	L3982	301.37
L1860	900.20	L2260	161.64	L2830	78.74	L3640	37.48	L3984	321.69
L1900	243.87	L2265	94.95	L2840	43.94	L3650	47.23	L3995	27.00
L1901	15.34	L2270	43.30	L2850	49.93	L3651	51.95	L4000	1,051.88
L1902	66.23	L2275	105.36	L3000	272.36	L3652	156.59	L4002	0.00
L1904	379.17	L2280	391.43	L3001	114.66	L3660	81.10	L4010	591.93
L1906	110.80	L2300	220.95	L3002	140.03	L3670	113.04	L4020	739.38
L1907	487.87	L2310	99.19	L3003	151.06	L3671	710.98	L4030	407.10
L1910	215.63	L2320	165.90	L3010	151.06	L3672	884.18	L4040	329.14
L1920	281.89	L2330	316.61	L3020	172.02	L3673	963.66	L4045	264.50
L1930	190.75	L2335	186.26	L3030	66.16	L3675	138.48	L4050	332.89
L1932	773.68	L2340	439.51	L3031	0.00	L3700	55.08	L4055	215.55
L1940	431.06	L2350	718.47	L3040	40.80	L3701	16.07	L4060	256.25
L1945	791.61	L2360	41.72	L3050	40.80	L3702	227.84	L4070	244.49
L1950	600.59	L2370	206.99	L3060	63.95	L3710	114.40	L4080	86.19
L1951	728.14	L2375	91.11	L3070	27.57	L3720	570.76	L4090	76.29
L1960	446.94	L2380	99.27	L3080	27.57	L3730	751.34	L4100	86.04
L1970	661.04	L2385	108.00	L3090	35.30	L3740	844.38	L4110	68.38
L1971	406.39	L2387	146.57	L3100	37.48	L3760	394.60	L4130	470.61
L1980	295.93	L2390	88.26	L3140	77.19	L3762	84.85	L4350	84.79
L1990	380.22	L2395	134.76	L3150	70.57	L3763	626.48	L4360	237.21
L2000	817.84	L2397	94.50	L3170	44.12	L3764	624.78	L4370	152.22
L2005	3,552.80	L2405	75.60	L3224	47.41	L3765	1,011.77	L4380	93.33
L2010	745.54	L2415	105.32	L3225	54.54	L3766	1,071.40	L4386	137.47
L2020	941.50	L2425	124.27	L3300	45.20	L3806	358.43	L4392	20.42
L2030	816.84	L2430	124.27	L3310	70.57	L3807	197.30	L4394	14.90

Orthotic/Prosthetic Devices (continued)

Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees	Code/MD	Fees
L4396	145.52	L5636	218.89	L5714	386.45	L5993	0.00	L6645	344.79
L4398	66.96	L5637	248.17	L5716	626.10	L5994	0.00	L6646	2,739.90
L5000	454.62	L5638	432.30	L5718	782.56	L5995	0.00	L6647	451.06
L5010	1,098.00	L5639	963.13	L5722	826.75	L6000	1,141.39	L6648	2,825.81
L5020	1,864.68	L5640	549.30	L5724	1,296.64	L6010	1,270.18	L6650	357.98
L5050	2,062.68	L5642	532.23	L5726	1,494.35	L6020	1,184.25	L6655	70.36
L5060	2,372.67	L5643	1,337.04	L5728	2,044.07	L6025	6,951.73	L6660	78.85
L5100	2,067.23	L5644	507.38	L5780	983.52	L6050	1,631.84	L6665	39.56
L5105	2,984.25	L5645	685.42	L5781	3,475.86	L6055	2,274.37	L6670	43.74
L5150	3,016.67	L5646	470.67	L5782	3,664.35	L6100	1,653.31	L6672	173.59
L5160	3,281.17	L5647	683.33	L5785	552.85	L6110	1,753.61	L6675	103.16
L5200	3,142.19	L5648	565.57	L5790	617.67	L6120	2,043.59	L6676	119.26
L5210	2,084.52	L5649	2,049.37	L5795	1,229.79	L6130	2,223.80	L6677	257.73
L5220	2,369.44	L5650	419.37	L5810	418.23	L6200	2,343.53	L6680	199.31
L5230	3,267.93	L5651	1,031.63	L5811	626.51	L6205	3,128.24	L6682	220.36
L5250	4,457.16	L5652	374.52	L5812	485.61	L6250	2,455.47	L6684	299.44
L5270	4,437.38	L5653	499.95	L5814	3,226.28	L6300	3,200.45	L6686	676.20
L5280	4,403.40	L5654	284.89	L5816	734.95	L6310	2,763.44	L6687	495.50
L5301	2,362.96	L5655	241.43	L5818	824.95	L6320	1,509.62	L6688	492.52
L5311	3,382.42	L5656	323.88	L5822	1,462.86	L6350	3,364.78	L6689	590.09
L5321	3,425.18	L5658	312.34	L5824	1,317.39	L6360	3,026.10	L6690	643.03
L5331	4,364.37	L5661	522.76	L5826	2,712.88	L6370	1,810.72	L6691	297.63
L5341	4,543.32	L5665	439.85	L5828	2,425.86	L6380	1,049.27	L6692	480.40
L5400	1,169.87	L5666	60.13	L5830	1,630.05	L6382	1,578.59	L6693	2,466.25
L5410	358.92	L5668	96.99	L5840	3,013.97	L6384	2,183.80	L6694	610.82
L5420	1,433.64	L5670	233.10	L5845	1,557.06	L6386	344.98	L6695	509.00
L5430	432.28	L5671	493.96	L5848	934.12	L6388	377.65	L6696	1,142.70
L5450	351.68	L5672	256.15	L5850	109.89	L6400	1,993.31	L6697	1,142.70
L5460	468.53	L5673	610.82	L5855	295.29	L6450	2,663.01	L6698	493.96
L5500	1,103.29	L5676	311.29	L5856	20,854.11	L6500	2,786.06	L6703	312.30
L5505	1,525.88	L5677	423.55	L5857	7,399.79	L6550	3,348.89	L6704	503.08
L5510	1,250.65	L5678	34.11	L5858	16,145.13	L6570	3,759.90	L6706	299.74
L5520	1,235.34	L5679	509.00	L5910	311.12	L6580	1,435.45	L6707	1,104.78
L5530	1,483.76	L5680	284.72	L5920	455.79	L6582	1,300.13	L6708	722.23
L5535	1,456.76	L5681	1,142.70	L5925	384.85	L6584	2,038.93	L6709	1,040.75
L5540	1,554.82	L5682	537.23	L5930	2,923.97	L6586	1,908.11	L6805	292.27
L5560	1,669.61	L5683	1,142.70	L5940	430.90	L6588	2,507.23	L6810	165.67
L5570	1,735.81	L5684	41.34	L5950	673.75	L6590	2,381.49	L6881	3,551.48
L5580	2,026.43	L5685	1,11.27	L5960	828.15	L6600	161.14	L6882	2,693.99
L5585	2,493.85	L5686	43.88	L5962	545.01	L6605	159.10	L6883	1,363.19
L5590	2,065.07	L5688	52.47	L5964	804.51	L6610	152.79	L6884	2,023.25
L5595	3,648.23	L5690	84.06	L5966	1,025.14	L6611	357.66	L6885	3,026.10
L5600	3,921.67	L5692	114.15	L5968	3,156.83	L6615	164.64	L6890	146.11
L5610	1,778.54	L5694	155.84	L5970	174.46	L6616	61.00	L6895	537.50
L5611	1,384.06	L5695	143.87	L5971	174.46	L6620	263.40	L6900	1,533.90
L5613	2,163.92	L5696	158.94	L5972	325.88	L6621	1,986.98	L6905	1,525.18
L5614	1,465.91	L5697	68.96	L5974	200.18	L6623	734.72	L6910	1,304.19
L5616	1,169.37	L5698	112.77	L5975	402.74	L6624	3,271.63	L6915	657.55
L5617	486.05	L5699	203.14	L5976	481.08	L6625	522.04	L6920	5,732.98
L5618	257.13	L5700	2,461.30	L5978	250.69	L6628	411.52	L6925	7,717.58
L5620	238.83	L5701	2,955.84	L5979	1,960.12	L6629	125.68	L6930	5,768.53
L5622	311.42	L5702	3,739.58	L5980	3,185.06	L6630	185.14	L6935	7,837.35
L5624	312.31	L5703	1,935.27	L5981	2,573.09	L6632	64.30	L6940	7,536.96
L5626	409.58	L5704	460.45	L5982	496.62	L6635	151.30	L6945	9,209.27
L5628	437.94	L5705	822.74	L5984	489.37	L6637	322.73	L6950	8,566.82
L5629	273.00	L5706	806.51	L5985	245.30	L6638	2,172.41	L6955	10,259.93
L5630	385.53	L5707	1,063.26	L5986	544.36	L6639	1,324.93	L6960	11,621.94
L5631	377.44	L5710	321.27	L5987	6,249.28	L6640	286.70	L6965	12,395.22
L5632	210.66	L5711	449.00	L5988	1,735.41	L6641	137.81	L6970	12,916.03
L5634	261.31	L5712	376.23	L5990	1,576.02	L6642	186.80	L6975	14,125.98

Orthotic/Prosthetic Devices (continued)

Code/MD	Fees
L7007	2,956.00
L7008	4,652.44
L7009	3,016.06
L7040	2,421.78
L7045	1,388.49
L7170	6,393.11
L7180	28,062.26
L7181	34,807.47
L7185	6,313.29
L7186	7,598.66
L7190	6,631.10
L7191	7,940.15
L7260	1,690.60
L7261	3,077.55
L7266	1,134.02
L7272	1,963.79
L7274	4,933.96
L7360	204.98
L7362	215.22
L7364	342.31
L7366	461.10
L7367	338.20
L7368	438.43
L7400	266.26
L7401	298.07
L7402	321.87
L7403	319.93
L7404	482.82
L7405	631.46
L7611	0.00
L7612	0.00
L7613	0.00
L7614	0.00
L7621	0.00
L7622	0.00
L7900	470.15
L8000	37.79
L8001	108.95
L8002	143.33
L8015	52.07
L8020	195.85
L8030	283.29
L8035	3,182.62
L8040	2,099.82
L8040KM	1,994.83
L8040KN	839.93
L8041	2,530.93
L8041KM	2,404.37
L8041KN	1,012.37
L8042	2,843.73
L8042KM	2,701.55
L8042KN	1,137.48
L8043	3,184.99
L8043KM	3,025.72
L8043KN	1,273.99
L8044	3,526.23
L8044KM	3,349.93
L8044KN	1,410.50
L8045	2,208.22
L8045KM	2,097.80
L8045KN	883.29
L8046	2,274.99
L8046KM	2,161.24
L8046KN	909.98
L8047	1,165.92
L8047KM	1,107.63
L8047KN	466.37
L8300	83.66
L8310	128.64
L8320	56.20
L8330	55.70
L8400	16.28
L8410	18.52
L8415	18.41
L8417	65.32
L8420	21.53
L8430	23.67
L8435	21.25
L8440	45.04
L8460	62.68
L8465	55.87
L8470	5.74
L8480	7.90
L8485	9.55
L8500	5,66.93
L8501	1,25.91
L8507	36.39
L8509	94.88
L8510	219.52
L8511	63.19
L8512	1.90
L8513	4.52
L8514	81.93
L8515	54.83
L8600	536.42
L8603	376.73
L8606	197.76
L8609	5,660.03
L8610	550.24
L8612	580.34
L8613	259.83
L8614	16,446.04
L8615	391.80
L8616	91.26
L8617	79.71
L8618	22.76
L8619	7,054.74
L8621	0.53
L8622	0.29
L8623	56.20
L8624	140.06
L8630	289.41
L8631	1,942.28
L8641	314.11
L8642	257.84
L8658	269.47
L8659	1,676.32
L8670	478.18
L8680	399.03
L8681	981.19
L8682	5,178.96
L8683	4,558.65
L8684	598.65
L8685	11,359.92
L8686	7,248.56
L8687	14,783.80
L8688	9,433.27
L8689	1,498.46
L8690	4,132.59
L8691	2,316.45
L8695	14.48
Q0480	7,8239.88
Q0481	12,623.10
Q0482	3,953.79
Q0483	16,287.84
Q0484	3,163.05
Q0485	305.39
Q0486	254.17
Q0487	296.54
Q0489	14,120.67
Q0490	610.79
Q0491	960.21
Q0492	77.38
Q0493	220.26
Q0494	186.39
Q0495	3,628.69
Q0496	1,302.40
Q0497	406.68
Q0498	446.22
Q0499	144.97
Q0500	26.52
Q0501	443.65
Q0502	564.81
Q0503	1,129.65
Q0504	596.08
V2020	69.24
V2100	33.65
V2101	35.45
V2102	50.29
V2103	29.22
V2104	32.35
V2105	39.61
V2106	40.20
V2107	42.26
V2108	40.99
V2109	47.11
V2110	54.99
V2111	48.47
V2112	47.83
V2113	66.08
V2114	58.45
V2115	63.55
V2118	63.00
V2121	65.04
V2200	44.04
V2201	48.00
V2202	56.49
V2203	44.43
V2204	48.18
V2205	52.86
V2206	64.35
V2207	53.72
V2208	54.37
V2209	59.81
V2210	76.95
V2211	65.62
V2212	71.41
V2213	73.23
V2214	78.49
V2215	84.93
V2218	86.89
V2219	38.25
V2220	31.02
V2221	82.88
V2300	57.19
V2301	66.32
V2302	72.67
V2303	60.19
V2304	63.00
V2305	77.25
V2306	72.04
V2307	71.43
V2308	76.22
V2309	89.16
V2310	98.08
V2311	93.41
V2312	82.34
V2313	112.38
V2314	123.10
V2315	136.67
V2318	126.01
V2319	42.66
V2320	45.00
V2321	134.71
V2410	77.03
V2430	100.29
V2500	69.82
V2501	106.35
V2502	131.02
V2503	125.35
V2510	95.32
V2511	136.95
V2512	161.83
V2513	135.86
V2520	89.59
V2521	155.98
V2522	151.79
V2523	129.36
V2530	191.59
V2531	470.36
V2623	771.11
V2624	52.29
V2625	338.73
V2626	214.90
V2627	1,230.37
V2628	281.31
V2700	37.63
V2710	55.08
V2715	9.99
V2718	24.53
V2730	18.12
V2744	18.79
V2745	10.66
V2750	21.86
V2755	15.80
V2760	13.76
V2762	51.79
V2770	17.77
V2780	14.35
V2782	55.91
V2783	63.07
V2784	41.01
V2786	0.00

Clinical Laboratory Services

The following fee schedules are effective for clinical laboratory services furnished **on or after January 1, 2008.** Payment for clinical laboratory codes is based on CMS national clinical laboratory fee schedule. Hospital laboratory services are reimbursed at the "60 percent" rate except for "sole community hospitals," which are reimbursed at the "62 percent" rate. Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Code/MD	60%	62%
ATP02	7.28	7.52
ATP03	9.29	9.60
ATP04	9.80	10.13
ATP05	10.93	11.29
ATP06	10.96	11.33
ATP07	11.42	11.80
ATP08	11.83	12.22
ATP09	12.13	12.53
ATP10	12.13	12.53
ATP11	12.34	12.75
ATP12	12.62	13.04
ATP16	14.77	15.26
ATP18	14.87	15.37
ATP19	15.45	15.97
ATP20	15.95	16.48
ATP21	16.45	17.00
ATP22	16.95	17.52
ATP23	16.95	17.52
G0027	9.09	9.39
G0103	25.70	26.56
G0123	28.21	29.15
G0143	28.21	29.15
G0144	29.39	30.37
G0145	34.70	35.86
G0147	14.76	14.76
G0148	14.76	14.76
G0306	10.86	11.22
G0307	9.04	9.34
G0328	22.22	22.96
G0328QW	22.22	22.96
G0394	4.54	4.69
P2038	7.02	7.25
P3000	14.76	14.76
P9612	3.00	3.00
P9615	3.00	3.00
Q0111	5.96	6.16
Q0112	5.96	6.16
Q0113	7.56	7.81
Q0114	9.99	10.32
Q0115	13.83	14.29
36415	3.00	3.00
78267	10.98	11.35
78268	94.11	97.25
80047	30.51	31.53
80048	11.83	12.22
80051	9.80	10.13
80053	14.77	15.26
80061	18.72	19.34
80061QW	18.72	19.34
80069	12.13	12.53
80074	66.54	68.76
80076	11.42	11.80
80100	20.32	21.00
80101	19.24	19.88
80101QW	19.24	19.88
80102	18.51	19.13
80150	21.06	21.76
80152	25.01	25.84
80154	25.84	26.70
80156	20.34	21.02
80157	18.52	19.14
80158	24.31	25.12
80160	24.05	24.85
80162	18.55	19.17
80164	18.93	19.56
80166	21.66	22.38
80168	22.83	23.59
80170	22.90	23.66
80172	22.76	23.52
80173	20.34	21.02
80174	24.05	24.85
80176	16.26	16.80
80178	9.24	9.55
80178QW	9.24	9.55
80182	18.93	19.56
80184	16.01	16.54
80185	18.52	19.14
80186	19.23	19.87
80188	23.18	23.95
80190	23.41	24.19
80192	23.41	24.19
80194	20.39	21.07
80195	19.17	19.81
80196	9.92	10.25
80197	19.17	19.81
80198	19.77	20.43
80200	22.52	23.27
80201	16.66	17.22
80202	18.93	19.56
80299	19.13	19.77
80400	45.56	47.08
80402	121.46	125.51
80406	109.34	112.98
80408	175.34	181.18
80410	112.23	115.97
80412	460.50	475.85
80414	72.16	74.57
80415	78.08	80.68
80416	184.38	190.53
80417	61.46	63.51
80418	809.76	836.75
80420	100.64	103.99
80422	64.38	66.53
80424	66.56	68.78
80426	207.40	214.31
80428	93.16	96.27
80430	109.60	113.25
80432	177.43	183.34
80434	141.30	146.01
80435	143.85	148.65
80436	127.36	131.61
80438	70.41	72.76
80439	93.88	97.01
80440	81.24	83.95
81000	4.43	4.58
81001	4.43	4.58
81002	3.57	3.69
81003	3.14	3.24
81003QW	3.14	3.24
81005	3.03	3.13
81007	3.59	3.71
81007QW	3.59	3.71
81015	4.02	4.15
81020	5.15	5.32
81025	8.84	9.13
81050	4.19	4.33
82000	17.31	17.89
82003	28.28	29.22
82009	6.31	6.52
82010	9.99	10.32
82010QW	9.99	10.32
82013	15.61	16.13
82016	19.37	20.02
82017	23.57	24.36
82024	53.97	55.77
82030	18.08	18.68
82040	5.73	5.92
82042	2.46	2.54
82043	2.46	2.54
82044	6.39	6.60
82044QW	6.39	6.60
82045	47.43	49.01
82055	15.10	15.60
82055QW	15.10	15.60
82075	16.84	17.40
82085	13.56	14.01
82088	56.94	58.84
82101	41.94	43.34
82103	18.77	19.40
82104	20.20	20.87
82105	23.44	24.22
82106	23.44	24.22
82107	89.99	92.99

Clinical Laboratory Services (continued)

Code/MD	60%	62%
82108	35.60	36.79
82120	4.02	4.15
82120QW	4.02	4.15
82127	19.37	20.02
82128	19.37	20.02
82131	23.57	24.36
82135	23.00	23.77
82136	23.57	24.36
82139	23.57	24.36
82140	20.36	21.04
82143	9.61	9.93
82145	21.72	22.44
82150	9.06	9.36
82154	40.29	41.63
82157	40.90	42.26
82160	34.94	36.10
82163	28.68	29.64
82164	20.39	21.07
82172	19.80	20.46
82175	26.51	27.39
82180	13.81	14.27
82190	17.08	17.65
82205	16.01	16.54
82232	22.61	23.36
82239	23.94	24.74
82240	24.31	25.12
82247	7.02	7.25
82248	7.02	7.25
82252	2.73	2.82
82261	23.57	24.36
82270	4.54	4.69
82271	4.54	4.69
82271QW	4.54	4.69
82272	4.54	4.69
82272QW	4.54	4.69
82274	22.22	22.96
82274QW	22.22	22.96
82286	9.62	9.94
82300	13.25	13.69
82306	41.36	42.74
82307	45.02	46.52
82308	37.41	38.66
82310	7.20	7.44
82310QW	7.20	7.44
82330	19.09	19.73
82331	7.23	7.47
82340	8.43	8.71
82355	16.17	16.71
82360	12.22	12.63
82365	17.30	17.88
82370	17.51	18.09
82373	24.35	25.16
82374	6.83	7.06
82375	17.22	17.79
82376	7.94	8.20
82378	26.51	27.39
82379	23.57	24.36
82380	12.89	13.32
82382	24.02	24.82
82383	35.01	36.18
82384	33.28	34.39
82387	29.07	30.04
82390	15.01	15.51
82397	19.74	20.40
82415	17.70	18.29
82435	6.42	6.63
82436	4.55	4.70
82438	6.83	7.06
82441	8.38	8.66
82465	6.08	6.28
82465QW	6.08	6.28
82480	9.93	10.26
82482	8.31	8.59
82485	20.02	20.69
82486	24.35	25.16
82487	20.02	20.69
82488	20.02	20.69
82489	20.02	20.69
82491	24.35	25.16
82492	24.35	25.16
82495	28.34	29.28
82507	38.85	40.15
82520	21.17	21.88
82523	26.11	26.98
82523QW	26.11	26.98
82525	17.34	17.92
82528	31.45	32.50
82530	23.35	24.13
82533	22.78	23.54
82540	6.48	6.70
82541	24.35	25.16
82542	24.35	25.16
82543	24.35	25.16
82544	24.35	25.16
82550	9.10	9.40
82552	18.71	19.33
82553	13.00	13.43
82554	13.00	13.43
82565	7.16	7.40
82565QW	7.16	7.40
82570	7.23	7.47
82570QW	7.23	7.47
82575	13.20	13.64
82585	11.98	12.38
82595	9.04	9.34
82600	27.11	28.01
82607	21.06	21.76
82608	20.01	20.68
82610	19.00	19.63
82615	11.41	11.79
82626	35.31	36.49
82627	31.07	32.11
82633	43.28	44.72
82634	40.90	42.26
82638	17.11	17.68
82646	27.81	28.74
82649	35.91	37.11
82651	36.07	37.27
82652	53.78	55.57
82654	19.11	19.75
82656	16.12	16.66
82657	24.35	25.16
82658	24.35	25.16
82664	48.00	49.60
82666	30.01	31.01
82668	26.26	27.14
82670	39.04	40.34
82671	45.13	46.63
82672	30.30	31.31
82677	33.79	34.92
82679	34.88	36.04
82679QW	34.88	36.04
82690	21.99	22.72
82693	13.75	14.21
82696	32.95	34.05
82705	7.11	7.35
82710	22.12	22.86
82715	24.05	24.85
82725	12.08	12.48
82726	24.35	25.16
82728	19.03	19.66
82731	89.99	92.99
82735	12.62	13.04
82742	27.66	28.58
82746	20.54	21.22
82747	4.30	4.44
82757	16.89	17.45
82759	30.01	31.01
82760	15.64	16.16
82775	29.43	30.41
82776	11.71	12.10
82784	12.99	13.42
82785	23.01	23.78
82787	4.36	4.51
82800	4.88	5.04
82803	27.04	27.94
82805	39.65	40.97
82810	12.20	12.61
82820	13.96	14.43
82926	7.61	7.86
82928	7.32	7.56
82938	24.72	25.54
82941	24.64	25.46
82943	19.97	20.64
82945	5.48	5.66
82946	21.06	21.76
82947	5.48	5.66
82947QW	5.48	5.66
82948	4.43	4.58
82950	6.64	6.86
82950QW	6.64	6.86
82951	17.99	18.59
82951QW	17.99	18.59
82952	5.48	5.66
82952QW	5.48	5.66
82953	6.63	6.85
82955	13.55	14.00
82960	8.12	8.39
82962	3.27	3.38
82963	30.01	31.01

Clinical Laboratory Services (continued)

Code/MD	60%	62%
82965	7.28	7.52
82975	22.13	22.87
82977	10.06	10.40
82978	19.91	20.57
82979	9.62	9.94
82980	24.31	25.12
82985	21.06	21.76
82985QW	21.06	21.76
83001	25.97	26.84
83001QW	25.97	26.84
83002	25.88	26.74
83002QW	25.88	26.74
83003	23.29	24.07
83008	23.45	24.23
83009	94.11	97.25
83010	17.58	18.17
83012	24.02	24.82
83013	94.11	97.25
83014	10.98	11.35
83015	26.31	27.19
83018	30.68	31.70
83020	17.99	18.59
83021	24.35	25.16
83026	3.30	3.41
83030	11.56	11.95
83033	6.50	6.72
83036	13.56	14.01
83036QW	13.56	14.01
83037	21.06	21.76
83037QW	21.06	21.76
83045	4.88	5.04
83050	5.86	6.06
83051	10.21	10.55
83055	6.87	7.10
83060	8.12	8.39
83065	6.00	6.20
83068	11.83	12.22
83069	5.51	5.69
83070	6.64	6.86
83071	9.61	9.93
83080	23.57	24.36
83088	41.26	42.64
83090	23.57	24.36
83150	17.30	17.88
83491	24.47	25.29
83497	18.01	18.61
83498	37.95	39.22
83499	35.22	36.39
83500	31.65	32.71
83505	33.96	35.09
83516	16.12	16.66
83518	11.85	12.25
83518QW	11.85	12.25
83519	18.88	19.51
83520	18.09	18.69
83525	15.98	16.51
83527	18.09	18.69
83528	22.22	22.96
83540	9.05	9.35
83550	12.21	12.62
83570	12.36	12.77
83582	19.80	20.46
83586	17.89	18.49
83593	36.75	37.98
83605	14.92	15.42
83605QW	14.92	15.42
83615	8.44	8.72
83625	17.88	18.48
83630	27.42	28.33
83631	27.42	28.33
83632	28.24	29.18
83633	7.69	7.95
83634	11.17	11.54
83655	16.91	17.47
83655QW	16.91	17.47
83661	27.56	28.48
83662	26.43	27.31
83663	26.43	27.31
83664	26.43	27.31
83670	12.80	13.23
83690	9.62	9.94
83695	18.09	18.69
83698	47.43	49.01
83700	15.73	16.25
83701	17.30	17.88
83704	29.52	30.50
83718	11.44	11.82
83718QW	11.44	11.82
83719	16.26	16.80
83721	13.33	13.77
83721QW	13.33	13.77
83727	24.02	24.82
83735	9.36	9.67
83775	10.30	10.64
83785	34.36	35.51
83788	24.35	25.16
83789	24.35	25.16
83805	24.63	25.45
83825	22.72	23.48
83835	23.67	24.46
83840	22.81	23.57
83857	15.01	15.51
83858	18.72	19.34
83864	27.82	28.75
83866	13.76	14.22
83872	8.19	8.46
83873	24.04	24.84
83874	18.04	18.64
83880	47.43	49.01
83880QW	47.43	49.01
83883	19.00	19.63
83885	7.94	8.20
83887	33.09	34.19
83890	3.56	3.68
83891	3.56	3.68
83892	3.56	3.68
83893	3.56	3.68
83894	3.56	3.68
83896	3.56	3.68
83897	3.56	3.68
83898	23.42	24.20
83900	46.84	48.40
83901	23.42	24.20
83902	15.17	15.68
83903	23.42	24.20
83904	23.42	24.20
83905	23.42	24.20
83906	23.42	24.20
83907	18.66	19.28
83908	23.42	24.20
83909	23.42	24.20
83912	3.56	3.68
83913	18.66	19.28
83914	23.42	24.20
83915	15.58	16.10
83916	27.42	28.33
83918	21.19	21.90
83919	21.19	21.90
83921	21.19	21.90
83925	27.19	28.10
83930	9.24	9.55
83935	9.52	9.84
83937	28.73	29.69
83945	17.99	18.59
83950	89.99	92.99
83970	57.67	59.59
83986	5.00	5.17
83986QW	5.00	5.17
83992	20.54	21.22
83993	27.42	28.33
84022	21.76	22.49
84030	7.69	7.95
84035	5.11	5.28
84060	10.32	10.66
84061	11.06	11.43
84066	13.50	13.95
84075	7.23	7.47
84078	10.20	10.54
84080	20.66	21.35
84081	23.09	23.86
84085	9.42	9.73
84087	11.31	11.69
84100	6.63	6.85
84105	6.50	6.72
84106	5.99	6.19
84110	11.80	12.19
84119	12.03	12.43
84120	20.55	21.24
84126	35.59	36.78
84127	16.28	16.82
84132	6.42	6.63
84133	6.01	6.21
84134	20.38	21.06
84135	26.73	27.62
84138	26.46	27.34
84140	23.53	24.31
84143	31.89	32.95
84144	29.15	30.12
84146	27.08	27.98
84150	34.88	36.04

Clinical Laboratory Services (continued)

Code/MD	60%	62%
84152	25.70	26.56
84153	25.70	26.56
84154	25.70	26.56
84155	5.12	5.29
84156	5.12	5.29
84157	5.12	5.29
84160	7.23	7.47
84163	21.03	21.73
84165	15.01	15.51
84166	24.92	25.75
84181	23.80	24.59
84182	25.15	25.99
84202	10.67	11.03
84203	10.67	11.03
84206	18.72	19.34
84207	26.00	26.87
84210	15.17	15.68
84220	7.28	7.52
84228	7.94	8.20
84233	89.99	92.99
84234	90.64	93.66
84235	73.12	75.56
84238	51.09	52.79
84244	30.73	31.75
84252	17.81	18.40
84255	35.67	36.86
84260	21.19	21.90
84270	11.17	11.54
84275	10.28	10.62
84285	32.90	34.00
84295	6.72	6.94
84300	6.79	7.02
84302	6.79	7.02
84305	27.55	28.47
84307	21.61	22.33
84311	9.77	10.10
84315	3.50	3.62
84375	12.22	12.63
84376	7.69	7.95
84377	7.69	7.95
84378	11.17	11.54
84379	11.17	11.54
84392	6.64	6.86
84402	35.57	36.76
84403	36.08	37.28
84425	12.22	12.63
84430	16.26	16.80
84432	22.44	23.19
84436	9.61	9.93
84437	7.94	8.20
84439	12.60	13.02
84442	20.66	21.35
84443	23.47	24.25
84443QW	23.47	24.25
84445	24.31	25.12
84446	19.81	20.47
84449	21.05	21.75
84450	7.22	7.46
84450QW	7.22	7.46
84460	7.40	7.65
84460QW	7.40	7.65
84466	17.84	18.43
84478	8.04	8.31
84478QW	8.04	8.31
84479	9.04	9.34
84480	19.81	20.47
84481	21.97	22.70
84482	21.97	22.70
84484	13.75	14.21
84485	10.01	10.34
84488	10.01	10.34
84490	10.01	10.34
84510	12.22	12.63
84512	7.58	7.83
84520	5.51	5.69
84525	4.02	4.15
84540	6.64	6.86
84545	9.23	9.54
84550	6.31	6.52
84560	6.64	6.86
84577	17.43	18.01
84578	4.54	4.69
84580	9.92	10.25
84583	7.02	7.25
84585	21.66	22.38
84586	26.81	27.70
84588	47.43	49.01
84590	16.20	16.74
84591	16.20	16.74
84597	9.77	10.10
84600	22.45	23.20
84620	16.55	17.10
84630	15.91	16.44
84681	26.81	27.70
84702	21.03	21.73
84703	10.49	10.84
84703QW	10.49	10.84
84704	21.03	21.73
84830	14.02	14.49
85002	6.29	6.50
85004	9.04	9.34
85007	4.81	4.97
85008	4.81	4.97
85009	5.19	5.36
85013	3.31	3.42
85014	3.31	3.42
85014QW	3.31	3.42
85018	3.31	3.42
85018QW	3.31	3.42
85025	10.86	11.22
85027	9.04	9.34
85032	6.01	6.21
85041	4.20	4.34
85044	6.01	6.21
85045	5.59	5.78
85046	7.80	8.06
85048	3.55	3.67
85049	6.25	6.46
85055	5.86	6.06
85130	16.62	17.17
85170	5.05	5.22
85175	6.35	6.56
85210	8.12	8.39
85220	24.66	25.48
85230	25.02	25.85
85240	25.02	25.85
85244	28.53	29.48
85245	32.06	33.13
85246	32.06	33.13
85247	32.06	33.13
85250	26.60	27.49
85260	25.02	25.85
85270	25.02	25.85
85280	27.04	27.94
85290	22.83	23.59
85291	12.42	12.83
85292	7.28	7.52
85293	7.28	7.52
85300	8.12	8.39
85301	15.11	15.61
85302	16.80	17.36
85303	19.32	19.96
85305	16.20	16.74
85306	21.41	22.12
85307	21.41	22.12
85335	17.99	18.59
85337	14.56	15.05
85345	6.01	6.21
85347	5.95	6.15
85348	5.20	5.37
85360	11.17	11.54
85362	9.62	9.94
85366	12.03	12.43
85370	14.83	15.32
85378	9.97	10.30
85379	14.22	14.69
85380	14.22	14.69
85384	11.87	12.27
85385	11.87	12.27
85390	6.63	6.85
85400	12.36	12.77
85410	10.77	11.13
85415	13.25	13.69
85420	9.13	9.43
85421	14.23	14.70
85441	5.88	6.08
85445	9.52	9.84
85460	10.81	11.17
85461	9.26	9.57
85475	12.40	12.81
85520	13.25	13.69
85525	13.25	13.69
85530	13.25	13.69
85536	9.04	9.34
85540	12.02	12.42
85547	12.02	12.42
85549	26.21	27.08
85555	9.34	9.65
85557	18.66	19.28
85576	30.01	31.01

Clinical Laboratory Services (continued)

Code/MD	60%	62%
85576QW	30.01	31.01
85597	25.12	25.96
85610	5.49	5.67
85610QW	5.49	5.67
85611	5.51	5.69
85612	13.37	13.82
85613	13.37	13.82
85635	13.76	14.22
85651	4.96	5.13
85652	3.77	3.90
85660	7.71	7.97
85670	8.07	8.34
85675	6.50	6.72
85705	11.17	11.54
85730	8.38	8.66
85732	9.04	9.34
85810	16.32	16.86
86000	9.75	10.08
86001	7.30	7.54
86003	7.30	7.54
86005	11.14	11.51
86021	21.03	21.73
86022	25.66	26.52
86023	17.40	17.98
86038	16.89	17.45
86039	15.60	16.12
86060	10.20	10.54
86063	8.07	8.34
86140	7.23	7.47
86141	18.09	18.69
86146	23.12	23.89
86147	23.12	23.89
86148	22.44	23.19
86155	22.33	23.07
86156	9.36	9.67
86157	11.27	11.65
86160	16.78	17.34
86161	16.78	17.34
86162	28.39	29.34
86171	14.00	14.47
86185	12.50	12.92
86200	18.09	18.69
86215	18.51	19.13
86225	19.20	19.84
86226	16.92	17.48
86235	25.06	25.90
86243	28.68	29.64
86255	16.84	17.40
86256	16.84	17.40
86277	21.99	22.72
86280	11.44	11.82
86294	27.41	28.32
86294QW	27.41	28.32
86300	28.50	29.45
86301	28.50	29.45
86304	28.50	29.45
86308	7.23	7.47
86308QW	7.23	7.47
86309	9.04	9.34
86310	10.30	10.64
86316	28.50	29.45
86317	20.95	21.65
86318	18.09	18.69
86318QW	18.09	18.69
86320	31.32	32.36
86325	31.24	32.28
86327	31.70	32.76
86329	19.62	20.27
86331	16.75	17.31
86332	34.05	35.19
86334	31.21	32.25
86335	41.00	42.37
86336	21.77	22.50
86337	29.92	30.92
86340	21.06	21.76
86341	27.65	28.57
86343	17.41	17.99
86344	11.16	11.53
86353	68.49	70.77
86355	52.70	54.46
86356	5.86	6.06
86357	52.70	54.46
86359	52.70	54.46
86360	9.77	10.10
86361	5.86	6.06
86367	52.70	54.46
86376	20.33	21.01
86378	27.51	28.43
86382	23.62	24.41
86384	15.91	16.44
86403	14.24	14.71
86406	14.87	15.37
86430	7.93	8.19
86431	7.93	8.19
86480	86.59	89.48
86590	12.22	12.63
86592	5.96	6.16
86593	6.16	6.37
86602	8.11	8.38
86603	17.98	18.58
86606	21.03	21.73
86609	18.00	18.60
86611	8.11	8.38
86612	18.03	18.63
86615	18.43	19.04
86617	21.64	22.36
86618	21.05	21.75
86618QW	21.05	21.75
86619	18.69	19.31
86622	12.48	12.90
86625	18.33	18.94
86628	11.31	11.69
86631	16.52	17.07
86632	17.74	18.33
86635	16.03	16.56
86638	16.94	17.50
86641	15.86	16.39
86644	20.11	20.78
86645	23.54	24.32
86648	21.25	21.96
86651	18.43	19.04
86652	18.43	19.04
86653	18.43	19.04
86654	18.43	19.04
86658	18.20	18.81
86663	18.33	18.94
86664	21.38	22.09
86665	25.35	26.20
86666	8.11	8.38
86668	14.53	15.01
86671	17.13	17.70
86674	19.64	20.29
86677	20.28	20.96
86682	18.17	18.78
86684	22.14	22.88
86687	11.72	12.11
86688	19.57	20.22
86689	27.05	27.95
86692	23.98	24.78
86694	20.11	20.78
86695	18.43	19.04
86696	27.05	27.95
86698	17.46	18.04
86701	12.41	12.82
86701QW	12.41	12.82
86702	18.88	19.51
86703	19.17	19.81
86703QW	19.17	19.81
86704	16.84	17.40
86705	16.44	16.99
86706	15.01	15.51
86707	16.16	16.70
86708	17.31	17.89
86709	15.73	16.25
86710	18.94	19.57
86713	21.39	22.10
86717	17.12	17.69
86720	18.43	19.04
86723	18.43	19.04
86727	17.98	18.58
86729	16.69	17.25
86732	18.43	19.04
86735	18.23	18.84
86738	18.51	19.13
86741	18.43	19.04
86744	18.43	19.04
86747	21.00	21.70
86750	13.00	13.43
86753	17.32	17.90
86756	18.01	18.61
86757	27.05	27.95
86759	18.43	19.04
86762	20.11	20.78
86765	18.00	18.60
86768	16.26	16.80
86771	18.33	18.94
86774	20.68	21.37
86777	20.11	20.78
86778	20.12	20.79
86781	18.50	19.12

Clinical Laboratory Services (continued)

Code/MD	60%	62%
86784	11.31	11.69
86787	18.00	18.60
86788	23.54	24.32
86789	20.11	20.78
86790	18.00	18.60
86793	18.33	18.94
86800	22.22	22.96
86803	19.94	20.60
86804	21.64	22.36
86805	73.05	75.49
86806	66.49	68.71
86807	55.29	57.13
86808	41.47	42.85
86812	36.06	37.26
86813	81.02	83.72
86816	38.92	40.22
86817	89.95	92.95
86821	78.88	81.51
86822	51.07	52.77
86880	7.50	7.75
86885	7.99	8.26
86886	7.23	7.47
86900	4.17	4.31
86901	4.17	4.31
86903	8.46	8.74
86904	13.28	13.72
86905	5.34	5.52
86906	10.83	11.19
86940	11.46	11.84
86941	13.27	13.71
87001	18.47	19.09
87003	23.52	24.30
87015	9.33	9.64
87040	14.42	14.90
87045	13.18	13.62
87046	13.18	13.62
87070	12.03	12.43
87071	13.18	13.62
87073	13.18	13.62
87075	13.22	13.66
87076	11.29	11.67
87077	11.29	11.67
87077QW	11.29	11.67
87081	9.26	9.57
87084	12.03	12.43
87086	11.28	11.66
87088	11.31	11.69
87101	10.77	11.13
87102	11.74	12.13
87103	12.60	13.02
87106	14.42	14.90
87107	14.42	14.90
87109	21.50	22.22
87110	23.73	24.52
87116	15.10	15.60
87118	15.29	15.80
87140	7.79	8.05
87143	17.51	18.09
87147	7.23	7.47
87149	17.79	18.38
87152	7.31	7.55
87158	7.31	7.55
87164	15.01	15.51
87166	15.78	16.31
87168	5.96	6.16
87169	5.96	6.16
87172	5.96	6.16
87176	8.22	8.49
87177	12.43	12.84
87181	1.17	1.21
87184	9.63	9.95
87185	1.17	1.21
87186	12.08	12.48
87187	14.48	14.96
87188	8.12	8.39
87190	7.90	8.16
87197	20.99	21.69
87205	5.96	6.16
87206	7.50	7.75
87207	8.37	8.65
87209	25.11	25.95
87210	5.96	6.16
87210QW	5.96	6.16
87220	5.96	6.16
87230	27.59	28.51
87250	27.32	28.23
87252	36.42	37.63
87253	28.22	29.16
87254	27.32	28.23
87255	47.31	48.89
87260	16.76	17.32
87265	16.76	17.32
87267	16.76	17.32
87269	16.76	17.32
87270	16.76	17.32
87271	16.76	17.32
87272	16.76	17.32
87273	16.76	17.32
87274	16.76	17.32
87275	16.76	17.32
87276	16.76	17.32
87277	16.76	17.32
87278	16.76	17.32
87279	16.76	17.32
87280	16.76	17.32
87281	16.76	17.32
87283	16.76	17.32
87285	16.76	17.32
87290	16.76	17.32
87299	16.76	17.32
87300	16.76	17.32
87301	16.76	17.32
87305	16.76	17.32
87320	16.76	17.32
87324	16.76	17.32
87327	16.76	17.32
87328	16.76	17.32
87329	16.76	17.32
87332	16.76	17.32
87335	16.76	17.32
87336	16.76	17.32
87337	16.76	17.32
87338	17.19	17.76
87339	16.76	17.32
87340	14.43	14.91
87341	14.43	14.91
87350	16.10	16.64
87380	22.94	23.70
87385	16.76	17.32
87390	15.61	16.13
87391	15.61	16.13
87400	16.76	17.32
87420	16.76	17.32
87425	16.76	17.32
87427	16.76	17.32
87430	16.76	17.32
87449	16.76	17.32
87449QW	16.76	17.32
87450	13.39	13.84
87451	13.39	13.84
87470	17.79	18.38
87471	41.65	43.04
87472	59.85	61.85
87475	17.79	18.38
87476	41.65	43.04
87477	59.85	61.85
87480	17.79	18.38
87481	41.65	43.04
87482	58.33	60.27
87485	17.79	18.38
87486	41.65	43.04
87487	59.85	61.85
87490	17.79	18.38
87491	41.65	43.04
87492	48.84	50.47
87495	17.79	18.38
87496	41.65	43.04
87497	59.85	61.85
87498	41.65	43.04
87500	41.65	43.04
87510	17.79	18.38
87511	41.65	43.04
87512	58.33	60.27
87515	17.79	18.38
87516	41.65	43.04
87517	59.85	61.85
87520	17.79	18.38
87521	41.65	43.04
87522	59.85	61.85
87525	17.79	18.38
87526	41.65	43.04
87527	58.33	60.27
87528	17.79	18.38
87529	41.65	43.04
87530	59.85	61.85
87531	17.79	18.38
87532	41.65	43.04
87533	58.33	60.27
87534	17.79	18.38
87535	41.65	43.04

Clinical Laboratory Services (continued)

Code/MD	60%	62%
87536	98.47	101.75
87537	17.79	18.38
87538	41.65	43.04
87539	59.85	61.85
87540	17.79	18.38
87541	41.65	43.04
87542	58.33	60.27
87550	17.79	18.38
87551	41.65	43.04
87552	59.85	61.85
87555	17.79	18.38
87556	41.65	43.04
87557	59.85	61.85
87560	17.79	18.38
87561	41.65	43.04
87562	59.85	61.85
87580	17.79	18.38
87581	41.65	43.04
87582	58.33	60.27
87590	17.79	18.38
87591	41.65	43.04
87592	59.85	61.85
87620	17.79	18.38
87621	41.65	43.04
87622	58.33	60.27
87640	41.65	43.04
87641	41.65	43.04
87650	17.79	18.38
87651	41.65	43.04
87652	58.33	60.27
87653	41.65	43.04
87660	17.79	18.38
87797	17.79	18.38
87798	41.65	43.04
87799	59.85	61.85
87800	35.58	36.77
87801	83.30	86.08
87802	16.76	17.32
87803	16.76	17.32
87804	16.76	17.32
87804QW	16.76	17.32
87807	16.76	17.32
87807QW	16.76	17.32
87808	16.76	17.32
87809	16.76	17.32
87810	16.76	17.32
87850	16.76	17.32
87880	16.76	17.32
87880QW	16.76	17.32
87899	16.76	17.32
87899QW	16.76	17.32
87900	182.11	188.18
87901	359.69	371.68
87902	359.69	371.68
87903	682.72	705.48
87904	36.42	37.63
88130	21.02	21.72
88140	11.17	11.54
88142	28.21	29.15
88143	28.21	29.15
88147	14.76	14.76
88148	14.76	14.76
88150	14.76	14.76
88152	14.76	14.76
88153	14.76	14.76
88154	14.76	14.76
88155	8.37	8.65
88164	14.76	14.76
88165	14.76	14.76
88166	14.76	14.76
88167	14.76	14.76
88174	29.39	30.37
88175	34.70	35.86
88230	162.77	168.20
88233	196.63	203.18
88235	205.74	212.60
88237	176.47	182.35
88239	206.12	212.99
88240	14.11	14.58
88241	14.11	14.58
88245	190.23	196.57
88248	241.96	250.03
88249	241.96	250.03
88261	246.93	255.16
88262	174.14	179.94
88263	190.23	196.57
88264	174.14	179.94
88267	251.17	259.54
88269	190.23	196.57
88271	20.22	20.89
88272	35.39	36.57
88273	44.89	46.39
88274	48.63	50.25
88275	56.11	57.98
88280	35.07	36.24
88283	95.84	99.03
88285	26.54	27.42
88289	40.56	41.91
88371	31.05	32.09
88372	31.79	32.85
88400	7.02	7.25
89050	6.61	6.83
89051	7.70	7.96
89055	5.96	6.16
89060	9.99	10.32
89125	6.03	6.23
89160	5.15	5.32
89190	6.64	6.86
89225	4.67	4.83
89235	7.69	7.95
89300	12.45	12.87
89300QW	12.45	12.87
89310	12.03	12.43
89320	16.84	17.40
89321	16.84	17.40
89321QW	16.84	17.40
89322	21.65	22.37
89325	14.91	15.41
89329	29.30	30.28
89330	13.83	14.29
89331	27.37	28.28

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EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

January 2008 – March 2008

Hot Topics: Medicare Updates – Type of Event: Teleconference/Webcast

When: **Tuesday, January 15, 2008**

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

Medicare Final Rule for 2008 – Type of Event: Webcast

When: **Tuesday, January 22, 2008**

Time: **1:00 p.m. – 3:00 p.m. Eastern Standard Time**

Ask the Contractor: Recovery Audit Contractor (RAC) – Type of Event: Teleconference/Webcast

When: **Tuesday, February 12, 2008**

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

Type of Event: **Teleconference/Webcast**

Hot Topics: Medicare Updates – Type of Event: Teleconference/Webcast

When: **Tuesday, March 11, 2008**

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

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: ____________________

E-mail 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.fcso.com* or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

Preventive Services

Medicare Provides Coverage for Many Preventive Services and Screenings

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for Medicare-covered preventive services and screenings provided to Medicare beneficiaries.

Provider Action Needed

This article conveys no new Medicare policy but serves as a reminder of the many preventive services and screenings now covered by Medicare and provides a list of related provider educational resources developed by the Centers for Medicare & Medicaid Services (CMS) to inform FFS health care professionals and their staff about the preventive services and screenings now covered by Medicare. CMS needs your help in spreading the word about preventive health care and ensuring that people with Medicare take full advantage of preventive benefits covered by Medicare that are appropriate for them.

- Keep this special edition *MLN Matters* article and refer to it often.
- Order appropriate provider resources for yourself and your staff.
- Talk with your Medicare patients about their risk factors for disease and benefits of preventive health care, and encourage utilization of appropriate preventive services covered by Medicare for which they may be eligible.

Introduction

Heart disease, stroke, cancer, diabetes, osteoporosis, influenza, pneumonia, and other chronic diseases have a significant impact on the health and well-being of seniors in the United States. Yet the reality is, many of these diseases can be prevented and complications can be reduced. Medicare now provides coverage for a full range of preventive services and screenings that can help seniors and other people with Medicare stay healthy, detect disease early, and manage conditions to reduce complications. Preventive services and screenings now covered by Medicare include:

Medicare Provides Coverage for the Following Preventive Services and Screenings (subject to certain eligibility and other limitations)

- Adult Immunizations
  - Influenza (flu)
  - Pneumococcal
  - Hepatitis B
- Bone Mass Measurements
- Cancer Screenings
  - Breast (mammogram and clinical breast exam)
  - Cervical & Vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular Disease Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Diabetes Supplies
- Medical Nutrition Therapy (beneficiaries diagnosed with diabetes or renal disease)
- Glaucoma Screening
- Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling Services
- Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)

Help in Spreading the Word

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about potentially life saving preventive services and screenings. While Medicare now helps to pay for more preventive benefits than ever before, many Medicare beneficiaries are not yet taking full advantage of them, leaving significant gaps in their preventive health program. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. As a health care professional, you can help your patients with Medicare understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life.

CMS hopes that you will join with us in spreading the word about preventive health care by educating your patients about their risk for disease. Talk with them about the importance of preventive health care, early detection, and the preventive services covered by Medicare that are right for them, and encourage utilization of these benefits when appropriate. As people with Medicare increase their knowledge of their risk for disease and understand the benefits of early detection and disease prevention, they will be better prepared to take full advantage of the preventive benefits covered by Medicare.

Medicare Provides Coverage for Many Preventive Services and Screenings (continued)

Educational Products and Informational Resources for Health Care Professionals

As a trusted source, a physician's recommendation is one of the most important factors in increasing the use of preventive services and screenings by people with Medicare. However, we know the discussion can be complicated. Therefore, CMS has developed a variety of educational products to:

1) Help increase your awareness of Medicare's coverage of disease prevention and early detection.
2) Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible.
3) Give you resources to help you effectively file claims for these services.

These provider education products may be ordered, free of charge, from the CMS *Medicare Learning Network* (*MLN*). All print products are available as downloadable PDF files and may be viewed online, reprinted, and redistributed as needed. Some print products may only be available as a downloadable PDF file. To order *MLN* products, visit the *MLN* Product Ordering page on the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

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

Bookmark

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

Brochures

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals – This series of seven tri-fold brochures provides an overview of Medicare's coverage of preventive services and screenings. Available in print and as downloadable PDF files.

- **Adult Immunizations** – (influenza, pneumococcal, and hepatitis B) available at *http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization.pdf*.
- **Bone Mass Measurements** – available at *http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass.pdf*.
- **Cancer Screenings** – (colorectal, prostate, and breast cancer screenings, and pap tests and pelvic examinations) available at *http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf*.
- **Diabetes-Related Services** – (diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other covered services for beneficiaries with diabetes) available at *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.
- **Expanded Benefits** – (initial preventive physical examination (IPPE), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests) available at *http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf*.
- **Glaucoma Screening** available at *http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf*.
- **Smoking and Tobacco** – Use Cessation Counseling Services available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf* .

Guide

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, 2nd Edition – This updated comprehensive guide, available at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf,* for Medicare FFS providers/suppliers and their staff provides information on coverage, coding, billing, and reimbursement guidelines for preventive services and screenings covered by Medicare. Available as a downloadable PDF file.

Quick Reference Information Charts

Medicare Preventive Services – This two-sided laminated chart, available at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf,* gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifies coding requirements, eligibility, frequency parameters, and co-payment/coinsurance and deductible information for each benefit. Available in print or as a downloadable PDF file.

Medicare Immunization Billing – This two-sided laminated chart at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf* 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.

The ABCs of Providing the Initial Preventive Physical Examination – This two-sided laminated chart at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf* may be used by Medicare FFS physicians and qualified nonphysician practitioners as a

Medicare Provides Coverage for Many Preventive Services and Screenings (continued)

guide when providing the initial preventive physical examination (IPPE). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information. Available in print and as a downloadable PDF file.

Video Program

An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – This educational video program provides health care professionals and their staff with an overview of preventive services and screenings covered by Medicare. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered, free of charge, through the *MLN* Product Ordering web page on the CMS Web site at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.

Web-Based Training Courses

Medicare Preventive Services Series Web-Based Training (WBT) Course – This series of three WBT courses has been designed to help fee-for-services providers/suppliers and their staff understand Medicare's coverage and billing guidelines for preventive services and screenings covered by Medicare. (To register, to take these WBT courses, free of charge, visit the *MLN* Product Ordering Page - http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.

- ***Medicare Preventive Services Series: Part 1 Adult Immunizations Web-Based Training (WBT) Course*** – This WBT course contains four learning modules that provide information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Information is also included about mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion.
- ***Medicare Preventive Services Series: Part 2 Women's Health Web-Based Training (WBT) Course*** – This WBT course contains five learning modules that provide information about Medicare's coverage of mammography services, pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements. This course was updated October 2007 and has been approved for .2 IACET* CEUs for successful completion.
- ***Medicare Preventive Services Series: Part 3 Expanded Benefits Web-Based Training (WBT) Course*** – This WBT course contains seven learning modules that provide information about Medicare's coverage and billing guidelines for the three services added to the Medicare program in 2005, as a result of the Medicare Modernization Act of 2003: the initial preventive physical exam (a.k.a. "Welcome to Medicare" physical exam), and diabetes and cardiovascular disease screenings. The course also includes information about diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as detailed information on colorectal, prostate, and glaucoma screenings, and bone mass measurement services. This course was updated November 2007 and has been approved for .2 IACET* CEUs for successful completion.

Web Page

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/suppliers. PDF files provide product ordering information and links to all downloadable products. This Web page is updated as new product information becomes available. Bookmark this page for easy access on the CMS Web site http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage.

Other Useful Provider Resources

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.

CMS Prevention Web Pages – CMS has created preventive services Web pages. For additional information, visit http://www.cms.hhs.gov/home/medicare.asp and scroll down to the "Prevention" section.

Preventive Benefit Information for Medicare Beneficiaries – For literature to share with your Medicare patients, please visit http://www.medicare.gov. Medicare beneficiaries can also obtain information about Medicare preventive benefits at this Web site or they may call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

*The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and Web-based training course were developed without any commercial support.

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Effective Date: N/A
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Source: CMS Special Edition *MLN Matters* Article SE0752

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Medicare Diabetes Coverage

American Diabetes Month is just over, but the importance of talking with your Medicare patients about the seriousness of diabetes, their risk factors for the disease, and the importance of early detection and treatment remains, as millions of people in the United States are living with diabetes and don't know it. Together, we can make a difference in the lives of people with Medicare by encouraging eligible beneficiaries to take advantage of the diabetes screening services covered by Medicare. And we can help those already diagnosed with diabetes manage their condition by recommending diabetes self-management training and medical nutrition therapy services, also covered by Medicare.

To Learn More

Health care providers and their staff can learn more about Medicare's coverage of diabetes screening tests, supplies and other services for beneficiaries with diabetes, including coding, billing, and reimbursement details, by referring to the following provider education resources:

- The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- Diabetes-Related Services brochure *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.
- National Diabetes Education Program (NDEP) *http://ndep.nih.gov/*.
- Educational literature for beneficiaries *http://www.medicare.gov*.

Thank you for helping the Centers for Medicare & Medicaid Services spread the word about the importance of diabetes education and the benefits covered by Medicare for the early detection and treatment of diabetes. ❖

Source: CMS Provider Education Resource 200711-23

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.

December Flu Shot Reminder

It's seasonal flu time again! If you have Medicare patients who haven't yet received their flu shot, you can help them reduce their risk of contracting the seasonal flu and potential complications by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – 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 but the influenza vaccine is not a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing special edition *MLN Matters* article SE0748 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf*. ❖

Source: CMS Provider Education Resource 200712-01

Medicare Provides Coverage for Many Preventive Services and Screenings

The Centers for Medicare & Medicaid Services (CMS) has released the special edition *MLN Matters* article SE0752 *Medicare Provides Coverage for Many Preventive Services and Screenings*, located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0752.pdf*.

This article serves as a reminder of the many preventive services and screenings now covered by Medicare and provides a list of related provider educational resources developed by CMS to inform fee-for-service health care professionals and their staff about the preventive services and screenings now covered by Medicare. ❖

Source: CMS Provider Education Resource 200712-12

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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.

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

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

*** ATTENTION BILLING MANAGER ***